Help-seeking & mental health in the Northwest of Ireland:

Exploring the experiences, impact and outcomes

for young people aged 16-25 years

by

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Abstract

Youth suicide and mental health is an important issue of global concern and one that requires timely and evidence-based interventions to prevent deaths and increase quality of life. Young people are described in the wider literature as reluctant to seek help and there is a lack of qualitative research examining why. This research examined mental health and help-seeking with young people aged 16-25 years (*N*=18) who were experienced service users and practitioners employed to provide mental health support (*N*=6). Data were analysed using Constructivist Grounded Theory methods by Charmaz (2014). The findings were presented in two parts; Part A has four categories from young people's data and include: 1. *"Young people's lives";* 2. *"Managing mental health problems";* 3. "*The help";* and 4. *"Impact and outcomes of their experiences".* Part B identified two categories from practitioners' data: 1. "*On being a helper*" and 2. "*Understanding of young people".* The key findings described young people's contexts and their help-seeking journeys with regard to their cultural and historical context. Research insights contributed to theory development regarding help-seeking behaviour as well as a new conceptual model of youth help-seeking behaviour for mental health problems, which includes the embedded role of informal networks. Critical discussion into young people's needs in mental health care was provided including developmentally appropriate approaches, up to the age of 25 years. This study concluded that current youth mental health care provision does not meet young people's needs and that provision needs to be reformed in partnership with young people, and with consideration given to appropriate design and interagency collaboration. Reform can contribute to earlier and meaningful interventions, improved quality of life and the reduction of youth death by suicide.

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1. Introduction

1.1. Young people, suicide, and mental health

Suicide is the third leading cause of death globally among people aged 15–29 years with 90 percent of all youth suicide occurring within low to middle income countries (World Health Organisation, 2021b). In the United Kingdom (UK), suicide rates increased for all groups of young people in 2018 and across the UK and Ireland 759 young people took their own life (Samaritans, 2020). On the island of Ireland, people in the age range 15-24 years are at a high risk of suicide (ONS, 2019; Samaritans 2019) and in Northern Ireland, young men aged 25-29 years of age have the highest suicide rate across the general population (Samaritans, 2020). Statistics from the Republic of Ireland are produced by the Central Statistics Office (CSO) and interpreting these numbers can be difficult as they are not always up to date, with the most recent years being provisional due to the impact of the COVID-19 pandemic (NOSP, 2021). However, between 2005 and 2020 trends in youth suicide rates (15-24 years) have generally decreased, from 16.1 to 7.8 per 100,000 (NOSP, 2021). When analysed for sex differences, suicide rates with young men have been halved, but are still nearly double that of young women. Rates of suicide in young woman have fluctuated throughout the last 15 years, with 2018 rates as high as those in 2007 (NOSP, 2021). These statistics do not provide detailed demographic information and so it is important to consider that young people who identify as LGBTI+ have three times the attempted suicide rate as non-LGBTI+ youth, and that 21% of those surveyed in a national study had attempted suicide in the previous year (Higgins et al., 2016). According to a recent report by TUSLA, the Irish government agency providing state care services, almost 25 per cent of young people in care, or who were known to child protection services, who died over the last decade, died as a result of suicide (TUSLA, 2020). It is worth noting that in 2012, Ireland had the third highest youth suicide rate in Europe and while improvements in rates are encouraging, the extent to which young people are affected by suicidal ideation are not well understood.

The World Health Organisation (2021b) states that mental health problems are a primary determinant of suicide in youth and that these conditions are a leading cause of disability in young people. In high-income countries there is an established link between mental health problems and suicide (Bilsen, 2018; WHO, 2021b) and that unaddressed mental health problems can last into adulthood and result in a lower quality of life, stigma and educational difficulties (Pompili, 2003; WHO, 2021a). Accurate statistics regarding the prevalence of

mental health problems in youth is unknown with the WHO (2021a) estimating that 10-20 percent of young people experience mental health conditions and that the majority of these are underdiagnosed and undertreated. In a study from America (N = 506,820), rates of major depressive episodes were shown to increase in adolescents aged 12 to 17 years by 52 percent from 2005 to 2017 and by 63 percent among young adults aged 18–25 from 2009 to 2017 (Twenge et al. 2019). Suicide is considered a preventable death when timely and evidence-based interventions are provided (O'Neill et al., 2012) and thus supporting young people to seek help when they are distressed is considered critical to suicide prevention.

1.2. Young people and help-seeking

There is an established consensus that young people are reluctant to seek help (Gulliver et al. 2010). Research to date has focused on the factors that influence help-seeking, predominantly in the form of barriers or facilitators (Radez et al. 2021). It is estimated that half of all mental health disorders emerge between the years 14 to 24 and so understanding what facilitates young people to seek help for a mental health problem, and stay engaged in mental health care, is important in the design and provision of timely, evidence-based, and meaningful interventions that can contribute towards quality of life and suicide prevention (Bramesfeld et al., 2006; O'Neill et al., 2018; WHO, 2021b). Across countries, juristictions and communities, there are differing conceptualisations of mental health and approaches to mental health service provision (Gopalkrishnan, 2018). Culturally relevant approaches consider and acknowledge the research background, and the impact of family context, community traditions and values, and the wider environments and cultures of an individual or group of people (Gopalkrishnan, 2018). Research to date on this topic has produced excellent information on the breadth of the issue of youth help-seeking and there is a dearth of in-depth and culturally relevant research (Biddle et al., 2007; Gulliver et al., 2010) especially on the island of Ireland. As such, culturally relevant research that communicates understanding about young people's needs, from within their unique environments, is necessary for the design and provision of appropriate mental health services that can provide meaningful interventions.

1.3. Key terms

Three terms are repeated frequently throughout this research and will be further described with a full list of key terms is provided in **Appendix 1**. The first, "help-seeking", does not have a unified definition (Clark et al. 2020) but can be described as an intentional and active action to solve a problem (Cornally & McCarthy, 2011) and an important coping-mechanism (Chan, 2013), which has three main features: the recipient, the helper and the task or problem (Nadler, 1987). In this research the term *help-seeking* is used to describe the behaviour of a young person when they seek external support to lower their mental health distress.

The second term, "young people" has varying definitions. The WHO defines "young people" including adolescents and young adults aged 10-24 years of age (WHO, 2021) with "adolescence" being recognised as ending at nineteen and "young adulthood" beginning at around twenty (UNESCO, 2015). However, in developed countries, Arnett (2014) argues that following adolescence there is a distinct life-stage until late twenties called "emerging adulthood", which can last until 29 years of age. A definite term does not currently exist for "young people" and how the concept of youth is defined and understood is continuously evolving and can be dependent on the economic conditions of a particular region (UNESCO, 2010; Arnett, 2014). In this research the terms, "young people" or "youth" are used interchangeably to refer to individuals in the age range of 10 to 25 years approximately and includes findings from adolescence and emergent adulthood.

The term "mental health problem" is used throughout this thesis to refer to the spectrum of personal distress and mental conditions that can affect an individual (Lynch et al. 2020). Finally, the terms "helper" and "practitioner" are used to refer to people in services who offer one-to-one therapeutic support for an individual's mental health (Lynch et al. 2020).

An additional term "LGBTI+" is used throughout this thesis and refers to individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, which is the most commonly used acronym throughout Ireland (Department of Children, Equality, Disability, Integration & Youth, (2021).

1.4. Research questions, aim and objectives

The *research questions* that guided this study were:

1. What are the key elements that determine whether young people will seek help or not for a mental health problem?
2. How can mental health practitioners engage and facilitate young people in meeting their needs and accessing services?

This *research aimed* to explore young people's (aged 16 - 25 years) experiences and perspectives on help-seeking for a mental health problem; both young people and practitioners' perspectives.

The *research objectives* were:

1. To explore young people's experiences of and perspectives on help-seeking for a mental health problem.
2. To explore practitioners' perspectives of youth help-seeking.
3. To identify key elements that facilitate help-seeking among young people.
4. To explore how help-seeking experiences impact young people's lives and their perspectives on future help-seeking.
5. To provide recommendations on how to facilitate young people in seeking professional help for mental health concerns.

1.5. Thesis overview

This thesis provides the information for a qualitative study conducted with 18 young people and 6 practitioners to examine their experiences of help-seeking for a mental health problem and is presented over six chapters, the first being this *introduction*.

The second chapter provides a primer to understanding the *research context* with the following chapter providing a *literature review* including an overview of the systematic search strategies employed to locate international literature on the topic. This third chapter provides the background on what research what is known about young people's help-seeking behaviour for a mental health problem, and considers the personal factors, the environmental factors and the sources of help young people typically use. Some critical discussion is provided on the interaction between these factors. The chapter concludes with a discussion on the *theoretical*

framework for this study which explores a healthcare help-seeking model by Cornally & McCarthy (2011) and an interpersonal help-seeking model by Chan (2013).

The fourth chapter, *methodology*, provides a transparent and thorough description of the research design of this study which included a constructivist grounded theory approach to data collection of semi-structured interviews. Participants comprised of young people (*N*=18) and practitioners (*N*=6) living in the Northwest of Ireland and were selected using purposive and snowball sampling techniques. NVIVO software was used to support coding and analysis of data was informed by a constructivist grounded theory approach from Charmaz (2014). The fifth chapter presents the *findings* from this data analysis over two parts. Part A explores the data from young people in four categories: 1. *Young people's lives*, 2. *Managing mental health problems*, 3. *The help* and 4. *Impact and outcomes*. Part B provides the findings from practitioners in two categories: 1. *On being a helper*, and 2. *Understanding of young people*.

The sixth chapter provides a critical *discussion* of the findings with regards to the wider literature across six sections. The first two sections discuss findings regarding young people's lives and their actual experiences of seeking help. The next two sections consider the insight that findings can bring to help-seeking theory in relation to the strengths and limitations of the models used in the theoretical framework and theories of development. The fifth section proposes a youth specific conceptual model of help-seeking that acknowledges the important roles of informal networks, services and helpers in shaping young people's pathways. The final section addresses an important objective of the research aim, which is to present the core needs in youth mental health care. The final chapter *concludes* this research with an overview of key findings, discussion on limitations and recommendations, dissemination and impact and a final summary of the research.

1.6. Conclusion

This research project was devised in response to the need to understand qualitatively how to support young people to seek help from mental health services, as this demographic have been found to be reluctant to seek help for mental health problems. The demographic of youth is a broad age-range and incorporates important developmental milestones and can be acknowledged as a distinct life stage. Early intervention in youth mental health is important for

improving quality of life and in reducing death by suicide. This research was informed by the need identified from the wider literature for culturally relevant and qualitative research that inquires about young people's actual experiences of and perspectives on help-seeking for a mental health problem. This research also sought to understand how these experiences impacted young people's mental health and future help-seeking for distress and importantly, identify the key elements that can facilitate help-seeking. The research study is presented over seven chapters and begins with a review and analysis of the extant literature on young people, help-seeking and mental health.

2. The Context of the Northwest of Ireland

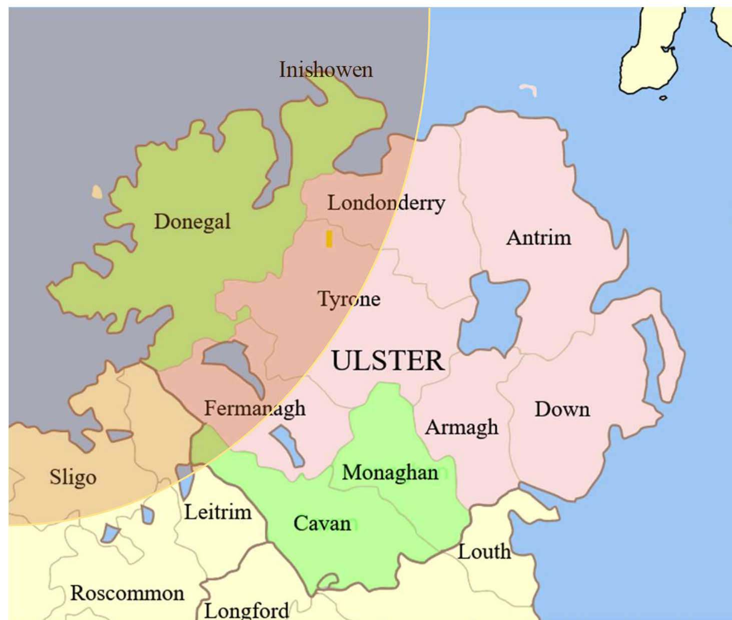
2.1. Introduction

This chapter provides an overview of the historical, geographical, social, legislative, and service and features that are relevant in understanding the context of the Northwest of Ireland. The discussion includes analysis on how identity is shaped by living in between two jurisdictions and how different services in the Northwest approach youth mental health. Important topics such as the role of resources, consent, and the wider context of cultural shifts in attitudes to mental health are also discussed.

2.2. Historical territories and modern divisions

The Northwest of Ireland is located in the province of Ulster and to a lesser extent the province of Connaught. This region contains two distinct legal jurisdictions: 1. *Northern Ireland* which has six counties under a devolved government 'the Northern Ireland Assembly', a region in the United Kingdom (Hayward, 2017) and 2. three counties governed by the *Republic of Ireland*. This separation known as *partition*, a process which began in 1920, was part of the terms of agreement ratifying Irish independence in 1937, in which the United Kingdom would retain the six counties in Ulster (Hayward, 2017). Partition is part of a wider historical story involving the Plantation of Ulster in the 17th century and the recent conflict known as "The Troubles" which began in the 1960s and ended with the Good Friday Agreement in 1998. This conflict involved a predominantly binary divide in attitudes, beliefs, and identity between those who wanted a united Ireland and those who remained loyal to the British crown, and included equally important factors connected to civil rights, religion, and social and economic opportunities (Hayward, 2017). The three counties that surround the six counties in the Republic are known as *border counties* and have experienced The Troubles to a lesser extent than those in the retained six. The term *Northwest* generally is not a political area but a loosely defined geographical region that in general includes counties Donegal, Leitrim and Sligo in the Republic and the western parts of Derry, Tyrone, and Fermanagh in Northern Ireland (**Figure 1**).

Figure 1: The Northwest of Ireland



The Northwest region has historically suffered economically because of its distance from Dublin, its proximity to The Troubles and the stigma associated with black market border activity and paramilitary activity (Hegarty, 2014; Hayward, 2017). Areas where communities speak Irish as their first language are called *Gaeltachts* and these areas in particular have experienced some of the most disadvantage nationally, due both to their exclusion of English language culture to ensure Irish language survival and the neglect of consecutive government policies throughout the 20th century (Donegal County Council, 2016). Emigration for economic and educational reasons, predominantly to Scotland and England, but also to Australia and America is also quite common for people in the Northwest. Within the wider geographical context, Donegal has a unique issue regarding transportation as the main infrastructure to Dublin goes through Northern Ireland (Donegal County Council, 2016). This includes the public transport system, and young people from refugee or migrant backgrounds can be affected disproportionately by this; in order to travel to Dublin for personal, educational, recreational, economic or visa related issues, they have to travel through Northern Ireland and technically require a UK travel visa (Department of Justice, 2021) or risk deportation if discovered travelling.

Donegal is the largest county in Ulster and encompasses most of the Northwest region and during The Troubles, it was sometimes interpreted as a safe place to escape to during conflict.

It is surrounded by the Atlantic Ocean on the west side and three counties on the east, connected only to the Republic of Ireland by a small border with Leitrim. Donegal is both 'South' (politically) and 'North' (geographically) and has an ancient connection with Scotland with both regions having strong linguistic, cultural, and economic connections, and sharing the unique Dalradian geological landscape (Prave, 2009). At the centre of Donegal is the economic centre of Letterkenny, and to the east of Donegal there are many Ulster Scots communities. Letterkenny was established during the plantations and is an important gateway town to the west Donegal and to the *Gaeltachts,* which extend to the southwest. Southeast Donegal has a small boundary with Leitrim and these southern areas of the Northwest are connected economically and culturally to the towns in Northern Ireland of Omagh, in Co. Tyrone and Enniskillen in Co. Fermanagh. Census records from Enniskillen show that approximately one third of people living there identify as Irish, another third as British and the final third as Northern Irish, demonstrating the different ways people self-identify in the Northwest (NISRA, 2011). Northern county Sligo can be often considered part of the Northwest and the county town also called Sligo, also represents an important economic centre for the region.

From a wider historical perspective, county boundaries and territories have changed over time and these older legacies can continue to impact how communities view themselves and why many people in the Northwest live in a cross-border manner (Border People, 2022). An example of this regards the region known as 'Inishowen', meaning 'Island of Eoghan', which is part of the Republic of Ireland and is the largest and most Northerly peninsula on the island (Lacey, 1983). This region was an island before land was reclaimed during the 16th century and contained the area surrounding the city of Derry/Londonderry (Lacey, 1983). As the Northwest border regions also represent some of the most economically disadvantaged or stigmatized areas (Hegarty, 2014; Donegal County Council, 2016; Hayward, 2017), communities and councils often share resources across jurisdictions, who often coordinate plans and meetings to manage border healthcare and economics which provides economic opportunities and challenges (Donegal County Council, 2016; Aleong et al. 2017; Border People, 2022). The lived reality for many families in the Northwest includes living, learning and working in a wider borderless and shared economic area, which has led to a complex and distinct *border identity*.

2.3. Identity in the Northwest

The Northwest border region is an ‘in-between’ place, and communities manage two jurisdictions and currencies. Using a liminality framework, identity in the Northwest can be better understood. Although the concept first emerged from the work of Van Gennep (1909; 1960), it was popularised by Turner (1967) to describe both the abstract and the physical, situations or objects, that can be characterised as ‘in between’, or in the process of transitioning across life-stage boundaries. The use and meaning of liminality frameworks are widely used across artistic and academic domains (Thomassen, 2009; Carson, 2014), including geography that contains differing legal jurisdictions (Fourny, 2013). Whilst liminality can be associated with instability, the Northwest is a region that has culturally adapted to living ‘in-between’ and accommodates dual jurisdictions, and to some extent, is an identity that holds expectations of daily instabilities. With many communities having adjusted to the longer-term nature of border living and lifestyles, this *liminal-adapted* identity is based on a familiar and knowable ‘in-between’. Anxiety and fears about the future of the border and the possibility of another transition witnessed during the British government’s management and negotiation of the border issues under Brexit. These discussions triggered legitimate concerns about the peace established under the Good Friday Agreement (1998) being destabilised (Hayward, 2017) and fears of separation or a change to the current state of ‘in-betweenness’.

Young people living in the Northwest can be described as managing a liminal life-stage, as young people are in significant transition through developmental milestones, on their journey to the status of adulthood (Arnett, 2011; Labelle, 2012). This framework of liminality is important when considering young people, particularly those who have arrived in the Northwest region as a result of displacement, such as those with refugee status or those in state care from other regions within island of Ireland. Young people who can have their own experiences of marginalization, intersectionality (Atewologun, 2018), and transition might be further impacted by living in liminal borderland. This perspective might also support insight into what way challenges can be different for young people in this region, specifically as mental health help-seeking is a highly stigmatised healthcare issue. It is important to further understand the context of mental health help-seeking and the types of services that are available on either side of the border.

2.4. Mental healthcare services in the Northwest

There are three main formal systems in the Northwest from which a young person can avail of mental health support, including public services, private services, or charity-based services. In the Republic of Ireland, the public health care system is a single body run by the *Health Service Executive* (HSE) and was designed to meet the public's health and social care needs (HSE, 2022). This public system is funded by taxation and has early foundations in 1947 (Browne, 2007) but formally began in the 1970s with the regional *Health Boards* which were replaced by the HSE in 2007. This system provides mental health services through many different and siloed services (Dopp & Lantz, 2021), including hospital, community, and regional facilities. For this research, the two most prominent and relevant services include: 1. *Child and Adolescent Mental Health Service* (CAMHS); and 2. *Adult Mental Health Services* (AMHS) which are accessed through a GP referral (HSE, 2022). The systems are free of charge to those with a government identification number (Personal Public Services number), but access to them is means tested, with higher earners having to pay a GP fee. The Northern Irish counterpart, *The Northern Health and Social Care Trust* (HSC), has similar underpinnings to the HSE, being established in 1948, undergoing significant reorganisation in the 1970s, and in the 2000's, which have contributed to its current incarnation today (HSC, 2022). The HSC provides a range of services, including CAMHS and community mental health teams for adults and for older people (HSC, 2022). The HSC is also funded publicly, and administrated by the Northern Ireland executive, but is considered as an overall part of the United Kingdom's *National Health Service* (NHS). This service is free of charge to all those living in Northern Ireland with a government identification number (National Insurance number) and includes GP fees.

Public services are notoriously difficult to access and involve referral process, primarily through a GP and usually placement on a waiting list, as services do not have capacity for demand, which is often attributed to government underfunding (Barnardos, 2017; Dopp & Lantz, 2021). If families can afford private healthcare, they can choose this route because of increased access, increased privacy from government systems or from dissatisfaction at public services and waiting lists. In early 2022, an independent inquiry into a CAMHS service within a region in the south of Ireland found that the provision was harmful and inadequate (Kelleher, 2022). This provoked a call for an investigation into all CAMHS services, with the Taoiseach (Prime minister) Michael Martin calling the report a 'damning indictment' of mental health services in Ireland (Kelleher, 2022). On the border, system inadequacies or issues can also

result in individuals crossing jurisdictions to make use of the other side's public or private services to get their needs met.

The Mental Health Act (2001) legislates that people under 18 years of age in the Republic of Ireland cannot consent to nor refuse mental health treatment, this includes being assessed, diagnosed, and includes attendance at in-patient services (Oireachtas, 2022). As the lack of individual consent is highly problematic, the legislation is currently being debated in government, with the aim of introducing an amendment for those aged 16 and over to be legally allowed provide their own consent to attend or exit mental health care and to consent to the type of treatment they are prescribed or advised (Mental Health (Capacity to Consent to Treatment) Bill, 2021). This would bring legislation in line with Northern Ireland and the UK, which presumes that those over 16 years of age have sufficient capacity to decide and consent to their own medical treatment without their caregivers' consent. In addition, Gillick competence (Griffith, 2016) is used under the NHS, which is a term used to guide professionals to assess if individuals under 16 years can demonstrate that they have sufficient "intelligence, competence and understanding" of what is involved in treatment (NHS, 2022).

The HSE and HSC public systems were significantly influenced by the existing Victorian public mental health asylums that were established within the UK under the 1808 County Asylums Act (Stebbings, 2011). Both systems have evolved and have been revised over time, and the CAMHS model can be seen throughout other similar cultures, specifically other ex-colonies or across the British Commonwealth, such as Canada, however each jurisdiction has cultural and regional differences, with some having already begun the reform process (Rickwood et al. 2019). The de-institutionalization movement, which promoted the move of mental health care to community settings, began across many countries in the 20th century and many asylums remained open until the early 2000s (Fotaki & Hyde, 2014). The asylum buildings are still prominent throughout the Northwest but have been repurposed for other health-based services or hotels (HSE, 2022).

There has been a shift away from the fears and stigma of 'lunacy', and beliefs about and attitudes towards mental health have improved to some extent globally but have remained steady over the previous 40 years (MacKenzie et al. 2014; Dey et al. 2016). On the island of Ireland, the need to encourage help-seeking and de-stigmatize mental health has become a matter of urgency due to increasing suicide rates, in particular, youth suicide, which significantly rose between the years 2000 and 2014, spiking in the years directly proceeding

the global financial crash of 2011 (NOSP, 2021). There has been a concerted effort amongst wider media and healthcare to promote help-seeking and contribute towards the de-stigmatization of mental health, to contribute to the normalization of talking about distress (HSC, 2022; HSE, 2022). Many factors can contribute to suicide and mental health, and can involve stigma, economics, and culture (WHO, 2022) but it is well established that the legacy of trauma from 'The Troubles' in Northern Ireland has significantly impacted post-conflict suicide rates (Tomlinson, 2012).

Aside from the public system, there are community organizations which are comprised of charities or *not for profit organizations* (NFP's) who provide access to free of charge and predominantly short-term counselling interventions (Pieta House, 2022; Jigsaw, 2022). These bodies are funded by different agencies including philanthropist organizations, government departments, private donors, or through fundraising. As an example, Pieta House, which is a community organization that provides national support with self-harm and suicide, are 80% funded by public donations (Pieta, 2022). Many of these community organizations provide direct and easier access than public services but can also be subject to issues associated with underfunding and under resourcing. Community organizations are essential healthcare providers and are often accessed through important gatekeepers from schools and youth work settings (Rickwood et al. 2005).

2.5. School and youth work settings

There are other types of mental health support that are not always readily acknowledged, and this relates to the provision of support through *pastoral care* in schools and through *youth work* (Gilchrist & Sullivan, 2006; Fox & Butler, 2007). Pastoral care is the provision of support to students while they are in the education system and pastoral care teams are generally comprised of a *guidance counsellor* and a *home school liaison officer* and can involve other faculty members, such as principals and vice principals (Doyle et al. 2017; Fox & Butler, 2007). Pastoral care support focuses on student case management, ensuring referrals are made to the appropriate services, that families are supported, that students have access to on-site support through listening ear support and to support positive relationship with teachers and peers (Department of Education, 2021; Department of Education NI, 2021). As it is an educational setting, the ethos of pastoral care is usually guided around how to support young people to complete their education and ensuring child safeguarding Department of Education, 2021;

Department of Education NI, 2021). The key difference in services across jurisdictions is that pastoral care support and guidance counsellors are specifically provided and funded in each school across Northern Ireland and are not funded in the Republic of Ireland (Leahy et al., 2017).

Youth work is a profession that began in Victorian England with the aim of providing young people with opportunities for recreation, guidance, and support in safe environments (Harland et al., 2005; Jeffs, 2020). Modern day youth work is guided by an ethos of person-centered relationships and voluntary approaches, that provide recreational and social spaces with access to informal education and life skills and support wider inclusion of youth people in society (Höylä, 2012). Youth workers provide important mental health supports due to both their easily accessed position in the community and training in listening ear support and counselling skills. Youth work is not well funded in the Republic of Ireland and has a different professional status when compared to the UK and to other parts of Europe and is underfunded (Forde et al. 2017). Youth workers are similar to pastoral care workers in schools, in that they can advocate for young people and families as well as locate services. Pastoral care and youth work are services that are important in providing mental health support but are rarely acknowledged for these important contributions to young people's well-being (Bernes et al., 2005; Höylä, 2012; Cooper, 2018).

2.6. Conclusion

Ulster has a unique story within the context of Irish history, and the Northwest region has distinct cultural, political and geographical features that contribute to a *border identity*. The Northwest of Ireland is one of the most economically disadvantaged areas in Ireland, with limited services, infrastructure as well as cross-border opportunities and challenges. This chapter has provided important information regarding the context of this study, specifically with regard to the wider historical, geographical, economical, legislative, and service factors that are present in the Northwest of Ireland. Acknowledging this context is important when researching how young people seek help for their mental health distress and for reviewing the wider literature base.

3. Literature Review

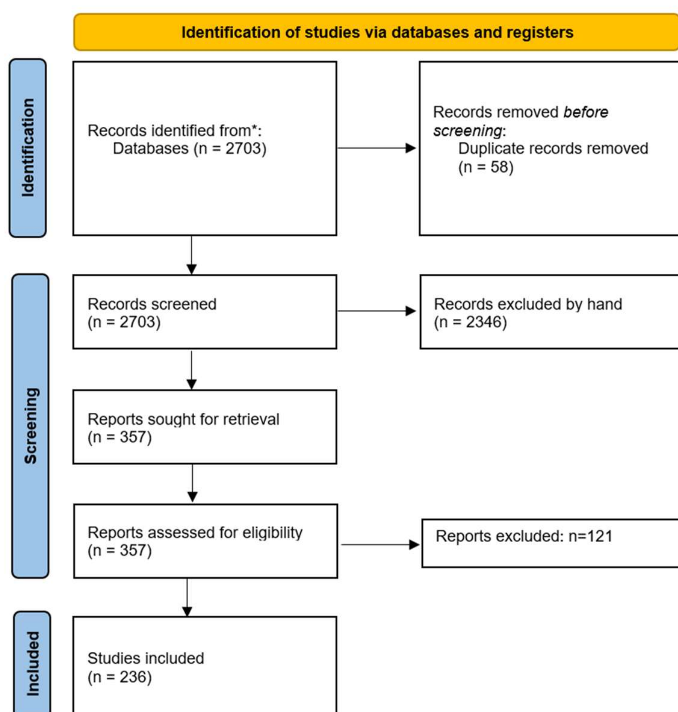
3.1. Introduction

This literature review collated and examined the available international evidence on young people's help-seeking behaviour for a mental health problem. As this research aimed to explore young people's experiences and perspectives on help-seeking for a mental health problem, relevant literature was reviewed using a *search strategy* and the findings are presented under three separate sections: 1. *personal factors* influencing young people's help-seeking behaviour; 2. the *cultural factors* that impact help-seeking behaviour and 3. the *sources of help* available to young people with a mental health problem.

3.2. Search strategy

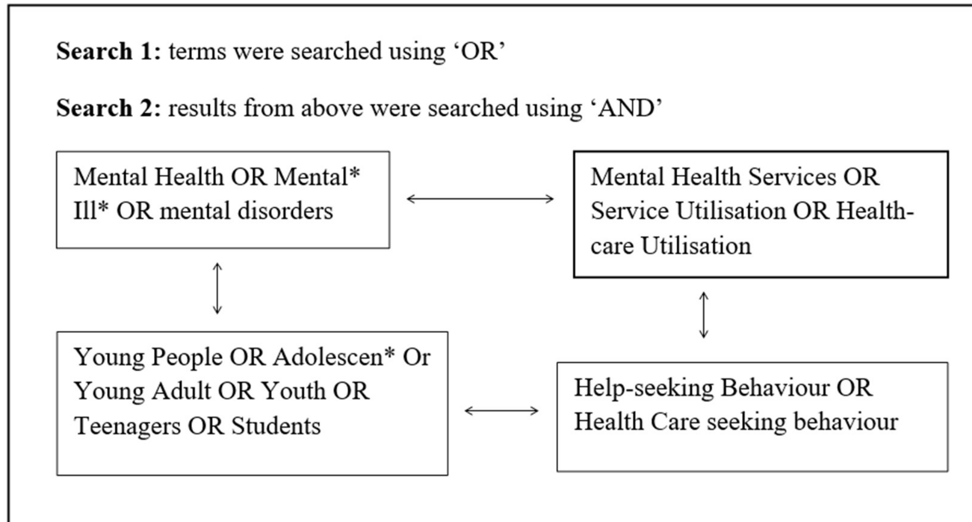
A systematic search was performed, and research was retrieved from nine databases including *Psychinfo, Medline, ASSIA, CINAHL, Web of Science, Scopus, SAGE, Science Direct* and *Google Scholar* (McFadden et al. 2012; Best et al. 2014; McGinn et al. 2016; Campbell et al. 2018). This procedure is provided in a PRISMA diagram (**Figure 2**).

Figure 2: Prisma Diagram



Analytical searches used Boolean logic to establish search parameters and this procedure was adapted to suit each database search. In databases without advanced search algorithms, the *browsing* method was used to conduct manual searches (**Figure 3**).

Figure 3: Sample search strategies



Selection criteria for this literature review included research published in an English language peer-reviewed journal between 1996 – 2021. This date was selected as it marks the beginning of the digital age which is important when exploring youth experiences (Cerf, 2009). Database searching initially took place in June 2016 and was updated in December 2018 and October 2021. Studies were selected that contained direct research with young people but also included studies that provided important insights into young people, service utilisation, help-seeking and mental health problems. Database searching returned 2703 studies after removal of duplicates and screening of abstracts identified 357 relevant studies, 236 meeting selection criteria. As qualitative healthcare data can be complex to assess this subjective process was further guided by an appraisal tool developed by Walsh & Downe (2006) which looks at essential criteria in eight areas for consideration: *scope and purpose, design, sampling strategy, analysis, interpretation, reflexivity, ethical dimensions and relevance* and *transferability*. All studies were read in-depth for relevant data and were guided by the boundaries set by the selection criteria.

3.3. Personal Factors influencing young people's help-seeking behaviour

The section of the literature review examined research regarding the personal factors that can impact a young person's help-seeking behaviour for a mental health problem. The most frequently reported personal factors included: the role of *mental health literacy*, *developmental needs*, common *self-management strategies* used to cope with mental distress, *attitudes,* the impact of *beliefs and previous experiences* of help-seeking and the *personal gains or losses* related to mental health help-seeking.

3.3.1. Young people's mental health literacy

In a systematic review of youth mental health help-seeking literature by Radez et al. (2021), the theme of mental health literacy was described as the most common barrier or facilitator to help-seeking for mental health. *Mental health literacy* is an evolving concept derived from the field of health literacy (Kutcher, Wei & Coniglio, 2016) and involves having knowledge about mental health conditions and treatments, the ability to recognise, describe and manage mental health problems, as well as understanding how to help-seek to services (Rickwood et al. 2005; Rickwood et al. 2007). Young people as a demographic have been found to have lower levels of mental health literacy than other age demographics and this has been associated with lower levels of help-seeking (Rickwood et al. 2007; Dogra et al. 2012; Del Mauro & Williams 2013; Coles et al. 2016; Aluh et al. 2018; Byrow et al. 2020; Wang et al. 2020). Research with older adolescents has found that they have more sophisticated conceptualisations of mental health than younger adolescents (Georgakakou-Koutsonikou, 2017), which can be expected as they have had more opportunity and time than younger adolescents to learn about mental health.

Research has found that lower levels of mental health literacy and lower levels of help-seeking were particularly associated with young people who had moderate to severe levels of depression (Rickwood et al. 2005), who hold refugee status (DeAnstiss & Ziaian, 2010) and who self-harm or experience suicidal ideation (Lam et al. 2014; Pumpa & Martin, 2015). In particular, much quantitative research has investigated the role of labelling and found that incorrect labelling or lower rates of recognition of mental health problems was associated with lower intentions of help-seeking (Burns & Rapee, 2006; Moses 2009; Yoshioka et al. 2014; Yamasaki et al. 2016; Radez et al. 2021). These findings imply that young people who do not understand, recognise correctly, or who experience confusion about mental health problems can find it more difficult to seek help for them.

Moderate levels of mental health literacy can be associated with help-seeking especially if a young person self-identifies as someone with a mental health problem (Oxele et al. 2020). When young people want to avoid mental health labels, they can avoid help-seeking completely (Kosyluk et al. 2020). Research has found that peer groups can normalise behaviours that parents or professionals would consider problematic and requiring intervention, such as substance use, eating problems, suicidal talk, depression, or anxiety (Draucker, 2005; Frojd et al. 2007; Mariu et al. 2011). Young people can view symptoms, behaviours and labels of mental health distress as stigmatised, normative, or as indicative of a mental health problem and this alongside mental health literacy can influence help-seeking. Research states that increasing young people's ability to describe and label symptoms more effectively can facilitate help-seeking and appropriate treatment choice (Wright et al. 2007; Wright et al. 2012). One study by Burns & Rapee (2006) found that when a young person does seek help for distress, the incorrect labelling of symptoms or the presentation of distress as acceptable, minimised, and normalised can result in inaccurate diagnoses.

An important first step in the help-seeking process is an individual's assessment and evaluation of their psychological distress (Cornally & McCarthy, 2011). This requires a young person to have awareness of their internal psychological state, the ability to apply mental health knowledge and evaluation to oneself, and the skills to express this effectively to others, which is considered a difficult task for a young person (Rickwood et al. 2005). Further factors that were found to contribute to help-seeking was a belief that it is acceptable to discuss emotions, an understanding of when a problem needs professional help and how to take the appropriate action necessary (Rickwood et al. 2005; Gilchirst & Sullivan, 2006; Wright et al. 2007). Young people can delay seeking help until distress becomes severe and outside of independent capacity to manage (Biddle et al. 2004; Rothi & Leavey 2006; Quinn et al. 2009; Del Mauro & Williams, 2013 Martinez et al. 2020). However, research has found that severity is not always a predictor of help-seeking, especially with adolescents who self-harm (Pumpa & Martin, 2015). Other research indicated that young people might not evaluate their distress as severe enough to warrant professional intervention (Rickwood et al. 2005; Samoulihan & Seabi, 2010; Eisenberg et al. 2012). Young people can have high thresholds for tolerating distress, expect problems to be self-limiting or believe that psychological services should only be used as a last resort (Rickwood et al. 2005; Vanheusden et al. 2008; Eisenberg et al. 2012). Some research indicates that young people can view clinical services as reserved for those who

exhibit dangerous or unpredictable externalising behaviours (MacLean et al. 2013; Yap et al. 2013a; Cheetham et al. 2019).

Increasing mental health literacy through education programmes is considered an important preventative measure for mental health problems in many countries (Draucker, 2005; Vanheusden et al. 2008; Ronnzoni & Dogra 2011; Lam, 2014; Rowe et al. 2014; Berry et al. 2020; Westberg et al. 2020). Two systematic reviews of randomized controlled trials by Klineberg et al. (2011) and Michelmore et al. (2012), which assessed the efficacy of school-based intervention programmes, found that while these programmes can improve knowledge of the signs and risk factors for suicide and self-harm, as well as attitudes to help seeking, there was no effect on actual help-seeking behaviour. Kosyluk et al. (2017) also found that mental health education approaches in college students were successful in decreasing personal stigma and increasing help-seeking intentions to formal sources but not informal as they can still perceive that stigma exists externally.

In summation, young people have lower levels of mental health literacy, and this factor is linked to lower rates of help-seeking (Radez et al. 2021). While knowledge of mental health can predict help-seeking behaviours other personal, cultural, and service factors have an equally important role in facilitating help-seeking (Klinberg et al. 2011; Michelmore et al. 2012; Pearson & Hyde, 2021).

3.3.2. Self-reliance and help-seeking behaviour

A barrier to professional help-seeking that was frequently reported in international literature regards young people's preference for self-reliance in resolving their mental health problems (Gonzalez et al. 2005; Raviv et al. 2009; Jackson Williams, 2014; Yoshioka et al. 2014; Radez et al. 2021). *Self-reliance* is a category associated with less help-seeking, and as an important developmental need in youth, needs to be understood in its contexts.

The developmental task of self-reliance

As a normal part of transitioning from a child into adult, adolescents learn to become more self-reliant and autonomous, viewing self-management as a skill that is necessary for adulthood (Michelmore et al. 2012; Wilson & Deane, 2012; Del Mauro & Williams, 2013; Pumpa & Martin, 2015). Self-reliance refers to an individual's ability to resolve their own problems and manage general life stressors and is a character trait that is highly valued in many cultures (Bramesfield, 2006). Young people can internalise that self-reliance is important for managing

all personal problems and as self-reliance is conceptually antonymous to help-seeking, asking for help can cause them to feel devalued, dependent, and regressive (Wilson, Deane & Ciarrochi, 2005; Bramesfield, 2006; Boyd et al. 2007). Young people may not be aware that coping strategies are skills that can be learned and can often consider the ability to cope as a fixed indicator of personal strength or weakness (Rickwood et al. 2005; Lee, 2009; Yap et al. 2013a).

Biddle et al. (2007) suggests that not all episodes of personal distress result in crises, with short-lived symptoms sometimes self-remitting and problems resolving themselves. Mental health problems can often be outside the limits of personal resources and can require professional assistance, but it can be appropriate for young people to attempt to solve their own problems first (Biddle et al. 2007). Some research suggests that young people have awareness of when to seek help, where to get it from and how they want to be helped for psychological distress (Charman et al. 2010). Young people can rely on personal resources and delay professional help-seeking until absolutely necessary, and this can be borne out of a need to control a personal problem before involving more complex systems that can result in feelings of exposure (Biddle et al. 2007; Burlaka et al. 2014). The many challenges of development can result in young people feeling self-conscious and hypervigilant and so they can require more sensitivity and privacy than older adults (Leavey et al. 2011; Best & Ban, 2021). Young people can be supported to seek help, if it is offered in a way that respects developmental needs and leverages self-reliance rather than viewing the latter as a barrier (DeAnstiss & Ziaian, 2010; Charman et al. 2010).

Self-management strategies used to cope with mental health problems

For personal problems, self-management methods are often the first and most widely used problem solving means that individuals use (Chan, 2013). *Self-management* in mental health refers to an individual's ability to manage the symptoms, treatment, physical and psychosocial consequences of living with a mental health problem in order to provide a satisfactory quality of life and is linked with self-help, self-reliance, and family or community reliance (Omisakin & Ncama, 2011). Young people can rely on their own resources to manage their distress out of preference or due to the multifarious barriers around help-seeking (Wilson, Deane & Ciarrochi, 2005; Coleman-Fountain et al. 2020). Young people can use their natural coping skills but some of these can be inadequate or exacerbate problems in the long term (Rickwood et al. 2005; Rickwood et al. 2007).

Research with young people regarding the influence that self-help interventions have on help-seeking is limited (Rickwood & Bradford, 2012). Some evidence suggests getting into a routine, self-help books, online support and physical activity are valued as helpful by young people (Jorm et al. 2008; Rickwood et al. 2007; Burlaka et al. 2014). One study has found that only a minority of young people rated self-help strategies as useful (Loureiro et al. 2013). Self-management techniques can be difficult for young people to acquire without adult support and improving self-management strategies in young people is generally regarded as an important resource to be developed to maintain positive mental health and are often an integral part of many therapies (Rickwood et al. 2007; Omisakin & Ncama, 2011). Common coping strategies include external measures, such as self-medicating with substances or the use of internal strategies such as delaying, escaping, distracting and denial.

Denial is a defence mechanism involving a disavowal or failure to consciously acknowledge thoughts, feelings, desires, or aspects of reality that would be painful or unacceptable (Colman, 2015). As a coping strategy, denial in the long-term can become inadequate for managing distress and is cited as a barrier to young people help-seeking for a mental health problem (Vanheusden et al. 2008; Cranford et al 2009; Bilican, 2013; Cohen, 2013). Denial can also relieve ambivalence in young people who are unsure about whether to express their emotions or not but can significantly delay seeking support (Lee, 2009).

Biddle et al. (2007) suggests that delaying and denying can also be considered as part of a cycle of *avoidance.* This avoidance can lead to the normalisation of mental distress and create higher distress thresholds resulting in difficulty for young people to determine what is 'real' distress and what is ‘normal’ distress, until they reach a crisis point (Biddle et al. 2007). Young people can avoid help-seeking and learn to accommodate distress rather than deal with the expected negative consequences or stigma that may result from help-seeking (Chan, 2013). Spence et al. (2016) found that avoidant strategies and self-stigma were higher in emerging adults who had experience with services which they argued was the result of stigmatising experiences with services, which was also found to have a negative effect on their identities and their choice of future help-seeking strategies.

Self-medication with alcohol and other substances has been found to be a common strategy used by young people for coping with distress and was rated as helpful in providing temporary relief (Hickie et al. 2007; Cranford et al. 2009). One study found that distraction was rated more favourably over substance use (Loureiro et al. 2013). Research has reported links with

the use of self-medicating, specifically binge drinking, and generalised anxiety disorder (Cranford et al. 2009). Young men have been described as using denial and substance-use to cope with their mental health more than young women (Biddle et al., 2007; Vanheusden et al. 2008; Cranford et al 2009; Lynch et al. 2018). Feeling disconnected from others, prioritising self-reliance, fear of stigma from others and a perception of low social support collectively appear to encourage young people to self-medicate with alcohol and other substances, in an attempt to resolve their problems (Jorm et al. 2006; Hickie et al. 2007; Burlaka et al. 2014).

Overview

The overreliance of coping strategies such as delaying, escaping, distracting and denial to alleviate personal problems can exhaust these self-management strategies and when they fail to work, some young people can turn to help-seeking (Biddle et al. 2007; Cornally & McCarthy, 2011). However, the preference for self-reliance over help-seeking can also be a result of a need to avoid stigma or the lack of services or the inability to identify a source of help (Freedenthal & Stiffman, 2007). Self-management strategies can be understood as both an antecedent to interpersonal help-seeking and as a source of self-help that is utilised when help-seeking to others has failed or has not produced the desired solution to the problem (Cornally & McCarthy, 2011; Chan, 2013). To protect self-esteem, young people can ensure they have exhausted self-management strategies first before seeking help externally and bringing their personal world into a public sphere (Biddle et al. 2007; Burlaka et al. 2014; Martinez et al. 2020; Westberg et al. 2020). Young people actively try to help themselves (Westberg et al. 2020) and it is often only when self-management strategies are ineffective that the process of turning to others for support begins (Cornally & McCarthy, 2011).

3.3.3. The role of attitudes, beliefs, and previous experiences on youth help-seeking behaviour

The role of attitudes and beliefs towards mental health services and professionals is one of the most frequently researched topics, cross-culturally, into young people's help-seeking behaviours (Rickwood et al. 2005; Rickwood et al. 2007; Jorm et al. 2008; Dogra et al. 2012; Chen et al. 2014; Wang et al. 2020). Attitudes and beliefs were often described together in research, but they have clear distinctions; a *belief* is "any proposition that is accepted as true on the basis of inconclusive evidence" (Colman, 2015); and an *attitude* can be described as "a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (Eagly & Chaiken, 1993, p. 1). Attitudes can stem from personal beliefs,

which can be formed through previous experiences (Rickwood et al. 2005; Georgakakou-Koutsonikou, 2017; Andriessen et al. 2018) and this relationship is explored below.

The role of attitudes in help-seeking

Much research in youth help-seeking behaviour has focused on the role of attitudes towards mental health treatment, services and professionals as a primary determinant in predicting and understanding young people's behaviours (Gonzalez et al. 2005; Klineberg et al. 2011; Michelmore et al. 2012). In particular, an association has been found between *negative attitudes* towards help-seeking and lower *intentions* to seek help for mental health problems (Pheko et al. 2013; Pumpa & Martin, 2015; Maloney et al. 2020). As such, it is often recommended that improving young people's beliefs about professional psychological help-seeking is important for increasing positive attitudes and hence increasing mental health service utilisation (Nada-Raja et al. 2003; Rickwood et al 2005; Rughani et al. 2011; Zorilla et al. 2019).

Not all research findings support negative attitudes as a central determinant in youth professional help-seeking. Eisenberg et al. (2012) challenges the prevailing premise that attitudes are the central determinant of professional mental health help-seeking. Pearson & Hyde (2021) also agree that while negative attitudes have a role in professional help negation, they do not solely prevent or predict help-seeking. Research with college students with untreated depression, anxiety, or suicidal thoughts, found that while participants maintained positive beliefs about treatment, they did not seek help, instead citing personal evaluation of distress as not urgent or essential (Eisenberg et al. 2012; Freedenthal & Stiffman, 2007). Al-Krenawi et al. (2009) also found that participants in their study, who held mental health services in high regard, had other reasons for not seeing a therapist suggesting that mental health help-seeking behaviour can be considered analogous to physical health help-seeking behaviour, in which unhealthy behaviours exist despite positive attitudes, beliefs and intentions (Al-Krenawi et al. 2009). A positive attitude towards mental health services is necessary but insufficient as a lone factor to determine help-seeking (Al-Krenawi et al. 2009).

The wider survey research is lacking regarding insight into why young people hold negative attitudes about services and professionals. Help-seeking models indicate that attitudes are influenced by social norms and can serve to inform an individual about possible stigma regarding mental health, help-seeking, or the suitability of services and helpers (Chan et al. 2013). This can help explain findings which demonstrated that negative attitudes in young

people did not appear to be generalised to others; young people expressed positive support for the help-seeking behaviour of others, to the extent that this would not change their opinion of the person but that they would not seek help for themselves (Vanheusden et al. 2008; Jorm et al. 2008, Del Mauro & Williams, 2013; Pederson & Paves 2014). Self-stigma might be an underlying factor in the formation of negative attitudes and explain why efforts to reduce public stigma has not always been effective in improving help-seeking behaviours (Eisenberg et al. 2009; MacKenzie et al. 2014). Some research recommends focusing on the reduction of self-stigma instead of general stigma when attempting to improve help-seeking attitudes in young people (Eisenberg et al. 2009; Raviv et al. 2009).

Much of the attitudinal research to date on negative attitudes as barriers to help-seeking is conducted utilising vignette characters, which asks participants to comment on what another might do, and can cause other important underlying reasons for behaviour to be over-looked (Hughes & Huby, 2004). Eisenberg et al. (2012) argues that having an intention to seek help is not the same as actual help-seeking behaviour and so the association between intentions and attitudes cannot be extrapolated to mean that negative attitudes are a determinant of help-seeking. Help-seeking can be better conceptualised as a dynamic process that involves attitudes among many other factors (Klineberg et al. 2011; Eisenberg et al. 2012). Findings that link negative attitudes directly to help negation can obscure the wider context in which the attitude is formed and the possible protective function or underlying beliefs of the attitude.

The role of beliefs in help-seeking

Beliefs about professionals, psychiatric treatments and the outcomes of therapeutic interventions are often reported alongside attitudes as influencing help negation (Rothi & Leavey, 2006; Gulliver et al. 2010). Findings report that some young people believe that help-seeking to psychological services is unhelpful, troublesome, or dangerous (Draucker 2005; Rughani et al. 2011; Jackson Williams 2012). Young people have also scepticism regarding the effectiveness of treatments (Draucker, 2005; Jorm et al. 2008; Neilson et al. 2014) or that help-seeking has no personal benefits nor can help reduce mental health symptoms (Jorm et al. 2008; Vanheusden et al. 2008).

Young people appear to have more awareness of pharmacological treatments over other therapeutic interventions, however common findings report that the majority of young people believe anti-depressant medication to be undesirable or harmful (Draucker 2005; Eisenberg et al. 2007; Jorm et al. 2008; Hickie et al. 2007; Eisenberg et al. 2011; Yoshioko et al. 2014;

Goodwin et al. 2016). Research by Quinn et al. (2009) provides some further insight as they found that some university students viewed medication as a short-term solution while others perceived the side effects of long-term use as incompatible with successful studying. Draucker (2005) suggested that negative beliefs can be founded in professionals' poor rapport with adolescent clients and the inability of professionals to help them understand how medication is helpful. Goodwin et al. (2016) in a review found that there is a high stigma around medication and a general lack of confidence in professionals.

Research would suggest that non-pharmacological therapeutic interventions, such as counselling, do not always emerge as more favourable. Michelmore et al (2012) found that many young people who self-harmed believed that professionals would force them to talk about personal problems, or that they could be admitted to hospital involuntarily or labelled crazy (Michelmore et al. 2012). One Canadian study has reported that young people experiencing suicidal ideation prefer psychotherapy over medication (Neilson et al. 2014) but large-scale surveys from Australia have found that counselling treatments, such as cognitive behavioural therapy, are not rated positively by young people (Jorm et al. 2008). Jorm et al. (2008) suggests that adolescents can be suspicious of any intervention which sounds clinical, believing such services to be linked with an image of severe mental illness, which they may not want to be associated with and connects with research about labelling (Kosyluk et al. 2020). Generic counsellors, who appear less clinical, can be perceived as more favourable than a specialist psychologist (Jorm et al., 2008). In some cases, young people's negative beliefs and associated attitudes towards mental health professionals and help-seeking can be connected to previous negative experiences.

The role of previous experiences of help-seeking

When an individual is problem-solving for a mental health problem, the ability to draw on past personal experiences, strategies and expectations can be a helpful resource when making decisions regarding help-seeking (Rothi & Leavey, 2006; Chan, 2013). Much research has found that future intentions to seek-help and positive attitudes towards help-seeking can come from positive past experiences of help-seeking (Rickwood et al. 2005; Wilson & Deane 2012; Rowe et al. 2014; Ryan, Toumbourou & Jorm, 2014; Andriessen et al. 2018). Not all sources of help will respond in positive or helpful ways and young people often have previous experiences of not being helped (Gilchrist & Sullivan 2006; Charman et al. 2010; DeAnstiss & Ziaian 2010). Young people have reported experiencing poor-quality professional support,

either directly or vicariously (Gilchrist & Sullivan, 2006; Charman et al. 2010) and experiences of not being able to get access to support, being offered medication alone and breaches of trust (Quinn et al. 2009; Charman et al. 2010; Simmons et al. 2011). Findings from research with young people with refugee status report experiences as ranging from minimising to stigmatising which causes distrust in future professional help-seeking (DeAnstiss & Ziaian, 2010; Byrow et al. 2020). Research by Neilson et al. (2014) into adolescents experiencing suicidal ideation, depression and anxiety reported variable previous help-seeking experiences involving inconsistent practices and outcomes for young people with a mental health problem. Studies with young people who self-harm have also shown that they often have a deep distrust of mental health services based on both personal and peer group experiences (Rowe et al. 2014; Michelmore et al. 2012).

Overview

Exploring how attitudes, beliefs and experiences interact to discourage young people from seeking help for a mental health problem is necessary to enhance understanding of why young people negate help. Bradford & Rickwood (2012) suggest that personal attitudes may only be adjusted after young people have experienced the help-seeking process positively and are able to determine that it assists them in overcoming other barriers and concerns. Help-seeking for a mental health problem is much more complex than having a negative attitude or belief and further understanding is needed of other factors such as the personal impact of help-seeking.

3.3.4. The potential gains and losses that help-seeking can incur

When seeking help for a mental health problem young people can weigh up the potential benefits and consequences that this process can incur, such as damage to self-image, public image, and negative changes to their social relationships (Rickwood et al. 2005; Chan, 2013). Help-seeking for a mental health concern can profoundly and negatively change the way a young person views themselves (Nam et al. 2013) and involves the ability to acknowledge distress and the need for external support, a self-admission that can result in damaged self-esteem, negative self-labelling and feelings that include vulnerability, failure, weakness, and abnormality (Gilchrist & Sullivan 2006; Quinn et al. 2009; Cornally & McCarthy, 2011; Burlaka et al. 2014). This response is triggered from a perception that others in society can have stigma towards mental health problems and individuals with them (Del Mauro & Williams, 2013; Pederson & Paves, 2014).

Young people can consider seeking help for mental health problems as something that is reprehensible or that warrants punishment with research reporting young people describing fears regarding being exploited, stigmatised, or punished by others (Gilchrist & Sullivan 2006; Charman et al. 2010; Chen et al. 2014). This can be particularly pertinent for young people who self-harm due to increased stigma and the possible negative consequences of disclosure (Rowe et al. 2014). One study found that one-quarter of teenagers who were experiencing depression or suicidal ideation indicated they would keep depressed feelings to themselves (Wilson, Deane & Ciarrochi, 2005). Negative reactions from potential support sources can result in embarrassment, guilt, shame, anger, hopelessness, despair, factors that were found to further inhibit future help-seeking to any source of help (Gonzalez et al.2005; Freedenthal & Stiffman, 2007; Yap et al. 2013b; Pumpa & Martin, 2015). Research with university students showed that young people feared that disclosing personal problems could affect their future career prospects, especially if mental health disclosure were stored within their medical records (Quinn et al. 2009).These fears can be warranted as help-seeking does not always result in appropriate support or the resolution of a problem but can create extra problems for young people who still have their original problem but now have the negative effects of others' reactions to manage (Ellis et al. 2010).

Help-seeking undoubtedly has implications and whether a help-seeking episode will be negative or positive is not always pre-emptively knowable. This unpredictability can cause young people to make cautious decisions based on the information available to them, which includes the prevailing negative stereotypes, attitudes, and beliefs. Even after repeated failed attempts to solve a problem, if there is an expectation that help-seeking can incur further damage to self-image and public image, a young person can be motivated to continue concealing problems from others, preferring to use personal resources, and avoiding help-seeking (Chan 2013; Biddle et al. 2007). Considering these findings, negating help can be viewed as an attempt to prevent further damage to self-image, often with the hope that if the young person can resolve the problem themselves without needing external assistance, they will be able to retain their sense of autonomy, project a public image of competency, label themselves more positively and repair their self-image (Chan, 2013; MacLean et al 2013; Pumpa & Martin, 2015).

3.3.5. Summary of personal factors

This section has explored findings regarding the personal factors involved in young people's help-seeking behaviour for a mental health problem. *Mental health literacy* was found to play an important role in decisions to help-seeking but as part of a wider tapestry of factors including the *developmental needs* of emerging autonomy and self-reliance, as well as *attitudes*, *beliefs*, and *previous experiences*. While attitudes and beliefs are described as predictors for help-seeking behaviour they can function as mediators between beliefs and behaviours and so need to be understood within the contexts of social, political, and cultural environments (Al-Krenawi et al. 2009). Previous experiences have not always been helpful for young people in the resolution of their personal problems and so young people rely on their personal resources, including *self-management strategies*. If a young person expects significant *personal* or *public* costs to occur as a result of help-seeking, they can conceal personal problems and attempt to resolve them independently, which can be viewed as a protective behaviour (Chan, 2013). It is essential to explore all the factors in a young person's environment, structurally and culturally, that interact with personal factors to either encourage or help for their mental health problems.

3.4. Environmental factors influencing young people's help-seeking behaviour

This section of the literature review considers the factors within a young person's environment that can impact the process of help-seeking. This section presents an examination of research on the role of *stigma, culture and community values* on young people help-seeking behaviours. This section also includes a discussion on the *Irish cultural context* and the impact of *media representations* on mental health and how *demographic factors,* such as socio-economic status, rural life and gender socialisation, affect young people's help-seeking processes. Finally, an examination of *trends over time* is presented.

3.4.1. The impact of stigma on young people's help-seeking behaviour

Stigma is reported within many review articles as one of the most common barriers to help-seeking for young people with a mental health problem (Rothi & Leavey, 2006; Gulliver et al., 2010; Nam et al. 2010; Michelmore et al. 2012; Rowe et al. 2014; Goodwin et al. 2016; Mbuthia et al. 2018; Martinez et al. 2020; Radez et al. 2021). *Stigma* can be defined as "visible

or invisible social distinctions that disqualify individuals or social groups from full social acceptance" (Calhoun, 2002) and can be a mechanism to ensure individuals conform to culturally normative behaviour (Ellis et al. 2010). Young people worry about *anticipated* stigma, *perceived* stigma and *personal* stigma (Tharaldsen et al. 2017).

For young people with a mental health problem, being stigmatised can result in others thinking negatively about them which can lead to damage to self-image and public image, deterioration of important relationships, negative labels or ostracization (Biddle et al. 2006; Fox & Butler, 2007; Quinn et al. 2009; Ellis et al. 2010; Nam et al. 2010; Kranke et al. 2012; Bilican, 2013; Yap et al. 2013b; Pheko et al. 2013; Pumpa & Martin, 2015). Cross-culturally, mental health has been associated with personal weakness and this stigma is threatening to young people (Tharaldsen et al. 2017; Cheetham et al. 2019; Tan et al. 2020). *Self-stigma* or personal stigma in mental health occurs when a person internalises society's devaluation of people with mental health problems (Chan, 2013). The fear of social repercussions can create protective and self-stigmatising attitudes that can encourage a young person to conceal distress or avoid the negative consequences of help-seeking (Chan, 2013; Pederson & Paves, 2014). Young people want to be socially included, often conforming to perceived norms, as losing social opportunities in adolescence can be devastating to a young person's personal and public image (Kranke et al. 2012; Tharaldsen et al. 2017).

Stigma can be an important factor in why young people often report ambivalence when seeking help for a mental health problem. It has been suggested that *ambivalence* is caused by a personal, internal conflict about how to proceed with a problem due to an individual's expressive style conflicting with expected social norms (Lee, 2009; Samoulihan & Seabi, 2010). Young people can worry about stigma beyond personal consequences and can fear bringing stigma to their family (Villatoroa et al. 2018). Young people who have parents with mental health problems can avoid help-seeking for their own distress due to stigma or fears of being taken from their parent's care (Davies et al. 2021). Those with higher distress such as psychosis can have higher stigma concerns (Gronholm et al. 2017) or young people already experiencing stigma, such as those identifying as LGBTI+ (Byron, 2019).

Many studies have evaluated anti-stigma education and produced variable findings. Shahwan et al. (2020) reports that anti-stigma interventions were associated with increased help-seeking in university students but that the effects decrease over time and require booster sessions. Kutchera et al. (2016) and Kosyluk et al. (2017) found that mental health education can be

successful in reducing self-stigma and for increasing intentions to seek help. However, Kosyluk et al. (2017) and Nearchou et al. (2018) also found that these intentions were to formal services, as perceived stigma remain and reduce informal help-seeking. Dardas et al. (2017) found the reverse, that lower stigma scores were associated with increased formal service help-seeking and higher stigma was associated with increased informal help-seeking. Fox & Butler (2007) found that even when young people report low self-stigma and do seek help, they fear the stigma of being seen going to a service. Much research that has shown that in contexts where stigma has been reduced, it does not always lead an increase in help-seeking behaviour (Al-Krenawi et al. 2009; Masuda & Boone, 2011; Prior, 2012; Eisenberg et al. 2012; Bilican, 2013; Yap et al. 2013b, Del Mauro & Williams, 2012). Al-Krenawi et al. (2009) has suggested that other cultural and social aspects of a particular society can have stronger influences on help-seeking than stigma alone.

Stigma is a complex topic and can greatly affect how communities, families and young people respond to mental health concerns. As a term, stigma has become ubiquitous in help-seeking research as a categorical factor for help-negation without deep inquiry into its role. A young person's experiences, expression and coping of mental distress is heavily influenced by their immediate community norms (Lee, 2009). Young people's stigmatised attitudes and beliefs can increase and embed with age (Georgakakou-Koutsonikou. 2017). What is stigmatizing from within the sociocultural context of a young person's community can vary in how this impacts a young person's decision to negate help (Al-Krenawi et al. 2009; Masuda et al. 2009).

3.4.2. Help-seeking as a concept

Velasco et al. (2020), in a systematic review of youth mental health help-seeking literature stated that there was not an agreed term or model used when conducting research on this topic. It is important to acknowledge that help-seeking for a mental health problem is regarded as a Western cultural concept and is not necessarily an established cultural practice in many socio-cultural contexts (Masuda et al. 2009; Choi & Miller, 2014). Even within many Westernised cultures, the concept of help-seeking for mental health problems is recent and is not completely accepted, for example, in Australia rural attitudes towards mental health help-seeking tend to be more negative than those coming from urbanised environments (Boyd et al. 2007; Hernan et al. 2010). Masuda et al. (2009) suggest that to further understand mental health service use, it is crucial to consider *emic* points of interpretation, which explore the view and meaning put forth by members of that culture (Markee, 2013). Al-Krenawi et al. (2009) support this view

stating that it is imperative to explore how national cultural contexts and social environments impact an individual's help-seeking process but also proposes an *etic* stance, stating it is possible that transnational research on this topic can lead to the extrapolation of new insights from one country that can assist in understanding another.

Help-seeking from within Western culture

Autonomous action fuelled by self-determination is a core value in contemporary Western societies (Bramesfield et al. 2006). *Help-seeking* falls into the category of an autonomous decision to solve a problem and is permitted within Western culture, however, the autonomous decision to seek help for a psychological problem that is associated with a personal weakness can also be regarded as a failure of autonomy. Mental health stigma can negatively affect a young person's social status and their perception of being a self-determining and contributing member to society (Bramesfield et al. 2006). This dominant value of autonomy combined with the stigma of having a mental health problem can support the belief that an individual should be able to solve their own problems by themselves, and on failure to do so, are not living up to their culture's standards (Bramesfield et al. 2006). Conceptually, the value of autonomy and the practice of help-seeking are in conflict; it is incongruent to be both self-reliant and require support from others for a mental health problem. Young people, under pressure in trying to resolve this incongruence, may experience ambivalence or decide to negate help (Lee, 2006).

Nam et al. (2010) conducted a meta-analysis into the psychological factors impacting American college students' attitudes towards seeking professional psychological help and examined the differences across different ethnic backgrounds, finding that the lower self-disclosure is in an individual's culture, the more negative attitudes that exist towards mental health help-seeking. Nam et al. (2010) suggested that as a culture gradually assimilates or emulates Western culture, help-seeking values may become more acceptable. Masuda et al. (2009) found that American university students who were Asian-American or African American had fewer direct or indirect experiences of seeking professional help from services than White American students. Draucker (2005) conducted qualitative research with African American youth and found that seeking help from a mental health service was seen as a feature of White American culture. Young people in African American communities can prefer to deal with problems by speaking with a religious leader, using prayer, relying on extended family, informal networks, or community workers (Draucker, 2005). Engaging in another culture's activities or adopting their values can compromise an individual's cultural identity and could be socially detrimental

if viewed in line with *social identity theory* (Turner & Tjafel, 2004). Kranke et al. (2011) found that African American youth conform to the values of their community as this is crucial for social inclusion, developing relationships, preserving social image, and ensuring a strong cultural identity, which can be a source of self-esteem and belonging, factors which can be more important than resolving a personal problem.

Minority communities living in predominantly Western cultures can have distrust of mental health systems (Kranke et al. 2012). Mental health services and therapies developed in parallel with Western medicine and Masuda et al. (2009) states it is critical to consider how minority populations were treated within these systems historically. This underutilising and distrust of mental health services can also be the result of culturally inappropriate delivery factors or differing conceptualisations of mental health care (Draucker, 2005; Valibhoy et al. 2017). Kilian & Williamson (2018) found that Western conceptualisations of pathology results in Aboriginal young people receiving culturally inappropriate care, that there were no pathways of care developed to meet their needs. Barksdale & Molock (2009) propose that culturally specific models of help-seeking behaviours are crucial to help increase utilisation of professional mental health services.

In refugee communities, informal networks remain the dominant source of help for young people, specifically friends, as young people who are refugees often have heightened distrust of professional services because of previous negative interactions from their refugee experience (DeAnstiss & Ziaian, 2010; Valibhoy et al. 2017b; Byrow et al. 2020). Ellis et al. (2010) found that sources of help for young people who are refugees, were often culturally segregated; help from one's own culture came from religious or community sources or externally from professionals in Western mental health systems. Adolescents may not feel comfortable accessing help from either source and can conceal problems to avoid community talk and possible stigmatisation from either (Ellis et al. 2010).

Research from Asia, Africa and Arabic cultures on youth help-seeking behaviour

Research from Singapore, South Korea, Japan and China, report that there are strong societal and cultural norms against seeking professional help for a mental health problem outside of the family and that young people in general prefer self-reliance or informal networks (Chen et al. 2014; Choi & Miller, 2014; Lee et al. 2009; Yoshioka et al. 2014; Martinez et al. 2020; Tan et al. 2020; Kim, 2021). These findings are similar with research from within Western cultures but have some differences on how stigma of mental health is expressed. Research by Kim

(2021) found that stigma is still of high concern for young people in South Korea and other research from Singapore reports that the expression of strong emotions in Asian cultures can be viewed as implying weakness, immaturity, and a lack of self-control on the individual, which is viewed as detrimental to society at large (Lee, 2009; Tan et al. 2020). Help-seeking can bring shame and embarrassment to the individual and their family (Nam et al. 2010; Berry et al. 2020). Research from Tawain reported that adolescents with suicidal ideation were more likely to seek mental health services and in Cambodia, symptom severity was described as a predictor of help-seeking (Khann et al. 2019). Adachi et al. (2020) found that stigma did not delay help-seeking in Japanese youth but was caused by the process of making the decision.

Due in part to the impact of globalisation, Lee (2009) states that as certain Asian cultures are becoming more Westernised, individuals are conforming less to traditional cultural values. Young people were found to have compounded distress and ambivalence about help-seeking when managing two cultural values (Lee, 2009). Reframing counselling as a self-enhancement tool might lower public stigma and encourage help-seeking for young people who manage dual cultures (Choi & Miller, 2014). Lee (2009) found that adolescents who conformed to Asian norms by inhibiting emotions experienced less ambivalence and distress than those who were influenced by Western values of self-expression. The value of individualism and self-reliance can support values of not wanting to burden or negatively impact the wider cultural group (Choi & Miller, 2014).

Al-Krenawi et al. (2009) highlights that in Arabic culture, it is preferable to deal with problems within family and community networks. A young person's problem is viewed as a family problem and so speaking about it outside of the family context can bring stigmatisation as well as shame and embarrassment. The concept of honour in Arab society is very important, and help-seeking to mental health services has stigma attached regardless of education and status (Al-Krenawi et al. 2009). In Tunisia, social support in preferred over formal (Fekih-Romdhane et al. 2020).

Research has found that Palestinian and Israeli Arab respondents had higher levels of openness towards professional help-seeking than Kuwaiti and Egyptian counterparts (Al-Krenawi et al. 2009) and in Galilee, Daeem et al. (2019) found that access barriers, not stigma, was a primary deterrent of help-seeking. Al-Krenawi et al. (2009) attributes this factor to be a result of Palestinian and Israeli Arab communities having had more immersion in mental services due to modernization and higher levels of intervention due to the ongoing political

conflict. Research from Jordan however has found that young people are not seeking help due to stigma (Rayan & Jaradat, 2016; Dardas et al. 2017). In India, research by Gaiha et al. (2020) found that young people living rurally have high stigma about mental health which can be rooted in beliefs that these problems are something that someone cannot recover from, that individuals with mental health problems were dangerous. This study also reported that different typical western psychiatric labels are not commonly used or understood. Similarly, Shinde et al. (2021) found that young people in rural India have distinct conceptualisations of mental health, use different language to describe and associate depressive tendencies with being female. Family were found to be the first source of support for distress, followed by a religious leader (Shinde et al. 2021).

In South Africa, Samoulihan & Seabi (2010) report that young people prefer to seek help from indigenous healers and traditional approaches to treating mental health but are often described from a Western perspective as a barrier to professional Western healthcare systems. Research from Nigeria, Nairobi and Botswana report similar findings, with young people and families concealing mental health problems when they expect or perceive stigma from others in their families or communities (Dogra et al. 2012; Pheko et al. 2013; Mbuthia et al. 2018). Much research from outside Western cultures reports similar problems with help-seeking regarding the social stigma of having a mental health problem.

Overview

Overall, international findings demonstrate that communities with collectivist orientations have the same underlying problem as individualistic cultures; valued social norms are incongruent with seeking psychological help (Pheko et al. 2013). Professional help-seeking can mean going outside community norms and Ellis et al. (2010) states that it is crucial to consider and assess how help-seeking can cause harm both socially and culturally for a young person.

3.4.3. Community Mental Health Literacy and adolescent help-seeking behaviour

Community mental health literacy refers to a community's knowledge and beliefs about mental health problems that aids their recognition, management, or prevention (Jorm et al. 2000). Communities for young people extend beyond traditional geographical or cultural boundaries and include their school, peers, and wider media (Kranke et al. 2012). The interpersonal relationships within a community network support the initiation and maintenance of the use of mental health services and parents' decisions to initiate help-seeking for their

child can be greatly influenced by community values (Lindsey & Kalafat, 1998; Ellis et al. 2010; Medlow et al. 2010).

Research to date has asserted that young people can be facilitated to seek help by increasing community health care promotion and knowledge of services (Jorm et al. 2008a; Jorm et al. 2008b; Phillipson et al. 2009). Much research promotes the idea of increasing community capacity, with the logic that if mental health stigma in the community can be reduced then attitudinal and personal barriers can also be reduced, which will facilitate young people to seek help to services. However, many authors have argued that this process is futile unless there is adequate provision of youth mental health services (Wilson & Deane, 2001; Hernan et al. 2010; Phillipson et al. 2009; Kranke et al. 2012; Radez et al. 2021). Michelmore (2012), in a systematic review of randomized controlled trials, has suggested that a lack of available mental health services has been suggested as a reason why school-based suicide education programs did not increase help-seeking.

As a result, some research suggests preparing adults within the wider community, who are seen as role models or leaders, as points of contact in which young people can seek help or can refer young people to professional services (Wilson & Deane, 2001). There is some evidence to show that there are opportunities for community capacity building through established community structures, such as sports coaches and youth workers (Mazzer & Rickwood, 2009; 2011). Community workers often play a pivotal role in increasing families and peers' capacity to assist young people to cope in times of distress, as their role in the community is often trusted already by adults, but their position is also detached enough to earn young people's trust (Gilchrist & Sullivan, 2006). Youth workers are by their profession skilled in working with adolescents regarding their specific needs and often encounter young people who are at high risk of mental health problems (Mazzer & Rickwood, 2009).

Research suggests that it is important that mental health services build direct relationships with communities to build capacity and the trust needed to facilitate professional help-seeking, especially within minority populations living within Western cultures (DeAnstiss & Ziaian, 2010). The role of a young person's community cannot be underestimated and as Medlow et al. (2010) proposes, mental health problems are a community problem and therefore researchers and practitioners need to acknowledge that the solutions to them lie within communities.

3.4.4. The impact of media representations on adolescent help-seeking behaviour

Western cultural beliefs around mental health are impacted by media representations of people with mental health problems (Goodwin et al. 2016). Research into this topic reported that most depictions of mental health in the media were misleading, negative, stereotyped and stigmatizing (Jorm, 2000; Coverdale et al. 2002). Films in particular have been shown to impact how adolescents view mental health services and care, particularly in perpetuating stigmatising beliefs (Goodwin et al. 2016). In particular, Butler & Hyler (2005) have discussed how Hollywood representations of distressing mental health problems are depicted as a normal part of adolescence and main characters do not seek treatment. Wahl (2003) reported that children learn about mental health from the media. Both images and references to mental illness are common in children's media often stereotyping individuals with mental health problems as violent, unattractive, and criminal and teach children to respond to mental illness in an avoidant or disparaging way (Wahl, 2003). In 2011, a review of newspaper coverage of mental illness suggests that the public gets the majority of its knowledge of mental health from news media and in general, from 1989 to 2009, the tone of reporting of mental health has become less negative, indicating a positive trend in stigma reduction (Wahl et al. 2011). Research from Australia by Morgan & Jorm (2009) looking specifically into how the media impacts young people's help-seeking, found that participants recalled news stories about mental health that included themes of crime, mental health system failures or discussion of mental health by prominent individuals. Thompson et al. (2020), in a study of a social media campaign in America, found that this platform was useful for addressing mental health stigma and encouraging help-seeking but that this effect was limited to Caucasian participants. While there is no conclusive evidence that the media directly impacts young people's help-seeking behaviour, the media does affect beliefs and attitudes towards mental health in general, factors which have been shown to affect help-seeking behaviour (Morgan & Jorm, 2009; Wahl, 2003).

3.4.5. The Irish cultural context on adolescent help-seeking behaviour

Irish society can be described as Western, but like other nations in this category it is culturally distinct (Murray, 2006). One of the most important influences on modern Irish identity and culture was Roman Catholicism (Ó Féich & O'Connell, 2015). This religion became enmeshed with Irish nationalism in the late nineteenth creating *Irish Catholicism*, a differentiating identity in a country experiencing British Imperialism and influenced by English Protestantism (Inglis, 2015; Ó Féich & O'Connell, 2015). While the influence of the Catholic Church on politics, governance, the media, the public sphere, and civil society in general has declined, its legacy,

handed down from family to family, still impacts Irish daily life, attitudes, beliefs, and culture, with the majority of the Irish population regarding themselves as belonging to an Irish Catholic heritage (Moore, Thornton & Hughes, 2017; Inglis, 2015; Ó Féich & O'Connell, 2015). The Catholic Church has played a major role in the provision of healthcare and education in Ireland, with 88 percent of schools in Ireland to date being under the patronage of Roman Catholicism (Department of Education, 2021). Personal and family problems were historically managed within the family, or if external help was needed, support via religious structures could be sought.

Although these institutions are disused, in Ireland their physical presence remains, often being used for other governmental services. Ireland is a modern and developed post-colonial society that is undergoing a process of de-institutionalisation from the Catholic Church. Goodwin et al. (2016) suggests that the legacy of the asylums and older psychiatric systems in Western countries continues to impact stigma today. How families view authority, specifically government systems and their imperial or religious foundations, can impact young people's attitudes, especially considering mental health help-seeking in previous times could result in institutionalisation (Murray et al. 2006; Masuda et al. 2009; Inglis, 2010). The concept of using mental health services is a recent idea in Irish culture and is still considered taboo (Lynch et al. 2018). Older generations can still disapprove of emotional expression outside of the family and younger generation's need for support can cause ambivalence around help-seeking (Lee, 2009; Lynch et al. 2018). These cultural legacies impact young people's beliefs, attitudes, and behaviour towards professional help-seeking.

3.4.6. The impact of social economic status on adolescent help-seeking behaviour

It is important to acknowledge that young people in general may experience marginalisation because of their age, and so other factors that can further impact marginalisation such as socio-economic status (SES), rural factors or refugee status can compound help-seeking for a mental health problem (DeAnstiss & Ziaian, 2010; Burlaka et al. 2014; Byrow et al. 2020). According to Ferrin (2009), the SES of a young person's family can have a considerable effect on their mental health and their attitudes towards help-seeking. Social disadvantage can result in young people having more life stressors than those with a higher SES and research shows that a high proportion of young people with mental disorders have experienced social disadvantage and abuse from others (Charman et al. 2010). In a study from Turkey, it is reported that students

with the most severe levels of depression came from the lowest level income families (Bilican, 2013).

Personal stigma has also been found to be higher among young people from lower SES families and lower levels of attendance to primary care services for young people with depression has been linked to lower SES (Ferrin et al. 2009; Ibrahim et al. 2019; Leavey et al. 2020). A young person's problems can stem from their home life or family circumstances and as parents are often gatekeepers to young people accessing help, disclosing their family circumstances can have negative repercussions for young people experiencing abuse or neglect (Charman et al. 2010).

Klineberg et al. (2011) suggests that SES can impact mental health literacy, but SES is not always a predictor of help negation or mental health literacy. Having more evident life stressors can alert school personnel and other community members that a young person needs support and high levels of stress emanating from low SES factors, such as living in an overcrowded house or living with one parent, can increase the likelihood of service utilisation (Mariu et al. 2011; Ryan, Toumbourou & Jorm, 2014). Leavey et al. (2020) suggests that social inequalities might be more impactful than the family environment in determining mental health problems, and that those most at risk of mental health may be least likely to seek it.

3.4.7. The role of gender socialisation on youth help-seeking behaviour

How young people are socialised in line with prevailing gender norms can have a significant impact on their propensity to seek help (Jorm et al. 2006; Vandheusden et al. 2008; Georgakakou-Koutsonikou, 2017; Çebi & Demir, 2020). Gender socialisation appears to negatively affect help-seeking behaviour in males more than females as studies have demonstrated that young men are less likely than females to seek help for a mental health problem (Biddle et al. 2004; Jorm et al. 2006; Rickwood et al. 2007; Vandheusden et al. 2008; Nam et al. 2010; Bradford & Rickwood, 2012; DeAnstiss & Ziaian, 2012; Coles et al. 2016; Çebi & Demir, 2020). It has been reported that young men may experience more pressure than young women to conceal mental health problems due to wider masculine ideals (Vanheusden et al. 2008; McClean et al. 2013; Jackson Williams, 2014; Lynch et al. 2018). Masculine ideals can cause the internalizing of the ideological position that men should always be tough, independent, competitive, in control and emotionally inexpressive and this can have detrimental effects on young men who need to seek help (Gonzalez et al. 2005; Vanheusden et al. 2008; Al-Krenawi et al. 2009; Nam et al. 2010). Leveraging masculinity and creating

positive meaning from help-seeking has been found to support help-seeking in young men (Lynch et al. 2018; Clark et al. 2020).

Women, in general, are socialised to be more accepting of help and are often positioned as dependent or in need of assistance and so help-seeking might not damage female gender identity to the same extent (Gonzalez et al. 2005; Lynch et al. 2018). Young women may also reject help-seeking to appear self-reliant and competent in an attempt to unshackle themselves from the gender stereotypes that present them as reliant and dependent. These behaviours reflect how gender identity can be positioned within opposing group behaviour norms, specifically, women seek help and men do not; for a man to behave as a woman can undermine his self-image, group image and masculinity (Lynch et al. 2018).

Findings about young men cannot be inversely extrapolated to imply young women find it easier to seek help for a mental health problem and young women's perspectives in general are inadequately researched (Lynch et al. 2018). Research has found that young women have strong fears of social judgement and rejection (Del Mauro & Williams, 2013; Pederson & Paves, 2014; Gilchrist & Sullivan 2006). While research shows young women can hold more positive attitudes than young men and young men do have higher suicide rates, young women are less likely to seek help than older females and help-seeking within the youth demographic is low when compared with all other demographics (Nam et al. 2010) and so it is important to avoid simplifications of gender differences (Nearchou et al. 2018).

3.4.8. How rural living affects adolescent help-seeking behaviour

Young people living in rural communities face different challenges when help-seeking for a mental health problem compared to those in urban areas (Judd et al, 2006; Boyd et al. 2007). To date, the majority of research on rural youth stems from Australian studies which reports that rural adolescents tend to have more stoic attitudes than urban populations (Judd et al. 2006; Hernan et al. 2010; Rughani et al. 2011). However, there is a study from Nigeria that has found that urban children were less knowledgeable than rural children about mental health issues (Dogra et al. 2012).

Adolescents in rural contexts are particularly affected by structural barriers to accessing care, meaning that if a young person can overcome personal barriers to help-seeking, it is unlikely that there will be available local support services (Hernan et al. 2010). A lack of services in rural areas can reinforce stoic attitudes and increase reliance on informal networks (Hernan et

al. 2010). Community and social networks in rural areas can benefit from mental health first aid training which could aid in stigma reduction and create potential beneficial partnerships between communities and mental health professionals (Hernan et al. 2010). Building community capacity can be beneficial in some communities and not in others as rural communities are not homogenous and vary in their unique cultures throughout different regions and countries. This type of intervention was found in an Irish study to discourage help-seeking in some communities due to confidentiality concerns (Lynch et al. 2018). Confidential outreach services can be an important solution in rural contexts (Hernan et al. 2010; Bilican, 2013).

3.4.9. Help-seeking behaviour trends over time

Help-seeking behaviours have fluctuated over time and are directly influenced by societal norms and cultural changes which have been impacted by public campaigns to address mental health stigma and improve attitudes and beliefs. In general, between 1992 and 2002, there was an increase in the amount of young people who described comfort when talking about mental health problems with adults other than their family members (Dey et al. 2016). On the contrary, one review study among American college students found attitudes towards mental health help-seeking as becoming increasingly negative over the past 40 years and suggests that this indicates that stigma has not decreased but remained steady or worsened (MacKenzie et al. 2014). Interpreting these findings in any definitive way is problematic and more evidence is needed. However, it is important to acknowledge when evaluating longitudinal findings that other factors such as trends in therapy options and the rise of pharmaceuticals have had an important impact on attitudes and beliefs (MacKenzie et al. 2014; Dey et al. 2016).

Youth mental health help-seeking research can be approached from different help-seeking models (Pearson & Hyde, 2021) and research is not always clear regarding their theoretical underpinnings. Clark et al. (2020) in a review of the wider literature on youth help-seeking for mental health states there is a need to develop definitions, theoretical frameworks and employ higher methodological standards when researching help-seeking behaviour in young people. There are three consistent conclusions cross-culturally that can be stated regarding youth mental health trends over time; first, that mental health literacy has increased; second, that youth suicide has also increased and finally, that young people, specifically in Western societies, are experiencing higher levels of life stressors and psychological distress than before (MacKenzie et al. 2014; Dey et al. 2016).

3.4.10. Summary of environmental factors

This section of the literature review has considered research that examines how different environmental factors influence young people's help-seeking behaviour. *Stigma* is undoubtedly one of the most important factors when examining young people's help-seeking behaviour but cannot be considered without examination of a young person's *cultural* influences. The fear of social exclusion and rejection by one's own culture or family for having a personal weakness appears more influential than a cultural value that permits or obstructs help-seeking. The *Irish context* has been shown to impact help-seeking values due to its unique cultural heritage and globally, research has demonstrated the impact of the *media* on stigma and cultural ideas about mental health. Demographic factors such as a lower *SES* or living in a *rural* environment can exacerbate a young person's mental health but can also be a factor that supports help-seeking. Research from *gender* socialisation can help understand how young men and women are impacted differently by help-seeking but ultimately shows that young people regardless of this find help-seeking for a mental health problem difficult.

3.5. Young people's sources of help for a mental health problem

This section of the literature review examined research regarding what sources of help young people look for when they are experiencing a mental health problem. The sequence of this section mirrors important points on a help-seeking pathway after self-management. This begins with a review of research on *self-management,* followed by an exploration of the role of *informal social networks* and *formal and statutory services* on young people's help-seeking behaviour. After this, how *community gatekeepers, schools* and *family doctors* can support, or block help-seeking is presented, and this section concludes with a review of what young people have reported as needing from the *helping relationship.*

3.5.1. The role of informal support in young people's help-seeking pathways

It is established within the international literature that young people initially prefer to help-seek to friends and families for a mental health problem (Tharaldsen et al. 2017; McNicholas et al. 2018; Gebreegziabher et al. 2019; Singh et al. 2019; Fekih-Romdhane et al. 2020; Powell et al. 2021). Friends and family can offer satisfactory support for their distress, such as listening, guidance and information (Draucker et al. 2005; Freedenthal and Stiffman, 2007; Bilican,

2013; Coleman-Fountain et al. 2020; Pearson & Hyde, 2020; Thai et al. 2020). As children grow up, general help-seeking for problem-solving to family and friends is a part of daily life and involves easily accessed help through ongoing, natural, and fluid interactions (Lindsay & Kalafat, 1998; Rickwood et al. 2005). Pearson & Hyde (2021) suggest that young people seek informal help due to low mental health literacy, but other research has shown that young people have fears about the unknown processes of help-seeking to a stranger in a service, and so prefer the familiarity and predictability of support within their trusted informal networks (Lindsey & Kalafat, 1998; Rickwood et al. 2005; Freedenthal & Stiffman, 2007; Coleman-Fountain et al. 2020). Hernan et al. (2010) has argued that families and friends are essential helpers to rural young people who are unable to access professional services. Similarly, research shows that family and friends are essential for young people with refugee status or young people in minority communities with differing conceptualisations of mental health, living within a majority western culture (Freedenthal and Stiffman, 2007; De Anstiss & Ziaian, 2010; Ellis et al. 2010; Valibhoy et al. 2017). Young people in care systems can prefer informal sources of support because of previous experiences of stigmatisation, lack of understanding, lack of collaboration and confidentiality issues from professionals as well as service inaccessibility (Powell et al. 2021).When young people do decide to help-seek to a formal service, informal supports play a central role in providing resources and in assisting young people to attend and stay within services (Medlow et al. 2010; Valibhoy et al. 2017; Westberg et al. 2020; Eigenhuis et al. 2021).

Research demonstrates that young people can need support outside of their social networks as their mental health problems were connected to their family or friends (Gilchrist & Sullivan, 2006; Fox and Butler, 2007; Moen et al. 2019; Westberg et al. 2020). As the resources of close relationships are needed to access services, young people can avoid help-seeking if it means having to disclose reasons for help-seeking to those causing or contributing to mental health problems (Fox and Butler, 2007; Medlow et al. 2010). Young people also fear being othered or stigmatised by their families and friends who can be unsupportive of help-seeking (Quinn et al, 2009; Medlow et al. 2010; Schmeelk-cone et al. 2012; Yap et al. 2013). Fox & Butler (2007) found that young people were likely to seek professional help if they perceived they had ‘no one to talk to’ in their social network.

Findings overwhelmingly report that young people regard their family and friends as playing a central role in their mental health and in professional help-seeking pathways (Burns & Rapee,

2006; Jorm et al. 2008; Bilican, 2013; Moen et al. 2019; Andriessen et al. 2018). Help-seeking to friends and family can be viewed as the first stage (Quinn et al. 2009; Hernan et al. 2010; Yamasaki et al. 2016) or are embedded throughout help in professional help-seeking pathways (Damian et al. 2018; Moen et al. 2019). Mariu et al. (2011) argues that not enough is understood about how the role of informal sources of help function in mental health help-seeking pathways. Moving beyond descriptors such as *barrier* or *facilitator*, Freedenthal and Stiffman (2007) argue that informal sources of help are a legitimate option of help.

The role of friends

Young people consistently report their preference for support as changing gradually from family to friends in adolescence (Rickwood et al. 2005; Burns & Rapee, 2006; Medlow et al. 2010; Klineberg et al. 2011; Lubman et al. 2016; Yamasaki et al. 2016; Maiuolo et al. 2019). Friends are described as able to support age-related problems (Gilchrist & Sullivan, 2006; De Anstiss & Ziaian, 2010) and parents, due to intergenerational disconnect, were found to be less supportive or able to relate (Maiuolo et al. 2019). Friends can provide trust and understanding as well as support in learning to solve age-related problems away from adults who could react negatively, especially if concerns are related to taboo topics such as sex and drugs (Fox & Butler, 2007; Freedenthal & Stiffman, 2007). Friends can be proactive in initiating help-seeking, locating, or signposting a peer to help, especially when suicidal (Rickwood et al. 2005; Schmeelk-cone et al. 2012). For young people who have experienced asylum seeking, research from America and Australia agree that peer groups are critical for both support with mental health problems and for connecting them with professional services (De Anstiss & Ziaian, 2010; Ellis et al. 2010).

Research has also found that young people can rate peers as untrustworthy, unreliable, lack understanding, empathy, or resources (Gilchrist & Sullivan, 2006; Fox and Butler, 2007; De Anstiss & Ziaian, 2010; Laureiro et al. 2013). Young people can avoid confiding in friends out of fear of ridicule, threats to self-esteem, confidentiality, or stigma (Gilchrist & Sullivan, 2006; Quinn et al. 2009; Yap et al. 2013). Rickwood et al. (2005) found that across the early to mid-adolescent years girls were increasingly socialised to use friends as a source of help and gradually reduce dependence on their parents and boys were socialised to help-seek less from all informal sources (Rickwood et al. 2005). More recent research by Pearson & Hyde (2020) reaffirms this role of friends in relation to gender.

Befriending peers with similar psychological problems can enable or encourage destructive self-management behaviours and discourage professional help-seeking (Freedenthal & Stiffman, 2007; De Anstiss & Ziaian, 2010; Bilican, 2013; Eigenhuis et al. 2021). Social rejection or abuse from friends and peers can significantly contribute to mental health problems (Draucker, 2005; Gilchrist & Sullivan, 2006; Fox & Butler, 2007; Quinn et al. 2009). Young people who are suicidal can avoid informal help-seeking out of fear of stigmatisation and can be a reason why they seek formal support (Nguyen et al. 2021; Pan et al. 2021).

The role of families

Families can be a source of comfort and immediate support for young people's emotional distress (Bilican, 2013; Coleman-Fontaine et al. 2020; Calear et al. 2021). Medlow et al. (2010) states that families offer "out of hours" support to young people during difficult periods. Research has also found that families often initiate help-seeking and provide important practical, logistical, and emotional resources to access care and overcome help-seeking obstacles (Draucker, 2005; Burns & Rapee, 2006; Medlow et al. 2010; Lubman et al. 2016; Persson et al. 2017; dos Santos Martin et al. 2018; Maiuolo et al. 2019; Coleman-Fontaine et al. 2020; Eigenhuis et al. 2021). Family members can notice young people's difficulties first and suggest problem-solving strategies or facilitate earlier interventions in mental health care (Maiuolo et al. 2019; Moen et al. 2019).

Much research implicates the quality of the caregiver-child relationship as important in mediating engagement and maintenance in mental health care (Draucker et al. 2005; Moen et al. 2018; Maiuolo et al. 2019). Young people can learn important help-seeking skills from caregivers when they are psychologically available and able to structure a young person's decision making and support autonomy (Rickwood et al. 2005; Yap et al. 2013; Maiuolo et al. 2019). Findings from a large-scale national survey in Norway (Moen et al. 2019) indicate that young people with high distress experience more conflict with caregivers and are less likely to seek help from those in their social network. Similar findings from Northern Ireland (Breslin et al. 2021) suggest that having a supportive family life was significantly related to fewer mental health problems and so young people were more likely to seek help from their families for emotional distress, who could then connect them with an appropriate service.

Caregivers are not always approachable or equipped to deal with or recognise young people's problems (Gilchrist & Sullivan, 2006; Lourerio et al. 2013; Wang et al. 2020; Eigenhuis et al.

2021). Not all families have the resources necessary, especially emotional ones to support help-seeking (Damian et al. 2018). Due to expressional styles, communication issues or stereotyped expectations of development, caregivers can miss distress or underestimate their child's problem (Gilchrist & Sullivan, 2006; Ellis et al., 2010; Lourerio et al. 2013; Damian et al. 2018). Intergenerational differences regarding values, and behavioural norms can mean young people help-seek outside the family unit or not at all (Draucker, 2005; Fox & Butler, 2007; Yap et al. 2013b; Maiuolo et al. 2019). Parents can respond to mental health distress in the early stages with stigmatised attitudes regarding their child's mental health which affects help-seeking decisions (Villatoroa et al. 2018). Wang et al. (2020) found that suspicion of professionals can be encouraged in young people. Young people also fear disapproval, embarrassment, invalidation, or punishment for going outside their families (Yap et al. 2013b; Gilchrist & Sullivan, 2006; Fox & Butler, 2007; Valibhoy et al. 2017; Arora & Persaud, 2019; Wang et al. 2020).

In many countries, young people under eighteen years of age, who are in a unique legal position of dependence on family can require consent to attend mental health services. When they do provide consent, caregivers, because of suspicion or concern, can become over-involved or exert pressure on their child into treatment and can interfere with the development of a trusting therapeutic rapport, and lead to earlier exits from health care and poorer outcomes (Gilchrist & Sullivan, 2006; Persson et al. 2017; Mahsoon et al. 2020). In-depth interviews by Draucker et al. (2005) with service users revealed that young people can hold back information, lie to therapists and parents, or pretend to be better in order stop attending a service. Under-involvement, where parents were dismissive of healthcare, resulted in earlier exits from therapy or a lack of supervision over prescription medication (Draucker et al. 2005).

Young people with asylum seeking experiences, and living in Western countries, reported that it is not always appropriate to talk to a parent about problems as discussing personal problems can disrupt the traditional family hierarchy and boundaries of the parent-child relationship (Ellis et al. 2010; DeAnstiss & Ziaian, 2010; Valibhoy et al. 2017). Not all young people view help-seeking outside of the family environment as appropriate (Valibhoy et al. 2017) and young people may not want to ask for help from parents who are recovering from traumatic experiences or who are too distressed to provide supportive or consistent parenting (Ellis et al. 2010; DeAnstiss & Ziaian, 2010). These findings may be analogous to young people who have parents with their own mental health concerns, trauma, financial difficulties, and other life

adversities (Gilchrist & Sullivan, 2006; Damian et al. 2018). Not all young people have supportive family backgrounds (Medlow et al. 2010) and some young people may have neither practical nor emotional support from families due to the life circumstances that result in state care or experiences of homelessness outside of the families (Draucker et al. 2005; Damian et al. 2018). While research by Mariu et al. (2011) has found that coming from a family with high levels of economic stressors can increase the likelihood of service utilisation, Damian et al. (2018) discussed how families in their research accepted distress and normalised trauma which negatively impacted their ability to view psychological problems as addressable or preventable.

Overview

Informal sources of support can be difficult to research or evaluate as it involves exploring patterns of nuanced interactions that happen in varying domestic and social contexts over time (Lindsey & Kalafat, 1998). How friends and families respond will vary depending on rapport, mental health literacy and cultural factors. Social networks that are supportive and have knowledge of help-seeking will increase the likelihood of a young person seeking professional help and inversely, those without helpful informal supports may have delayed help-seeking or complete help-negation. Findings also suggest that informal support can be layered, being both helpful and unhelpful at different points within a single help-seeking episode. Help-seeking for mental health is a relational and socially embedded process (Planey et al. 2019; Çebi & Demir, 2020) and MacDonald et al. (2018) states that families need to be included as pathway agents as their role is not always acknowledged.

3.5.2. The role of formal services young people's help-seeking pathways

In Ireland and Northern Ireland, formal services are provided as part of the Healthcare Service Executive (HSE) and the National Healthcare System (NHS), where professionals are accessed through a referral system (HSE, 2021; NHS, 2021). The Child and Adolescents Mental Health Services (CAMHS) or Adult Mental Health Services (AMHS) provide access to doctors, psychologists, counsellors, and psychiatrists. Certain formal services can be accessed privately. This format of mental health care exists internationally in varying compositions and according to research are not readily utilised by young people (Rothi & Leavey, 2006; Rickwood et al. 2007; Vanheusden et al. 2008; Raviv et al. 2009; Burlaka et al. 2014; MacKenzie et al. 2014; Samoulihan & Seabi, 2010).

Utilisation of formal services

Clinicians, policy makers, and researchers have been concerned about low rates of mental health service use for nearly three decades (MacKenzie et al. 2014). Purcell et al. (2011) reports that in Australia, the rate of young people with a mental health problem that are not engaging with professional services may be as high as 75 percent. Zivin et al. (2009) found from quantitative data of American college students over two years that only 50 percent of participants with a mental health problem received formal treatment over this time frame. Similarly, Hernan et al. (2010) found that less than 50 percent of rural Australian adolescents reported that they would see a doctor or other healthcare professional if they had mental health concerns. Vanheusden et al. (2008) in Holland has found that only 28 percent of young adults aged 19–25 years would seek help with formal services. Young people who experience marginalisation may be even less likely to seek help and have low trust in services despite needing extra support due to experiences of complex trauma (Collins & Barker, 2009; Narendorf, 2017). Research has discussed the need for services to provide trauma informed care, open door policies and skilled workers to young people who have endured complex trauma such as homelessness (Crosby et al. 2018; Damian et al. 2018).

Hodgekins et al. (2016) found that young people can experience long, varied, and complicated pathways to mental healthcare. While individual, social, and healthcare factors shaping pathways to care varied, systemic complexities were a common inhibitor (MacDonald et al. 2018; 2020). Quinn et al. (2009) found that young people in third level education did not access mental health services as these were provided through a disability service and young people did not want to be labelled with having a disability or simply did not know they were entitled to use this service without a label of disability (Quinn et al. 2009). Young people can perceive formal services as being for severe mental health problems only, especially when they are clinical in nature (Hickie et al. 2007; Samoulihan & Seabi, 2010; Klineberg et al. 2011; McCann & Lubman 2012; Del Mauro & Williams, 2013).

Discussion on service provision

Understanding how service-related factors impact help-seeking behaviours requires examining research regarding service provision factors, such as organisational structures, personnel behaviour, and online support as well as physical and structural influences. It has been well evidenced that young people's efforts to seek help are often thwarted by a lack of knowledge of and difficulty in accessing services (Rothi & Leavey, 2006; DeAnstiss & Ziaian, 2012;

Bilican, 2013; Rowe et al. 2014). Providing this information has been reported as an important facilitator to those seeking help, as young people without sufficient information cannot make informed decisions about their mental health care or understand what to expect. (Wilson, Deane & Ciarrochi, 2005; Fox & Butler, 2007; Quinn et al. 2009; Masuda & Boone, 2011; McCann & Lubman 2012; Williams, 2012).

A recent review has acknowledged that issues related to service factors is a significant and common barrier or facilitator related to young people's help-seeking behaviour (Radez et al. 2021). Structural barriers including transportation, cost, and availability of services are important barriers for young people and often disproportionately affected those outside urban areas (Freedenthal & Stiffman, 2007; Michelmore et al. 2012). Mental health outreach work was described as an important solution to counteract some structural barriers (DeAnstiss & Ziaian, 2010; Masuda et al. 2009) especially in countries where there is an existing developed mental health service (Bilican, 2013). Access barriers are real for many young people (Stunden et al. 2020) with Brown et al. (2016) stating that these access barriers can be compounded for young people experiencing marginalisation including LGBTI+.

The preference for the use of informal supports over formal supports has been found for both young people and caregivers (Jorm et al. 2008b). Professionals in formal services such as psychologists and psychiatrists rated informal sources of support the least helpful and so this disparity in beliefs between professionals and young people and their caregivers, combined with the low rates of mental health service utilisation, can indicate that formal services are failing to meet the needs of those who use them (Vanheusden et al. 2008; Purcell et al. 2011; Burlaka et al. 2014; Stafford et al. 2016). The design and structure of formal service pathways, where young people are dependent on assessment and referrals, often means that young people do not have much choice or autonomy in their mental health care (Purcell et al. 2011). Research calls for reform through co-design when creating youth mental health services, stating that clinical settings are uncomfortable and can be potentially retraumatising for young people who are managing trauma (Anderson et al. 2017; Davison et al. 2017; Hackett et al. 2018; Persson et al. 2018). Beyond the physical service environment, services as a whole, need to make young people feel valued and comfortable in order to foster the development of trusting relationships between adolescents and the whole agency (Medlow et al. 2010; Purcell et al. 2011).

An important area of concern in service provision is the divide between child and adult services at the developmentally pressurised age of 18 years (Purcell et al. 2019). Youth is understood

as a life-stage extending to a minimum of 25 years of age (Arnett, 2014). Young people can be cut off from vital services at 18 years and be transferred to adult services that can result in young people moving into a service with stricter intake and diagnostic criteria and one that is not designed to meet developmental needs (Birleson & Vance, 2008; Purcell et al. 2011). If help-seeking was to be understood as a skill to be learned, more understanding and sensitivity could be brought to support young people with this task and aid this process rather than minimising age-related needs (Rickwood et al. 2005; Jorm et al. 2007). Youth mental health systems are constructed around legal criteria and adult models which do not reflect developmental or life stage needs, and thus require complete reform to ensure services for young people up to their mid-twenties (Purcell et al. 2011; MacDonald et al. 2018; Masillo et al. 2018; McGorry et al. 2019; Lynch et al. 2020). Burns & Birrell (2014) argue that there is no requirement for a new design and refer to the *Headspace* model that was developed in Australia as being an example of successful youth mental health services (Rickwood et al. 2019).

Formal service capacity in Ireland

An independent report of the Child and Adolescent Mental Health Services (CAMHS) conducted by Barnardos (2017) has found that youth mental health resources in Ireland are overstretched and under resourced, with the number of young people on waiting lists being particularly high. From February 2016 to 2017 there was a 44 percent increase in young people on a waiting list for their first mental assessment with almost 60 percent waiting for over a year, and 26 percent waiting for more than two years for an initial appointment (Barnardos Waiting List Survey, 2017). This report also uncovered regional variation in service provision nationally that CAMHS service provision is inconsistent and geographically discriminatory; the quality of care received or length of time on a waiting list may depend on where a young person lives. Research has demonstrated that being placed on a waiting list results in delays in treatment, exacerbation of symptoms, negative experiences, distrust of mental health care professionals and a decreased likelihood of future help-seeking (Michelmore et al. 2012). A study by McNicholas et al. (2018) on young people with eating disorders in Ireland found that young people, their caregivers, and professionals report a lack of support for families, a lack of standardisation treatment protocol and that many policies are not being brought into practice. Formal services in Ireland are not in a position to respond in a timely and sufficient manner to young people's mental health needs.

In Ireland, a similar model to *Headspace* called *Jigsaw*, has been developed and their statistics show increased youth engagement and improvement in mental health problems. However, their evaluations are not conducted independently or externally, and sites vary in delivery with some funded and coordinated by the HSE, and so evaluations should be read with caution (HSE, 2021). Importantly in Jigsaw, young people can self-refer in and are not reliant on their family doctor but are subject to service criteria for access. Another research study from Ireland looked at the role of an integrated counselling service within an existing youth service and found it removed many formal barriers and has been received positively by young people (Lalor et al. 2006).

The role of the internet

Young people spend a significant amount of their time on the internet and can be described as *digital natives*, having grown up in the era of the internet (Burn et al. 2010). The concept of *e-help*, or online help, has garnered attention over the previous decade as a means for providing earlier intervention, facilitating help-seeking, and providing important information to young people about mental health problems (Burn et al. 2010; Birnbaum et al. 2015). Research suggests that providing services online has the potential to overcome some of the barriers that inhibit help-seeking such as structural barriers, stigma, lack of confidentiality (Hernan et al. 2010; Frost et al. 2015). In a systematic review of research regarding services online Kauer et al. (2014) found a lack of evaluation and evidence that online support can increase help-seeking behaviours. Since this review, some evaluations have shown to be promising (Alvarez-Jimenez et al. 2020) and Chan et al. (2016) proposes that for e-help to be successful it needs to create virtual clinics offering tailored information, self-help programs, access to professional support, confidential screening and feedback, peer support tools and private support after hours.

E-help can potentially provide support to young people when they are in crisis and when support services are not open (Burn et al. 2010). This immediacy of the online environment can actually cause further problems and create a dependency to go online to solve a problem, as well as changing a young people's expectations about the time it takes to resolve a problem (Burn et al. 2010). Late night internet use can negatively affect physiological health, current mental health problems and quality of online support, and it can also be argued that online support provides an outlet for stigma through access to anonymous discussion online (Burn et al. 2010). Research has also shown that connecting with others with similar issues can reduce the isolation caused by mental health (Frost et al. 2015) but can also perpetuate behaviours

such as self-harm further when young people are engaged in a community that supports and encourages it (Rowe et al. 2014). There are deeper issues with experiences of online help that can result in young people experiencing confidentiality breaches and negative experiences with others through access to unregulated and often unsafe online environments (Charman et al. 2010). Frost et al. (2015) states that services can be more effective when they include contact with professionals and peers in safe and moderated online spaces.

Despite these limitations the internet can play an important role in information dissemination, specifically in supplying accurate mental health information to rural young people (Hernan et al. 2010). Some authors consider the opportunity for e-health in monitoring young people for relapse and providing earlier opportunity for intervention, which could address funding issues in offline services (Cotter & Bucci, 2020). Wong et al. (2021) found that young people who seek help online were more likely to have poorer mental health, higher suicidality and spend a lot of time online for non-work-related purposes. Rickwood et al. (2016) and Oh et al. (2008) argue that online help can reach these groups of people who may wait longer than others before seeking help in person. Bradford & Rickwood (2012) suggest that simply providing alternative help through the internet will not decrease the likelihood of young people facing barriers that they would experience in real life. The digital divide has been described as the lack of access to the internet, and associated exclusion from services due to SES and structural inequalities (Chen & Zhu, 2016). Orlowski et al. (2018) states that technologies need to be developed for all young people and inclusive of young people with disability and social disadvantage.

Research suggests that the internet might only be of assistance to young people once they have had positive experiences of help-seeking in real life as online options of support cannot fully address the core issues that young people face in real-life (Bradford & Rickwood, 2012). Many studies found that many young people prefer face-to-face support when dealing with their mental health problems (Oh et al. 2008; Burns & Rapee, 2006; Bradford & Rickwood, 2012) and online help can be depersonalised and remove some of the important aspects of meaningful care (Burns & Rapee, 2006). Stretton et al. (2018) states that online help-seeking can be a ‘foot in the door’ approach for young people to become more comfortable with the idea of formal help-seeking. Some research suggests that young people do view the internet as helpful for accurate information or as an alternative or complimentary support from face-to-face support (Oh et al. 2008) but a review by Xu et al. (2017) reaffirms that online support is not as effective as face-to-face. Wong et al. (2021) suggests that a combination of online and offline is important as a dual opportunity to engage young people but not to replace traditional face-to-

face support. Pretorius et al. (2019) suggests considering online support as adjunct to offline help-seeking and that there is a need to develop understanding of online help-seeking and devise specific models.

Preferred environment for receiving mental health care

The recommendations from international literature on how to provide mental health care for young people agree that mental health services need to be 'youth friendly' in all aspects of service provision ensuring the genuine participation of young people in the delivery, development, evaluation and implementation of mental health services in accessible, non-clinical, and welcoming settings (Wilson, Deane & Ciarrochi, 2005; Rickwood et al. 2007; DeAnstiss & Ziaian, 2010; Simmons et al. 2013; Leavey et al. 2011; McGorry et al. 2019; Westberg et al. 2020).

Research has found that it is crucial that mental health professionals providing support and other service staff are suitably trained to relate and respond to the social, cultural and practical needs of young people (Wilson, Deane & Ciarrochi, 2005; DeAnstiss & Ziaian, 2010; Medlow et al. 2010). Young people's experience of being welcomed by all staff in a professional service was found to be a determining factor in the continuation of their attendance with that service (Medlow et al. 2010). Services that promote themselves as safe and confidential environments where young people can seek credible and reliable support removed from their immediate environment, can be more successful in engaging young people and providing meaningful care and interventions (Gilchrist & Sullivan, 2006; Medlow et al. 2010).

If a young person can overcome personal and social factors that can prevent help-seeking they can be negatively impacted by unsuitable, under resourced or inaccessible services. Westberg et al. (2020) states young people's attempts at help-seeking can be missed due to difficulty in accessing services especially when systems are siloed. The role of community services, such as social work and youth work, has been highlighted as potential services that can offer supportive roles for statutory services (Lindsey & Kalafat, 1998; Gilchrist & Sullivan, 2006). These services can provide consultation on appropriate ways to engage and work with young people and also have the potential to provide young people with easily accessed and flexible support in a non-stigmatised community setting that bridges the gap between young people and statutory services (Lindsey & Kalafat, 1998; Gilchrist & Sullivan, 2006; Boyd et al. 2007; DeAnstiss & Ziaian, 2010; Salaheddin & Mason, 2016; Westberg et al. 2020). Young people's preference in service provision will vary depending on context, cultural, environmental, and

personal factors (Boyd et al. 2007), but young people place value on having a choice in healthcare and can engage meaningfully when services are appropriate for young people and the benefits outweigh the risk (Lindsey & Kalafat, 1998; Wilson & Deane, 2001; Draucker, 2005; DeAnstiss & Ziaian, 2010).

3.5.3. The impact of gatekeepers in young people's help-seeking process

Mental health gatekeepers can be described as people in the community who are in a position to assist distressed individuals to access appropriate professional support services and for young people include parents, GPs, youth workers, teachers, social workers, religious leaders, or community leaders (Rickwood et al. 2007). The most common gatekeepers with whom young people have reported feeling comfortable and engaged with are often adults in *semi-formal mental health professions*, which can be described as service providers and professionals that do not have a specified role in delivery of mental health care but who encounter or provide support with those who need mental health care (Rickwood et al. 2005; Rickwood et al. 2012). These gatekeepers, typically youth workers and social workers, school nurses and youth counsellors, often have a decisive role in earlier interventions and encouraging the use of specialised services (Rickwood et al. 2005; Rickwood et al. 2012).

Cheng (2009) found that adolescents were likely to seek help from social workers for an anxiety, mood, or attention-deficit/disruptive behaviour disorder or when they were involved with the justice system. Similarly, youth workers have been identified as key community gatekeepers for young people, specifically for young people who experience marginalisation (Rickwood et al. 2005; Mazzer & Rickwood, 2009). Youth workers are described as having the capacity to provide support to young people with personal, familial, and situational problems (Mazzer & Rickwood, 2009). Young people experiencing homelessness can have difficult pathways to care (Lee et al. 2021) and so trust referrals from a youth worker that they have a trusting rapport with (Rickwood et al. 2005; Collins & Barker, 2014). One study by Mazzer & Rickwood (2009) found that youth workers do not always rate formal mental health services favourably and were reluctant to refer young people with distress to professional mental health service instead preferring to refer within the community agencies they worked in or a GP.

Schools and universities are described as being in an excellent position to assist parents and young people in getting access to professional services (Bramesfield et al. 2006; Quinn et al. 2009). In education settings, gatekeepers were found to be beneficial to students in assisting

them in choosing the appropriate service they require (Quinn et al. 2009; Gronholm et al. 2015). Findings from research with secondary students reported only accessing a school counsellor because the counsellor had approached them first (Boyd et al. 2007). Bramesfield et al. (2006) suggests that as young people were not always aware that they were experiencing a mental health problem the assigning of key workers in schools who can act as gatekeepers can help identify those who need help. Gatekeepers can be important in education settings for engaging distressed young people who may not be able to identify or know how to deal with their own problems (Quinn et al. 2009).

It is important to note that all individual's acting as gatekeepers do not perform or relate well with young people and can have a negative impact on mental health help-seeking pathways (Rickwood et al. 2005). The most common gatekeepers are parents and school personnel and while they can consider themselves approachable, young people often report that parents and teachers are often a source of fear or anxiety (Gilchrist & Sullivan, 2006). If a young person feels that they can only access help through a gatekeeper that they do not have a good rapport with, they can often negate help (Charman et al. 2010). Young people under eighteen usually have little autonomy when accessing professional mental health services and so the family can become the most powerful gateway provider (Ellis et al. 2010). In these circumstances, young people may not be able to access any help or alternatively can access help under coercion (Draucker, 2005).

Gatekeepers can be a roadblock on the path to help-seeking or a helpful support depending on the relationship with the young person. Barriers associated with gatekeepers may be a result of the gatekeeper's individual knowledge and skill set and research suggests that gatekeepers are not always prepared for such a role (Rickwood et al. 2005; Gilchrist & Sullivan, 2006) Professional gatekeepers, appropriate training, assessment, and referral practices need to be ensured to effectively support young people in help-seeking for their mental health concerns (Rickwood et al. 2005; Xu et al. 2017).

3.5.4. The role of the family doctor in young people's help-seeking pathways

The family doctor (GP) is the most widely acknowledged health care professional who provides formal mental health support (Zwannswijk et al. 2007). Accessing formal mental health services within the Irish and UK healthcare systems depends on a referral, and the GP is the most common starting point on this pathway (HSE, 2021; NHS, 2021). As the GP is both a

gatekeeper and a formal healthcare provider, their role is discussed separately from that of professionals and gatekeepers.

Much research reports that young people do not seek help to GPs because they do not perceive them to be an appropriate source of help for psychological health concerns nor do they have positive attitudes towards them (Biddle et al. 2004, Biddle et al. 2006, Burns & Rapee, 2006, Jorm et al. 2007, Boyd et al. 2007; Ferrin et al. 2009; Charman et al. 2010; Mariu et al. 2011; Lynch et al. 2018). Biddle et al. (2006) and Leavey et al. (2011) found that young people in England do not consider GPs as appropriate professionals for dealing with mental health problems, perceiving them as unqualified and lacking sufficient knowledge and training to respond to patients with mental health concerns. Young people can generally reject GPs as a possible source of help, even where there were no alternative help sources, with most being sceptical about whether a GP could help at all, other than prescribing unwanted medication (Biddle et al. 2006; Quinn et al. 2009; Lynch et al. 2018). Young people also fear negative responses from GPs including being dismissed, ridiculed, stigmatised, or being accused of wasting time (Biddle et al. 2006; Quinn et al. 2009). Lee (2009) found that the higher a young person's distress the lower their preference to seek help from a GP.

Caregivers are expected to coordinate the healthcare for their child until they are 18 years of age or until Gillick competence can be established and this includes communicating health concerns with the GP who then provides inoculations, medication, or diagnoses (HSE, 2021; NHS, 2021). Young people can view the family doctor as being too close to parents, especially in rural areas (Boyd et al. 2007, Hernan et al. 2010, Lynch et al. 2018), and as adolescents are dealing with highly sensitive issues, such as sexual and mental health concerns, they can avoid seeking help to a GP for fear of judgement or confidentiality breaches to parents (Wilson, Deane & Ciarrochi, 2005, Charman et al. 2010; Leavey et al. 2011; Lynch et al. 2016). Corry & Leavey (2017) found that girls fear being forced into treatment more than boys, but that overall young people in Northern Ireland are very reluctant to help-seek to a GP. Young people can have limited experience with independent health help-seeking outside of their primary care service and can rely on GPs referrals to access mental health care.

Other research has shown that with certain mental health problems, specifically psychosis, social phobia, food problems, and alcohol abuse, some young people do rate a GP as a suitable source of help (Leavey et al. 2011; Yap et al. 2013b). Young people can see psychosis as a more physically based condition in need of medication and alcohol abuse can be understood as

a condition beyond self-management or informal help. It was found though that having a non-family adult to talk to was associated with an increased likelihood of seeking help from a GP (Mariu et al. 2011). Yap et al. (2013b) found that there is an association between knowing someone who received support from a GP and young people's intentions to seek help, but it was also found to heighten fears of help-seeking due to hearing of others negative experiences.

While professionals, parents, and adults in general see the importance of a GP in help-seeking for mental health problems, young people generally do not view or trust doctors as a viable source of help for emotional or psychological problems (Boyd et al. 2007; Leavey et al. 2011; Yap et al. 2013b). GPs are one of the most influential professional gatekeepers, with international youth mental health campaigns still promoting and encouraging young people to visit the GP as the first point of contact for a mental health problem; for example, in Australia, the Beyond-Blue campaign and the National Health Service of the United Kingdom (Rickwood et al. 2005, Yap et al. 2013b). It would seem that rather than acknowledge young people's preferences and needs, campaigns are trying to change young people's attitudes to GPs, with little success (Boyd et al. 2007).

3.5.5. The role of schools in young people's help-seeking pathways

Young people spend a large proportion of their time in formal education and this environment can present opportunities to support young people, guide them to services and to provide mental health education programmes (Tharaldsen et al. 2017; O'Connor et al. 2018; Mashoon et al. 2020; Eigenhuis et al. 2021). In schools that employ counsellors, students have reported that they are more approachable than other faculty staff (Charman et al. 2010). A school counselling service can provide an accessible space during the school day that is familiar but not as involved as teachers, family, or friends (Fox & Butler, 2007). At third level, intervention can support academic success (McLafferty et al. 2017). School counsellors can have the opportunity to engage marginalised youth easier than other formal services (Ellis et al. 2010). Halladay et al. (2020) found that positive rapports with teachers in general can support mental health help-seeking. School counsellors are preferred to medical professionals for mental health problems and some research suggests it may be more beneficial to engage young people in schools with a counsellor before visiting a GP (Boyd et al. 2007; Fox and Butler 2007; Hernan et al. 2010). Many studies highlight the importance of specially trained practitioners in schools such as counsellors and school nurses (Arnold & Baker, 2018; Aldridge & McChesney, 2018; Moen et al. 2019).

In Ireland and Northern Ireland, school is a mandatory institution, in which young people must attend until the age of sixteen (Department of Education, 2021; Department of Education NI, 2021). Although schools have potential to support young people help-seeking for their mental health problems, the power imbalances that exist may hinder the development of the trust and rapport needed for a supportive environment. It is possible that professionals working in schools can be seen, by extension of the institution, as forces of control and oppression to young people (Pearow & Pollack, 2009). Young people are not always aware of what services are available in schools or how to access them (Fox & Butler, 2007; Jackson Williams, 2012). Staff are not always trained properly or in a position to provide information (Aldridge & McChesney, 2018). Leavey et al. (2011) found that school-based professionals, teachers, school nurses and counsellors, were poorly rated by pupils as sources of support for mental health problems. Schools in Ireland and Northern Ireland have different support structures for pupils with varying compositions of teachers, guidance counsellors, pastoral care teams and counsellors, and some of these positions can involve dual roles (Fox & Butler, 2007). Research reports that when schools that employ counsellors, who are also teachers, that this dual role is problematic because of limitations of time, fears over confidentiality and confusion about boundaries (Fox & Butler, 2007). This was found to be a common practice in the Irish school system (Doyle et al. 2017). The school environment itself has been implicated in young people's mental health problems (Fukuda et al. 2016; Aldridge & McChesney, 2018). Help-seeking in schools is also affected by the ongoing interactions between adults and students, and any negative interactions (Lindsey & Kalafat, 1998) specifically in dual role relationships, or fears of exposure can dissuade help-seeking (Loureiro et al. 2013; Doyle et al. 2017).

Fox & Butler (2007) report that the visibility of attending a school counsellor or low trust due to the lack of previous rapport with the counsellor, can prevent help-seeking. Jackson Williams (2012) also found similar results with Jamaican adolescents who reported being extremely reluctant to turn to teachers or guidance counsellors, regardless of the disorder, due to a lack of confidence in counsellor training, concerns about confidentiality, and fears about being labelled. Young people have legitimate fears about judgment, stigma, and ultimately social exclusion in a public environment that they have to attend regularly (Fox & Butler, 2007; Leavey et al. 2011; Wang et al. 2019). Young people can be suspicious of adults in general, who can be perceived as controlling or over-involved, which extends to the school context (Leavey et al. 2011). Wang et al. (2018) found that the higher a young person's mental health literacy combined with behavioural or emotional problems resulted in increased help-seeking

outside of school settings. Young people may perceive that the potential public and personal losses to image and self-esteem by help-seeking in school are too large to risk (Chan, 2013).

Schools have a central role to play in mental support and education (Rickwood, 2020) but evaluating the role of the school in providing help to young people with mental health concerns is difficult. School environments are not homogenous and may have individual cultures created as a result of leadership and governance. Whether a school environment is conducive to help-seeking or not can depend on the atmosphere that has been cultured (Aldridge & McChesney, 2018). When a school mental health support system functions well, it is valued and well regarded by students and when they are unhelpful and lack appropriately skilled staff, they can be harmful and stigmatising.

3.5.6. Young people's needs in the helping relationship

Research reports that (Chan, 2013; Rickwood et al., 2005) the role of the therapeutic relationship was the third most common facilitator or barrier to mental health help-seeking in young people mentioned in a systematic review by Radez et al. (2021). When a young person decides to seek professional help for psychological distress, they look for a supportive and trusting relationship in which they can feel safe, understood, respected, and guided to express and solve problems (Draucker, 2005; Salaheddin & Mason, 2016; Lynch et al. 2020).

Rapport

The qualities that young people prioritise in helpers are genuineness, feeling valued, care, non-judgment, warmth, respect, acceptance, and empathy (Lindsey & Kalafat, 1998; Wilson and Deane, 2001; Draucker 2005; Boyd et al. 2007). Young people prefer established relationships for help with personal problems (Gilchrist & Sullivan, 2006; Loureiro et al., 2013; Rickwood et al., 2007) as discussing personal problems with strangers can cause young people discomfort due to the lack of established trust (de Anstiss & Ziaian, 2010; Gilchrist & Sullivan, 2006; Gonzalez et al., 2005; Loureiro et al., 2013; Quinn et al., 2009; Rickwood et al., 2007; Burlaka et al. 2014). Rapport has been found to be essential to young people’s mental health care (Lynch et al. 2020) and young people need time to connect with and assess if a practitioner can provide the type of supportive rapport they need (Draucker, 2005; Jones et al. 2017). The role of the relationship is essential in young people with refugee experiences (Valibhoy et al. 2017b) especially as they can endure compounded stressors from immigration status, stigma, language, unstable housing, financial costs, and mental health knowledge (Byrow et al. 2020).

Trust and Confidentiality

In a review article, Lynch (2020) describes trust and confidentiality as central components of the helping relationship with young people and are features that are built, maintained, or broken within the context of a helping relationship. Adolescents can have fears about their caregivers, reactions to knowing they self-harmed, engaged in substance abuse, or had suicide ideation (Fox & Butler, 2007; Michelmore & Hindley, 2012; Wilson, Deane & Ciarrochi, 2005) and so the establishment of professional boundaries regarding confidentiality upon first meeting supports young people in making informed choices about disclosures and supports trust building (Gilchrist & Sullivan, 2006; Loureiro et al., 2013; Rickwood et al., 2007; Williams, 2012). Young people, due to a lack of privacy in their lives, can be hypervigilant about confidentiality and trust in the therapeutic process can emerge as a practitioner proves they can protect confidentiality and provide the right type of support (Draucker, 2005; Fox & Butler, 2007; Gilchrist & Sullivan, 2006; Gonzalez et al., 2005; Jones et al., 2017; Lindsey & Kalafat, 1998; Rowe et al., 2014; Williams, 2012; Wilson & Deane, 2001).

Helper's approach

Research shows that helpers need to provide developmentally appropriate and individualised treatment plans (Lynch et al. 2020). The type of approach needed can vary with age, although Lynch et al. (2020) states that not enough is known about this across the age range of youth, especially for those in emerging adulthood. In general, research suggests that young people prefer informal approaches, rapports and environments with younger adolescents requiring activities for rapport development (Davison et al., 2017). As caregiver consent can be required with adolescents, part of the practitioner's approach needs to inquire about a young person's participation, if it is voluntary and in what way they want their caregiver to be involved, if at all (Persson et al., 2017; Rickwood et al., 2005; Simmons et al., 2011; Wilson & Deane, 2001).

Young people experiencing severe distress, such as those in in-patient services or experiencing suicidal ideation, require practitioners that can be explicit in their demonstration of respect and understanding (Hackett et al., 2018; Neilson et al., 2014). When young people have had their trust broken by adults and experience state care or homelessness, trust building requires more time and looser boundaries (Collins & Barker, 2009; Fargas-Malet & McSherry, 2017). Ungar et al. (2018) states that young people in these circumstances need the helping relationship to feel "real" and that young people who appear to have higher levels of resilience can better manage more structure, expectations, and boundaries. Research shows that helpers need to be

trained and skilled at working across cultures and show respect and understanding for different conceptualisations of mental health, especially when supporting young people with refugee experiences (De Anstiss & Ziaian, 2010; Lynch et al. 2020).

Collaboration

Collaboration is described as central to young people's mental health care needs (Lynch et al. 2020). What young people require from healthcare may not always be initially evident and can only emerge as trust builds (Simmons et al., 2011; Ungar et al., 2018). To work collaboratively, research reports that young people want their distress to be taken seriously and for helpers to inquire and communicate effectively (Draucker, 2005; Fargas-Malet & McSherry, 2017; Lindsey & Kalafat, 1998; Neilson et al., 2014; Persson et al., 2017; Wilson & Deane, 2001). Young people primarily require listening interventions and want time to build rapport with their helper before disclosing personal feelings and thoughts (Davison et al., 2017; Persson et al., 2017; Wilson & Deane, 2001). The process of relationship building is supported by collaborative treatment which respects individuation, choice, balance and which puts the young person at the centre of all planning (Lynch et al. 2020). Research also shows that young people require practitioners that are flexible, creative, and knowledgeable, ensuring that their values, and preferences are considered in treatment planning and options (Davison et al., 2017; Draucker, 2005; Gilchrist & Sullivan, 2006; Hackett et al., 2018; Jones et al., 2017; Neilson et al., 2014; Persson et al., 2017; Quinn et al., 2009; Simmons et al., 2011; Ungar et al., 2018; Williams, 2012; Wilson & Deane, 2001; Loos et al. 2018). Practitioners need to explain interventions in age-appropriate language and ensure young people are involved in all aspects of decisions about their care in an open and transparent style (Jones et al., 2017). The use of collaborative methods in themselves can be therapeutic for young people as they support their autonomy and can help compensate for feelings of grief over failed self-management strategies (Chan, 2013; Simmons et al., 2011). This is very important for young people in in-patient placements as Simmons et al. (2011) suggests that being supported with smaller choices can compensate for having been excluded from larger decisions, especially as in-patient experiences can be retraumatising (Jones et al. 2017). Research demonstrates that failing to work collaboratively can result in young people withholding information and exiting treatment earlier (Davison et al., 2017; Draucker, 2005; Simmons et al. 2011).

3.5.7. Summary of sources of help

This section has explored the different sources of help that young people utilise when seeking help for a mental health problem beginning with a discussion on the pre-curser to help-seeking, *self-management* strategies, and the many ways young people use their personal resources to cope with distress. An in-depth discussion on *informal supports* revealed that these relationships are essential pathway agents and can also be the source of distress for some young people. Current provision of *formal services* was described as not meeting young people's needs. The opportunities and limitations of *e-help* in young people's mental health care was discussed as was young people's *preferred environments* which were found to be informal and non-stigmatised settings. Other important agents in young people's help-seeking processes were examined such as common *gatekeepers* and *GPs* with a discussion on how the *school environment* can support or block help-seeking attempts. This section ended with an important evaluation of literature on the type of *helping relationship* that young people report they need. Young people engage meaningfully when they are not considered problematic, disclosures are protected, they are respected, receiving genuine care and are with someone who can relate well to adolescents (Draucker, 2005; DeAnstiss & Ziaian, 2010; Lynch et al. 2020).

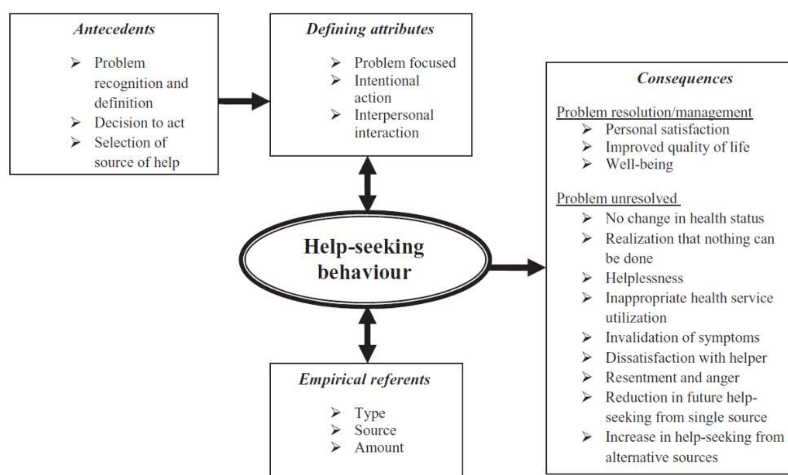
3.6. Theoretical framework

This research was guided by two conceptual models. The first, by Cornally & McCarthy (2011), provides a concept analysis of help-seeking behaviour of help-seeking within healthcare settings. The second model was by Chan (2013) and described an integrative framework of the antecedents of instrumental interpersonal help-seeking, which provides an in-depth and multilevel perspective on the decision to help-seek. Both models are conceptually derived from the Theory of Planned Behaviour (Ajzen & Fishbein, 1980) and provide differing but complimentary perspectives on help-seeking theory.

3.6.1. Model 1: Help-seeking behaviour: A concept analysis

Guided by the work of Walker & Avant (2005) on theory construction, Cornally & McCarthy (2011) developed their model by collating, condensing, and presenting knowledge on help-seeking behaviour across many disciplines. This model describes the *antecedents, defining attributes, empirical referents,* and *consequences* to help-seeking behaviour (**see Figure 4**).

Figure 4: Help-seeking behaviours: a concept analysis (Cornally & McCarthy, 2011, p.284).



The Model

Cornally & McCarthy (2011) identify the *defining attributes* of the complex decision-making process as being: *problem focused*, an *intentional action* and involving an *interpersonal action* with a third party. According to Cornally & McCarthy (2011), the *antecedents* are described as the necessary conditions required for help-seeking behaviour to occur. The first stage of the help-seeking process is *problem recognition and definition* of a problem, an individual must identify that a problem exists in which there is a need to seek help from others. This is often determined by the presence, cause, significance, severity, consequence, duration, type, and frequency of symptoms. An individual will engage in symptom appraisal, symptom perception, symptom evaluation or symptom interpretation (Cornally & McCarthy, 2011).

The next stage in this model refers to *planned behaviour*. The decision to seek help is influenced by demographic factors, fears, sociocultural norms and values, knowledge, expectations and attitudes. Personal factors such as self-efficacy, previous help-seeking experiences, gender norms and failed self-management will also impact help-seeking behaviour (Cornally & McCarthy, 2011). The decision will ultimately depend on a cost-benefit analysis, weighted on the personal cost of seeking help and if an individual decides to proceed; the next stage of the help-seeking process involves *selecting a source of help,* which includes locating a source of help and disclosure of the problem in exchange for help. An individual will choose a suitable helper who appears to have the characteristics, knowledge, and skills to assist in solving the problem, or to help lessen symptoms. Sources of help can be friends, family

or professionals and this process will happen before help-seeking behaviour is initiated (Cornally & McCarthy, 2011).

An important factor that influences the help-seeking process can be described as *empirical referents*. This can refer to the type, source and number of referents involved in help-seeking. Instrumental and emotional help-seeking, or a combination of both, are two types of help that can be sought. In addition, assistance can comprise of both formal and informal sources of help. Some sources of help can be overused because of familiarity and accessibility, such as the family doctor, and other sources of help, such as psychologists, can be avoided due to stigmatisation (Cornally & McCarthy, 2011).

Cornally & McCarthy (2011) identify the *consequences* of help-seeking which include problem resolution or management and problem unresolved. The first can result in personal satisfaction and a sense of well-being indicating that help-seeking was successful. The latter can result in no change in health status, invalidation of symptoms, stigmatisation, dissatisfaction, resentment, or anger. An unsuccessful resolution from help-seeking can result in a reduction in future help-seeking or future help-seeking from an alternative source.

Discussion

The model developed by Cornally & McCarthy (2011) provides an overview of help-seeking behaviour in healthcare settings and does not present an in-depth analysis of the factors in the help-seeking process. Cornally & McCarthy (2011) acknowledge important factors such as community and social networks, service characteristics, societal factors, and economic factors and how they can act as barriers or facilitators to the help-seeking process. The authors state that the aim of this model was not to present a reductionist model of a complex process but to present a succinct model, to be used as a guide for nurses on how to improve health help-seeking behaviour.

3.6.2. Model 2: Antecedents of Instrumental Interpersonal Help-seeking: An Integrative Review

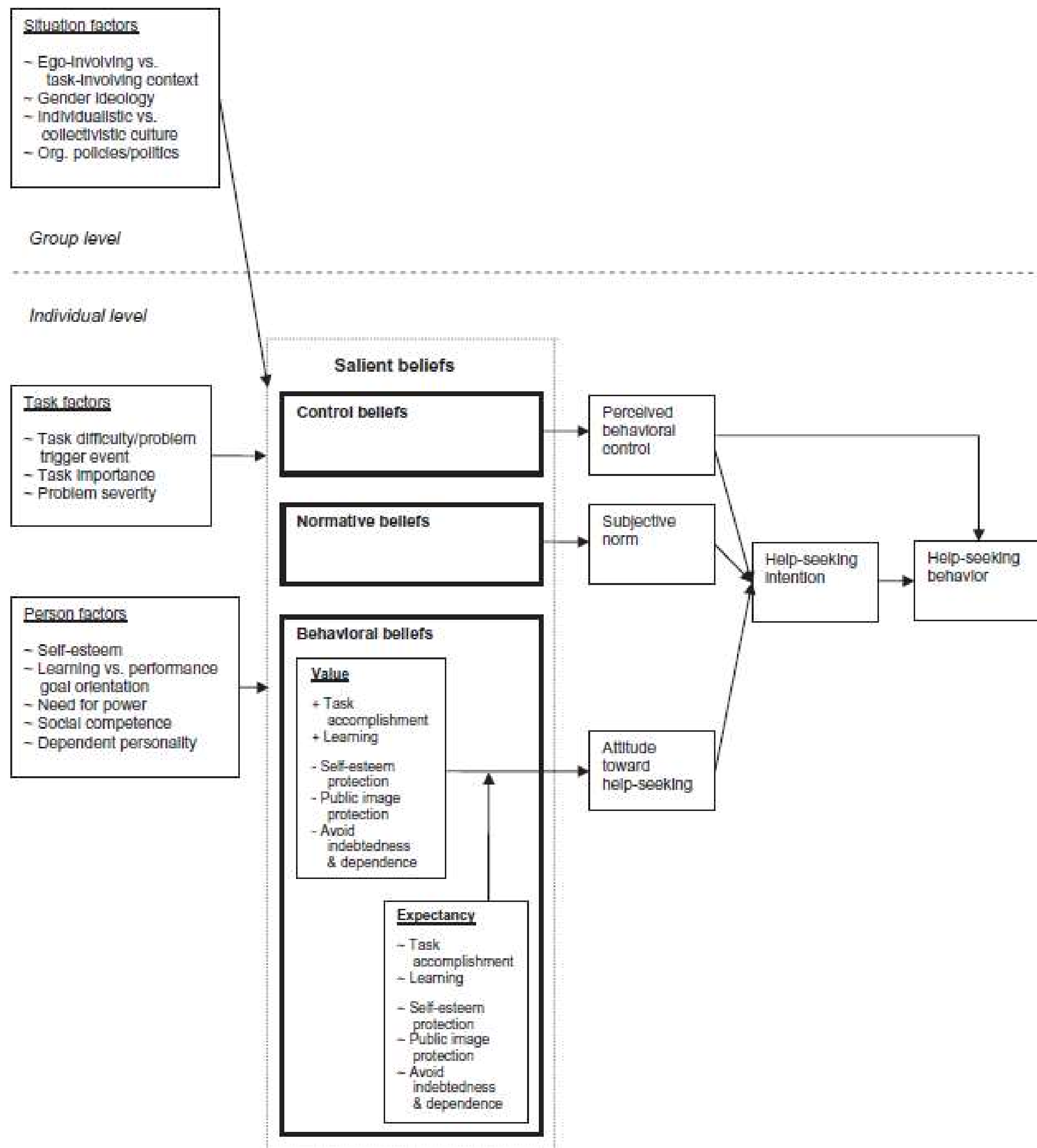
Chan (2013) proposes an interpersonal help-seeking model premised on the *Theory of Planned Behaviour* (Ajzen & Fishbein, 1980) and *Expectancy-value Theory* (Fishbein, 1963). This model synthesised and integrated findings from across disciplines on help-seeking behaviour

for instrumental or goal-directed reasons through the use of a constellation approach. Chan (2013) describes interpersonal help-seeking as when the need to seek help is triggered by difficulties or problems that obstruct individuals from successfully accomplishing the task goals on their own.

The Model

Chan (2013) refers to the three core tenets of the Theory of Planned Behaviour Model as important in the development of the model; an individual's intention to perform a specific behaviour is determined by an individual's *salient beliefs*, specifically, one's attitude towards the specific behaviour, the *subjective norm* about the behaviour and one's *perceived behavioural control*. Chan (2013) also includes how the task and personal and situational factors interact with these tenets to influence whether an individual can expect to gain or lose from help-seeking. Chan (2013) provides an integrative review of the antecedents of interpersonal help-seeking behaviour. When a difficult problem is encountered which hinders a person from successfully accomplishing their task goals, the need for help is triggered which activates various beliefs associated with help-seeking. These *salient behavioural*, *normative* and *control* beliefs will influence people's *help-seeking intention*, *subjective norm*, and *perceived behavioural control*, respectively, which will in turn impact their help-seeking intention. Lastly, people's help-seeking intention and perceived behavioural control serve as *proximal antecedents* to their help-seeking behaviour (see **Figure 5**).

Figure 5: Antecedents of Instrumental Interpersonal Help-seeking: An Integrative Review (Chan, 2013, p.9).



Chan (2013) states that in mental health, individuals can be motivated to learn skills for coping with their problems. Chan (2013) refers to this as *task-related learning*, as opposed to *goal-instrumental learning* where personal well-being is the perceived benefit that directs people to seek help. Individuals are more likely to seek help if they perceive the help to be useful but are less likely if they doubt the ability of the helper or the effectiveness of a treatment (Chan, 2013). If a person has an expectancy that help will not assist them with accomplishing their task and

their value is based on task accomplishment, they are less likely to seek help. Chan (2013) also predicts that if a person expects to acquire learning and also hold a value of learning that this will be positively associated with help-seeking. Chan (2013) then proceeds to describe the psychological costs of help-seeking as *private, public, indebtedness* and *dependency*.

Private Image Damage

Chan (2013) states that people are motivated to protect their self-esteem and that if an individual expects that this will be damaged by help-seeking then they will not help-seek. Chan (2013) also proposes that self-stigma is especially problematic with mental health, and that this inhibits mental health help-seeking. If the *value of protecting self-esteem* and the *expectancy of self-esteem protection* (the likelihood that self-esteem can be protected by not seeking help) are both strong, then the intention to seek help will be low. In mental health this can be seen when an individual avoids help-seeking because they believe they can manage independently.

Chan (2013) proposes that if an individual anticipates or perceives failing a task, they can still have the expectancy that they can protect their self-esteem. Individuals can shift their attention away from their distress and expend more effort or excel in other areas of their lives to counter the reduction in self-esteem produced by the mental health problems. If an individual cannot pre-emptively cover up the failure of a task, in this scenario of self-management, they can have the expectancy that they will not be able to prevent self-esteem damage and they will be more likely to seek help.

Public Image Damage

Seeking help can damage an individual's public image of competency. To prevent damage to public image, some individuals can prefer to let a personal task fail than seek the needed help (Chan, 2013). The concern with public image damage can also be reframed as *public image protection* and those with this value can avoid help-seeking. Previous models have theorised that if an individual cannot perform the task on their own and do not seek help, they will ultimately fail on the task and will not be able to uphold their public image of competence (Chan, 2013). However, with mental health problems, which can be less visible, individuals whose self-management strategies have ceased to be effective can still not seek help and continue to conceal distress from others to protect their public image (Chan, 2013).

Indebtedness and Dependence

Chan (2013) states that being indebted to helpers is a perceived cost of help-seeking and is often described as an aversive psychological state that most people try to avoid. When individuals do not seek help, they do not incur *indebtedness* and *dependency* on the potential helper and this value can have a strong effect on individual's help-seeking attitude. Chan (2013) suggest that individuals with high self-esteem, goals of attaining social status or those with a need for power can avoid help-seeking because of this value. However, those individuals who are high on interpersonal dependency are more likely to seek help. *Reciprocation* can play a moderating role with regard to indebtedness and dependence; the lack of a chance to reciprocate can lessen the likelihood of help-seeking.

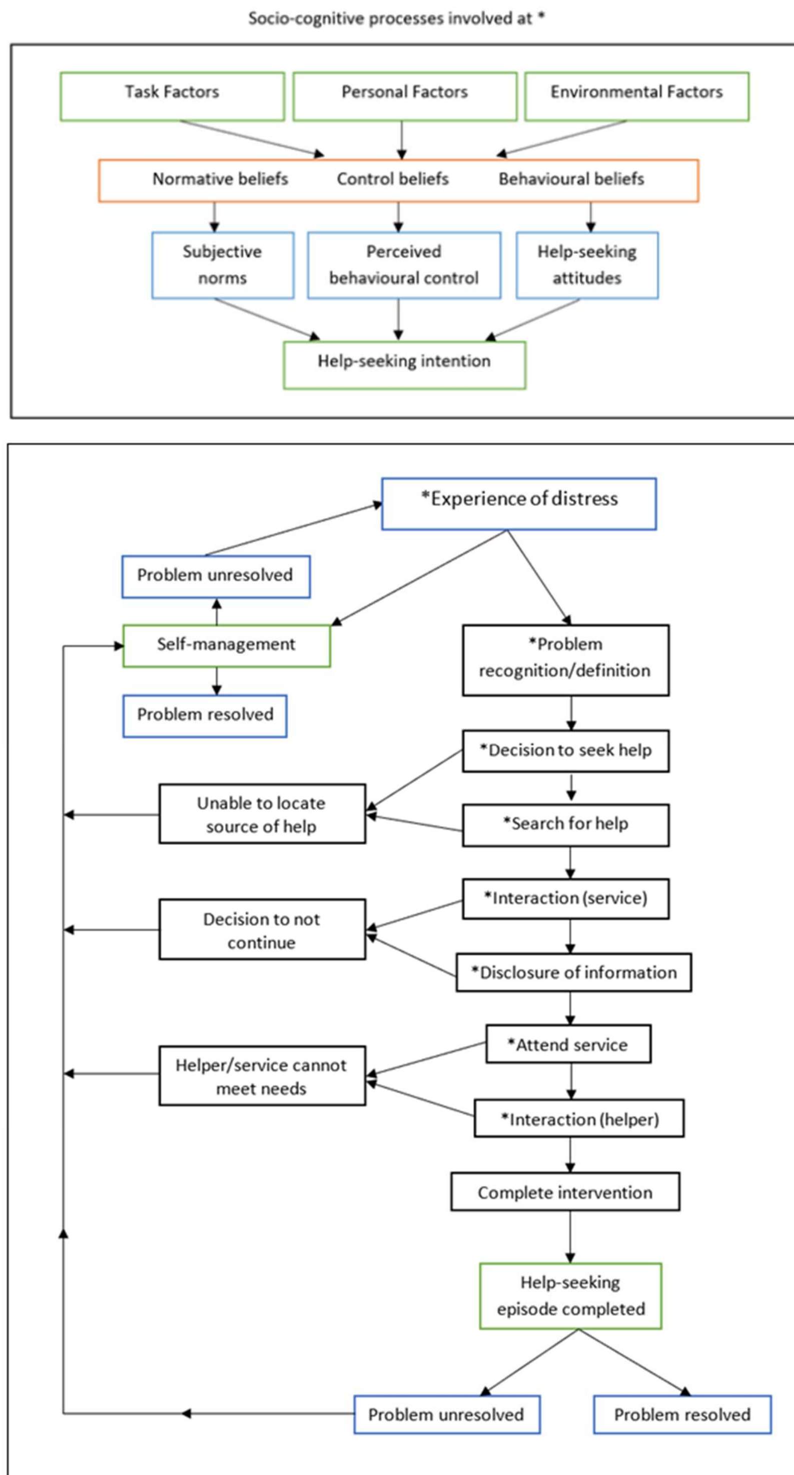
Discussion

Chan (2013) states the importance of considering the constellation of salient beliefs and how the person, task and situation factors affect each of the perceived benefit and cost beliefs of help-seeking. Chan (2013) presents new analysis to non-help-seeking from a beneficial standpoint and this provides an alternative perspective as to why an individual can be motivated to negate help. Chan (2013) also asserts that previous conceptualisations of the role of the factor of *expectancy* (what an individual expects will happen as a result of help-seeking or non-help-seeking) in help-seeking theory development has resulted in inconsistent findings as a main effect predictor in people's cost-benefit analyses on whether to seek help. Chan (2013) has conceptualised *expectancy* as a moderator in the help-seeking process and proposed that this can improve understanding of help-seeking behaviour.

3.6.3. Research framework

The models provided by Cornally & McCarthy (2011) and Chan (2013) form the theoretical framework for this study and **Figure 6** was developed to illustrate this combined framework.

Figure 6: Cornally & McCarthy (2011) and Chan (2013) - Combined models



Chan's (2013) complex model of cognitive antecedents can be understood within Cornally & McCarthy's (2011) concise conceptual model of help seeking behaviour to elaborate on what

is happening within the individual's decision-making process and whether they will proceed or exit a help-seeking episode. Chan's (2013) model provides understanding into the complex negotiation that takes place within the individual at each point of the help-seeking process, and how new information at each stage can be interpreted and combined into existing cognitions, beliefs, and attitudes to inform a decision with regard to the perceived losses and gains of help-seeking. Each model offers important understanding regarding help-seeking behaviour but when explored together, they provide enhanced insight into many of the processes involved in an individual's decision to seek help which provides a sound framework for this research.

3.7. Conclusion

This chapter has comprehensively reviewed information on youth mental health help-seeking across three themes: the *personal*, the *environmental* and the *sources* of mental healthcare support. This review has provided a discussion on how the external and wider factors intersect with the personal to create barriers or facilitators to young people's help-seeking attempts. There is an extensive extant literature on topic, with predominantly quantitative attitudinal research which has provided important links regarding issues such as stigma, help-seeking intentions, and mental health literacy. Qualitative research has provided insightful descriptions into what is a complex topic, offering a more thorough examination of the depth of the problem. This has resulted in a diverse but often incohesive body of literature reporting the barriers and facilitators to mental health problems. Quantitative findings can be overly descriptive or shallow in analysis regarding young people's motivations, with some taking judgemental or disconnected stances for young people's lack of participation in mental health services. Qualitative findings on the topic tend to provide in-depth and insightful findings that aid in understanding young people's socio-cognitive processes when seeking help, but ultimately can be confined to unique socio-cultural locations. An important conclusion from the literature indicates that the decision to seek help is informed by an individual assessment of the personal and public costs and benefits, and that for young people help-seeking is both logistically and emotionally difficult, involving a complex interplay between personal, sociocultural, conceptual, and service factors. A strong qualitative research design, that can address these intersecting factors, is thus necessary to explore about young people's mental health and associated help-seeking experiences.

4. Methodology

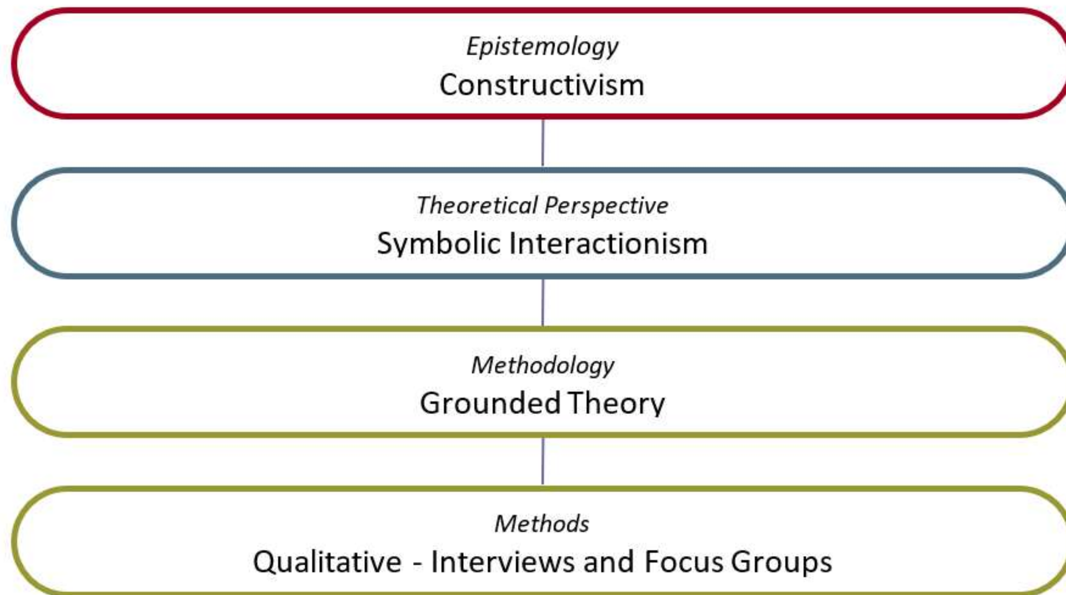
4.1. Introduction

This chapter provides a detailed and transparent description of how the current study was designed to meet the research aim of exploring young people's (aged 16 - 25 years) experiences and perspectives on help-seeking for a mental health problem. The chapter begins with a discussion of the *research design*, with regard to the methods employed, methodology, epistemology, and philosophical position. This is followed by an exploration of how data was *collected* as well as an in-depth description of the *participants* in this study, selection criteria, sampling strategies, recruitment, and procedures. The next section provides an account of how the data was *analysed* and this chapter concludes with a discussion on the *ethical considerations* and a discussion on *integrity* in research.

4.2. Research design

Richards (2015) said that it is crucial to be methodologically prepared for the process of collecting and making data because the research design functions as the blueprint for a study. This study follows the research design framework as proposed by Crotty (1998) which comprises four elements in research design: 1. the chosen *epistemological framework,* which underpins the selection of 2. the *theoretical perspective,* which in turn directs the 3. *methodological design* for data analysis and 4. *methods* of data collection. Following Crotty's (1998) framework, the research design for this study, as illustrated in **Figure 7**, was informed from a *constructivist* epistemology, a *symbolic interactionist* theoretical perspective, a *grounded theory* methodology and *qualitative* methods. The following sections describe each of these features and how this design was created to ensure the aim and objectives of the research were best addressed.

Figure 7: Crotty (1998) research design framework



4.2.1. Epistemology

Crotty (1998) described an *epistemology* as the theory of knowledge that is both embedded in the theoretical perspective and in the methodology. The choosing of an epistemological position that is well suited to a topic greatly assists the researcher in deciding how to make sense of the phenomena in question (Crotty, 1998). As this research sought to examine the multi-faceted topic of mental health, an epistemology that valued complexity and multiple realities, as well as supporting the deep exploration of such phenomena, was essential. A *constructivist epistemology* was adopted as most relevant for this research. This epistemological position views knowledge as socially constructed (Creswell & Miller, 2000) and individual perspectives towards reality are viewed as pluralistic, open-ended, and contextualised (Crotty, 1998; Golafshani, 2003). Meaning is not an objective phenomenon to be discovered but is constructed and developed by individuals who seek understanding of their world and their experiences (Creswell & Creswell, 2017). While the world individuals live in, their experiences, relationships, and objects around them can be imbued with meaning, constructivism views meaning as created only when an individual consciously engages with them and actively interprets to construct meaning (Crotty, 1998).

This epistemological position is appropriate for mental health research as it acknowledges multiple conceptualisations and facilitates their exploration without having to narrow them to reductionist explanations (Creswell & Creswell, 2017). The process of seeking help for a mental health problem is a highly complex interpersonal process that requires various skills such as self-awareness, communication of an internal state, social interactions, problem-solving, logistics, decisions, and stigma management (Chan, 2014). This process is embedded in an individual context, culture, and place in time. A constructivist epistemology was appropriate in this research to engage with people in a conscious conversation about mental health, examining how they construct meaning, how they reflect on the impact of these experiences and how they communicate and interpret them (Creswell & Creswell, 2017).

4.2.2. Theoretical perspective

According to Crotty (1998) the theoretical perspective in research design involves establishing a philosophical position from the outset and is important in a strong research design (Chamberlain-Salaun, Mills & Usher, 2013). This research adopted a *symbolic interactionist* position which assumes that reality is fluid, socially embedded, contextualised and somewhat indeterminate (Chamberlain-Salaun, Mils & Usher, 2013) and is a position that is companionable with a constructivist epistemology (Charmaz, 2014). This perspective evolved from the pragmatist work of Mead (1932) and was part of a humanistic movement in philosophy. Pragmatist philosophy is known for its unification of knowledge and action, and the mind and the body, and it was in the applying of theory to practice that distinguished pragmatist philosophy from other philosophical positions, which at the time were based on an empirical epistemology (Chamberlain-Salaun, Mills & Usher, 2013). Pragmatism views much of an individual's life as routine and habitual, and that it is only when faced with a problematic life experience that there is a drive for rethinking, reinterpreting and if necessary, action or reform to remedy the problem (Charmaz, 2014).

Pragmatism influenced symbolic interactionism by emphasising the perspective that the individual is as an active and agentic actor with the ability to think, create, reflect, and evaluate their decisions and contexts, altering them should they desire (Blumer, 1979; Charmaz, 2014). This perspective aligns well with mental health help-seeking behaviour, as it is an interpersonal action for a problem that involves thinking, evaluation and decisions, enacted to remedy or alter personal distress. Symbolic interactionism assumes that "people construct selves, society and reality through interaction" (Charmaz, 2014, p.344), and values the role of people in the

creation of their meaningful realities and the use of language and symbols in these constructions (Chamberlain-Salaun, Mils & Usher, 2013; Charmaz, 2014). Individual help-seeking experiences are embedded in a wider social context; humans often act according to the meanings they have attributed to others in their social world and structures in the culture and environment from dynamic relationships and interactions (Charmaz, 2014). Understanding data from within the theoretical perspective of symbolic interactionism supported analysis around how young people created meaning from reflections on their experiences of seeking-help for a mental health problem, and how this meaning impacted future actions (Charmaz, 2017). Symbolic interactionism also greatly supported the exploration of individual experiences and interpretations of help-seeking without separating the individual from their social realities (Charmaz, 2014).

4.2.3. Research methodology

The selection of an appropriate methodology that is in alignment with the research question, the adopted epistemology and theoretical perspective is important in achieving quality research (Richards, 2020; Charmaz, 2014). *Grounded theory methods* (GT) were chosen in this study for data collection and handling as they consist of a systematic and focused yet flexible toolset for conducting successful research regarding complex social phenomena (Charmaz, 2014).

Ground Theory Methods

GT originated with Glaser & Strauss' (1967) foundational work *"The discovery of grounded theory: Strategies for qualitative research"* and was an important landmark in scientific methodology (Charmaz, 2014). Firstly, it initiated the methodological movement away from testing existing theories to generating theory from new data acquired from the study of a social phenomenon (Charmaz, 2014). Secondly, GT challenged the mid-century positivist methodological consensus in research, with its preoccupation with complete objectivity and quantitative paradigms, as the only legitimate form of scientific research. Thirdly, and perhaps more importantly, these methods offered systematic strategies for qualitative research practice, which began the process of moving qualitative inquiry beyond descriptive studies into the realm of explanatory theoretical frameworks and helped legitimise qualitative research as a credible and rigorous approach (Charmaz, 2014). GT can be surmised as a qualitative descriptive analysis and is a powerful approach to facilitate the researcher's attention towards the different dynamics that can provide insight into the abstract and conceptual understandings of the studied phenomena, which assists in a much more robust

theory construction (Charmaz, 2014; Birks & Mills, 2015). GT are used mostly with qualitative methods and is one of the most popular research designs in scientific research with Birks & Mills (2015) listing eleven seminal grounded theory texts that have been published. GT are a distinctive approach because they aid a researcher in constructing theory from the data using an inductive approach (Charmaz, 2014). GT has pragmatic underpinnings as it provides methods to study actions, processes, and meanings, and facilitates the exploration of the individual conceptualisation of existence and reality, and how people understand their world and unique contexts (Birks & Mills, 2015).

Glaser & Strauss (1967) believed GT conceptualisations should meet the following criteria: a close fit with the data, usefulness, conceptual density, durability over time, modifiability, and explanatory power (Glaser, 1978, 1992; Glaser & Strauss, 1967). While GT has evolved over time, the current defining components of GT practice include: simultaneous involvement in data collection and analysis; constructing *analytic codes and categories* inductively from data; using the *constant comparative method*, which involves making comparisons during each stage of the analysis; advancing *theory development* during each step of data collection and analysis; *memo-writing* to elaborate categories, specify their properties, define relationships between categories and identify gaps; sampling aimed towards theory construction (*theoretical sampling*); and finally, conducting the *literature review* after developing an independent analysis. Engaging in these practices helps researchers to control their research process and to increase the analytic power of their work (Charmaz, 2014).

Using GT methods requires practices such as establishing a philosophical position, investigating methodological possibilities, planning a study, entering the field, applying essential GT methods, developing a theoretical model, developing a dissemination plan, evaluating a GT, and implementing strategies to increase impact of findings (Birks & Mills, 2015). GT practice means collecting data systematically, through observations, interactions, and materials, about the phenomena of interest and includes studying experiences, reflexivity, following hunches and generating theory (Charmaz, 2014; Birks & Mills, 2015).

Constructivist Grounded Theory Methods

This research adopted Charmaz (2014) approach to GT as detailed in her book *Constructing Grounded Theory.* This method dates to the early 1990s and while it was initially controversial, for challenging the strong positivist foundation of GT, by the end of the decade, there was a natural and visible convergence of GT and constructivism (Charmaz, 2000a). Charmaz's

approach emerged in response to her dissatisfaction in part with the social constructivists' approach at that time to data analysis which failed to consider their own role in research, viewing their analyses as accurate renderings of real life, instead of a construction (Charmaz, 2014). Constructivist grounded theory (CGT) methods combine "the inductive, comparative, emergent and open-ended approach of Glaser and Strauss (1967)" (Charmaz, 2014, p.12) with the epistemology of constructivism to provide guidelines for qualitative data collection and analysis. Charmaz's approach acknowledged the important work of social constructivists such as Vgyotsky (1962) and Lincoln (2013) who stressed the social context, however, Charmaz proposed an ontologically relativist and epistemologically subjectivist approach that emphasised the importance of the researcher's unique and subjective role in constructing and interpreting data (Mills, Bonner & Francis, 2006; Charmaz, 2014). CGT methods keep the position of the researcher in focus which greatly assists in building methodological skills, methodological self-consciousness and importantly, enhancing the researcher's ability to locate, code and categorise data within its social context (Charmaz, 2014; Charmaz, 2017). CGT methods became increasingly popular, and the controversial approach mainstreamed in the mid-2000s is widely used in psychology, education, and nursing research (Mills, Bonner & Francis, 2006). All variations of GT today can be described as existing on a methodological spiral (Mills, Bonner & Francis, 2006).

Symbolic interactionism as a theoretical perspective shares themes of meaning, action and interaction, self, and perspectives with essential grounded theory methods (Chamberlain-Salaun, Mils & Usher, 2013). The epistemology of constructivism is embedded in Charmaz's (2014) CGT methodology and emphasises the parallel origins in pragmatism of both symbolic interactionism and CGT, meaning they are ontologically co-constitutive (Charmaz, 2014). Charmaz (2014, p.277) has described this compatibility as a strong 'theory-methods package' that can expand the methodological and theoretical insights. The practical application of this 'theory-methods' package was evident during data collection. Aspects of help-seeking were explored through a focused and open dialogue between the researcher and the participant, with each reaching new understanding and creating new meaning of experiences, perspectives, and beliefs during their conversation. Each interview or focus group represented a unique set of interactions and opportunity for meaning making that impacted how data was collected with subsequent participants. This iterative process to develop new meaning and new understanding is at the core of both GCT methods and symbolic interactionism.

Charmaz (2014) approaches literature reviews and theoretical frameworks more favourably than the original GT theorists, suggesting that it is important to draft a literature review and a theoretical framework as these are “ideological sites in which you claim, locate, evaluate, and defend your position” (p. 305) but to not let them “stifle creativity or strangle youth theory” (p. 308). Charmaz (2014) argues that once analysis is complete, the constant comparative method can be taken outside of the research data to the wider literature and theoretical framework and used to critique, extend theory, or challenge dominant ideas. As such, this research has included a literature review and theoretical framework.

4.2.4. Research methods

When choosing a research method to address a research question, it is critical to understand how these connect and diverge. *Quantitative* and *qualitative* methods provide different ways in which researchers can create and record their observations about the world, and while both methods are connected to distinct approaches, either one can be used to inquire about the same phenomenon (Richards, 2020). Although qualitative techniques in modern scientific research can be traced back to the founding work of William Wundt in the early 20th century (McLeod, 2011), the dominant social scientific research paradigm, until the middle to the 20th Century, was quantitative and positivist in nature (Crotty, 1998; Charmaz, 2014). By the 1960s, many social scientists were dissatisfied with the limitations of quantitative methods to address more complex aspects of social phenomena and began developing qualitative methods and tools (Charmaz, 2014). Over time, qualitative methods became increasingly recognised for their ability to address complex social research questions in ways that quantitative research could not and became accepted within the scientific community as a legitimate and important scientific methodology (Charmaz, 2014).

Both quantitative and qualitative approaches have their histories, their supporters, and their detractors and while they are often pitted against each other as dichotomous or rigid, they represent different ends of the same continuum, with neither approach being superior to the other (Crotty, 1998; Richards, 2020; Creswell & Creswell, 2017). The decision on whether to use qualitative methods or quantitative methods depends on the research question being asked and how the researcher wants to answer it. Research methods can be conceptualised on a quantitative-qualitative continuum, with each approach offering differing characteristics or tendencies in the processes of data collection and analysis (Richards, 2020; Creswell & Creswell, 2017). *Quantitative* approaches can be predominantly described as numerical and

deductive with a fixed design, while *qualitative* approaches provide rich, descriptive, inductive and fluid data (Charmaz, 2014; Richards, 2020; Creswell & Creswell, 2017). Some research requires aspects of both, and so a mixed methodology resides somewhere in the middle of this continuum and incorporates elements of both approaches (Creswell & Creswell, 2017).

Quantitative methods are best used when testing objective theories to understand the relationships between what factors or variables influence an outcome, especially when using large data sets. This approach typically uses instruments, so that numbered data can be analysed using statistical procedures and is concerned with protection against bias, controlling alternative explanations and the generalisability and replicability of findings (Creswell & Creswell, 2017). Researchers using quantitative methods work with numbers to find associations, groups and patterns but cannot provide an in-depth understanding of the 'how' and 'why' a phenomenon occurs, which is why qualitative research methods are very important (Creswell & Creswell, 2017). In essence, it could be argued that quantitative scientists *collect* data and qualitative researchers *make* data (Richards, 2020). *Qualitative methods* are used by researchers who examine and gather experiential data on a phenomenon that impacts the lived reality of individuals or groups in a particular cultural or social context and is guided by a well-constructed research question (Mills & Birks, 2014). Research questions that require a qualitative approach usually have three distinct features: 1. The data needed is *complex* and 2. Data must be *understood within context* and 3. Data must be *handled* (Richards, 2020). 'Handling' can refer to how qualitative methods require skilful organising and managing of data and data sources with the memos, annotations, background material and reflective essays that will happen throughout a project and become part of the data (Richards, 2020). Creswell & Creswell (2017) state that qualitative methods are helpful if (a) a concept is underdeveloped due to lack of theory or previous research (b) current explanations might be inaccurate or inappropriate (c) there is a need to explore or describe phenomena to develop theory or (d) quantitative measures are inappropriate for the phenomena to be studied. Qualitative research strives to preserve context for increased understanding, often engaging with and celebrating the subjective, using the unique role of the researcher to meaningfully develop understanding of the 'how' and 'why' of the phenomena being examined (Mills & Birks, 2014). Qualitative research is not concerned with generalisability and replicability and focuses more on transparency, reliability, and trustworthiness (Mills & Birks, 2014; Richards, 2020). In the making of qualitative data, the researcher is seeking to learn from data, and sometimes make new theories rather than test an existing theory (Mills & Birks, 2014).

In this study, the research question concerned young people's experiences and perspectives around help-seeking for a mental health problem, an interpersonal behaviour that is considered complex (Rickwood et al. 2007; Chan 2013). As detailed in the literature review chapter, much of the research on this topic has been quantitative in nature and has resulted in a large body of literature that has provided interesting data on attitudes towards professional help-seeking, and in demonstrating the breadth of this problem globally. However, studies have often used hypothetical scenarios or other survey instruments that has resulted in much of the context of this phenomena being removed, providing shallow understandings of mental health help-seeking behaviours and a need for in-depth inquiry (Biddle et al., 2007; Gulliver et al., 2010; Richards, 2020). For this research, qualitative methods using focus groups and interviews were adopted to create rich data from perspectives and experiences of help-seeking while maintaining the unique socio-cultural context and meaning of what it is like to live in Ireland, be young and try to access healthcare for a mental health problem (Gulliver et al., 2010; Mills & Birks, 2014; Charmaz, 2014; Richards, 2020).

4.2.5. Overview

The research aims and objectives were best achieved with respect to the described epistemology, theoretical perspective, methodology and research methods (see **Figure 5**). As an epistemology and a theoretical perspective, *constructivism* and *symbolic interactionism* are highly compatible within this design as they both acknowledge the personal, social, structural, historical, and cultural meanings of an individual's reality, essential factors that shape mental health experiences (Golafshani, 2003; MacKenzie et al. 2006; Charmaz, 2016). Qualitative methods allow for flexibility to pursue, analyse, and construct theory from interesting data, and CGT methods provide a systematic and thorough set of guidelines for facilitating an in-depth inquiry into how young people experience, act, examine, create meaning, symbolise, and reflect on the physical and mental constructs that determine their beliefs, actions and attitudes regarding their lived experiences of mental health and help-seeking (Charmaz, 2014).

4.3. Participants

This research study took place in the Northwest of Ireland and included two sets of participants: young people aged between 16-25 years of age, and practitioners providing youth mental health care in semi-formal and formal mental services. A *semi-formal service* refers to service

providers that do not have a specified role in delivery of mental health care but encounter and support young people with mental health problems, such as a school pastoral care team and a professional youth work service (Rickwood et al., 2012). A *formal service* refers to professional health service providers with a specified role in delivery of mental health care, such as community-based counselling organisations, private counselling, and the statutory mental health services of the Health Service Executive (HSE) in Ireland.

4.3.1. Selection criteria

Youth participants

This research study examined young people's experiences, outcomes, and the impacts of help-seeking for a mental health problem, through data from participants actual experiences. Participants were selected because they were mental health service-users, those who had not sought help were excluded as inquiring about a hypothetical behaviour for a hypothetical problem to a hypothetical service would not meet the research question, aims or objectives. Studies have cited problems with investigating hypothetical help-seeking behaviour due to the lack of evidence that investigating intentions to seek help can predict or translate into actual help-seeking behaviour (Hughes & Huby, 2004; Eisenberg et al. 2012). Medlow et al. (2010) stated that speaking to young people who are already engaged in mental health care services provides real-life perspectives about what it is that facilitates entry of young people into mental health care systems. Raviv et al (2009) and Rughani et al. (2011) have also stated that there is a need for additional studies to investigate *actual* help-seeking behaviour and so hypothetical inquiry was excluded as it could potentially diminish or dilute the focus of the study.

This research included young people who had, at a minimum, made one attempt to ask for help, from a formal service or semi-formal service and thus provided data on episodes where they attempted, partially completed, exited, or completed help-seeking for a mental health problem. Importantly, this study recruited young people who were able to reflect and discuss their experiences, who were not currently in crisis or in the early stages of receiving mental health support. This study excluded those who were experiencing or had mental health distress and had not sought help to a service for a mental health problem. Young people with intellectual disability were not asked to participate in this study nor were young people who were referred by a practitioner or service employee in a directive manner, as there could be issues regarding undue influence or coercion. Participants self-reported how they met the selection criteria (**Table 1**).

Table 1: Young people selection criteria

Participants	Inclusion	Exclusion
Young people	Aged between 16 and 25 years	Have not sought support for a mental health problem with any service
	Have sought help with a formal, semi-formal and informal service with a minimum of one contact	Have been referred directly by a practitioner/service employee to the study
	Have sought help with a formal, semi-formal and informal service within the previous four years	Have an intellectual disability
	Is not currently in crisis or in the early stages of receiving mental health support	

Practitioner participants

Investigating practitioners who support young people with their mental health was important as they are closest to the phenomena being explored (Charmaz, 2014). As the other half of the helping relationship, these participants provided perspective from a service level which assisted in contextualising the help-seeking experience. The three services chosen, in which to recruit participants were: a secondary *school pastoral care service*, a *youth service*, and *formal mental health care* setting. Each service is a space in which young people encounter adults who can provide help for a mental health problem.

School is a space where young people spend a significant amount of time and often where young people's mental health problems are first noticed (Fox & Butler, 2007). Pastoral care teams were chosen as they provide mental health support on a daily basis and are responsible for guidance and referrals to formal services (Department of Education and Skills, 2014). The youth service is a universal service for young people aged 12-25 years and was chosen as it is a voluntary environment where young people can access a drop-in space, engage in informal education programmes and can access mental health support. The service also runs projects to support young people who experience marginalisation or exclusion, such as, young carers, LGBTI+ and refugees.

Formal settings include a variety of public and private services that exclusively provide mental health care. These can include private practice, specialist public services run by the HSE, such

as *Child and Adolescent Mental Health Service* (CAMHS) and *Adult Mental Health Services* (AMHS), or community based mental health services, including the youth specific service *Jigsaw* (12-25 years) or the suicide and self-harm service, *Pieta House*. This is a basic overview of common formal services in Ireland.

Practitioners were selected for their experience working within a service with supporting young people with their mental health in a one-to-one capacity. Permission was obtained from management to recruit those working in a school and youth service. The counsellors were independent contractors and so did not require permission from management. No health professionals, practitioners or employees from HSC in Northern Ireland were recruited as all recruitment took place in Co. Donegal. The full list of selection criteria for professionals is listed in **Table 2.**

Table 2: Practitioner Selection Criteria

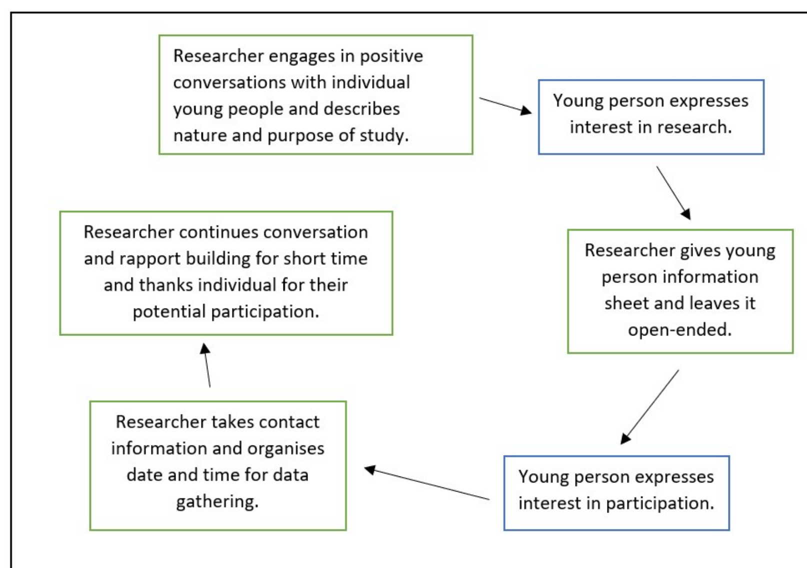
Participants	Inclusion	Exclusion
Pastoral Care Practitioners	Are part of a pastoral care team providing general support to students	School employees who are not providing mental health support directly with students, for example, principals, teachers, or admin
	Providing mental health support directly to students in a one-to-one capacity	
	Have worked in this role for a minimum of two years	
Youth Work Practitioners	Are employed as youth worker	Youth service employees who are not providing mental health support directly with young people, for example, managers/admin
	Providing mental health support directly to young people in a one-to-one capacity	Youth workers who work exclusively with groups
	Have worked in this role for a minimum of two years	
Formal Mental Health Practitioners	Are employed in a specified role in youth mental health care	Staff not providing mental health care directly with young people, for example, administrative staff
	Providing mental health support directly to young people in a one-to-one capacity	Health professionals from HSC
	Have worked in this role for a minimum of two years	

4.3.2. Recruitment

Youth participants were initially identified and recruited through a local youth service. This was completed either by the principal researcher directly or through youth workers who were asked to forward participant information sheets (**Appendix 2**) to young people. Once interest in participation was established, youth participants aged 16-25 years met with the principal researcher to review the information sheet together, to clarify the terms of participation, answer any questions the participant had and self-select to an interview or focus group. Once both verbal and written consent were obtained, a suitable time was organised for the interviews. A sample consent form is available in **Appendix 3**. The focus group participants were recruited through a pre-existing youth group. A youth worker informed this group about the research and many expressed interest in the research. Participant information sheets were distributed and procedures were followed as described above.

An important aspect of recruitment was a drop-in space in which ten participants were recruited. This space offered the opportunity to interact with and recruit young people from different backgrounds and life experiences. This youth space had a comfortable seated area, games table and access to tea and coffee facilities. Young people used this space while waiting on buses to go home, to do homework, to relax with friends, or to seek support or guidance with a youth work practitioner. With permission, the researcher was able to advertise, discuss and promote the research in an open and relaxed manner through natural conversations with young people and recruit effectively using a youth-led approach (see **Figure 8**).

Figure 8: Recruitment within a drop-in environment



Practitioners were recruited through existing professional networks and those who expressed an interest in the study were emailed participant information sheets (**Appendix 4**). Two practitioners were interested, and the principal researcher had a conversation over the phone with them to answer any further questions they had. Participants provided oral and written consent and a suitable time and venue were arranged.

4.3.3. Sampling strategies

This study used a combination of purposive sampling and snowball sampling (Barbour & Barbour, 2003; Bryman, 2012) with both young people and practitioners who met selection criteria (**Table 1** & **2**). Sampling strategies were thoughtfully considered as researching younger people and their mental health involves both a sensitive and personal psychological state, and a typically difficult to access population (Faugier & Sergeant, 1997). This was further complicated by the qualitative data collection methods, as opposed to an anonymous survey accessed through a computer. The planning for sampling strategies and recruitment processes were entwined in this study, with participants being recruited predominantly through careful conversations within existing networks, and selection criteria checks, before proceeding to the first stage of recruitment.

Youth participants

Young people are not a homogenous demographic and needs differ across the age range of 16-25 years. The sampling strategy purposively recruited young people for age, gender and ethnicity to ensure the inclusion of a diversity of perspectives and experiences (Bryman, 2012). In total, one focus group (N=6) and fourteen interviews were completed with young people aged 16-19 (N=5) years and 20-24 years (N=9), totalling 20 youth participants.

Multiple attempts were made to recruit young people who were members of the Travelling Community and positive contact was made with community workers. However, due to a complication of external factors, recruitment did not proceed. Recruiting young people within the 16-19 years age range was more challenging than older youths, due to the need for parental consent. Overall, participants responded in an open and non-stigmatised way, expressing interest and motivation to share their experiences and perspectives.

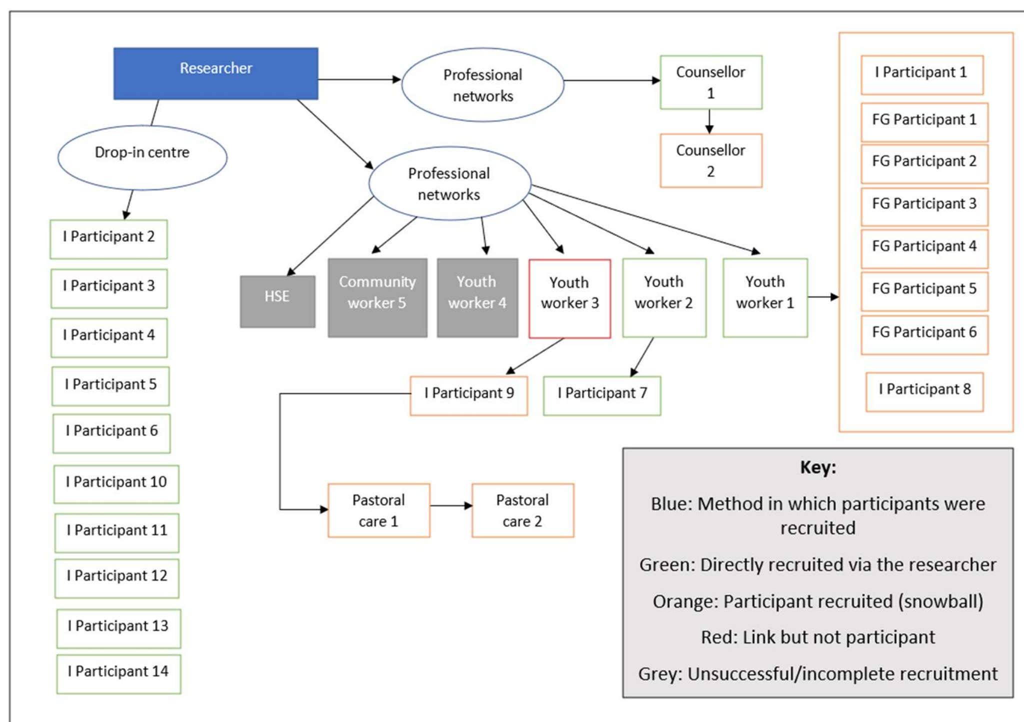
Practitioner participants

In total six practitioners were recruited; two community youth work practitioners, two pastoral care practitioners, and two counsellors who worked across many formal mental health settings, including private practice, community based and public services. This study initially tried to get access to recruit formal mental health practitioners through the statutory Health Service Executive (HSE) services where young people are referred to if they attend a GP for a mental health problem (HSE, 2021). Despite numerous conversations with eleven managers and employees over a 15-month period, the researcher was not able to get permission or refusal to recruit and so chose to withdraw the request to recruit in this setting.

Snowball sampling

Handcock & Gile (2007) stated that snowball sampling is used in different ways and so it is important to describe how it is used specifically in individual studies. *Snowball sampling* is often described as a form of convenience sampling, where the researcher makes initial contact with an individual or group of people relevant to the research topic who can then refer others who they know to take part in this research (Bryman, 2012). Snowball sampling can also be described in a relational way, as a method to access specific groups of people through existing social networks (Ghaljaie, Naderifar & Goli, 2017). It was through social networks and trusting relationships that individuals either responded or identified and referred on participants to this research, who were not aware of the study but were connected to the initial participant (Bryman, 2012). This strategy was helpful for recruiting practitioners in particular, as they were even more cautious to participate than young people. Through connections, rapport building, reassurances of confidentiality and anonymity, participants agreed to participate. Colleagues contacted other colleagues, young people spoke with friends, youth workers spoke with young people and in one instance a young person put the researcher in touch with two practitioners. A proxy trust was developed, in which one potential participant communicated trust or a positive experience with the researcher to a contact and this led to a conversation between the researcher and this contact, who was subsequently recruited. Observationally, this reduced fear associated with taking part in research with such a sensitive topic with an unknown researcher – by the time the interview began, participants had a rapport with the researcher, and this was a significant factor in the obtaining of rich data. A visual representation of the networks, strategies, and approaches used, both successful and unsuccessful, in this study is provided in **Figure 9.**

Figure 9: Accurate rendering of sampling pathways



4.3.4. Procedures

Youth interviews took place in a youth service meeting room. Staff were informed of the interviews and their expected duration. The participant was welcomed, offered refreshments, and given time to settle in the room before recording. Consent was reviewed and once participants agreed to proceed, audio recording began. The conversation was initiated with a general discussion about mental health which led naturally into different aspects of their experiences and perspectives regarding the topic. The interview schedule is available in **Appendix 5** and the full interview questions are in **Appendix 6**. Interviews lasted between 20 minutes and 1 hour 10 minutes. Once the interview was finished, recording stopped, and time was made available for participants to talk and ask questions. In one instance, recording began again as one participant wanted to communicate more thoughts on the topic. Participants were thanked, given a debriefing sheet with information for local services (**Appendix 7**) and left when they were ready. The principal interviewer remained on-site for some time, informed staff that the research had finished and left.

Additional procedures to those described were followed regarding two participants aged 16 and 17 years who took part in interviews. Parental information sheets and consent forms (**Appendix 8**) were also given to their caregivers. One parent organised a meeting with the

principal researcher and consent was given. The other parent posted the documents in a stamped addressed envelope provided by the principal researcher.

Upon meeting the focus group participants, the researcher spent time rapport building. Two young people withdrew before beginning and were supported to do this. Refreshments were offered and the research aim, and individual consent were reviewed again to ensure everyone agreed to proceed. Once oral consent was given, the focus group began with a general discussion about mental health, and some participants spoke openly about their experiences and perspectives regarding help-seeking. Others listened on and contributed by reinforcement in agreement with others' statements. The group lasted approximately 20 minutes and participants were thanked and debriefed afterwards. Two participants after the focus group volunteered to do an interview, to explore further some of the topics they had discussed in the focus group. The researcher remained on-site until the appropriate time, informed staff that the research had finished and left. The focus group schedule is available in **Appendix 9**.

The practitioner interviews took place at the practitioners' workplaces and began in a similar format to the youth participants' interviews, with a general conversation about mental health and then referred to specific questions that explored their role as a provider of youth mental health care (**Appendix 10**). All practitioner participants were thanked, debriefed, and provided with post-participation information sheets (**Appendix 7**). A copy of the interview schedule is in **Appendix 11**.

4.4. Data Collection

4.4.1. Interviews

Interviews are the most widely utilised data collection method and are regarded as an effective way at examining an individual's thoughts, attitudes, beliefs and knowledge about a phenomenon in-depth (Lambert & Loiselle, 2007). Regarded as both an ordinary and extraordinary method, conducting interviews can be challenging and requires experience, skill and planning on behalf of the researcher (Richards, 2020). This study employed *intensive interviewing,* a CGT technique, which was used to support and guide the participants with exploring meaning, actions, intentions and experiences (Charmaz, 2014). Interviews also offered participants the opportunity to discuss their experiences and individual perspectives in

private, outside of the group context, which increased comfort to explore deeply the subjective reality of help-seeking for a mental health problem (Bryman, 2008).

4.4.2. Focus groups

A focus group can be described as a carefully planned series of discussions designed to hear perspectives on a specific phenomenon in a permissive and non-threatening space (Krueger, 1994). They are a widely used data collection method and can produce qualitative data that provides insight into the perceptions, motivations, concerns and opinions of participants by generating a collective consensus (Gibson, 2007, p. 474). Focus groups are used extensively in healthcare research and their use with younger people is well documented as an important strategy as a valuable, interactive, fun and developmentally effective method in gaining understanding about young people's views on sensitive subjects, such as mental health (Gibson, 2007). Focus groups were a useful method in exploring mental health perspectives as they facilitated insight into how mental health attitudes, acceptable or taboo, were negotiated, created and exchanged among participants in a social setting, albeit created (Litosseliti, 2003). Focus groups also provide interaction and narrative data from discussion on how participants constructed their experiences, providing depth and perspective to the phenomena of help-seeking behaviour (Gibson, 2007; Lambert & Loiselle, 2008). Similar to interviews, early preparation, the skills and experience of the moderator, location, scheduling, and the environment were crucial for a successful focus group (Gibson, 2007).

4.4.3. Combining qualitative data methods

The combination of data collection methods in some literature is referred to as *methodological triangulation* and is believed to increase trustworthiness and quality of research and to assist in broadening conceptualisation (Creswell & Miller, 2000; Golafshani, 2003). Tobin & Begley (2004) prefer to describe this method combination as akin to a crystal as it illuminates multiple aspects of the phenomena. Morse (2002) encourages researchers to make use of multiple qualitative methods to enhance analysis of phenomenon. While this combination method is well established in the wider literature, Lambert and Loiselle (2007) state that researchers need to be explicit about their reasons for combining qualitative methodologies as "ad-hoc combinations of methods can threaten the trustworthiness of findings" (p. 230). As Vandermause (2007) emphasises the need for innovative methods and combinations of qualitative methods to address the complexity of healthcare phenomena, it was decided that a combination of methods would assist in the collection of reliable data on multiple and diverse

realities (Golafshani, 2003) in two ways. Firstly, this allowed participants self-select to either a focus group or an interview, depending on their individual preference and comfort levels (Lynch et al. 2018). In this study, this led to fewer refusals, minimal withdrawals, and increased convenience (Lambert and Loiselle, 2007). Secondly, this methodological combination was used for data completeness in researching help-seeking behaviours and meaning construction between the group (social) and the individual (subjective) realities on what is both a personal and interpersonal action (Lambert & Loiselle, 2008).

4.4.4. Interview guide development

This research used a *semi-structured* interview and focus group guide which included predominantly open-ended questions. This approach provided structure and focus in guiding the interview process but was also open enough to facilitate reciprocal discussion and for deeper exploration to uncover new meanings (Galletta, 2013). Using open-ended questioning helped focus the discussion on the most relevant aspects of participants experiences and supported both flexibility and structure for exploration of the topic (Bryman, 2008). Open-ended and semi-structured approaches to data collection are companionable with the constructivist grounded theory design (Galletta, 2013), as broad and general questions supported participants to construct their meaning regarding experiences (Creswell & Creswell, 2017). Three guides were created, one for the interviews, one for the focus groups, and one for the practitioners. A sample of questions can be viewed in **Table 3**.

Table 3: Sample interview and focus group questions

Area of focus	Questions
Introductory questions	• What is your understanding of the term mental health? • What does mental health mean to you?
Help-seeking questions	• What is it like to be a young person in Ireland with a mental health problem? • When did you first begin to experience some difficulty with your mental health? • How long did it take before you realized you had a problem? • When did you decide to ask others for help? • What things did you find helpful/unhelpful to cope with this distress in your life?
Service experience questions	• What did you imagine mental health care would be like? • Can you describe to me what your experience was like from the decision to ask for help to getting the help you received? • Can you describe what the service was like -the physical building/location like and how did that make you feel? • Can you describe to me your experience of working with a mental health practitioner/youth worker/pastoral care staff? • Were you offered a choice in the type of intervention you would like? • What did you need from that person? • Were you satisfied with your experience? • In what way, if any, do you think the service is helpful for young people? • Have you any suggestions that might improve the service?

Culture and family questions:	• Did you tell your family and friends you were looking for help with a mental health service? • Do you think culture has a role to play in young people's mental health? • Have you heard about other's experiences of asking for help? • From your experience/observations what makes it difficult or easy for a young person in Ireland to access mental health care? • Is there anything you would like to say that you haven't had the opportunity to do so yet?
Closing Questions	• What do you think are the most important features that a youth mental health care service should provide?

The interview guides were carefully developed from the aims and objectives of this research and used Bronfenbrenner's Ecological Systems Model (1979) to consider the factors that encompass mental health and help-seeking behaviour; participants were asked about their direct experiences, the influence of family and social networks, as well as wider culture and society. As interviews proceeded, the guides were updated and built upon through new insights from participants in keeping with a grounded theory approach whilst maintaining flexibility and variance (Lambert & Loiselle, 2008; Charmaz, 2014). This meant questions were added on themes that were identified during data collection and posed to subsequent participants. Deciding to stop was informed by the concept of saturating the theoretical concept; the sampling technique was not yielding new properties to the phenomenon studied (Charmaz 2014).

4.4.5. Interview techniques

Young people in general are keen and able to participate in research and decision-making that affects their lives, but they do not always have the opportunity to do so (Forde et al., 2017; Forde, 2018). Techniques and skills from the researcher's youth work experience were employed to ensure young people were supported to participate and be included in a manner that was appropriate for them. This began with reflexivity and consideration regarding the position of the researcher. The role of the relationship between researcher and participant was

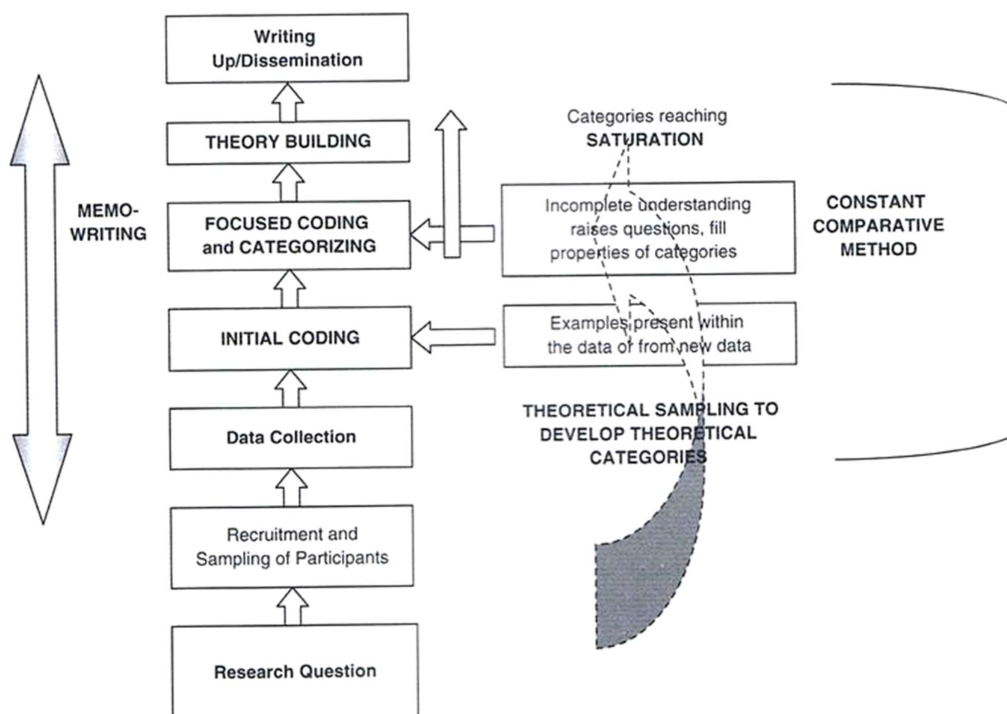
central to the chosen methods in this research, and the researcher spent time developing rapport and establishing some foundational trust with each participant, from initial contact to debriefing, and experienced a genuine positive regard for participants (Prior, 2018). The research was conducted in partnership (Richards, 2020) and participants communicated participation as a positive experience and the researcher conveyed genuine respect and gratitude for their knowledge and time.

Aside from checking with the interview guide, no notes were recorded until after the participant was finished and exited as this may have caused feelings of objectification. As the research investigated mental health, focus, care, and active listening were prioritised to each participant to facilitate participants to discuss what they deemed relevant. Reflective practice was used at all stages, sometimes during an interview, which led to exploration of interesting and relevant topics as they arose. During focus groups, the researcher managed challenges such as group pressure, group dynamics, withholding, embellishing and distortion and supported a successful group discussion (Richards, 2020; MacKay, 2012). Recording reflections and memos regarding the group interaction assisted with understanding during the data analysis stage. This approach and skill set combined with open-ended questions, great sensitivity and an interactional space were successful in conducting an ethically sound and impactful interview that respectfully gathered rich data (Lambert & Loiselle, 2008; Charmaz, 2014; Richards, 2020; Prior, 2018).

4.5. Data analysis

The data collection process based off the study design was successful in yielding rich in-depth data about young people, help-seeking and mental health. Charmaz's (2014) constructivist grounded theory (CGT) approach informed data analysis in this study and proved ideal for the handling of the rich and detailed data obtained (**Figure 10**).

Figure 10: Visual representation of CGT Methods (Tweed & Charmaz, 2011, p. 133)



4.5.1. Beginning analysis

Analysis is embedded in all stages of CGT, for example, *theoretical sampling* was used throughout data collection and involved inquiring in subsequent interviews new lines of inquiry that were intriguing from earlier ones (Charmaz, 2014). After data was collected, it was transcribed by the researcher in sequential order. A practitioner transcript and a youth participant transcript are available in **Appendix 12** & **13**. The researcher then repeatedly listened to the original audio and made notes (**Appendix 14**) as well as reading transcripts and making notes (**Appendix 15**), which helped increase familiarity with the data. Transcripts were uploaded to the Nvivo 12 software programme for coding and systematic organisation of data. CGT methods facilitated the researcher to bring the interaction with participants into an interactive and analytical space, beginning a process of deeper and focused *data analysis*. During all stages of the research the researcher made many *memos* to capture burgeoning ideas, thoughts and insights, which were transcribed to Nvivo 12 (**Appendix 16**). Memo-writing is considered an important process for a grounded theorist, representing the space between data collection, and writing drafts (Charmaz, 2014). The iterative approach or the *constant*

comparative method of grounded theory was helpful for analysing data for complementary, similar, or different patterns across data, within data and with data obtained from different collection methods (Charmaz, 2014). This provided further understanding of different aspects of the same phenomenon from different perspectives (Lambert & Loiselle, 2008).

4.5.2. Coding

Transcripts were coded following Charmaz's (2014) framework using a combination of *word-by-word*, *line-by-line,* and *incident with incident* coding techniques during the *initial coding* stage. This stage focuses on 'theoretical playfulness' (Charmaz, 2014, p.137), to try out ideas while providing analytic direction in looking for subtle meanings, new insights with the ability to return to the data at any stage and make new codes. This stage is more than just sorting and organising, it is the beginning stage of theoretical insight (Charmaz, 2014). Each participant's transcript data resulted in an extensive initial coding process which came to a natural end (**Appendix 17**). The next stage was *focused coding,* which was less time consuming than initial coding and brought codes together into categories, sub-categories and concepts (**Appendix 18**). This stage is important for what is termed *theoretical sensitivity*. Charmaz (2014) describes this as an important hallmark of grounded theory, the 'ability to understand and define phenomena in abstract terms and demonstrate abstract relationships' (p.161). In this process, analytical codes are constructed, which lead to abstract concepts that have defined empirical connections and are distinguishable from other concepts. *Axial* coding strategies were employed to understand connections between sub-categories and categories by bringing the data, which is fractured from analysis, together again to provide dimension and 'dense texture to the relationships around the axis of a category' (Strauss, 1987, p. 64 in Charmaz, 2014, p.147). This stage is connected to *theoretical coding* which was an integrative process and provided coherence across categories of broader structural connections and relationships (Charmaz, 2014). *In-vivo* codes represented what was happening in the data theoretically, for example, terms that were used to convey condensed but significant meanings or a new perspective and were often taken direct from the participant's dialogue (Charmaz, 2014). Once the focused codes were completed, it became clear across participant folders on Nvivo that categories were evolving, and so the whole data set was again organised into categories, sub-categories, and concepts, all of which fed into the overall theoretical concept of young people's help-seeking journey (**Appendix 19**).

4.5.3. Treatment of data

There were two distinct data sets in this study, interviews and focus groups. Each set was analysed separately but in the same manner. Regarding the combination of qualitative methods, using the crystal analogy (Tobin & Begley, 2004) the researcher integrated the focus groups and interview data discovering great convergence, little divergence, and predominantly complementary data (Lambert & Loiselle, 2008). Grounded theory methodologies were appropriate and compatible for analysis of this focus group data and interview data (Gibson, 2007; Stevens, 1996). This researcher had previous experience with this style of analysis and found that when performed meticulously, the integration of individual interview data and focus group data was a productive strategy that led to an enhanced understanding and confirmation of the phenomenon's structure and essential characteristics as existing in personal and social realms (Lambert & Loiselle, 2008).

4.6. Ethical considerations

Ethical approval was obtained from Ulster University Research Ethics Committee prior to data collection (UUREC No: 180010). Permission was provided by the service providers to recruit staff working in their service for this study. This research had elevated risks as it involved young people and mental health. The British Psychological Society's (BPS) *Ethical Principles for Conducting Research with Human Participants* (2014) guided the research design.

Participants were provided with an information sheet detailing the aims, methods, procedures, the type of data collected, expected duration, how data will be used, limits of confidentiality, planned outcomes, prospective research benefits and the contact details of the researcher (BPS, 2014). Participation was voluntary without incentives and participants were informed about their right to withdraw at any stage without adverse consequences. Informed written and verbal consent was obtained.

Pseudonyms were used and all personal information and all personal identifiers were removed. In addition to this, certain information within in-text quotations was removed, omitted, or changed if the researcher deemed it as having the potential to compromise anonymity. Data was stored according to the General Data Protection Regulation (2018) and freedom of Information Act (2000). Paper documents were stored in a locked filing cabinet and electronic

data, including audio, was stored on a private password protected server for the appropriate length of time. Only the researcher had access to the data and took responsibility for the data storage. No participant withdrew data post participation.

To safeguard against potential risks, such as triggering of distressing feelings, written and verbal briefing and debriefing was provided as well as literature detailing local mental health services. A distress protocol was developed (**Appendix 20**). A separate parental information sheet and consent form was provided to participants aged 16 and 17 years as they required parental consent to participate. These participants were offered the option of having a chosen adult present during data collection. The principal researcher was trained in child safeguarding and had access to a support structure already in place to deal with any safeguarding concerns. No safeguarding issues were disclosed during the research.

4.7. Integrity in research

4.7.1. Trustworthiness and authenticity

The provision of a transparent and thorough description regarding the design of this study has increased its trustworthiness (Golafshani, 2003; Lambert & Loiselle, 2008). Acknowledging the methodological triangulation and the associated epistemological assumptions and how they were analysed also promotes integrity and trustworthiness in this research (Cresswell & Miller, 2000; Lambert & Loiselle, 2008). Trustworthiness checks can be done within the data itself through the production of thick and rich descriptions of the setting, the participants and the statements (Creswell & miller, 2000). The researcher adopted a strategy for trustworthiness which involved developing an in-depth knowledge of the people and the phenomenon in question as Charmaz (2014) suggests this can reduce the likelihood of making assumptions or projecting preconceived ideas into the work. Careful reflection on the data, the codes and the concepts, engaging in initial and focused coding and checking for how concepts and data increase understanding, and revisiting the context to ensure that the data supports assertions, can all contribute to revealing preconceived ideas (Charmaz, 2014).

The sampling strategy was thoroughly considered and detailed. Questions were carefully constructed for their wholeness, their ability to inquire about the phenomena, and for their appropriateness, sensitivity, and flexibility (Galletta, 2013). An important validity check in this

study was to test the trustworthiness of the researcher's analysis and understanding of data through the use of *member checking* where the researcher shared the results with some participants (Creswell & Miller, 2000). One participant reported back that they valued hearing others' experiences while reviewing research findings and how this validated their mental health experiences and participation in this research Also used was the *peer debriefing* where peers who were familiar with the topic and grounded theory but who were not conducting the research were engaged throughout the whole process (Creswell & Miller, 2000).

4.7.2. Reflective Analysis

An important validity check in qualitative research is the reflection on the researcher's position. I have used guidelines form Creswell & Miller (2000), Galletta, (2013) and Charmaz, (2014) to explore and acknowledge my privileges, perspectives, reality and self-disclosing assumptions beliefs and biases.

My interest in this research comes from my professional experience working with young people for over 15 years in the community youth work sector. I trained in psychology, and I initially wanted to pursue clinical psychology but through volunteering in youth services, preferred youth work for its broad application, its creativity, and its flexibility. I have both provided mental health care to young people over this time, and supported young people to care, in a variety of ways and methods. I also have a network of colleagues in other semi-formal and formal services who I work with, socialise with, and share thoughts with regarding different methods and strategies to support young people. Over this time, I have engaged with many young people and observed how they navigate their way through youth and development while managing a mental health problem. I feel that I have seen most outcomes, positive and negative, while simultaneously observing the quality of care for young people by services and other adults in their lives. I have observed systems succeeding and failing, with different young people in different contexts. It always seemed complicated and uneasy to predict whether a referral would result in help or harm.

My biases move around, I have been a champion of all services at one time or another. Some days I feel quite neutral about mental health services and there are other times where I am sure one type of service is better than the other, and then other days where I am provided with evidence of the contrary. This has greatly informed my research – all services work well, some of the time – but why don't they work well most of the time? Something felt deeply wrong about the current options for mental health care being a matter of chance as it is an essential

healthcare service. I wanted to critically examine youth mental health care within context and was motivated towards a deeper analysis, to purposively stop for a moment and consider what is actually happening? To take stock in how far we have come but what do we need to do? How can I figure out what can work for young people?

I have also been motivated to do this research as a result of my direct experience of young people telling me about their mental health care journeys. I have seen young people with a problem get timely support and how immediately and quickly they adapt and resolve problems, returning to growing and developing. While I have seen some of the most amazing young people cope in ways I could not have imagined, despite poor mental health care, I have witnessed the outcomes of not having support when problems first emerge; in their quality of life, their development and how they grow into adults; their ability to pursue and build their own lives, their relationships, their children, their physical health, their addictions, their suicides. I just wanted to do something rather than remain a silent witness.

I believe young people are often othered, dismissed or discriminated against because of their age, and how important opportunities are missed to improve their lives. Understanding early intervention and an appropriate way to provide mental health care to young people seems obvious and important to me. I knew that young people were willing to talk about their needs if asked in the right way and at the right time; I have heard hundreds of volunteered stories of help-seeking experiences and felt in a position to start exploring that in a formal academic way.

I am in the privileged position of being an adult, yet I have experienced adolescence; youth is a type of marginalisation that you can grow out of. I can connect well with others and provide space for them to tell their stories. I see my adult role as an antenna, with some grounded understanding, in having experienced youth. I view my primary role as to create spaces for story-telling, listening and meaning making, which when recorded could have the potential to be communicated respectfully and transformed into action, through my analysis and write-up.

4.8. Conclusion

This chapter has provided a transparent and thorough account of the methodological aspects undertaken in this research which were designed in line with the study's aims and objectives. In the examination of complex phenomena, such as mental health and the subjective experiences of help-seeking with personal distress, *constructivism* as an epistemology and

symbolic interactionism as a theoretical perspective were successful (Golafshani, 2003; MacKenzie et al. 2006; Charmaz, 2016), especially when used within the highly compatible methodology of Constructivist Grounded Theory. This chapter also detailed how both young people and practitioners (*N*=24) were selected and recruited, as well as providing a discussion on the importance of a well-designed sampling technique. In addition, an examination of the importance of interview skills and ensuring a good rapport with participants was provided, with insight into how these factors supported trust in the data collection process. It has also addressed the methodological challenges and how these were negotiated, with reference to important risk and ethical decisions. In the interest of ensuring trustworthiness and authenticity, this chapter concluded with a reflective analysis. The careful preparation of study design was important as it led to the collection of rich and in-depth data.

5. Findings

5.1. Introduction

This chapter presents the findings from research with *young people* aged 16 - 25 years and *practitioners* who provide youth mental health support, investigating participants experiences of and perspectives on being young and help-seeking for a mental health problem. Data were collected and organised into two sets for analysis using a constructivist grounded theory informed approach (Charmaz, 2016). Research is presented in two parts, representing the two perspectives investigated; *young people*, who took part in interviews (N=14) and a focus group (N=6), are presented in *Part A* and findings from practitioners, who took part in interviews (N=6), are presented in *Part B*.

5.2. Part A – Findings from the Young People

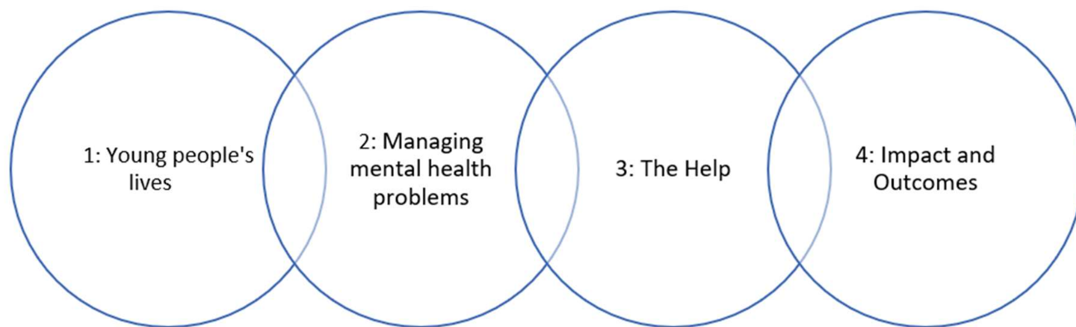
This study recruited eighteen young people whose demographics are represented in **Table 4**. Information has been presented in a way that protects anonymity.

Table 4: Youth participant demographics (N=18)

	Age	Gender	Location	Ethnic background	Education or employment status
Richard	16	M	urban	Irish	student
Claire	16	F	rural	Irish	student
Gerard	18	M	Gaeltacht	Irish	student
James	18	T	urban	European	student
Michael	19	M	urban	Polish	student
Josie	19	F	urban	Irish	student
Rachel	19	F	urban	Irish English	employed
Niamh	21	F	urban	Irish	student
Cathy	22	F	urban	Irish	employed
Laura	22	F	urban	Irish	unemployed
Erin	23	F	urban	Irish	unemployed
Andrew	23	M	urban	Black African	employed
Thomas	23	M	urban	Black African	employed
Robert	24	M	rural	Irish	employed
Enda	25	M	rural	Irish	employed
Aine	25	F	urban	Irish	employed
Liam	25	M	Gaeltacht	Irish	employed
Joseph	25	M	urban	Irish	employed

Part A explores findings regarding young people's direct experiences of help-seeking for a mental health concern, in four categories (**Figure 11**). Category 1, *Young people's lives*, illustrates participants' environmental and interpersonal contexts and provides a foundation for findings in Category 2, *Managing mental health problems.* This category describes how participants' conceptualisations of mental health, and their social relationships influenced their decision to search for help, and their experience of asking for help. Category 3, *The help,* explores in rich detail, participant's experiences of services, interventions, and helpers. The final category *Impact and outcomes,* examines how their experiences affected them and the key elements that young people need from mental health care.

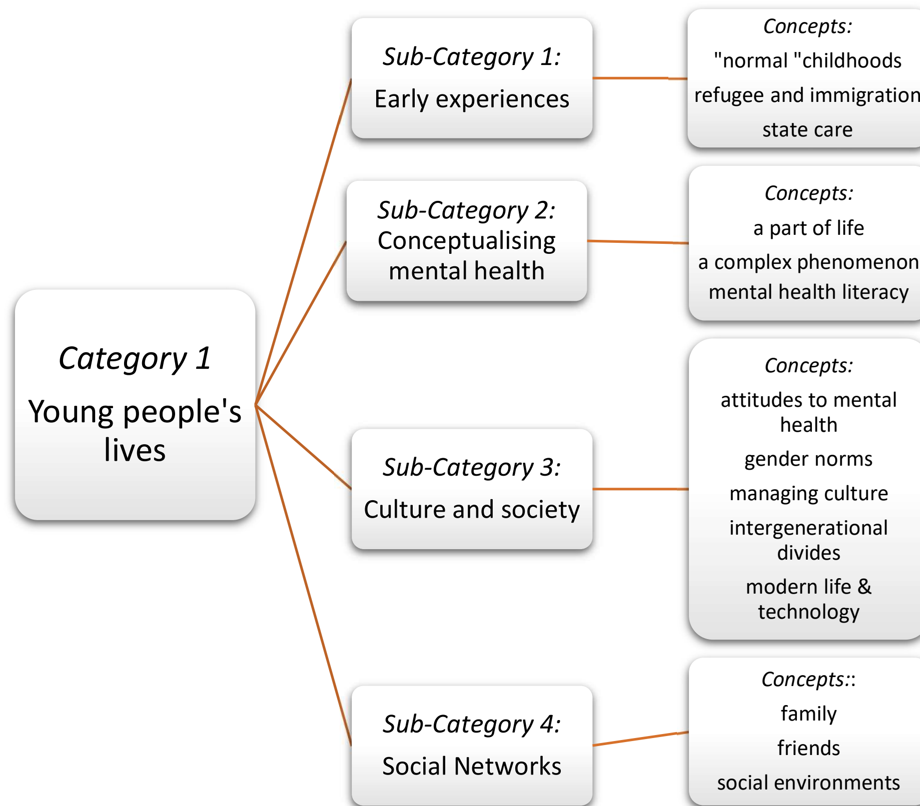
Figure 11: Part A categories



5.3. Category 1: Young people's lives

This first category presents findings from participants descriptions of their individual life circumstances and their personal conceptualisation of mental health. Before understanding help-seeking experiences, it is essential to first appreciate what context young people help-seek from, and how this impacts their journey of help-seeking and engagement in mental health care. This category discusses findings from four sub-categories: 1. Participants' *Early experiences;* 2. their *Conceptualising of mental health;* 3. the impact of *Cultural and society;* and 4. their *Social networks* (**Figure 12**).

Figure 12: Young people's lives



5.3.1. Early Experiences

Participants shared memories of their childhood and the environments they grew up in, with more females than males able to recall early life experiences. Participants described what was *"normal"* for them in childhood including *refugee* and *immigration experiences*, and experiences of being in *state care.*

"Normal" Childhoods

Many participants described childhood as a time where they experienced different and challenging life situations. Some participants described not having their needs for attention or love met during childhood:

"You want to feel loved by somebody… it's a natural thing…and you'd get put down for it" – ***Cathy***

Many participants described having caring responsibilities during childhood often as a result of parental bereavement. Gerard described caring for his mother who had severe mental health problems which resulted in missing school regularly; unsupportive experiences with social work, and Laura described her experiences as a young carer for differently abled family members: *"I went there [school] to get a break because I would go home and then I would get to work!"*

A few participants experienced parental separation and divorce during childhood. Claire discussed her parent's drawn-out separation, their eventual divorce and how moving to a new house triggered her subsequent and ongoing mental health problems: *"… being that young and not understanding, that it seemed far worse than it is, because I don't have the pieces to put together"*.

Many participants indicated that their mental health problems in adolescence and emerging adulthood were either a direct result of early life experiences or a continuation of the issues they faced as children:

"I remember just wanting to hurt myself… and of course you never know what it is, you just think you're a crazy little kid …but then that carried on through and got worse as I got older" – ***Cathy***

Overall, mental health distress was described as present in childhood with some participants describing a general awareness:

"Just there was always something itching at me, just I wasn't feeling right" – ***Cathy***

While others recalled memories of intense distress as a normal part of childhood:

"I started having panic attacks when I was about five or six, so I was really young" – ***Laura***

Andrew described that when the distress that he carried from his childhood was finally addressed in later adolescence, that these experiences could be reframed and contributed to his resilience in emerging adulthood: *"and I think when you actually go through some stuff … and you get* ***past*** *it … you go woah, you're actually a lot stronger than you think"*.

Participants talked about others they knew who had similar challenging childhood experiences and did not view their own experiences as abnormal but part of a wider range of circumstances that children in general experience.

Refugee and immigration experiences

Four participants in this study described experiences of immigration to Ireland during childhood or early adolescence. As a member of a family seeking asylum, Thomas described his experiences of feeling powerless and overwhelmed: *"I don't want this [laughs]… It's not like I wanted to come to your country … it wasn't my decision, it was out of our hands ... it can be very, very tough for especially African children that emigrated here".*

Language and accent barriers greatly impacted Thomas' ability to communicate with others: *"they could be just trying to understand the* ***accent*** *alone!"*

Thomas discussed the difficulty of connecting to other Irish children and making friends with other African young people due to similar life experiences: *"African kids in Ireland, the ones that came here whether through like refugee or whatever, they feel like they always like separated themselves from the culture but it's not that it's just that they hang around with people from similar backgrounds 'cos they know they seen the same things… even though they may not talk about it, it's like there's almost an unsaid* ***unity,*** *whether it be struggle or it's like you can identify and that they've been through hardship as well, so that's why … the bonds are so tight".*

Thomas described how he felt unable to talk about his experiences of trauma to others within his culture or outside of this culture: *"I've seen [pauses] … I've seen a man being killed in front of me… they burned him… like scary do you know what I mean? I was a kid and I saw that and I'm like [face astonished], like nobody? [pauses] like it was like a normal thing…"*

Asylum seeking can compound other issues such as intergenerational differences, cultural differences, and family dynamics: *"you see your [Irish] friends… telling their parents how they feel and* ***you can't,*** *my Mum said "why you sad? you have food at home? …you have somewhere to sleep? you have your own house? you have a uniform? you have shoes? you have a jacket? [laughs] why you sad?" – they just don't get it… they had to go through a lot to survive and I always say like they honestly believe they're doing a better job than their parents" –* ***Thomas***

Two participants described feeling alien, othered and isolated from how others treated them:

"…then coming to a whole new place … they try to make friends; they're really trying but people look at them different" – ***Thomas***

Especially when others in society, such as teachers and taxi drivers, repeatedly question their origins:

"Their biases are very real … I don't know how to explain it but someone going as far as, 'oh where are you from', and you say '[large town]' and they say, 'no ***where*** *are you from?', you know what I mean? that kind of thing" –* ***Thomas***

Thomas described how inexperienced, racist or poorly trained Garda officers rely on racial stereotypes from media to inform their interactions with young African men: *"I've met some Gardai…who've literally just come from one town somewhere in this country and come up here right and all they ever knew was that, so when they see foreigners they just, they only know them through tv, does that make sense?"*

Racism, on top of the stress of immigration, exacerbated participant's distress. Parents advice was to ignore racism and focus on creating a new life, which was the purpose of immigration. Andrew described this as an impossible task: *"if somebody is being racist to you, don't pay attention to them … but then they [parents] don't know that there is only so much you can take".*

Andrew spent his childhood in foster homes and described feeling different and disconnected from his wider family. This practice was a private arrangement between Andrew's parents and another African family living in Ireland, who took on his legal guardianship and fostered him and his siblings until he finished his education: *"it's just different from everyone else because everyone else has got either a mum or a dad, if not both, or aunties and extended families but as for me it's just [pauses] it's just you and your [siblings]".*

Andrew reflected on how many difficult life situations were compounded by instability in foster homes: *"I just grow really, really fast, because I wouldn't have had my parents around me… I lived in this person's house, this and that… no parents, just us three like… there's so many stuff you go through as a young person"*

Immigrating as a child is extremely difficult and has a lasting effect on mental health: *"African parents should take into consideration more about mental health".*

Some participants immigrated on their own in an attempt to improve well-being and to search for connectedness. James decided to immigrate to Ireland, to live with extended family, due to feeling unsafe, unwell, and unable to get support and acceptance in his home country. The

recent cultural resurgence in the popularity of extreme right-wing political views across countries in Europe resulted in attitudes becoming increasingly less accepting of people in the LGBTI+ community: *"…I think my health was kind of deteriorating, because well first I live in [home country], it's not very friendly environment for LGBT people, I was still in the closet… I was very tired of pretending and came to Ireland hoping that I could find some acceptance"*.

James struggled with his expectations of immigration as a solution to his distress: *"not that I was disappointed, but I had some, maybe too big expectations, because I still felt a bit too weak, um to be honest with myself and others"*.

Rachel, who experienced parental abandonment, also immigrated to Ireland to live with extended family and seek connection, find identity and live a better life: *"I was like, no I'm going to be fine … I was so excited but six months later I was in a new school in a new country, and I didn't know anybody, am [pauses] and I became very suicidal"*.

Rachel described living in Ireland with a family member who had addiction issues, how she was unable to escape distress she carried from childhood, and how she ended up in state care: *"…this was meant to be a good thing that I came to Ireland, I'm safe now and going to school, why is not everything going to plan? But she kind of knew everything would be difficult for me, but she had her own issues too I guess."*

How immigration impacted participants mental health was a result of different factors including choice and support networks. Immigration was a complex and unique process for each participant and while it mostly offered physical safety, it intensified some participant's mental health.

State care

Two participants reported experiences of spending time in care of the state in childhood and adolescence. Participants discussed their experiences of going into care, an act of institutional safeguarding, as traumatic and lacking emotional support:

"You have people who are social workers, who have the power to take away children, they don't look at the emotional side of it …but it was almost like after the safeguarding is done, their job is done - they just leave you to wonder about all of these depressing feelings" – ***Rachel***

Aine described her experience of living in a care home, having limited confidentiality and privacy, and not being able to find the help she needed: *"So I had no trust in them because*

anything you say when you're under 18 goes straight back to whoever in the care home…even when you know it's not a child protection issue it still goes back, I could have told them 'I think the sky is green' and they're repeating what I said."

Participants described social workers as being allied with other professionals and colleagues in the health services:

"Because my legal guardian was a social worker, who was also in the health service, they were kinda like, well we're on the same power as you, we're a health service, we should be involved in everything got to do with this young person. I think that's mainly why they told them everything." – ***Aine***

Participants developed deep distrust towards professionals in health and social care services. Rachel discussed how after admission to a psychiatric unit, due to previous and ongoing unhelpful experiences she still would not reach out to her legal guardians (social workers):

"even though I was under their care I would never actually go to them for a problem… even when I was admitted into the psychiatric hospital… the person I told was Mary… and she came to visit me every day and she was like Rachel you need to tell your social workers, you need to tell people that are looking after you and I remember I was like – ***no****" –* ***Rachel***

Aine described how the constant turnover of staff resulted in few opportunities for developing trust with social workers: "*So you don't trust them in that sense and then you kind of give up on them because … it always changes. The person always changes."*

Participants shared experiences of instability in placements which resulted in new schools, new friends and repeatedly trying to develop new support networks:

"I first moved to [large town] when I was 17 and I didn't know a single person" – ***Rachel***

Aine identified that 'being in care', specifically the instability of placements, resulted in instability in mental health care: *"I think my biggest one [barrier] was probably actually* ***being in care****, because I moved so much, so by the time they were getting the referrals sent I was being moved… straight back to the beginning… of having to wait, and it's like no wonder I ended up in crisis so many times."*

Aine discussed how attending care plan meetings left her feeling objectified, excluded, disrespected and othered: *"they still always talked about you like as if you weren't there and*

said things that like any human would know would be hurtful to anybody and especially to a teenager…"

Both participants discussed having mental health problems before being 'in care':

"…any kid in care is going to have issues already. You didn't end up in care for the fun of it" ***– Aine***

Participant's overall experience of this system was overwhelming, unstable, and involved recollections of incidences of psychological harm. Aine and Rachel, who were already dealing with intense distress, found that their placement in 'state care' further compounded their mental health.

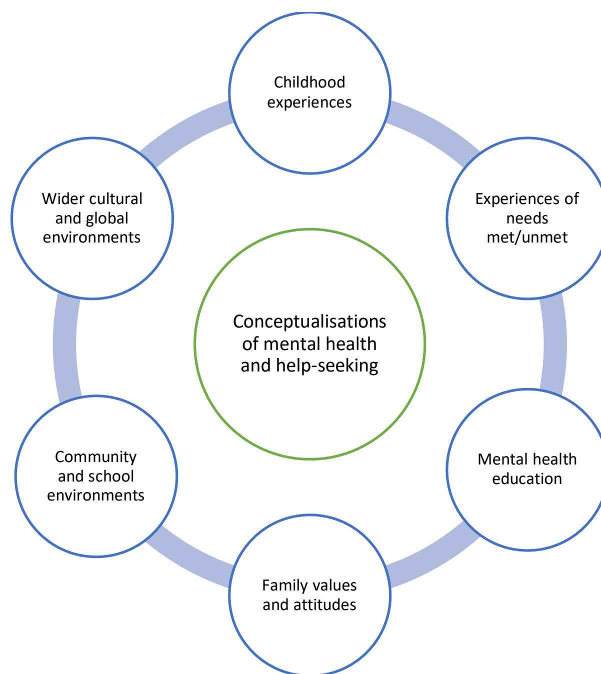
Summary of early experiences

Findings from this first sub-category indicate that childhood is a period of life in which many types of varied and challenging experiences can occur and are normal for the individual experiencing them. Experiences of asylum seeking and immigration and being in state care can be a barrier to formal help-seeking. Young people experienced unmet needs, family caring responsibilities, family separation, family mental health problems, caregiver addiction, abuse, parental bereavement or abandonment, and trauma, which was found to contribute to distress in childhood and youth. Childhood experiences were found to shape participant's understanding of their own distress and conceptualisations of mental health.

5.3.2. Conceptualising mental health

This sub-category explores participant's ideas, analyses and understanding of mental health (**Figure 13**). Participants discussed the *normality* of mental health, the broad spectrum of human experiences, the mind as a *complex* and at times perceived as an independent force, connections to physical health, their *knowledge* of the topic and the role of problem-solving and personal responsibility in managing mental health.

Figure 13: Conceptualising mental health



As a part of life

All participants believed that mental health was a neutral phenomenon, one that could change depending on the context or the challenges they face:

"We could be thinking really well and living a good life and happy or we could be struggling with our mental health meaning that we're going through some kind of phase or depression" – ***Cathy***

Liam depicted his experiences of ongoing mental health problems as a normal part of his life: "*it's a fact of life you know?"* and Joseph discussed the ubiquitous nature of mental distress: *"it is like the common cold in Ireland, everyone in Ireland is touched by it in some way"*.

Some participants took comfort in the commonality of mental health problems, identifying and connecting with other's pain, and feeling less othered:

"I think everybody is kind of a bit mad [smiles]… even the psychiatrist or counsellor I was talking to actually has to go see somebody else! [astonished smile] ... everyone is struggling at the end of the day" – ***Rachel***

Mental health problems were described as stigmatised and some participants observed that although a lot of young people suffer distress, it can be ignored, denied or rejected:

"it's like your normal health really and a lot of people probably ignore it… they deny themselves the fact that they do have mental health sometimes…" – ***Laura***

One participant in the focus group expressed frustration at the persistence of extreme stereotypes about mental health:

"…not only do they think negatively, they think the extreme end of negatively, they think the whole schizophrenia, bipolar, total breakdown … rather than just depression" – ***FG Aine***

Andrew stated the need for cultural acceptance of distress as a typical part of health and human experience: "*it's not a disease, it's not a sickness that you have to hide from everybody".* Participants regarded mental health as a normal part of life, an aspect of being human that all people have to manage, despite the stigma from others.

As a complex phenomenon

When asked about what mental health is, many participants described it as primarily concerning emotions and feelings discussing intrapsychic processes and abstract and intangible aspects of the self. Erin succinctly stated, *"it's the part you can't see"* and described how mental health encompassed cognition, memory, and perception. She also described it as a lens, which filters how she perceives the world, interacts with others and also how she remembers experiences.

Andrew initially explained mental health in a binary manner but later conveyed a more fluid understanding of the phenomenon: *"… you can have bad and good at the same time".*

James discussed how intrapsychic processes are directly connected to the external expressions of the self, in an input-output analogy: *"Well it's the state of your well-being or not… if it's not bad then it's good, if you're healthy mentally, you're happy".*

Some participants described an internal duality between the self, as experiencing the distress, and the brain, as having independent qualities, inflicting the distress. Cathy expressed: *"it's*

just the way our minds go", describing her experiences of: *"trying to redirect your brain from thinking about the bad stuff".*

Joseph described this internal duality as an adversarial relationship and felt defeated when he acknowledged his need for external help to manage his distressing behaviours with food: *"I'm kind of thran, it's like I can win this battle myself, but that wasn't the reality…so it did take a few years for me to finally give in to the illness and just say I need something else here because this is not working".*

Liam stated: *"the mind is a terribly confusing thing and it's good to get some context and perspective from the outside every now and then".* Andrew reframed this confusion as a positive challenge: *"it is just a fact of digging in deep and finding it… I take life as a big puzzle".*

Participants discussed in detail the internal struggles they faced with their mental health. They offered language to explain the complexity of their internal and abstract experiences and their impact, which was often based on their knowledge of mental health.

Conceptualizations

Participants discussed how their knowledge of mental health has affected their ability to notice and manage it. Participants usually referred to schemas of physical health to explain mental health, describing an interconnected and interrelated nature between them:

"it's just as important as physical health and if one isn't too well then the other suffers and vice versa" – ***Robert***

Some participants described learning how to recognise, understand and attribute personal distress as a mental health problem:

"I didn't realise that like that I'd get sick a lot every Christmas and every birthday and someone said to me once, 'I think you're just having a panic attack' and I was like - ***what?*** *[laughs] are you being serious? I thought it was a normal part of my life, I didn't realise that it was something that I could solve" –* ***Laura***

Andrew expressed how his own self-awareness, knowledge and positive attitude to mental health only came to him in emerging adulthood through experience: *"… I only developed that about 2 years ago".*

Erin described how knowing about and comparing other's experiences of mental health caused her to minimise her own experiences as not severe enough to warrant support: *"…relative to what some other people are going through it seems little, but at the same time trying to compare yourself against other situations, it just makes yourself feel worse and feel guilty for feeling the way you do… it might just end up causing you to feel more shame and to go into that hole even deeper"*

Most participants described learning about mental health by themselves or through friends or family. Aine attributed a lack of knowledge about mental health with formal education: *"…we were never taught about mental health or anything like that".*

Andrew believed mental health was something to be monitored and prioritised, that mental health had a problem-solution dynamic. Andrew also conceptualised his mental health as controlled by the brain, and was motivated to take care of his mental health for better performance in sports:

*"Mental health is probably one of the most important factors of human life because I think your brain controls absolutely **everything** that goes on through your body… how can I make my mental health better so I can play better?" – **Andrew***

Many participants stated that it was their responsibility to maintain their mental health:

*"Everyone has to look after their **own** mental health they just can't say 'oh I don't have mental health issues' but like you never know down the line you might have" – **Robert***

Enda discussed how problem-solving in mental health was about trying to articulate thoughts, feelings and images from an emotional space into the physical world through language, in an attempt to connect with another person and to help relieve distress: *"just trying to vocalise whatever's going on up here and then relate it in terms to other people".*

Some participants described problems as defects, that they could get fixed but developed more helpful conceptualisation over time:

*"…I wanted help to stop it and I needed somebody to analyse it and to be like okay this is what's wrong here and we're going to put you on this for a while and we're going to get you help … [pauses] they can't stop the flashbacks…I don't feel like that there now" – **Laura***

Knowledge of mental health directly impacted how they viewed their role in managing their distress or in further getting support.

Summary of conceptualizing of mental health

This sub-category presents findings regarding how participant's conceptualised mental health. Young people view mental health as a normal but complex part of human experience, existing on a spectrum and connected to physical health. Findings show young people differ on how they view problem-solving and personal responsibility, with personal understanding and knowledge of mental health described as learned from experience and others.

5.3.3. Culture and Society

This sub-category presents findings regarding how culture, societal attitudes and *gender norms* impact young people's understanding and experiences of mental health and help-seeking. This section also explores how participants *manage culture*, *intergenerational divides* and navigate life and mental health in a modern, *globalised,* and *technological* world undergoing a *climate change* crisis.

Attitudes to mental health

All participants relayed their views about attitudes regarding mental health in Ireland, with the majority concluding that awareness has increased, and conditions were improving:

"I would say it's a lot better… compared to years ago …there's definitely a lot more support" ***– Robert***

Some participants noted an increase in mental health as a visible and relevant topic on social media and believed that this has contributed to foundational mental health literacy:

"it's much more topical now, everyone at least has a basic understanding of what it is" ***– Liam***

This increased public discourse around the commonality of mental health has contributed to increased help-seeking:

"At the time I think I was the only person I know in my immediate circle of friends who had gone to any kind of counselling … in that year I have been speaking to some other friends and they have started on it themselves… so whatever is going on whether it's like the increased

recognition of it or like the push to get people to start talking it seems to be working" – ***Liam***

Other participants reflected on the helpfulness of increased awareness of mental health and questioned whether this translated into increased availability of access to help:

"We're great with words but we're not great with action, so I think it has to be worse seeing everyone saying that and nobody actually doing nothing about it… awareness is great, but it doesn't do anything if you don't actually follow up on awareness" – ***Aine***

Rachel discussed how that despite increased awareness, families and friends are unsure how to help or understand the impact of mental health: "*… they are aware of mental health, but they don't know how to deal with it, and they don't realise like what they say affects the person".*

Participants in general observed attitudes to mental health problems as becoming increasingly positive over time and those trends indicate more acceptance in public discourse towards distress and seeking help.

Gender norms

All participants discussed the impact of gender on help-seeking with most agreeing that being male added an extra barrier to seeking help for mental health:

"it's very common here… there's like this macho effect that nobody wants to talk about, it's hard" – ***Thomas***

Joseph attributed male help-seeking behaviour as reflecting what is modelled in the home:

"…the male culture for asking for help is non-existent, unless you have family behind you that is quite progressive and, maybe understanding of those kind of things…" ***– Joseph***

Thomas discussed parental role modelling regarding emotional expression in an African household*: "apparently at the funeral my Dad was crying and for me to hear that I'm like 'so he's human?', that's how much of like a crazy idea it is to be a man in an African household and cry, it's just unheard of, that's part of why I found it like very hard to talk to people as well."*

Robert stated that while gender may play a role, expression style can have a larger impact: *"I'm a bottler"* and Richard believed that ideas regarding masculinity and help-seeking were in transition: *"men have more suicides than women, because women talk … I think it's changing;*

I really hope it's changing, and I feel it's becoming more common to talk about things" – ***Richard***

Laura discussed how young men's externalising behaviours communicating distress are misunderstood: *"a lot of them [young boys] … are very, very scared, they don't know how to ask for help"*.

Many male participants labelled women as more natural, open, and therapeutic than men and are the preferred gender for support:

"…the way that people talk about that stuff is with girls" – ***Joseph***

Some participants stated that the role of gender in the ease of help-seeking was relative:

"*…it is still very hard for a woman to come out about certain things as much as it is for a man to come out about other things"* – ***Cathy***

Participants discussed how help-seeking was difficult for all young people, for many reasons, and discussed how they manage culture and stigma.

Managing culture

Many participants described Irish culture as in transition. Claire referred to the influence of the legacy of asylums and institutions that fed into stigma in Irish culture: *"…like ages ago you would have been locked up if you had anxiety… and like obviously we have gotten better at looking at it but it's not where it should be"*.

Aine discussed the impact of transgenerational trauma on mental health and believed Irish culture was practiced in concealing problems and lacking in accountability and apology at a structural level: *"… we like to be seen as being such a friendly and accepting country that if that means brushing everything under a carpet, we will, and we have for centuries and we're very good at it. We're not good at admitting our faults and actually rectifying them – we're good at admitting it and then going 'okay we're sorry we did this like that 50 years ago' – under a carpet. Gone. Instead of going 'right I'm sorry we done this this let's do something about it'"*.

Laura described typical Irish cultural responses to mental health as secretive and dismissive: *"the Irish culture is very much joke about it… don't really take anything seriously… very hush-hush, we know it's happening but let's not talk about that sort of thing."*

Laura also discussed transgenerational trauma and how legacies of abuse affected many areas of Irish life. Specifically, she discussed how the Catholic church, and their authority across personal and public life, helped cement a culture of concealment and shame: "*I think as well with the way that like everything to do with the church and all this here kind of stuff has messed with so many men's heads, so many women's, it's messed with all of them, and then the shame, constantly under a cloak of shame to try and [pauses], and then they don't open up and they don't talk about it and then nobody wants them to talk about it as well, nobody wants them to come out and say it, I don't know, I just think the Irish culture is very, very bad for mental health and the people don't realise how closely linked probably the church is with a lot of that stuff".*

Cathy also recalls dismissive reactions when asking for help from her family in early adolescence: *"the Irish family being… ah sure there's nothing wrong with you… you'll grow out of it"*.

James offered contrast, discussing how positive values were in Irish society compared to his home country, and how support was easier accessed: *"I think Ireland is like, sure it's not perfect, but it's in the top countries where you can actually find help…".*

Two participants from an African background described managing African and Irish cultural influences, and how mental health was viewed as a *'myth'* in their family environments:

"As a black African, I grew up in an African background, in an African home, Africans just don't really believe in mental illness, mental health or whatever it is" – ***Andrew***

Thomas explained that stoicism was the primary cultural expectation around emotional expression for both men and women: *"a big part of like why … I don't like talking about, like the emotion, it's very emotional to talk about stuff like this and the fear of showing emotion [with emphasis] especially from an African household".*

As a result, mental health professionals can be viewed with stigma and suspicion:

"…our parents have kinda like passed down to our brain, it's like, they get paid? [looks sceptically] Just – to – talk [with emphasis]?" ***– Thomas***

Participants discussed varying experiences of stigma:

"… the stigma of shame and embarrassment attached to mental health … there's still a lot of secrecy around it and this whole having to pretend everything is fine" – ***Aine***

Rachel commented on how despite mental health conversations being more acceptable in peer groups, stigma still exists regarding derogatory terms used to disparage others: *"one of my good friends …was like messaging her and it stopped, and I said what happened? and he said 'ah, she is crazy' and I sat and I think, the amount of people who have sat and said that about me, like your mental, there's something wrong with you"*.

Many participants expressed annoyance and frustration, viewing stigma as redundant:

"It's hard… there's still a stigma to it but the sad part is, I don't know why there is a stigma when it's so common" – ***Thomas***

Young participants described more fears of the effects of stigma, especially on social media:

"There is such a bad stigma around it…I was scared to put something up on my Instagram about mental health which is so weird because I shouldn't be scared to do it" **– *Claire***

Participants in emerging adulthood communicated less fears of stigma, believing that the promotion of encouraging messages in public spheres had reduced aspects of stigma, and increased positivity around mental health:

"… there's a lot more services saying it's alright, talk to your friends, talk to family, so it's getting better thankfully" **– *Cathy***

Some participants believed that for mental health to be acceptable, change begins with the individual:

"Trying to cultivate a culture that is a bit more open and things like that, people talking to each other and just having a cuppa tea with someone else that suffers…it takes massive bravery, and it takes yourself to change the way things are at the minute" – ***Joseph***

However, Laura explained how more common aspects of feeling unwell, such as anxiety and depression, states that can be attributed to thinking styles or personality traits, are less stigmatised and more acceptable than other types of intense distress: *"…people think you're really fucking crazy if you have got PTSD, because people think if you have anxiety, you're just a worrier"*

Some participants described stigma as present in physical buildings and in the cultural fabric around mental health:

"I think especially in Ireland, as much as we want it to be gone it is still there" – ***Claire***

While attitudes towards mental health were described as transitioning, participants explained, in the interim, having to manage cultural values and expectations, often passed down from older generations.

Intergenerational divides

Most participants discussed differences between generations with younger generations expressing more open and accepting attitudes towards mental health. Liam noted that there has been significant change within the last decade alone: "*I think it is much easier to bring up in general context than it would be to even five, ten, five years ago"*

Some participants described how family units can transmit or leave behind the attitudes of previous times and specifically how the coping strategies of previous generations are not appropriate now:

"They just have different methods of dealing with it, go say your confession and have a pint, job done, [laughs] so that's why they are very well-adjusted now [sarcastically]" – ***Liam***

Claire noted how stoicism, concealment and reticence are transmitted to younger generations and how older generations have different conceptualisations and language around mental health: *"you don't see granny and grandad's chatting, 'that one has depression' you don't hear that!... and that has been passed down because they didn't talk about it, we don't talk about it now"*.

Andrew discussed how growing up in Ireland with African influences emphasised intergenerational differences: *"they [parents] don't understand … because of the environment that we are in now… black African teenagers are in, it's a lot different from what they had back then"*. Andrew discussed traditional African cultural expectations: *"it is breeded into you, that you must have this strong mentality, which is true"* and how he negotiated this value by incorporating help-seeking as a modern way of maintaining a strong mentality: *"... they have been brought up in a way that means they just have to get on with it, back then, it is not the same as it is now… if you need help you go and get it…"*.

Thomas discussed intergenerational trauma and how older generations can dismiss younger people's problems: *"Such taboo, such taboo [with emphasis] Like imagine if me at 7 and I saw like a lot of crazy stuff, imagine what my parents have seen? So, you go to them, it's like 'at least that's all you got' [laughs]?".*

Some participants discussed how older generations expect younger generations to be happier because they are materially better off than their parents, leading to unhelpful comparisons and debates regarding mental health:

"it's complex, because I mean from one perspective, we have it so good, like you know we're in a real time of peace, nobody is going off to war … [older people say] well look what we had to go through, we went through this, you went through nothing, you've nothing to be sad about…" – ***Erin***

Thomas empathises with the sacrifices of his parents and their experiences of seeking asylum: *"they suffered… the reason why I never like blame my parents or anything is 'cos I know how hard they've had to work to be there"*. He believes the intergenerational differences represent different but equal struggles: *"I felt like yeah my parents were literally trying to survive, whereas for us, it would be in the mind".*

After much consideration, Liam decided that *"it's very hard to say whether one generation has it harder than the other".*

Participants described how intergenerational divides deepened with new technology and social media, often bringing new challenges and stressors not experienced by previous generations.

Modern life and the role of technology

Some participants discussed the mounting pressures of modern life and technology on young people's biology:

"I think that society is evolving faster than we can evolve to catch up with it… advancements in technology and social media, say in industry … and our bodies don't fully know, and our brains don't fully know" – ***Erin***

Liam discussed information overload and the internet providing access to an unprecedented amount of information: *"…and of course I don't know if this is just like due to the increased*

globalisation and social media and the fact that everybody is aware of everything that is going on now".

Cathy stated that access to too much information affects young people's developing identities: *"there's too many variables being posted that kids can overthink, they see too many possibilities, so the mind can't focus, which I think is a big contributor to overthinking and anxiety"*.

Liam commented on how the internet has created a platform for expression and has normalised the broadcasting of personal information to a wide audience: *"The introduction of social media has given everyone an external monologue… some dark personal stuff, people are willing to share that out to the entire world, that's good in some ways, if that helps people be able to process"*.

Liam examined some deeper anxieties he had arising from modern life describing how his generation have been dealing with a *"constant existential dread … like its constant low-level worry for me that you know the way things are going climate change, the rise of horrible global inequality and the international fascist movement, ah things are getting pretty bleak and pretty dark and maybe it's just me… but it is something that I am very, very concerned about and you know, the planet is on fire and the Nazis are back so think I'm pretty justified being a little bit concerned"*.

Liam also discussed climate issues: *"I definitely think it is a worry… that is beginning to affect my generation and will probably have an impact on the next generation below me who have spent their entire lives dealing with constant, like climate issues"*.

Liam expressed a profound sense of helplessness and powerlessness feeling overwhelmed by global issues stating: *"It is beyond my individual capacity"*. Liam also expressed hopelessness about his mental health problems in the face of global issues: *"… I have dealt with it and tried to get my own internal house in order, but as much as that helps and as much good as you do, [pauses] I don't personally see things getting better"*.

Liam described how the economic conditions since the 2008 Global Financial Crisis has impacted what would have been common life goals for previous generations and have resulted in his adolescence being prolonged: *"Oh I'm never going to have like a career, job, family, I've had plenty of discussions with people of my generation about like the lunacy of the idea of owning a house, the staple for generations"*.

Despite these concerns, he takes time to acknowledge the discrimination he observed his partner of a different ethnic background enduring and his own protection from that:

> ***LIAM:*** *...I got very kind of lucky, in the fact that I am a heterosexual white guy [both laugh]*
>
> ***CI:*** *Is that helpful?*
>
> ***LIAM:*** *It is! As much as I've been dealing with, I started life in easy mode…there are certain things I am never going to have to deal with but if I was like a minority of any kind in this day and age along with all the anxiety of never going to own a house and the planet -* ***there are people who want you dead*** *in leading governments around the world…"*

Participants described trying to manage mental health problems within the context of technology, globalism, social changes, and climate change and how this could impact motivation and opportunity to seek help.

Summary of culture and society

In this sub-category, findings show that young people are directly impacted by a multitude of factors within Irish society. Wider values and societal attitudes around mental health were found to have been significantly impacted by the legacies of institutional abuse and concealment. Although described as in transition, participants discussed cultural change as slow and stigma and intergenerational divides as impactful on mental health. Findings also show that being young today in a globalised, technological society that is facing climate change, is extremely challenging.

5.3.4. Social networks

This last sub-category describes findings from participant's discussions of their social worlds. Participants explored their *family and friend's* roles in their mental health and how their *social environment* supported or exacerbated their problems.

Role of family in mental health

For many participants, their family circumstances, conflict in the home or strained relationships were found to be a major contributor to their mental health problems:

"I realised that there was an awful lot… going on in my family and that I just couldn't deal with it on my own" – ***Erin***

Claire described being overwhelmed by her parents' new partners and new family arrangements after their divorce: *"…almost like I was an adult before I was a teenager"*.

Cathy portrayed growing up in a family with unhelpful or stigmatising conceptualisations of mental health and trying to find an alternative: *"you're kinda brought up with it so you're trying then to phase out of it"*.

Some participants discussed caregivers that did not have a lot of knowledge about mental health or a limited capacity to provide emotional support:

"Why how dare you? do you know how lucky you are to have an education? … so like you feel almost ungrateful for even bringing it up" – ***Thomas***

Robert described supportive family members: *"she has done a lot of work with mental health herself"*.

Many participants stated that their family members had mental health problems. Joseph confided in his father because: *"he has been strong himself in the past"* and Thomas sought help from his mother when she openly shared her experiences of depression and how this modelling encouraged him to re-examine his understanding of mental health and his hope to one day speak with his father about it: *"… I know 20 years down the line, God willing, me and my dad will probably talk about it but as of right now there is not a chance … but my Mum? Because she went through it, it's so much easier to talk to her about it"*.

Gerard regrettably discussed how his mother *"wouldn't go for help"* and how it resulted in family breakdown, estrangement, and homelessness.

Claire described about having to manage openness and concealment within her family due to stigma: *"Most of my family doesn't know what I deal with… on my mummy's side, my aunties and uncles would have had a sense that I was going through something … my daddy's side of the family, would know nothing"*.

Some participants discussed concealing mental health problems from family because of stigma, distrust, to protect, not to burden or for autonomy:

"… I had to go outside first and then later on talk to her about it" – ***Thomas***

Some participants discussed often talking with family members for support with distress due to their proximity and experience, but others described friends as offering more options for support.

Role of friends and partners

Most participants discussed the role of peers in their mental health. Liam explained how in recent times the offering of support from friends has become more common and Robert described how reciprocal support was helpful: *"we can help each other through things, so say if I'm in a good spell and she's not so good, I make sure to go see her and go to her house and we chill and we chat and we enjoy each other's company".*

Thomas also described supporting others by being open about their own struggles: *"I'm always telling people… it's okay… sometimes I feel alone… so it makes it easier for people to open up to me I think".*

Supportive friends were often described as the ideal and preferred type of support:

"I am lucky enough to have one… fella, must be just as sensitive as me but we just meet for coffee and ah last year I was telling him that I was suicidal, having thoughts or whatever, and he told me about how he was feeling and everything else, honest to say, it's invaluable" - ***Joseph***

Some participants described keeping the more intense aspects of their distress to themselves:

"bits and pieces… so when I do certain things, when I don't want to do certain things at least they have that little bit of me… and then two months down the line, maybe I'll say something… they understand you a little bit more, not fully, they may never" – ***Thomas***

Other participants described caution due to previous confidentiality breaches and finding it difficult to find friends who could understand or support them:

"… many people like they really feel for you in that moment…but give them five minutes they're going back to their lives… and you're still in it" – ***Thomas***

Thomas, who manages two cultural influences, described finding it difficult to find support: *"my Irish friends kinda wanted to get it but my African friends were like 'suck it up'…"*

A few participants discussed how their romantic partners could contribute to their problems or were unable to understand, leading to the breakdown of a relationship:

"…like my ex-boyfriend, I finished with him because he was not mature enough to understand what I was going through" – ***Claire***

Several participants mentioned the suicide of a peer, and two participants discussed their direct experiences with peer suicide as having affected them profoundly. Thomas described his friend, who had taken his own life, had recently spoken about his mental health problems openly: *"when he talked to me about it [mental health] he was cool… and then I told him I was going through the same thing… and I just found out like two days ago… I see him and then he was okay, he was fine you know?"*.

Thomas discussed how mental health problems can lead to suicide: *"for a minority it can result and end in suicide…"*.

Joseph described the impact of his friend's suicide as devastating to their peer group: *"it is a very emotional thing for all of us… it has an effect, it's not just his family, it has affected the whole place"*.

Joseph expressed about the hopelessness, after his friend's suicide, that many people felt with regard to prospects for treatment: *"there must be 10 to 15 people that are suffering anxiety or depression or whatever, who are scared, scared to talk, and the suicide didn't change things."*

Rachel discussed how her peer group openly discuss the disillusionment they feel about the potential for help with their distress: *"it's like almost like everyone has given up on the system"*.

While friends were an appropriate and preferred support for mental health problems, some participants found difficulty in finding the right type of support, especially when friends and peers are simultaneously experiencing their own distress.

Social environment

General findings regarding young people's social environment described the importance of having a positive social environment and how mental health was exacerbated by negative treatment and bullying from others:

"I remember them calling me and just been like go lie in your bed and cut yourself" **– *Rachel***

Joseph described conversations with a sports coach that triggered eating problems: *"that two-minute conversation caused 10 years of turmoil, [I'm] still going through it."*

Laura also discussed her experiences of growing up in a community in which predatory adults were known for sexually abusing children, and some who were abused took their own lives: *"there's a good few of the ones that I would have known who would have killed themselves and their am, grandparents were known paedophiles but nobody did anything and they still lived out their lives but nobody ever got arrested and nobody was ever brought to court and the kids killed themselves and sure they [the community] didn't have to think about it then"*.

Richard believed that the quality of friendships was deteriorating because of technology, as impacting his mental health: *"It's detrimental to health like because you're not forming social connections other than the phone"*.

Many participants discussed how they try to protect their public image from mental health stigma. Rachel described how she *"will observe, I will look at how people act around here and try and gel in"* whereas Claire described how she adopts the role of helper: *"I wouldn't want to chat to my friends about it because I am the kind of person where I love helping people"*.

Claire described going to Northern Ireland to access services due to privacy issues in smaller towns and Gerard, who lived in a very rural area with no access to public healthcare described the financial stress of having *"to get a taxi"* to another townland to access a private counsellor.

Niamh described limited transport and services in rural areas: *"there's not a lot of services for young people here for us culchis"*.

A few participants discussed how the lack of social connections in Western rural regions with traditional farming communities can compound mental health: *"especially for younger, the straight farmer juck from Connemara or like Glenties or whatever, his head is deeved in and I'm sure it's very hard"*.

A few participants discussed lasting stigma in rural communities:

"everybody in town thinks I'm crazy [laughs]" – ***Rachel***

Participants described positive and negative experiences in their social environments and how the impact of infrastructure affected participant's access to services, which often further affected their mental health problems.

Summary of social networks

In this final sub-category of category 1, social networks were found to have a significant impact in either supporting or exacerbating mental health distress. These roles are complex but essential in help-seeking and whether young people would continue to self-manage or help-seek to professionals often depended on the resources from families and friends. Lack of services, transport or privacy in rural areas was found to impact young people's help-seeking behaviour.

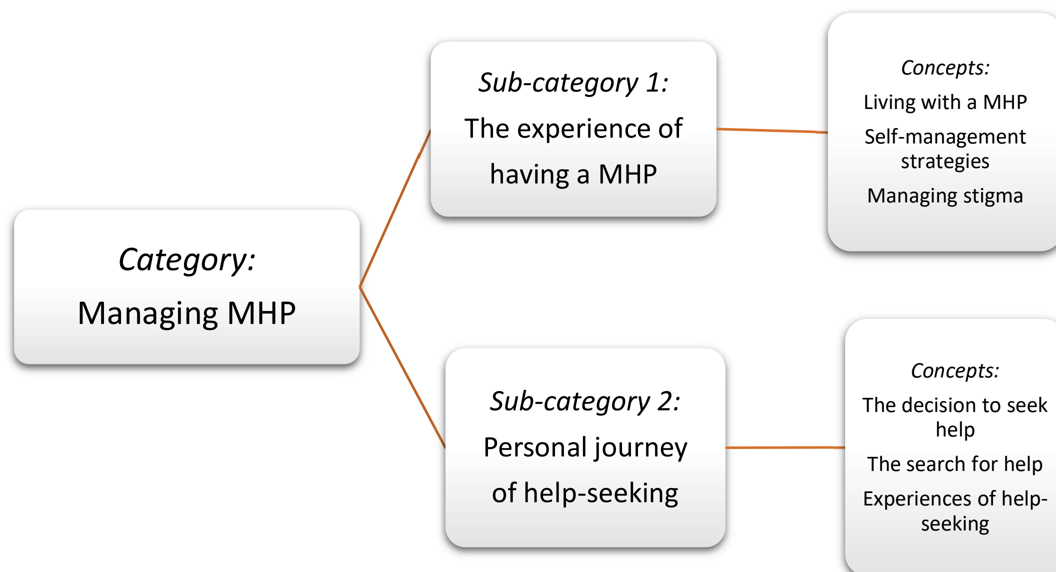
5.3.5. Summary of category 1

This first category, *young person's lives,* presented findings from four categories regarding young people's interpersonal and environmental contexts. Findings describe childhood as a time when young people can experience challenges related to both development and adversity and that these *early experiences* in life are significant, with distress often being carried with them into adolescence. Mental health problems can be compounded by other experiences of marginalisation such as being in state care, immigration, or homelessness. Wider *cultural and societal factors* were found to shape young people's *conceptualisations* of mental health and associated help-seeking behaviours. Mental health was also found to be impacted by the pressures of being young in the modern age of globalism, the internet, social media and climate change. *Friends and family* were found to play a significant role in mental health and help-seeking, both being involved in the causes and solutions to distress. The findings presented from this first category are essential in providing understanding around young people's contexts and lay the foundation for understanding further how young people experience their mental health problems, how they self-manage, and how they subsequently seek help from services.

5.4. Category 2: Managing mental health problems

This second category develops upon the previous findings by exploring how participants managed their mental health problems. Findings are presented in two sub-categories, 1. participants lived *experiences of a mental health problem;* and 2. their *personal journey of help-seeking* (**Figure 14**).

Figure 14: Managing mental health problems



5.4.1. Experiences of mental health problems

In this first sub-category, participants described what it is like to be young and *live with a mental health problem*, the different *strategies* they use to manage distress, and for navigating *stigma*.

Living with a mental health problem

The experience of living with and managing mental health problems varied from person to person but had some important similarities. Mental health problems were a constant but could be characterised by oscillating periods of intense distress and relief or respite from the distress:

"I would always have a few months where I would be bad and a few months where I would be good" – ***Laura***

Rachel described her experience of these intense cycles of distress during her adolescence as living from crisis to crisis with low quality of life: *"just surviving and that's it"*.

Some participants described how an underlying sense of unease followed them through everyday activities and feeling an increase in tension or pressure within themselves, becoming more distressing with each cycle over time: *"you kind of explode and that's what it's like with*

mental health" – ***Rachel***

All participants discussed how their daily lives were affected, including sleep, eating, self-care, interest, motivation, relationships, and planning for the future. They described becoming exhausted and withdrawn:

"just insomnia, depression, everything so you're like, this is really shit" – ***Cathy***

Laura described reducing her work hours due to traumatic flashbacks and discussed how her employer was unsupportive of her missing time for counselling appointments: *"it ruined work for me going to counselling"*.

Gerard described his experience of homelessness and the intense loneliness he felt trying to manage mental health problems alone: *"I didn't have anything; everything was just shit and I was on my own and everything was awful"*

Participants shared experiences of living with intense emotion, anger, feelings of chaos, and sometimes behaving aggressively. Richard shared: *"…I put my fist through the window"* while Laura described using self-harm to manage intense flashbacks: *"… I'd beat the shit out of myself, and I couldn't sleep at night unless I had one of my rage outs"*.

Liam described intense distress over a difficult few years: *"it was specifically the circumstances of my life at the time were the primary cause of it snowballing to what it did"* and how he took time off from the pressures of life to recover: *"I needed some recovery after that, like mental rehab"*.

After a sports coach told him to lose weight, Joseph described developing obsessions with eating that consumed his everyday life: *"I started putting more and more pressure on myself… around that time I definitely had an eating disorder as well"*.

Some participants discussed enduring mental health problems because they did not conceptualise them as problems:

"if you can't identify the problem how can you fix it?" – ***Thomas***

Most participants noted that awareness of distress developed in mid-adolescence and was usually marked by a significant change in behaviour:

"My mood was more in a down stage rather than elated or hyper … I just lost a lot of motivation with going to school, doing work… helping out around the house you know that kind of thing, got very stuck in a wee bubble". – ***Robert***

For some, such as Rachel, distress was indicated to them by another: *"As soon as I came here, I was told that I needed help".*

All participants discussed how self-management and autonomy was their initial preference, or at least had been, before wanting to seek help to others:

"I like to deal with things by myself" – ***Laura***

Rachel described how learning to self-manage was important for self-esteem and developing self-efficacy: *"I don't want to take this to feel better, I just want to feel better on my own [without medication] and I was never able to vocalise that".*

In the end, the personal impact of enduring and suppressing emotional pain over long periods could cause emotional exhaustion:

"It led to a very painful road" – ***Joseph***

Self-management strategies

Participants discussed a variety of ways in which they managed their mental health. By emerging adulthood, some participants had learned the benefit of earlier intervention:

"If you feel yourself starting to get down it's best to kind of deal with that now and acknowledge that that's happening" – ***Liam***

Others described learning more effective ways of managing distress but the difficulty in translating the theory into action:

"… even now I don't manage my mental health in the way that I should, until there is a crisis" – ***Rachel***

Claire described how withdrawal was a helpful self-management strategy: *"I just want to stay at home have a bit of a cry have some chocolate, and I should be okay".*

Laura described concealing painful emotions from others so she did not have to manage their reactions: *"see if I am in a bad place I need to be alone and I can't let anybody see it".*

Suppressing and concealing pain was described as an important strategy to ensure continued participation in daily life, especially in attending school in adolescence:

"I am the master of faking stuff like you wouldn't believe" – ***Claire***

Laura described withholding information from her therapist until she had first resolved an important personal problem: *"so after I broke up and got out of the situation, I told them the truth"*.

Some participants discussed using denying and minimising behaviours as strategies in self-management or distraction through humour, watching TV, or waiting for distress to pass. Rachel found suppression not helpful in the long-term: *"you've been feeling these feelings for so long… you suppress it and then it just kind of explodes"*.

These strategies were often advised or learned from others and generally represented a temporary fix: *"just play football and forget about it? [Laughs]… but it's still there*" – **Thomas**

Liam discussed using alcohol and how this became ineffective with time and could cause embarrassment: *"I would have the occasional drunken breakdown with friends… just one whiskey too many and all the walls breakdown, a blubbering mess… that happened more and more frequently when I was going through some really bad stuff"*.

Some participants described using exercise, enjoyment and making plans:
"… doing things, you enjoy in life and look forward to" – ***Joseph***

Andrew described acceptance of his problems and using his imagination to create solutions: *"they're a part of life"*.

Some participants praised the effects of art, playing music or writing about feelings:

"I found a lot like writing and making stories about like, the way that I express my emotions" – ***Laura***

For some participants, removing themselves from difficult environments, economic conditions or relationships, and making fresh starts helped manage their mental health:

"I moved out of home… left Ireland for a while … found a new job, met my girlfriend" – ***Liam***

Andrew discussed problem solving in stages and reframed help-seeking as a choice; that finding help for a problem was an autonomous and a decisive self-management strategy.

*"There is a lot of ways that you can help yourself, I think, number one is definitely talking to someone… talking to people would be, a way that I would deal with it" – **Andrew***

Sometimes knowing support was available could help manage distress:
*"Okay I'm feeling shit now, but it's okay I can go and talk to someone tomorrow!" – **Cathy***

Rachel managed intense emotions by talking with someone and letting herself *"mini-explode"* to limit mental health crises.

Joseph discussed having confidants and using them when needed: *"having that maybe one or two people you confide in"* and Robert also found regular socialising as a helpful self-management strategy: *"I just find social things that helped me like, a cup of tea with a couple of friends… it's wee simple things, that make my day a bit better" – **Robert***

Liam described how he would connect with others for a bit of *"cheering up and touching base every now and again"* and some participants described connecting with others aggressively as a way to release tension: *"I was a **bitch** in school for a while and if the teacher started on me by God, I would finish it" – **Claire***

Liam gained perspective by saying something out loud: *"when you say things out loud, and see how people react to that, oh! That's a load of shite!"*

Participants described and discussed many varied types of self-management strategies they had learned, some of these were reflexive and some were learned over time and was often connected to protecting their self- image.

Managing Stigma

All participants described managing stigma and self-stigma. Some participants labelled themselves negatively, such as "freak" or "crazy" when retelling instances of intense distress. A few participants described feeling defective:

*"I felt like there was something wrong in my brain" – **Laura***

Liam used humour to explain his view of his mental health: *"I was half functioning two years ago and I was a ball of neuroses held together by substance abuse! [laughs]" – **Liam***

Laura also described how she perceived herself as looking like *"an insane person"* whilst trying to manage panic attacks: *"which you hate being compared to but it's so true sometimes!"*.

Some participants described how the need to protect self-image resulted in not help-seeking:

"I thought mental health was a very big deal of course and that it was very important, but I was one of those people who was like I wouldn't go and do that sort of thing" – ***Laura***

Thoughts of help-seeking could trigger or compound distressing feelings:

"I don't know how to explain this like a ***shame,*** *you feel like you're being ungrateful, you feel embarrassed, you feel weak … the stigma is like* ***you're weak,*** *am it may not be the case but that's just how you feel" –* ***Thomas***

Some participants discussed how going to counselling can cause embarrassment:

"you know it's not easy as a 19-year-old to be, going to counselling on campus where your friends probably are" – ***Joseph***

Laura discussed trying to avoid the associated stigma of generational labelling: *"the 'snowflake generation' and the 'millennials' … it's a spiteful thing, you don't want to show anyone else that you're hurting, especially if they make fun of you for being a cry-baby, you're still going to cry about it [laughs] but you don't wanna show them"*.

Some participants discussed how long-term endurance of mental health problems impacted their identity development:

"I'm like well this is the person I have become … I don't know what I'm like when I'm not like this. I've grown up with it, so it is already embedded in me… I don't know if I want to get better, I don't know if people will like me when I'm like myself" – ***Claire***

Experiences of stigma often impacted how participants made decisions about managing their mental health problems and to protect themselves, delayed help-seeking.

Summary of experiences of managing mental health problem

In this sub-category, participants described their daily reality of living with mental health problems and how they used self-management strategies to, both helpful and unhelpful, to manage their distress. Findings suggest young people endure mental health problems, stigma,

self-stigma, and personal pain for many years on their own. Making the decision to seek help usually occurred after self-management strategies became increasingly ineffective.

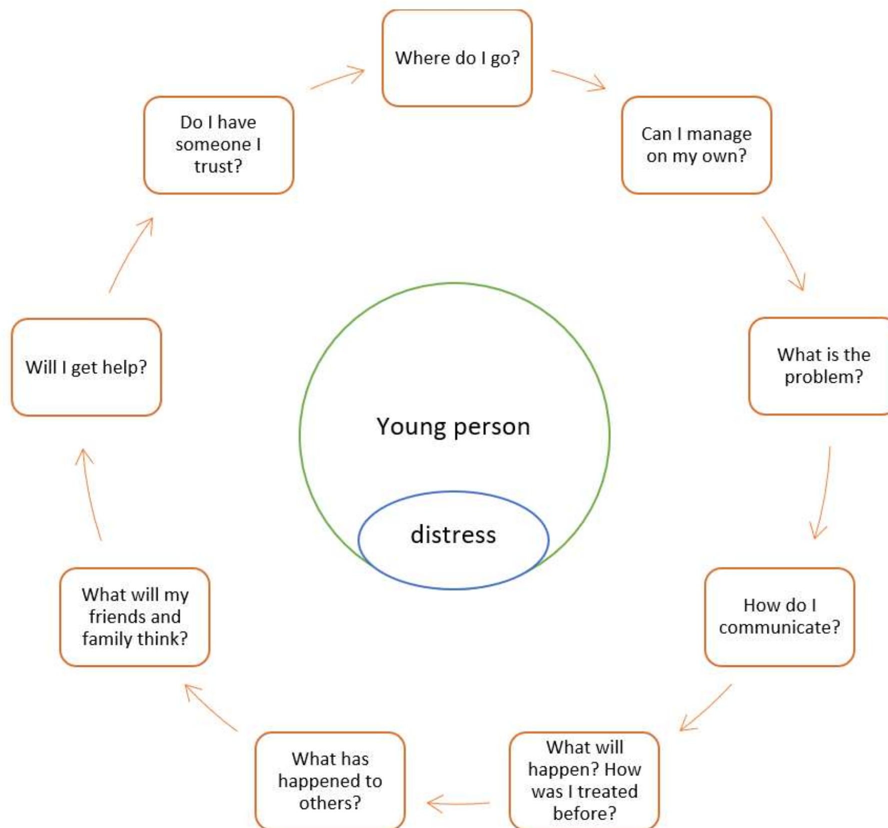
5.4.2. Personal journey of help-seeking

This second sub-category presents the findings of participants' experiences regarding their *decisions to seek help*, the role *family and friends* played in that decision, *their search for help*, their *overall experience.* This section also includes a discussion on *LGBTI+* experiences, and the impact of hearing about *others' experiences*.

The decision to seek-help

All participants discussed the factors involved in their decision to seek help (see **Figure 15**).

Figure 15: Deciding to seek help



Some participants discussed prioritising self-managing mental health problems throughout adolescence but naturally reaching a point in emerging adulthood where the time *felt* right:

"Then when I was 21, I was like okay it's time to talk to someone" – ***Laura***

Others struggled internally with the competing needs for external resources and self-managing:

"I thought I can beat this on my own and probably took me a couple of years just to realise that… I needed to reach out" – ***Joseph***

Richard delayed help-seeking as he thought he may be taking up the place of others:

"Because I feel like people have worse problems than I do" – ***Richard***

For Laura communication difficulties initially prevented her from seeking help sooner: *"I couldn't understand myself, so I didn't know how I was meant to tell someone how I was feeling".* Once Laura decided to go to a service for help, it took a long time to go into the physical building: *"I'd always be… like going in tomorrow for the entire month and I just could not do it".*

Most participants described the decision to seek help as mediated by an internal emotional barometer of distress. Some participants reported low-mood and struggling with daily life as a signal for the need to talk, while others described aggressive behaviour and relationship difficulties as signalling the need to seek help:

"Things were going really down-hill so I had to speak to somebody" – ***Richard***

For some, exhausting self-management strategies and reaching severity was a necessary process for participants to be open to engage with help-seeking pathways:

"I think going in at a low moment, kind of took down all the barriers that I may have put up" – ***Liam***

Liam described how this decision was easier in emerging adulthood: *"the ball is a bit at least in your court, when you are older and more emotionally mature, it definitely helps with that".*

A few participants described recognising the need to seek help once they were in crisis or having suicidal feelings:

"You have the choice of whether you're going to go and get help or going to attempt suicide" – ***Rachel***

Some participants recalled moments of intense periods of distress during crises:

"About a week, but it was a very difficult week" – ***Gerard***

For some, suicide attempts were a way accessing mental health care. Aine described, after being unable to access support elsewhere, how stopping an essential medication to manage a medical condition would result in an A&E attendance, and this was her way of communicating that she could not continue living with her distress: *"I knew that if I stopped taking my medication chances were it would kill me".*

Two participants described signalling to others that they wanted help. Laura described changing her behaviour and hoping someone would notice: *"I didn't want to go out and reach out for help I just couldn't…".* Thomas described how he changed his communication style: *"he kinda knew where I was coming from, that was my way, I thought I'll be able to wake him up like, open his eyes to like -* ***I want to talk*** *- to you" –* ***Thomas.***

Some participants described teachers and school counsellors who noticed a change in their behaviour and approached them to offer support:

"She noticed my attendance and so she called me up for a wee chat into her room" – ***FG Josie***

A couple of participants, after disclosing distress, discussed how a school counsellor made referrals or contacted caregivers without their knowledge or consent:

"I've been very mad ever since" – ***FG Niamh***

Some participants felt the need to keep help-seeking secret from extended family, but others described being offered extra support:

"There was never like, in the extended family, any stigma" – ***Gerard***

Once the decision to seek help was made or made for them, participants then had to find the right support which meant asking a GP for a referral to public services or attending a community service or private practice directly.

The search for help

Most participants expressed that help-seeking was complex and occurred over numerous episodes. Initially many participants were not sure where to go for help or what type of help was available, especially when they were younger:

"I wasn't aware at the time that there was any services for underage people" – ***Robert***

Many participants, who were under 18 years of age at the time, required their caregivers to provide consent for them to attend a mental health service. Some participants directly asked a parent to search for help on their behalf***:***

"I just said to my mum one day I'm not feeling the best, is there any way, could I chat to somebody?" – ***Robert***

Some recalled persuasion: *"Mum essentially persuaded and persuaded and persuaded until I finally gave in"* – ***Richard***

Others recalled coercion: *"I was taken to the GP"* – ***Cathy***

Richard described how when he did not like his helper his mum helped him find someone else: *"Mum didn't like her either"* – ***Richard***

Some participants described how families provided emotional and financial resources as well as transport to services:

"When I was 13 we went to a professional counsellor, we had to go out of our town" – ***Erin***

Some participants discussed fears around accessing the service, meeting professionals, and what the processes for assessment and subsequent diagnosis or labelling would be like:

"I was a wee bit wary in getting there" – ***Cathy***

When help-seeking outside of the family, many participants searched for an adult who could sign-post them to the right help:

"…I need to talk to someone, so she sent me to the guidance counsellor" – ***James***

Some participants discussed not knowing what they needed in early adolescence but with experience and time figuring that out in emerging adulthood:

"I know what I need from you, just sit there and let me talk" – ***Cathy***

Others knew what they did not need:

"I'm the one that knows me the best… I'm with me twenty-four seven" – ***Aine***

Searching for help meant finding someone to trust, which for some participants was a process that took years:

"I think a part of why it took me so long to talk to someone was 'cos I didn't like trust anybody" – ***Thomas***

Some participants observed potential helpers in school or youth services over a long period for trustworthiness and predictability:

"… like scouting him out… looking at his movements getting to know him a little bit…" – ***Thomas***

In earlier adolescence, trust was often based on previous rapport but Joseph discussed how in emerging adulthood, trust was based on proven ability to help: *"…somebody's got the knowledge and the tools and they've got the professionalism and everything else, is going to help you"*.

Laura required a deeper trust, as her distress regarded family secrecy and sexual abuse, and she was afraid of the consequences of help-seeking: *"I was keeping a lot of secrets for other people, and I got very scared… I just didn't want anybody to be upset"*. Laura knew she could trust her counsellor when: *"she handed me over a leaflet, for like am, childhood abuse, and I was just like thank you! Finally! somebody has got the tips I've been dropping!"*. However, she was not able to talk about her distress due to the counsellors training and had to begin searching for help again: *"she wanted to refer me onto someone else who could help me, because she didn't feel like she would be able to talk about it"*.

Participants described the search for help as complicated and experiences of help-seeking were often different from what participants expected.

Experiences of help-seeking

Participants had varying experiences of trying to find an appropriate service or helper. Many participants did not know what to expect and some described excitement at the prospect of recovery:

"I remember being in there and being like a bit excited… I'm going to counselling and going to be able to talk to somebody and sort out my shit, yes!" – ***Laura***

Some referred to stereotypical expectations:

"a Freudian scene where you had to lie down on a couch! [laughs]" – ***Liam***

Others expected a therapist who would assess, diagnose, and fix their problems:

"I just wanted her to solve my anxiety" – ***Claire***

Participants expected support and change and above all, to be helped:

"I suppose there was real hope there that it would help in some way" – ***Joseph***

For some, the help received was the opposite of what was expected. James expected his teacher to be judgemental about him looking for help with gender transitioning: *"normally religious people are rather am, not that open-minded [laughs]".*

Due to previous negative experiences, some participants had low expectations:

"By the time I was seeing the youth worker, I didn't really have [pauses] good expectations so it massively exceeded them! [laughs]" – ***Aine***

Many participants explained how they were not helped:

"There is no point in me going back to this counsellor, I was only 18 but I knew, this woman is not helping me" – ***Joseph***

Most participants described how challenging disclosing personal distress and painful memories to someone else was:

"I think it's much easier for me to talk about now 'cos I've talked about it more times before … but imagine having to like bring stuff up that was almost unspoken of like since you were a kid" – ***Thomas***

Aine described disclosure with an unknown person as a risk: *"I took a gamble obviously! [laughs]"*

Many participants discussed how help-seeking can trigger shame and feelings of weakness. Cathy described how experiences of being shamed for disclosing distress in childhood and adolescence meant having to make new meaning regarding help-seeking in order to help-seek: *"because of your experiences coming into your teenage years… coming out to an adult or something like that is a lot harder because you don't want to be shamed by an adult… just a process you go through and just you have to learn that it's okay to chat about it".*

James described distress from issues surrounding gender transitioning and placing all his hope in that his disclosure would be met with support: *"Yeah I had no idea about how it goes when I tell everything"*.

Most participants described anxiety before attending the first session as it meant going into an unknown situation:

"it was like I have to go to this place, oh my God, I don't know who this woman is, I have to sit in this room and have to smell this room" – ***Rachel***

Some participants described physical reactions to help-seeking such as shaking with fear, freezing, or feeling a blockage in their throat and not being able to speak:

"I would just freeze and go very mute, and I couldn't get the words out, no matter what I tried" – ***Laura***

Rachel stated that before meeting her psychiatrist: *"I used to get sick before I would meet her because I was very nervous"*.

Some participants described their overall experiences of disclosing distress as a helpful event in their life. Thomas stated that he: *"would look for help again"* if he needed it and Laura was surprised with her help: *"they did more than I thought they could do!"*.

Even when help-seeking was helpful, it was still difficult:

"I'm not saying it was all sunshine and rainbows chatting to her either" – ***Cathy***

Weeks into therapy, Laura discussed how she had still not fully disclosed what she wanted to talk about: *"so I'd always be in my head, I want to talk about this today, but I never would talk about it"*.

Many participants described multiple help-seeking episodes and outcomes, with large gaps between help-seeking episodes:

"Even when I went to college then it took me a couple of years to go and seek help" – ***Erin***

Some participants described how negative experiences of help-seeking were still strong in their memories and how it deterred them from help-seeking again in the short-term: *"it was negative I didn't like it at all"* – ***FG Niamh****,* but not in the long term *"If I was to get back to that point yes"* – ***Cathy***

Some participants described losing motivation after multiple help-seeking episodes:

"What happened to me then was that I had a little bit of a mid-teen crisis, where I was like I don't want to get better" – ***Claire***

Some participants described help-seeking being complicated by the limited capacity of their caregiver to support help-seeking when they were also managing their own mental health problems or when caregivers did not support attendance:

"I remember when I got my first appointment letter, [she] didn't want me to go" – ***Rachel***

Many participants talked about their friends' role in their help-seeking journey. Robert described a friendship of 10 years: *"she understands what I'm going through as well, because she's been there and wore the t-shirt"*.

Liam described how a friend's knowledge of services helped him find the right help: *"…pointed me in the direction, like made the introductions … it was important in that like the friend had some experience with it knew like what I was getting into"*.

Some participants described the helpfulness of connecting with others' experiences:

"I feel when I meet someone who has the same thing as me, or is relatable… you have real conversations, those real conversations are nearly as good as counselling sometimes and they're free" – ***Joseph***

Others described how friends can be unable to offer any understanding or direction for help-seeking: *"nobody knew like what mental health was about so how are they going to tell me to go talk to somebody"* – ***Thomas***

A few participants discussed openly about their sexuality and identity in relation to mental health problems. Aine described how young people in the LGBTI+ community will look for signs of acceptance from a potential helper or service, such as the placement of posters supporting young LGBTI+ and will sometimes not seek help for their mental health because of the risk of being outed: *"If you didn't know whether you could trust them and whether they're going to out you or not"*.

James described fatigue and distress from concealing his need to gender transition and how help-seeking for his mental health would mean coming out: *"basically my problem was being forced into the role that didn't fit me"*.

Aine described a homophobic response she received from her psychiatrist who referred to her sexuality as *"a phase"* and another incident with a female GP: *"who when she heard that I was a lesbian actually got up and opened the door… because she was a female, you never know what might happen"*.

Aine also discussed how young people in the LGBTI+ community suffer mental health problems because of discrimination: *"Now let's just clarify, not because you're more likely to have mental health problems, because of the way you're treated and bullied… you're more likely to end up with mental health problems"*.

Participants described hearing a range of experiences from other help-seeking experiences and learning vicariously through friend's experiences about how to help-seek and what to expect:

"I saw my friend going through the same sort of stuff and then I saw her get better" – ***Laura***

Gerard discussed how his experiences with his mother's mental health problems encouraged him deal with mental health differently: *"she would lie and tell social workers and myself and my sister that she was going to get help"*.

Participants discussed hearing discouraging accounts of others on long waiting lists, involuntary participation, inappropriate in-patient experiences, children in adult units and people not being helped:

"I only heard one story about a guy who was depressed… he had to wait so long that while he was waiting… he tried to kill himself and then the next day he was put on an emergency list, and he still had to wait half a year for it" – ***James***

Joseph believes that: *"if this is the way the services are you know? What is the point in bothering?"*

In particular, one participant described the anger and trauma he experienced at his close friend's suicide:

"He was failed by the services… he went up, actually attempted suicide a couple of times and went up to the services or whatever to become an inpatient and said listen if you do not bring me in now, I will kill myself, he stated that, they said to him he was not sick enough to go in and so he killed himself the next day".

He described the community impact:

"… you can't believe that the fella is dead, a fella that young, dead and buried, he had so much to live for, he was just married, and everything else, and the HSE have a lot to answer for… I know there is a lack of resources there and stuff as well but how any human being questioning him, them people who turned him away, like what are you doing in your job that somebody is dead? that you knew were suicidal and you turned away? how can you do that as a human being? It's beyond me".

He also disclosed his fears over other young men hearing stories about his friend's help-seeking and suicide and he worries about what he states is a silent epidemic in the Northwest of Ireland:

"It's grim, it's grim. HSE is very, very grim. I just hope young fellas don't hear the stories because you need hope and if a young fella heard these stories, the three or four of them [stories] that I have outlined… they're not gonna go for help."

This participant stated that his reason for participation in this research *"to be honest that is the reason I came here today"* was to tell the story of his friend's help-seeking experience which ended in suicide. This finding reminds and reinforces the reality that some young people's help-seeking and mental health care experiences will never be heard.

Summary of experiences of help-seeking

In this sub-category, findings were presented regarding participants experiences of deciding to seek help and how others helped initiate this process when requested and sometimes without their consent. Participants also described the search for the right help, how expectations were met and unmet, LGBTI+ experiences, learning vicariously through others' experiences.

5.4.3. Summary of category 2

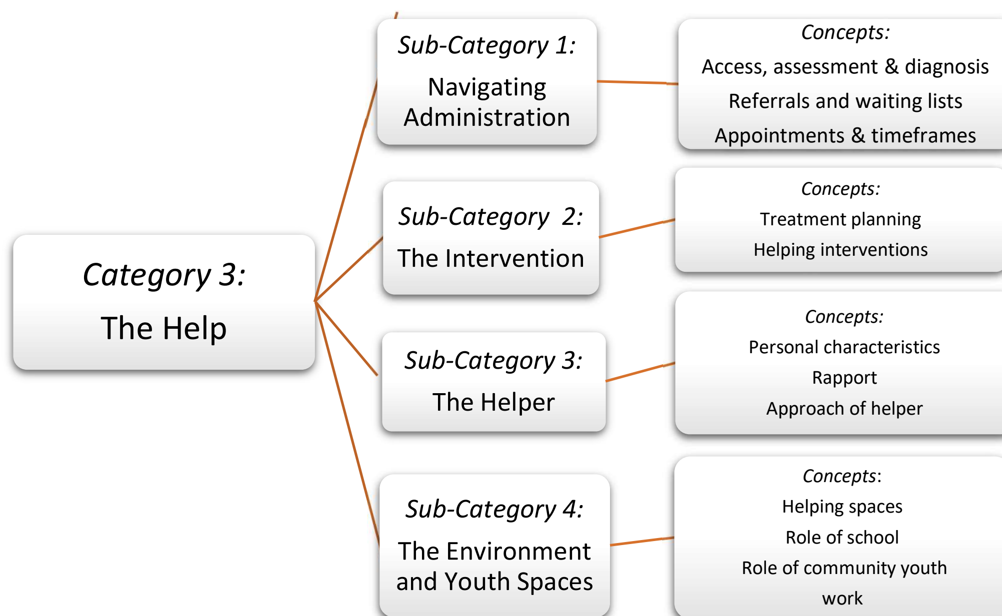
This second category *managing mental health problems* presents findings regarding participants' individual experiences of the day-to-day reality of managing mental health, the varied strategies they developed to self-manage, the role of friends and family and their experiences of protecting themselves from stigma. Differing levels of distress could signal the

need for help from others and participants also discussed their search, their fears, personal disclosures, the risks and their expectations in looking for a trustworthy helper. Participants also discussed the compounded stress of being LGBTI+, learning from others' journey of help-seeking, and the impact of suicide, which can be the result of mental health problems. These findings build upon category 1, by providing insight into participants overall experiences of help-seeking. This understanding is important before further exploring how young people engage with services and helpers.

5.5. Category 3: The Help

The third category explores the next stage of participants help-seeking journey, their experiences at a service, with findings presented in four categories: 1. Their experiences of passing through the service *administration* checkpoint; 2. Their experiences of *interventions*; 3. The help provided by a *helper* and 4. Their experiences of the *helping environment and youth spaces*, school, and community youth work services (**Figure 16**).

Figure 16: The help



The term "help" and "helper" is defined as any service or individual who provides an offer of support, and the term "support" refers to a participant's experience of being helped. Young

people in this study described using both private and public mental health services on both sides of the border, with some using private in-patient services. Young people in this study did not speak of border activities distinctly, as these actions are very much ingrained in their way of life. Most participants in this study were resident in Donegal, with three participants in this study came from native Irish speaking regions. No participant spoke of the Troubles or referred to any border dynamics in their interviews.

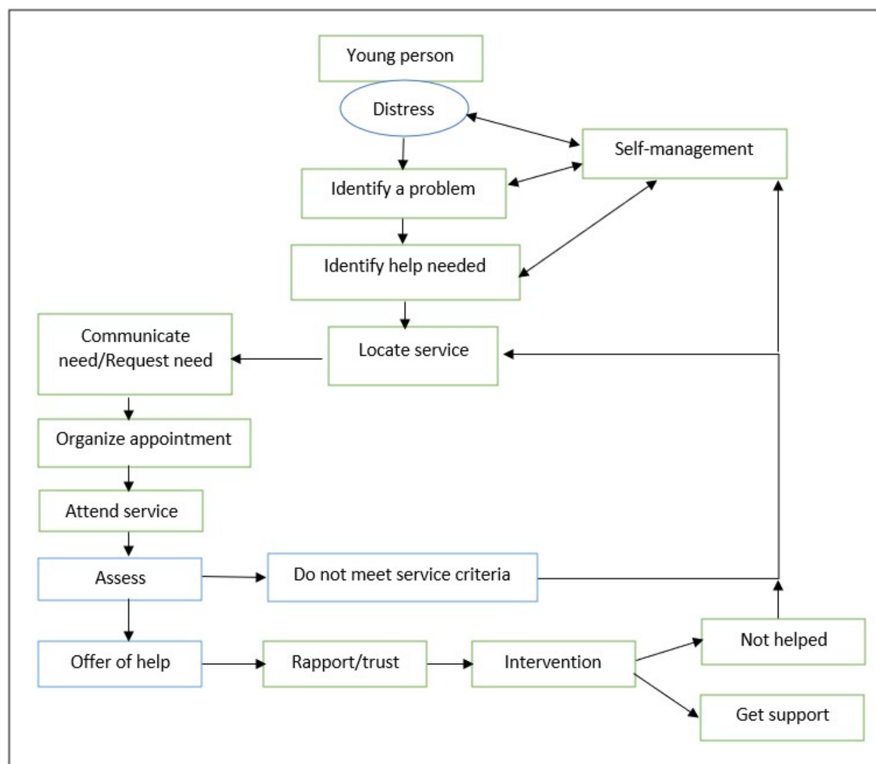
5.5.1. Navigating administration

This sub-category presents findings on participants experiences of requesting help with a mental health service (MHS) for support. They described their experiences with *referrals, and waiting lists*, and how they navigated the administration processes discussing initial *access, assessment, and diagnosis*, as well as first *appointments* and *time frames* for recovery.

Referrals and waiting lists

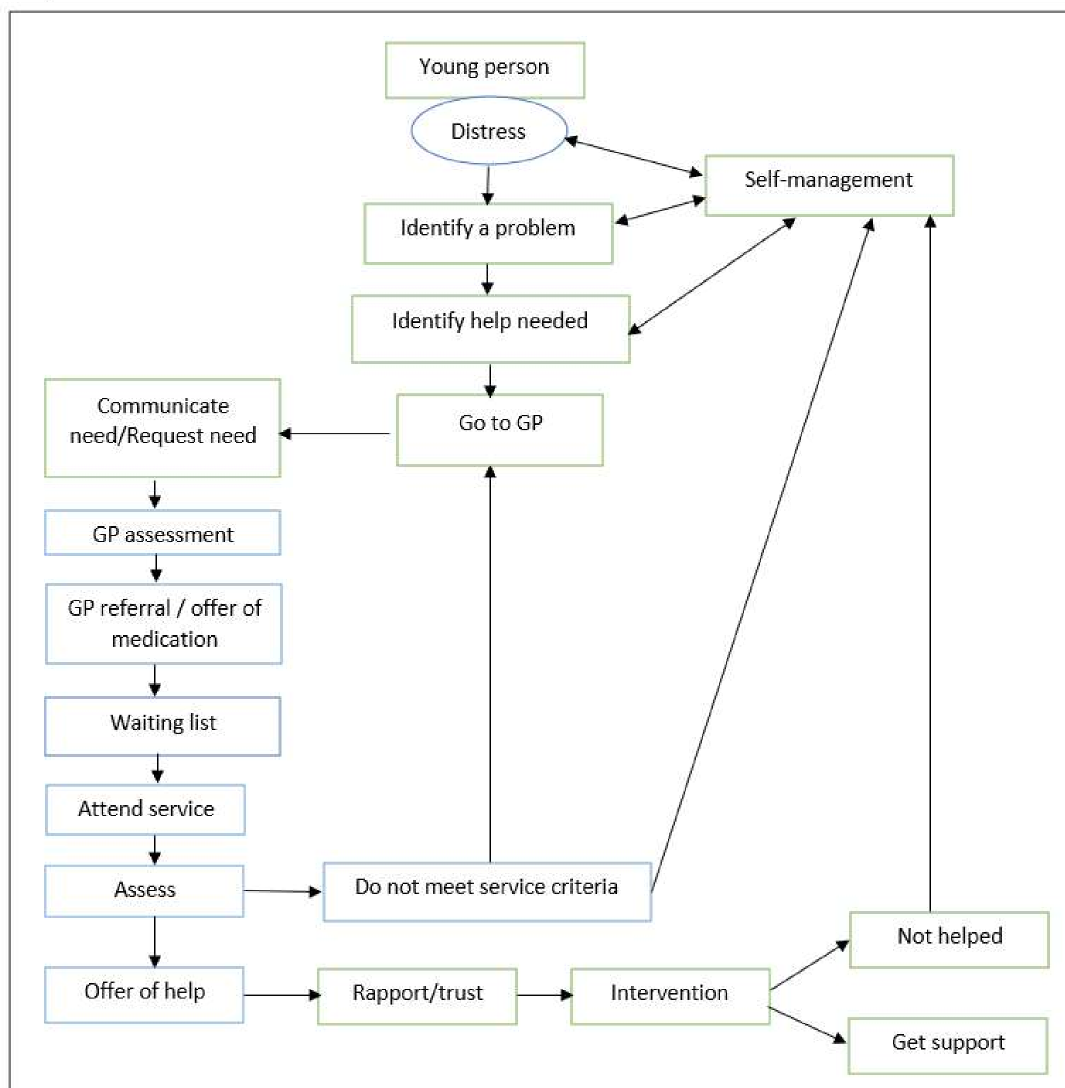
Participants discussed accessing formal mental health support through their GP, public healthcare, private counselling, college counselling services, community based mental health organisations. **Figure 17** details the process of help-seeking *outside the public system*.

Figure 17: Help-seeking outside the public system.



and **Figure 18** shows the process of help-seeking *within a public system*. Participants also received mental health support with semi-formal services such as community youth services and school pastoral care services. Once participants located a service, they were required to engage in either an initial conversation, interview, or assessment, essentially exchanging personal information in hope of an offer of support. Most participants experienced a referral from their GP to a public MHS or a place on a waiting list.

Figure 18: Help-seeking within the public system.



All participants described waiting on an offer of help from two months to four years. Most participants accessed mental health support through their GP and were either referred or not

referred, publicly or privately, at the doctor's decision: *"he sorted me out with a counsellor"* – ***Gerard***

Cathy recalled being shamed by her GP for having mental health problems: *"…'you're only doing this to act out on your parents, it's all to do with you, get yourself sorted' and I was like, shit, it's all my fault…"*. Cathy also described how the GP's description of her to the public MHS stereotyped her distress as normative: *"they were given a note by the GP, which was coming across as an angry teenager who is acting out"*.

Rachel described the referral processes as *"like a ladder"* and how being placed on a waiting list forces further self-reliance and decreases motivation to engage in help: *"If I can go … nine months without killing myself or harming myself then what's the point in me going to see this doctor to talk about all the things that I have suppressed for the past nine months?"*

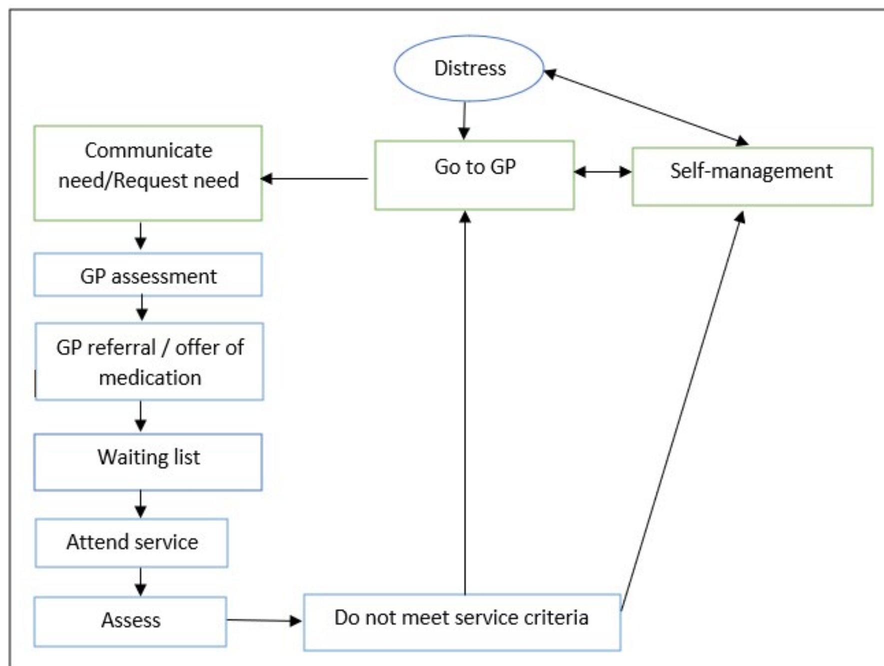
Participants attending public MHS transitioned to adult services at 18 years. Robert described it as a *"really smooth"* experience but Rachel, who was in state care, described her transition as *"horrific"*. Rachel was re-traumatised as she lost nearly all the supportive professional relationships that she had built over the previous 5 years. She waited 12 months for an initial appointment in adult public MHS, without support, whereupon she was deemed too unwell, and was discharged and referred back to her GP, who referred her to another service who could not help. Eventually her GP referred her to in-patient services:

"…okay I can't access the service, and this is the only service I can come to? where am I meant to go from here? … sent me to my GP and my GP sent me straight up to the psychiatric hospital and there was like no in between. It's just from doctor to doctor to doctor, when you are an adult, and once you are in the loop, it's very hard to come out of it" – ***Rachel***

Other participants also described experiences of the "referral loop" (**Figure 19**), being continually referred between professionals in services, and not accessing mental health support:

"Every time I seen a new psychiatrist, psychologist, whoever the hell it was, I have to repeat the same stuff again and again… they then decided, oh no I'm not qualified enough for this let's send you to the next person, so I'm just on the repeat..." – ***Aine***

Figure 19: The referral loop



Aine discussed eventually being referred to in-patient care for self-injury and having that treatment discontinued for continuing to self-injure: *"So I got kicked out and was sent back under the care of my psychiatrist who sent me there in the first place who clearly felt she couldn't help me. That's who they then sent me back to [bewildered tone]".*

A few participants described watching their mental health deteriorate while waiting:

"It's almost like [pauses] everyone is waiting for you to do something [suicide attempt implied] and that is the worst feeling, you're sitting there, and you're thinking – I need help…" – ***Rachel***

Erin described grief over the time lost on a waiting list: *"…all of those months that I could have been… working towards myself, I could have had an easier time…".*

Claire described feeling powerless on a waiting list: *"you have to wait"* and unclear expectations for help: *"…it could be six months, or will you get a letter? I don't know*?" and feelings of guilt once she received an appointment: *"I got a feeling that I don't deserve this… there could be someone out there that is worse than me that is waiting longer, and I could be taking up their time".*

Aine stated: *"I've never seen anybody getting an appointment with the [public MHS] in under a month,* ***never****."*

Rachel described how being put on a waiting list as re-traumatising, as she spent: *"six months without any care"* and experienced: *"a lot of anger, shame"*.

Joseph describes after an assessment by a college counsellor being referred to a book: *"... and then basically told to come back **if** I needed help... there wasn't even an offer of her helping me with the book… it was the worst experience I have ever had with services"*.

Laura described her own experience with a community MHS, where she was assessed as not *"in immediate danger"* because her experiences of CSA were historical, despite experiencing severe distress. After being placed on a six-month waiting list, and waiting, nobody contacted her*: "...so it wasn't that it was my choice to not go there for help, I just never heard back from them"*. Laura sought further help again through her GP and was referred for counselling, waiting a further two months for an assessment:

> ***CI:*** *What were those two months like?*
>
> ***LAURA:*** *It was like* **hell** *... some of the worst months of my life like… I spent like every single night crying myself to sleep, I was constantly having panic attacks, every single day… and I'd be very violent, I would break so much shit and… I had bruises all over my body.*

The processes of referral and waiting for help were at best neutral but mostly harmful experiences for most participants, who often experienced an exacerbation of distress and powerlessness. When the time came for an appointment, participants described varied formats in how they were assessed or offered help.

Access, assessment, and diagnosis

Once participants received an initial appointment with a service, or accessed a service directly, they described various experiences with assessment and offers for support. Richard described ease of access through administration and helpful staff at a youth community MHS: *"The lady at the counter has a really nice voice, she's just like very calm..."*.

Participants described access to on-campus counselling as conveniently located and free. Joseph stated that being able to email this service reduced stigma: *"the receptionist and things like that was a hundred percent"*.

A few participants described experiences of assessment and diagnosing, during their first appointment with a service, as helpful: *"...she did the right test... she kinda found out where I was like"* – ***Joseph***

Liam described in his initial meeting with a youth worker how they prioritised offloading over an assessment: *"…we just really did do that word vomit, [she] was really kind and considerate about it".*

Rachel described being denied access to support at a public MHS due to mental health history: "*I actually went to a service before, very recently, and they opened up my file, and were like 'no'. They haven't even spoken to me…"*

Participants described assessments as an unhelpful or inappropriate experience, especially in early adolescence:

"…the whole um clipboard in front of you, 'do you feel like this?'… just kinda crossing things off the list rather than asking, 'well how are ya?' [astonished laugh] … trying to put words in your mouth rather than you coming across as what you feel…" – ***Cathy***

Cathy described feeling that their diagnosis did not match their personal understanding of their own experiences of mental health or that the professional focused too much on symptoms during an assessment: *"… is it bipolar? is it something else? is it just depression? what's going on here? They were going by that, instead of - is this wee girl okay?"* but how she received an appropriate assessment at a college MHS: *"they were very helpful in the assessment; they were quite sympathetic and empathetic…"*

Other participants discussed how the assessment criteria and subsequent diagnosis were gatekeepers to help. Erin described how it took 7 years and several assessments for her to get access to support: *"…once I was actually diagnosed in college, all these services came in".*

Rachel described being excluded from many MHS's for being too unwell: *"… I've had that so many times, where I have been referred to a service and they've been like 'you're too unwell, you are too unstable, we can't help you' and then there was nowhere for you to go".*

Aine discussed multiple assessments at different stages in her life. She described how dissociative behaviour would be mistaken for coping and her experiences with not meeting clinical assessment criteria: *"So they kinda like, 'you don't have a mental health illness', what they would see as stereotypical illness like bi-polar, schizophrenia, whatever… you have*

mental health problems, but that's because of your life experience …'we don't know how to treat that'". For Aine, no diagnosis proved more harmful than an inaccurate one as she described the unsafe decision she took to try and meet assessment criterion: *"It's the same thing with feeling frustrated and hopeless all over again, and then sometimes you get angry to the point of – well I'll have to prove you wrong then – which is very dangerous when someone is suicidal"*.

Overall, participants had differing experiences regarding access to services with a few getting immediate support, most having to wait and some not getting access to help at all.

Appointments and timeframes

Participants described varying frequencies regarding offers of help timeframes from MHS's; some received weekly appointments, others every six to eight weeks, and the length of offer of help varied from one session to what Laura described as being offered, *"an open-ticket"*.

For participants help-seeking under 18 years of age, appointments were often scheduled during school, which Robert disliked, as it meant catching up. Richard enjoyed time off from school but was too tired to talk in morning appointments and did not need to offload as much: *"I think I'd rather have gone after school because in the morning … she had no other time so…they close early"*.

Appointment times varied from 20 minutes to 1 hour. Some participants preferred longer but others felt they had sufficient time and their needs were met: *"... which was great, you didn't feel like oh I've got 10 minutes left"* – ***Robert***

Erin discussed how generic 6-8 week "recovery" time frames put pressure on her and the counsellor: *"…they can work out a way to again help me as best as they can within that time limitation, but it definitely stunted or affected whether I felt better."*

Sometimes a supportive episode ended because of staff leaving:

"She was so nice, she was brilliant and then she went on maternity leave" – ***Claire***

Rachel stated that *"everyone is different, everyone has different time limits…"* and discussed how time was the most limited resource in public MHSs, especially in appointments and in helping her examine and develop understanding of her distress: *"… who will give you the time? ... nobody had enough time, the system doesn't have enough time for that"*.

Joseph expressed his belief that all access to MHSs needed rethinking: *"...something has to change, some sort of progressive thinking, some sort of way of doing things."*

Some participants received support in a youth service and found it easy to access, with no dictated timeframe. Claire described texting a youth worker as and when she needed support: *"so if I needed somebody to be like remind me, I'm not crazy, I've got this".*

Participants' experiences of appointments depended on the type of service system they accessed with under-resourced services proving more unhelpful with long-waiting lists.

Summary of navigating administration

The findings in this sub-category demonstrate that young people are negatively impacted by administrative processes on the help-seeking journey. Easier access and timely responses were associated with improved mental health, and long waiting lists and referral processes were considered harmful. In some instances, findings show that some young people, often the most distressed, received no mental health support despite repeated requests. For most, access was determined by their assessment or diagnosis, eventually receiving an offer of help.

5.5.2. The interventions

This sub-category presents reports of participants' experiences of helping interventions. Once proceeding through a referral or assessment process, participants received an offer of support from a potential helper. Participants discuss these experiences of being provided with help in the form of *treatment plans*, *interventions,* and *medication*.

Treatment planning

Few participants described an open and transparent conversation with a helper about their treatment plan. Some participants discussed how a lack of treatment planning or choice around helping strategies was unhelpful and discouraged them from engaging in treatment:

"…and that plan wasn't scripted at all that day" – ***Joseph***

Participants who entered the public system under 18 years of age did not recall any discussion or choice regarding treatment and often described experiences of coercion or being "brought" to appointments which impacted their ability to engage with treatment:

"I don't feel that… worked for me because of the way I was kind of entered into it" – ***Cathy***

Participants also discussed how personal expectations of treatment plans did not match professional expectations:

"Some weeks I wouldn't want to talk and then the mental health service, they would take that badly, they'd be kind of, 'you're not helping yourself'" – ***Aine***

Rachel described involuntary participation in a treatment plan and experiencing intense fear and discomfort with her psychiatrist: *"I was so young, I was so scared and I didn't want to take this medication …".*

Aine, who had received multiple interventions over ten years, described her role in her mental health treatment plan:

> ***CI:*** *I was thinking back to you describing how you were "given" antidepressants, I was "sent" here, I was "moved" to this person…*
>
> ***AINE:*** *No, I had no choice [laughs]… it wasn't my decision, it was you're doing this and you're going there that's that.*

Some participants discussed accessing private healthcare in emerging adulthood, and how treatment plans and needs were negotiated:

"…they're not doing it to the point of being overworked, you have more of a choice over things, you decide who you're seeing and when you're seeing them" – ***Aine***

Joseph's experience with private CBT, while offering choice in treatment was costly: *"I was… paying €120 per session up in [Hospital in Dublin] I was going up once a week"*. When it did not work out for him, he found suitable and affordable private healthcare that met his treatment needs: *"…unless I'm paying for something, I'm not getting anything".*

The lack of a treatment plan that met participants needs and provided them with consistent care was a prominent experience in public systems. Many participants described beginning interventions without choice or transparency which often resulted in unhelpful experiences, especially in earlier adolescence.

The helping interventions

Participants described the intervention strategies they experienced, ranging from appropriate to inappropriate. Some participants discussed how the lack of information regarding the interventions used caused mixed expectations and limited effectiveness:

"I don't know what I expected, I didn't understand what counselling would be like, but are we just going to fucking talk about it or are you going to fix me?! How am I meant to do this?!" – ***Laura***

Claire reflected on being provided with anxiety and anger management techniques that she did not understand properly and found difficult to use in her daily life. She also experienced age-inappropriate interventions: *"…and playing with sand and all, like I'm not a five-year-old, just let me talk".*

Laura discussed the limitations around the counselling she attended and how certain problems were not being addressed: *"I wasn't eating and … I was very confused because I did not understand why I wasn't being sent to maybe a psychiatrist or something".* Laura described how a CBT intervention, accessed through a youth service transformed her life, and provided strategies for panic attacks and self-care: *"it's like doing math, when it comes to CBT, you can see your problem written down and you can solve it".*

Joseph described how a private CBT intervention with homework exacerbated his problems with obsessive and compulsive behaviour and Erin discussed how a CBT intervention at university was completely inappropriate: *"...I would spend an entire day in bed, but this blank page where I didn't do three things, and then feel like even more of a horrible person… because I wasn't just failing in my life… they're willing to help me and I couldn't do what they wanted with my life, I couldn't even 'I brushed my teeth today' [laughs]" –* ***Erin***

Many participants discussed receiving listening ear interventions in different services, either as an intervention in of itself or as part of a wider therapeutic approach. All participants valued helpers who actively listened over helping techniques or strategies: *"she was the only person that would actually listen to me" –* ***Rachel***

Rachel described her interventions in the public services as predominantly clinical and involuntary, but she also described a non-clinical weekly meeting with a support worker, as the most helpful aspect of her treatment: *"…it was me who would go to Mary… I wasn't dropped off".*

Niamh described her experience with being referred to community group mental health intervention with early morning starts while trying to manage insomnia: ***"****it was very patronising, and it was really aimed towards like getting you into work and there was no focus on like, like recovery…".*

Aine describes being part of an unsuitable group therapy intervention: *"the first time I was involved in mental health services I would have been eight and I was made go to group counselling and it was* ***horrendous".*** Aine also described seeking help to a local community mental health service: "*…they told me I was too high risk because I was suicidal".* She was immediately referred to A&E but was declared not high enough risk and discharged: *"…the next day I was rushed into hospital having nearly died from having too many seizures…".* Once her seizures were under control she was discharged again: *"Anybody who has made an attempt on their life is not well enough to be left alone".* Aine recalled another time in which she was referred to A&E for self-harm and was sent to in-patient services: *"Self-harming is a coping mechanism; it's trying to stay alive. So, I get sent to the psych ward for trying to stay alive yeah? I get sent home for trying to kill myself".* Aine described this experience at an in-patient facility for self-harm as inappropriate and left her feeling punished: *"like being in a psych ward is bad as it is, but if you're not actually* ***that*** *unwell it's even worse…".*

Rachel commented that in her experience: *"The people providing help are often under others who control terms and conditions of mental health treatment… The people who help the most have the least power".*

Many participants discussed how their GP prescribed psychopharmaceutical interventions for their distress, usually solely but sometimes as a combined treatment. Some participants found this helpful: *"…which I am on to this day and continues to work" –* ***Joseph***

Aine and Rachel discussed being prescribed medication in early adolescence. They both discussed side-effects as making them feel worse or physically unwell and how they were not offered appropriate counselling treatment alongside medication*:*

"I was on an anti-depressant, two different anti-psychotics and a sleeping tablet by the time I was 15 … for anxiety and depression and post-traumatic stress you should not be medicated to the point of, you don't know what day of the week it is." – ***Aine***

Some participants wanted medication:

"…I went back later… to see about some medication because I was like right, I need to be able to work, I cannot do this anymore, and they just wouldn't do it" – ***Laura***

Others described coercion: *"I absolutely refused to take medication first time… and then I was made to… she knew I didn't want to take it, and she would give me a glass of orange juice and put the medication in my hand"* – ***Rachel***

Others described wanting counselling and being offered medication instead due to long waiting lists: *"I was pushed at that age [20] a lot towards medication, and I didn't want it"* – ***Erin***

Some participants described not being instructed on how to take medication properly or expecting a cure: *"it was 'here you go just take this and that'll kind of like solve life's problems"* – ***Aine***

A few talked about using medication not as prescribed or using it to attempt suicide: *"the only reason I was seeing anybody after I started those drugs, was because I took an overdose and ended up in hospital and then they decided I might need to see a psychiatrist!"* – ***Aine***

Liam believed GPs were limited with mental health: *"their heart is in the right place and bless them they are trying to keep up with things, but they are pretty much not trained for that sort of thing"* – ***Liam***

Participants described different experiences with interventions, some receiving many, with different helpers in different services, and others having relatively uncomplicated experiences.

Summary of the interventions

This sub-category presented findings that young people are not often involved in treatment planning and can receive inappropriate interventions for distress. Whether a helping intervention, such as the use of medication or CBT, met the participants needs or not was often influenced by treatment planning and communication with their assigned helper.

5.5.3. The Helper

This third sub-category presents findings on participants experiences with their helper. Participants described the *personal characteristics* of the helpers they met in services, how *rapport* was established and maintained as well as the helper's overall *approach* to their needs and mental health care.

Personal Characteristics

Participants described how their helper's personal qualities impacted how they connected with them. Some participants described negative experiences with helpers who were dismissive, lacked understanding and who did not communicate well. Claire describes attending a psychiatrist who was difficult to understand, who used offensive language and did not listen to her: *"… he did not understand what I was saying, and it was so frustrating… I can't be bothered to go…".*

A few participants discussed experiences with guidance counsellors, who were not suited to the role. Laura described being chastised after a panic attack: *"…I just really don't get it because the counsellor was awful, I was being given out to".* At another service, Laura described disclosing to a helper who was unable to manage her own emotions: *"I was just talking away and then the woman just burst out crying".*

Participants described experiences of listening to their helper, or helpers trying to impart wisdom or guidance inappropriately:

"it's more for [pauses] her trying to let you know what she knows rather than her getting to know you." – ***Richard***

Some participants described helpers who were biased, judgemental or made decisions based on their own belief or value system. Joseph described his experience with a counsellor accessed through a GP referral in the public healthcare system: *"…I think it was a very Roman Catholic approach… and she told me that she didn't believe I should do that".*

Rachel discussed the lack of options in helpers: *"it's hard when you don't click with somebody because there isn't enough people".*

Most participants stated the importance of feeling welcomed by a friendly and non-judgmental helper who created an open, warm and emotionally safe dynamic:

"Very nice, very supportive, made me feel completely welcome… there was an openness and a warmth there that really made it easy to open up" – ***Liam***

Other's described helpers who were knowledgeable, insightful, enjoyed their work and had a good sense of humour:

"She was still, laugh at it sort of thing, and I was like this is good [laughs]" – ***Laura***

Several participants discussed genuine and compassionate helpers, with some describing the most supportive helpers as having innate qualities that ensured they were suited to their role:

"Training can't teach you care, compassion and being non-judgemental, which is what you need… that's just the way someone is" – ***Aine***

Rachel recalled two people who helped her throughout her adolescence who she described as "special" people, describing the comforting nature of her guidance counsellor: *"that was the first person ever that I felt comfortable to say to that I don't feel well, I don't feel safe"*.

Once participants connected with their helper, the process of building rapport was the next important step in being supported.

Rapport

Some participants described the ability of helpers to create an instant rapport, while others discussed needing time for rapport development to engage in therapy:

"There are certain people who genuinely care about you and give you the time and that's what you need" – ***Erin***

Many participants described how a genuine rapport with good boundaries, in which they felt connected and understood, provided them with a safe place to explore distress:

"Because you know they won't judge you, you know their personality, you know that they do actually care" – ***Cathy***

Erin described how time limits in services could prevent the development of a deep rapport with a helper: *"yeah and by the time I could build up kind of that friendship and trust with a person it was already the ending"*.

Participants who had experiences with being in state care, homelessness, fostering and asylum seeking, needed more "real" rapports:

"it's like, she knew that it was all about the relationship" – ***Rachel***

Rachel described her support worker's commitment to her: *"she did do so much, just the simplest things, being there no matter how much I fucked up or messed up, no matter how alone*

I was when I had lost absolutely everything, from the transition to teenage years, moving towns, from being in care".

Gerard, who experienced homelessness, described building a supportive and lasting rapport with a youth worker: *"…she has been incredibly helpful, I have told her many times that meeting her is the best thing that has ever happened to me"*.

Thomas valued a pre-established rapport with his guidance counsellor: *"just seeing him around always saying hello… I think that's what led to me eventually actually going to him as a counsellor"*.

Aine described the benefit of getting to know her youth worker within appropriate boundaries: *"she's told me about her, whereas professionals they barely like telling you their surname… I actually knew her as a person… yeah I don't need to know her life story… but I don't want to talk to a stranger either",* and how she felt like she contributed to the relationship: *"I helped her decide that that's what she definitely wanted to do in life"*.

Participants who experienced abuse and parental abandonment discussed how helper's going above and beyond repaired trust and communicated care. Rachel described being supported with daily tasks: *"She used to take me to school every morning… and she used to knock on my door and made sure, and if I didn't, she'd be like - okay! [laughs]"*. Rachel described her support worker visiting her daily in in-patient services: "*I felt like I was a burden, but she would always reassure me that, 'Rachel I actually care about you' and that was very special"*. When Rachel turned 18, she had to transition to adult services and experienced terror at losing this professional relationship. The helper, with adapted boundaries, stayed in a supportive role in her life: *"and she just laughed at me and said Rachel, I'm not going to go, and she still messages me to this day, you know 'how are you?'"*.

Participants described the ability to relate as an important part of rapport:

"Whenever I go to a counsellor in the first one or two sessions, I know whether that person's been through something" – ***Joseph***

Aine described how a poor rapport resulted in professionals blaming her for being *"uncooperative"* and *"not helping myself"*.

Some participants described how a helper sharing either their own or another's experiences with distress and coping, in an appropriate manner, enhanced rapport and balanced power relations*:*

*"The best counsellors that are out there are people who have suffered in the past and have gone through something, some struggles and they know what it is like" – **Joseph***

The ability to relate was very important for participants needing support with LGBTI+ related concerns:

*"I remember she told me that she was in similar situations, like she had to hide… and her life changed… it was good to meet someone who knows how it feels, who understands you" – **James***

All participant's described trust as foundational to rapport and engagement in treatment. Trust development could take anywhere from 1 session to a couple of years, with the earliest interactions rated as important:

*"It could take me months to get to just a stage where I trust this person enough…" – **Erin***

Appropriate sharing of information supported trust and rapport building:

*"There has to be mutual trust – if she doesn't trust me, why am I going to trust her?" – **Aine***

Many participants discussed a preference for a prior relationship, but some discussed how they would not consider help-seeking to someone they did not know:

*"I would have never talked to anybody if I had no relationship with them" – **Thomas***

Prior relationships gave participants an opportunity to observe a potential helper to assess for predictability, trust and faith in the helper to support distress in the way needed:

*"Once you have that connection with them that you know, aye. this is the right person who is going to help with this" – **Andrew***

Some participants described trusting helpers who had assisted them previously: *"…if they have helped you with problems before, like you can definitely trust them like… like that's where the trust starts building…" – **Andrew***

Thomas described how prior trust could alleviate other help-seeking fears, especially in earlier adolescence: *"I don't know what I thought it would be like, but I knew I trusted him".* Cathy described how it was easier in emerging adulthood to approach talk without a prior rapport: *"I suppose being able to chat to adults at that point, I was 20, so it was easier."* – ***Cathy***

The time to build a supportive rapport with a helper was described as crucial to most participant's therapeutic engagement and services differed on whether they were able to provide participants with the opportunity to do this. The quality of the helping relationship was often connected to the helpers' approach.

Helper's approach

Regarding the helper's approach to support, participants described both helpful and unhelpful experiences. The first helper for many participants was their GP who was described by some as approachable and encouraging but by others as clinical and not providing enough guidance:

"The doctor just gave me a list … the next they will see you is in like two months, or there are people out in other places who will give you other opportunities" – ***Liam***

All participants valued an informal, personal, and friendly approach: *"…rather than just sitting on a hard seat and just staring at this person like an interview [laughs]"* – ***Cathy***

Intrinsic to this informal approach included hiding administration. Cathy described receiving the most help from a counsellor who *"…never picked up a pen and paper"* and Aine described how a youth worker remembered their conversations without notes: *"…I'm sure she'll do it afterwards! but she doesn't do it when I'm there!... there's no forgetting".*

When participants described positive and collaborative support, they used "*we*". Participants valued helpers who took individual approaches, taking feelings seriously, who inquired about needs and validated concerns:

"*…she didn't just have one way to deal with every other person, she sort of listened to me and considered what I may need"* – ***James***

Others valued the immediate comfort of refreshments:

"…whenever they give you tea, offer you biscuits [smiles]" – ***Richard***

Erin noted the importance of physical closeness and active listening: *"…the woman was just, no further away than you are now, just like a foot, was looking at me… 'and I am going to listen to you', really on my level and that made me feel a lot more comfortable".*

Some participants discussed how their needs could change throughout their support. They valued learning new skills and strategies for coping with distress, after an appropriate length of time being listened to:

"At the end day you need to see a result like" – ***Joseph***

Claire described how helper's encouraged appropriate self-management: *"… then like I thought like okay I'm not completely better but I'm okay to do this on my own"* and Cathy discussed how a helper using multiple interventions or strategies: *"it was more holistic than I thought was going to be!"*

Challenging at the right time was helpful for gaining perspective and feeling better and building self-esteem:

"She challenged me a lot definitely, for sure, and I needed that you know" – ***Robert***

Erin described a counsellor who challenged her feelings of helplessness effectively: *"…it is not something that has stuck itself on me, it is not something ingrained in who I am, it's part of life and I can deal with".*

Some participants commented that helpers, particularly in schools or youth services, "checking-in" and "noticing" were signs of genuine care:

"…even just "you're looking a bit down today I will put on the kettle", something as simple as that… you would feel like they actually care, they are actually noticing stuff" – ***Cathy***

James described help-seeking to a teacher who gained reputation amongst peers for their approach*: "she is just the kind of person that everyone can turn to, she will always do her best to help".*

Aine described how a youth worker upskilled in response to her mental health needs: *"So it wasn't like right yeah I'm not trained in this, go somewhere else. It was… so we'll figure this out and while we're figuring this out, I'll get trained. [both laugh]".*

In a crisis, some participants valued a helper who responded in a calm, sensitive and reassuring manner. Gerard described his need for an impartial helper and an outside perspective after a family crisis: *"someone that wasn't involved in the whole situation and wasn't didn't have anyone's interest at heart other than my own, or in mine"* and how they provided much needed hope: *"I told her everything that happened, and she told me I'd be fine"*.
Aine explained how a youth worker took a non-judgemental approach to her self-harm: *"…has never ever tried to tell me not to self-harm, never. They never obviously encouraged it, but they'd never been like 'no you need to stop doing that now'"* and how when she was fatigued from managing distress, her helper was appropriately persistent and creative: *"...you don't have the energy actually to do it yourself so I will help you go to the park!"*.

Some participants described helpers who located extra support for them. Gerard's counsellor provided him with direction to a housing service and a youth work service: *"she got me a couple of numbers and I got people to talk to out here then"*.

James' guidance counsellor connected him with specialised support for gender transitioning and Robert described how his public health nurse identified his need for community: *"…the great thing was you know then I was about to come out to friends and family then, and it was herself who referred me on to [LGBTI+ service] … and I really, really became a part of that… and that's helped me along with my mental health as well"*.

Some participants described helpers who were not appropriately trained or who offered limited approaches:

"That was the style, and would either work for people wouldn't work for people" – ***Erin***

And how helpers in peripheral roles could offer more help than those in assigned ones:

"I got more care and support from her than anybody, like from a counsellor or a nurse" – ***Aine***

Joseph described the helping approach he valued: *"there's learning ... through books and through academia and then there's having been there, and the best counsellors have both"*.

Regarding unhelpful strategies, participants described unhelpful experiences of being stereotyped, stigmatised or othered by their helper:

"... I was trying to discuss issues with my father, this guy just, tried to downplay everything I was feeling and said your father sounds like a nice man maybe the issue is with you?" – ***Erin***

A few participants described the impact of clock-checking and notetaking:

"... are you really listening to me like? When they're concentrating on this pad of paper... I would lose my train of thought and would be looking down at it thinking like what are they doing?" – ***Robert***

All participants described aspects of clinical approaches as unhelpful or uncomfortable. For some this was due to caregivers' presence at appointments, the formulaic or repetitive nature of appointments or the manner of psychiatrists and consultants:

"...she would ask me about medication and very to the point questions, like did I feel suicidal? Did I feel like harming myself? Did I feel like hurting anybody else? ... it was just literally a checklist and I found that very hard" – ***Rachel***

Aine believed clinical approaches did not prioritise relationships: *"they didn't value the relationship enough"* and throughout her experience could not remember having anybody's role explained to her: *"...it was never explained, um [pauses] who done what or even who they were"*.

This lack of explanation of roles combined with an expectation of support resulted in some participants thinking that their helpers were not qualified:

"She was really nice, but I don't think she was really qualified?" – ***Richard***

Some described clinical approaches as communicating a distinct right or wrong approach to getting better:

"...they're like 'you need to find the strength, you need to find out who you are' but then they're like 'this is what's wrong with you'" – ***Rachel***

Aine also relayed how practitioners invalidated her distress: *"...so they're telling me I'm not suicidal so that must mean that I'm not? so why did I just try to take my own life? I don't know?"* and inappropriate approaches from helpers: *"...when people over-react, they come across that they're angry and so then you think, they're angry with me and I'm in trouble and I'm never telling them again and then"*. She also described how under-reacting invalidated disclosures: *"if people under-react, you're like, so am I exaggerating this and maybe this is all*

in my head?". Both responses were unhelpful and could decrease future help-seeking*: "so you're going to stop asking for help both ways"*.

Aine described the clinical approach to self-harm as to obstruct it rather than to address it: *"…but not actually dealing with the underlying issues, you're then going to take away the one coping mechanism I have. It's gonna make things worse, not better."*

Participants also discussed how consistency in the public healthcare system affected support. Robert stated feeling consistently supported throughout his treatment, even during staff changes while many others described having a different psychiatrist at each appointment: *"at the time I was going for it there wasn't a resident psychiatrist at all… you'd have a different fella, then a woman then a fella, then a different woman…"* ***– FG Niamh***

Most participants who attended public healthcare under the age of 18 described a lack of privacy and confidentiality throughout their treatment. Cathy discussed how conversations about her treatment between her psychiatrist and her mother, while she waited outside, were unhelpful: *"It's a bit uncomfortable, you're kind of like, shit what are they talking about? are they talking about something that I don't know?"*

Many participants described helpers neither reading files properly nor following up with referrals, and inappropriate questioning or pace of intervention by helpers:

"… rather than just intervene all the time because he did that a lot" ***– Claire***

A few participants described observing a lack of resources in public services, such as lack of physical space, lack of appropriate in-patient facilities, and a lack of staff:

"there's no option you're lucky enough to get what you're given" ***– Rachel***

A few participants referred to professional-led ending of treatment, in particular when their psychiatrist or psychologist was not available over the summer months, resulting in earlier discharges from treatment:

"that was really hard because I felt like I was building a relationship with her" – ***Erin***

Rachel described having no choice but to accept inappropriate care at public MHSs: *"like they have to do their job, they have to judge you"*.

Helper's approaches were often described as being rooted in a wider service approach and could be dependent on the individual capacity, training, or ability of the helper to meet their needs.

Summary of the helper

Participants were able to recall rich and detailed memories of their rapports with their helpers as the helper was central to their experience. Findings demonstrate that the helping relationship and associated approach are central to young people's experiences. Helpers with unsuitable character or inappropriate approaches exacerbated young people's distress. Others recalled feeling supported and cared for by helpers who prioritised rapport, genuine care and who provided creative and supportive interventions, which met their treatment needs.

5.5.4. Helping Environment and Youth Spaces

This final sub-category presents findings from participants reflections on the role of the environment in mental health support. Two sub-categories deal specifically with important youth spaces that offer mental health support; a mandatory space - the *school* and a voluntary space - *community youth services*.

Helping spaces

Most participants discussed how the location and buildings of public MHSs could become stigmatised:

"If you're going into the mental health service then it's separated, everyone knows why you're going in there [with emphasis]" – ***Aine***

Robert, speaking of the same service, perceived it as better at managing privacy than schools or the youth services: *"...it's more private... you got a private room, like I know we have that here but it's kinda on view".*

Claire believed that a community MHS's location in town inferred stigma: *"...it's almost hidden and I don't know if that's intentional ... and nobody ever walks up that road...".*

Richard described how meeting other young people he knew in the service waiting area was problematic: "*...you're kind of afraid people are watching or whatever".*

Regarding the appointment spaces, most participants preferred comfortable and private spaces designed for support and connection: *"... and you were sat in a cosy office and cry, and you*

felt comfortable and again there was no clipboard there was no paper it was just talking" – ***Cathy***

Thomas described the lack of privacy at the guidance counsellor's office in school: *"No I wouldn't say, I wouldn't it was a good location* ***at all****… they couldn't hear anything, but they could look in".*

Claire was uncomfortable with CCTV in her counselling room: *"…almost like a one-way mirror and like cameras in the corner and I was kind of like I don't know if I like this".*

Aine stated that the use of public spaces could reduce stigma: *"I was also out in public [park] there was no like secrecy to it… there was no like 'okay you're coming to me because you've mental health issues, let's be quiet about this…'"* but also the benefit in the anonymity of a GP waiting room: *"…you could be going in for anything".*

Many participants described the impact of the environment as waning in priority as they got older and more comfortable with help-seeking:

"…it was a good environment, but I don't really think the environment affected my decision-making one way or another" – ***Liam***

Robert described how being involved in a youth service offered a counterbalance to his formal care: *"the great thing about that service that helped me was that it wasn't so clinical".*

Overall, participants described increased comfort in community settings with clinical and medical settings increasing distress:

"…hospitals are upsetting" – ***James***

Formal mental health services are primarily in clinical or community environments, however semi-formal mental health provision often occurs in school and youth work settings and can be easily accessed by young people.

Role of School

As schools are spaces where most young people spend a lot of their time, many participants described disclosing distress to staff they knew. Teachers were in a good position to sign-post and support help-seeking:

"It was my Irish teacher who referred me on … she just knew that there was a lot going on and she wanted me to just talk about it" – ***Laura***

School pastoral care staff can be key gatekeepers to external services but also providers of mental health care to students:

"…I remember doing breathing exercises and just talking and I kinda got over that" – ***Thomas***

In some instances, pastoral care did not provide appropriate support, and other staff stepped in: *"a few teachers that would have caught me in the middle of a really bad panic attack and they would have been really, really nice"* – ***Laura***

Some participants discussed the problems with dual relationships, lack of understanding of roles and school-focused guidance:

"*I think the only teacher who did that in our school was a religious teacher… it was more veered towards career guidance"* – ***FG Josie***

Josie described a teacher who offered a space in school to relax, which resulted in better self-management and avoidance of clinical services: *"… never a huge focus on her to try and discern what was wrong with me it was just her saying 'if you need to unwind, I am here' and that helped me so much".*

Some students discussed how school could contribute to their mental health problems, how other students and staff could further stigmatise them and how this was ultimately part of a wider school culture:

"…they did just took us all as emotional girls sort of thing" – ***Laura***

Some discussed the lack of mental health education in schools:

"I've never been in a class, and they were like 'oh let's talk about mental health', the most I got was a lollipop in our science class" – ***Claire***

Laura described how school was not a priority for her but a break from her caring responsibilities at home: *"I needed them to understand as well that not everything revolved around school a lot of us had a lot more stuff going on all".* Laura also described teachers as disconnected from student's problems: *"I wasn't even concerned with that [exams] because I thought I was going to be dead before the leaving cert".*

Thomas highlighted how young people not in education are likely to go unnoticed: *"a lot of people that are not in education are the people that talk to me about stuff"* and may rely on their peers or become involved with community youth work services.

Role of community youth work services

Many participants described youth workspaces as accessible, appropriate, and supportive environments for their mental health:

"It was a lot more comfortable because I was coming here with friends before, and it was a very welcoming place, all the youth workers were friendly" – ***Cathy***

Help-seeking for mental health was made easier because it was a familiar space:

"It's just like opening up and talking to someone that you really trust and people that you really feel comfortable around" – ***Andrew***

Some participants discussed drop-in spaces as providing time and opportunity to observe, choose and build rapport with youth workers who can potentially help:

"I do think that in this youth service there is a lot of variety, different cultures different specialities" – ***Cathy***

Andrew noted how role modelling and scaffolding in problem-solving or being guided to solve more practical life problems, encouraged him to seek help for more sensitive issues: *"but I've felt like, whenever I speak to* **someone,** *people in the youth service, it's like they showed me the action that I have to take".*

Some participants engaged in multiple programmes, which offered distraction and respite from problems:

"…it was great it would take you away from everything, you are concentrating on something else, and it was brilliant" – ***Cathy***

Some participants stated that the youth work methodologies used in mental health work encouraged them to use other community mental health support services:

"… it's great for everybody to see other people sharing their experiences and talking about it, people in there sitting in circles talking about it, so from that you could go on then to other ones" – ***Thomas***

Participants disagreed on privacy in youth work settings. Richard described privacy as built-in to a multi-functional space: *"it's really easy to go to without being spotted or judged or anything"* and how it was easy to speak with a youth worker: *"on the down low"*. Gerard stated that drop-in spaces were unsuitable for young people who require more privacy: *"Well that has drawbacks because then you can run into people"*.

Rachel discussed how youth services have stigma and can be associated with young people who experience marginalisation: *"…that everyone comes here is unwell and it is filled with freakers and stuff like that"*.

Participants who had experienced state care, homelessness and immigration described youth work as the most appropriate service for mental health support for them, as it offered more autonomy, a longer-lasting supportive relationship, and ease of access as and when needed:

"*I was given the choice of whether I wanted to be there or not…with the youth worker there was no pressure of when and if you wanted to. I might want to talk to you for a few weeks and then I might not! Who knows? [laughs]" –* ***Aine***

Aine described the flexibility of the youth work approach in providing support: *"…if you don't show up in the mental health service - you're in trouble. I don't show up to a youth worker – it's 'oh my God are you okay?'"*.

Gerard described how a drop-in service relieved the loneliness he experienced living in a hostel*: "Because it always makes me feel better, if I just sit in my house, I don't do anything and I don't talk to anyone and I feel miserable and it's not fun, so I come here and I see the people that I enjoy seeing, and that I enjoy spending time with, and I feel a lot better".* He also described how drop-in services can attract young people experiencing similar issues and an opportunity to connect and create community with peers: *"we're weird, we all have stuff going on, we are all kind of, we fit in because we don't fit in, and it's nice"*.

Richard valued the ability to offload in an informal way and the opportunities to develop a peer support network: *"…just like playing a game of pool and you're like 'ah I had a shit day today' and then like 'ah well talk to me about it', everybody tends to chat to their friends and it's hard to make friends whenever you've nowhere to go"*.

Rachel, who spent time in care, described developing rapport with many different staff: *"I got to know more youth workers, I got to know them individually"* and Andrew, who grew up in foster homes, spent 10 years attending a youth work service and described finding community: *"…once you know people, once you know you can trust them, once they have done so so so much for you, and once you have given them so so so much back, it makes it so much easier… yes that's my community"*.

Participants described youth workers providing them with ongoing support during a crisis, advocacy while attending other services and out of hours support:

"if I was suicidal and felt that I could no longer keep myself safe even for a minute longer I took up the phone and ring her, whereas [pauses] there's no other profession really you can be like okay it's 2 o'clock in the morning that's fine…" – ***Aine***

Some participants described youth services as appropriate for mental health support: *"I think here is just honestly amazing and I think the best we're very lucky to have it… all the hope is in organisations like [youth services]" –* ***James***

Laura felt that youth services had much to offer regarding mental health support: *"There is a lot that goes on, and it covers about as much help as they can…"* but was concerned about how access to youth services varied across Ireland: *"like I know ones down the country that would not have anything like that around them at all and they're just waiting there, just going to their GPs and are still on the same old awful waiting lists"*.

Summary of helping environment and youth spaces

This sub-category presented findings regarding the impact that the environment has on mental health support, especially regarding how stigma is maintained, and privacy managed. Young people dislike clinical environments and feel more comfortable in community or public spaces, especially when there is opportunity for rapport building. School presents opportunities for rapport building and intervention while youth services were found to provide opportunities for respite, recreation, and community building.

5.5.5. Summary of category 3

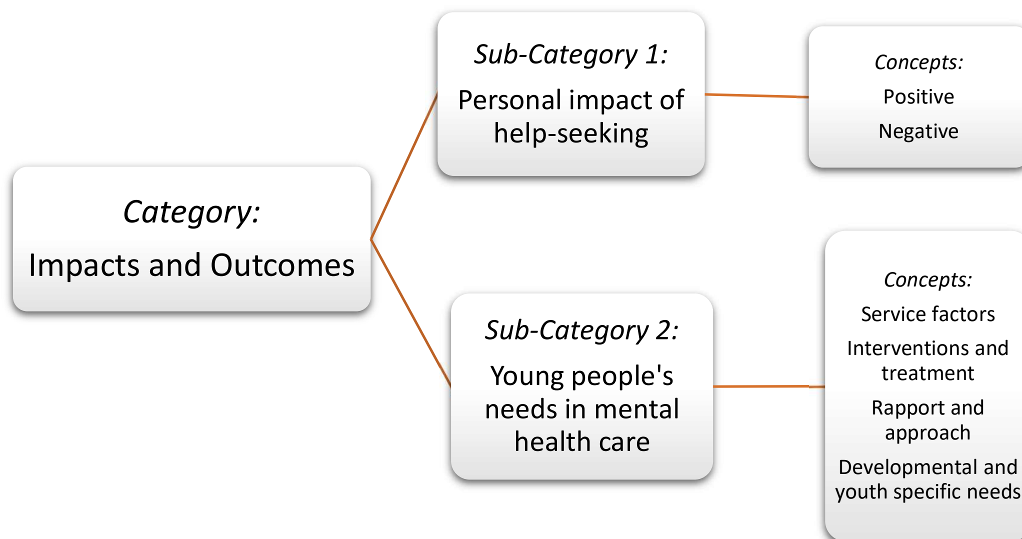
This category *the help* presents important findings regarding participants individual experiences help-seeking. Findings show that access is difficult, and young people were often

placed on waiting lists, with some not accessing support at all. Young people were rarely included in treatment planning, and choice and collaboration in mental health care was associated with private counselling and more likely in emerging adulthood. Findings also showed that offers of help received could be conditional, time-bound, and engagement was dependent on the characteristics and approach of the helper. All agreed on the essential role of the helping relationship and how different environments could impact feeling supported. Exploring these central experiences of mental health care is critical in understanding how participants were impacted by services and what their core needs are in mental health care.

5.6. Category 4: Impacts and Outcomes

This final category of Part A presents findings regarding participants reflections on how their lives were impacted by their experiences of help. This category presents findings on the *personal impact of help-seeking* and what participants, as experienced service-users, stated were their *core needs* in mental health care (**Figure 20**).

Figure 20: Impacts and Outcomes



5.6.1. Personal impact of help-seeking

Participants discussed their journeys through services for a mental health problems and the outcome of that experience. This sub-category explores how a help-seeking episode impacted their lives, considering *positive* and *negative* effects.

Positive impact

Participants described the search for help as being rooted in a need to feel connected and heard and finding a helper who would listen:

"It's not like my problems were solved, disappeared but at least… I have some to talk to" – ***James***

Many participants described a reduction in distress:

"*I just started settling into my body again and not feeling disgusting or anything and it stopped me having panic attacks"* – ***Laura***

The feeling of receiving genuine care could be profound:

"… there's no words to put down how much that woman helped me" – ***Rachel***

Important positive outcomes also included increased self-worth, confidence, self-efficacy and self-image and a reclamation of power over life:

"I just did not care anymore, like fuck it, go cry, I'm not going to cry over it" – ***Laura***

Joseph described his desire to take personal action: *"I wouldn't have been able to do it if not for what happened to my friend giving me the courage to just speak up, fuck that, this isn't the way we need to be"* and how he used social media to openly discuss and share resources to tackle stigma and taboo of mental health: *"I started blogging and I have my own Instagram page with the aim of showing that regardless of struggle and regardless of the bad services there is things out there that can help you".*

Through positive and non-stigmatising experiences of help, Andrew described new meaning for mental health: *"I don't think anybody should be afraid about speaking about the mental health".*

Some participants described increased self-knowledge, and the processes of learning to *"understand triggers"* and trying new skills:

"…if that like vicious internal monologue ever starts coming back, I know what it is, and I know where it's coming from and how to deal with it if I need to" – ***Liam***

Many participants experienced personal growth: *"I completely changed"* – ***Laura***

Helpers who modelled and fostered trust assisted participants to repair and build trust in their personal lives:

"…that only comes from the fear going away… I trust people way, way easier now and I think that was part of it" – ***Thomas***

Some participants described feeling grateful, fated or fortunate to receive helpful support:

"I am I was extremely lucky, I think… I don't know how my experience would have been if I had someone completely different…" – ***Rachel***

Positive outcomes were described by participants as powerful and encouraged them to seek help again, reporting increased quality of life and better social connections.

Negative impact

Most participants described the impact that unhelpful or inappropriate treatment had on their life. Some impacts were short-term, others had lasting effects. After long waits for help, participants experienced confusion or disappointment:

"And I was just thinking what am I doing here? – ***Laura***

A few participants described experiences of being stereotyped or stigmatised:

"… if you're female it's seen that, well you're just a teenager you're being a drama queen, so your emotions are just all over the place, it's puberty, that's the end of that." – ***Aine***

Many participants described experiences that left them feeling uncared for:

"How can it make you feel? Like shite. You know like, like they don't give a fuck. Sorry about the language" – ***Joseph***

Aine described how when professionals did not model care it increased feelings of worthlessness: *"why should I care if they don't care?... it makes no odds if I do commit suicide"*.

Abrupt endings to treatment triggered feelings of abandonment and rejection:

"Just felt like she was cutting me off as if I was nobody" – ***Erin***

Repeated rejection triggered anger for a few participants:

"That was the point where I was fuming, I was absolutely ready to kill people" ***– Aine***

Others experienced blame for not getting "better" in time and Rachel described guilt and self-blame for developing positive relationships with her helpers: *"I know I shouldn't have became attached to them and become dependent on that service".*

Joseph felt judged: *"… and for that there to tell me who I should, who I'm meant to be?"*

Niamh felt patronised: *"we had so many rules and things we had to follow….and if you're a bit late you would get an eating"*.

Aine felt punished for not feeling well and missing appointments as well as shamed for self-harming: *"I technically got kicked out for self-harming in front of two other patients. So the reason they sent me there is the reason I got kicked out*

Erin experienced counselling as *"alienating at times".*

A few participants discussed regret at disclosures:

"You shouldn't have told them" – ***Aine***

Rachel described how being on medication damaged her self-image: *"…what it felt like? there is something wrong with me and I need this to feel better…I was on Prozac… and it was like she was feeding a sick person".*

Erin also discussed how inappropriate interventions contributed to the eroding of her self-image: *"…they are the person that is trained in this and the experience and all the knowledge … I feel like, if it's not helping me at all, then I feel like the problem is with me".*

Aine was disappointed by repeated inappropriate treatments: *"… because I wasn't given the help I needed at 8 that by the time I got to 15 I had got ten times worse and by 16 I had given up on the mental health services by then."*

Unhelpful services or helpers increased distrust in services:

"I think what they want to do, if they do get in there, is put drugs in you and let sit and look at the walls" – ***Joseph***

Many participants described how public healthcare left them feeling like a burden within an overcrowded system:

"…just trying to get as many people in and out as possible, diagnose them and push them on, but that was my thinking behind it at the time" – ***Cathy***

This could cause feelings of being objectified or dehumanised:
"Like you're just invisible and like it's also as if you're just a number to them" – ***Aine***

Or feelings of violation at having your life history in a file with someone you do not know:

"It was almost like I was going to this lady who knew everything about me, and I hadn't even said a word" – ***Rachel***

Assessments and approach of helper could exacerbate negative feelings:

"… this person had a clipboard and was ticking boxes and that just made me feel worse…" – ***Cathy***

Rachel felt scrutinised and mistrusted by helpers: *"it's like they are so sceptical of everything that comes out of your mouth, and they are so observant of how you act and eye contact and everything… what you say if you stutter, if you're shaking, everything".*

Some participants described how their experience of help exacerbated their mental health distress and some were left feeling helpless:

"Maybe I can't be helped" – ***Erin***

Aine described feeling hopeless: *"if you are suicidal… what is the point of me not doing it, because it's not like as if I'm going to get help".*

Summary of personal impact of help-seeking

This study found that young people experience a range of positive and negative effects as a direct result of help-seeking. Positive experiences of feeling listened to and helped were powerful and unhelpful experiences caused or triggered intense emotions including hopelessness and suicidality.

5.6.2. Young people's needs in mental health care

This last sub-category, within the final category of Part A, presents findings that are central to the aim of this research, to identify the key elements participants needed when help-seeking to services for a mental health problem (see **Table 5**). This sub-category explores needs from a *service, approach and rapport, interventions,* and a discussion on *developmental* needs.

Table 5: Young people's needs in mental health care

Service	Approach & Rapport	Interventions	Developmental
Welcoming staff and reassurance of help	Safe, approachable, and friendly	Individualised face to face support	Services for 12-25 years
Information and expectation setting	Opportunities for trust building	Developmentally appropriate interventions	Longer-term access and support
Direct access and timely response	Confidentiality and privacy protected	Flexible, adaptable, and creative methodologies	Opportunity to develop conceptualisation of mental health
Appropriate assessments	Collaboration and planning	Self-management spaces	Opportunities for rapport development prior to healthcare
Inter-agency and multi-disciplinary service	Non-judgemental and empathetic support	Consistent care	Support and guidance with other life concerns
Voluntary participation	Appropriate professional boundaries	Respite	Age-appropriate expectations for service use
Flexible service times	Relatable and understanding helpers	Culturally appropriate interventions	Ad-hoc, routine and crisis support as needed
Policy that supports interventions	Genuine care	Positive attention	Support with psychopharmacological interventions
Option of helper	Appropriately trained and experienced helpers	Opportunities for community	Scaffolded learning with formal help-seeking skills

Service factors

Participants described aspects of service provision that facilitated them to attend. Receiving positive regard and being welcomed by staff could alleviate fears and anxieties about accessing help:

"…friendly people is huge, someone to be friendly to you when you walk in a door can change your day" – ***Cathy***

Most participants needed staff to provide them with information about the service:

"Maybe make it a bit easier for people … it's not always easy to understand what services are, need a better sense of clarification around what the services provides" – ***FG Enda***

All participants needed information on different helper's roles and limitations:

"Education on their roles and why they're there are those are why they're important, how they can help, that's the most important, how they can help" – ***Thomas***

Participants needed empathy and sensitivity during assessments:

"Have a conversation, assess them without them knowing they're being assessed" – ***Cathy***

Many participants stated their need to choose a helper to ensure compatibility:

"You should be able to decide who you want to see" – ***Aine***

Meeting the same helper at each session was a core need for participants:

"Like how can somebody get better if they see a different person every week?... where is the progression, where is the hope, where is the path forward?" – ***Joseph***

Participants stated that they were already highly distressed when they asked for help and so required a timely response:

"If they're in crisis and you're like all like "wait a week", feeling like this? I might not be here in a week" – ***Laura***

And some required an immediate response:

"there's quite a lot of young people that like, it's bad, they just desperately need help right then and there" – ***Laura***

When young people were put on waiting lists or were referred elsewhere, participants needed services to provide *"reassurance that you're going to be helped"* – ***Claire***

Participants described their need for appropriate scheduling of appointments, especially in the evenings:

"I only wake up around this time [interview is taking place after school]" – ***Richard***

Young people who experienced state care described needing out of hours support:

"She would say any time you need me just call me and I'll come down" – ***Rachel***

Participants described their need for appropriate, calming, and private helping spaces:

"She had a lovely wee art room with all these pictures and sculptures, it was such a nice thing" – ***FG Josie***

Some participants in small communities needed access to services that ensure privacy:

"…I have to go somewhere else outside of where my dad works like" – ***Claire***

Participants described needing flexibility around where their support took place:

"It could've been in the youth centre, or we could've in a café somewhere, or we went to a park" – ***Aine***

For some young people with experiences of asylum seeking, immigration or state care, trust was connected to the environment, and they needed access to familiar community-based and non-clinical settings:

"…if it's an environment that you trust, if it's a positive environment, if you always go there, if they have helped you with problems before" – ***Andrew***

Aine stated that young people identifying as LGBTI+, need explicit advertising of acceptance, such as the placement of posters in receptions and waiting areas: ***"****if they have nothing up my answer is gonna be 'well I'm not telling you!'"*

Richard described how a multi-functional environment, such as a drop-in centre, helped him manage stigma and discomfort: *"I wouldn't have it mental health specific, well the whole basis and grounds of it would be mental health, but it would be somewhere like this"*

Participants discussed their needs regarding service factors and how this can affect engagement in interventions and treatment.

Interventions and treatment

Different participants described needing different types of interventions at different times. All participants needed one to one support. Rachel described how a weekly appointment, without

pressure to talk, provided her with a "safe space" to gradually build trust: *"… and I wouldn't even have to say anything at all, and I gradually obviously became comfortable".*

Clear boundaries around confidentiality needed to be established from the beginning of an intervention:

"… you need to make sure that the young person is 100 percent on board with confidentiality and that the person they are talking to is on board" – ***Claire***

Aine stated that helpers need to check or manage child protection concerns and inter-agency work in an appropriate way: *"…it wasn't a case of okay so mental health's already involved, social workers already involved, so I'll just ring them and tell them you've said blah de blah and see you later".*

Time for trust-building was a core need for participants in their mental health care:

"The main issue that because people need time to open up to gain trust to feel like they can connect with the person they talk to" – ***Rachel***

Consistency with a supportive and trusting helper, for as long as needed, was the intervention young people in care described needing most:

"It was all about consistency, because I knew I had an appointment like every Wednesday, it was every Wednesday for years and years and years" – ***Rachel***

For participants who had little or no social supports, a single helper in a service could not meet all their needs, they needed to be connected with multiple helpers and opportunities to build a support network:

"I know if I rang [school counsellor] and said 'oh my god what? I do' she would be there, and obviously Mary is always there she still messages me, even if I came here to the youth service, I know I would be supported no matter what" – ***Rachel***

Cathy discussed the need for artistic or creative interventions as an option for young people: *"I would always encourage artistic activities to be done with in mental health"* and emphasised how respite from distress through other activities, alongside support, is important: *"…getting them into activities that take them away from what's going on".*

Robert described his need for time to learn how to be in a supportive relationship: *"I was just able to take my time … that was really important because you know some people find it hard to maybe express their feelings, they don't know how to do it, what to do"*.

Participants in later adolescence or emerging adulthood, stated needing structured interventions to learn skills and strategies for self-management:

"Sometimes you do need to learn how to live" – ***Laura***

Some participants described how being provided with space and time for self-management in school was the intervention they needed:

"It was positive for me definitely" – ***FG Josie***

Erin stated that helpers need to manage timing in appointments respectfully: *"… I would say try to be sensitive… and not try to come across like pushing people out the door at the end of the session"*.

When participants were asked what they ultimately needed when they were distressed, the two interventions that all participants valued, above all other approaches, techniques, and therapies, were listening and offloading:

"Just listen. That would have been problem solved… just sit down and ***actually listen****" –* ***Aine***

"I just needed someone to listen" – ***Rachel***

"Just to listen more than anything" – ***Cathy***

"I think that was the real thing that I needed; I don't think it was the technique" – ***Claire***

"I needed him to listen and am try to understand" – ***Thomas***

Most participants described needing to offload distress and be heard:

"I just needed the release of just being able to say all these things" – ***Liam***

"I just wanted someone, I wanted to tell someone without them squirming away from the conversation" – ***Laura***

"I just felt like I need someone to know" – ***James***

"I already had a shit ton on my brain, it was just talking to someone" – ***Claire***

"I just needed someone to chat to, really and just say what's been going on" – ***Robert***

Some participants needed to offload during a crisis:

"It was just having someone listen to me… that was all I wanted her to do, I just wanted to talk – ***Gerard***

Participants described needing to hear their problems said out loud:

"You do just need to get these things out, and like the act of seeing things out loud I think really helps" – ***Liam***

Regular offloading in of itself was often enough to manage distress:
"It is good to just let it out because once you let it out, you just feel so much better" – ***Andrew***
"It was like, so you don't bottle things up, like [youth worker] she just let me rant [laughs]… but she let me complain so that's what I need" – ***FG Josie***

"once I got everything out I felt fine" – ***Rachel***

Participants discussed their needs for interventions and treatments on an individual basis and how their ability to engage in treatment was affected by their rapport with and approach of their helper.

Rapport and approach

Many participants need to feel emotionally safe with a helper:
"Something as simple as I'll make you a cup of tea, straight away you get a comfortable feeling" – ***Cathy***

Participants described needing a helper who could communicate well and appropriately:

"The person has to be very comfortable they have to be able to have a good conversation with them … somebody who isn't uptight, somebody isn't like scientifically smart about psychology" – ***Claire***

Participants needed helpers to inquire, from the outset, about their well-being and their needs for mental health care and then collaboratively devise a care plan:

"So, you like the layout of this plan? do you think this will work for you? do you know what you need? and if you don't that's okay, um, there are other counsellors in the service that may do it this way or different ways" – ***Erin***

Participants needed the helping relationship to feel like a partnership:

"I would describe the relationship between therapist and patient is like being a relationship between two partners" – ***Joseph***

Participants described needing to assess a helper before disclosing to them:

"The young person has to learn the person that they're with and analyse what they are like, what do they like? how are they with them? are they comfortable in my presence? that's very important" – ***Rachel***

Aine stated needing open, honest, and transparent helpers: *"teenagers can tell when someone's bullshitting them… so I knew she wasn't bullshitting, so that's probably the most important".*

All participants stated the need for a person-centred approach:

"It was my decision so what we discussed, and when we met, if we met, it was always because I wanted to" – ***Aine***

Participants also needed a flexible approach:

"For some people talking therapy doesn't work or it might work one week and not the other" – ***Aine***

An informal approach was preferred:

"You called your doctor by their first name and you called your nurse by their first name" – ***Robert***

All attendance and participation with a service needed to be voluntary. Participants needed to have their autonomy appropriately supported to make informed decisions, from the beginning of help-seeking to participation in a service:

"Forcing somebody to talk when they don't want to is actually more detrimental to their mental health" – ***Aine***

Aine needed her helper to support her autonomy and respect her choices, and stated how this was part of trust-building: *"I trust you to be mature enough to know".*

Some participants needed an established rapport before engaging in support, while others stated that working with a stranger was acceptable if the helper prioritised rapport building:

"…like I know a bit about you now, I know you like cats! little bit of context about that person to talk to" – ***Claire***

All participants said they needed a good rapport, centred on trust, to engage with counselling: *"if there is no relationship between you and the other person, then the method of counselling is not going to work"* – ***Joseph***

All participants needed varying lengths of time to establish trust, including when participants met and what they wanted to talk about:

"Choosing whether you want to even speak about something is more important than choosing what type of therapy you want" – ***Aine***

Trust was connected to time and duration of relationship and young people in care needed extra time for trust-building:

"Um, it took me a very, very long time to open up to Mary. A very long time." – ***Rachel***

Participants who had previous experiences of trust being broken by adults needed a commitment of support from a helper for the long-term:

"I will help you through every process that you are going through" – ***Cathy***

For many, a supportive and trusting rapport, was the intervention they needed:

"I needed, like this foundation level of 'you're not a horrible human being and everybody doesn't hate you and you deserve to live' and then I can get to writing things in books" – ***Erin***

Participants needed to feel genuinely cared for:

"If they're genuinely aren't interested in your well-being, it's not going to work" – ***FG Aine***

Aine described a long-term and caring relationships with a youth worker from ages 17 to 25 years as the intervention she needed: *"…you know especially after so many years she's not doing it because it's her job, she's doing it because she actually cares about me"*.

Some participants stated that they needed helpers to check-in, provide after-care, follow up after referring on, and ensure that they were receiving the right support:

CI: *How did you know she cared?*

Aine: *"Because she followed up – pretty much [laughs]"*

Many participants described getting "better" and how they needed a helper who took time to get to know them:

"How do you expect someone to get better or to help them if you don't know them? If you don't actually care for somebody, how can you help them?" – ***Rachel***

For some participants, they needed a "real" feeling rapport:

"Just needing… wanting to be wanted in that room, and not feel like I was a burden, I felt like I was a burden in every other aspect of my life" – ***Erin***

Some participants wanted to be liked:

"She actually liked me as a person you know [laughs]" – ***Rachel***

Many needed some attention:

"Because you do need a bit of attention at the time" – ***Laura***

Richard described needing connection, acceptance and community from helpers: *"really down to earth and not stuck-up, just really real people that sit down and chat to you and take time out of their day to ensure you're okay, everyone wants to feel like they matter… if you walk in here and somebody remembers your name… and have a conversation with you, it's huge, in fact it's helped me it's helped hundreds of people".*

Joseph needed a compassionate rapport: *"caring and compassion are basic human, basic human qualities and it should be especially inbuilt, especially with people working in a mental health service".*

Liam described feeling vulnerable and his needs for emotional warmth and empathy from his helper*: "it's a very kind of personal thing and the relationship… is going to have an impact on you …. just really warm, really friendly and made it very easy to just".*

Participants did not need sympathy:

"…looking down feeling sorry for you manner, but understanding that you need to sort out some shit up here" – ***Laura***

They did not need to be patronised or dismissed:

"I didn't want it normalised what I was going through, at the time, I didn't want someone to say aww it's just a phase and you'll grow out of it you'll be fine" – ***Cathy***

Nor stereotyped or othered:

"Especially my generation where everybody's there's so much like bullshit, excuse my language, like going on, not everybody's trying to be an idiot…just take it serious" – ***Thomas***

Participants described needing relatable helpers:

"The one counsellor I had, that I clicked with, had been through something" – ***Joseph***

All participants needed non-judgemental helpers who can manage their own distress:

"Give me a way where I can get it out without worrying about your reaction" – ***Laura***

All participants needed to feel understood:

"I need someone to be there to understand what I'm going through" – ***Claire***

Some participants needed a helper who could see how mental health can affect an individual's ability to attend appointments: *"It really doesn't work, sometimes you're too sick to see people and you're like I can't deal with talking to you… I'm too depressed and too tired and there's no point, I just don't want to do anything today" –* ***Aine***

Participants needed to feel respected, validated, and that their distress was taken seriously:

"At the start I needed her to tell me I am not crazy" – ***Claire***

LGBTI+ youth needed demonstrations of acceptance:

"I think they needed someone to really genuinely understand and just accept me the way I am, and I just got that straight away" – ***James***

All participants needed hope and reassurance:

"It's them counsellors that give you hope and make you feel like there is a way forward here… you need what every kid needs that struggling, you need hope" – ***Joseph***

Participants described that they needed helpers to encourage personal power:

"I needed someone to tell me ***yes*** *you can deal with it"* – ***Erin***

Participants needed an ally, especially when they were experiencing family conflict:

"To speak to someone about that, that was entirely impartial and there for me and not anyone else was what I needed at the time" – ***Gerard***

Some participants needed support with romantic relationships:

"I needed someone to be on my side ... I needed someone to tell me that you're not making it up in your head" – ***Claire***

Professionalism was important to participants which included clear boundaries, even for participants who needed a more 'real' feeling rapport:

"…not like crying because you're leaving them relationship…something like that like I know a bit about you know… so it easier for me to open up and talk to you" – ***Claire***

Some participants wanted a helper to assist them in getting access to the right help:
"it's nothing personal but I might actually benefit from going to someone else, who has a different style of different whatever" – ***Erin***

A couple of participants from African backgrounds stated that they had extra needs:

"I don't like talking about like, as if Africans are different, but it is different" – ***Thomas***

Participants from refugee and African backgrounds would not use formal services, needing community networks and established relationships to support their mental health, which were found in schools and youth services:

"They have to build relationships first… so for a young African, it would be environments where they can build relationships… I feel like through youth services is probably the best way about it because again, an environment to build a relationship, because without, for me, I would have never [sought help]" – ***Thomas***

Thomas stated that many young people from African backgrounds who have experienced immigration or asylum seeking are likely to have other stressful or traumatic life experiences. He needed an appropriately experienced or trained helper, able to offer a trustworthy rapport, provide validation and be sensitive:

"…it's much harder, I feel like and it's because people have witnessed so many things do you know what I mean from a young age, it builds up and it's like [pauses] Nobody ever [pauses] and our parents… talk to us about it as if it's a myth"

Young people from different ethnic communities need helpers who were not racist:

"…I get that everybody does… but someone who's smart enough to like put his or their own ego aside" – ***Thomas***

Rapport and the approach of the helper was central to young people's needs in mental health care and was dependent on the helper's ability to be adaptable in understanding their developmental needs and the pressures they were experiencing.

Development and youth specific needs

Participants reflected on the rapid changes in different aspects of their development that they experienced throughout their youth. Needs were different, at different stages, across this developmental phase:

"you're not the same person that you are at 16 and 20, or even 10 or even at seven, whenever it first started… so you have different needs and somebody at 20 could have the same needs as somebody at 16" – ***Cathy***

All participants described the ages 12-25 years as a challenging time:

"Teenagers are complicated [with emphasis] and add in mental health, and that's adding a whole other new universe of complications [with emphasis]" – ***Aine***

Many participants explained how distress from childhood became worse with time. No participant described growing *out* of their distress but growing and changing *with* their distress:

"All the stuff you have been experiencing since you were a child comes to another level of understanding" – ***Erin***

Participants described how problems ebbed and flowed, manifesting in different ways throughout adolescence. Claire described how through offloading space could be made to return to social and sexual development: *"I was sort of like okay, but I wasn't at the same time, I was going through that stage where I thought - I look amazing, my bum looks big, all the boys want to kiss me!".*

Some participants described adolescence as a lonely time:

"…I just remember feeling like just alone like. I'd be in a class full of people but I just felt alone" – ***Thomas***

Rachel described times where she was unable to communicate her needs because of her age: *"which was really difficult"* and Claire discussed how because of her age, she needed help learning about distress and developing self-awareness: *"I kind of knew it but didn't, I just needed someone to help me to open up and realise what was going on with me",* especially in late childhood and early adolescence: *"I'd say I was kind of like depressed like fourth, fifth and sixth without knowing it".*

Throughout adolescence participants needed more education and guidance:

"If you don't know you have a problem, you'll never try to fix it" – ***Thomas***

Liam stated that aspects of mental health education could be irrelevant to children and young people: *"teenagers should be given some kind of training in it but yeah, like I said it would probably help recognise what my mind was doing at the time… if I was younger … I would have just ignored it"* until they need to learn strategies and skills when they were relevant: *"you're going to need to figure out how those tools work for yourself".*

Many participants talked about specific differences between adolescence and emerging adulthood:

"I was pretty much the same person I was at 18 that I was at 16 but I was a completely different person at 21 and a completely different person at 25" – ***Liam***

Many participants stated that 18 years of age was a "*crucial life stage*", an important legal transition point, and a time for major life decisions. Participants discussed adult expectations in Irish culture, for young people to achieve academically, and become independent around 18 years of age:

"How do I navigate this while also having mental health issues?" – ***Aine***

Some participants described this as a stressful and pressurised pathway which requires support networks. Rachel discussed her feelings of failure and stigma for taking a different path: *"it is extremely hard for young people because everyone has this idea that young people have to go into school, have a nice family, get their leaving cert, go to like university, get a good job, have a nice house, have a nice family… this is the way you have to do it and if you don't, then you are a lost cause"*

Many participants described needing their mental health care to incorporate mental health education, relationship guidance and general life support:

> ***A:*** *you are expected to have your life together too young*
>
> ***JS:*** *there's just too much pressure on young people*
>
> ***CI****: … what recommendations do you have for those services in supporting young people?*
>
> ***JS:*** *just making it clear that there is other options*

For participants who transitioned to university, the experience was intense, and they needed support:

"…I was coming out of teenage years and I was like oh [overwhelmed] what is this new world? So, they just wanted to unburden everything that was going on" – ***Cathy***

Liam described the impact of leaving home:
"At 16 it'll be okay, but when you are older like 18, 19, like you're first trying to find your feet in the world, am, you don't necessarily have the support base that you had for like all the years up to that, it can be rather overwhelming".

Many participants needed to improve self-management strategies in line with autonomy and developmental needs:

"I needed someone to help, to support me in getting better myself" – ***Erin***

This age, 18, also represented a divide in public mental health services. For participants, children's services were often patronising for adolescents and moving to an adult bracket at 18 was not always developmentally appropriate:

"… cutting off the care at 18, moving you into a different bracket? That's not a good idea because you are not a fully formed person yet and your brain is still developing, like – huge, different changes, in like your emotional well-being" – ***Aine***

Some participants stated the need for services to address this:

"I think adolescents should be separate totally from children's mental health service and adult mental health service – being a teenager is totally different" – ***Aine***

Participants needed longer term support, accessible throughout adolescence, and that continued with them throughout the developmental phase:

"If the same services and the availability that was there when you were younger is still there, I think it would have a much bigger impact … we had a drop-in centre you could go speak to people when you needed to… the relationship that you may have necessarily built up with those people… I think it's like a continuity from like the late teenage, early adulthood years would be preferable" – ***Liam***

This was crucial for participants who experienced state care, who needed proxy family style relationships from professionals to provide connection, comfort, and care. Being in state care during childhood and adolescence is a unique and profound life-stage experience that does not occur in adulthood:

"She was the only person, like when I talk about her I literally, it touches my soul … no one in my life has helped me that much" – ***Rachel***

Claire described using multiple services with unsuccessful shorter-term interventions: *"mummy said 'maybe you need something long-term' and I thought oh my God, and everything just kind of clicked…"*

Participants living in a family that experienced conflict or abuse needed their adult helper to provide support, safety, and perspective:

"I wanted someone to say what your dad is doing is wrong, and it is okay to feel like it's wrong, and there's nothing wrong with you" – ***Erin***

All participants described medication, specifically without talking therapies or life skills support as inappropriate:

"I don't think any 14-year-old should be automatically put on an antidepressant" – ***Aine***

Some participants believed that adults were more experienced in life and better equipped for help-seeking. Liam discussed needing life experience to increase self-awareness and to engage in CBT, and that this can be harder to get in earlier adolescence: *"it gives you the tools to deal with it and they try to teach you how to do that, but I do think that you do need some amount of life experience".*

Some participants described feeling very vulnerable, sensitive, protective, and defensive in their early teenage years:

"When you are that vulnerable and you feel like you hate yourself, you're looking around for other people to hate you or for other people to think negatively towards you… you are looking for signs of you being a burden … be aware that young people can be so fragile" – ***Erin***

For some participants, their distress related to their caregiver and so the gender of the helper became a need in support:

"Whereas daddy and that man were both men and automatically I'm kind of like closing up because I don't want to open up to another man" – ***Claire***

Some participants, because of negative childhood experiences with a father or male role model or gender socialisation norms, needed to talk to female helpers:

"…it's more how you've grown up and who you have spent your life with" – ***Richard***

Many participants also needed flexibility regarding the amount of time they need at an appointment and the frequency at which they engage with appointments:

"… there was times where I did disappear for months" – ***Aine***

Some participants needed consistent and predictable appointments, while others described needing enough support, as and when problems arose, to get them through a personal situation or intense support during crises:

"…there was a point where I would have to go like maybe twice a week" – ***Claire***

Younger adolescents need endings managed slowly and carefully:

"…I remember I cried when it was our last session because I almost thought of her as a friend because I was telling her all of this and then looking back, I think, I was I so naïve?" – ***Claire***

Participants described their needs as young people and the many ways that being young impacted their ability to understand and seek help for their mental health.

Summary of young people's needs in mental health care

Participants described in great detail about their core needs in services, for interventions and what they needed from their helper in terms of rapport and approach. Using real experiences and reflections, findings indicate that youth is experienced as a challenging time regardless of mental health and the specific life-stage pressures they experienced. Young people need support with expected developmental challenges in line with the distress they are experiencing. Services need to be welcoming, youth-centred and provide ad-hoc, immediate or flexible options, and interventions need to be decided in partnership within the context of a trusting and confidential rapport.

5.6.3. Summary of category 4

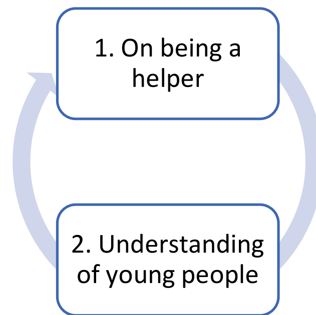
This final category, *impact and outcomes*, described findings from two categories about the effects and outcomes of help-seeking. When positive, young people felt connected and heard and were often able to return to the usual tasks of development. Negative experiences could create distrust of systems, re-traumatise young people and in some instances, contribute to hopelessness, helplessness, and suicidal pathways. Findings describe *core needs* of youth-centred mental health services that support mental health and well-being in ways that are developmentally appropriate, that prioritise rapport development and listening in a non-stigmatised manner or environment. These findings bring together critical insight into youth mental health through participants lived experiences with services and brings closure to the topic and to participants journeys of help-seeking.

Part B – Findings from practitioners

This section explores practitioner's experiences of working with young people, and their perspectives on being young and help-seeking for a mental health concern, in two categories (**Figure 21**). The first, *On being a helper*, describes participant's approach to support, their experiences with other services and their reflections on their own service. The second,

Understanding of young people, examined practitioners beliefs about young people, and the social and cultural influences they have observed as impacting their mental health. This category also describes their understanding of how young people seek help and their understanding of key needs for mental health care.

Figure 21: Experiences and perspectives of being a helper for young people



This section of the findings chapter provides further insight into young people's mental health from the perspective of the other half of the helping relationship - the helper. Participant demographics are presented in **Table 6**. Six practitioners were recruited from three spheres of helping, *pastoral care* service in a school, *youth work* service and counsellors working across *formal mental health* services. A male and female helper were recruited from each setting and included those with experience in rural and urban settings. Information has been presented in a way that protects anonymity.

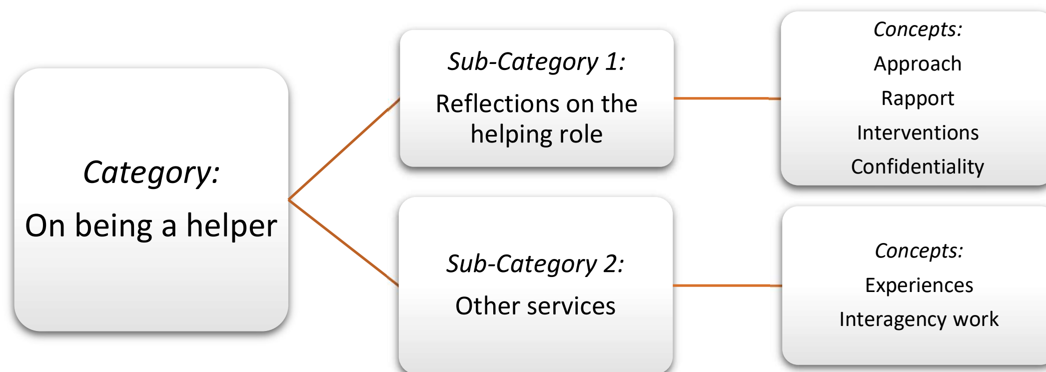
Table 6: Demographics of the professionals (N=6)

Participant	Code	Length of time in role	Formal Training	Employment Setting
Pastoral Care 1	PC1	10+ years	Teaching Guidance counselling	Secondary school
Pastoral Care 2	PC2	2 years	Teaching	Secondary school
Youth Worker 1	YW1	10+ years	Teaching Youth work	Youth service
Youth Worker 2	YW2	10+ years	Youth work	Youth service Outreach services
Counsellor 1	CS1	15+ years	Psychology Counselling	Private practice Agency work in public MHS's
Counsellor 2	CS2	5+ years	Counselling with young people	Private practice Agency work in community MHS

5.7 Category 1: On being a helper

The first category of Part B presents findings from the viewpoint of the helper (**Figure 22**). Participants were asked to reflect on their *role as a helper* in providing youth mental health support, their experiences with other services providing youth mental health support and experiences of working with and supporting young people in help-seeking to *other services*.

Figure 22: On being a helper



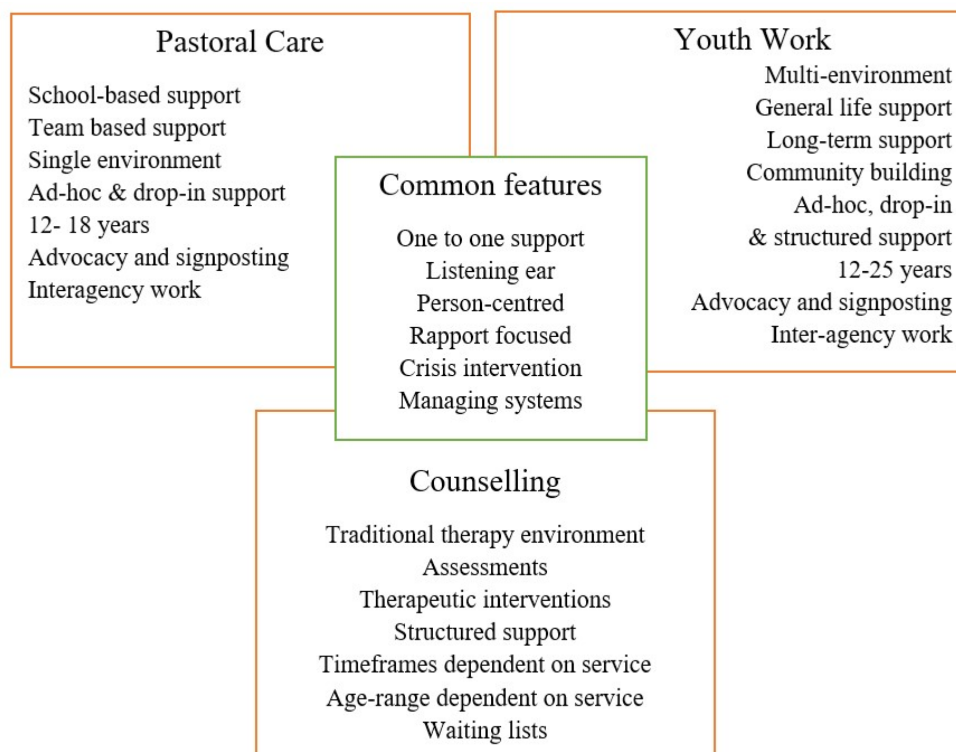
5.7.1. Reflections on the helping role

This first sub-category presents findings on how participants viewed their roles in youth mental health support, *their approach, rapport, and interventions.* This is followed by an exploration on how participants viewed their own professions, *youth work, school pastoral care* and *counselling*, and how they manage *confidentiality*. These findings are important to increase understanding of how the service impacts the individual helper and the young person who help seeks to them.

Common approaches, rapport, and interventions

All participants described the approaches they employed when helping young people and how this was connected to their professions and their services (see **Figure 23**).

Figure 23: Practitioner approaches



All participants discussed the importance of the rapport in the helping relationship and how trust was earned with time:

"I think that's something that kind of evolves" – ***CS2***

All participants valued one to one listening ear support and discussed the importance of genuine care:

*"That person will keep saying to you 'nobody cares about me, nobody cares, nobody cares' and I will be there going '**I care**'"* – ***PC2***

All participants valued inquiry:

"Taking up throwaway comments and trying to at least scratch the surface of what's going on in a young person's mind" – ***YW1***

Mental health was understood by participants as about *"well-being"* and this underpinned their support style:

"Mental health is the fundamental part of who we are" – ***YW2***

All participants stated they "loved" working with young people, with some considering it challenging but rewarding:

"I love the work, but … it's tough" – ***CS2***

Young people's problems were described as involving complex systems, such as family environment and other professional services. All participants referred to frustrations arising from the inability to remove young people from systems compounding their mental health:

"a lot of the time you can't fix things" – ***CS2***

Several participants valued experience, stating that training had not prepared them for the reality of young people's lives:

"life experience brings that to you more so than being educated about it" – ***YW1***

Most participants discussed the idea of being *"one good adult"* in a young person's life as a motivation to be a helper with some empathising from experience:

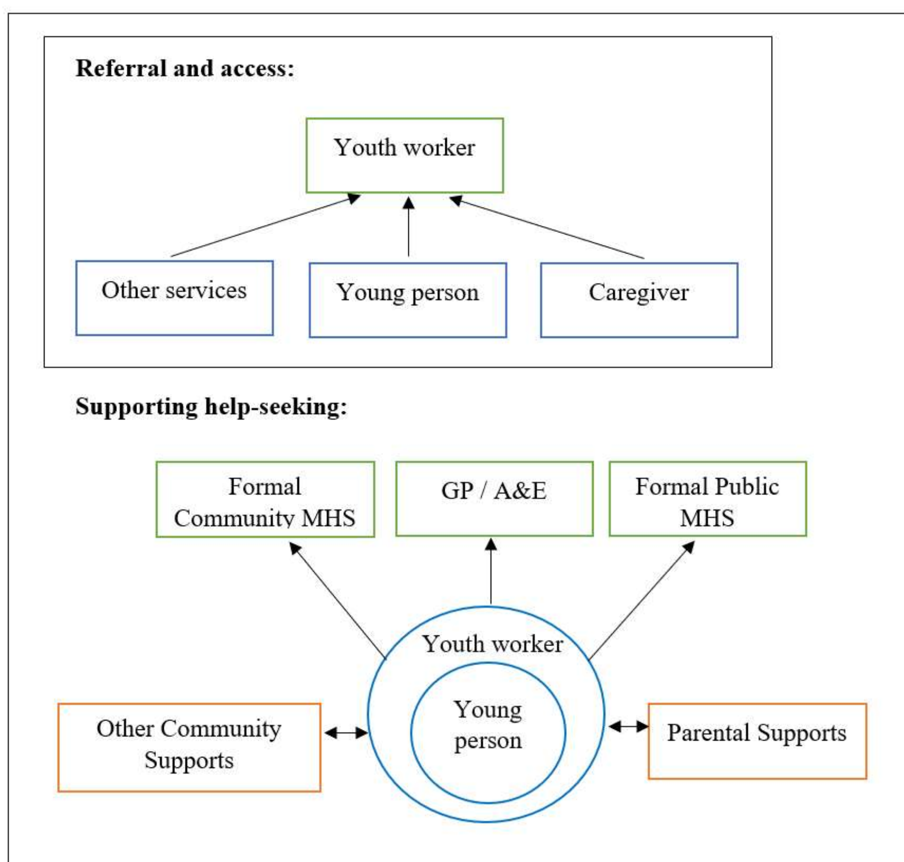
"I found the teenage years really tough myself" – ***CS2***

All participants discussed the common aspects of being a helper with each profession having distinct approaches.

Youth workers

Participants use of language positioned themselves within a young person's help-seeking pathway and their approach was described as youth-led and in partnership for as long as needed (**Figure 24**).

Figure 24: Youth worker view of youth help-seeking



Youth workers discussed their profession as 'a calling', viewing their roles in youth mental health as in the provision of long-term positive and supportive relationships with young people:

*"the majority of youth workers, go into youth work for a reason … the main part of it is around to **help** … it's to be able to to walk with a young person on their journey, to give them that confidence … and then you let them go and that's a beautiful part of our job" –* ***YW2***

Participants stated that they worked from a genuinely youth-centred approach:

"… we're [pauses] maybe an approachable environment, we're not clinical, we're not here to prescribe medication, we're here to listen, to put the young person at the centre of what's going on and be a decision maker. I don't feel that happens in every other agency" – ***YW1***

Participants described offering open access ad-hoc support in a drop-in space or regular scheduled meetings providing listening ear support, using multiple environments.

"…they can come and leave when they feel the need" – ***YW1***

While under 18-year-olds were required to provide parental consent for scheduled meetings, participants could be contacted directly via phone, text or face to face and that young people were offered support when they asked:

"…we've got a 'no doors closed' … anybody can refer here…" – ***YWI***

A youth worker described providing immediate support for young people in crisis:

"…they're the number one priority, and you would be dropping everything that's going on around you and dealing with that young person" – ***YW1***

Participants expressed pride at their free and universal, listening-ear support service:

"Youth work doesn't work like that, and yet some services won't take them but we're not in that game to say you're not welcome here at the inn, you're very much welcome at the inn, at all times, regardless of what is going on for you" – ***YW2***

This participant prioritised trust-building before interventions:

"It's about building that trust and that is the fundamental big one, am because if they have had a negative experience with a different service, they're automatically coming in not trusting you" – ***YW2***

Youth workers discussed rapport building, voluntary participation, and individual planning, using youth-led approaches, based in practical and creative strategies, which they stated helped young people build trust and communicate:

"… the young person was in painting one wall, and I was painting the other wall, back-to-back, and they told me everything" – ***YW1***

Another youth worker described supporting practical interventions:

"… it could be fear of going out on a bus, I'll go on the bus with them, or fear of going to the shop, we'll go and we'll order lunch…" – ***YW2***

Youth workers described good rapport with everyone in the young person's systems as necessary for successful interventions:

"…and not just with the young person, possible relationships with everybody in the young person's environment" – ***YW1***

Youth workers support included keeping young people safe:

"...you will have to look at different things in relation to if there is alcohol, if there is risk, sexual risk-taking behaviour, it could be online? stuff in relation to getting that attention" – ***YW2***

Participants stated their responsibility to find an approach that works and their responsibility to find external support if their approaches do not help:

"... well then it's a priority that I go and get somebody that can" – ***YW1***

Youth workers described daily work with young people as manging crises, informal education, life skills, relationship building and advocacy. One participant described their role as: *"I'm here to do what needs done",* explaining how their responsibility and capacity as a helper was embedded in how the service functioned: *"If somebody sets off the fire extinguisher, I'm not going to try and say 'it's not my job to clean that up', because if this building is not effective and working then it's my job to get it effective and working" –* ***YW1***

Youth workers discussed supporting self-esteem, and confidence building and how developing and supporting autonomy was an important intervention:

"... not dragging, not pulling, not pushing, you know ... ***asking*** *the right questions of* ***them*** *so they can come up with the right answers for themselves, would be I think something I've learned ... and knowing when's the right time" –* ***YW1***

Participants also valued working in a service that had other youth projects, such as employment or education support, that they could sign-post to internally:

"... there's so much here!" – ***YW2***

Youth workers also discussed the importance of self-education in their role concerning youth issues and expressed high regard for young people:

"I have met some of the most amazing young people in 10 years, it's just been fantastic" – ***YW2***

Feedback was important and small changes over the long-term were viewed as success:

"... a young person that I was working with maybe 9 months ago has had a bit of a relapse was telling me it's not as bad ... but feels he needs to get help now rather than let himself go

to the point where he was the last time, so that in itself is an improvement … I think that's fantastic as well, that's a good bit of self-awareness…" – ***YW1***

Participants also discussed improvements for their service, with a need for more funding and staff, better premises, further training, increased supervision, and access to professional development:

"…you constantly are like, you know, you could do more…" – ***YW2***

Youth workers described levels of youth engagement as evidence of the service being effective:

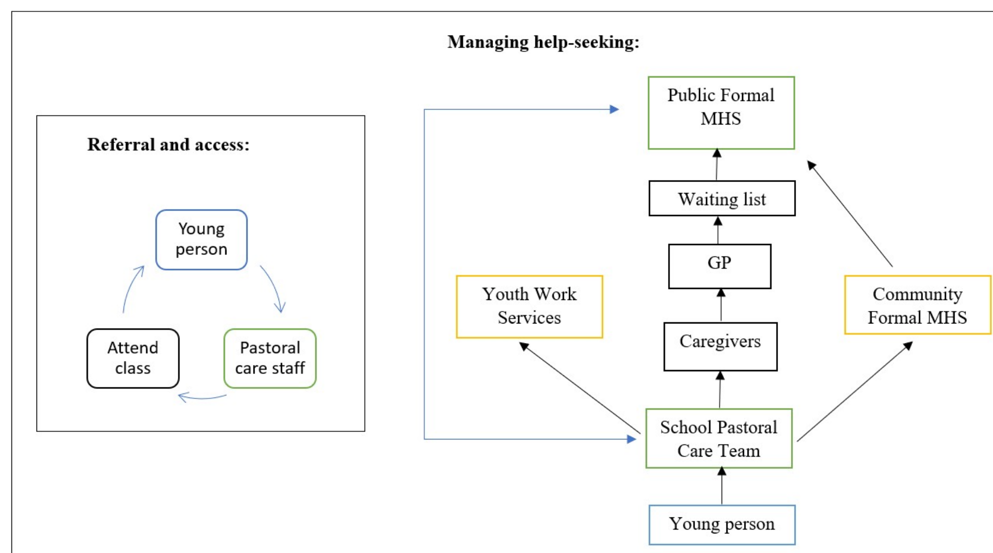
"Young people definitely vote with their feet ... there is young people here you might only have talked to once and that's okay and they get what they need out of that session and move on, but I think that the amount of young people that actually continue to avail of the service would be testimony to the service." – ***YW1***

Youth workers enjoyed working in an informal and voluntary community setting, describing their personal ethos as aligned with their service ethos, and helping young people with youth specific approaches.

Pastoral care

Participants use of language positioned themselves within a young person's help-seeking pathway but as one part of a hierarchical system (**Figure 25**).

Figure 25: Pastoral care view of youth help-seeking



The school setting was distinct as young people legally had to attend up to 16 years of age. Staff discussed the dual role of enforcing attendance while supporting young people with the stressors and anxieties that prevent them from engaging or achieving academically:

"A lot of it would be down to maybe more stress and anxiety about coming to school" – ***PC2***

Pastoral care team participants regarded their role in youth mental health as managing young people's problems, during the school day, through listening ear support, strategic problem solving, and advocacy to ensure they can maintain them in education:

"We talk about the problem … okay what kind of strategies can we put in place? and we try to put an objective or a goal or a solution…" – ***PC2***

Participants described having an "open-door" policy:

"…they all know that no matter how busy we will always find time" – ***PC1***

Pastoral care teams rarely received referrals and made referrals out to other services. In busy school settings, help-seeking was described as ad-hoc, in-between classes, after or before school or under the guise of another problem such as careers guidance, and helpers described providing timely responses:

"I would never send a kid away" – ***PC2***

Participants described an experienced and effective school pastoral care service that has inverted the type of support offered to meet demand:

"The job used to be about 90 per cent careers, 10 per cent counselling, now it's like 20 per cent 80 per cent" – ***PC2***

Participants described the challenges of working in a school system, about moving roles, and working between punitive and restorative systems, as well as trying to manage loyalties and remain neutral and objective in conflict between students and teachers:

"… I have to be loyal to the child, even if they're [the teacher] right, your kinda caught in a no man's land … you're trying to provide solutions and from that point it's a very difficult job to manage … trying to stay out of it is wile hard" – ***PC2***

One participant discussed a whole school approach where all staff observed for behaviour that was out of character:

"… our secretary … she would often phone up and say, 'look this is the second time this week this child has signed out home I don't believe they are really sick could you come and have a word with them?'" – ***PC1***

In school settings, participants provided space, time, and opportunities to offload:

"… sometimes … all it needs is tea and chocolate or like tea and company, and they are able to pick themselves up and go back to class." – ***PC1***

And providing a trauma-informed approach and managing expectations to return to class:

"*It can be difficult for child who's in a really traumatic situation to bring it up in the middle of a school day…" –* ***PC1***

Participants described crisis intervention work and regularly providing supportive interventions to students with panic attacks:

"… but are able to work their way through it just through gentle talking" – ***PC1***

Participants reflected on working in an unpredictable environment and the expectations of their roles:

"you have to be a teacher … a caregiver … a social worker, you nearly have to be a legal expert … it's very difficult" – ***PC2***

Participants described how helpers in school services are operating in a mental health pandemic *"fire-fighting"* and knowing that there may not be services ready to respond to their referral which means they have to continue managing young people with severe distress:

"We are the first line, and the first line sometimes takes the biggest hit because you see what the problem is, you are dealing with the problem, you know you can't deal with the onslaught, you go looking for help and as much as the student needs the help … ***we*** *need the help because we're not fit for purpose to deal with expertise like that." –* ***PC2***

Participants described their service as underfunded, how burn-out was factored into some pastoral care roles and not having access to supervision:

> ***CI:*** *Do you get any external supervision?*
>
> ***PC2:*** *What do you mean?*

Participants described the most important aspect of their service was that students had access to chat with someone who cares about them:

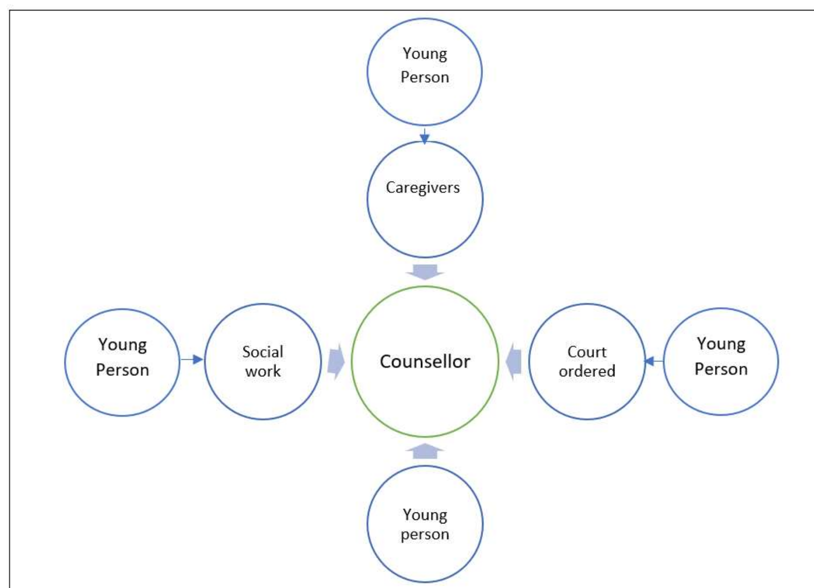
*"I would be very **proud** of about this school… I actually feel very privileged to be doing the job I'm doing and the school I'm doing it in"* – ***PC1***

Participants described an overall school ethos of care, believing their support to be effective and an important part in referring young people to the wider system of formal mental health support.

Counsellors

When counsellors described their position, their language portrayed themselves at the centre of a young person's help-seeking pathway, with young people being referred inwards to them and this is represented in **Figure 26**.

Figure 26: Counsellor view of youth help-seeking



Counsellors discussed their approaches as providing safe and positive relationships where young people could therapeutically explore the underlying reasons for their distress:

"Mirroring and modelling a positive adult relationship, so they know it's ok to be me, it's ok to express and it's not the end of the world if I don't execute my intentions" – ***CS1***

Participants described their values as prioritising their client's needs, listening and empathy:

"If somebody can look back and think, 'you know she really listened'" – ***CS2***

Counsellors' approaches included building self-awareness and providing perspective. For emerging adults, counsellors described using approaches that support exploring barriers to their developing autonomy:

"what's that all mean for you? ... your mum has dropped you off ... at the end of the session you're going to text your mum ... how does that inhibit you? ... that can be keeping someone depressed" – ***CS1***

Counsellors discussed providing interventions that helped young people understand how depression and anxiety can be connected to power, self-expression, and boundaries:

"…that is the therapy" – ***CS1***

One counsellor described an important intervention as providing understanding: *"even being able to feed that back to young people - your parents really don't get it"* – ***CS2***

With under 18s, counsellors discussed the importance of age-appropriate and helpful interventions:

"... it was called like 'group therapy by proxy' ... so that they're hearing lots of other stories of kids in similar situations" – ***CS2***

Participants worked in private practices but often took contract work in various formal MHSs across the Northwest of Ireland. Counselling could be accessed for free or through private practice and was formal and structured to 50-minute sessions with initial sessions conducting an assessment and a contract of expectations:

"…there's a contract between us which is discussed at the end of the assessment session" – ***CS1***

Private practice was described as more flexible for counsellor and client needs and how agency work in services could be stressful due to demand and service policy:

"I would feel that the service is limited because you have a 50-minute slot … and then you've got somebody else coming in 10 minutes" – ***CS2***

One participant stated that a lack of investment in public services made it difficult to meet a young person's needs: *"when you're trying to target an individual's needs, then that ought to*

be the agenda, not expecting the individual to meet the service's needs … because of that they can often feel like unheard and am often can feel disrespected" – ***CS1***

Young people over 18 years of age were described as enjoying confidentiality and privacy in adult services*:*

"… talk about alcohol and self-harming and it's my body and ' it's my self-harm' and so it's sometimes can actually be really good" – ***CS1***

Counsellors described the trust building process, sometimes it was instant and sometimes a trusting rapport was not always possible:

"I worked with a young fellow last year who was in care, and I don't think he ever fully trusted me" – ***CS2***

A counsellor described encouraging young people under 18 years to try out counselling, and encouraging voluntary participation, using the first session to let the young person assess them: *"it's giving the young person the opportunity to suss me out and for me to explain how I work"* – ***CS2***

One counsellor discussed how their ethos of voluntary participation can conflict with agency service ethos, with an example of court-ordered counselling with young people under 18:

"I've had people coming here because they have to… the [caregiver] had … told her "just have to go for the six weeks" … I said earlier that I won't work with people who don't want to be there, but like she would tell me that she was okay being there because she knew that she had to be there …" – ***CS2***

Another counsellor described the structure and format of formal counselling therapy as challenging for young people to engage in and seek help for:

"I think young people do struggle to stay …" – ***CS1***

Counsellors described support and supervision; private practice could be lonely and disconnected work while agency work meant access to a team of colleagues which was helpful and motivating:

"… even just ringing up and saying to one of your colleagues, 'can I have a chat'" – ***CS2***

Access to counselling services through the public system involved a GP referral. In all services those under 18 years of age needed caregiver consent. Young people were placed on service waiting lists with intake teams reviewing their referral, matching young people to workers, and organising appointments:

"… ah she might be good with her…" – ***CS2***

Counsellors described how those in emerging adulthood needed caregiver support for practical, logistical and financial aspects of attending therapy:

"it's getting them to identify what it is to put in place in order to turn up for a session" – ***CS1***

One participant viewed young people's difficulties with help-seeking directly as a problem with the agency policy they had worked in:

"a young person can't just present themselves… and I think that's a problem" – ***CS2***

Counsellors as formal mental health care providers valued person-centred approaches in therapy but discussed the challenges of working in different services and in managing the young person's needs and the service needs.

Managing confidentiality and autonomy

All participants were trained in child safeguarding and described different strategies for managing confidentiality in their settings. All participants agreed that confidentiality was central in the helping relationship:

"If a young person feels that you've let them down then that relationship is probably broken" – ***YW1***

One youth worker described protecting confidences of small incidences of experimental or one-off risk-taking behaviour that they did not view as harmful:

"…but if a young person is, whatever, drinking alcohol … you know if they're 17 years of age, we don't go ringing them up [parents] and telling them, nor do we if they come out as LGBT or Trans" – ***YW2***

While confidentiality was easier managed with young people over 18 years, participants described young people as uncomfortable and fearful of breaches to other professionals, especially their GP:

"it's almost like they're frightened … and some are terrified" – ***CS1***

A counsellor described explaining child protection obligations during initial conversations to those under 18 years and their caregivers: *"…so there's no kind of confusion on the part of the young person or the parents that I don't discuss content … if I did there would be no point in coming here"* – ***CS2***

This counsellor described how service policy in one agency can undermine trust and support with young people under 18's: *"Not only do they have to have a parent do the referral, a parent has to accompany them to each session … not in the session, but they have to stay in the building … they have to speak to the therapist at either the beginning or the end of each session …"* – ***CS2***

Young people can perceive these meetings as a breach of confidentiality and need lots of reassurance:

"I prefer to have as many conversations as possible in front of young people or with the young person and the parent present … and the young person's sitting in the waiting room thinking, I've just told my therapist all of this stuff …" – ***CS2***

Managing confidentiality in schools was different from other settings. Participants described having to discuss young people's situations with other staff members as they often directly affected attendance or engagement in school:

"…if they're suffering panic attacks in their class then you may, with their permission, go around to other teachers and explain … please allow him to come to the careers' office…" – ***PC1***

Participants described trying to manage confidentiality and suicidal behaviour in a school environment but how most help-seeking did not involve safe-guarding:

"there's an awful lot of stuff that they can discuss that would never, ever go home because it doesn't need to, it's just venting …" – ***PC1***

One participant described stopping young people before a disclosure to remind them of their legal obligations, and how young people can withhold information: *"They are giving you enough to go on, but you know that there is something, but they are not telling you…when they are at their wits end, they will divulge things"* – ***PC2***

Another participant described encouraging autonomy by guiding the young person to disclose distress to caregivers: *"I would often phone home and say look like, John wants to speak to you this evening"* – ***PC1***

Participants rated confidentiality as well maintained in the school and discussed how young people know, from the behaviour of other staff, if confidentiality has been broken:

"They know by people's body language what they know about them and what they don't and for students that is very important" – ***PC1***

Pastoral care participants also described safeguarding for *"self-preservation"* and to ensure they do not: *"become collusive with them in not you know in keeping secrets from their parents"* – ***PC1***

One youth worker described appropriately encouraging autonomy in help-seeking on an individual and developmental level: *"… 'I want you to come back and see me next week because I would have the gut instinct that you need to maybe talk more and open up more' and then there would be young people then I'd be saying, 'if you need to talk to me you can call me and arrange'…"* – ***YW1***

Participants discussed managing family members to encourage and support autonomy:

"…and I told them why don't you suggest that they call me?" – ***YW1***

A counsellor encouraged autonomy and voluntary participation through modelling:

"They then hopefully will, at some level, mirror their own you know autonomy and responsibility and accountability" – ***CS1***

A counsellor stated how voluntary participation was not always a reality:

"… they really don't want to be there and it's really hard work in the session" – ***CS2***

Participants described how different service policies and styles of working impacted how they managed confidentiality and autonomy.

Summary of the role of helper

Participants reflected upon their roles as helpers to young people and described what

approaches and interventions they felt were most helpful. Findings show that across different services, practitioners value voluntary participation and supporting autonomy. Participants all discussed prioritising rapports and confidentiality and discussed frustrations, not at young people, but at the complex systems that came with, or exacerbated young people's problems. Each participant's approach to mental health care was shaped by their own conceptualisation of the topic combined with the policies, ethos and practices that a particular service used.

5.7.2. Other services

This sub-category explores the helper's experiences of working with other services that offer mental health support to young people. Participants reflected on how service *resources and funding* impacted young people, the challenges of *inter-agency* work as well as their overall *experiences with services*. **Table 7** displays the terms used in this section as described by participants and are grouped together into broader terms to ensure participant anonymity.

Table 7: Service terms

	Term	**Description of services**	**Referral source**
Formal Mental Health Service (MHS)	**Formal Public MHS**	Publicly funded HSE provided mental health services including children's, adults, in-patient and community psychology	- GP - Senior social worker - Senior psychologist - Within service referral
	Formal Community MHS	Youth specific and general community-based counselling organisations and private practice	- Formal Public - MHS referral - GP referral - Self-referral - Care-giver referral

Resources and funding

All participants described the lack of funding across all MHSs which has resulted in schools and youth services providing increasingly more mental health support:

"We are you know just a band aid on a very, very big problem" – ***PC2***

Participants in school and youth work settings, providing listening ear support, described trying to sign-post, research, advocate, refer or liaise with other services to find the *"right help"* for a young person:

"... it's [listening ear] not enough, and we have students who are ***desperately,*** *waiting on the proper help…"* – ***PC2***

Some participants described *"go to"* services as the Formal Public MHS, accessed through a GP referral, and the associated protocols, hierarchies, and politics of waiting lists:

"…it's difficult to navigate ... when you get at a point where you are almost afraid for the child, they do respond" – ***PC1***

A pastoral care stated a distrust for services and interventions outside of the hierarchy: *"... you know sometimes no intervention might be best…than the wrong intervention… you never know the one that will come in that you could do so much harm"* – ***PC1***

Some participants received "*interim advice"* and described how those advocating for young people often get them accessed quicker:

"...sometimes you think it's the one who cries the loudest" – ***PC2***

One participant could influence waiting lists because of their position: *"I think they do take school seriously and they know that you don't just 'cry wolf'"* – ***PC1***

Participants discussed anger and frustration at how under-funding and under-resourcing results in a queuing system with some young people waiting up to 18 months for an appointment. Some participants described after getting appointments in Formal Public MHS's how young people still did not receive the appropriate support:

"We hear all sorts of things about students who have severe mental health needs and can't get the support" – ***PC2***

Due to long waiting lists or unavailability of services, participants discussed turning to networks and other professionals who could offer help to a young person.

Interagency work

All participants discussed interagency work and searching for supports outside the public system for young people on waiting lists:

"As an adult it's a long time, and as a teenager it's a long time but … there is other services we would use in the meantime" – ***PC1***

One participant described an increase in interagency work: *"historically they don't like working together…"* – ***YW2***

And some participants contacted other professionals for guidance and support in their work and discussed how successful interagency work was based on understanding and trust between professionals:

"… you realise you are dealing with so many agencies and you have to learn what you can say to who and what you can't say to who" – ***PC2***

A few participants described issues with interagency teamwork:

"When they work they're brilliant, when they don't work they are a chore … you sometimes resent that you even have to go in because you feel you are just being dragged to a meeting for the sake of the meeting" – ***PC2***

A youth worker described encountering conflicting definitions of confidentiality from professionals: *"[Sighs] I suppose it actually annoys me sometimes, because some services talk about confidentiality but it's not confidential because they talk within each other"* – ***YW2***

Interagency work could help participants solve problems or in some instances create more, often directly impacting young people and provided an impression of what to expect from a service.

Different experiences of services

All participants described their experiences and observations with different types of services as well as the feedback young people have provided them with. School-based participants valued youth services for providing support to young people on waiting lists as well as appropriate interventions for LGBTI+ support:

"we've had students that it's been their lifeline on so many occasions … I would go so far as to say that [youth service] completely changed the life for one of our students here" – ***PC1***

One participant discussed the dual nature of community based MHSs in rural areas:

"…they're trusted, they're valued within their community, they live in the community generally, they are the community, they know the community … 'I'm not going to go to her because she knows my mammy, my auntie, my uncle, my brother" – ***YW2***

One participant expressed beliefs that the Formal MHSs were always helpful, appropriate and experts in youth mental health *"we've never seen a child who's been disadvantaged by walking into [formal community MHS]",* despite describing 18 month waiting lists, chasing referrals and fighting to ensure young people do not "*end up in that vacuum*" of getting no help: *"I know that the service they provide is amazing when the children can access it… the mental health service I feel has made a huge difference in the lives of some of my students" –* ***PC1***

Another participant described reports of young people having harmful or inappropriate experiences in Formal MHSs; young people were objectified and problematised by practitioners: *"they were the 'subject' rather than somebody",* and unhelpful experiences of not being listened to: *"…they've been to [formal public MHS], they've been to [formal community MHS], they weren't able to help them … some of them cases I was able to manage myself and it was a listening ear exercise" –* ***YW1***

This youth worker believed part of this may have been a result of expectations not being met: *"…young people perceive that they're going to get help in a certain place and when they don't get that help, and it's because that agency might not have the capacity to deliver that help" –* ***YW1***

Other participants discussed aspects of Formal MHSs that were inappropriate or unhelpful. This included sporadic appointments with long breaks:

"… you would be lucky to have one every 2-3 months" – ***PC2***

Some participants disagreed with the ethos of formal services:

"…say they're person-centred, they're not ***real*** *person-centred" –* ***YW2***

Other participants described Formal Public MHSs as focused on medication and coming across as uncaring and clinical: *"I know a client of mine yesterday told me … that she had been at [public MHS] a week or two before … they don't even ask you 'how you are?'" –* ***CS2***

A youth worker described a focus on administration and service needs: *"…it's always secondary to the young person and the work that we do, so maybe they don't have that same kind of ethos that we do" –* ***YW2***

One participant described the difficulty young people experience getting information or access to Formal MHSs and the concerns they have regarding awareness campaigns and a lack of parallel government investment in services: *"I suppose different national campaigns … I think that they [young people] don't know where to go when they do… that's the let-down" –* ***YW2***

Formal Public MHSs are referral dependant, often through a GP, a service that is not free to all young people:

"It's a very closed-door policy" – ***YW2***

This youth worker discussed how the environment and protocols of the clinical environment of Formal Public MHSs can also be observed in Formal Community MHSs:

"… you go to a reception, and 'can I speak to', 'I have an appointment for', and you go into a room and it's very closed, it's very, very clinical" – ***YW2***

A counsellor observed inappropriate experiences of youth interventions: *"…young people, have been quite critical or let down I suppose by [formal public MHS], they haven't felt listened to or they've been thrown into group sort of counselling when they needed a one-to-one" –* ***CS1***

A youth worker described how some services have *'youth friendly'* veneers but that the procedures and approaches are still informed by clinical practice. They discussed the hyper-focus on privacy as reinforcing stigma: *"…but it is very clinical* ***again*** *… that was their whole premise to get away from that idea, but it still says on the door, 'engaged, non-engaged', a sofa and a seat and a wee tiny table with tissues on, it's the same [with emphasis]" –* ***YW2***

While attitudes were improving in Ireland towards mental health, this participant described how services and professionals maintain and perpetuate stigma through their policies and procedures and questioned whether this approach was helpful, necessary, or appropriate for modern youth mental health care: *"…we have went a wee bit forward in relation to stigma in Ireland, but then has the services come along with it?" –* ***YW2***

Many participants believed policies regarding assessment criteria for service access within Formal MHSs could be harmful to young people's mental health:

"if they go to [Formal community MHS] they are told categorically that they are almost [pauses] "too mental" for the service … or they need to be referred onto [Formal public MHS] and I think that sends out a very negative message to young people … that ***are*** *seeking help, and they're kind of panicking about their anxiety, about their depression, they hear about suicide, they don't want to go down that road, they're really nervous, and then when they're told they're* ***too severe*** *for the service, then I suppose that increases their anxiety and depression … that has a massive impact on their mental health" –* ***YW2***

This participant discussed their experiences of observing young people on waiting lists: *"… so if you do have a young person that fits the [Formal Community MHS] bill you're looking at a 3 month waiting list, their symptoms getting worse… and they have really pushed themselves to ring that phone, or walk into that service… by the time the 3 months comes they're like* ***forget it****, it's done, I'm not going to go there again… they will find something else to numb that, so alcohol, dope, drugs … I'm grand I have my crutch now… not that 'I'm not going to bother', it's 'do they care?'" –* ***YW2***

This youth worker described trying to repair trust and provide appropriate support to young people after negative experiences with services: *"if …they have tried to access different services and we get them later on, there may be some undoing of work we need to do" –* ***YW2***

All school and youth work participants expressed frustration with how referral hierarchies functioned. Many described providing mental health care for young people while waiting on appointments to MHSs, and the lack of recognition of youth workers and pastoral care helpers as providers of on-going and sometimes long-term mental health care:

> ***CI:*** *… if what you're describing is, you're basically providing care in a mental health capacity for a young person while they're waiting on their mental health care, then what's the point of them going to [Formal MHSs]?*
>
> ***YW:*** *[pauses] I don't know, that's the answer. Well, I suppose, what's the point? [long pause and stares] I don't know. And that is not being any way kind of blasé about it … I don't know. Is it a thing that we have become, not confident in what we provide? that we feel the 'professionals' need to say it? Is that what it is?*

A few participants acknowledged improvements across all Formal MHSs when compared to the 1980's and 1990's:

"…it's better than it was, although I suppose it's not ideal by any means" – ***CS2***

Many participants valued individuals within formal MHSs:

"I work with the most phenomenal workers out there, but them workers will work 13 hours a day … they'll go above and beyond… you have people that are very, very rare in that service" – ***YW2***

Participants related to other practitioners in underfunded services and stated that criticisms mostly lay with systems rather than individuals:

> ***PC:*** *No, the people are fantastic, the people are brilliant, but the system is broke, and it's, and [pauses] so is this confidential?*
>
> ***CI:*** *100 per cent*
>
> ***PC:*** *The whole HSE, from the top down is not fit for purpose…*

Participant's opinions of other services greatly depended on whether they were able to secure help for a young person and whether the support could provide support and meet a young person's needs or not.

Summary of other services

Participants experiences with other mental health services greatly varied, depending on the young person and the situation. Findings suggest that underfunding of service resources has a negative impact on youth mental health and can result in inadequate mental health care. Findings also indicate that positive interagency support can mean better outcomes for the young person involved.

5.7.3. Summary of Category 1

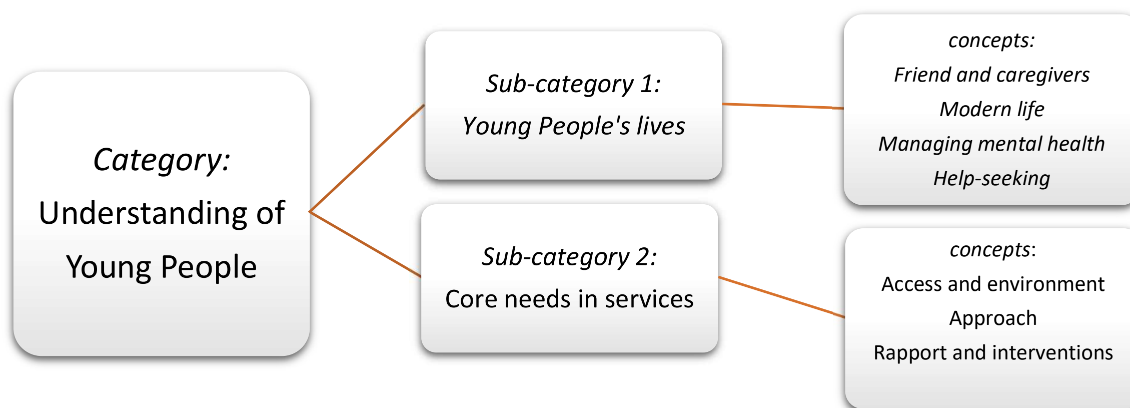
This first category presents findings from two sub-categories, 1. *Reflections on the helping role* and 2. *Other services*. Participants described the different services they worked in and how their service ethos and personal ethos shaped their approaches. Confidentiality was complicated in school settings and counsellors described service policy as impacting the development of a trusting rapport with under 18s, especially when voluntary participation could

not be guaranteed. Findings demonstrated that practitioners prioritise connection and care in the helping relationship and supporting autonomy. Practitioners described public MHSs as underfunded and problematic, with school pastoral care and youth work participants described providing mental health care but not receiving the professional acknowledgement or support for their roles. These findings provide for contrast and comparison with the findings from youth participants in providing a more dynamic understanding of young people's help-seeking experiences.

5.8. Category 2: Helper's understanding of young people

This first category presents findings from participants understanding of young people's lives. This exploration was important as to how participants viewed young people as a cultural group impacted how they helped them. This category discusses findings from two sub-categories: 1. *Young people's lives* and 2. Their *core needs in services* (**Figure 27**).

Figure 27: Understanding of Young People



5.8.1. Young people's lives

In this first sub-category, participants discussed the influence *friends and caregivers* had on young people's mental health as well as the impact of *modern life*. Participants also discussed, from their perspective, how young people *manage* distress and how they typically *help-seek*.

Friends and caregivers

All participants described young people's closest relationships as playing an important role in their mental health:

"I still think a good rapport with a responsible parent and a friend is massive" – ***PC2***

Participants discussed how friends were instrumental in help-seeking by providing information, sharing experiences, recommending help, but how young people's distress was predominantly caused by the impact of conflict, rejection and exclusion in peer relationships:

"… the fear of being left out, the fear of something being said or the fear of not being accepted" – ***PC2***

A counsellor discussed how young people often deal with mental health issues together: *"… you know there's clusters of it – they can kind of feed off each other, and … it makes it easier for people to access services"* – ***CS2***

This counsellor described how young people can create less stigmatised meaning from help: *"[young person] was going to see a therapist and am it was kind of a cool thing"* – ***CS2***

They also described witnessing young people comparing distress or how having a therapist can infer status: *"my anxiety is worse than your anxiety and that kind of thing"* – ***CS2***

All participants stated that caregivers were central to young people's help-seeking and mental health. Participants described varying degrees of caregiver involvement in helping young people seek help for their mental health:

"…we have parents who are doing their best … we have parents that …are not trying, we have parents that have no clue what they are doing, we have parents that don't care" – ***PC2***

Some participants described how pressure from modern life can cause fatigue and distract parents from their children's attentional needs:

"… you come home, you get your dinner, you get your work done … you want 'me time' and that is now going on a device" – ***PC2***

Some participants stated supporting parents with their children's needs:

"Sometimes I have to remind a parent 'you're the parent, you have to give them an hour of your time in the evening'" – ***PC2***

Young people find ways to get their need for attention met:

"But then she will go home, she will probably getting no attention, get nothing and then she comes in here, annoys everybody because that's her way of getting attention" – ***PC2***

Many participants discussed how young people's mental health was a direct response to their family and life context and expressed regret that they could not support young people because of their wider environments:

"This job just reinforces there is no bad kids, they just have bad environments or bad situations" – ***PC2***

Some caregivers were described as viewing their children's mental health problems as external to the family system and the need for family interventions to help relieve young people's distress:

"…a lot of the time it's family work that's needed" – ***CS2***

This counsellor described caregivers who do not understand self-harm which results in negative labelling and policing self-harm behaviours: *"why do you need this? and you're only looking for attention"* – ***CS2***

Caregivers could miss or ignore externalising behaviours of distress:

"The coping thing is, the big one obviously, is the drink and some parents know that it happens but turn a blind eye" – ***PC2***

One counsellor observed how living with parents in emerging adulthood, combined with relationships difficulties, can cause young people to be depressed and delay development: *"… more and more young people are living at home … so that can obviously create a lot of our mental health issues"* – ***CS1***

Some parents were described as treating them like younger adolescents, which exacerbated mental health distress: *"reinforces that powerlessness and inadequacy am that, that young people can be carrying… it affects their experience of themselves in the world"* – ***CS1***

This counsellor described how some young people needed mental health support and choose private practice due to long waiting lists. Parents often pay for therapy in these circumstances which complicates the therapeutic relationship: *"… there's a third person here somewhere! i.e. the parents"* – ***CS1***

This counsellor also observed parents attempting to ensure participation in therapy: *"some clients feel they're being policed … rather than … there's your therapy money I'll see you tonight … they're being dropped off at the doorstep it's almost like … it's being ensured that they're spending the 60 euro for the plan that they were given it for"* – ***CS1***

These dynamics can further deteriorate parent-child relationship that they are dependent on: *"…because then there's outbursts or there's reactions to that, or they become withdrawn or they overreact then in a negative way … because they know they can't bite the hand that feeds them so to speak, am so there's a real tension there for a lot of young people"* – ***CS1***

All participants noted that caregivers predominantly initiated help-seeking with services, with varying degrees of involvement once support was established. A pastoral care participant stated that it was difficult for a young person to get support without caregivers organising and advocating for them and yet how difficult this task is for adults: *"It would be few and far between that a parent has the knowledge, the contacts, the time, the understanding to do it themselves"* – ***PC2***

Most participants discussed inappropriate caregiver help-seeking behaviour and how even good intentions were unhelpful:
"… you can immediately sense how oppressed young people can feel…" – ***CS1***

One counsellor described caregivers initiating counselling as problematic: *"… we can't **send** anybody else to counselling"* – ***CS1***

This counsellor described a common experience they observed of caregivers help-seeking for their child who was in emerging adulthood: *"and very often then it's a case of, [puts on voice] 'oh well Martin's upstairs right now he'll pick the phone up, [shouts] Martin!' … that's usually how the process will go, and then Martin's on the phone, it's like that awkwardness and it's almost like poor old Martin's been shamed all over again, this stranger on the phone and, the therapist has just come into his bedroom, the place in the world that he goes to escape from everybody and it's just everything is upside down again"* – ***CS1***

Another counsellor described how caregivers dominated the appointment timeslot with their own distress or how they were unsupportive, suspicious, or sceptical of support offered and

attempted to control family information: *"I suppose there's that thing with families, what are you talking to your therapist about?" – **CS2***

This counsellor experienced young people under 18 years asking to attend counselling without their parents knowing: *"... there's a lot of young people who won't reach out because it's a family issue" – **CS2***

All participants described the importance of good rapport with caregivers and how managing caregivers was a time-consuming and frustrating part of working with young people:

*"...there's a lot of frustration about dealing with parents" – **CS2***

Participants described the central role young people's closest relationships play in their mental health as sources, contributors or supports.

Modern life

Looking at trends over time, all participants agreed that there was increased awareness, acceptance, and improvement in attitudes across society towards mental health as well as a significant recent rise in mental health problems in young people:

*"... it's like that snowball rolling down the hill it's just, nobody can put their finger on it" – **PC2***

Young people were described as affected by stigma, and some participants believed national campaigns were beneficial in some ways, with one participant querying whether they created more confusion about mental health:

*"We don't know if people are more aware, and they are all coming forward and maybe they don't need help? and they think they need help" – **PC2***

Many participants discussed the profound changes in Irish society over the previous 20 years:

*"Life has changed for everybody" – **PC2***

Some participants described judgement and noted a lack of understanding or compassion from older generations:

*"... when you hear older people 'them younger generations are soft' ... it's not given the respect or its not given the seriousness" – **PC2***

One participant did not believe young people were as good at coping as previous generations: *"…and I don't think their coping skills are as good maybe as they used to be in some cases" –* ***PC1***

Another participant believed differently: *"there's so much more pressure on young people now than there ever was before [with emphasis] and if someone gave me 5 million euro to going back to be 15 today I wouldn't take it, not on your life because it is a very, very different world than when we grew up and young people do not get the credit that they deserve because young people are phenomenally amazing" –* ***YW2***

While young people were described as both less and more isolated than previous generations by different participants, connections through technology were viewed as a new and impactful yet inescapable influence that is embedded in young people's general development:

"I think social media is a massive burden" – ***PC2***

Participants agree that young people were suffering from information overload:

"They are exposed to far too much" – ***PC2***

Participants described their role in keeping up to date with social media:

"…like even with dating, like I'm married … but …I have to understand Grinder, I'm not a gay man or gay boy but I have to understand Grinder because I want to see how this works and it's not fun at all, it's very, very dangerous" – ***YW2***

Pastoral care participants discussed trying to manage technology in schools with respect to wider societal influences and how social media has an insidious impact on young people's lives beyond school's control:

"It's huge, it's high … it's subtle it's …highly hateful … we follow it up, we try to track it but it's, it's bigger than any of us really you know" – ***PC1***

School pastoral care participants noticed a gender effect where female school attendance is impacted more by social media dynamics:

"it's filtering so much into real life…"– ***PC1***

Participants discussed the prevailing gender stereotypes around men and help-seeking as related to values of machoness and fears of being perceived as weak, and how gender expectations are embedded in wider cultural values around stoicism:

"Ireland is one of these countries ... men are macho, and women work hard, and everyone gets on with it" – ***PC2***

Most participants discussed that males and females have been socialised differently as children regarding how to manage emotions:

"The girl's brought over to her daddy and you know, 'are you okay wee pet?' but the boys? 'Get outside and cop on'" – ***YW2***

This was described as directly resulting in differing communication styles in gender-based friendships in later life:

"... like girls sitting around a table will say how they're feeling, where men will not, and maybe get upset when no one's there" – ***YW1***

Participants described how some gender behaviour expectations were relaxing and this was impacted by older male role modelling:

"We have a lot of great male role models ... I think that helps them" – ***PC1***

The pastoral care participants noted an increase in young men seeking mental health support and participants in the youth service believed help-seeking was connected to relationships:

"Now we do have a lot of men accessing our one-to-one service ... but then that's down to the relationship building within the service – ***YW2***

Participants still believed that young men are disproportionately affected by suicide and stigma and will still help-seek less than young women:

"that's very difficult to get away from that and we see that young men are way more likely to die by suicide than their am female, sisters" – ***YW2***

Participants described a profound change in how people live due to technology and globalisation, resulting in intergenerational differences and shifting social and gender roles which have impacted young people's development.

Experiences of managing mental health

Participants discussed their observations of how young people manage mental health problems. Young people were described as coping with their distress through avoidance, withdrawal, distraction, and escapism:

"… that a young person will use to recede into a world of their own" – ***YW1***

Some participants described young people engaging in risk taking behaviour, or substance use:

"The big one obviously is the drink" – ***PC2***

Self-harm was a common reported coping behaviour by many participants:

"I probably see quite a lot of self-harm" – ***CS2***

One participant described young men as coping through belonging and group identity: *"… the hair and, the hoods…"* – ***YW1***

Coping styles were described as related to young person's wider context:

"I knew it all came from the home and it all came from society" – ***PC2***

A counsellor commented on young people's lives as faster evolving than older adults and this impacts how they manage distress: *"… I mean terminologies and needs, and stressors can change very, very quickly"* – ***CS1***

Young people experience and manage anxiety, depression eating disorders, OCD, PTSD, sleeping disturbances, relationship difficulties on top of managing developmental and life-stage needs:

"…there are so many different things going on for you, 'who am I' is a big question for young people, 'where am I going', 'what is my prospects in Ireland today?'" – ***YW2***

Some young people were described as living with a lot of chaos or tension:

"it's almost like living on the edge of their seat" – ***CS1***

Managing developmental needs for autonomy and mental health for young people often resulted in waiting until distress was severe:

"…it's like they're battling ..., their fire or something, they're fire-fighting" – ***CS1***

These inner conflicts and instability can mean they use services differently:

"Much different patterns of interactions … but it's not like borderline instability it's more just like identity instability" – ***CS1***

One participant described supporting young people who required foundational self-management strategies:

"… they need extra support to be able to cope and it's a very genuine anxiety … but there is also some people … never developed any form of real resilience, any real coping methods … we just need to keep re-enforcing those" – ***PC1***

Many participants described how young people can feel like failures for discontinuing education and the pressures from growing up in a digital landscape:

"…unfortunately, because of how the world has changed in relation to social media … they are maybe getting mis-informed in relation to, you know [sighs] what life should be like …everyone is having a greater life than I am, everybody has more money than I do going on holidays, it's all fake…" – ***YW2***

A few participants believed young people were sexualised earlier than previous generations and about how technology impacts sexual development:

"…we have a massive problem with young people in the western world with their sex and porn and the imagery that they're getting in relation to sex…" – ***YW2***

Many participants described the unrealistic expectations that adults have on young people:

"I just don't think they have enough support. I don't think they are given time to grow up. I think there is far too much placed on them, they are not being allowed to be a child. They go to secondary school nearly as if someone has stolen 4 or 5 years and just expected them to go from 12 to 18 kind of thing" – ***PC2***

Young people experience differing levels of distress and have various methods for coping. Academic and social media pressures were found to add extra strains to their mental health and impact how they seek help.

How young people seek help

One counsellor described help-seeking for young people as *"quite a struggle"*. When young people directly sought help, they were usually over 18 years and preferred to get information on services via text or email: *"I would get a significant amount of enquiries from young people who never come through the door"* – ***CS1***

This counsellor stated that young people communicate differently to older adults: *"is very vague, it's like, 'when can I see you' or, 'are you free Mondays'?"* – ***CS1***

Young people can find it difficult to negotiate the logistics of therapy including how to communicate around appointments and can be avoidant of phone calls, with one participant describing endings as difficult: *"usually the way I know that is they won't turn up then for that last session"* – ***CS1***

Some young people may have to disclose to others their need for mental health support in exchange for consent or logistical support such as transport:

"I very quickly know if a client is saying … 'oh I need to find out can I get back to you" – ***CS1***

A youth worker described how thoughts and attempts at help-seeking can be interrupted for young people to protect self-image from self-stigma and that little is known about the young people who have not sought help: *"… I'm thinking of young people who didn't cope, who maybe are still at home today"* – ***YW1***

A pastoral care participant described the impact of not seeking help: *"students who I think really struggled in the worst possible way… we weren't aware of it and they weren't aware of it… it's taken them to adulthood to realise that they should've been looking for or seeking help … they could've had a very different life"* – ***PC1***

Participants also stated that mental health was a complex issue to identify and understand let alone seek help for:

"…I think that they don't know where to go, when they're feeling that…" – ***YW2***

Other participants described some young people as open and articulate about mental health and good at help-seeking, but that young people primarily search for help through relationships that can offer a likelihood of support:

"They feel more likely to ask for help of people who they know care about them" – ***YW2***

One participant described young people as often seeking help for a specific issue but needing help with multiple issues: *"they might come in with a reason, they all come in, 'I'm having anxiety'"* – ***YW2***

A counsellor described young people can be good at asking for what they need once they are supported to: *"... once they learn it's ok to ask, like they would maybe ask"* – ***CS1***

Some young people did not engage with the format of formal counselling:

"I would say probably most young people maybe come for a session or two and then actually drop out" – ***CS1***

And how symptoms of mental health can make attending therapy difficult:

"they're sleeping all day so even an afternoon appointment for them can feel like 7 in the morning" – ***CS1***

A counsellor described young people as engaging in therapy when a balanced power dynamic was established: *"the last thing I want to do is get into 'parent mode' and them to stay in 'child mode' because psychologically we're coming together to try to get out of that transaction and usually my experience then, they do come back sooner or later"* – ***CS1***

This counsellor described young people's attendance style in formal MHSs: *"I think their tendency to engage in long enough therapy"* – ***CS1***

As a result of being uncomfortable with therapy young people only seek help when absolutely necessary:

"*... when there's been a crisis then they turn up"* – ***CS1***

Young people were described as seeking help differently from adults which for some participants was challenging.

Summary of young people's lives

Findings from this first sub-category provide insight into how helper's view young people's lives, finding that the challenges of *modern life* and navigating development in technological landscapes impacts young people's mental health. *Caregivers and friends* were found as central to young people's problems in different ways and young people were described as *experiencing*

high levels of distress. The most common way young people cope was through using alcohol and self-harm. Young people have different ways of *seeking help* and different patterns of service use than what would be expected of adults in formal mental health settings and supports the need to develop youth specific mental health care.

5.8.2. Core needs in services

Participants were asked about their thoughts on the key characteristics that a youth mental health service should have based on what they would describe as young people's core needs. Participants discussed *access and the environment* and *rapport and approach* as the two key focus points for a service.

Access and environment

All participants discussed 'drop-in' facilities, with flexible times and where young people could seek support informally as important, with one counsellor describing an ideal mental health service as allowing, to some degree, access to support without parental consent or presence on-site:

"… drop-in and accessible services with somebody who will… work through what they need and how to involve or not involve parents" – ***CS2***

A youth worker stated that all mental health services should be *"universal"* and *"free of charge"* and that young people should have an opportunity to assess a service, building and helper before deciding: *"…no doors closed approach"* – ***YW1***

All participants stated that help-seeking needed to be less complicated, and that young people would be given a timely response with no waiting lists:

"It would be an open door, walk into, sit down, have a coffee and be able to chat to a person there at that moment" – ***YW2***

Participants described the need for appropriate confidentiality:

"…that there's rooms, that the conversation is not going to be heard, it's going to be confidential, it's not going to be interrupted, it's going to be comfortable – ***YW1***

Participants wanted more youth MHSs in rural areas and the use of alternative spaces:

"… rather than the traditional, you know sort of, 'you have to come to my room'" – ***CS1***

One participant elaborated on the idea of working outside of a 'room' and using different methodologies to remove mental health from a stigmatised and clinical space: *"... isn't necessarily in a room, it can be over pool, you're making coffee together, yous could be having lunch together, it's that chilled out space"* – ***YW2***

This participant emphasised the need for the creation of genuine 'youth friendly' services: *"...like* **really** *youth friendly, not tokenistic youth friendly, proper open door, walk in, what's the craic? [smiles]"* – ***YW2***

Two participants elaborated further on the idea of a non-stigmatised setting as being embedded in a multi-functional setting, where staff can provide other types of life-stage support:

"Young people could be going in for anything positive that a young person would be getting done in their life, even grant applications ... it would be maybe a multi-service building that they can also go to for mental health appointments without being stigmatised" – ***YW1***

One participant described access to a single role therapist in the school setting as important and some participants described the need for dedicated spaces in schools: *"I think it's really good for them to have a safe place maybe like that a student is just feeling really anxious at the moment in time"* – ***PC2***

A counsellor suggested that there should be flexibility in service policies supporting longer time frames for rapport building and for talking about problems - length of sessions based on individual need: *"there's nothing worse than if you're dealing with ... someone who is really struggling and in the middle of something you can't [motions to look at the time]"* – ***CS2***

Participants viewed access to services and the environment in which they were offered as important for developing a rapport and providing helping interventions.

Approach, rapport, and interventions

All participants discussed young people's need for a person-centred and trusting relationship:

"... well, your relationship is the most important [with emphasis]" – ***YW2***

Some participants described young people as needing some form of pre-existing relationship, or time for rapport building, in which helpers can provide empathy and genuine care:

"**Young people are fantastic, they know genuineness, they know people that really care about them and they can just sense it" – **YW2

Young people who have had their trust broken by adults previously need more time to build a trusting rapport:

*"… very much defensive but you know how it is, you keep at it. Like once the wall goes up its very, its quick to go up but very hard to go down and so, I think just having someone they trust" – **PC2***

Young people need individual approaches:

*"You cannot have a one approach fits all … because we're all different sizes" – **YW2***

Young people need to feel that they have an ally:

*"it's that you truly believed in them, supported them" – **YW2***

Young people need to offload and receive guidance regarding their relationships:

*"Sometimes it's just that they want to get something off their chest that they maybe don't understand that somebody's taken advantage of them, that maybe they don't understand the way of the world and they just want to be heard, just want help" – **PC2***

Clear boundaries of engagement and confidentiality are a priority for young people and need to be established from the outset:

*"I think that as people grow up… they know what to say and what not to say, but at a younger age when they're not maybe on top of that, confidentiality is paramount for them" – **YW1***

Young people need helpers who can listen:

*"90 percent of the kids would come to this door … all they want to do is chat" – **PC2***

Young people need appropriate responses for their problems and not to be referred on without interim support:

*"Whatever issue a young person brings to the table, that's their issue" – **YW1***

Participants stated young people need autonomy and voluntary participation prioritised in a welcoming environment:

“they’re engaged as a human being and made feel welcome and informed that they’re going to be the decision-maker … they’ll get to decide whether they come back again” – ***YW1***

Helpers need to limit the number of other professionals involved in their care:

“It becomes unmanageable…” – ***CS1***

Some participants believed that helpers needed to provide understanding to young people and advocate to caregivers:

“… and can see about stress and anxiety and the concerns and the pressure that young people are under” – ***PC2***

Mental health care for young people needs to both address and provide for life-stage needs, that are developmentally appropriate:

“it’s kind of encompasses everything about their well-being, whether it be about their education … social supports, going to groups, accessing … healthcare in relation to fitness or whatever it may be … it’s about being, ‘that one good adult’ in a young person’s life where they are ***the*** *centre part of that”* – ***YW2***

Services need to have capacity to provide care to all young people:

“We have all sorts of things about students who have severe mental health needs and can’t get the support” – ***PC2***

Care and attention were described as an important intervention for many young people:

“They don’t need a counselling session for 30 minutes every day or every week but what they need after that is just the realisation that … somebody just sort of cares” – ***PC1***

Service time frames need to be more flexible as young people are in a unique process of development:

“it’s not a six-week ding dong … it’s for how long it takes.” – ***YW2***

Some participants considered the suitability and relatability of helpers working with young people:

"… I'm beginning to go grey; will I be as appealing for a young person to sit down and have a conversation with when I'm totally grey? I don't know, I don't want to be ageist towards myself either" – ***YW1***

One participant addressed cultural underpinnings of help-seeking and mental health directly: *"that's a cultural thing as well, like we need to go hands on it" –* ***YW2***

Participants described the different considerations needed at different ages across youth. Early adolescence was described as a time when young people are beginning to separate from their family and beginning to start secondary school:

"I don't know at 12 or 13, I suppose as they get older, I think they just need me to be not just another adult, not a nagging parent or a nagging teacher" – ***CS2***

All adolescents need creative and appropriate approaches to support young people to understand themselves:

"Getting to, what's underneath" – ***CS2***

One participant described mid-adolescence as a time of internal conflict and a lot of stress comes from trying to meet others' expectations: *"it's them trying to fit into social norms can be, can actually be a battle in itself" –* ***CS1***

Emerging adulthood was acknowledged by all participants as a difficult period:

"I think there can be developmental anxiety there…" – ***CS1***

Wider economic conditions can be intimidating for emerging adults:

"Not to mention the whole depression around thinking that they're never going to get on the property ladder and all these things that they think they have to be doing or they have to be in education" – ***CS1***

Participants discussed from their experience how emerging adulthood was a distinct stage within youth but needed to be included in youth service provision:

"…a particular age range that needs maybe something that little bit different" – ***CS1***

Ideal youth mental health services need more funding and resources with appropriately trained and experienced helpers. A youth worker described the need for professionals to change their expectations of young people and view them as individuals with less life experience who have had less opportunity and time to develop coping mechanisms:

"I don't think they would fully understand enough of the depths of mental health and what effects of and how they can turn around themselves, and the wee coping mechanisms that you learn through life…" – ***YW1***

All participants described the approach taken with young people and the rapport as central for young people's needs in a youth mental health service.

Gender, LGBTI+ and young people in care

Participants stated that extra considerations were needed for young people in mental health services. Regarding gender, boys externalising behaviours need to be acknowledged as communication and helpers can think about how to engage with, communicate and create supportive and safe environments for young men:

"Particularly boys that are on the verge of turning 18-, 16- and 17-year-olds" – ***PC2***

One participant discussed specifically about the need of young people identifying as LGBTI+ who were at a very high risk of mental health. This participant stated that *"99.9 percent"* of LGBTI+ work was mental health work. They stated that because young people explore their sexuality online, they are vulnerable to online predation and are less likely to report crimes committed against them: *"because they're not out they're less likely to report if something does happen"* – ***YW2***

This participant also stated there is no *"best practice"* guidelines for LGBT youth coming out other than an individual support plan: *"… if I went in with a checklist … that's wrong [with emphasis] … I have the meeting with the young person before-hand, what do you want? … I could give them ideas about what's the best advice around what young people have done before"* – ***YW2***

As LGBTI+ related concerns and fears can be socially based, this participant stated the need for support work with parents: *"it's like the polar opposite,* ***polar opposite****, it's like suicidal ideation and severe mental health if their parents aren't with them … and we all understand,*

... how important it is that our parents are with us, that they support us that they are proud of us" – ***YW2***

And advocacy work across their environment:

"...support with the family, you're talking about support work within the schools, homophobic bullying, and improving awareness within schools to ensure that they are not impacting on the LGBT young people they are teaching every single day in their class" – ***CS2***

LGBTI+ peer support groups are essential for supporting mental health and young people are good at protecting each other's confidentiality:

"in ten years no one has ever been outed" – ***YW2***

A couple of participants discussed young people involved with social work or in state care. Some participants described shock and disappointment by how poorly confidentiality was managed with social work professionals:

"It's an eye opener" – ***PC2***

Another participant described how a confidential query to a social worker was not protected: *"... you tell the social worker; you never see the young person again."* – ***CS2***

A counsellor described how young people in care often have low trust in adults and experience coercion into mental health care: *"I think it was social workers had insisted on him coming here and I often find in those cases, they're just here because they have to be here"* – ***CS2***

A youth worker stated how a young person had described to them that: *"they knew which foster parent was genuine or who was in it for the money [with emphasis]"* – ***YW2***

Participants described how high staff turn-over in services, especially social work, can impact the young person negatively:

"... for that student we were talking about, there have been 3 different social workers in the last 3 months" – ***PC2***

Another participant described how poor relationships and communication combined with inexperience can have dire consequences for young people: *"... there was a fairly new social*

worker on the case, the social worker maybe, pushed mammy in a direction she didn't really need to push her and severed the potential relationship in early days and that led to the demise of the young person, whereas if the social worker had kept mammy on side, we possibly could have had a better result for that young person" – ***YW1***

Summary of core needs in service

Findings based off practitioners' experience demonstrate that young people's primary needs for youth mental health services concern open access to a suitable environment in which they would receive timely responses for their requests for help from appropriate helpers with less focus on specific methodologies. Young people who identify as LGBTI+ can have increased distress due to not being accepted and for those who have experienced state care, experiences in systems can have a detrimental impact on their mental health. All participants described experiences supporting young people whose mental health was compounded by other life circumstances.

5.8.3. Summary of category 2

This second and final category presents important insights into how helpers understood *young people's lives*. Findings show that young people carry pressures from modern life and the intergenerational disconnect that can accompany rapid social, cultural and technological developments. Young people's mental health was found to be embedded in their environments and their interpersonal relationships, and distress was often caused by social rejection or exclusion. A constant technological vein was described as impacting all aspects of their lives and their development. Young people were described as having different mental health care needs and help-seeking patterns than adults. It was found that young people's *core needs* in a mental health service regarded easier access, non-clinical and positive environments, caring and connected rapports and a youth-led approach that prioritised listening and confidentiality.

5.9. Conclusion

This chapter presented findings that addressed the research aim: "to explore young people's (aged 16 - 25 years) experiences and perspectives on help-seeking for a mental health problem; both young people and practitioners' perspectives". *Part A* presented data from young people in four categories which explored in depth, *young people's lives.* It was found that childhood experiences, social environments and culture has impacted young people's mental health and

shaped their conceptualisation of distress and mental health care, including how and when to seek help. Findings also showed that young people *manage mental health problems* predominantly through self-management strategies until these cease to be helpful, often only help-seeking when distress was high. Actual experiences of help-seeking demonstrated that access is difficult, and interventions vary depending on service and the approach of the helper. Positive experiences resulted in young people feeling *"helped"* and negative encounters could have lasting and harmful *impacts and outcomes* on mental health. These findings importantly were all derived from interviews and focus group with participants who were experienced mental health service users. *Part B* offered another dimension by providing insight into young people and help-seeking from the perspective of *the helper.* It was found that practitioners' approaches were guided by their personal ethos and shaped by their wider service ethos. Working with young people was found to be challenging due to the many systems in their lives, such as family, school, and social work. Young people manage technology, wider economic conditions, and intergenerational divides on top of development, and this can cause distress. Findings show that practitioner and youth data aligned well, with both providing similar information on what young people's *core needs* were for mental health care. These *core needs,* as presented in **Table 5**, describe the key elements that youth services can provide regarding *service* factors, *approach* and *rapport*, *interventions*, and *developmental* considerations. The investigation of both participant groups provides a rich and deep understanding, from those closest to the phenomenon, of young people and mental health help-seeking and met the objective "to identify key elements that facilitate help-seeking among young people". The findings offer an important contribution of young people's perspectives and experiences of having a mental health problem and help-seeking with distress from a culturally relevant position, that can connect and contribute with the wider literature.

6. Discussion

6.1. Introduction

This research explored young people's (aged 16 - 25 years) experiences and perspectives on help-seeking for a mental health problem from both young people and practitioners' perspectives with consideration of their individual histories and lived realities. This chapter provides a discussion of the findings with regard to how it connects with wider literature. This discussion locates the research within five major sections – the first examines young people's early *contexts*; the second, examines actual *experiences of help-seeking* and their impact; the third, reviews what findings contribute to help-seeking and developmental *theory* and the fourth presents a *conceptual model* of youth mental health help-seeking behaviour. The final part of this chapter addresses the research question, what are *the core needs* for young people in mental health care and provides a concise conclusion to this research study.

6.2. Young people's context

6.2.1. Introduction

This research inquired about how the broader context of young people's lives affects their mental health problems, examining what it is like to be young today and manage a mental health problem, and how this context impacts *when* and *how* young people seek help with emotional distress. Young people and practitioners were asked about their experiences and perspectives on childhood, culture, relationships, development, and conceptualisations of mental health. This section discusses these findings and provides understanding on young people's lived realities, their experiences predating their help-seeking experiences and how this connects with the wider literature.

6.2.2. Distress in childhood

It is well established that adversity in childhood is associated with negative consequences for physical and mental health in adulthood (Finkelhor et al., 2015). The use of the term *adversity* in this chapter refers to stressors and traumas that young people in this study experienced outside of expected developmental challenges. Some young people in this study described experiences of distress and trauma that met criteria for Adverse Childhood Experiences (ACE)

by Finkelhor et al., (2015), however, other young people's adversity experiences in this study were excluded. The ACE International Questionnaire (ACE-IQ) (WHO, 2018) was designed to include and measure ACEs in *all* countries and broadly captures all young people's experiences from this research.

In this research, challenges across childhood were found to have similarities and differences connected to a young person's unique social and environmental makeup (Bronfenbrenner, 1995; Davies, 2018). Some young people in this study recalled distress from their early years distinctly, with clear memories of negative experiences, while others recalled a general sense of discontent. This connects with research by Pillemer et al., (2007) who found that negative self-esteem memories in adulthood recalled from childhood and adolescence are usually related to interpersonal conflict and can impact identity development. A common experience described in this study regarded how unprocessed and distressing emotional content from adversity or interpersonal conflict in childhood was carried with young people into adolescence until there was both the ability, from natural maturation processes, and the opportunity from a supportive other, to articulate and process the meaning of these experiences.

Some young people experienced pervasive emotional distress in childhood which was normalized. Davies (2018) advocates the view that an individual's *challenges* in life are not 'abnormal' but emanate from individual-environmental challenges and that there is an opportunity to reconsider language and reframe distress without pathologizing the individual. Distress was found to greatly impact young people's quality of life, development, and self-esteem. The ability to independently disentangle distress from within the individual, and understand it as dynamic, was found in this research to occur later in adolescence and tended to require the knowledge and support of another to begin this process.

6.2.3. Adult modelling

Mental health literacy can be viewed as a life skill (Rickwood et al., 2005), and skills can be learned from others in a child's social environment, often observationally through a process of modelling (Bandura, 1978). Caregivers' roles within Western society can be considered as life guides (Moen et al., 2019) and childhood adversity are experiences that often require adult intervention or skills (Finkelhor et al., 2015). This research found that young people did not learn to seek help for distress if the adults in their lives did not model help-seeking or value it as a tool for supporting mental health. Caregivers were mostly described as not fully equipped with the skills needed for managing mental health problems or help-seeking, with the most

common behaviours of coping with distress modelled being stoicism, concealment, alcohol, and prayer. When help-seeking behaviours were modelled, young people in this research described less shame and stigma for help-seeking and reduced difficulty in accessing mental health services.

Children can observe others completing help-seeking episodes for other general life issues but not for emotional distress. In the space left by inaction, taboo can take root and help-seeking schemas can be informed about the types of problems that are acceptable to seek help about and those you are expected to endure privately (Moore et al., 2013). This study found that unhelpful responses to emotional distress from caregivers involved silence, avoidance, minimisation, anger, or dismissal, which communicated that emotional pain was not valued, desirable or important. This both contributed to distress and taught that expression of pain was shameful and similar conclusions have been found in wider literature (Lee, 2009; Dogra et al., 2012; Pheko et al., 2013; Burlaka et al., 2014; Lynch et al., 2018). There are some gender differences in Irish culture regarding expression of pain (Lynch et al., 2018) and this study found that male caregivers who model open conversations with sons can mitigate some of personal impact of not meeting expected masculine norms of being tough and inexpressive (Vanheusden et al. 2008; McClean et al. 2013; Jackson Williams, 2014; Lynch et al. 2016).

This research found that when children sought comfort for distress from those closest to them and they did not have these emotional needs met, they learned to internalize distress, and *exclude* help-seeking behaviour as a means of problem solving (Wilson, Deane & Ciarrochi, 2005; Freedenthal & Stiffman, 2007). Young people in this study expected similar responses from other adults in their community and thus chose to manage distress alone throughout their youth. Participants described using reflexive, creative and destructive self-management strategies throughout childhood and adolescence which became increasingly ineffective in later adolescence and emerging adulthood (Jorm et al., 2006; Hickie et al., 2007). To later engage in help-seeking behaviours, family values about coping had to be examined, and others who could model help-seeking were sought. This research found that help-seeking *schemas* (Piaget, 1952) developed in childhood that excluded help-seeking were adapted progressively to include help-seeking when a supportive adult modelled and reframed help-seeking in a non-stigmatised and acceptable way.

This research found that *stoicism* is still highly valued in Irish society, making help-seeking difficult for all young men and women, for different reasons. In examining stoicism, Moore et

al., (2013) states “The contemporary term has become largely associated with silence, non-admission, and endurance of adversity, such as pain, without complaint (or help seeking).” (p.170). Moore et al. (2013) also writes that the sociocultural factors underlying stoicism are critical to understand in healthcare research as it has been linked to negative attitudes in help-seeking behaviour and can be partially considered a ‘generational phenomenon’ (p.164).

6.2.4. Culture and intergenerational factors

Ireland is a high-income Western nation with dominant influences from Gaelic indigenous traditions, Roman Catholicism, British Imperialism and the American Dream (Murray, 2006; Inglis, 2015; Ó Féich & O’Connell, 2015). These distinct historical and cultural traditions permeate community, family and personal values, attitudes and stigma around mental health and help-seeking. Young people in this study described how a cluster of factors in recent history, including asylums, legacies of institutional abuse, religious control over private spheres, concealment, and suicide, have intersected with modern life and technology. Irish Identity was described as in transition, attempting to de-institutionalise and decolonise attitudes to mental health, through increasing openness and communication and that this was connected to wider social change within an international human rights movement (Neier, 2020). Young people perceived change as slow and described how their attempts to move attitudes and values forward was restrained by older legacies and generations. Notable campaigns around the acceptability of mental health were described as disappointing, in that they encouraged help-seeking to services that in reality cannot provide a timely response due to lack of wider government reform and financial investment, an assertion found in other international studies (Phillipson et al., 2009; Hernan et al., 2010; Kranke et al., 2011; Dopp & Lantz, 2020).

Findings contained much discourse on the intergenerational impact of inheriting unresolved distress from previous generations with particular attention to how stoicism facilitates *concealment* (Johnston et al., 2013; Fargas-Malet & Dillenburger, 2015; McLoone-Richards, 2012). Stigma in Irish society originates in legitimate fears from previous times where families lost members with mental health distress, amongst other issues, to asylums or institutions and thus concealment of mental health problems was possibly the most important protective strategy to avoid institutionalization (Murray et al., 2006; Masuda et al., 2009; Inglis, 2015; Goodwin et al., 2016). Young people in this study described how older generations conditioned them to conceal distress through responses of silence, avoidance, disapproving looks or threats

of punishment if they continued emotional expression. Concealment meant that all distress, including the traumatic, remained silent (Long, 2020).

In just over 15 years, the Irish government produced three major impactful and at times culturally devastating reports on investigations into institutional abuse including the *Ferns Report* in 2005, the *Irish Child Abuse Commission* in 2009 and most recently the *Mother and Baby Report* in 2020 (Department of Children, Equality, Disability, Integration & Youth, 2021). All participants and their families in this study were affected, directly or indirectly, to varying degrees, by the intergenerational and cultural trauma caused by institutional abuse. Openness can be a psychologically threatening concept to those individuals who have spent their lifetimes in fear of the repercussions and stigma of openness. Tension was found between the concepts of openness and concealment, in a time of ongoing attempts at transitional justice to address and redress traumas of older generations (McAlinden, 2012). Findings indicate that young people, from childhood, are inundated with narratives of institutionalised trauma due to the detailed and widely covered media reports over the years (Charles, 2019). Young people have observed problems with continued silence, accountability, and further concealment, by state and church inquiries into legacy abuse (McAlinden, 2012) in which individuals and families were denied "memory, expression and connection" (Long, 2020, p.11).

Young people in this study described how mental health stigma was transmitted through families (Pompili et al., 2003). Young people described a *knowing,* that their parents and grandparents had experienced trauma, through observations of what was expressed and unexpressed, and empty spaces in conversations were interpreted as containing taboo experiences that were potentially too overwhelming to communicate. This research found that young people can imagine and project horrors in this vacant space, which can create internal representations and anxiety about wanting to know, but afraid to find out (Charles, 2019). Unarticulated caregiver pain can act as an unworkable barometer for young people's distress. Thomas, who experienced asylum seeking, discussed witnessing a community instigated murder as a less traumatic event than those of his parents and grandparents - despite not knowing what they had faced - and his guilt and shame for needing support, when they had endured worse without support. He expressed this situation through humour, as its entirety was too complex and too traumatic.

This study found that there is a significant divide in approach and communication styles regarding mental health (Van Dyke et al., 2009). Previous conceptualizations of mental health

distress were associated with personal negative character traits (Moore et al., 2013). Claire described being mindful, when speaking with her grandparents, of how some words and phrases could trigger stigma or discomfort. This research found that young people manage many conceptualisations of mental health when help-seeking for mental health problems, including their families, their community and culture, often navigating between different frameworks of taboo. Young people in this study found that a proven method to prevent further guilt, shame, embarrassment or stigmatization within their family or community, while meeting their needs for mental health support, was to reluctantly, conceal their service use from older or disapproving family members.

Both practitioners and young people in this study discussed an intergenerational “us” versus “them” narrative in Irish society, as a reaction from older adults to young people’s distress. This study found that some caregivers and older adults can be disconnected from the emotional side of their negative life experiences and can associate younger generations as weak when they communicate their pain, or actively try to address their mental health (Moore et al., 2013). This positioning and othering were found to be stigmatising, and exacerbated young people’s distress, contributing to shame, guilt, and embarrassment. Practitioners and young people spoke respectfully about the material struggles of the older generations and how with improvement in material wealth came an expectation of psychological contentment. Caregivers can struggle with empathy and understanding for the challenges of modern life on top of the inherited psychological burdens that young people manage. Thomas reframed the intergenerational divide succinctly in its context, that the struggle for previous generations was material and for young people today, the battle is for the mind.

6.2.5. Modern life

Compounding the inherited life, is the new, and modern life with its unprecedented technological developments which has created many opportunities and challenges. Childhood and youth as life stages can be experienced differently due to these advancements with increased parental monitoring and less outdoor activities (Martin et al. 2018). Common sources of resilience in people’s lives have changed such as family and peer relationships, community structures, religion, school environment, and personal characteristics (Gatt et al., 2018). Findings in this research show that technology blankets young people’s lives, and reaffirms their position as ‘digital natives’, the first generation born into a technologically infused world (Burns et al., 2010). This recent layer of existence is navigated, managed, and integrated into

daily living and requires cultural tools, as well as individual, to manage continued rapid social, industrial, and technological changes. Young people in this study have caregivers who were born before the advent of the internet age, which Cerf (2009) asserts began in 1996. The intergenerational divide becomes a chasm, where the world that young people are temporally developing in, is vastly different from that of their parents and the ability to relate to each other can be diminished (Aarsand, 2007). Key social, biological, and sexual developmental tasks, in which risk-taking or experimental behaviour is normal (Best & Ban, 2021), happen in technological spaces with increased visibility, monitoring and recording and this was found to contribute to young people's self-consciousness and stress. This research suggests that young people as digital pioneers develop and share skillsets within their peer groups for managing this layer of technology, with caregivers becoming less relevant, thus disrupting the transgenerational transfer of skills and this may be a feature that appears in other industrialized societies.

Most young people have a smartphone by age 11 years (Moreno et al., 2019) and this powerful device is both an antenna to broadcast the self to the wider world and a receiver of information, on demand, which this research found can cause information overload. Ongoing existential dread and threat was described regarding climate change, political instability, online conflict, wars, and social disparity (Salo et al., 2018; Guadagno & Guttieri, 2021). Liam described internalising global issues which contributed greatly to his feelings of anxiety, dread, shame, and depression. With the global becoming the unmanageable local, identities of passive observers of destruction emerged alongside narratives of powerlessness and hopelessness. Global issues can undermine motivation to manage and seek help for individual mental health problems. With the increase of tribes in a technological space, young people can have online in-group and out-group dynamics to manage from their bedrooms (Tajfel & Turner, 1979). School pastoral care staff in this study reported that young women's attendance at school was greatly affected by negative interaction with peers on social media.

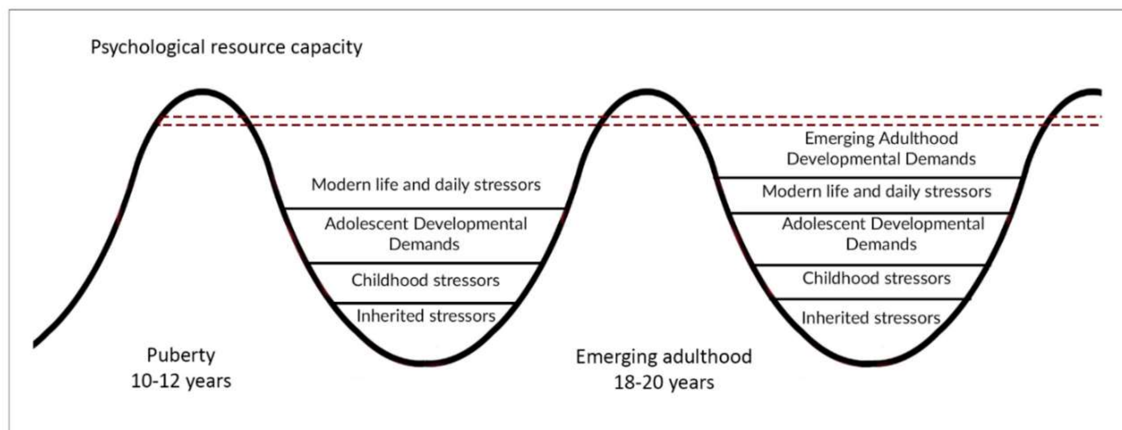
Arnott (2011) stated that the prolonging of adolescence due to economic market demands creates less opportunities for young people to practice roles which are needed for their development into adulthood. Older generations, who experienced a shorter adolescence can have unrealistic expectations for young people which this study found contributes to feeling inadequate, disappointed, and unmotivated. Young people in this study experienced their childhoods and adolescence in Ireland during the 2008 Global Financial Crisis which caused much economic displacement (Cullingford, 2014). Young people expressed pessimism around

the lack of economic opportunities to become financially independent, and the associated anxiety, hopelessness, shame, and futility of trying for a future that appears unattainable (Farlow, 2013). Some caregivers were described by counsellors in this study as lacking understanding on how wider economic and global factors impact youth development and how this contributed to intergenerational divides. These wider factors can be personalised, and young people can be pressured into counselling. Young people can conceal distress and not seek help to prevent further shame at their lack of economic independence.

Young people in industrialised societies, specifically on the island of Ireland, grow up in a culture that prioritizes independence (Bramesfield, 2006), with less emphasis on interdependence. This study showed that young people who are not able to progress due to wider economic barriers, whilst managing personal distress alongside inherited distress, can be labelled negatively by their wider culture, predominantly older adults in their society, as “snowflakes”, “soft”, or “millennials” (Wrathall, 2017; Alyeksyeyeva, 2017). Alyeksyeyeva (2017) described how the term “snowflake” has become pejorative and is used to denigrate young people. Laura, who experienced Childhood Sexual Abuse (CSA), described how this intersectional stigma threat, between experiences of CSA and being “snowflake”, contributed to her avoidance of help-seeking (Miller et al., 2011).

This research developed **Figure 28** to illustrate how the increased pressures of inherited stressors and modern life can stretch the cognitive, social, and emotional resources needed for the challenges of development, creating mental health distress, especially around key developmental pressure points.

Figure 28: Compounded life pressures across youth development



If unresolved, distress can be carried into the next developmental phase which can result in a young person reaching their personal capacity and experiencing high distress which can trigger the need to seek help.

6.2.6. Sexual development

Within Irish culture, the topic of sex, sexuality and sexual development has been typically a taboo subject of conversation, due in part to the influence of Catholic moral teaching and British Victorian attitudes experienced during colonialism (Parker et al., 2009). Access to sexual and reproductive information has a complicated history in the Republic of Ireland and attempts at implementing sex education can be traced back to 1947 where to address high infant mortality rates, Dr. Noel Browne, the then Minister for Health, proposed basic education for women regarding pregnancy, which was already in place in Northern Ireland (Browne, 2007). The Catholic hierarchy intervened due to fears that non-religious medical advice could lead to contraception, abortion, or even communism in the form of state medicine (Millar, 2003). When Dr. Browne published the private letters between the church and the government, the scandal resulted in the collapse of the government in 1951 (Millar, 2003). Religious moral teaching was to remain the dominant influence on medical law, with contraception legalised in 1978 and access to abortion legalised under amendments to the Health Act, 2018 (Oireachtas, 2021). Sex education, with catholic moral teaching, was introduced into post-primary schools in 1995, becoming mandatory at primary level in 1999 (Keating, Morgan & Collins, 2018). Within ten years, most adolescents had their own smartphones with easy access to pornography and sexual media that can include unhelpful, extreme, illegal, or harmful depictions of sexual activity (Horvath et al., 2013).

The impact of technology on sexual development was implied by many participants, but not explicitly discussed, revealing the lasting impact of this taboo. A similar finding was found in an Irish study with children and young people by Martin et al. (2017) were participants were reluctant to talk about certain activities online. Much public discourse in Irish media on the topic of sex regarded sexual abuse, as resulting from the aforementioned government reports and this research found that conversations about healthy sex, sexuality and development are still taboo. Caregivers, due to their own upbringing, might not always be equipped to provide sexual education or guidance to young people. Young people may not seek-help, or withhold information, if their concerns include or are connected to taboo topics, such as sex, for fear of punishment or shame (Fox & Butler, 2007; Freedenthal & Stiffman, 2007). In research from

the UK, Attwood et al., (2018) described young people as benefiting from access to sexual media, with technology offering a space in which they can learn and communicate about sex, as well as engage in sexual activities. It is well established that young people through social media and dating sites can be exposed to older adults with predatory intentions (Santisteban et al., 2018) and this study found that when LGBTI+ young people are not out, they can explore their sexuality online anonymously and can be less likely to report any sexual crimes that happen to them. Sex in a technological space, whilst simultaneously in a culture recovering from institutional abuse, and without space for positive conversations, can be a difficult place for young people to sexually develop in.

In a culture where sex and mental health problems are taboo, CSA is even more so, and remains a very real issue within Irish society, one that contributes to youth mental health problems (Vallières et al., 2020). In 2002, the SAVI report from found that 40 per cent of women and 24 per cent of men, in an anonymous telephone survey, reported sexual abuse during childhood (McGee et al., 2002). Nearly twenty years later, a report by the Central Statistics Office (2020) found that approximately 62 per cent of individuals reporting sexual violence in 2020, were under the age of 18. This research found that aside from the direct abuse, young people are greatly affected by how their communities respond. Young people can know about others being abused and observe open secrets, subsequent inaction, coping by means of addiction, and suicide. Suicide was explained as an outcome in a community that perpetuates silence and prioritizes concealment. Laura spoke about when victims 'go away', it can mean the stigma and burden of addressing CSA also ‘goes away’, resulting in the formation of a belief that suicide might be a more acceptable solution than seeking justice or support. Pompili et al., (2003) discussed how individuals who experience a stigmatised chronic illness, such as a long-term mental health problem, can perceive suicide as an option for resolving stigma and that this can be unconsciously supported as a solution by families. The complex interaction of community beliefs, stigma and shame can prevent young people from seeking help for issues related to CSA. When young people who experience CSA do seek help, findings from this research indicate that they can use familiar topics that have predictable responses of empathy, such as stress at home, as a conduit for offloading, omitting abuse experiences until trust is established. Fear was found to be such a prominent barrier, that Laura waited until she was over 18 years before disclosing abuse, for legal reasons and control over consequences, which connects with existent research by Sanderson (2006).

6.2.7. Friends and family

It is well established that young people seek help through social networks and are dependent on their family's resources to access support (Wilson & Deane, 2012; Burlaka et al., 2014; Valibhoy et al., 2017; Westberg et al., 2020; Eigenhuis et al., 2021). Findings in this study connect with other research that demonstrates the difficulty of seeking help for a problem within an environment that is contributing to distress but also when young people's distress stems from difficult rapports or caregiver mental health problems (Moen et al., 2018; Gatt et al., 2019; Maiuolo et al., 2019). Positive caregiver-child rapports support help-seeking and can minimise the distress associated with mental health problems and can become excellent champions, coordinating healthcare, and advocating for needs, especially when young people are under 18 years of age (Medlow et al., 2010; Mariu et al., 2011; Schmeelk-Cone et al., 2012; Maiuolo et al., 2019; Eigenhuis et al., 2021). Joseph spoke of how an open and supportive connection with his father ensured he found the right professional support whereas Gerard's deteriorating parental mental health situation directly resulted in him experiencing homelessness.

As a young person's mental health distress can affect everyone in a family ecosystem, findings from this research show that when one family member begins to address their mental health needs it can encourage others to do so which can change family attitudes around mental health and help-seeking. This research also found that when caregivers feel threatened or criticised for their child's mental health problems, they can conceal wider family problems from professionals or other young people's distress as being external to the family (Medlow et al., 2010; Wang et al., 2020). Findings also indicate that parents can dismiss or minimise distress due to their own failure to recognise and manage mental health problems. Observations of parental ineffective management of mental health, were also described by Gerard as a motivation to seek help in emerging adulthood. Findings also show that young people can experience an internal conflict of needs; longing to connect, be heard and share experiences of distress and concealing mental health issues so as to not upset, disrupt, or burden parents who were juggling many challenges. This was particularly relevant for young people from refugee backgrounds and reflects findings by Ellis et al., (2010) and De Anstiss and Ziain (2010). This research also found narratives of growth and adaptation, and how families evolve over time with support. Thomas described how he and his mother bridged intergenerational divides through open and honest communication about their mental health.

In 1996, Ireland became the last country in Europe to legalise divorce (McDonough, 1996). Young people in this study discussed the impact of divorce and how this was exacerbated by cultural stigma and a pre-divorce mandatory 4-year separation period, which caused drawn out separations and proceedings that prolonged stress for families. This research also found that when young people experience parental bereavement, abandonment, addiction, or mental health problems, it can lead to them assuming caring roles (Ungar et al., 2018; Cree, 2003). Findings also indicate that when adult responsibilities are placed on children, they can have less time to consider personal needs or develop self-care strategies which connects with findings by Becker & Sempik (2018). In emerging adulthood, young people described becoming more reliant on friends and an increased ability to view their childhoods, adolescence, and family dynamics, in a broader way which may be linked to cognitive development (Best & Ban, 2021).

This study found that friends can understand the modern landscape of youth and age-related problems and can compensate for intergenerational divides (Fox & Butler, 2007; Freedenthal & Stiffman, 2007; De Anstiss & Ziaian, 2010; Bilican, 2013; Cakar & Savi, 2014). When effective, friends were found to be ideal supports due to their established relationship and capacity for genuine care. Gender divides in Ireland may be changing regarding friendships, with young men in this study describing relying on male friends for valued support (Lynch et al., 2018). Young people can also address the gaps in support received from services as this current research found that friends with similar problems can be knowledgeable, relate to distress and validate distress and validate experiences in healthcare. Importantly, reciprocal support in friendships can manage feelings of indebtedness (Gilchrist & Sullivan, 2006; Chan, 2013). Findings also demonstrate that not all young people can find such friends, and issues around trust and feeling connected were common problems, as was the increased use of technology for socialisation (Gilchrist & Sullivan, 2006; Fox and Butler, 2007; Laureiro et al., 2013). Unsupportive partners or conflict in romantic relationships were described as exacerbating distress with findings from this study describing young people becoming caught in familiar and unhelpful dynamics, experiencing a lack of understanding and a loss of self. Leaving romantic relationships was sometimes necessary to improve mental health. This research supports studies that have found a young person has a significant need for positive attachment to family and friends (Lee et al., 2018) and that mental health can be greatly affected in the absence of this.

6.2.8. State care

Young people who are in state care are more likely to be at a greater risk for mental health problems (Fargas-Malet & McSherry, 2017). Placement into state care is an action of child protection and can entail removal from the family environment, the young person's community, and sometimes their school, and placement with a foster family or in a residential care home, possibly in a different geographical location. This research found that the abuse from family and the separation from them are separate traumatic experiences. Young people described feelings of shock, loneliness, rejection, abandonment, and powerlessness on placement into care, with little time or space to begin to process the separation. These findings support research from Watson et al., (2020) who reiterates the need to converse with young people to help them process this transition.

Young people in state care have to build new lives and create new support networks while managing school and developmental tasks. The care system becomes a proxy family and caregivers are the on-duty social workers, and community comprises of mental health professionals and other young people in care. Young people in this study described moving from neglectful family circumstances to professionally micromanaged lifestyles, with their education, mental health care, development and progress scrutinised and observed for signs of improvement. Findings also indicate that young people cope by oscillating between compliance, due to fatigue, and defiance, in attempts to reclaim power.

Young people in care described great discomfort at how their information is passed around from professional to professional, and findings described many violations of privacy and confidentiality breaches, which intensified distrust. To avoid punishment or further rejection, young people familiarised themselves with service policy to learn the rules of the system and findings indicate that young people in care learned to perform wellness, with mandatory attendance at appointments, and pressure to adhere to plans for their care as outlined by professionals. Findings also indicate that when mental health became worse, and interventions were 'unsuccessful', young people in this study experienced negative labelling by professionals such as 'non-compliant' which served to other young people as problematic (Sinkfield-Morey, 2018). Young people also described visibly perplexed mental health professionals whose response to unsuccessful treatment was onward referral to another service, which triggered feelings of defectiveness and helplessness. An important finding from young people in this study was that the instability in placements, social workers, and mental healthcare, as well as

coercive practices, negatively impacted mental health and lead to disengagement, emotional withdrawal and re-traumatisation (Damian et al., 2018).

This study found that experiences of state care were overwhelming for young people and involved further psychological harm and trauma. Aine spoke of concealing the extent of her parents' abusive behaviour in therapy, in the hope of returning to them, as they were preferable to state care. Participants in this study described turning 18 years of age, and being discharged from care, and having to face living alone and with inadequate aftercare. This is another point in the process that can be retraumatising and connects with research by McGorry et al., (2019) that states that cutting off mental health care at peak periods is "anachronistic and developmentally inappropriate" (p.140). It was during this time that young people in this research spoke about multiple suicide attempts, not having access to mental health care, and not being able to complete their education, which compounded feelings of failure and defectiveness. It was through community-based youth services that young people in this study found support with life skills, genuine care, community, and began slowly rebuilding their lives. This study found that young people who have experienced care valued support workers who broke service policy and rules to ensure basic needs were met, and similar findings were reported by Ungar et al., (2018) in research with young people in juvenile systems. Considering the involuntary nature of care and the circumstances that lead to its occurrence, this research shows that young people in care experience further marginalisation within the youth demographic, who due to service practice can suffer frequent re-traumatisation (Damian et al., 2018).

6.2.9. Homelessness

Young people who are experiencing homelessness outside of their family have much in common with those who are in care, often having experienced complex trauma and marginalisation but are generally over 18 years of age (Narendorf, 2017). Youth homelessness in Ireland increased between 2015 and 2018 by 85 per cent and includes young people who have been in state care and who are parents (Focus Ireland, 2018). Other research has shown that young people who experience homelessness often have care experiences (Collins & Barker, 2014; Narendorf, 2017). Young people can also appear as "hidden homeless" because they move from house to house within their social network. In some countries, youth homelessness can be connected with substance use (Narendorf, 2017) however in Ireland, it is predominantly fuelled by the lack of appropriate housing (Focus Ireland, 2018).

Similar to those in care, this study found young people can form deep attachments quickly with a helper with the right qualities who can provide genuine care (Crosby et al., 2018). The offering of a supportive and genuine rapport can also trigger feelings related to experiences of previous caregiver trust breaches, abandonment, and rejection. Fears related to trust were found to affect engagement and cause further distress and young people in this study who experienced homelessness needed many supportive adults over a longer-term. Having one key worker was an emotional risk as support could be lost if that worker went on leave, or changed job, and this could cause re-traumatisation (Crosby et al., 2018; Damian et al., 2018). Rachel described attending a local drop-in youth centre and accessing a wider range of supportive adults, where she had opportunities to socialise and build community, as well as longer-term relationships, and genuine peer friendships, on her terms. These findings connect with research from the UK with young people experiencing homelessness (Collins & Barker, 2014). This research indicates that when young people experiencing homelessness do not have access to community spaces, they stitch together an unstable community out of hostel workers, social welfare staff, mental health professionals and other individuals who are experiencing homelessness. Community building resources which supported development into adulthood were described as a priority by young people who experienced homelessness in this study (Crosby et al., 2018).

6.2.10. Experiences of immigration

There are multifarious reasons why young people immigrate, which may not always be evident until inquired about. Young people can come to Ireland as part of a family seeking asylum, having been displaced due to life-threatening situations, such as war in their home country and often have experienced adversity and trauma (Gatt et al., 2011). Reasons for immigrating in this study were found to be connected to increasing safety or improving economic and psychological wellbeing. Ireland itself has a long history of immigration to the United Kingdom, America and Australia, with research suggesting that mental health distress is common among second-generation Irish children (Das-Munchi et al., 2013). This study found that some young people who experienced problems with their caregivers immigrated to Ireland to connect with wider family, in the hope of finding stability and lessening their mental health distress.

Another reason for immigrating to Ireland was connected to the increase in anti-LGBTI+ laws across the European Union (EU) in the previous decade (Evans, 2014) and the Marriage Equality Act (2015) (Oireachtas, 2021). This has resulted in Ireland being viewed as a safe

place within the European Union for young people who are threatened by this political action. While declaring LGBTI+ asylum is a practice globally (Jordan & Morrissey, 2013) this study suggests that as young people can freely travel and immigrate within the EU without the need to declare asylum, this type of asylum seeking can remain hidden, as can the distress of the young person in this situation.

Caregivers who have their own distress and other settlement problems to solve might not have enough resources to help their children cope with immigration and its effect on mental health, and this supports findings by Ellis et al., (2011). Thomas stated that parents can misinterpret their child's struggle with the challenges of immigration as ungratefulness and to avoid upsetting parents, young people can conceal mental health problems further. There are many reasons for African migration to Ireland, apart from seeking asylum (Ejorh, 2012). This research found that young people can also immigrate to Ireland during childhood from African countries under a 'kinship foster care' system (Palacios & Jiménez, 2009). This is a private arrangement in which a child is legally fostered by friends or other family relatives who are already established in Ireland, for the purposes of economic and educational opportunities. This study found that young people in these circumstances have experienced loneliness and distress associated with family separation, which can be obscured or minimised by the prioritised economic opportunity.

Young people from African backgrounds can have different needs when seeking help for their mental health than young people of white Irish identity. Both Thomas and Andrew described immunity to distress as an important part of African identity, which can result in cultural minimisation or dismissal of distress, and links with research from Nigeria by Dogra et al. (2012). A preference for socialising with friends from similar African backgrounds was found to be due to a connection, often unspoken, of the adversity endured in immigration and shared experiences of racism. The impact of racism on young people who identified as black African, from white Irish adults in general life, was an othering experience, causing harm, anger and undermining trust in wider structures provided in Irish society, which often demonstrated institutionalised racism (Fanning, 2018). Young people of African identity in this study stated that they would only help-seek for mental health distress to community workers or teachers, due to the need for deeper trust which is similar to young people in care and those experiencing homelessness (Collins & Barker, 2014).

When young people arrive in Ireland, they face many challenges and this study found that immediate focus was on the transition, often suppressing distress, until they have found some stability. Identity challenges associated with immigration can compound normative adolescent identity development, specifically in the management of two or more cultural influences. This research found that young people need to stay connected with their home culture and to also be supported to adapt to live in another and this connects with wider international research (Ellis et al., 2010; De Anstiss & Ziaian, 2010; Valibhoy et al., 2017). This research demonstrates that young people can find ways to accommodate both influences and associated conceptualisations of mental health.

6.2.11. Conceptualising mental health

Mental health literacy includes how an individual recognises problems, describes and manages emotions, as well as their knowledge about treatment and services (Rickwood et al., 2007; Kutcher, Wei & Coniglio, 2016). While a useful term in health research, literacy implies the existence of a curriculum and can be a limited term without reference to the wider learning context. This concept is biased towards Western viewpoints of healthcare and while there is an understanding that there can be different conceptualisations of mental health globally, Cosgrave et al., (2019) advocates for the need to understand "locally relevant and psychosocially informed approaches". Beyond global and local is the personal and there is often a lack of inquiry and understanding into how young people conceptualise the nature and meaning of mental health for themselves (Law et al., 2019).

As this research took place in the Northwest of Ireland, common narratives from Western health-based paradigms were found when conceptualising mental health through analogies to physical health. These often had limited explanatory power for the complexities of internal life and this study found that personal conceptualisations on the nature of mental health were considered to involve the intangible aspects of the self. Young people expressed confusion, conflict, duality, and challenges when trying to define or articulate their understanding verbally, moving between trying to satisfy wider constructs and express personal interpretations, with meaning often being shaped during the research, in the moment of discussion. This research found that individual concepts of mental health are greatly impacted by upbringing, social networks, social media, educators, and mental health services, and that despite variation, young people can create similar frameworks and understanding. Young people understand mental health as a profound and central part of the self with an important

role in over-all health. The experience of distress was described as a common human experience which could help to depersonalise mental health problems as rooted in the individual, creating comfort and reducing self-stigma (Law et al., 2019). The conceptualisations discussed in this section convey the voiced aspects of participants thoughts and feelings, as many conflicting and unprocessed facets remained unarticulated, but were witnessed by the researcher in the non-verbal expressions and body language of participants. Young people's understanding, concepts, memories, ideas, attitudes, and feelings were found to directly affect how they viewed mental health problems, personal distress, help-seeking and problem-solving and connects with research from Rayner et al., (2018) and Law et al., (2019).

6.2.12. On being young

Youth is a time of transition, instability, and insecurity due to regular and sometimes rapid changes in personal, cognitive, physical, social, and sexual development (Best & Ban, 2021). This research takes the position of viewing young people as individuals belonging to a distinct cultural group (Sawyer et al., 2018; Rickwood et al., 2019; Lynch et al., 2020). Group membership of *youth* is defined by developmental status; the key physiological, psychological, and cognitive milestones have not yet been reached that would classify them within Western paradigms as having reached 'adulthood' (Arnett, 2014).

Youth an also be a time of fun, expression, and exploration although much of life can exist in controlled environments (Pearow & Pollack, 2009). Findings show that when young people cannot remove themselves from environments that cause distress, it causes feelings of imprisonment, oppression, and powerlessness. The status of adolescence and being legally dependent on caregivers can be a factor that results in marginalisation in industrialised countries but one that can be grown out of at 18 years of age. This study found that for young people who experience compounded marginalisation, such as homelessness or state care, the normative challenges of development in emerging adulthood often exceeded personal capacity, which was occupied with trying to manage the effects of trauma without family or community support. Young people described much adversity and how living from crisis to crisis interfered with space and time for development as well as their education.

Mental health distress can be experienced as a constant state or as fluctuating between manageable and severe. Waves of increasing tension are managed until they passed, were released via an outlet, or emerged as a crisis. Findings indicate that with increasing frequency of surges, help-seeking is considered, attempted, or completed. Having mental health distress

is experienced as painful and affects global functioning and quality of life, including eating, sleeping, interests, motivations, self-care, education, relationships, and planning for the future (Meade, 2016). Findings show that young people who manage distress from early childhood can learn to accommodate distress early in life, doing their best to self-manage and attend to age-related activities. Distress generally exacerbated over time, with help-seeking being inevitable (Biddle et al., 2007; Burlaka et al., 2014).

Self-management refers to an individual's ability to manage their mental health to produce a satisfactory quality of life (Omisakin & Ncama, 2011). Young people described using self-management strategies for intense feelings, such as rage, despair, shame, panic, and chaos, and often had limited understanding of these states beyond their direct feeling and their impact. This research found that depending on what or who is available, young people can use talking, socialising, exercise, creative activities, aggression, self-harm, distraction, alcohol, and drugs, which work to relieve distress or delay help-seeking which links with some international findings (Jorm et al., 2008b; Rickwood et al., 2007; Burlaka et al., 2014). This research found these self-management strategies were the only means for coping when services did not provide support.

Corrigan et al., (2015) discusses findings that indicate humour contributes to stigma reduction in mental health and Cross (2012) describes how humour can "reflexively puncture their public image as "nuts"" (p.1). This study confirms that young people can use humour and self-labelling, such as 'crazy', as a way of releasing tension and self-stigma. Other important coping strategies described in this study included withdrawal, concealment, and suppression of emotional pain. *Withdrawal* provides young people with respite from the social aspects of life that can put extra pressure on them or affect their ability to self-manage. Young people, who experience abuse or social rejection, can use isolation to prevent distress from being triggered by the source of pain – other people. This is not typically regarded as a self-management strategy but as a symptom of mental health. Findings also show that *concealment* can provide mental respite, while supporting engagement with other social activities and protect public image. Respite could create other distress, with withdrawal and concealment eventually causing loneliness. Once foundational mental health awareness was acquired through a supportive rapport with a helper, young people in this study described replacing less effective self-management strategies with more effective ones, which is regarded by other research as an important part of therapy (Rickwood et al., 2007; Omisakin & Ncama, 2011). An interesting finding was the reframing of help-seeking as a self-management strategy, that the decision to

access somebody who has the resources to help manage the problem is an act of personal power and agency.

Normative developmental challenges or identity development can be conflated with mental health problems (Loueriro et al., 2013) with findings from this research showing that young people had distress dismissed, stereotyped, and minimised as a feature of youth by adults. Loneliness is considered prevalent in adolescence with some studies suggesting it as normative due to many reasons such as social restructuring and genetics (Wong et al., 2018). This research found that loneliness stemmed from concealing stigmatised problems and managing alone out of fear of social rejection. When young people perceive that adults view their distress as something to be 'grown out of', findings show young people can feel very vulnerable, sensitive, protective, and defensive when interacting with adults in services, expecting to be dismissed but hoping to be listened to (Lynch et al., 2020). No young person in this study grew out of their problems but watched them intensify with each new developmental stage. Importantly, findings show that supportive adults in social networks or services could identify distress and provide them with support during highly distressing episodes. One youth worker stated that "young people are phenomenal" in recognition of how they face challenges with their mental health.

6.2.13. Summary

Young people are greatly impacted by their family environment which is situated within a wider cultural, national, global, and temporal context (Bronfenbrenner, 1995). Young people who navigate adversity in childhood without adequate support from adults in their social network often rely on innate or reflexive coping mechanisms. Young people are caught in between, carrying the legacies of the past alongside the burdens and opportunities of modern life. Awareness campaigns without resources cause inconsistent and confusing messages about help-seeking. This study also found that both young people's mental health distress and prospects of support lie within their relationships and environments. This research presents young people's experiences of state care, homelessness, and immigration. Importantly, this section increases understanding of the experience of living with mental health distress while being young and is an important primer for the next part of the research which explores young people's actual experiences with mental health services.

6.3. Actual experiences of help-seeking to services

6.3.1. Introduction

The findings of this research demonstrate that young people experience a broad range of life challenges, including the global, the inherited, the interpersonal and the intrapersonal. When young people are distressed and seek help from others, they attempt to bring their private worlds, and the associated personal and social consequences, out into the wider world. This section discusses this process and what was found regarding young people's *actual* experiences of help-seeking to a service for a mental health problem, exploring young people's *decisions*, their *search* for the right help, *access* to services, *interventions*, *helpers* and the service *environments*. Importantly, this section concludes with a discussion on how this experience *impacted* their mental health.

6.3.2. The decision to seek help

Many factors are considered before young people actively decide to seek help (Chan, 2013). Young people in this study had to recognise that they had a problem, evaluate their self-management strategies, and acknowledge their limitations (Cornally & McCarthy, 2011). This process, as described by young people, required knowledge, reflection, analysis, and the ability to communicate with others about internal states. This study found that young people were more able for this process in emerging adulthood. It was found that many young people due to age, inexperience, and the difficulty in accessing services, were not able to make these decisions in a fully informed or independent manner and links with findings from Quinn et al. (2006). Help-seeking was not necessarily about moving from a concrete state of *undecided* to *decided* but was often described as a sudden knowing or as a reaction to intense emotional pain during periods of increasing distress. At any age across youth, feelings of suicidality were found to be first indicator that help was needed.

Many decisions to seek help are *co-decided* or *initiated by others* and findings show that a concerned family member, teacher or friend often approached a young person after having observed distress and offered support or encouraged them to seek help. This supports findings in wider international literature and emphasises the central role of family and friends in the early stages of young people's help-seeking processes (Boyd et al., 2007; Moen et al., 2019). In earlier adolescence, young people can have some awareness of distress but little understanding of it or what to do about it. This study also found that young people can seek-

help *indirectly*, through actively changing their behaviour to signal desire for an intervention, which was also found by Bramesfield et al. (2006). Receptive helpers who noticed were usually adults in daily or weekly proximity to them. In later adolescence, it was found that young people began to understand the need for external help, but often ensured that all self-management strategies were first explored (Michelmore et al., 2012). In emerging adulthood, young people's conceptualisations of mental health broadened and often included increased *independent* help-seeking, as part of the wider need for independent life skills (Cooper, 2018).

This study found that young people did not always want to seek help through their caregivers or friends, but involvement in help-seeking came from a need for consent or other's resources to access services and this was found to complicate decisions for those under the age of 18 years (Gilchrist & Sullivan, 2006). This study found that young people's need for parental consent, especially in later adolescence, could result in a decision not to seek formal help, and strategically delay help-seeking until they were over 18 years (Draucker, 2005; Wahlin & Deane, 2016). International research has shown that caregivers can provide a range of responses from supportive to unsupportive actions, even blocking help-seeking (Draucker et al. 2005; Freedenthal and Stiffman, 2007; Bilican, 2013; Coleman-Fountain et al. 2020; Pearson & Hyde, 2020; Thai et al. 2020). When young people in this study disclosed distress, some lost autonomy when decisions were made for them by others without consultation or explanation of the process which also contributed to self-image and public image damage (Chan, 2013). Young people at all ages can risk their autonomy when help-seeking, and findings in this study show that fears regarding the legacy of asylums and media depictions, can overshadow decisions to make help (Goodwin et al., 2016).

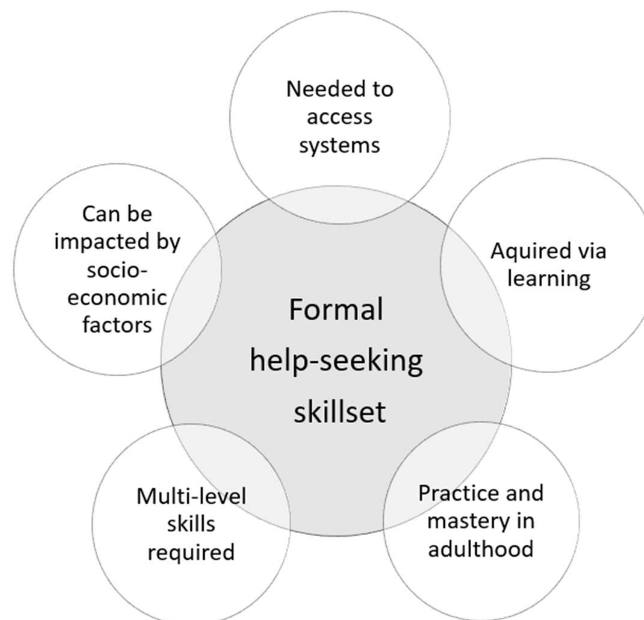
Bramesfield (2006) proposed that help-seeking may be incompatible with the Western value of autonomy and self-reliance. This study found that the thought of asking someone else for help could trigger feelings of shame at the perceived failure of emotional self-management, of which their culture expects. Some young people in this study when put on a waiting list were concerned whether they were severe enough for support and would they take up the place of someone in a perceived worse position. For young people with previous negative experiences of not being helped, thoughts of help-seeking could be a painful reminder and caused anger or hopelessness. Indirect help-seeking was linked to these experiences, as low trust in the prospect of being helped made it difficult to seek help directly. Overall, decisions were found to be complex, fluid and highly dependent on important external factors such as availability of services. Young people, generally across all ages, can change their minds and postpone help-

seeking until they assess it to be absolutely necessary or until they can locate the right help (Biddle et al., 2007). Only when there is a likelihood of support, and benefits outweigh costs, young people might make the reasoned decision to seek help (Chan, 2013).

6.3.3. The search for help

Searching for help often occurs after a decision is made but can also occur beforehand and contribute to informing the decision. Knowing that help is needed is a different task from knowing what *type* of help is needed. Young people in this study, especially in earlier adolescence, did not fully understand what they needed from help, but they knew what they did not need. This research shows that young people look for a trusted social support first, someone who may seem predictable or reliable in their response to problem-solving or a request for help (Michelmore et al., 2012; Rowe et al., 2014). Young people greatly rely on adult *formal help-seeking skills* **(Figure 29).** This figure was developed from the findings to illustrate the features of this toolset, usually acquired in adulthood, that is necessary for accessing any formal service in industrialised societies.

Figure 29: Formal help-seeking skills



Young people also require resources provided by others within their social networks, such as the informational, financial, emotional, or logistical. The findings show that not all caregivers have the skills or resources for formal help-seeking, and due to previous negative experiences,

marginalisation, or economic and educational inequalities, can encounter great difficulty and stress in finding appropriate care. If a young person cannot locate a social support first, there can be no other option but to end the search for help (Medlow et al., 2010; Wilson & Deane, 2012; Burlaka et al., 2014). Findings in this study show that young people can also have difficulty locating or attending a service when caregivers are not committed, are managing their own issues or cannot provide the necessary resources which is also reported in other research (Gilchrist & Sullivan, 2006; Ellis et al., 2010). In some instances, young people attempted seeking help from services alone but did not have successful results until they were in emerging adulthood. Practitioners in this study, as experienced and knowledgeable help-seekers and advocates, with mastered formal help-seeking skills, described the obstacles they encountered in locating the right help for young people and observed how difficult this process is for families without experience, and how impossible it is for young people on their own. This highlights the critical situation that exists regarding access to mental health care.

As part of professional help-seeking young people in this study described having to tell many adults about their distress, including caregivers, GPs, and administration staff, before accessing an unknown helper. Young people often do not know what to expect from formal processes, and due to previous negative experiences with authority figures can anticipate punishment, judgement, embarrassment, disapproval, or rejection for their emotional disclosures. This connects with research by Leavey et al., (2011) who found that young people in the UK can have a suspicion or distrust of adults in general and this can extend to adults in services. The negative treatment of minority populations in Western systems and previous negative experiences with culturally inappropriate healthcare delivery can impact trust in service use (De Anstiss & Ziain, 2006; Masuda et al., 2009; Kranke et al., 2011). Young people in this study, who had experiences with other government service environments, such as immigration, gardai or social work, often expressed aversion toward public formal services. For young people identifying as LGBTI+ in this study, the fear of being outed was intense and they described scrutinizing potential helpers and services for any signs of openness and acceptance. Aine described how homophobic responses from professionals caused her to withdraw from a help-seeking process to prevent further stigmatisation. This connects in with research by Fish (2020) who highlights the urgent need for a wider response across systems to support the mental health needs of LGBTI+ young people.

This study also found that help-seeking processes can cause physical distress such as shaking from fear, vomiting, not being able to speak, not being able to think or describe what is

happening; essentially the triggering of what Katz et al., (2021) describes as human peritraumatic responses to trauma. This study found that young people can be retraumatised by services and this disproportionately affects young people in state care. Even when young people access help easily and positively, it was described as an emotionally difficult experience causing anxiety, fear, and discomfort. Informal supports are unlikely to trigger this level of discomfort and young people seek help from them until these relationships reach their capacity for support (Freedenthal & Stiffman, 2007). This study also found that when young people sought help with a parent or friend, they increased the combined skill-set, and resources, meaning young people did not have to manage stigma or negative experiences alone.

Much research has demonstrated that friendship networks can provide important resources for accessing professional care (Jorm et al., 2007; Ellis et al., 2010; Medlow et al., 2010; Loureiro et al., 2013; Lubman et al., 2016; Westberg et al., 2020; Eigenhuis et al., 2021). This study found that friends were more relevant in emerging adulthood than earlier adolescence and that friends were least helpful in earlier adolescence. Friends were found to provide much needed connection, recommendations or sharing of skills learned on how to communicate, manage, or negotiate mental health care. Young people shared their experiences of mental health care to help inform and protect each other from negative experiences or harm. Stories of long delays and inappropriate treatment contributed to fear and potential disappointment, but also provided realistic expectations about the formal help-seeking process. Stories about friends who were not able to access appropriate help and died suicide were found to either motivate young people to search further, to prevent a crisis, or inspire hopelessness that maybe there is no help. Everyone in this study was impacted by suicide either in their social network or community, with many describing the devastating impact and the existence of a silent epidemic of suicide in the Northwest of Ireland.

Trust is central in the search for help and this research found that in early to late adolescence, young people observed potential helpers over time before approaching them, preferring to seek help within predictable and easily accessed relationships and this is well established in the wider literature (Rickwood et al., 2005; Coleman-Fountain et al., 2020). Jones et al., (2017) reports that young people establish trust as positive results are observed, and this study found this to be common in emerging adulthood. This study also found that young people with ACE, often search for opportunities for a longer lasting rapport before engaging in any therapeutic process, as they required a helper to demonstrate trust and commitment that they will move forward without them withdrawing support. This research suggests that this was a logical

defensive strategy for young people who had their trust broken by adults in their lives and this connects with research by Loos et al. (2018) who found that young people prioritise stable and consistent relationships and how these can be lost in the transition to adult services.

For some young people, seeking help was described as an exciting time, as marked the beginning of the end to the loneliness of self-management and the prospect of an improved quality of life. Some young people in this study were influenced by media depictions and expected stereotypical scenes of couches and psychotherapists (Goodwin et al., 2016). Others expected treatment to be similar to physical services, expecting an assessment, a diagnosis and a fix which caused disappointment and confusion when this did not happen. When young people searched for mental health support, they expected to be helped, however, many in this study were not, and findings suggest that most young people experience multiple attempts at help-seeking before accessing appropriate support.

6.3.4. Accessing help

In the context of the Northwest of Ireland, in which this study is based, young people can access *formal services* through a GP referral in the public healthcare system, directly through community-based counselling services or via private practice. Other services that provided mental health support to young people were *semi-formal services*, such as youth services and school pastoral care, who provided easily accessed listening ear support. This study found that young people and their families accessed support firstly through the public system or community-based counselling services, as these services have no financial cost, only going private when their needs were not met. Findings also show that families can engage private counselling support if they want to avoid becoming involved in government systems. Access to services in Ireland has been previously identified as a core issue within formal youth mental healthcare due to underfunding and long waiting lists (Barnardos, 2017). This study found that beyond funding issues, processes connected to assessment and diagnosis could be a barrier to access.

Young people predominantly access public mental health services within Ireland through a GP referral (HSE, 2021). Similar to other studies (Biddle et al., 2006, Burns & Rapee, 2006, Jorm et al., 2007, Charman et al., 2010; Mariu et al., 2011) this study found that young people do not regard GPs as equipped to support their mental health concerns. GPs were described as attempting to manage the mental health of young people with medication alone, as waiting lists were too long. Some young people, wanting a referral for a talking intervention, reported

receiving prescriptions for medication only, which was also found by (Quinn et al., 2009). This study found that GPs can make referral decisions based on their own assessment of a young person's distress, which can be influenced by their personal attitudes and beliefs, affecting how the referral is communicated (Leavey et al., 2011). For young people under 18, referrals are reviewed by an intake team who often inquire with parents and school staff about the degree of a young person's distress, without speaking to the young person (HSE, 2021). If the team deem a young person's distress meets criteria, they will send a letter confirming an appointment for an initial assessment-based appointment. When over 18 years, appointments are provided to young people based on assessment of urgency by an intake team (HSE, 2021).

Young people in this study reported anger and frustration at referral processes and waiting lists, as referral pathways were unclear and complicated and young people waited between two months and four years to access services. A scoping review by Anderson et al. (2017) found that these processes are a common problem across mental health care systems. As it is well-recognized that young people usually wait until they are very distressed before asking for help, this study found that waiting, after requesting help, can be an intensely painful period in young people's lives and can damage their mental health and quality of life (Michelmore et al., 2012). Findings also show that placement on a waiting list can be perceived as rejection, impact motivation or communicate that their problems are not valued. For young people without supportive adults, waiting lists can exacerbate feelings of hopelessness and abandonment and encourage a return to self-management strategies. Practitioners described in this study observed how substance use, increases in self-harm and suicide attempts occurred while young people were on waiting lists.

This research found that youth workers and school pastoral care practitioners use their position and professional relationships to navigate the hierarchy of a referral process and to advocate for young people and their families. Findings also demonstrate that these practitioners provided critical and ongoing mental health care through listening ear support and positive relationships while young people waited on formal mental health care. These roles appear to be an integral yet adjacent part of the public mental health care system, ones that are not fully acknowledged (Kelly et al., 2009; Cooper, 2018). Youth work and pastoral care practitioners in this study described lacking support, training, or supervision structures and described their work in mental health as 'firefighting'. Young people were described as not being able to access the mental health services when needed due to healthcare system inefficiencies. Practitioners also described the outcomes of lost time and deteriorating mental health when young people were

referred to the 'wrong' service and had to be referred on to a new waiting list to access the 'right' service resulting in waiting years for help. Findings also show that when young people transfer to adult services at 18 years, this "hard border" (McGorry et al., 2019, p.1) means they can lose supportive relationships and care at a vulnerable age (Loos et al. 2018). Many processes associated with the referral systems and associated waiting lists were found to be harmful and unhelpful to young people and this connects with broader findings around the inefficiency and inadequacy of single dimension, fragmented and siloed healthcare systems (Hickie et al., 2019; Dopp & Lantz, 2020; Westberg et al. 2020). There is a need for inclusive participatory processes in governance, particularly regarding increased coordination, integration or "joined-up thinking" (Forde, 2020, p.15).

Some services use initial appointments to assess whether young people's distress meets service inclusion or exclusion criteria. Findings demonstrate different assessment styles are utilised across services, with young people reporting common experiences of invasive, objectifying, passive, and uncomfortable approaches. This study also found that young people experienced confusion, after disclosing much personal information, to not having access to their assessment 'results'. Young people described how diagnoses were withheld, medications prescribed without explanation and therapies entered without understanding of their purpose. This study found that supportive informal styles of assessment with appropriate inquiry, rapport building and planning benefitted young people and increased motivation and engagement with their helper (Gilchrist & Sullivan, 2006; Gonzalez et al., 2005; Loureiro et al., 2013; Rickwood et al., 2007; Davison et al., 2017; Lynch et al., 2020). Young people in this research valued space for offloading during assessment, before diagnosis or treatment planning. Younger adolescents, due to their age, were not able to engage in assessment procedures properly and without rapport or knowledge of the process, questions were misunderstood, and fears of punishment resulted in withholding information about distress which potentially contributed to inaccurate diagnosis and planning (Simmons et al., 2011; Draucker et al., 2005; Jones et al., 2017). An important finding indicated that young people did not always agree with their diagnosis and that labels caused confusion and damage to self-image (Burns & Rapee, 2006; Kosyluk et al. 2020).

Exclusion from a service can communicate to a young person that to access help they need to meet assessment criteria. Findings show that some young people in this research altered their behaviour, with self-harm or suicide attempts, when they interpreted that this is what is required to access help. It was also found that exclusion from a service resulted in being referred back to the initial referrer, usually a GP, who may try another service and placement on another

waiting list (Anderson et al., 2017). When distress was severe, young people interpreted exclusion as meaning they were *too* unwell and that they were unwanted due to the complexity of their distress. Findings show that young people can end up in a referral loop, where over many months they are referred from one waiting list to another and receive no treatment (**Figure 19**). When there was nowhere else to be referred to, GPs referred to an emergency department. Findings indicate that young people in state care are specifically impacted by the referral loop, and that their experiences in the mental health system were re-traumatising. A study from Northern Ireland has shown referrals and waiting lists to be problematic for young people in care (Fargas-Malet & McSherry, 2017). Repeated requests for help that were denied caused powerlessness, anger, grief, and hopelessness with findings showing that this could contribute to a suicidal pathway. Suicide attempts, which resulted in unwanted access to inpatient services, were found to be further stigmatizing, by adding to the complexity of the issues presented in *mental health history status*, which can follow a young person around and result in further exclusion from other services. These findings connect with research that has shown young people with severe distress need care plans developed from the outset that last multiple years (Reid et al., 2019).

6.3.5. Interventions

The most common intervention received by young people in this study was psychopharmaceutical and findings describe a range of experiences with this approach. Medication was a contentious issue, with many young people and practitioners believing it to be over-prescribed to compensate for long waiting lists. Cosgrave et al. (2020) and Hengartner (2020) have expressed concerns about the over-prescription of psychopharmacological medication in adolescents as this intervention has well documented limitations, risks, and concerns regarding efficacy of evidence. In Ireland, trends show that young people are increasingly being prescribed medication for mental health problems (HSE, 2018). Some young people described taking medication willingly and others wanted medication but were refused. Young people, especially those in state care, also described being coerced by professionals or caregivers to take medication, despite ineffectiveness and intolerable side effects. Young people who manage their own medication can use it inconsistently or inappropriately (Draucker et al., 2005), with this study finding that it was used for suicide attempts. Obtaining buy-in for the use of medication in mental health, can involve proposing disease-cure models for mental health problems. As such, young people in this study expected to have improved wellbeing on medication and described feeling increasingly helpless when

this did not occur, becoming confused about mental health and associated interventions. This study found that the prescribing of medication alone, without a talking intervention, can reinforce feelings of biological defectiveness in young people and directed attention away from the source of issues in young people's lives, ones that can involve dynamics between the social, personal, and environmental. Findings indicate that when young people do not want medication, it is because it can damage their self-image, interfering with autonomy and self-efficacy and cause undesirable mental and physical side-effects (Biddle et al., 2006; Quinn et al., 2009; Neilson et al., 2014). This links with research by Quinn et al (2009) who found that side-effects of medication interfered with students' ability to study which could add to distress.

Other interventions reported by young people included talking therapies, emergency mental health care or inpatient services. Inpatient placements were found to be extremely distressing and sometimes traumatic, and interventions in a hospital emergency department were described as inadequate and lacking in empathy. Findings show that interventions were unhelpful or harmful when they were not suitable to the individual or developmental needs, such as group therapy or play therapy during adolescence. Cognitive behavioural therapy (CBT) was a common intervention in this study, second to pharmaceutical interventions and had polarising effects. Some young people described completing homework, without understanding or engagement, to please their helper and not incur rejection or disapproval. The degree of adversity of life events in childhood can result in a forced maturity in some adolescents making CBT interventions appear highly suitable. The findings indicate that young people needed a supportive rapport established, empathy and listening prioritised, and that CBT was inappropriate in young people without first addressing other foundational skills needed for engaging in mental health interventions. The focus on activities, such as cognitive restructuring, to cope with distress can reinforce unhelpful ideas that young people's distress can be controlled by managing their own perceptions, when young people can be overwhelmed from managing distressing situations and environments that, unlike adults, they are not able to leave. This can further understanding into why other research has reported young people as rating CBT poorly (Jorm et al., 2008a). In emerging adulthood however, CBT at the right time, could be a transformative and powerful intervention for young people that could contribute to their development positively. In a meta-analysis on the effectiveness of CBT in anxious adolescents, an age difference was reported, although without definitive conclusions (Podina et al., 2009).

Collaboration and planning in mental health care is important to all young people and can be therapeutic as it supports autonomy, power, and self-efficacy (Lynch, 2020). Findings from this study suggest that young people are rarely included in treatment planning, particularly if they are under 18 years of age and that some services working with young people under 18 years of age, require helpers to speak to parents privately before or after an appointment, while the young person waits outside the room. This practice was described as patronising and disrespectful, as well as causing discomfort and previous research has demonstrated that inappropriate parental involvement can undermine trust and engagement in interventions (Draucker et al., 2005). Lack of consultation can also impact understanding of a young person's needs and can result in inappropriate interventions which exacerbate distress and discourage future help-seeking (Loos et al., 2018). This study found that the receiving of repeated inappropriate treatments was related to increased suicide ideation in young people.

Young people spoke about varying timeframes across different services but that 6 to 8 weeks, at 50 minutes a session, with some additional appointments if required, and between 9-5pm, was standard. Findings indicate that evening and weekend appointments supported helpfulness of interventions with morning appointments being the least beneficial time for support, interfering with young people's school, employment, and much needed sleep. Findings indicate that set timeframes for intervention in youth are likely to be unhelpful and unsuitable and put pressure on young people to 'get better' in line with service needs (Dopp & Lantz, 2020). The lack of perceived 'improvement' can damage self-image and trigger feelings of defectiveness or shame. Young people observed helpers checking clocks and under pressure for appointments which indicated to them that their needs may not be met. Some practitioners confirmed these practices due to waiting lists and policy requirements. Young people in this study often used multiple services, to try and patchwork longer-term support, which was the intervention they actually required – access to a consistent and supportive adult (Loos et al., 2017; Reid et al., 2019). However, this style of service use could be regarded by professionals as problematic or in need of more specialist psychiatric services. The findings show that interventions typically ended as and when service policy or professional assessment dictated and that a young person can be discharged without consultation or when practitioners take leave.

The single most important intervention reported by all participants in this study was listening. It was found that young people will tolerate inappropriate treatment and uncomfortable settings, if there is access to a listening intervention. Listening provides young people with the opportunity to offload and make sense of chaotic and difficult feelings, which can boost self-

management capabilities, provide respite, and create space for development (Wilson & Deane, 2001; Davison et al., 2017; Persson et al., 2017).

6.3.6. The helper

An important finding in this research is that the role of the helper is central in young people's mental health care and that this relationship is considered more important than the approach taken (Lynch et al., 2020). When young people attend a service for the first time an open, friendly, and welcoming helper can relieve much anxiety and fear. First interactions can create the foundation for a supportive rapport and findings support wider literature that discusses the importance of helper personal characteristics in engaging young people in mental health care (Cniro et al., 2005; Collins & Barker, 2009; Draucker, 2005; Fargas-Malet & McSherry, 2017; Hackett et al., 2018; Jones et al., 2017; Medlow et al., 2010; Neilson et al., 2014; Ungar et al., 2018; Wilson & Deane, 2001). The provision of ongoing genuine care and positive attention can counterbalance other service factors that make young people uncomfortable.

Previous research has discussed the importance of time and opportunity to build positive rapports and establish stable relationships (Davison et al., 2017; Jones et al., 2017; Persson et al., 2017) and this study found that service factors and time restraints interfered with trust building, with some young people describing how it was only as interventions were ending that they were beginning to trust their helper. When young people lose autonomy in mental health care (Purcell et al., 2011) this research found that small choices, such as where to sit and what to talk about, was highly valued. This supports research by Simmons et al., (2011) who found that power over small decisions can help compensate for exclusion from larger decisions in mental health care. A trusting rapport was also found to be very important for young people identifying as LGBTI+. Findings show that helpers who provided knowledge and problem solving around specific LGBTI+ concerns, and who could identify with or relate to challenges regarding stigma and discrimination were highly valued (Fish, 2020). These findings are similar to other young people who perceive certain topics as taboo within their own families. Helpers can provide a non-judgemental space to discuss and explore concerns related to identity and sexual development (Leavey et al., 2011).

Confidentiality is embedded in trust and is of primary concern for young people. A recent literature review on the topic found that young people can engage well with helpers and share personal information comfortably when reliable boundaries are established (Lynch et al.,

2020). This research found that within the professional context, confidentiality is part of a learning process and can involve reinforcing and negotiating boundaries until full understanding of the rules and duty of care are understood (Persson et al., 2017; Rickwood et al., 2005; Simmons et al., 2011; Wilson & Deane, 2001). This research found that helpers, through the modelling of trust and confidentiality, support the learning of the foundational skills necessary to engage in therapy. Breaching confidentiality unnecessarily, even in minor ways, breaks trust and findings show that this was experienced by young people, especially for those involved in social work. Without confidentiality there is no helping relationship (Lynch et al., 2020), and this research finds that young people's needs for confidentiality do not appear prioritized in the same way an adults would be.

This study found that informal approaches and professional boundaries are compatible practices and that young people in general need more informal styles of contact in their support as this is the type of social dynamic that they are most comfortable with. Young people described how the appropriate use of humour helped release tension and counter stigma (Corrigan et al., 2015). It was found that young people in emerging adulthood tend to have more understanding of the purpose and structure of formal support than adolescents who can be intimidated by formal styles of interacting (Lynch et al., 2020). Findings show that young people who experienced state care, homelessness, fostering, or asylum seeking, were unlikely to engage with helpers unless they could provide this style of relationship (Ungar, 2018). It was also found that young people in these circumstances prioritised a consistent and secure relationship with a helper appearing genuinely committed, allied and supportive (De Anstiss et al., 2009; Collins & Barker, 2014; Fargas-Malet & McSherry, 2017). However, findings also show that helpers who provided this type of support were often described as breaking the rules, which was also found by Hackett et al. (2018). Rule breaking included providing extra appointments, support outside of the 9 – 5pm workday, visiting whilst in inpatient services or supporting with attendance to other services and transport to appointments. This research also found that young people needed many helpers for support with other factors that affect mental health and valued those who can provide knowledge and guidance with the challenges of relationships, education, employment, and accommodation (McGorry et al., 2011). If a helper reaches their professional capacity to support a young person with a specific issue, findings show that young people do not want to be referred on but continued to be supported and connected with specialised support.

This research found that young people experienced stigmatization, shaming, judgement and blame from helpers. Helpers were not always properly trained to work with young people and sometimes communicated poorly, offering limited approaches, appearing disinterested or as though they did not enjoy their role (Lindsey & Kalafat, 1998; Wilson & Deane, 2001; Draucker, 2005; De Anstiss & Ziaian, 2010). Findings show that some helpers brought their personal religious beliefs into the counselling space. Some helpers treated adolescents as hyper-emotional and minimized their experiences to biological development. Public healthcare was not considered to prioritize relationships nor ongoing support, but focus on diagnosis, medication and discharging, communicating a very distinct right and wrong, formulaic, problem-cure approach. Pearson & Hyde (2021) reported how young people can be assigned helpers who they feel uncomfortable with due to gender or age and this research found similar findings. It was also found that professionals can displace blame onto a young person's commitment, for a perceived lack of engagement, when the issue can lie in an unsupportive or incompatible rapport. Having a choice of helper or intervention was described as a feature of private healthcare and this research found that some young people in emerging adulthood valued paying for private therapy, to ensure they had access to an appropriate helper and intervention.

6.3.7. The service environment

Formal

The design and presentation of service spaces can communicate the power relations between the staff and service users and was found to be an important factor that impacted young people's experiences in mental health care (McSween, 2002). Findings from this research suggest that stigma is embedded within the design and provision of mental health services within Ireland with common descriptions of formal meeting spaces in buildings located in quiet parts of town, with administration staff that speak softly and quietly and being directed around controlled and segregated spaces, such as waiting rooms. Helpers dress in formal attire and assist young people to a small room with an expectation of disclosing personal problems, with paperwork in hand and tissues on the table. While privacy is important to young people, this study found that some features of formal mental health services can further reinforce stigma, that mental health is embarrassing or should be concealed. Formal services are uncomfortable for this reason and findings indicate that individuals who create policy can unknowingly instil their own stigma or maintain legacy stigma in the overall design (McSween, 2002).

School

School environments were described as an ideal location by practitioners for identifying mental health problems in young people, due to daily attendance and the opportunity to develop pre-existing relationships (Bramesfield et al., 2006; Quinn et al., 2009). However, findings show that young people do not always rate school staff as helpful (Leavey et al., 2011; Williams, 2012) or schools as helpful spaces to provide mental health care, beyond one off interventions. This supports research from Ireland on the role of school counselling (Doyle, et al., 2017). Issues were found to relate to having to take time out of class, privacy, and the fact that school is involuntary and a part of life that can contribute to mental health problems. Young people in this study experienced bullying, exclusion and unhelpful teachers and guidance counsellors who stereotyped and stigmatised them in school (Lindsey & Kalafat, 1998; Leavey et al., 2011; Loureiro et al., 2013). Limitations aside, this study found that schools provide opportunities for young people to develop supportive rapports and can provide respite from a difficult homelife. Young people experienced intense emotions during the school day such as anxiety attacks, and some teachers offered support and signposted to further help. Findings also demonstrated that young people can benefit from simple mental health resources such as self-management spaces, when having a difficult time, without needing an intervention provided by a teacher. Many countries include counsellors and youth workers within schools for these specific issues (Bernes et al., 2005; Höylä, 2012; Cooper, 2018) however, this is not the case in Ireland. Guidance counselling within pastoral care support teams is not provided in all schools and is a missed opportunity (Leahy et al., 2017). For schools with pastoral care teams, this study also found problems with dual relationships (Fox & Butler, 2007).

Youth work

Youth spaces are under-resourced in Ireland with community youth work settings being one of few spaces in which young people are welcome and supported in engagement (Forde et al. 2017). Young people in this research described youth work settings as ideal environments because these were voluntary and welcoming places that offered recreational activities and mechanisms for community building (Höylä, 2012; Forkby & Kiilakoski, 2014). Youth centres were described by young people as having less structural barriers to overcome. Help-seeking was easier in drop-in centres which were described as welcoming and unstructured spaces outside of home and school, in which young people have opportunities to develop supportive relationships, receive support, guidance, respite, socialization, or recreation (Höylä, 2012). Findings also demonstrate that youth workers are trusted adults who can sign-post, support and

maintain young people in formal services (Rickwood et al., 2005). Youth work services were described by youth workers as not well funded and lacking important resources to provide mental health support to young people. Young people in general can be problematised by their communities (Forde et al. 2017) and so it is logical that settings in which young people congregate can also become misrepresents. Participants described how youth work settings can suffer from stigma and stereotypes of working with people with social disadvantage, low achievement, excluded or 'dangerous' youth (Harland et al., 2005; Jeffs, 2020). Aside from these drawbacks, young people valued meeting other young people with similar experiences who they could relate to, which could reduce loneliness and provide peer support and bolster wellbeing. This was found to be particularly important for young people experiencing homelessness (Collins & Barker, 2014; Cooper, 2018), state care and asylum seeking (Ellis et al., 2010). Some young people in this study, especially in severe distress, often preferred meeting youth workers in parks and other public locations. Young people who have experienced great instability in their relationships, their environments and their geography can find an anchor point in a youth service, where they can develop longer lasting relationships, and build community networks, with access to a range of staff who can support this (Kelly, 2009; Höylä, 2012; Forkby & Kiilakoski, 2014).

Overview

Young people can distinguish between private spaces and stigmatised spaces and described the increased comfort and reduced mental health stigma found in multi-functional spaces and from informal approaches. The lack of privacy in busy school thoroughfares or youth centres was found to be unhelpful (Fox & Butler, 2005) but the use of public or multifunctional spaces communicates openness and acceptability, which could counterbalance feelings of stigma. McGorry et al. (2019) discussed the need for youth mental health care to be provided in a non-stigmatised and integrated way.

6.3.8. Impact of help-seeking

The overall aim of seeking help to a professional service is to solve problems and increase well-being and this research found that this is the primary rhetoric underpinning the promotion and awareness of help-seeking and associated services (HSE, 2021). Findings from this research indicated that this assumption, based on experiences of service users, is problematic as the assumed outcome was a minority experience.

Positive outcomes

Positive outcomes were associated with 'feeling helped' which is the personal experience of relief from distress, through expression, validation, respect, choice, and connection (Neilson et al., 2014; Davison et al., 2017). Findings also show that the helping relationship can create psychological space, increasing energy and ability to self-manage between support sessions. Young people described how knowing support and genuine care would be available when needed was found to be a powerful boost to feelings of self-worth and value (Davison et al., 2017; Hackett et al., 2018).

The modelling of a positive and trusting rapport supports learning and development as young people described personal growth, increased self-awareness, improved self-management strategies, increased stability and quality of life which led in some cases to the repairing of relationships and trust in personal networks. Young people in this research described how they came to view help-seeking as a tool for future distress and earlier intervention, increasing feelings of personal power, self-efficacy, and security, which promoted optimism and hope. These positive experiences of acceptance could counter personal and social stigmas and taboos, promoting openness with friends, family and in public forums, such as social media. Positive outcomes reported by young people included finding less stigmatized meaning, shedding unhelpful labels, and reframing feelings of defectiveness into a more positive understanding of self and wellbeing (Masuda & Boone, 2011; Prior, 2012; Eisenberg et al., 2012; Bilican, 2013; Del Mauro & Williams, 2012). This research demonstrates that positive experiences can be formative and profound, with young people describing themselves as lucky or fated compared to the negative experiences they had heard from others.

Negative outcomes

It is generally regarded in wider research that previous negative experiences can create a negatively impact future help-seeking (Rickwood et al., 2005). This research found when a helping relationship was unhelpful, the outcome was further distress, alienation and intensified feelings of worthlessness. Findings from this research show that when helpers do not engage with compassion or empathy, young people feel that their distress is not valued. Other research has demonstrated young people can experience poor quality support (Gilchrist & Sullivan, 2006; De Anstiss & Ziaian, 2006; Charman et al., 2010). Beyond unsupportive, some helpers caused emotional injury, as findings show young people experienced helpers who stigmatized and personalized their problems, attributing distress to a lack of effort or deliberate

misbehaviour. Shaming, judging, and blaming behaviours were found to cause young people to internalize their distress deeper and increase negative labelling, reinforcing beliefs about extreme self-reliance, substance-use, which lead to withdrawing trust in others, in services and in future help-seeking. This was found particularly relevant to young people who used self-harm to manage their distress (Neilson et al., 2014). Hackett et al., (2018) described findings where young people experienced trauma as a result of clinical procedures in inpatient facilities and this research also found that clinical settings in general could also cause young people to feel objectified, dehumanized or scrutinized and some described feeling violated by how their information was recorded and shared.

This research found that for young people who had childhood experiences of neglect, abuse, abandonment, and rejection from adults in their families, negative responses from mental health professionals could contribute to suicidality and this connects with Damian et al., (2018) and Crosby et al., (2018) on the importance of trauma informed care. Negative help-seeking experiences can confirm a young person's suspicions that there was something fundamentally wrong with them, some biological failure, of which there is no remedy. It is important to note that findings suggest that any practice that can reaffirm feelings of defectiveness or helplessness can contribute to hopelessness, and hopelessness is the door to a suicidal pathway - "If life is to be sustained, hope must remain, even where confidence is wounded, trust impaired" (Erikson, 1964, p.115).

Overview

Some young people expressed deep regret and embarrassment at having asked for help and the negative responses received only served to reinforce harmful experiences from childhood. Importantly, this research found that young people can leave a help-seeking experience without having accessed help, feeling rejected and having gained more distress. Some of these findings can help explain why other research has found that young people do not always seek help for their mental health problems (Purcell et al., 2011; MacKenzie et al., 2014).

6.3.9. Summary

Examining the experiences of young people who actually sought help is crucial for understanding why or in what way they can be supported or encouraged to seek help. Youth help-seeking happens through a relationship and requires adult skills and resources but does not always provide the results that young people hope for, instead causing further distress or harm. The impact of help-seeking can be long lasting and when unhelpful can contribute to

suicidality. The role of the helper is paramount and a positive and supportive rapport with listening interventions could help counter any wider service issues. When young people were offered appropriate developmentally and cognitively appropriate support, they considered help-seeking beneficial and learned the foundational skills needed to engage with therapy.

6.4. Theory building

6.4.1. Introduction

This section discusses the two help-seeking models that contributed to the theoretical framework of this research. These models by Cornally & McCarthy (2011) and Chan, (2013) are re-examined and critiqued for their relevance and usefulness (Charmaz, 2014) in relation to the research findings regarding the behaviours, patterns, and pathways that young people reported within this study. Further, a discussion on how this research contributes to help-seeking theory and a new conceptual model of youth help-seeking behaviour for a mental health problem is proposed.

6.4.2. Help-seeking models

This study was informed by two help-seeking models, Cornally and McCarthy (2011), *healthcare help-seeking model*, and Chan (2013), an *interpersonal help-seeking model*. Both models were chosen for their differing and complimentary perspectives on help-seeking and are discussed regarding findings about the *formal help-seeking skills* that are needed to access healthcare (**Figure 28**).

Healthcare help-seeking

Cornally and Mc Carthy (2011) described three important stages in help-seeking, *problem recognition and definition, planned behaviour,* and *selecting a source of help*. This study found that the processes and stages described in this model were evident in young people's help-seeking pathways. With regard to *problem recognition and definition*, young people due to their family circumstance, education, development, and culture, were not always able to recognise or define a mental health problem and this proved an important first challenge when attempting to seek help. *Planned behaviour*, proved to be a more complicated concept with findings showing that young people under 18 years can be brought through these stages of help-seeking by others, in both involuntarily and voluntarily ways. When older adolescents or those

in emerging adulthood exercised planned behaviour, their skill set and ability to make an informed decision was expectedly more limited than an older adult's capacity. Connected with this, findings show that young people under 18 years rarely selected their *source of help* but relied on others such as GPs or caregivers to locate and refer to services. Healthcare settings are fragmented adult spaces that require permission, consent and formal skill sets to access which make them difficult to navigate (Westberg et al. 2020). In instances where young people were dissatisfied, planned behaviour could be seen in how they disengaged with a service, found another service, or instructed caregivers to do so on their behalf.

When positioning young people's experiences within this healthcare help-seeking model, contrast was observed between the natural style of help-seeking that young people engage in and the behaviours that services require for access. **Table 8** was developed from the findings to summarise the key differences between help-seeking behaviours and service features.

Table 8: Comparison of help-seeking and service features in mental health care

Youth help-seeking features	Public service features	Private service features	Formal help-seeking skills
Self-referral	GP referral, practitioner referral, or caregiver referral	Self-referral, practitioner referral, or caregiver referral	Locating and contacting services
Easily accessed others	Assessment	Option of helper	Communicating personal information
Voluntary participation	Single point of entry	Assessment	Organising appointments
Skills learning	Appointment based	Flexible scheduling	Coordinating logistics
Supportive and consistent rapport	Hierarchical	Appointment based	Repeating skills on a regular basis to maintain engagement
As and when needed	Use of medication	Partnership approach	
Longer-term	Practitioner discharge	Financial cost	
	Short, fixed or longer-term	Shorter or longer-term	

Findings indicate that young people's formal help-seeking pathways are shaped by service access policy (Aday & Andersen, 1974). This might be an explanation for why young people's pathways as found in this study reflect those proposed by Cornally & McCarthy's (2011). This model is important and helpful in providing a concise conceptual analysis regarding the required pathways young people need to take to access the dominant systems.

Importantly, Cornally & McCarthy (2011) acknowledge *empirical referents*, which includes the use of formal and informal sources of help, which this research found as central in youth help-seeking behaviours. Cornally & McCarthy (2011) also acknowledge *consequences*, regarding wellbeing and personal satisfaction as important in healthcare help-seeking outcomes, which was a prominent finding in this research. Consequences such as 'no change' in health status, invalidation of symptoms, stigmatisation, dissatisfaction, resentment, or anger, are legitimate outcomes of help-seeking (Cornally & McCarthy, 2011), which this current research emphatically confirms and deepens insight into the *consequences* of unresolved problems in mental health help-seeking, specifically that there can be a change in health status - mental health can be worsened - and young people can be re-traumatized by services, which can contribute to suicidal pathways.

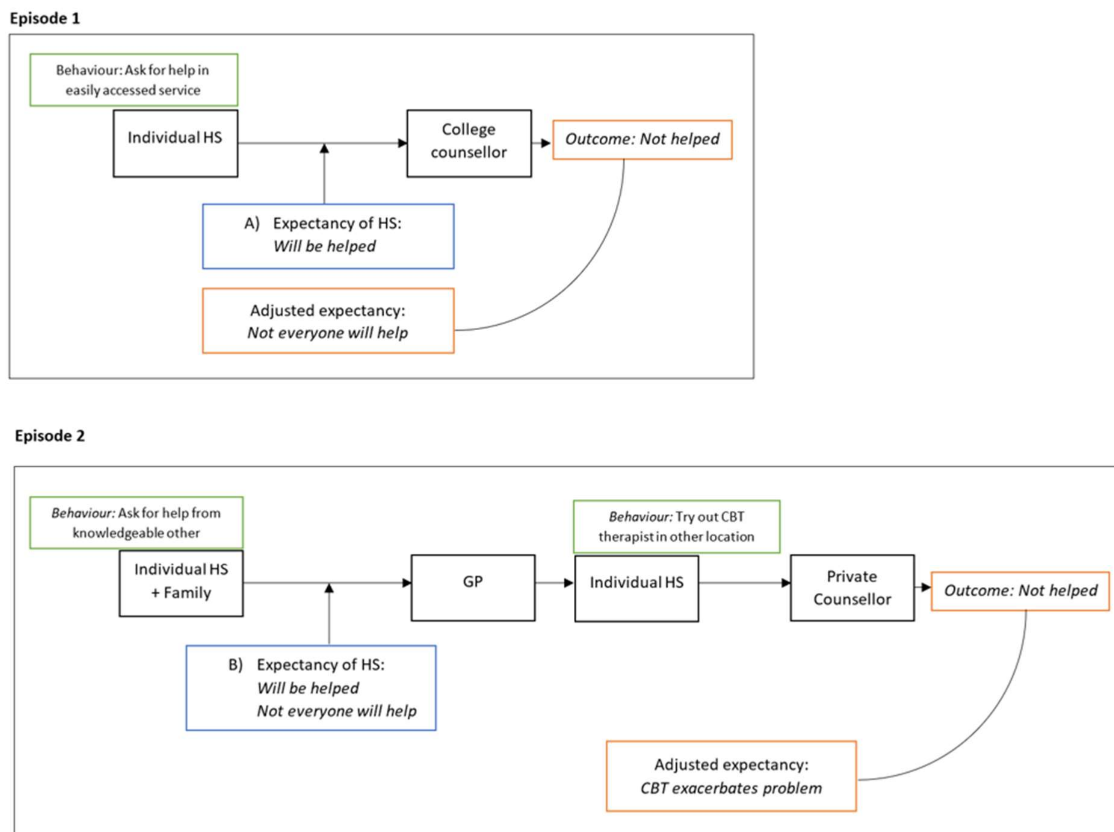
Interpersonal help-seeking

Chan (2013) described a multi-disciplinary and multi-level approach to provide in-depth understanding for *instrumental* or *goal-directed* help-seeking. Chan's (2013) model examines the motivations for help-seeking as reasoned and resulting from an individual assessment of the perceived *costs and benefits* in both private and public spheres, with a focus on the role *expectancy* in moderating decisions. This research found that mental health help-seeking in young people can be viewed through the lens of *goal-instrumental help-seeking*, where the goal of well-being is the motivation to learn skills (Chan, 2013). Findings indicate that in earlier adolescence, young people tend to seek help only to acquire the minimum amount of information or skills that they need to lower distress and continue self-management. In later adolescence and emerging adulthood, the opportunity for independent living motivates young people to seek help to learn new skills to manage well-being more effectively. This research also found that young people assess potential helpers for their ability to help before deciding to seek help.

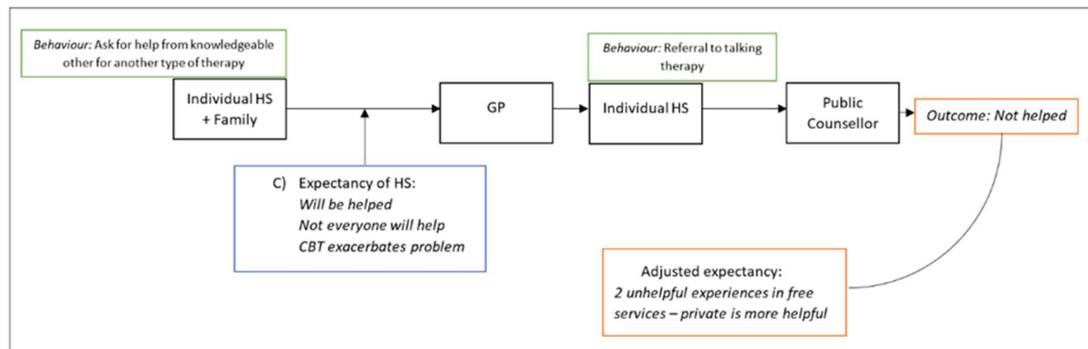
Chan (2013) discussed how an individual negotiates *cost and benefit* in terms of impact in the *private* and *public spheres*, as well as *indebtedness* and *dependency*. This research found that practicing autonomy and learning self-management are important developmental tasks to young people and help-seeking can be avoided if it caused feelings of dependency, stigma or self-esteem damage. Findings also demonstrate that the actual emotional costs from help-seeking such as embarrassment, inappropriate treatment, and triggered painful feelings were not often anticipated. While help-seeking begins with a perceived *cost and benefit* assessment,

experienced help-seekers update their help-seeking schemas to include actual experiences of costs, to increase accuracy of expectation for future help-seeking decision-making. Chan (2013) argued that *expectancy* alone is not a direct predictor effect in whether help-seeking will occur but that it is a moderator. Findings from this research repeatedly reported that young people who had unhelpful or harmful experiences, often did help-seek again, but in altered ways to avoid some of the expected costs based on experiences. **Figure 30** was developed using a case study of a participant in emerging adulthood who explored three options of help before locating appropriate support. This process tested the role of expectancy as a moderator to behaviour and found that each episode provided information about how to adapt expectations to increase chances of successful help-seeking for the next episode. These findings also support the role of *perceived behavioural control* as this participant demonstrated in their narrative a high perception that they or their family would be able to locate help successfully (Chan, 2013). These findings expand upon Chan (2013) theory of the role of expectancy in interpersonal help-seeking.

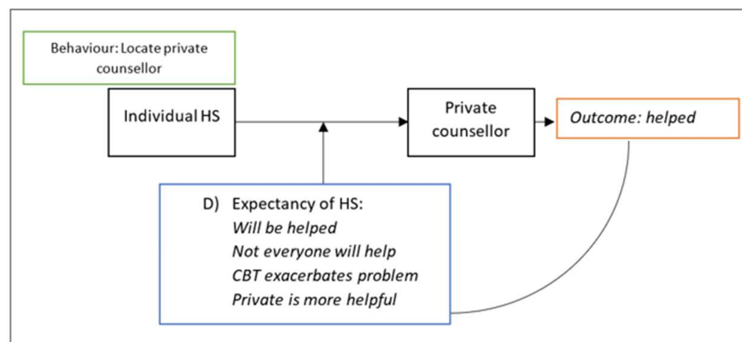
Figure 30: Analysis of participants help-seeking pathway through four consecutive episodes for role of expectancy



Episode 3



Episode 4



This research also found instances of narratives which communicated how young people manage *indebtedness*, through providing reciprocal support from a friend. Narratives of dependency were prominent in discussions around medication, and this was found to damage self-image. Some young people, particularly young men, in this study whose narrative contained topics of the need for public success or status, did delay help-seeking longer, in line with Chan's (2013) model.

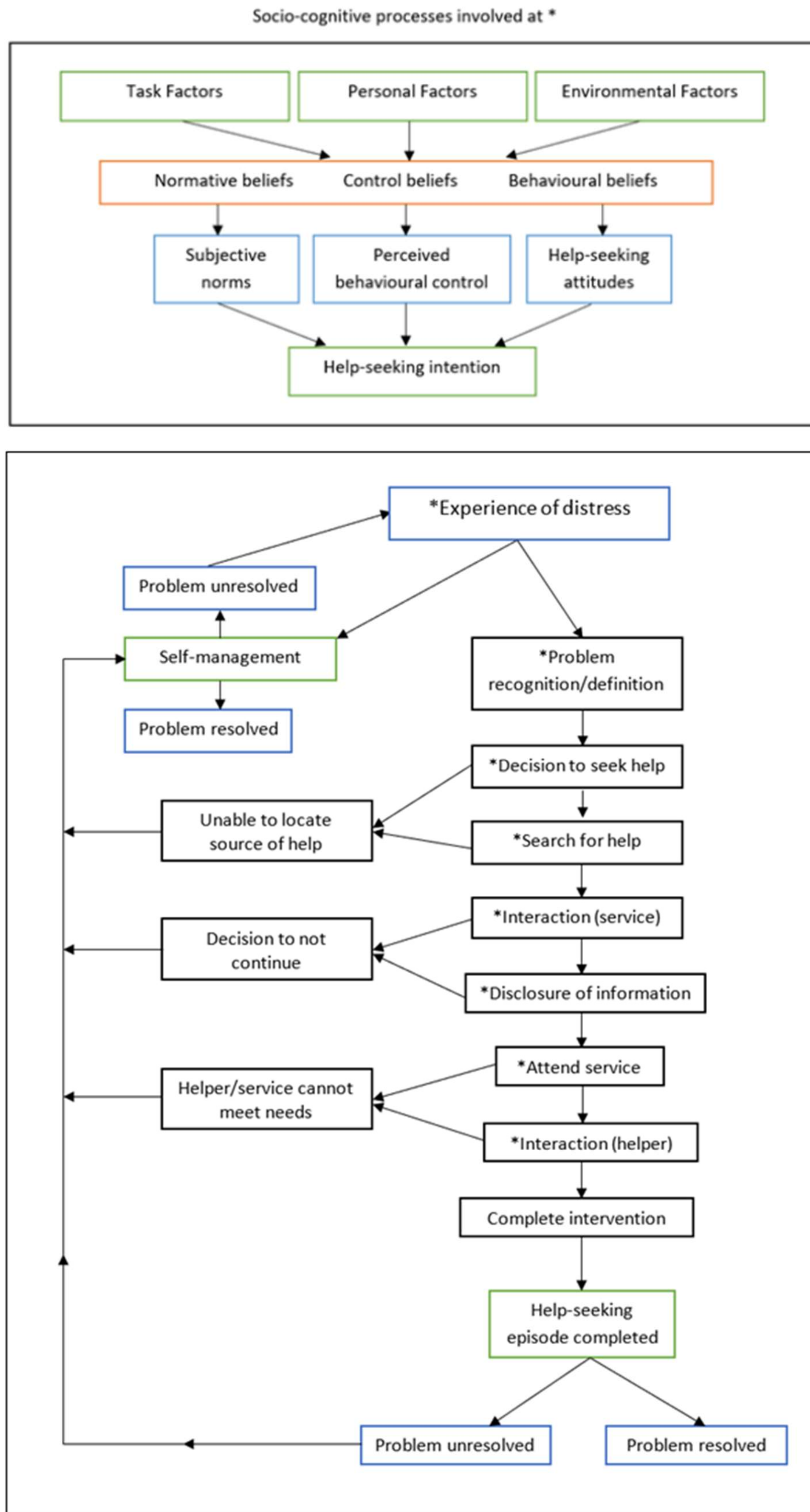
Chan (2013) brings the algorithmic focus of the Theory of Planned Behaviour (Ajzen & Fishbein, 1980) to the examination of the role of an individual's *salient beliefs*, their *attitude* to the behaviour, the *subjective norm,* and the *perceived behavioural control*. This study found descriptions of how cultural factors directly impacted how families and subsequently young people formed attitudes, beliefs, conceptualisations, and help-seeking schemas, which influenced how they negotiated the perceived *benefits and costs* in the help-seeking process. If a young person believes they can conceal a mental health problem, continue with the task of self-management, and *protect self-esteem*, findings show they will delay or not seek help. If a young person experiences intense distress, and is not meeting the task of self-management, self-esteem can be negatively affected; they may seek help to continue *protecting their value*

of learning the task of self-management. Narratives revealed that young people experience high levels of societal stigma and self-stigma around mental health and that this contributed to feeling devalued and the subsequent avoidance of help-seeking to *protect public image*. Findings also indicate that when treatment interventions are not successful, some young people can internalise feelings of failure regarding the experience and avoid help-seeking to *protect* further damage to *self-esteem*. Alternatively, some findings show that others perceived they had failed in the task of locating help to assist with self-management strategies and begin another help-seeking episode to protect their *value* of increasing self-management. This research contributes to increased understanding of this theoretical model by demonstrating how actual help-seeking experiences can be explained.

6.4.3. Strengths of Models' Applications

This research found that both models provide important insight into young people's help-seeking behaviours and that when explored together provide greater explanatory power. Chan's (2013) in-depth descriptions of cognitive antecedents to help-seeking can be located easily within Cornally & McCarthy's (2011) concise conceptual model and demonstrates on a theoretical level of the complex processes involved in a decision to seek help. **Figure 5** was developed to provide an initial theoretical framework for this research and the findings confirm that many aspects of these models to be relevant in youth help-seeking. Examining findings through the Cornally & McCarthy's model (2011) highlights the macro; the expected pathways, processes, skills, and consequences that a young person seeking help has to engage with, to access healthcare. Findings examined through Chan's (2013) model focuses attention on the micro, the cognitive processes involved in whether young people enter or exit a help-seeking pathway, with emphasis on the role of learning and task accomplishment. **Figure 5** illustrates how young people continuously weigh up the cost and benefits of help-seeking and at each point in the process they have three options: 1) proceed with or exit the help-seeking process; 2) withdraw and return to self-management or 3) identify a new help source and begin a new episode of help-seeking.

Figure 5: Cornally & McCarthy (2011) and Chan (2013) - Combined models



This combined model (**Figure 5**) provides a framework that supports further understanding of youth help-seeking through services, which can shape service use and facilitate engagement in healthcare or encourage withdrawal from a help-seeking episode when they do not meet young people's needs and this links with wider research (Purcell et al., 2011).

6.4.4. Limitations of models' applications

Both models, Cornally & McCarthy (2011) and Chan (2013) have some important limitations in explaining young people's pathways, with some critical incompatibilities when viewed within this research's findings. The first important limitation regarding these models related to their theoretical underpinnings of *Theory of Planned Behaviour* (Ajzen and Fishbein, 1980). Planned behaviour includes "one's attitude toward the specific behaviour, the subjective norm about the behaviour, and one's perceived behavioural control" (Chan, 2013, p. 4). The findings of this research consistently showed that young people are dependent on others' skills to locate help and for services to provide information and access. Young people described being voluntarily and involuntarily engaged in help-seeking pathways, without a clear understanding of the processes, expectations or options meaning they did not make informed decisions or were afforded opportunities to plan sufficiently.

Findings also show that young people's cognitive resources are often overloaded with managing intense personal and stigmatized emotional distress which permeates identity, self-esteem, and the self. With regard to these findings, expecting or asking a young person to coordinate their own healthcare independently within siloed systems under 25 years of age is unreasonable and unrealistic. This study found that many young people, including those over 18 years, were reliant on caregiver resources for attending healthcare. Outcomes for accessing help and staying engaged with treatment were largely dependent on the child-caregiver rapport and caregiver commitment (Moen et al. 2019). For those involuntarily engaged in mental health care, findings show that attendance can be mandated, engagement can be falsified, and withdrawal can be internal. Help-seeking models focusing on planned behaviour alone are limited and insufficient for understanding how the majority of young people seek help. The concept of *Planned Behaviour* is much more complicated in young people and this model can apply to adults or at very least, or to a minor subset of young people. As young people's actions cannot be separated from their immediate systems which provide the necessary resources to engage in such behaviour, help-seeking models that are not exclusively designed for youth

could be inadequate and these findings support Breslin et al. (2021) who propose adaptation, revision, or new thinking to youth help-seeking.

This research found incompatibility when viewing models within young people's actual experiences of help-seeking. Young people described multiple help-seeking episodes and outcomes, with gaps between episodes or parallel episodes - young people seek help while on waiting lists, and they can seek help to multiple people and places at the same time, until they find suitable help. This connects with Ungar (2018), who found that young people when help-seeking move between self-management and sources of help as needed and sometimes simultaneously.

Adults and young people have different developmental tasks, and help-seeking can interfere with fledgling autonomy. This research found that avoiding help-seeking can be an attempt to protect development and mental health support needs were more in line with the ebb and flow of young people's lives, their learning, their relationships, and their environment. Support frequency varied from longer periods to short bursts or one-off sessions, in line with challenges they encountered with development and the perspective changes that occur as adolescence begins and ends. These patterns of behaviour were not linear or time-bound and were mostly incompatible with expected formal help-seeking skills and models based on adult behaviour. These patterns indicate other processes at work that need attention when interpreting young people's help-seeking behaviour and the need to pay further attention to young people's learning and development.

6.5. Help-seeking and developmental theories

6.5.1. Introduction

Young people, as a demographic, are defined by their developmental status (Best & Ban, 2021) and so it is critical to examine how the findings of this research link to what is known about young people's learning and development in general. It is also important to consider how help-seeking affects development and how development affects help-seeking, with a specific exploration on how young people learn to problem-solve help-seek (Piaget, 1970; Vygotsky, 1978).

6.5.2. Learning theories

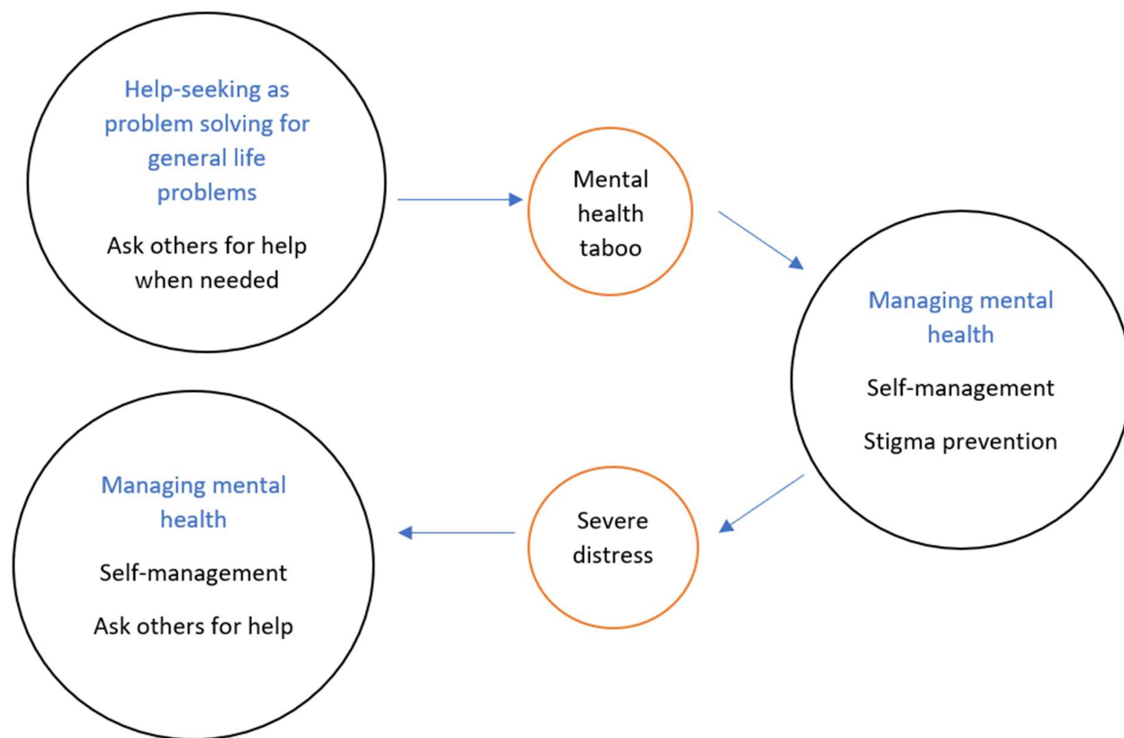
In understanding the role of learning and mental health help-seeking behaviour, it is helpful to revisit young people's *observational learning* and how they can imitate behaviours, attitudes and emotional reactions that are modelled by others (Bandura & Walter, 1977). Based on theories of learning through *conditioning* (Guthrie, 1942), Bandura (1977) emphasised the role of the environment and the social factors mediating learning. When learning about mental health, this research found that *modelling* becomes important in the absence of active teaching and learning of skills, especially when there is stigma. When family members modelled mental health management and help-seeking, findings show that young people had more favourable experiences using a formal service. Young people learned formal help-seeking skills through observations of how caregivers contacted and liaised with services and what resources were needed to achieve mental health outcomes. In environments where mental health conversations were taboo, seeking help was considered as behaving in opposition to what was modelled, and this tension caused ambivalence between wanting to seek help and not wanting to go outside social norms which could cause further emotional distress.

Piaget (1970) theorised that children think differently to adults, and created a sequential model of cognitive development, with the final stage beginning approximately around adolescence. This stage, *formal operations*, marks a profound shift in an individual's cognitive development specifically regarding abilities for abstract thought and deductive reasoning (Piaget, 1970). Young people in this study described the beginning of adolescence as a time when they noticed that their understanding of their feelings and ability to conceptualise problems was changing to include the wider context of their life. Findings also showed that with this increased understanding was an awareness of the absence of knowledge and skills for managing distress and a desire for learning. However, the presence of stigma around mental health could infer the need for an alternative approach rather than using traditional learning and problem-solving strategies.

Piaget (1952) theorised the concept of *schemas*, used to describe how children organise knowledge and experiences, through processes of *assimilation* and *accommodation*, into manageable categories of information (Berger, 2011). This study found that young people can have schemas for *help-seeking for general problem-solving* and can use related skills for mental health concerns, such as asking a teacher for help. **Figure 31** was developed from findings to illustrate succinctly schema development for mental health help-seeking. A common finding

was that the observation of stigma and taboo regarding mental health could prevent *assimilation* – the modification of new information to fit into a schema – of mental health problem-solving into a schema for *help-seeking for general problem-solving*. Instead, young people can perceive the need to create a new separate schema *managing mental health.*

Figure 31: Schema assimilation and accommodation in mental health help-seeking



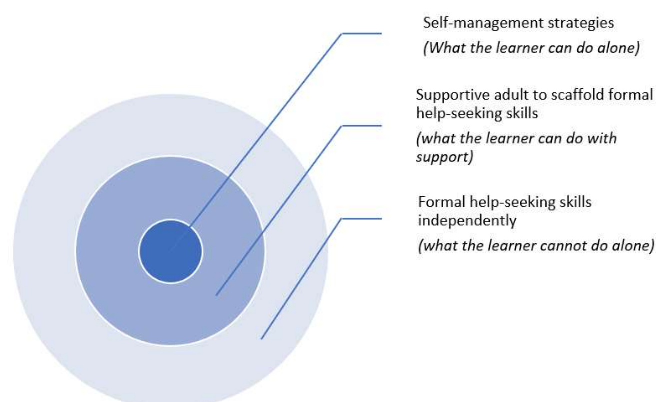
Developing a new schema, *managing mental health,* was challenging, and findings show that young people sought to find ways of coping that could exclude help-seeking and avoid stigma. This resulted in prioritising self-management strategies that could support concealment of distress. Eventually, due to severe or ongoing problems, young people had to help-seek or their distress was noticed by others, and so help-seeking, even informally, as a concept was *accommodated* - where existing ideas have to be altered to accept new information - through the creation of new and less stigmatised meaning. Some young people sought help while enduring stigma, risking self-esteem and public image, which this research found to be particularly difficult to do, emphasising the damaging impact when a service could not provide support or responded with further stigma. Inadequate service provision was found to further revise schemas to accommodate ideas such as, 'nobody will help me', which could contribute to the development of suicidal pathways. It is important to note that while findings in this

research support the role of schemas in mental health pathways, they did not appear to be deterministic or linear in outcome but were dynamic and responsive, with opportunities for amendment in positive and negative paths. Young people without developed schemas sought help and sometimes schemas were developed through positive experiences of help-seeking.

Vygostky (1978) theorised that a child's learning and development was deeply impacted by the individual history of the child and the history of humankind (Bodrova & Leong. 2006). Findings in this research demonstrated the importance of young people's individual life experiences within their cultural and historical context and how this impacts the learning of help-seeking skills. Vygostky's (1978) most famously proposed concept of the *Zone of Proximal Development* (ZPD), which describes three zones in learning: the central, what a learner can do independently, an external zone of what they cannot do, and a layer in between where they can learn from a more knowledgeable other. The concept of *scaffolding* was developed by Wood, Bruner & Ross (1976) and describes how pressure points in learning are supported dialectically and iteratively, until mastery, with support lessening as ability increases. It is through interaction and making sense of challenges that the learner develops abilities in independent problem solving.

Older and independent adults over time have increased opportunity to learn and master formal help-seeking skills. Findings from this research demonstrates that a *more knowledgeable other,* usually an adult or a peer, is very important when learning formal help-seeking skills, for accessing services. This research found that informal help-seeking is the important pre-cursor to service use meaning knowledgeable others will support or scaffold young people to access services, transferring skills through practical demonstrations. **Figure 32** was developed to illustrate the ZPD within the context of help-seeking.

Figure 32: Adapted Zone of Proximal Development for formal help-seeking skills



Young people in this study described patterns of observing a *potential helper* and going to supportive adults with mental health problems, who often provided support or facilitated them on to formal services. This mirrors how children learn in general and further discussion is warranted on what is known about learning and help-seeking behaviours in other contexts.

6.5.3. Learning theory within help-seeking models

Help-seeking is a broad term, one that is used widely in healthcare research and to describe an instrumental behaviour in learning contexts (Nelson-Le Gall, 1985). Research has also identified its important role in how children learn abstract problem-solving in mathematics (Mathews & Mitrović, 2008). It is necessary to understand the difference between *help-seeking as a pre-curser to learning*, and the previously discussed *formal mental health help-seeking skills* (**Figure 4).** In healthcare, help-seeking can be assumed to be linear and episodic as described in Cornally & McCarthy (2013), whilst in academia, help-seeking is understood as an iterative and dialectical process, where children can easily access a helper as needed and are supported to solve the problem, sometimes over many episodes (Martín-Arbós et al., 2021). **Table 9** was developed to provide information on how young people's mental health help-seeking behaviours, as identified in this research, are more aligned with academic help-seeking models, rather than healthcare help-seeking models (Martín-Arbós, Castarlenas, & Dueñas, 2021).

Table 9: Mental health and academic help-seeking characteristics comparison

Youth help-seeking characteristics (mental health)	**Youth help-seeking characteristics (academic)**
Assesses sources of help	Uses diverse sources for help
Sources are accessible others (peers, family, community, school)	Sources are accessible others (classmates, teachers, parents)
Wanting to improve well-being	Important role in task learning
Wanting to improve self-management skills	Affects achievement
Used in an instrumental fashion (as and when needed to cope)	Used in instrumental learning – only amount needed to complete task
Wanting others to fix the problem (wanting cure)	Used in expedient learning – wanting other to solve the task
Self-referral	Involves self-regulation

Young people's approach to mental health problems follows help-seeking patterns and pathways are similar to problem-solving in other areas of learning. This can explain why young people's preference for self-management and patterns of service use, as and when needed, to

solve just enough of their problem to resume coping, are connected to intrinsic and practiced learning patterns and problem-solving approaches. As such, young people's help-seeking behaviours can be viewed as developmentally appropriate learning behaviours, and that *mental health well-being* and a *formal help-seeking skill-set* are the end goal which presents a conundrum; individual needs both to access mental health systems but generally only acquire them through experience. This analysis points to the possibility that research examining help-seeking behaviours to date does not distinguish between *help-seeking as a precursor to learning* and a *formal help-seeking skill-set,* which can result in conflation of two distinct concepts. It is possible that instrumental styles of problem-solving for distress (Chan, 2013), when compared against formal help-seeking skill-sets, can appear as erratic, lacking focus, reluctant or avoidant, and result in young people's help-seeking behaviours to mental health care being misrepresented. When viewed using academic models of help-seeking, young people's natural styles can be regarded as self-regulating, agentic, analytical for cost-benefit and decisive (Martín-Arbós et al., 2021). Findings in this research demonstrate that reluctance to seek help, or disengagement from a service, can result from an assessment that the service or helper could not meet their individual needs, and so moved on to the next source of help to increase their chances of having their distress supported. Young people from this perspective appear as highly resourceful, open and resilient help-seekers, engaged in broader developmental tasks.

When evaluating mental health help-seeking behaviours within healthcare and learning theories, neither approach can sufficiently address the help-seeking processes of young people to Western healthcare systems, which use caregiver assisted means expected in those under 18-years of age and the independent approaches used in emerging adulthood. As services provide the framework for help-seeking pathways (Aday & Andersen, 1974) and this research has found that service frameworks are incompatible with developmental frameworks, there is a need for a youth specific model, to guide research appropriately and ensure service design is not harmful. From this perspective current access and provision of youth mental health services in Ireland are developmentally inappropriate and inadequate, a finding that has been echoed in other countries with similar systems, such as Australia (McGorry et a. 2011; 2019).

6.5.4. Adolescent development and emerging adulthood

Youth is conceptualised as a time of transition, a liminal phase between childhood and adulthood, marked by profound changes in the neurological, cognitive, emotional, and existential aspects of an individual (Best & Ban, 2021). *Adolescence* is a developmental stage beginning around 10 with the onset of puberty and ending somewhere between 19 and 21 years of age (Best & Ban, 2021). The process of sexual maturation is an important developmental feature that requires support and education to navigate (Sawyer et al, 2018; Rickwood et al., 2019) and yet findings from this research indicate that sexual development is still a taboo topic within Irish society resulting in young people potentially experiencing their sexual development as stigmatised. Young people undergo individuation processes and significant development in their identity during youth (Erikson, 1950; Kroger and Marica, 2011) and this is impacted by their parallel social and sexual development. Friendships become intensely important (Lubman et al., 2016; Yamasaki et al., 2016; Maiuolo et al., 2019) and romantic relationships of increasing interest. Young people in this research described how interpersonal relationships contributed to distress (Moen et al., 2019). Due to the increased socialisation online, a fundamental way of relating has changed and findings suggest young people can experience social rejection or loneliness in an indirect way, stemming from a lack of physical contact. Young people can withdraw from their social development when dealing with emotional pain and engage with online spaces, which can also contribute to identity development.

As identity development can be mediated by feedback from a young person's environment and their close relationships, findings show that having a mental health problem, in a society that stigmatizes this, can cause young people to view mental health distress as an embedded etiological trait. Findings showed narratives of negative self-labelling and identities of defectiveness as impacting self-esteem and self-efficacy regarding mental health care planning. Treatment that offered medication reinforced the idea of a biological vulnerability and could reduce attempts at problem-solving or misdirect attention from environmental or social stressors. Erikson (1950; 1968) regarded the primary challenge of adolescence as to resolve the challenges associated with identity development and this research found that in emerging adulthood, young people can solve the problems of identity instability and confusion by accommodating or accepting the negative labels and overwhelming feelings, finding community with others who also share similar perspectives. This research found that a young

person's identity can become enmeshed with their mental health distress, especially when most of their life has been spent dealing with ongoing and unresolved issues throughout their youth.

Youth is understood as a complex life stage with many transitions. The theory of emerging adulthood by Arnett (2000) proposes a framework to describe a normative life-stage of people aged 18-29 years of age which has arisen from the demands of modern life, in economically developed countries where there is a need for continued education to enter the labour market (Arnett, 2014). Findings in this research confirm the presence and impact of this life stage on young people, and how these wider environmental and chronological factors impacted intergenerational divide (Bronfenbrenner, 1995). Emerging adulthood is a phenomenon because of the prolonging of opportunities for love and work than earlier decades (Tanner & Arnett, 2011). Most young people held expectations of their caregivers of adulthood beginning between 18-21 years and had limited awareness of emerging adulthood as a life-stage. This resulted in young people personalising wider economic conditions, believing they had failed at becoming independent in the expected timeframe. This prolonging also facilitated hopelessness for life goals such as home ownership and family life as unattainable, with the implication being that they might fail completely in becoming an independent individual (Bramesfield, 2006).

Part of the unseen development in adolescence regards the profound reshaping of the pre-frontal cortex, which is an area in the brain responsible for decision-making, planning, understanding of consequences and impulse control (Blakemore, 2018; Choudhury et al., 2008). Full biological and brain development completes around 26 years of age (Murray and Clayton, 2013) and research suggests that there is an increased refinement of the cognitive structures, regarding emotional regulation and decision making, needed for adulthood. Young people in this study, who were over 20 years of age, could communicate experiences with more reflection and clarity an d articulate better than younger counterparts, being more certain about their needs in mental healthcare. They also demonstrated an increased need for life skills to support their role experimentation and practical interventions, such as CBT, which was described as appropriate and desirable in emerging adulthood but unhelpful or ineffective, specifically tasks related to cognitive restructuring, in adolescence.

Across youth, developmental demands were described as sometimes suppressed or temporarily stopped by the more pressing need of mental health concerns and the associated problem-solving challenges. Emotional pain can be experienced as intensely as physical pain (Sachs-

Ericsson et al., 2017) and it was often when psychological distress was relieved that developmental tasks could return into focus. For young people who experienced state care, homelessness or immigration, their attempts to create stability in their environment and relationships could trump even mental health needs, completely putting developmental tasks on hold. When stability was secured, often in emerging adulthood, the task of engaging with a developing self while experiencing the effects of complex trauma could be overwhelming. Findings show that for these reasons, young people prioritised listening over any other therapy (Nielson et al., 2014). Opportunities to offload created space for development, to return to the tasks of making friends, forming identity, and experimenting with the roles of adulthood.

An overarching topic from findings regarded young people's need for autonomy. Previous research cites the desire for "self-reliance" or "need for autonomy" as a *barrier* to help-seeking but this research found that this was part of a normative developmental drive of individuation, encouraged by the wider cultural ideal of achieving economic independence which marks entry into adulthood (Bramesfield, 2006). Practicing self-management through demonstrating competency and avoiding dependency became increasingly important to young people in preparation for adulthood and in providing self-esteem (Wilson & Deane, 2012; Arnett, 2014). These findings also found a distinction between a developmental need for autonomy, a desirable *state* to be achieved and autonomy as a learned *behaviour,* developed from managing distress alone. When adults proved unhelpful, a belief of self-reliance was shaped and learning to survive in the world alone became an important coping mechanism. Help-seeking could undermine this reliable coping mechanism, which could upset internal schemas and cause further distress. When managed well, this research found autonomy was leveraged and young people reframed it positively, even managing to reframe help-seeking as an autonomous skill set, without destabilizing their identity. This links with international research that has demonstrated the ability of young people to position themselves positively within mental health concepts (Masuda & Boone, 2011; Prior, 2012; Eisenberg et al., 2012; Bilican, 2013; Yap et al., 2013b, Del Mauro & Williams, 2012).

6.5.5. Adolescence from a psychosocial perspective

An overarching narrative across findings in this research regarded the intergenerational tension and associated unconscious dynamics that permeate the individual, the organisational, the systemic and the societal (Fotaki & Hyde, 2014). The polarising of *age*, the "us" versus "them" narratives described in this study, is reminiscent of in-group and out-group dynamics proposed

by Tajfel & Turner (1979) and reflects other polarisation narratives occurring currently within society (Fletcher & Jenkins, 2019). The youth-adult divide can be observed in practice and in research, where distress in youth is conceptually separated from adulthood distress, resulting in the labelling, and minimising of youth issues as individual, pathological, developmental or generational - as an enigma belonging to their group – disconnected and externalised from the adult group distress. This reflects the failure in understanding of youth pain as collective human pain, and an integrated understanding of distress as existing across the lifespan, traversing stages, regardless of age. These organisational, systemic, or societal divides may be a 'social defence' strategy against anxiety that can originate at the individual level (Menzies, 1960).

Splitting is a defence mechanism that an individual can use in times of stress to cope with something that causes conflict or anxiety (Rosenfeld, 2003; Fotaki & Hyde, 2014). The whole can be split into 'good' and 'bad' objects, with the good being idealised and the bad, with their potential for harm, rejected, denied, or projected out onto the other (Klein, 1952). Childhood is a cultural construct and a state often idealised by adults (Spigel, 2001). The construct of adolescence can be thus blamed for the ending of the construct of childhood's innocence, predominantly as a result of sexual maturation processes, which can be stigmatised. This splitting can be projected onto a societal level, where youth can become misrepresented and blamed for societal failings, which can cause young people to internalise stigma and shame. Adulthood, a less preferrable state to childhood, is a way out of the liminal, stigmatised, and chaotic adolescence. However, there are not three individuals experiencing a lifetime but one whole individual. Youth is a marginalisation that can be grown out of and tensions and self-stigma from this life-stage can be carried resulting in splitting. This can be an important coping mechanism to manage anxieties from youth but can cause an intergenerational split within the individual's psyche. Youth, as a concept and a demographic, can be projected onto, and as a place to pass on the pains that cannot be managed.

Findings in this study indicate that young people can be suffering from problem overload, (Charles, 2019) as many problems without the development of cultural tools can take generations to solve. Whether observed or experienced, youth mental health problems are distressing – to avoid the reminders of this distress, blame and idealism can support splitting and create continued commitment to failing strategies on an individual, organisational, or societal level (Fotaki & Hyde, 2014). In a study of mental health systems, Fotaki & Hyde (2014) state that many of these psychodynamic processes are visible within the NHS and refer to a case study in a psychiatric ward to demonstrate how individual processes that keep

'madness' (patients) separated from the 'sane' (staff) sustained ineffective wider policy that was based on unrealistic ideals for deinstitutionalisation and community care that resulted in inpatient underfunding. Findings in the current research have shown that mental health services for young people are not working, and there is no indication of reform, despite other countries, such as Australia, beginning reform practices in 2006 (McGorry et al., 2019). Adults, as caregivers and professionals, are highly influential in help-seeking and lead in service policy design, and delivery of healthcare. It is possible that young people can experience marginalisation and stigmatisation in healthcare due to individual psychodynamic processes sustained through systemic and societal action (Fotaki & Hyde, 2014; Cosgrave et al., 2019).

6.5.6. Summary

This research connects findings with wider theoretical insight regarding the role of learning, development, and psychosocial processes. Narratives of learning were ever present throughout the data with regard to *modelling*, help-seeking as a *precursor to learning* and *formal help-seeking skills*. Understanding help-seeking behaviour within developmental perspectives impacts how young people are viewed and treated. Rather than attributing help-negation to an informed personal choice, or a mystery to be uncovered, this perspective can remind adults in helping positions to provide scaffolded approaches to mental health learning and associated help-seeking, and to ensure young people are not signposted or referred on without guided support. This perspective can provide a realistic, compassionate, and supportive framework, that views young people as individuals in distress who need help in learning new problem-solving skills (formal help-seeking) for personal and sensitive concerns (mental health) in the context of a unique life-stage (youth). These findings contribute to the advancement of help-seeking theory within a developmental context, specifically in providing the foundation of a youth specific model of help-seeking.

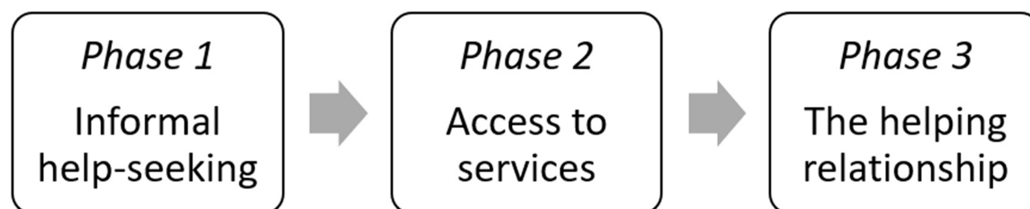
6.6. Conceptual model of youth help-seeking behaviour

6.6.1. Introduction

This research proposes a three-phase model of youth help-seeking for a mental health problem to a professional service. The purpose of help-seeking in youth is multi-level and can involve the need for safety, crisis intervention, positive attention, and validation. The primary goal is to lower distress and increase well-being *enough* to continue with self-management, the tasks

of development and daily life. This is accomplished through connection with another who can offer genuine care and the opportunity to learn new information that can contribute to the development of self-awareness or skills for self-management. Derived from the data, these distinct phases present the key processes and pathways in a young person's help-seeking episode: *Phase 1* describes informal help-seeking approaches; *Phase 2* describes accessing a service and *Phase 3* presents the factors in the helping relationship that complete a help-seeking episode (**Figure 33**).

Figure 33: Overview of youth help-seeking for a mental health problem

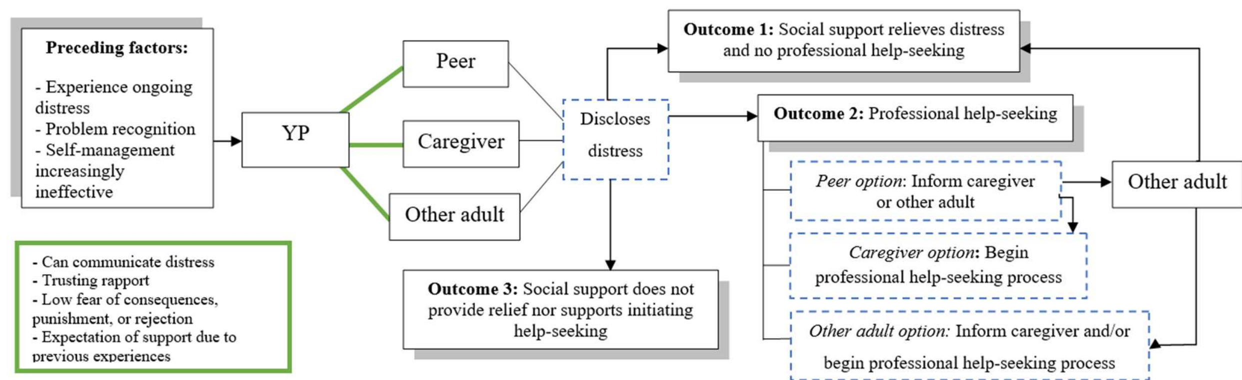


6.6.2. Phase I: Informal help-seeking pathway

Professional help-seeking begins with a decision to inform or exclude relationships within a young person's immediate social network. This initial phase describes the important social processes that occur prior to professional help-seeking. The key features of this phase include problem recognition, decision to disclose distress, search for a trusting or *knowledgeable other* and decisions to seek professional help or not. This research has identified four common pathways: 1. *Active-assisted help-seeking;* 2. *Indirect help-seeking*; 3. *Directed help-seeking* and 4. *Self-directed*.

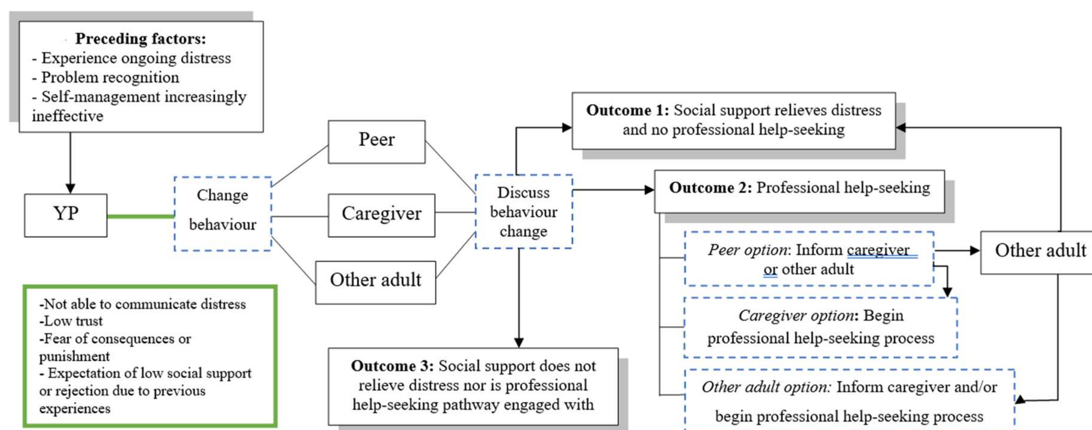
This first pathway *active-assisted help-seeking* describes how young people will use their learned problem-solving skills from childhood to seek help from another for a mental health problem. This begins with disclosing a problem to a trusted and knowledgeable other, typically a friend, family member or another adult in their community, such as a teacher or sports coach, who can offer support. Young people can have distress relieved through disclosure, avoiding professional help-seeking, or they can ask friends to assist them in telling another adult or caregiver, or they can ask their caregiver(s)s to coordinate professional help-seeking on their behalf. This process is illustrated in **Figure 34.**

Figure 34: Active-assisted pathway



This second pathway *indirect-assisted* describes how young people change their behaviour to signal to a peer, caregiver(s), or other adult that they are distressed and want assistance. This approach is common in young people who are unsure how to articulate needs, have low trust in others to meet these needs or can be connected to previous experiences of having emotional needs rejected, dismissed, or punished. Once distress is disclosed, similar to *active-assisted*, young people can find relief and exit the help-seeking episode, or ask friends, other adults, or caregivers to assist in further help-seeking or coordination of professional help-seeking (**Figure 35).**

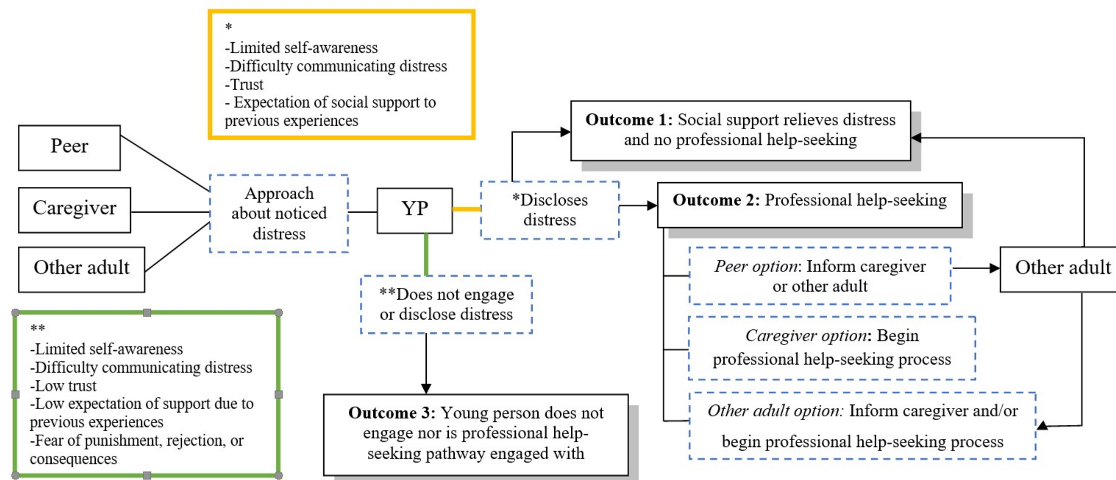
Figure 35: Indirect-assisted pathway



This third pathway *directed-assisted* describes how a young person is approached by a concerned other who has noticed behaviour indicating distress but is unlike *indirect-assisted*, where the young person has actively changed their behaviour to communicate a need for assistance. The young person can engage with the concerned other and disclose distress, being

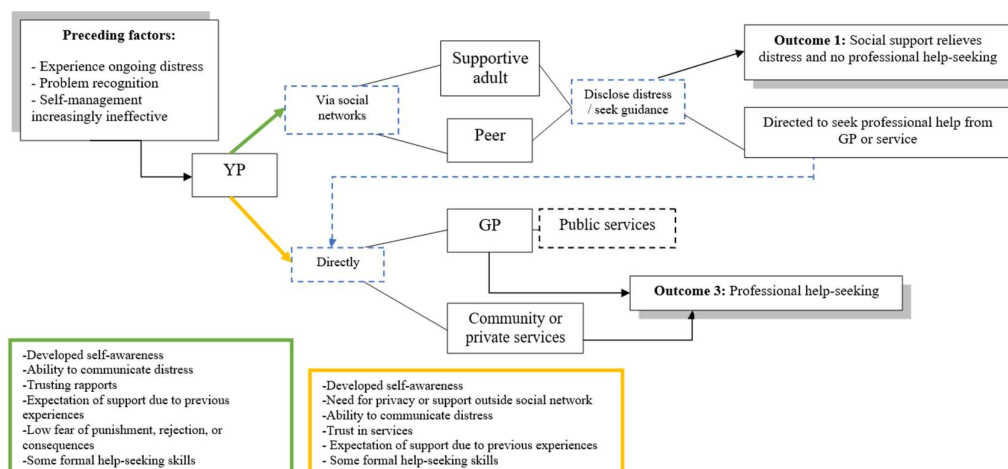
directed on pathways to outcomes similar to the first two approaches. As the young person does not initiate this pathway, there is also the option to not disclose distress, which can happen due to low trust, fear of consequences, avoidance, or previous negative experiences. This process is illustrated in **Figure 36.**

Figure 36: Directed-assisted pathway



The fourth approach, *self-directed* describes the way in which young people initiate their own professional help-seeking pathway. This approach is common when young people have some skills to coordinate help-seeking but require guidance or benefit from the reassurance and emotional support from others in their network. Going directly to a service alone is another self-directed approach that is used when young people need privacy or confidentiality away from their social networks, and is a method used when concealing help-seeking behaviour due to low trust, stigma, or fear of responses (**Figure 37**).

Figure 37: Self-directed pathway



Overview

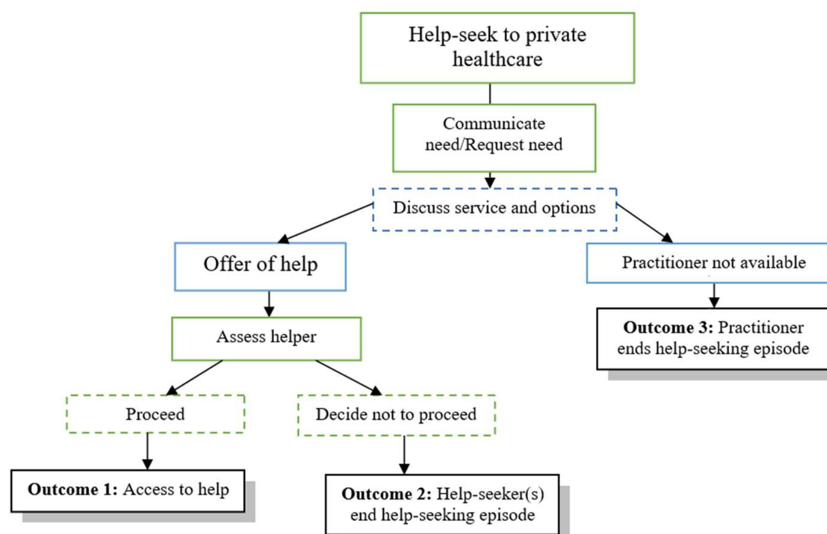
This first phase, *Informal pathways*, presents the most common pathways that young people initiate professional help-seeking. Help-seeking occurs through relationships first, or in some instances at the deliberate exclusion of them, highlighting the central role of the social network in influencing help-seeking action. *Indirect-assisted* help-seeking and *self-directed* help-seeking can happen after a failed episode beginning with *active-assisted* or *directed-assisted* pathways. This first phase also acknowledges that young people are learning about mental health and help-seeking using natural patterns of problem-solving, that when supportive others provide *just enough* relief from stress young people can end a help-seeking episode and return to self-management.

6.6.3. Phase II: Accessing services

The second phase of this model represents the point in the overall pathway where the help-seeker(s) initiate contact with a service and discloses information with the hope of access. This phase is designed to provide an overview of the most common procedures in appointment-based services, both nonclinical or clinical settings, and is of high relevance to *public health care*, *community services* and *private healthcare* in Western systems. Proceeding through this phase is directed by the service requirements and policy.

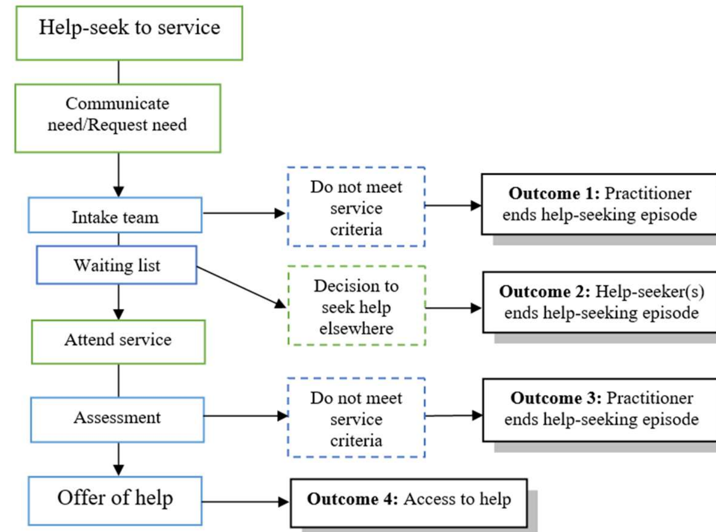
Accessing *Private health care* is an uncomplicated pathway requiring a conversation with a practitioner about their services, and a help-seeker(s) assessment of whether this service will meet the young person's needs. Boxes in green indicate where the help-seeker(s) have control and blue indicates where services are in control (**Figure 38**).

Figure 38: Access to private healthcare



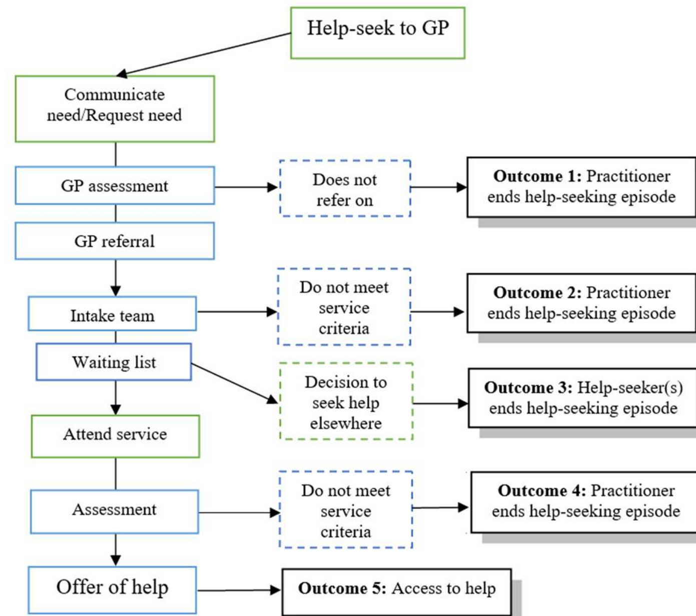
Young people can access *community services* directly or by referral but often proceed through processes of review, waiting lists and assessments, depending on the service and demand and policy (**Figure 39**).

Figure 39: Access to community services



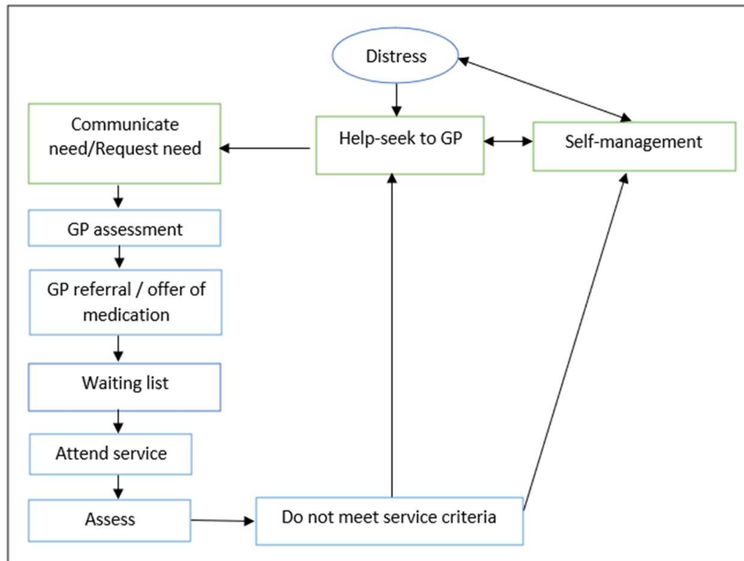
Access to *public mental health care* requires a referral, which in most cases is through a GP and is illustrated in **Figure 40**.

Figure 40: Access to mental health care in the public system



In this second phase, a help-seeking episode can be ended by the service or the help-seeker(s). It is also in this phase of help-seeking that young people in the *public mental health care* system can become caught in a referral loop (**Figure 18**).

Figure 18: Referral loop



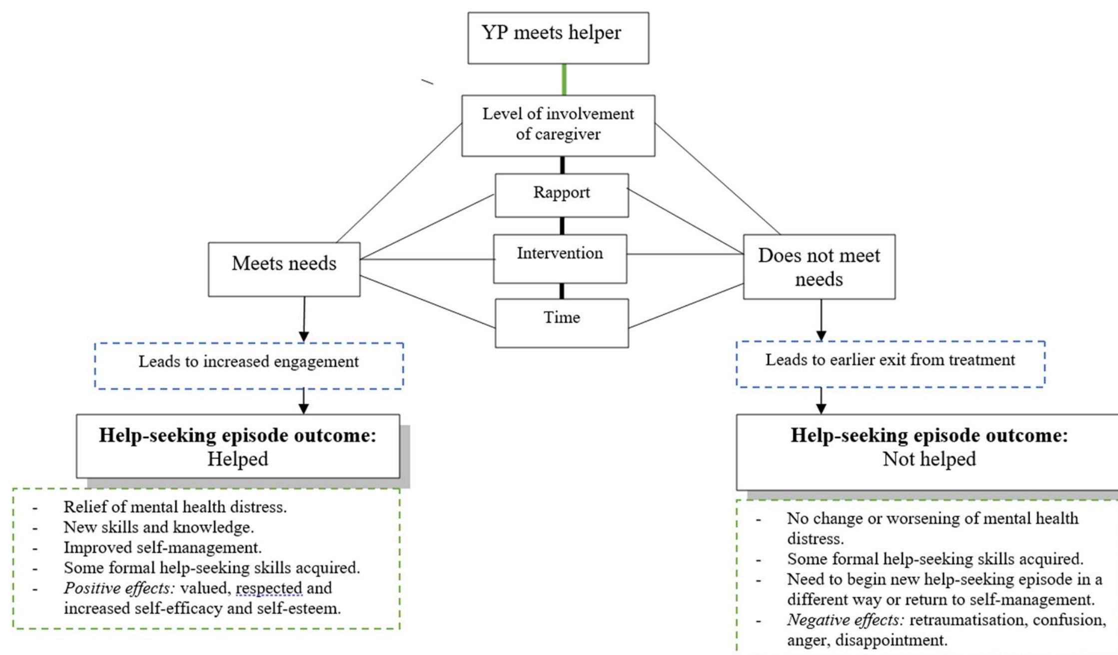
Overview

Procedures in this second phase can cause young people help-seeking with a supportive adult to be reliant on their formal skills of communicating, negotiating, and advocating. This phase can be very difficult for young people on their own who can have difficulty overcoming the barriers of access at this point.

6.6.4. Phase III: Engaging with help

The *third phase* of this help-seeking model regards the point where the help-seeker(s) have gained access to the service and a young person meets their helper, and plans for treatment are made or not made, and the intervention begins (**Figure 41**). The logistical, financial, or emotional resources and skills of an adult are required to support the young person to maintain motivation to engage with treatment. There can also be an increasing need for confidentiality and the degree of caregiver involvement depends on the comfort levels of the young person. Alternatively, if a caregiver(s) is not committed to this process, or the balance is not correct, young people can disengage from treatment and end the help-seeking episode. This phase can also be navigated with independent help-seeking skills usually beginning to develop in emerging adulthood.

Figure 41: Staying engaged in mental healthcare



Overview

Young people are still in a process of help-seeking until their distress is relieved *enough* for them to consider themselves 'helped'. This phase illustrates how young people navigate the rapport, intervention options, the overall approach and time offered to them. An important part of this phase is the outcome of 'helped' or 'not helped' and the impact this has on mental health.

6.6.5. Help-seeking modes

Another level to this model regards findings that indicate common patterns in the way that help-seeking pathways are engaged. This research presents three modes of help-seeking: 1. *Co-help-seeking*; 2. *Coerced help-seeking* and 3. *Independent help-seeking*. Young people can gain a collaborative other to seek-help professionally or can lose control to a non-collaborative other. The patterns of these modes, the key features and some limitations and benefits are presented in **Table 10.**

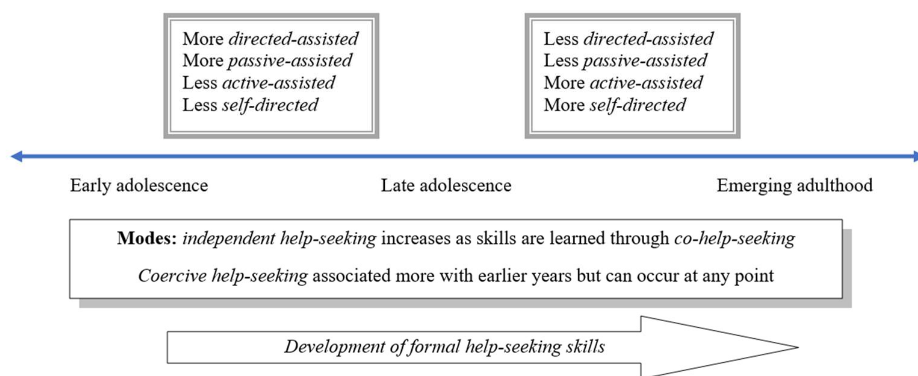
Table 10: Help-seeking modes in youth

	Co-help-seeking	**Coerced Help-seeking**	**Independent Help-seeking**
PATTERN ACROSS YOUTH	Primarily under 18's – helpful adult(s) are typically caregiver(s) or social worker.	Primarily under 18's – help-seeking initiated by caregiver(s) or social worker.	Includes under 18's – typically to a youth worker or pastoral care support.
	Includes over 18's – helpful adult(s) are typically a caregiver, friend or youth worker.	Includes over 18's – typically a caregiver accessing private healthcare.	Primarily over 18's who have experience of or observed help-seeking.
KEY FEATURES	Young person and a supportive adult(s) collaboratively proceed with professional help-seeking.	Young person (involuntarily) and caregiver(s) proceed with professional help-seeking.	Young person has developed enough formal help-seeking skills to proceed with help-seeking alone.
	Young person reliant on adult skill sets and resources.	Young person can be compliant with adult instruction.	Services that do not require parental consent.
	Caregiver(s) consults young person and advocates needs.	Young person problematised.	Increased privacy and confidentiality.
	Positive rapport, and good communication.	Poor rapport and communication	Increased choice.
	A desire for external support	A desire for external support	A desire for external support
BENEFITS/ LIMITATIONS	Decreased negative feelings and reduced stigma	Increased negative feelings, distress and stigma	Young person can help seek help autonomously
	Modelling and transfer of skills, sharing of skills.	Unhelpful outcomes	Can be difficult without support
	Less privacy		

All pathways are dynamic and can involve more than one mode per episode, for example, a help-seeking episode can begin with *co-help-seeking* but transition to *independent help-seeking*. Young people can move between modes over different help-seeking episodes, for example, returning to *co-help-seeking* in a second episode of help-seeking when they were unable to locate help *independently*.

When a young person assesses that *co-help-seeking* is unlikely or are reluctant or fearful to ask caregiver(s) for support, they can try to seek help *independently* and this is common in early adolescence. In these cases, help-seeking will often get them as far as a friend or a teacher - another knowledgeable other as they have not yet developed formal help-seeking skills or require consent to attend a service. It is important to note that due to the difficulty in accessing services in Ireland, caregivers can need supportive others when seeking the right help for a young person emphasising how help-seeking for mental health at any point and at any age can require many people, including advice from professionals such as GP, pastoral care, youth work or private counsellor. How patterns regarding use of these *phase 1 pathways* correspond to *modes* across different periods in youth and are presented in **Figure 42**.

Figure 42: Transitional diagram of help-seeking approaches and modes across youth.



6.6.6. Discussion

This model was developed through an in-depth examination of data from young people's actual experiences of help-seeking and informed by the theoretical frameworks of Cornally & McCarthy (2011) and Chan, (2013) which are derived from the Theory of Planned Behaviour (Ajzen and Fishbein, 1980). The first phase presents informal support as an essential and embedded part of youth help-seeking, a role that can be assumed, overlooked, or underestimated in the wider literature, and thus not understood in-depth (MacDonald, 2018).

This crucial *first phase* illustrated in **Figures 34, 35, 36** & **37**, demonstrate the role of relationships, social dynamics, personal risks, decision-making and managing stigma of informal help-seeking which creates the foundation for Phase 2. The *second phase* reflects the limited action that help-seeker(s) have on a help-seeking pathway and how access is shaped by service actions. This aspect is often neglected when considering how young people seek help. The *third phase* reinforces the importance of the need for young people to be engaged through rapports and interventions that meet their needs. *Modes of help-seeking* reflect the wider dynamics in a young person's interpersonal relationships and are influenced by self-awareness, quality of rapports, communication, modelling of help-seeking and the availability of services. For example, one participant in this study described accessing a service during adolescence using an *active-assisted* approach to *public health care* in a mode that was *coercive help-seeking* and how this did not work out. From caregiver(s) modelling of formal help-seeking skills, they were able to access *private health care* using a *self-directed* approach and *independent mode* in emerging adulthood successfully. Young people seek help with the support of friends and family unless these relationships are the source of their concerns, or they anticipate stigma. When under eighteen years they can still take this route, but it can have negative outcomes, or they can attempt to seek help privately.

This model acknowledges the developmentally expected pattern in mental health help-seeking and how this is connected with intrinsic problem-solving help-seeking patterns in learning. This conceptual model of youth help-seeking draws on models of planned behaviour but importantly integrates key relational factors that help-seeking in youth is rarely an individual action. This model illustrates how decisions are made between caregivers, friends and other adults who can provide skills or resources to navigate formal services. Informal networks are embedded in the first phase of this model and this placement acknowledging their central role rather than viewing them as in competition with professionals. Young people seek help until either enough distress is relieved to continue with self-management or until they incur further stigma or negative treatment and withdraw from a help-seeking episode.

6.6.7. Summary

This model is a multi-level, flexible and relationally based concept which is representative of the prominent pathways young people and their supportive other engage with professional help-seeking and highlights the importance of relationships in the help-seeking pathway, how services shape outcomes and the importance of the helping relationship. When one approach,

mode or service pathway does not result in help, another iteration can be sought, or the next episode adapted. This is the first conceptual model that the researcher is aware of that combines the relational with planned action theory that acknowledges the systems and social actors most commonly experienced in young people's pathways.

6.7. Core needs in a service

6.7.1. Introduction

The primary aim of this research was to identify the key elements that support young people's mental health help-seeking processes. Young people were asked to reflect on their experiences of help-seeking and service use - before, during and after - and what they perceived they needed from that service and their helper to facilitate and engage them appropriately in care, at that time. Young people are not a homogenous group and have varied life and healthcare experiences (Höylä, 2012) and so the aim of this section is not to present a reductionist list of facilitators but to describe common needs across the shared experience of being a young person and asking for help for a mental health problem in the Northwest of Ireland. The term "core needs" represents findings across four features of healthcare that this research found is a necessary base from which to provide individualised care (**Table 5)**.

Table 5: Youth core needs in mental health services

Service	Approach & Rapport	Interventions	Developmental
Welcoming staff and reassurance of help	Safe, approachable, and friendly	Individualised face to face support	Services for 12-25 years
Information and expectation setting	Opportunities for trust building	Developmentally appropriate interventions	Longer-term access and support
Direct access and timely response	Confidentiality and privacy protected	Flexible, adaptable, and creative methodologies	Opportunity to develop conceptualisation of mental health
Appropriate assessments	Collaboration and planning	Self-management spaces	Opportunities for rapport development prior to healthcare
Inter-agency and multi-disciplinary service	Non-judgemental and empathetic support	Consistent care	Support and guidance with other life concerns
Voluntary participation	Appropriate professional boundaries	Respite	Age-appropriate expectations for service use
Flexible service times	Relatable and understanding helpers	Culturally appropriate interventions	Ad-hoc, routine and crisis support as needed
Policy that supports interventions	Genuine care	Positive attention	Support with psychopharmacological interventions
Option of helper	Appropriately trained and experienced helpers	Opportunities for community	Scaffolded learning with formal help-seeking skills

6.7.2. Service

Systemic policy and practices, often hidden from young people, create the soil from which service provision and service culture blossoms, directly influencing management, staffing and the general environment of the service (Dopp & Lantz, 2020). Young people have distinct needs *due to* their life stage and *because of* their life stage and thus need the creation of developmentally appropriate services, with suitable environments and specialist youth trained staff; all of which include and consider the essential role of families in their mental health care (McGorry 2019; Rickwood et al., 2019). Youth mental health services must evolve beyond *youth friendly* and become *youth centred* (Sawyer et al., 2018; Rickwood et al., 2019). Child services are to be delivered to children, and adult services to adults, as youth is a well-defined and understood developmental life stage (WHO, 2021); accordingly there needs to be *youth mental health services*, in the age range of approximately 12-25 years (McGorry et al., 2019; Westberg et al. 2020). Ending service provision at 18 years of age was found as possibly the

most harmful time during youth as it is a key developmental transition point to emerging adulthood (Arnett, 2014; McGorry et al., 2019). This transition can be re-traumatising for young people in state care, as they lose professionals who become proxy family members, on whom they depend on for ongoing connection, comfort and care, beyond 18 years of age (Stein, 2007).

Access is currently very difficult for young people and their families in Ireland and self-referral, which is a practiced in most community services, needs to be considered within the Irish public system. First meetings with staff are critical for young people and they need to be welcomed and provided with information regarding expectations, options of treatment, timescales, staff roles and limitations, how their information is stored, and how confidentiality is managed with age-appropriate examples (Lynch et al., 2020; Hackett et al., 2018; McGorry et al., 2019). Voluntary participation is a critical conversation in youth mental health care as there are some concerning grey areas found in this research regarding consent in participation and decisions about mental healthcare (Draucker et al., 2005). Without engaged voluntary participation, interventions and outcomes can be at best only partially successful and at worst harmful (Damien at al. 2018). Respecting and leveraging developing autonomy is a priority for young people (Wilson & Deane, 2012), and young people need to make informed decisions about their healthcare. Young people can be offered some choice regarding helper with attention to the gender of the helper as some young people’s distress can be connected to the gender of a caregiver (Pearson & Hyde, 2021).

Young people need a timely response and reassurance on request for help. This research demonstrates that waiting lists are harmful to young people’s mental health and are generally connected to underfunding of services or a lack of service reform (Barnardos, 2017; Dopp & Lantz, 2020). Being young impacts how mental health is understood and how help is sought, booking appointments ahead of time and other *formal help-seeking skills*, is not often within developmental capacity until later in emerging adulthood. Services need to accommodate this developmental related style and allow for appropriate ad-hoc or crisis support, which can be common and expected in youth and may appear different from crisis support in adulthood (McGorry et al., 2019; Rickwood et al., 2019). Services can reconsider support beyond the 9-5pm paradigm and ensure suitable and more appropriate hours for routine support for young people which could potentially contribute to reductions in cancellations or no-shows at mental health services (Sims et al., 2012).

Informal approaches are essential at all levels of service provision, this includes young people and helpers using first names and excluding the use of academic or medical titles, which serve no purpose other than to reinforce hierarchy. Assessments can be an experience that defines how a young person engages with the service and as such, the same individual that provides the intervention should also complete the assessment, as young people should not have to retell their stories to multiple staff (Hackett et al., 2018). Assessments need to be completed with empathy, compassion and in a paperless and informal manner, by mental healthcare practitioners who are trained to do this. Clipboards, administration, and notetaking are regarded as intimidating, distracting and unnecessary to young people. As attending formal appointment-based services requires resources from caregivers, support and flexibility needs to be offered to caregivers who can be managing other responsibilities, such as employment and childcare. Services can consider how their policies can result in the exclusion of groups of people who traditionally experience marginalization from government services (De Anstiss & Ziain, 2006; Masuda et al., 2009; Fanning, 2012).

Formal and clinical spaces can be frightening, intimidating and unfriendly to young people (McGorry et al., 2019). Unstructured community-based spaces are the least harmful service environments for young people and having access to a positive and safe physical environment in itself can be therapeutic, especially to young people experiencing instability and upheaval from state care, immigration or homelessness (Crosby et al., 2018). Young people with low social support need community services, specifically youth services, for supporting and maintaining them in mental healthcare and for community building, peer connectedness and to provide proxy familial style roles to assist problem-solving, advocating, and encouraging interests (Rickwood et al., 2005; Harland et al., 2005; Kelly et al., 2009). Young people who identify as LGBTI+ need explicit demonstrations of acceptance at a service such as visible placement of posters and social media posting which can reduce some of the anxiety and fears that young people in this community can experience when they ask for help (Fish, 2020).

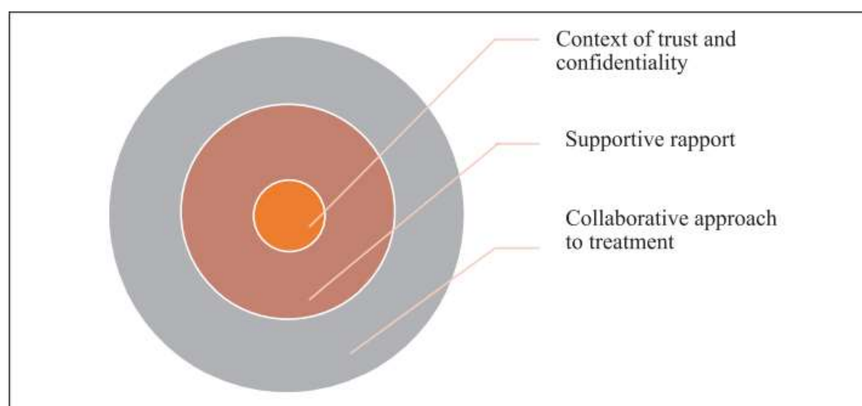
As formal services are often provided in clinical environments, they can contribute to feelings of defectiveness or alienation. Waiting rooms are not comfortable for young people experiencing distress and can intensify anticipatory based anxieties. Services can consider how and when their physical design reinforces stigma and secrecy, or supports privacy, openness and acceptance about mental health (McGorry et al., 2019). Young people feel safe in comfortable settings and value refreshments, such as warm drinks or food, which can communicate nurture and care, and mimic features of informal help-seeking, increasing

comfort and lowering anxiety. Young people, especially in early to late adolescence, prefer multi-functional community-based environments, which can manage stigma, fears, and discomfort better. This process has been initiated in countries such as Australia with integrated services that provide a holistic approach to young people's development and mental health and with some successes (McGorry et al., 2019; Rickwood et al., 2019). Those in emerging adulthood can manage more formal spaces if helpers are appropriate. In a review of research, Tillman et al., (2018) found that interventions involving being outside in nature positively influences mental health and this research proposes that the concept of therapeutic spaces for young people is revised to include support outside of a room or a building, such as a park or a public space, for young people who would prefer that. Drop-in or unstructured spaces for self-management in schools and youth centres can also be considered.

6.7.3. Rapport and approach of helper

Supportive rapports are central to young people's mental health care (Lynch et al., 2020) and young people need person-centred approaches from helpers who inquire about their well-being and who use active listening skills (Davison et al., 2017; Persson et al., 2017; Wilson & Deane, 2001). These relational exchanges create opportunity for safety and trust, in which young people can feel connected, heard, receive positive attention, and feel liked, which is a developmental need. Young people need warmth, reassurance and hope from helpers alongside having personal power supported through collaborative problem-solving and in developing self-management supports (Hackett et al. 2018; Lynch et al., 2020). Collaboration is a central need in the helping relationship (**Figure 43**).

Figure 43: The core components of the helping relationships in youth mental health care, (Lynch et al. 2020, p.8)



Another important aspect of a supportive rapport is trust and the length of time needed to establish trust is individual (Lynch 2020). To compensate for formality, helpers can, in the initial stages, create space for some young people to "assess" them and consider this process as an essential part of care (Draucker et al., 2005; Jones et al., 2017). Young people who have had their trust broken previously by other adults, including mental health professionals, need the helping rapport to feel genuine or "real" which supports trust building, and this can include some looser professional boundaries whilst maintaining professional responsibilities (Ungar, 2018; Jones et al., 2017). Young people cannot always articulate or understand their distress; healthcare needs may only reveal over time, with increased self-awareness and communication skills (Simmons et al., 2011; Ungar et al., 2018). Young people can be trusted to know what they do not need, or what is not working for them and need to be allowed to try out different things and ask questions about their interventions (Jones et al., 2017).

Confidentiality is an essential part of the supportive rapport (Lynch et al., 2020) and young people need helpers who can provide clear boundaries, protect confidentiality, and manage child safeguarding in a calm and responsive manner. Boundaries may need to be explained to young people many times to ensure full understanding of the context of confidentiality and the consequences of disclosures. For young people who have low social supports or have experienced much adversity, trust breaches or trauma in childhood, confidentiality is of higher priority and connected with wider research on youth homelessness, immigration, and sexuality (Cniro et al., 2005; Collins & Barker, 2009; de Anstiss & Ziaian, 2010). Young people experiencing marginalization need a helper who can understand the compounded stress of issues they face related to discrimination or racism. Helpers can ensure they are mindful of familiar adult-child power dynamics, paying attention to undue influence, power, or control over the direction of support.

Young people also require helpers who can understand the challenges of mental health and provide compassion and empathy on how attendance can be affected by distress and adopt flexible, adaptable, and creative approaches to mental health. Helpers can be supported to communicate well and in age-appropriate ways, with attention to manner, body language and dress through training. In early to mid-adolescence, young people can become attached to their helpers and so endings or transitions need to be managed sensitively. An important part of providing care regards understanding how a young person conceptualises mental health, regardless of cultural background. Helpers can scaffold learning about associated services, treatments, options, and processes that can align with a young person's conceptualisations. It

is important for helpers to be transparent and forthcoming about expectations and limitations (Jones et al., 2017). Young people require access to longer-term and consistent supportive relationships up to the age of 25 years, who can provide help when and as needed. This type of support reflects natural patterns of problem-solving and developmental needs and connects with findings in wider research by Dopp & Lantz (2021). When a consistent supportive rapport is developed, young people feel respected, listened to, validated, and cared for, they can engage more meaningfully and openly with their helper and begin addressing their mental health concerns (Lynch et al., 2020).

6.7.4. Interventions

Young people need one-to-one individual support unless they request otherwise. Group support settings are not appropriate without the foundational skills needed to communicate and participate in such activities. As young people are constantly evolving and changing, they can require different interventions at different times (McGorry et al., 2019). Support can move between listening, guidance, and skills building, as and when needed. Listening is the single most important intervention young people need; to offload or to hear problems out loud can be sufficient for many to return to self-management. Other specialised treatments, including CBT, needs to be explained for their purpose and hoped outcomes, with specific attention to pharmaceutical interventions as young people need support to understand the role of medication, how it is best used and how to manage it on their own (Draucker et al., 2005).

Short interventions, adapted from adult models, which provide specific strategies for specific issues might not meet the needs of young people, these approaches are not reflective of how problems arise and are managed in youth (Hackett et al., 2018). The frequency and duration of support required can vary from daily, during a crisis or difficult transition, to routine weekly meetings. During times of stability, support can be offered fluidly in the manner of check-ins, following up and open offers of support by direct contact which young people perceive as demonstration of genuine care. Young people should not be discharged because they are doing well but offered information on how to return for support with future challenges. Young people can be trusted to make these decisions by helpers who are backed by responsive and supportive service policy.

It is normative that young people need access to accurate information and guidance around relationships, sex, education, employment and accommodation, and any other developmental related concerns, such as social, economic, or legal support (Harland et al., 2005; Rickwood et

al., 2019). Young people often need more than one supportive person and mental health care with young people benefits from interdisciplinary approaches using clinical and non-clinical interventions (McGorry et al., 2019). In the absence of integrated mental health care, young people use multiple siloed services in an attempt to get their needs for longer-term support met (Damian et al., 2018; Dopp & Lantz. 2020). Trauma informed care in youth should consider the implementation of multiple supports across disciplines as standard so that young people with severe distress are not retraumatised through the loss of a supportive and consistent relationship (Damian et al., 2018). The referral loop is a harmful practice of siloed systems and results in young people not being able to access appropriate services. If a helper cannot provide resources, referrers need to remain in a supportive position, to assist with advocacy and ensure that needs are met before ending support.

6.8 Conclusion

The chapter presented an in-depth discussion on how young people's childhoods, their wider family and community environments, and important cultural legacies affected their mental health. This research also found that young people's development can be impacted by their mental health and developed a diagram to visually demonstrate the compounding pressures of life on individual resources and coping capacities. This chapter also provides a critical discussion on mental health and intergenerational divides, close social relationships and wider global issues. As participants were experienced service users, their experiences were analysed and mapped to further understanding of their help-seeking pathways, and how these were significantly shaped by services. Important findings indicate that some young people may never help-seek to a professional service in Ireland because of conflicting conceptualisations of mental health, or due to the multifarious practical and logistical barriers of modern Irish youth mental health care. Based off the actual help-seeking pathways, a critical analysis of the help-seeking models that provided the theoretical framework for this research was provided, which was important in highlighting the issues with current theory. This insight combined with the findings about young people's wider context and help-seeking behaviours supported the development of a new conceptual model of youth mental health help-seeking behaviours. This multi-level model includes the most common pathways and modes of engagement young people use when seeking help and embeds the important role of informal relationships. This chapter concluded that that current service provision across sectors is inconsistent in approach

and varies greatly in how it meets the core mental health care needs of young people. It is likely that young people's needs are not being met due to the siloed nature of services in Ireland, which is an inefficient model in healthcare (Dopp & Lantz, 2020). As such, no service is discussed in-depth as the variation in provision of care is too diffusive and dependent on individuals that worked in services, the policies they worked under and the funding structures. Instead, features that were helpful and unhelpful, which were found in all services to different degrees, are combined and analysed to present what works and what does not work as reported by young people in the Northwest of Ireland for their mental health needs.

7. Conclusion

7.1. Introduction

This chapter provides the conclusion to this research project that explored young people's (aged 16 - 25 years) experiences on help-seeking for a mental health problem and that included both young peoples' (*N*=18) and practitioners' (*N*=6) perspectives. This study used Constructivist Grounded Theory methods to guide the collection and analysis of interview and focus group data. This section provides a *summary* of this thesis, a brief review of the *key findings* and the *limitations* of this research. This chapter also provides *implications* and *recommendations* for policy, practice and future research, and concludes with the plan for *dissemination*.

7.2. Summary of thesis

Mental health problems and associated help-seeking behaviours are embedded in young people's environment and interpersonal relationships. Young people are resilient and adaptive problem solvers for their distress and primarily rely on more natural self-management strategies and help-seeking skills to learn more about themselves and what they can do to improve their wellbeing. Young people prefer easily accessed supportive adults or friends to assist them in managing their distress and developmental tasks and when distress becomes too intense, social support is limited, and self-management strategies are exhausted, the need for professional support is triggered. The impact of managing distress can interfere with developmental tasks, which can temporarily divert emotional and cognitive resources. Access to mental health care in Ireland is not easy and often requires *formal help-seeking skills* and other important resources by a supportive adult, as coordinating mental health care is often outside of developmental capacity, even in emerging adulthood. This presents as a significant barrier to both young people's development, their independence and self-esteem, especially if a supportive adult with the required skill set cannot be found or problems are connected to adults who are needed to access healthcare. Experiences of services vary and depend on the ethos of a service, and the training and resources of helpers, with most young people reporting multiple help-seeking episodes before accessing the right support, sometimes enduring harmful or retraumatising experiences on the way. Help-seeking for mental health is a personal journey and through an in-depth investigation of these experiences, this research has identified young people's core needs in mental health care whilst providing insight into the wider environmental context, developing help-seeking theory and the sharing of important life experiences.

7.3. Summary of findings

The findings presented four categories from young people's data in Part A: 1. *"Young people's lives";* 2. *"Managing mental health problems";* 3. "*The help";* and 4. *"Impact and outcomes of their experiences".* Practitioner data in Part B identified two categories: 1. "*On being a helper*" and 2. "*Understanding of young people".* Important findings from these categories were discussed under four headings and included: 1. *"Young people's early life experiences";* 2. *"Young people's actual experiences of help-seeking";* 3. *"Contributions to help-seeking theory"* and 4. *"Young people's core needs within services".*

Firstly, a key finding indicated that psychological distress associated with *early life experiences*, a child's environment, social relationships, or *adverse childhood experiences* (ACE) can be carried into adolescence and emerging adulthood and so by the time young people seek help, they can be highly distressed. Problems with mental health in youth were found to be inextricably connected to family systems, community contexts, wider culture, and the pressures from living in a modern globalised and technologically advanced society. It was found that young people live with substantial intergenerational divides and are managing the legacies of institutional abuse and transgenerational trauma, which impacted trust in authority figures, institutions and systems and contributed to a culture of concealment. These findings also help further understanding about mental health issues and associated suicidality. An important outcome from findings is the combined understanding about how these challenges, whether inherited, acquired, or normative, create pressure on cognitive capacities at key developmental points (**Figure 27**).

Secondly, with regard to *actual help-seeking experiences*, a key finding was that young people's help-seeking pathways are rarely simple, singular, or accessed without adult support. As a result of service design, help-seeking is complex, access is not easy and there are wider structural problems regarding funding of services, siloed provision, stigmatising policies, and outdated or harmful, practices. This research also found that young people can become caught in a cycle of referrals (**Figure 18**) and that mental health services in Ireland currently do not meet the needs of young people on an individual or developmental level and that inappropriate care can contribute to increased mental health distress or suicidal pathways. To find support young people seek help many times, often using both public and private services, with some young people attempting suicide when they feel that no help is available. This research identified that mental health help-seeking requires *formal help-seeking skills*, which is a learned

skill set and has distinct features, usually mastered in adulthood (**Figure 28**). These findings centralise the complex role of families, friends, and other supportive adults in help-seeking pathways with these key relationships acting in a supportive or obstructive manner.

Thirdly, this research offers important contributions to *theory*. With regard to existing models, this research found that youth mental health help-seeking behaviours can be viewed within Cornally and McCarthy's (2011) model of healthcare help-seeking, but that these similarities can be a result of how service usage design shapes service users' pathways. Chan's (2013) model was found to be helpful for explaining the cognitive factors in help-seeking behaviours. A review of one participant's help-seeking pathways across four episodes, as a case study, supported Chan's (2013) hypothesis that expectancy can act as a moderator in help-seeking (**Figure 30**) and explains why young people repeatedly seek help. This research developed an understanding of how both models above can be understood within an adapted model but with limitations, especially regarding theories of planned behaviour (**Figure 5**).

Finally, the fourth key finding, which answered the research question regarding what young people's *core needs* are within services for the Irish context (**Table 5**). This finding provides *four* categories, which bring together common factors, that are regarded as important in youth mental healthcare provision including 1. *service*; 2. *rapport and approach;* 3. *Interventions*; and 4. *developmental*. Together these create a blueprint for how to provide developmentally appropriate services and can be a useful resource for policy makers, service providers and practitioners.

7.4. Limitations

This study has some limitations. Firstly, this research involved young people from different economic and social backgrounds and included young people who are part of groups that typically experience marginalisation, such as those in state care, asylum seeking and experiencing homelessness. However, despite efforts to initiate and include young people from the travelling community, research participation was not completed by anyone from this group. Travellers represent an important ethnic group within the island of Ireland who are often underrepresented in research and marginalised within wider society (Fanning, 2012) and who have been reported to be disproportionately affected by suicide in Ireland (Tanner & Doherty,

2021). Alternative approaches, such as participatory action research (McIntyre, 2007), need to be considered to recruit Travellers in the design and conduct of research on this topic.

Secondly, this study provided a transparent description of the methods used and while this approach encourages the use of reflection on subjective experiences, it is possible that unconscious researcher bias could exist.

Thirdly, while this study provided a rich and in-depth exploration of an important complex topic, it was a small qualitative study conducted in one region of Ireland which could have limitations due to its size and geography. Finally, the experiences of young people who do not seek help are not included and this can result in some limitations in understanding the topic holistically.

7.5. Implications

7.5.1. Theory

Help-seeking theory

This research is important for contributing further understanding to help-seeking theory and mental health by including perspectives from developmental psychology, learning psychology and educational perspectives. The investigation into the actual term 'help-seeking' has improved understanding of how this important behaviour by clarifying the distinction between, help-seeking as a *precursor to learning* and help-seeking as a *formal skill set,* demonstrating how the two processes can be easily conflated due to overlapping processes and a shared name (**Table 9**). Each process has an underlying theory attached which when confused or conflated can obscure underlying behaviours, patterns, and mechanisms, greatly diminishing understanding of young people. Thus, this research might have important implications for how help-seeking behaviours and processes are better understood and studied in the future.

Contribution of conceptual model

The findings of this research were derived from actual experiences of help-seeking, and this has contributed significantly to the development of a multi-level *conceptual youth model of mental health help-seeking*. This model provides a three-phase understanding of the help-seeking process, the modes in which help-seeking can occur, the differences in approach across

the life stage of youth, the embedded role of informal networks, the role of services in access and provision as well as the role of the helper (***see section 6.6***). As the first of its kind, this model might be very important as it was designed specifically to acknowledge how young people seek help for their mental health, and this has the ability to significantly impact policy, practice, and decision-making. With a clearer and thorough understanding of the actual processes, people and systems involved in help-seeking, that respects natural problem-solving styles whilst acknowledging how a service can shape a pathway, this model can change the direction regarding how this topic is studied, how services are designed and how supports are provided.

7.5.2. Methods

This research successfully used Constructivist Grounded Theory methods to obtain rich and in-depth data, which was meticulously analysed and developed into a comprehensive model. This research developed a design that supported an individualised and developmentally appropriate approach and detailed systematically the benefits and strengths of using snowball sampling in qualitative research. There is limited research about the strengths of snowball sampling approach in qualitative mental health research and so this research might be important for contributing to methodological development in mental health care research, especially with young people.

7.5.3. Research

The key findings of this study might be important regarding for future research in a number of ways. Firstly, correct usage of *help-seeking* terminology can ensure that avenues are researched more accurately, and this can improve how future research on this topic is approached, and how the topic is addressed. Secondly, findings from a psychosocial analysis highlight the enduring marginalisation and stigmatisation of youth as a demographic and insight into analyses can promote more inclusive mental health care and an increased understanding of the individual across the lifespan. Thirdly, the contribution of a framework of young people's needs in mental health care can support future research in refining or furthering understanding of youth needs as well as research into system reform. Finally, the findings from the conceptual model are critical for guiding future research in this area, as it has provided detailed information about pathways that can be used to inform future directions in help-seeking research.

7.6. Recommendations

Based on the findings from this research, policy, practice, and research recommendations were developed and are presented below.

7.6.1. Policy

Dopp & Lantz (2020) discuss children's mental health care and how *upstream* (government policy makers) decisions impact the ability of the *midstream* (local service providers) to provide services to the *down-stream* (service users) services. These recommendations are designed to support capacity building and reform in existing mental health services or inform the design of new youth services for the Irish context at policy level.

1. To reform mental health service provision to align with young people's needs.

This research developed a framework which provides guidance on how to provide for young people's *core needs* in mental health care (**Table 5**). This research found that mental health services do not adequately meet young people's needs for mental health care and that current provision is embedded with unconscious bias and maintains legacy stigma. Service policies need to consider how they can, at minimum, reduce harmful practices and ideally, reform youth mental health services. It is advised that these findings (**Table 5**) be considered in line with local, regional, and cultural practices as required and with regard to the international evidence-base (McGorry et al., 2019; Rickwood et al., 2019). This process can be supported through meaningful co-design between policy makers and service users, with the aim of creating policies grounded in real world outcomes and based off inclusion and participation of young people (Forde, 2018). Importantly, while it is somewhat beneficial to consider how services can improve, the continuation of the current siloed approach to youth mental healthcare within the public sector, creates self-limiting infrastructure which impacts what can be realistically achieved by individuals and practice alone.

2. *To address issues of accessibility and under-resourcing*

The design and structure of services that require an adult with a *formal help-seeking skill set* for access can exclude young people, as well as families that are experiencing marginalisation from wider structures or other government services. Time is the scarcest resource within current service provision that needs remedied; services need to be accessed easily in a timely manner, with flexibility around duration, treatment timeframes and frequency of attendance.

Most of the issues regarding service provision can be resolved with adequate government funding and investment into resources and training.

3. To acknowledge the role of semi-formal services

This research recommends that community youth work services and pastoral care teams in schools are recognised as key mental health providers. The findings in this research demonstrate the significant role that these semi-formal service practitioners play in not just gatekeeping or advocating, but in providing essential and on-going mental healthcare support to young people. Without the appropriate acknowledgement of these important providers, their roles can be devalued and access to the typical support and self-care structures that are essential when supporting others' mental health, such as training and supervision, can be diminished. Since young people often seek help in schools and youth work settings, it is vital that services are funded appropriately to ensure helpers in these environments have access appropriate professional support.

7.6.2. Practice

This research provides recommendations for how practitioners can support young people aged 12 – 25 years.

1. To ensure that all individuals working within a mental health service have specialised training for working with young people.

Practitioners can receive training on young people's needs which addresses how their practice impacts young people and how they can acknowledge their own preconceptions and stigma towards youth and mental health. Practitioners can inquire about young people's life circumstances and informal networks to increase understanding of how these key relationships support or block engagement and impact well-being. For under 18's it is critical that practitioners are sensitive and appropriate with their confidentiality needs.

2. To provide one to one listening ear support within a supportive rapport

This research recommends that interventions with young people, unless requested otherwise, are provided on an individual one-to-one basis that prioritises listening and emotional offloading interventions within the context of trust, confidentiality, collaboration, and genuine care with appropriate time for rapport building (Lynch et al., 2020). Young people benefit more from interventions that prioritise consistency, connectedness, and respite above structured

time-bound interventions. This is also a necessary foundation before beginning other interventions such as CBT.

3. *To provide mental health care with young people using a trauma informed approach*

As young people can experience ACEs and need time to establish trust before disclosing their reasons for needing mental health care, ensuring that practice is voluntary, respectful and non-stigmatizing can support young people who can be managing trauma. For those with complex trauma such as those in state care or experiencing homelessness, opportunities for a consistent, safe, and trusting rapport *is* the primary intervention needed in mental health care. Those working with young people in care need to be aware of their individual and service capacity to provide longer term support.

4. To work with young people on an individual basis

This research recommends that helpers inquire about individual conceptualisations of mental health as well as individual needs for care as this research highlights that public or formal mental health care is not suitable for all young people. Practitioners have an important role in locating a service that is appropriate for a young person if formal services could cause harm, such as a pre-existing relationship within their community or educational networks. This can be more relevant for young people from different ethnic backgrounds, or those experiencing compounded marginalisation whose primary needs are relational. Practitioners working with young people who do experience marginalisation can prioritise training and learning that can increase awareness around intersectionality, to understand the effects if intersecting identities upon experiences of mental health and specifically how mental health distress is compounded by experiences of immigration, managing multiple cultures and prejudices and discrimination such as racism.

5. To support young people with appropriate interventions

This research recommends that practitioners use age-appropriate strategies that are creative and flexible in response to developmental demands. This research recommends that supporting life-skills is important for young people's development and is core to mental health work. This research also recommends that young people who are prescribed psychopharmacological medication are supported with it until they can manage independently.

6. *To work collaboratively with other services*

Youth mental health care is best provided when young people can easily access a range of practitioners and when these services can work well together. Helpers need other helpers, especially when services are siloed. For young people with low social support this research recommends the placement of a key worker who can model formal help-seeking skills and provide consistent and scaffolded support. Findings suggest that this style of work has emerged organically within some community organisations and knowledge on how to do this already exists, which is worthwhile exploring.

7.6.3. Future research

This research has provided important insights into young people and their needs in mental health and has suggestions for areas that require further investigation.

1. To further develop help-seeking theory

Future research can consider developing mental health help-seeking theory further from data acquired from research with actual help-seekers. The findings presented here need to be further considered with regard to *help-seeking as a pre-cursor to learning*, its role in how young people seek help for their mental health problems and how this contributes to the development of a *formal help-seeking skill-set*. Important avenues for examination could include how this skill-set is acquired, the length of time involved, the amount of practice needed, and the important actors in this pathway. In the interest of a more comprehensive understanding of help-seeking, it would be beneficial to investigate the experiences of those who ceased help-seeking, who perhaps did not find the help they needed, if it were possible to recruit participants with these experiences. It is critical to understand how and why people leave help-seeking pathways, the interpersonal dynamics, and individual characteristics and the different needs from adolescence to emerging adulthood. Further knowledge is also needed on the interaction between family systems, transgenerational trauma, and personal capacity for managing distress. Listening to an individual and communicating their experiences and knowledge on the topic is a key part of ensuring this topic is researched with compassion and empathy.

2. Develop further understanding of Irish mental healthcare systems

Regarding future directions for research in service design, mapping exercises could be beneficial as mental health services in Ireland are diffusive in their practice and provision. This is possibly due to the siloed and hierarchical approach of public mental health care, and the

response of private and charitable organisations to devise interventions to address gaps at local level. Understanding the variety of services across the Island, that are run either privately, publicly or through a charity platform, could provide further understanding of the whole system of mental health care. Some services might already provide appropriate services which could be studied to further learning on the topic based on the professional experience and knowledge that already exists.

3. Develop global understandings of youth mental health

Further research is needed into mental health care from global perspectives, to ensure that broader topics and important discussions on youth mental health are kept in focus. The successes and failures of different systems and approaches can be shared, as well as creating important critical discussion around traditional, alternative, or novel approaches, models, and conceptualisations to mental health care, which is necessary to further expand the knowledge base. With context in mind, it is essential that all research is conducted, and provision evaluated at a local level.

4. Ensure all young people are included in research

This study has communicated some of the ways in which young people living in Ireland can experience marginalisation, such as those in state care, asylum seeking and homelessness, but further understanding is needed with young people from the Travelling community and the Roma community. As these communities have experienced marginalisation by wider structures, particularly within educational institutions, the format, time limitations and presentation of a university research study could have been a barrier and so it is crucial that future research design is carefully planned in a suitable and collaborative to ensure participation. The Irish government has recently placed families seeking asylum from the conflict in Syria and the Ukraine throughout the country and these communities have young people and children who might need support now or in the future due to multiple adverse childhood experiences. Before providing any support it is critical that future research inquires on how to collaborate with community workers on what is the most appropriate way to research within communities that have different conceptualisations of mental health and who live in a majority western culture. There are some people who will never use mental health services because of how they are conceptualised and how they were conceived. Western frameworks of healthcare can also be incompatible with personal, family or community values for mental

health care. Inclusive systems need to understand how to bridge these divides and meet people where they are.

7.7. Dissemination and Impact

The dissemination of this research includes publication and planned publications in high dissemination journals to ensure that findings are disseminated through the right channels to maximise the impact for policy, practice and decision-making. An important part of dissemination includes writing practice guides for those who can act as gatekeepers, developing training materials and toolkits for professionals, and important messaging with young people, to support them further with help-seeking. Included in this list would be academic, youth and community organisations, and public health agencies.

Publications

1. The first paper is titled: “What Type of Helping Relationship Do Young People Need? Engaging and Maintaining Young People in Mental Health Care—A Narrative Review” has been published in *Youth and Society* (2020).

2. The second paper is titled: “Parents and peers – help or a hindrance? A narrative review on how the role of informal sources of help affect adolescent mental health help-seeking pathways” is under review with *The Journal of Child and Family Studies* for consideration.

3. A third paper titled *“’How can somebody get better if they see a different person every time?’:* A grounded theory study from the Northwest of Ireland on young people’s core needs in mental health care” is planned for a summer submission 2022, which will communicate the findings in this thesis regarding young people’s core needs in mental health care (**Table 5)**.

4. A fourth paper is titled: “*‘I felt like there was something wrong in my brain’:* young people’s experiences of living with and managing psychological distress and trauma.”. Submission for publication is planned for summer 2022, which will communicate the findings in this thesis regarding young people’s experiences of having a mental health problem and self-management strategies.

5. A fifth paper is titled: *“’You have the choice of whether you’re going to get help or going to attempt suicide’:* An exploration of young people’s (16-25 years) mental health help-seeking

journeys." Submission for publication is planned for summer 2022, which will communicate the findings in this thesis regarding young people's experiences of asking for help with a discussion important help-seeking pathways.

6. The sixth paper, is titled "Access issues, referral processes and helping interventions: An exploration of system barriers in youth mental health care.". Submission for publication is planned for summer 2022, which will communicate the findings in this thesis regarding young people's experiences with access, referrals and will highlight issues such as the referral loop.

Conferences

Due to maternity leave (February 2019 to September 2019) and the impact of the Covid 19 epidemic (since March 2020), traditional modes of dissemination such as attendance at conferences was greatly impacted.

Planned conference attendance includes:

1. NINE DTP Conference, November 2021

2. Grounded Theory Conference, September 2022

7.8. Conclusion

This chapter concludes this research into young people's mental health and help-seeking pathways and what services can do to facilitate access, engagement, and maintenance in mental health care. Key findings identify how the impact of early life affects how, when and in what way young people seek help. Examination of actual help-seeking experiences revealed it to be complex, multi-episodic and involve the resources of family and friends. These findings have supported development of help-seeking theory and are central to understanding the core needs of young people in mental health care. A new conceptual model which reflects key findings was developed. Future directions in academia are provided with key areas for theory development and research that can improve inclusion and reduce marginalisation. Recommendations provide direction for practitioners and services in reforming this essential healthcare service with regard to the core needs across the age range of 12-25 years. Youth mental health care provision needs to be reformed in partnership with young people, and with consideration given to appropriate design, the role of families in help-seeking pathways, and

interagency collaboration. Young people can be facilitated to mental health care when their needs for time and rapport are met, with access to developmentally appropriate approaches, up to the age of 25 years. Reform can contribute to earlier and meaningful interventions, improved quality of life and the reduction of youth death by suicide.

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Appendix 1

Glossary of Terms

Adolescence

People aged 10 – 19 years of age

AMHS

Adult Mental Health Services

CAMHS

Child and Adolescent Mental Health Services

Emerging adulthood

A life-stage in industrialised or developed regions that lasts from approximately 20 – 29 years.

Help-seeking

This term can be described as an intentional and active action to solve a problem and an important coping-mechanism, which has three main features: the recipient, the helper and the task or problem.

Formal mental health services

This describes service providers and professionals who have a specified role in delivery of mental health care such as counsellors, psychologists, psychiatrists and mental health nurses.

Formal public mental health services

Publicly funded HSE provided mental health services including children's, adults, in-patient and community psychology.

Formal community mental health services

Youth specific and general community-based counselling organisation and private space.

LGBTI+

This refers to individuals who identify as Lesbian, Gay, Bisexual, Transgender, Intersex.

Mental health literacy

This refers to the knowledge and beliefs about mental health problems that aids recognition, management, or prevention

Mental health problem

The spectrum of personal distress and mental conditions that can affect an individual

Mental health services

Service providers that can offer support for mental health problems

Semi-formal mental health services

This describes service providers and professionals that do not have a specified role in delivery of mental health care but who encounter or provide support with those who need mental health care.

Young people/youth

Adolescents and young adults aged 10-24 years of age

Appendix 2

Help-seeking & mental health: Exploring the experiences of young people aged 16-25 years

Information sheet and consent form for interview/focus group participants

Background and aims of this project

My name is Louise Lynch and I am a PhD researcher at the Ulster University, Jordanstown. I am doing research that will explore young people's views about mental health. Specifically, I would like to understand what it is like for a young person when they look for help from others for a mental health problem. I am inviting young people aged between 16-25 years of age to participate in this research project. This type of research is important as international research has shown that young people are the least likely of all age groups to ask for help when experiencing a mental health problem (Gulliver et al. 2011). This research study aims to help us understand in what way young people would prefer mental health care to be provided to them from professional services. As part of this project, I am carrying out focus groups and interviews with young people aged 16-25 years living in the Letterkenny area. You can choose to take part in an interview or a focus group. This project is part of an ongoing doctoral research dissertation funded by the Ulster University at Jordanstown.

What is an interview?

An interview is a conversation between two people with the aim of discussing and exploring their perceptions, opinions, beliefs, and attitude about a particular topic for the purpose of research. If you choose to take part in an interview, I will ask to meet you for a one-to-one discussion about your experiences of asking for help from others for a mental health problem. The interview will be audio recorded and the Interviews typically last from 20 minutes to 1 hour. Interviews will be confidential, and your personal information will be made anonymous.

What is a focus group?

A focus group is when a group of people meet to discuss and explore their perceptions, opinions, beliefs, and attitude about a particular topic for the purpose of research. If you choose to take part in a focus group then you can expect to meet with 6 – 8 other young people, aged 16-25 years of age, who will be discussing what their experiences were of asking for help from a service for a mental health problem. The focus group will be audio recorded and the focus groups typically last from 30 minutes to 1 hour. Focus groups are less confidential than interviews and as there are other people present in the group, so anonymity cannot be guaranteed during the session.

What will happen during the interview or focus group?

In particular, I will be looking to explore what positive and negative experiences you had with professionals in school, youth services and the HSE mental health services. Importantly, I would like to understand how these experiences influence your decision to ask for help again in the future. There are no right or wrong answers, I am interested in your opinions and want to gain a deep understanding of what it is like for a young person when seeking help for mental health problems in Ireland. The interview is not a counselling session for mental health but an opportunity to discuss and explore your own opinions and experiences which can help researchers further understand what young people think works within our mental health care services and what needs improvement. The interview will be arranged at Donegal Youth Service Headquarters during opening hours (10am - 8pm) and I am happy to run them during the day or early evening, depending on your preference.

An example of an interview question would be: *''What makes it easier or more difficult for young people to ask for help when they have a mental health concern'.* The researcher will make notes during the interview, and it will be audio recorded for analysis purposes only.

What is required from you?

If you decide to participate in this research project, you will be asked to participate once in an interview for up to one and half hours, to include registration and discussion.

- You will be required to give written informed consent.
- All participation is voluntary and there will be no incentive offered in this research project.
- You will be required to talk about your opinions and experiences of what it is like for a young person when they seek help for a mental health problem from a service.
- You will not be required to talk about anything you do not want to.
- You can decline to answer any questions asked.
- You also have the right to withdraw from the study at any point without negative consequences.
- If you want to leave the study, for any reason, it is advised you let the principal investigator know.

What will happen with my personal information and data?

Please be assured that all information will be anonymous and treated as confidential. This means that no real names will be used, and I will not inform anyone else that you have participated in the study. I will also not name you in any reports or publications. Data storage arrangements will be as according to the Data Protection Act (1998; 2018). This includes all paper documents will be stored in a locked filing cabinet within a locked office. Electronic data will be stored on the study laptop, which is password protected plus the back-up portal hard drive will be also password protected. Only the research team will have access to the data. The chief investigator will take responsibility for the data storage of the study data. However, your identification will only be revealed if legally required in the event of the project not adhering to research procedures. You will also have an opportunity to review the transcript relating to the focus group or interview you took part in if you choose to and after reading it you can request for any material to be deleted.

What will happen to the results?

The results of this research will be presented in my PhD dissertation. The dissertation may be read by supervisors, examiners, faculty staff or future students and quotes from the study may be published in a research journal; however, I will never use your real name.

What if there is a problem or I would like to withdraw from this study?

If you agree to take part in the study, but then decide to withdraw before, during or after, then that is fine. Just contact me (Louise) by email to lynch-l11@ulster.ac.uk. At the end of the interview, I will discuss with you how the experience was and how you are feeling. If you feel distressed at any point, you will have an opportunity to discuss this with myself, leave the interview or proceed if you choose. I will also give you an information sheet about looking after your mental health and local mental health services.

Who has reviewed this study?

Ethical approval has been obtained by the Ulster University Risk and ethics Committee (UUREC) School Research Governance Committee (SRGC) at Ulster University Jordanstown, which allows this study to take place.

What are the possible benefits for taking part in this research project?

You will be part of a valuable project. Mental health is an important area for research and your perspectives will contribute to helping understand the lives and needs of young people in Ireland who experience mental health problems. You will have the opportunity to share your experiences and offer your opinions on how to improve youth mental health services from a young person's perspective.

What are the possible disadvantages of taking part?

Discussing topics around mental health can cause distress and the researcher is aware of the sensitive nature of this topic. If you feel that discussing mental health may distress you or make you feel uncomfortable, then it is advised to not take part.

Contact details

If you would like further information on mental health services, this research or to discuss further about participating in an interview or focus group, please do not hesitate to contact myself or the research supervisor with any queries.

Louise Lynch (Principal Researcher) - **Lynch-L11@ulster.ac.uk**
Dr. Anne Moorhead (Research supervisor) - **a.moorhead@ulster.ac.uk/T:** 048 9036 8905

Appendix 3

Participant Consent Form (Over 18)

I would like to participate in *(please tick)*

An Interview ☐

A Focus Group ☐

I…………………………………… aged ……… agree to participate in Louise Lynch's research study based on the information supplied and explained to me both in writing and verbally.

(Please tick)

- ➢ The purpose and nature of the study has been explained to me and I understand what I am consenting to ☐
- ➢ My participation is voluntarily and I understand what is required of me ☐
- ➢ I give permission for my interview with Louise Lynch to be tape-recorded and I understand how my information will be stored and protected ☐
- ➢ I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating ☐
- ➢ I understand how I can withdraw from the study at any time before, during and after ☐
- ➢ I am also aware I can withdraw my data within two weeks of the interview, in which case the material will be deleted ☐
- ➢ I give permission to Louise Lynch to use the data in her PhD thesis and any reports or publications ☐
- ➢ I understand that as part of the write up my real age will be used but not my real name ☐
- ➢ Anonymity will be ensured by disguising any characteristics which may reveal my identity ☐
- ➢ I give permission and understand that disguised extracts from my interview may be quoted and used in the thesis and any subsequent publications ☐

Signed…………………………………… Date……………….

Signed…………………………………… Date……………….

Louise Lynch (Principal Researcher)

Appendix 4

Help-seeking & mental health: Exploring the experiences of young people aged 16-25 years

Information sheet and consent form for practitioners

Background and aims of this project

My name is Louise Lynch and I am a PhD researcher at the Ulster University, Jordanstown. I am doing research that will explore young people's views about mental health. Specifically, I would like to understand what it is like for a young person when they look for help from others for a mental health problem. I am inviting mental health practitioners and young people aged between 16-25 years of age to participate in this research project. This type of research is important as international research has shown that young people are the least likely of all age groups to ask for help when experiencing a mental health problem (Gulliver et al. 2011). This research study aims to help us understand in what way young people would prefer mental health care to be provided to them from professional services. As part of this project, I am carrying out focus groups and interviews with young people aged 16-25 years living in the Letterkenny area. This project is part of an ongoing doctoral research dissertation funded by the Ulster University at Jordanstown.

What will happen during the interview?

I will ask to meet you for a one-to-one discussion about your experiences of working within a service that provides mental health care to young people with a mental health problem. In particular, I will be looking to explore what positive and negative experiences you have had working with young people, exploring what you feel encourages or discourages young people to engage in your service. There are no right or wrong answers, I am interested in your opinions and want to gain a deep understanding of what it is like for practitioners working with young people who seeking help for mental health problems in Ireland. The interview is not a counselling session but an opportunity to discuss and explore your own opinions and experiences can help researchers further understand our youth mental health care services in Ireland and what needs improvement. The interview will be arranged at a convenient time and place and I am happy to run them during the day or early evening, depending on your preference.

An example of an interview question would be: *''What makes it easier or more difficult for young people to ask for help when they have a mental health concern'.* The researcher will make notes during the interview and it will be audio recorded for analysis purposes only.

What is required from you?

If you decide to participate in this research project, you will be asked to participate once in an interview for up to one hour, to include registration and discussion. The interview will be held in a private and appropriate meeting room that will be arranged by the researcher with

agreement by the participant.

- You will be required to give written informed consent.
- All participation is voluntary and there will be no incentive offered in this research project.
- You will be required to talk about your opinions and experiences of what it is like for a young person when they seek help for a mental health problem from a service.
- You will not be required to talk about anything you do not want to.
- You can decline to answer any questions asked.
- You also have the right to withdraw from the study at any point without negative consequences.
- If you want to leave the study, for any reason, it is advised you let the principal investigator know.

What will happen with my personal information and data?

Please be assured that all information will be anonymous and treated as confidential. This means that no real names will be used and I will not inform anyone else that you have participated in the study. I will also not name you in any reports or publications. Data storage arrangements will be as according to the Data Protection Act (1998; 2018). This includes all paper documents will be stored in a locked filing cabinet within a locked office. Electronic data will be stored on the study laptop, which is password protected plus the back-up portal hard drive will be also password protected. Only the research team will have access to the data. The chief investigators will take responsibility for the data storage of the study data. However, your identification will only be revealed if legally required in the event of the project not adhering to research procedures. You will also have an opportunity to review the transcript relating to the focus group or interview you took part in if you choose to and after reading it you can request for any material to be deleted.

What will happen to the results?

The results of this research will be presented in my PhD dissertation. The dissertation may be read by supervisors, examiners, faculty staff or future students and quotes from the study may be published in a research journal; however I will never use your real name.

What if there is a problem or I would like to withdraw from this study?

If you agree to take part in the study, but then decide to withdraw before, during or after, then that is fine. Just contact me (Louise) by email to lynch-l11@ulster.ac.uk. At the end of the interview, I will discuss with you how the experience was and how you are feeling. If you feel distressed at any point, you will have an opportunity to discuss this with myself, leave

the interview or proceed if you choose. I will also give you an information sheet about looking after your mental health and local mental health services.

Who has reviewed this study?

Ethical approval has been obtained by the Ulster University Risk and ethics Committee (UUREC) School Research Governance Committee (SRGC) at Ulster University Jordanstown, which allows this study to take place.

What are the possible benefits for taking part in this research project?

You will be part of a valuable project, mental health is an important area for research and your perspectives will contribute to helping understand the lives and needs of young people in Ireland who experience mental health problems. You will have the opportunity to share your experiences and offer your opinions on how to improve youth mental health services from a young person's perspective.

What are the possible disadvantages of taking part?

Discussing topics around mental health can cause distress and the researcher is aware of the sensitive nature of this topic. If you feel that discussing mental health may distress you or make you feel uncomfortable, then it is advised to not take part.

Contact details

If you would like further information on mental health services, this research or to discuss further about participating in an interview or focus group, please do not hesitate to contact myself or the research supervisor with any queries.

Louise Lynch (Principal Researcher) - **Lynch-L11@ulster.ac.uk**
Dr. Anne Moorhead (Research supervisor) - **a.moorhead@ulster.ac.uk/**T: 048 9036 8905

Interview participant consent form for practitioners

I…………………………………… agree to participate in Louise Lynch’s research study based on the information supplied and explained to me both in writing and verbally.

(Please tick)

- The purpose and nature of the study has been explained to me and I understand what I am consenting to ☐

☐

- My participation is voluntarily and I understand what is required of me.
  I give permission for my interview with Louise Lynch to be tape-recorded and I understand how my information will be stored and protected ☐
  I understand that I can withdraw from the study, without repercussions, at any time, whether before it starts or while I am participating ☐
  I understand how I can withdraw from the study at any time before, during and after
- I am also aware I can withdraw my data within two weeks of the interview, in which case the material will be deleted. ☐
  I give permission to Louise Lynch to use the data in her PhD thesis and any reports or publications ☐
- I understand that as part of the write up my real name, organization/company/school name will not be used nor anything that can identify me ☐
- Anonymity will be ensured by disguising any characteristics which may reveal my identity. ☐
- I give permission and understand that disguised extracts from my interview may be quoted and

  used in the thesis and any subsequent publications ☐

Signed…………………………………. Date………………

Signed…………………………………. Date………………

Louise Lynch (Principal Researcher)

Appendix 5

Interview Questions for young people aged 16-25 years

The following open questions listed are designed to guide a semi-structured interview with young people aged 16-25 years. They have been derived to address the topics listed in the literature review. Questions will be used if and when appropriate with young people to prompt a discussion and encourage exploration of young people and mental health.

Introductory Questions:

- What is your understanding of the term mental health?
- What does mental health mean to you?

Core Questions:

Mental health literacy, coping and help-seeking decision

- What is it like to be a young person in Ireland with a mental health problem?
- When did you first begin to experience some difficulty with your mental health?
- How long did it take before you realized you had a problem?
- When did you decide to ask others for help?
- Were you hesitant about telling anyone or seeking help for your mental health issues?
- Was there anything that caused you to wait longer/act quicker?
- What things did you find helpful/unhelpful to cope with this distress in your life?

Service provision and relationship with mental health practitioners

- What do you think, in general, about mental health services for young people in Ireland?
- What did you imagine mental health care would be like?
- Who did you turn to or where did you go to get help with your mental health?
- What was your experience like of asking this service/person for help?
- Can you describe to me what your experience was like from the decision to ask for help to getting the help you received?
- Can you describe what the service was like to go to? What was the physical building/location like and how did that make you feel?
- Can you describe to me your experience of working with a mental health practitioner/youth worker/pastoral care staff?
- Were you offered a choice in the type of intervention you would like?
- Was the experience of meeting with a mental health practitioner/youth worker/pastoral care staff? In what ways?
- Was the experience of meeting with a mental health practitioner/youth worker/pastoral care staff? In what ways?
- What did you need from that person?

- Were you satisfied with your experience/ did it match your expectation?
- In what way, if any, do you think the service is helpful for young people?
- Have you any suggestions that might improve the service?

Culture, family and environment

- Did you tell your family and friends you were looking for help with a mental health service?
- If so, how did your family and friends respond?
- Do you think culture has a role to play in young people's mental health?
- Do you think young men or women experience different barriers when looking for help with their mental health?
- Have you heard about other's experiences of asking for help? If so, what were these like?
- From your experience/observations what makes it difficult or easy for a young person in Ireland to access mental health care?

Closing Questions:

- What do you think are the most important features that a youth mental health care service should provide?
- Based on your experience would you go to a professional mental health service again if you experienced mental health problems again?
- Is there anything you would like to say that you haven't had the opportunity to do so yet?
- Are there other recommendations that you have, or suggestions you would like to make?

Appendix 6

Interview Questions for young people aged 16-25 years

The following open questions listed are designed to guide a semi-structured interview with young people aged 16-25 years. They have been derived to address the topics listed in the literature review. Questions will be used if and when appropriate with young people to prompt a discussion and encourage exploration of young people and mental health.

Introductory Questions:

- What is your understanding of the term mental health?
- What does mental health mean to you?

Core Questions:

Mental health literacy, coping and help-seeking decision

- What is it like to be a young person in Ireland with a mental health problem?
- When did you first begin to experience some difficulty with your mental health?
- How long did it take before you realized you had a problem?
- When did you decide to ask others for help?
- Were you hesitant about telling anyone or seeking help for your mental health issues?
- Was there anything that caused you to wait longer/act quicker?
- What things did you find helpful/unhelpful to cope with this distress in your life?

Service provision and relationship with mental health practitioners

- What do you think, in general, about mental health services for young people in Ireland?
- What did you imagine mental health care would be like?
- Who did you turn to or where did you go to get help with your mental health?
- What was your experience like of asking this service/person for help?
- Can you describe to me what your experience was like from the decision to ask for help to getting the help you received?
- Can you describe what the service was like to go to? What was the physical building/location like and how did that make you feel?
- Can you describe to me your experience of working with a mental health practitioner/youth worker/pastoral care staff?
- Were you offered a choice in the type of intervention you would like?
- Was the experience of meeting with a mental health practitioner/youth worker/pastoral care staff? In what ways?
- Was the experience of meeting with a mental health practitioner/youth worker/pastoral care staff? In what ways?
- What did you need from that person?

- Were you satisfied with your experience/ did it match your expectation?
- In what way, if any, do you think the service is helpful for young people?
- Have you any suggestions that might improve the service?

Culture, family and environment

- Did you tell your family and friends you were looking for help with a mental health service?
- If so, how did your family and friends respond?
- Do you think culture has a role to play in young people's mental health?
- Do you think young men or women experience different barriers when looking for help with their mental health?
- Have you heard about other's experiences of asking for help? If so, what were these like?
- From your experience/observations what makes it difficult or easy for a young person in Ireland to access mental health care?

Closing Questions:

- What do you think are the most important features that a youth mental health care service should provide?
- Based on your experience would you go to a professional mental health service again if you experienced mental health problems again?
- Is there anything you would like to say that you haven't had the opportunity to do so yet?
- Are there other recommendations that you have, or suggestions you would like to make?

Appendix 7

Help-seeking & mental health: Exploring the experiences, impact and outcomes for young people aged 16-25 years

Debriefing Information

Purpose

The purpose of this study was to explore the perspectives of professionals working with young people directly, to help us understand what way services can provide the type of mental health care that young people need and want from a mental health service. You have helped me do this, thank you very much for taking part in this research.

Confidentiality

Please be assured that all information will be anonymous and treated as confidential. All personal information and anything you say during the focus group will be held in confidence and stored securely. No real names will be used and I will not inform anyone else that you have participated in the study. I will also not name you in any reports or publications. On completion of the research, data will be securely retained for a further six months and then destroyed. However, your identification will only be revealed if legally required in the event of the project not adhering to research procedures.

Final Report
If you are interested in obtaining a copy of the final report on this project please contact the principal researcher on **Lynch-L11@email.ulster.ac.uk**

Further Contact
If you have any questions regarding this research, its purpose or procedures please contact Louise Lynch at **Lynch-L11@email.ulster.ac.uk** or the course director at the University of Ulster, Dr. Anne Moorhead on **a.moorhead@ulster.ac.uk**

Mental Health Organisations

Websites
http://www.mentalhealthireland.ie

http://e-mymind.org

http://ie.reachout.com

http://www.aware.ie

www.teenline.ie

Local Support in Letterkenny for information and services regarding mental health:
Jigsaw, Pearse Rd., Letterkenny (074) 97 26920 - *15 - 25 years*
Teen Talk One to One Support; 16-18 Port Rd., Letterkenny, 074 9129640 - *12-25 years*
St. Eunan's Court, Letterkenny (Addiction & Counselling) (074) 9128130 / 9128769
Worklink Letterkenny, 4A Pearse Rd, Letterkenny, (074) 91 28872- *Over 18's*
Create-a-link, Arts Centre, Pearse Rd, Letterkenny (074) 9168745 - *Over 18's*
Counselling Services: Letterkenny pastoral centre (074) 9121853 - *all ages*
Donegal Community Counselling Service (074) 9124985 - *Over 17's*

HSE Services
If you would like to access the Child & Adolescent Mental Health Service (CAMHS) (074) 9120340 or the Adult Mental Health Services (AMHS) you will need to contact your GP and they will refer you to the appropriate service.

Other Services

National Traveller Suicide Awareness Project

National Traveller Suicide Awareness Project (NTSAP) employs a community development approach to address the issue of Traveller suicide which is over six times higher for Traveller men compared to the general population. Tel: 01 872 1094

Stop Suicide Derry

Stop Suicide value and care for each person who seeks our services. Through our experience of working with self- harm and suicide we acknowledge the very difficult life events that can lead people to hurt themselves, or end their lives.

Call Stop Suicide on FREE PHONE 1850 211 877, Lines are open Monday to Friday from 9am to 6pm

Support Groups throughout the Northwest

Alcoholics Anonymous
Address : Pastoral Centre, Letterkenny, Donegal
Tel : 074-9121853/9121394

Aware Donegal
Address : Art Studio beside Profiles Building, 4a Pearse Street, Letterkenny, Donegal
Opening Hours: Every Tuesday at 8.00 pm SUFFERERS support group only
Tel : 086 173 0032
Website : www.aware.ie E-Mail : info@aware.ie

Aware Northern Ireland

Address: (Waterisde) Shared Future Centre, 61 Irish Street:
Tuesdays at 8.00pm
Website: www.aware-ni.org

Address: Aware Offices: 15 Queen Street, BT487EQ
Tuesdays at 7.30pm
Website: www.aware-ni.org

Address: Strabane Library
Thursday at 6.30pm
Website: www.aware-ni.org

CAUSE Derry

CAUSE is a Northern Ireland-based charity supporting carers and families of people with mental illness

HELPLINE: 0845 6030291
Available daily from 9am-9pm
Tel: 028 9023 8284, www.cause.org.uk

Claredon Beacon Centre (NIAMH) – Derry
Our aim is to provide a range of opportunities and support to people with mental health needs. Support comes not only from trained staff but also from meeting and talking to others who have had or are experiencing mental health difficulties, in a relaxed unhurried atmosphere. Members can drop in or take part in any of the activities / groups available.
Address: 20 Claredon Street, Derry, BT48 7ET
Telephone Number: 028 7126 9517
Email Address: clarendon@beaconwellbeing.org
Web Address: http://www.beaconwellbeing.org/

Gamblers anonymous
Self-help organisation holding regular meetings around the country. Operates a 24 hour telephone service
Address : Pastoral Centre, Letterkenny.
Hours: Meeting Times Tuesdays @ 8.30pm
Tel : 074-9121853
Website :www.gamblersanonymous.ie
Email: info@gamblersanonymous.ie

GROW Donegal
GROW is a mental health organisation which helps people who have suffered, or are suffering from mental health problems.

Trinity Court Day Centre - Newtoncunningham

Time: 10.30am Monday
New Group in Newtowncunningham in the Trinity Court Day Centre, Monfad Road, Newtowncunningham Co. Donegal. Every Monday at 10.30am. When entering the village go over the bridge and take the first right - the Day Centre is on the left hand side of the road.

District Day Centre Hospital, Dungloe

Time: 7.30pm Monday
Approach Dungloe past SuperValue Shopping Centre. Turn right at sign for Gorthork, hospital on the right.

The Pastoral Centre, Letterkenny

Time: 7.30pm Monday
The Pastoral Centre is on Monastery Avenue, Cathedral Square, Letterkenny. Parking is available in the Cathedral car park.

Buncrana IDP Building

Time: 7.30 pm - Tuesday
The IDP office is behind the Library in Buncrana.

The Family Enrichment Centre, Stranorlar

Time: 7.30 pm - Tuesday
The Family Enrichment Centre is up Drumboe Avenue. Turn in right as if you were going to St. Colomba's school. As you go into the school entrance there is a road up to the left with a small sign saying "Family Enrichment Centre"

Donegal Town Day Hospital, Donegal Town

Time: 8.00 pm - Tuesday
(As you drive into Donegal Town from Ballybofey you pass a big Lidl shop on the left. There is a Shell Garage on the left and a Maxol garage on the right. After the Maxol garage there is a right turn into the Day Centre.

Mohill, Family Support Centre

Time: 2.30pm - Tuesday
A new meeting will commence every Tuesday at 2.30pm in the Mohill Family Support Centre, Canon Donohoe Hall, Mohill. The meeting is located on your left when you enter Mohill directly across from the church.

Carndonagh, Milltown House, Tulnaree

Time: 8.00pm - Wednesday
A new Meeting will take place in the Milltown House, Tulnaree, Carndonagh, Co. Donegal starting on Wednesday 23rd September 2015 at 8.00pm

Niall Mor Community Centre, Killybegs, Co. Donegal

Time: 6.30pm - Thursday

Private Counselling
For private counselling please see the following websites which include a list of accredited counsellors. Here you can browse and choose a suitable counsellor in your local area.

- The Irish Council for Psychotherapy (ICP), www.irish-counselling.ie
- The United Kingdom Council for Psychotherapy (UKCP), https://www.psychotherapy.org.uk/
- The British Association for Counselling and Psychotherapy (BACP), https://www.bacp.co.uk/
- The Psychological Society of Ireland (PSI), https://www.psychologicalsociety.ie/
- The National Health Service (NHS), www.nhs.uk
- The British Psychological Society (BPS), www.bps.org.uk

Appendix 8

Exploring the experiences of young people aged 16-25 years who have sought help for their mental health

Information sheet and consent form for parents/guardians for under 18's

Dear Parent/Guardian,

My name is Louise Lynch and I am a PhD researcher at Ulster University, Jordanstown. I am sending this letter to explain why I would like for your child to participate in my project.

Background and aims of this project

As part of my research with the Ulster University I will be exploring young people's views about mental health. Specifically, I would like to understand what it is like for a young person when they look for help from others for a mental health problem. I am inviting young people aged between 16-25 years of age to participate in this research project. This type of research is important as international research has shown that young people are the least likely of all age groups to ask for help when experiencing a mental health problem (Gulliver et al. 2011). This research study aims to help us understand in what way young people would prefer mental health care to be provided to them from professional services. As part of this project, I am carrying out focus groups and interviews with young people aged 16-25 living in the Letterkenny area. Participants can choose to take part in an interview or a focus group. This project is part of an ongoing doctoral research dissertation funded by the Ulster University at Jordanstown.

What is an interview?

An interview is a conversation between two people with the aim of discussing and exploring their perceptions, opinions, beliefs, and attitude about a particular topic for the purpose of research. If you choose to take part in an interview, I will ask to meet you for a one-to-one discussion about your experiences of asking for help from others for a mental health problem. The interview will be audio recorded and the Interviews typically last from 20 minutes to 1 hour. Interviews will be confidential, and your personal information will be made anonymous.

What is a focus group?

A focus group is when a group of people meet to discuss and explore their perceptions, opinions, beliefs, and attitude about a particular topic for the purpose of research. If you choose to take part in a focus group then you can expect to meet with 6 – 8 other young

people, aged 16-25 years of age, who will be discussing what their experiences were of asking for help from a service for a mental health problem. The focus group will be audio recorded and the focus groups typically last from 30 minutes to 1 hour. Focus groups are less confidential than interviews and as there are other people present in the group, so anonymity cannot be guaranteed during the session.

What will happen during the interview or focus group?

In particular, I will be looking to explore what positive and negative experiences your child had with professionals in school, youth services and the HSE mental health services. Importantly, I would like to understand how these experiences influence their decision to ask for help again in the future. There are no right or wrong answers, I am interested in your child's opinions and want to gain a deep understanding of what it is like for a young person when seeking help for mental health problems in Ireland. The interview or focus group is not a counselling session for mental health but an opportunity to discuss and explore opinions and experiences which can help researchers further understand what young people think works within our mental health care services and what needs improvement. The interviews and focus groups will be arranged at Donegal Youth Service Headquarters during opening hours (10am - 8pm) and I am happy to run them during the day or early evening, depending on your preference.

An example of an interview question would be: *''What makes it easier or more difficult for young people to ask for help when they have a mental health concern'.* The researcher will make notes during the interview and it will be audio recorded for analysis purposes only.

What is required from your child?

If your child decides to participate in this research project and you provide consent, they will be asked to participate once in an interview for up to one and half hours, to include registration and discussion.

- Your child will be required to give written informed consent.
- A signed consent form from the guardian or parent for participants under 18 years of age with contact details.
- All participation is voluntary and there will be no incentive offered in this research project.
- Your child will be required to talk about your opinions and experiences of what it is like for a young person when they seek help for a mental health problem from a service.
- Your child will not be required to talk about anything you do not want to.
- Your child can decline to answer any questions asked.
- Your child also has the right to withdraw from the study at any point without negative consequences.
- If your child wants to leave the study, for any reason, this is not a problem, it is advised you let the principal investigator know.

What will happen with my child's personal information and data?

Please be assured that all information collected from your child and audio recordings will treated as confidential. This means that no real names will be used, and I will not inform anyone else that your child has participated in the study. I will also not name you or your child in any reports or publications. Data storage arrangements will be as according to the Data Protection Act (1998; 2018). This includes all paper documents will be stored in a locked filing cabinet within a locked office. Electronic data will be stored on the study laptop, which is password protected plus the back-up portal hard drive will be also password protected. Only the research team will have access to the data. The chief investigators will take responsibility for the data storage of the study data. However, your child's identification will only be revealed if legally required in the event of the project not adhering to research procedures. Your child will also have an opportunity to review the transcript relating to the focus group or interview you took part in if you choose to and after reading it you can request for any material to be deleted.

What will happen to the results?

The results of this research will be presented in my PhD dissertation. The dissertation may be read by supervisors, examiners, faculty staff or future students and quotes from the study may be published in a research journal; however I will never use your real name.

What if there is a problem or I would like to withdraw from this study?

If you agree for your child to take part in the study, but then decide to withdraw before, during or after, then this is not a problem just contact me (Louise) by email to lynch-l11@ulster.ac.uk. At the end of the interview, I will discuss with your child how the experience was and how your child is feeling. If your child feels distressed at any point, they will have an opportunity to discuss this with myself, leave the interview or proceed if they choose. I will also give your child an information sheet about looking after your mental health and local mental health services.

Who has reviewed this study?

Ethical approval has been obtained by the Ulster University Risk and ethics Committee (UUREC) School Research Governance Committee (SRGC) at Ulster University Jordanstown, which allows this study to take place.

What are the possible benefits for taking part in this research project?

Your child will be part of a valuable project, mental health is an important area for research and your child's perspectives will contribute to helping understand the lives and needs of young people in Ireland who experience mental health problems. Your child will have the opportunity to share your experiences and offer your opinions on how to improve youth mental health services from a young person's perspective.

What are the possible disadvantages of taking part?

Discussing topics around mental health can cause distress and the researcher is aware of the sensitive nature of this topic. If your child feels that discussing mental health may distress them or make them feel uncomfortable, then it is advised to not take part.

Contact details

If you would like further information on mental health services, this research or to discuss further about participating in a interview, please do not hesitate to contact myself or the research supervisor with any queries.

Louise Lynch (Principal Researcher) - **Lynch-L11@ulster.ac.uk**
Dr. Anne Moorhead (Research supervisor) - **a.moorhead@ulster.ac.uk/**T: 048 9036 8905

Parental Consent Form

Please return in the provided stamped addressed envelope

I…………………………………… consent to my child .... participating in Louise Lynch's research study based on the information supplied and explained to me both in writing and verbally.

(Please tick to confirm)

- The purpose and nature of the study has been explained to me and I understand what I am consenting to my child partaking in ☐
- I give permission for my child's interview with Louise Lynch to be tape-recorded and I understand how my information will be stored and protected ☐

- I understand that my child can withdraw from the study, without repercussions, at any time, whether before it starts or while they are participating ☐
- I am also aware that my child can withdraw their data within two weeks of the interview, in which case the material will be deleted ☐
- I give permission to Louise Lynch to use the data in her PhD dissertation and any reports or publications ☐
- I understand that as part of the write up my child's real age will be used but not their real name ☐
- Anonymity will be ensured by disguising any characteristics which may reveal their identity ☐
- I give permission and understand that disguised extracts from the interview may be quoted and used in the thesis and any subsequent publications ☐

Signed…………………………………….   Date……………….

Print ....   Contact details ....

I certify that I have explained to the above named individual the nature and purpose, the potential benefits and possible risks associated with participation in this research study. I have answered all questions that have been raised by this parent. These elements of Informed Consent conform to ethical guidelines of the British Psychological Society Code of Ethics and to Ulster University code of conduct policy for human participants in research. I have provided the participant's legal guardian with a copy of this signed consent form.

Signed…………………………………….   Date……………….

Louise Lynch (Principal Researcher)

Appendix 9

Focus Group Schedule

A. In Preparation for the Focus Group *(25 mins)*

1. Talk to Staff (*5 mins approx*)

•Researcher will approach staff in centre to let them know what time the research will commence, expected duration and that they will be informed when research is finished.

•Communicate with staff the need for privacy in meeting room and to interrupt only in extenuating circumstances.

2. Set up the room *(10 mins approx)*

- Chairs are set up in a circle to create an open and equal space
- Check windows, air conditioning/heating to make sure temperature of room is comfortable.
- Lights and electricity are working correctly
- Fire exits are noted
- Open door so participant feels they can enter
- Refreshments are in place; tea, coffee and biscuits are set up
- Recording equipment is working correctly and ready to begin

3. Arrival of Participants *(10 mins approx)*

- Introduce myself to participants
- Offer tea, coffee and biscuits to participants
- Spend five minutes speaking with participants building rapport
- Offer participants to take a seat
- Close door and affix sign on door stating *focus group is in session – do not disturb*
- Clarify participant is okay to continue
- Clarify participant is okay with session being recorded
- Inform participant of fire exits in case of emergency
- Ask participant to turn off their phone or put them on silent for the duration of focus group

B. Beginning the Focus Group - *(20 mins)*

Introduction ***(10 mins approx)***

- Explain that the session will last a maximum of 1hour 30 minutes
- Explain the format; a semi-structured session with open-ended questions
- Review information briefly on participant information sheet
- Establish some ground rules informally:

  - you can speak freely – there are no right or wrong answers

  - If you would like to stop at any point or leave the focus group that is fine

  - If you are concerned about anything said during the discussion you can speak with me after, I will be available after the session is completed for up to 10 minutes.

- Thank them for partaking in the discussion and explain the importance of their participation

Rationale for Focus Group - ***(10 mins)***

- Explain rationale of the session to participants
  I am looking to understand the perspectives of young people directly, to help us understand in what way services can provide the type of mental health care that young people need and want from a mental health service. I am interested in what you have to say.
- Explain the term 'mental health problems'
  For this research, when I talk about mental health problems I am talking about when someone's thoughts or feelings are troubling them, to the extent of affecting their day to day activities or relationships. They may not necessarily have a mental illness, but could need help to get them through a difficult time. Examples of this can be depression or anxiety.
- Explain professional services for mental-health
  When I talk about professional services I am talking about people who work in services that can offer support and treatment to improve an individual's mental health. Examples of this are your local doctor, a psychologist working in a hospital, youth workers, school counsellors.
- Seek clarification
  Do you understand what I mean by mental health problems and by professional mental health services? [Wait for a response]
- If any participant asks questions respond to them
  Do you have any questions before we begin? [Wait for a response]

C. The Focus Group Session ***(40 mins approx)***

1. Questioning ***(40 mins approx)***

- Begin recording
- Researcher will use prepared questions on a sheet of paper that will guide the discussion around the key points of understanding barriers and looking for solutions.
- The semi-structured nature of the discussion along with open-ended questions will be used to allow participant to reflect and explore their statements. These will also allow the researcher to clarify statements without the use of leading questions.
- Clarify periodically to make sure researcher has interpreted the statements correctly

D. Ending the Focus Group *(10 mins)*

Ending the discussion *(5 mins approx)*

- The group discussion may end naturally but if there is a lot of discussion wait until key questions have been answered and do not continue too far past the prescribed time (5-10 mins max)
- Close the focus group
  "*I think this is a good time to end the discussion and I thank you very much for your participation today...*"
- Feedback
  "*Can you tell me briefly what their experience was like at this focus group...*"
- Stop recording

E. Leaving the Focus Group *(20 mins)*

1. Participant Exit *(15 mins approx)*

- As participant is leaving thank them and hand the debriefing sheet with information about local mental health services.
- Tidy up the space and wait in case any participant returns to speak after.
- Leave space as found and thank staff at centre, letting them know that research has finished.

Total time: 115 mins

Appendix 10

Interview questions for practitioners from formal and semi-formal services

The following open questions listed are designed to guide a semi-structured interview with practitioners working with young people and their mental health. They have been derived in coordination with the interview questions for the young people, as the purpose of the practitioner interviews is to provide perspective and context from a service level to the experiences and perspectives of young people. Questions will be used if and when appropriate to prompt a discussion and encourage exploration of young people and mental health.

Introductory Questions:

- What do you think it is like to be a young person in Ireland with a mental health problem?
- What do you think, in general, about mental health services for young people in Ireland?

Core Questions:

Background

- How long have you been working in your current position?
- Can you describe for me what it is like to work in your role?

Mental health literacy, coping and help-seeking decision

- From your experience/observations what makes it difficult or easy for a young person in Ireland to access mental health care?
- From your experience what are common coping mechanisms do young people use for their mental health problems?
- Do you think young people in Ireland have a good understanding of mental health?

Service provision and relationship with clients

- How does a young person access the service you work in?
- What parts of your service are helpful/unhelpful to young people?
- What parts of your service do you think can be improved to better assist young people?
- Are there any particular barriers in your work that impact your ability to work with young people?
- Are you able to offer a choice of interventions to young people?
- How do you feel young people respond to your service?

- Can you describe the service you work in terms of its physical building/location and how do you think that impacts young people?
- Are you satisfied with how your organization approaches youth mental health?

Culture, family and environment

- What is your experience of working with young people's families?
- Do you think culture has a role to play in young people's mental health?
- What role, if any, does stigma play in youth mental health?
- Do you young men or women experience different barriers when looking for help with their mental health?
- Have you heard about young people's experiences of asking for help? If so, what were these like?
- If you could imagine the ideal mental health care for young people what would be like?

Closing Questions:

- What does mental health care mean to you?
- What do you think are the most important features that a youth mental health care service should provide?
- Is there anything you would like to say that you haven't had the opportunity to do so yet?
- Are there other recommendations that you have, or suggestions you would like to make?

Appendix 11

Practitioner Interview Schedule

A. In Preparation for the Interview *(25 mins)*

1. Talk to Staff (*5 mins approx*)

•Researcher will approach staff in centre to let them know what time the research will commence, expected duration and that they will be informed when research is finished.

•Communicate with staff the need for privacy in meeting room and to interrupt only in extenuating circumstances.

2. Set up the room *(10 mins approx)*

- Set up two chairs opposite each other, spaced appropriately
- Check windows, air conditioning/heating to make sure temperature of room is comfortable.
- Lights and electricity are working correctly
- Fire exits are noted
- Open door so participant feels they can enter
- Refreshments are in place; tea, coffee and biscuits are set up
- Recording equipment is working correctly and ready to begin

3. Arrival of Participant *(10 mins approx)*

- Introduce myself to participant
- Offer tea, coffee and biscuits to participant
- Spend five minutes speaking with participant building rapport
- Offer participant to take a seat
- Close door and affix sign on door stating *interview is in session – do not disturb*
- Clarify participant is okay to continue
- Clarify participant is okay with session being recorded
- Inform participant of fire exits in case of emergency
- Ask participant to turn off their phone or put them on silent for the duration of interview

B. Beginning the Interview - *(10 mins)*

Introduction *(5 mins approx)*

- Begin recording
- Explain that the session will last a maximum of 1hour
- Explain the format; a semi-structured session with open-ended questions
- Review information briefly on participant information sheet
- Establish some ground rules informally:

  - you can speak freely – there are no right or wrong answers

  - If you would like to stop at any point or leave the interview that is fine

  - If you are concerned about anything said during the interview you can speak with me after, I will be available after the session is completed for up to 30 minutes.

- Thank them for partaking in the interview and explain the importance of their participation

Rationale for Interview - *(5 mins)*

- Explain rationale of the session to participant
  I am looking to understand the perspectives of practitioners who work with young people experiencing mental health problems, to help us understand in what way services can provide the type of mental health care that young people need and want from a mental health service. I am interested in what you have to say.
- Define/clarify the term 'mental health problems' that will be used in the research questions
  For this research, when I talk about mental health problems I am talking about when someone's thoughts or feelings are troubling them, to the extent of affecting their day to day activities or relationships. They may not necessarily have a mental illness, but could need help to get them through a difficult time. Examples of this can be depression or anxiety.
- Seek clarification
- If participant asks questions respond to them
  Do you have any questions before we begin? [Wait for a response]

C. The Interview Session *(40 mins approx)*

1. Questioning *(40 mins approx)*

- Research will being audio recording the interview
- Researcher will use prepared questions on a sheet of paper that will guide the interview around the key points of understanding barriers and looking for solutions.
- The semi-structured nature of the interview along with open-ended questions will be used to allow participant to reflect and explore their statements. These will also allow the researcher to clarify statements without the use of leading questions.
- Clarify periodically to make sure researcher has interpreted the statements correctly

D. Ending the Interview *(10 mins)*

Ending the discussion *(5 mins approx)*

- The interview may end naturally but if there is a lot of discussion wait until key questions have been answered and do not continue too far past the prescribed time (5-10 mins max)
- Close the interview
  "*I think this is a good time to end the interview and I thank you very much for your participation today...*"
- Feedback
  "*Can you tell me briefly what their experience was like at this interview...*"
- Stop recording

E. Leaving the Interview *(10 mins)*

1. Participant Exit *(10 mins approx)*

- As participant is leaving thank them and hand the debriefing sheet with information about local mental health services.
- Tidy up the space and wait in case any participant returns to speak after.
- Leave space as found and thank staff at centre, letting them know that research has finished.

Total time: 105 mins

Appendix 12

CI: Am, so just to get us started, what do you think it's like for a young person in Ireland today, em, who has a mental health problem?

YW1: Well when you say young person, under 18 now at the minute there is 'go to' CAMHS would be recognised, we got Jigsaw is recognised, ourselves in [youth service] is recognised and we're publicising it. For, ah, young adults, a young person that's over 18 and under 25, I'm experiencing difficulty *[pauses]* I'm finding ourselves basically, I can only reference right now ourselves as a 'go to' agency for a young person of that age. *(0.48)*

CI: Yeah and so what do you think it's like then for young people, to be a young person having that mental health problem, you know, between 16 and 25?

YW1: Well, even ah *[pauses]* have they got the capacity to self-diagnose? Do they know what's wrong with them? You know, they might have an idea that they're not functioning like other young people at that particular time but they might not have the capacity to even to know that they need to go and get help.

CI: Yeah am and so what do you think about the mental health services for young people in general, just in general, what do you think about them?

YW1: I like the [youth service] model as regards, ah, we're a *[pauses]* maybe an approachable environment, we're not ah clinical, we're not here to prescribe medication, we're here to listen, we're here to put the young person at the centre of what's going on and the decision maker. I don't feel that happens in every other agency. I feel that the ah, state mental services with provision from the HSE, is maybe a wee bit on the clinical side.
CI: Yeah
YW1: The young person has a block before they even get in to meet the person, the building is a block never mind meeting the actual clinician who's going to be working with them.

CI: You seem to be quite aware of things like even the physical space and the building

YW1: Yeah well that's based on feedback that I've got from other, ah, from young people and parents. I've had countless parents that have come to me told me that they've been to CAMHS, as an example, **twice** and maybe there's nothing wrong with the CAMHS model it just didn't work for those individual young people but they didn't relate to even the building that they were going in to *[pauses]* they were going 'No mammy, no daddy I don't want to go in there', and then meeting the clinician then, they just felt that they were the 'subject' rather than somebody that was actually helping them. *(2.46)*

CI: Okay so it was a wee bit de-personalised?

YW1: Yeah, ah from that then I would have been talking to lecturers I had at

university and they would have been guiding me and I did find one particular lecturer an asset, a Psychologist, a practising Psychologist, and he took on extreme cases that I'd asked him to.

CI: So how long have you been working in your current position?
YW1: Current position 3 years, as a youth worker 11 years.

CI: Okay and so I suppose then, your positions are varied but in that sense probably a little over 10 years, but in regard to I suppose you've been working with young people for 10 years, so can you describe to me what it's like for you to do your job?

YW1: For me to do my job, am, I would describe myself as a balancer, in an awful lot of what's going on in the world and with, you know, in an ideal world there would be no calls for me at all but in balancing situations ah *[pauses]* when a young person comes in here in a state of crisis well they're number one priority and you would be dropping everything that's going on around you and dealing with that young person, am *[pauses]* when there's no young people in crisis maybe we're trying to engage in all kinds of education, be it good manners or progression in education itself or, you know, taking up throwaway comments and trying to at least scratch the surface of what's going on in a young person's mind, specially their faulty thinking. There's loads of stuff going on Louise, I could talk to you for the rest of the day about what's going on *[laughs] (4.28).*

CI: Well I suppose

YW1: If you want to get the definitive of what, what was the question originally again? *[both laugh]*

CI: It was about what it's like, I, I kind of get the vibe from you that, am your job, is multi-layered and that you enjoy it just from the way you're talking?

YW1: I'm here to do what needs done

CI: Right. Very practical?

YW1: That's the only way I could sum it up. I wouldn't, I wouldn't put any boundaries like ah, ah I'll give you an example of the somebody sets off the fire extinguisher, I'm not going to try and say it's not my job to clean that up, because if this building is not effective and working then it's my job to get it effective and working so I have to, that would be my attitude.

CI: Yeah, so do you think that attitude then translates to the young people you're working with if something is not?

YW1: I would like to think it does like there are probably negative parts of my attitude that , that would translate to young people too because I'm always bitching and crying about cleaning up behind yourself, you know, and actually that probably annoys some young people, you know, but, I think it's important

to do that too.

CI: Aye, but even in terms of the way you said, my role here is like if something needs doing, or like, there's a goal, I'll do what I have to, to get there. Do you feel like that about young people's mental health?

YW1: Ah definitely yeah, if young people's mental health needs to be ah, what would you say

CI: Supported?

YW1: Yeah supported, and thinking needs challenged, definitely yeah, definitely and if, if I'm not capable of helping or supporting that young person well then it's a priority that I go and get somebody that can or help them to find somebody that can. *(5.58)*

CI: So from your experience then, in those situations, ah whether it's crisis or you know point or not what makes it difficult or easy for young people to access mental health care? I know you spoke about the environmental barrier are there any other barriers for them?

YW1: Stigma, stigma is a huge barrier, you know, that you can't ah, cope with what's going on in your own life, ah I would say more so for young men than young women in my experience, ah, young men, maybe growing up myself and having an understanding, ah, there's an aura out there you shouldn't need help, you know, and that would be among young men themselves, ah seeking help would be ah or even let's break it down to ah being bullied at school, you know, you don't tell anybody because if you tell somebody you're weak *[with emphasis]* and like that has grown into a different kind of psychology you know for going seeking help then you're weak. Does that make sense to you?

CI: Absolutely yeah of course, am so it is different for young men and young women

YW1: I would say it's different and ah seeking help yeah, different in talking, I would be inclined to find that more young women would be able to go and talk to other young women where young men wouldn't have the same, men in my opinion wouldn't have the same relationships or friendships that young women would. (*7.27)*

CI: So, that's kind of, I'm thinking that kind of brings up a curious point then, as a male youth worker how do you find working with young men, do they, does that translate or do they open up?

YW1: Maybe that's why I would have an advantage in creating the right environments, you know, not, not dragging, not pulling, not pushing, you know, asking the right questions to get the right answers, **asking** the right questions of **them** so they can come up with the right answers for themselves, would be I think something I've learned over the, probably learned that more

so from Orla O'Reilly than anybody else, you know, getting the right question in there at the right time and knowing when's the right time. *(8.07)*

CI: Yeah, am *[pauses]*, ah from your experience then what are the common coping mechanisms young people use to cope with mental health problems, just in general that you see?

YW1: Right

CI: Young people in Ireland or in society or the young people here, how do they cope with mental health?

YW1: Some of them don't, some young people just don't cope with their mental health issues at all like, and some take an awful long time to seek help, ah maybe it goes beyond that and when you ask that question I'm thinking of young people who didn't cope, who maybe are still at home today and don't have jobs and aren't contributing to society the way society would like them to, ah

CI: Sometimes am different substances can be referred to or would you see any of that in terms of alcohol or?

YW1: Yea, self-harming would be prevalent here, ah the use of narcotics and the use of alcohol definitely would be prevalent here, ah the three Hs, the hair and ah, the hoods and you know, the docs(?) just all the blocks that a young person will use to recede into a world of their own.

CI: Yea, so they withdraw from the world to ah

YW1: Yeah *(9.27)*

CI: Yeah and some of these questions like you've ah, sorry, some of these questions I'm asking you, you may have touched on already, do you think young people in Ireland have a good understanding of mental health? I know you said that you think one of the barriers is they mightn't be able to understand themselves, but even mental health as a concept do you think they have a good understanding?

YW1: They would have an understanding of that, what mental health is in comparison to physical health but I don't think they would fully understand enough of the depths of mental health and what effects of and how they can turn around themselves, you know, and the wee coping mechanisms that you learn through life and ah, I don't think they would have a full understanding, life experience brings that to you more so than ah, being educated about it, but maybe unless you experience it or feel it or you know having and engage with someone else and, and gain an understanding through working with them, I keep thinking fully understand. Myself 10 years ago wouldn't have had, any idea at all the depths of what's in mental health. *(10.37)*

CI: Yeah. So, I suppose looking at the service provision here that you provide

then in your one-to-one work and your relationship with clients, how does a young person access the service?

YW1: How does a young person access our service? Well they can be self-referred, they can be referred by parents, by teachers, by school principals, by social workers, guards have referred here, we've got a, maybe a 'no doors closed' approach to referral, anybody can refer here and ah we would do our best to engage young people as early as possible, we don't believe in waiting lists, if someone is in dire need of attention we try to get them that attention as soon as possible and ah then the whole journey into the building then from stepping in the front door and knowing and seeing and feeling that this isn't a clinical setting and maybe by the time you get to meet the youth worker you might have had a wee bit of apprehension and that apprehension is quickly removed due to the ah, maybe the mannerism of the youth worker that they're meeting that they're engaged as a human being and made felt welcome and ah informed that they're going to be the decision-maker and everything that's going to be happening here, they'll get to decide whether they come back again and there will be no pressure or nothing whether they come and basically they're empowered from the outset. *(12.07)*

CI: How important do you think all of that is in terms of the young person?

YW1: Well, if we're going to be ah looking for people to be able to leave the building and manage themselves, well isn't it not most important that they be able to take control from the beginning?

CI: Yeah

YW1: I've something else that comes to mind and ah can we just can we branch off this

CI: Yea, you talk in whatever direction you want!

YW1: I'm just thinking now that when referring to myself 10 years ago I think that could be an issue for young people and services and I have felt it myself working with other agencies and I suppose I'm thinking of myself, number one, if I'm inexperienced and I'm dealing with someone who needs someone with a good degree of experience well maybe they're being let down at that point, and if there's a new social worker on the scene with lacking experience well maybe they're being let down at that point, ah you know, and that could filter out through **all** the agencies as well

CI: So despite then, let's say, qualifications or the amount of letters after your name, how important is experience working with young people?

YW1: Well, I, I think, you know, experience and knowing what's important, I'll give you an example, maybe make a better situation, I was working on a case, there was a fairly new social worker on the case, the social worker ah maybe, pushed mammy in a direction she didn't really need to push her and severed the potential relationship in early days and that led to the demise of the young person, whereas if the social worker had kept mammy on side, we possibly

could have had a better result for that young person.

CI: Okay

YW1: Now this was an extreme case with a social worker maybe in a first year practising *(13.50)*

CI: Right. So it's about experience but I'm also hearing you talking about relationships?

YW1: Relationships
CI: How important is that?

YW1: Key absolutely the important thing going and not just with the young person, you know, possible relationships with everybody and the young person's environment is going to assist and help you as well.

CI: Am, and so how do you manage then young people and, for the under 18s, because we know about the issues in Child Protection and confidentiality, how do you manage that then, regarding the relationship with parents and the relationship with the young person?

YW1: I will be, I will be ah very direct very honest with everybody from day one, let them know you know, if anything untoward is happening here where I believe that someone's going to come to harm, I tell them at the outset and tell them what I'm here to do as well, I'm not here to manage their situation, I'm here to listen and help them ask the right questions of themselves.

CI: Yeah, and so what role do you think confidentiality has then?

YW1: Confidentiality well the run of the mill stuff that's not going to lead to anybody being harmed, you know, that's really important, that's important. If a young person feels that you've let them down then that relationship is probably broken to the point that it's never going to be renewed again. *(15.09)*

CI: So what do you find then when you're working with young people, that they're sensitive about confidentiality or do they ask about it or?

YW1: Yeah! **big time.** I think that as people grow up, they're not as sensitive or maybe more inclined to, they know what to say and what not to say, but at a younger age when they're not maybe on top of that, confidentiality is paramount for them.

CI: Yeah. What parts of your service then do you think are helpful or unhelpful?

YW1: What parts of our service are helpful? Probably touching on the same things again.

CI: Yeah

YW1: Yeah

CI: Probably the stuff you've mentioned.

YW1: Yea, there's the referral process, the 'no doors closed' approach, ah we'll work with anybody at any level, any capacity, am, what else is helpful, ah, you don't have to be a doctor or anybody to refer you, you can refer yourself, a parent can refer, ah probably the most beneficial thing that I can say about our service is that it's free of charge. Nobody is looking for any money or trying to gain financially whatsoever, and a young person is not obligated to continue to come to the service, they can come and leave when they feel the need. I just had a case myself yesterday and a young person that I was working with maybe 9 months ago has had a bit of a relapse was telling me it's not as bad as the previous relapse but feels he needs to get help now rather than let himself go to the point where he was the last time, so that in itself is an improvement. That young person has identified I'm not in a good place here, I need to pick myself up before I get to that bad place I was the last time and I think that's fantastic as well, that's a good bit of self-awareness that maybe they've achieved through working with us. *(16.55)*

CI: It sounds like you're describing to me that there's a sort of a flexibility like that young person obviously contacted you? They were able to contact you directly?

YW1: They contacted, actually an in-law contacted me first and told me that they felt they were on the slippery slope again, and I ah I told them why don't you suggest that they call me and that's them empowered again, they were taking the liberty to use their own ability to call me.

CI: And how long would a young person have to wait in that situation to see you?

YW1: Well ah this young person was invited over the same day but couldn't make it so we had a discussion over the telephone and there's an arrangement now for that young person to see me on Friday.

CI: Okay so

YW1: And it's down to them they can only make it Friday.

CI: Do you think that's helpful for young people?

YW1: Oh it has to be helpful like there's no waiting list in that, that young person needs help this week, that doesn't need help in two weeks' time. That young person need help today if possible, if they're not feeling great now, they might through time, you know

CI: It sounds quite responsive

YW1: Yeah

CI: Hmm. Is there any parts of your service you think could be better improved to better assist young people?

YW1: How could you answer this now without being biased?

CI: You do your best!

YW1: How could we improve? *[pauses]* We could have more space here, we could have more purpose-built rooms for doing what we do, for one-to-one provision and *(18.39)*

CI: So it's resource and financial kind of?

YW1: Yeah it would be yeah and we possibly could expand our PR, but I think if we expand our PR we'd also have to expand our team, because our team right now at the minute is maybe not stretched, but you know it could become stretched very quickly. I would be, would be very wary of mass advertisement to all 170,000 people living in Donegal, because I think we would have an onslaught afterwards. I think we'd need to drip our advertisement out in different areas at different times.

CI: Yea, so, are there, just connected to that, you seem quite positive about your work practises and about your workplaces in general and some of the issues are around maybe funding and resources?

YW1: Yeah

CI: Is there any other barriers that get in the way if you would like to do something more?

YW1: Well let's not take this to a personal level let's take it to a team level, I would like if our team would ah progressively try to improve everybody on the team, I would like if our team, I can't remember the name of the sessions you do, but would actually do facilitations among each other under the spotlight of the camera and be able to see what they're doing and the body language that they're portraying and hear the language that they're using and refine all of that.

CI: So reflective, more reflective work and lab work?

YW1: Yeah

CI: Yeah

YW1: Even once a year I think would be a huge benefit because, I'm just looking at myself, the lab work that I done through the master's degree would have done, actually benefitted me in every aspect of presenting, be it one-to-one, be it on a stage in front of 500 people I'm now more aware of what I'm doing, the body language and the words I'm using because of that lab work.

CI: So an option to refine your skills

YW1: Yeah, yeah

CI: Are you able to offer choice of intervention to young people?

YW1: Well that young person I was working with yesterday, ah because I would know that young person growing up, I did offer to them now you know you don't have to talk to me you can talk to any other of our staff members who wouldn't know you and you wouldn't be able to work with them and ah they wouldn't know your background and you can keep that anonymous, whereas you might feel there are elements of their issues they might not be able to talk to with me, so that was offered. That young person is now considering that. They can still see me on Friday and if they want they can meet with someone else, I'll arrange that for them, so

CI: So even down to choice of who you want to work with?

YW1: Yeah

CI: there's a lot of

YW1: Yeah and let's face it you know some young people can come in and they might not just click with the person that's there and I think that it's important that we give young people that opportunity like you know you don't, if this isn't working with someone well maybe someone else can come in here, and that has happened in this organisation. I'm aware of young people, that I have asked other staff members to take over and I'm aware of other staff members have asked me to take over their one-to-ones, especially when you get to know a young person, am, you know another staff member will have way more in common and maybe a better understanding of where they're coming from. *(21.48)*

CI: Yeah I get it you're sort of matching people up and

YW1: Yeah

CI: Constantly maybe even re-assessing?

YW1: Yeah

CI: It sounds like it's not just well we're for this it's like every, every now and again you're like, is this still working? Or you seem to be telling me that's the way you work?

YW1: Yeah but let's not lock in here and say

CI: Yeah

YW1: this is a fixed position, like you know, even ah there'd be certain young people

that I would be asking, I want you to come back and see me next week because I would have the gut instinct that you need to maybe talk more and open up more and then there would be young people then I'd be saying, if you need to talk to me you can call me and arrange another appointment and we'd be glad to help you. *(22.28)*

CI: So, flexibility?

YW1: Yea, as much as possible

CI: How do you, so, when am, I suppose what I'm looking to understand as well is about choice of interventions as in like the actual style and approach in work you do with young people, do you adapt that or is it just the same approach?

YW1: Okay, *[laughs]* I have done everything from exercise, I have gone painting rooms in houses, so I have, I have had one particular young person who just could not talk whenever they were face to face with me, they could not talk, and ah I suggested to the parents they just can't look at me and talk, whatever is going on with them, and ah, we have to find something else to do and the parents said, well there's bedrooms that need to be painted here so you want to come and paint bedrooms, so I actually went to the house and parents, parent's were in their house and the young person was in painting one wall and I was painting the other wall back to back and they told me everything

CI: Powerful

YW1: Everything that was going on in their head, yea, so what else have I done

CI: So, sounds like you've done, you don't just have the exact same approach every time?

YW1: Yeah, yeah you can't be thinking that, you have to think outside the box, you know, if something isn't working for a young person or you've taken them as far as you believe you can take them, well then it's time to move on and open up them to other ideas. *(23.52)*

CI: How do you feel when young people respond to your service?

YW1: People vote with their feet. Young people definitely vote with their feet, ah, the amount of young people that will come back again for that further assistance, you know, would be fairly good, fairly high here. There is young people here you might only have talked to once and that's okay and they get what they need out of that session and move on but I think that the amount of young people that actually continue to avail of the service would be testimony to the service. People vote with their feet and it's the same with the situation.

CI: So are you satisfied then with how your organisation approaches mental health?

YW1: In some aspects yeah, and some aspects I'm sure we could improve. I will be biased *[pauses]* I think the organisation is maybe ah a great environment to

work in, I would find it really difficult to work in another environment even though I might have stuff I might be annoyed about that's going on in the organisation, I still think it's a fantastic organisation with a great philosophy

CI: Yeah

YW1: And

CI: With their approach to mental health?

YW1: What can you ask me that question again because I've kind of going off the point

CI: You're okay. Are you satisfied with how the organisation approaches youth mental health?

YW1: I'm satisfied, I would be satisfied yeah, but I do think there's room for improvement, there's always room for improvement.

CI: Yeah

YW1: Yeah

CI: And you don't have any ideas right now for that improvement?

YW1: Well, we could be putting funding towards it so we could, you know, it could be better funded, it could be better organised, it could get bigger, we could have better counselling methodologies for our employees, you know, we could make sure that ah, I know as a younger facilitator I struggled

CI: Yeah

YW1: I struggled, I carried some of the ah, the ah troubles of young people home with me and, you know, that could have been taken care of very easily if I had have been debriefed or you know *(25.53)*

CI: A little bit more support then

YW1: Yeah support

CI: Especially for maybe people coming in with less experience

YW1: Yeah

CI: Stuff like that

YW1: Yeah, yeah. Now 10 years on 11 years on I'm able to manage most of that myself, I know when I need to talk to somebody I go and talk to them and debrief and offload and I find other more experienced staff members the same. They'll come and debrief to me and talk to me and we never have to give away, break confidentiality issues, but we can discuss cases and assist each other in progressing cases and 'specially the debrief part, letting go that terrible happening that you might have been exposed to.

CI: Yea, am so having a quick look there at ah, we've talked already a little bit about culture and family and things like that, so just in case we missed some parts, I'm thinking what is your experience then of working with young people's families, am, and the role that the family has then in mental health?

YW1: Probably the biggest part of it, you know, 99.9 per cent of every human being is the environment that they're growing up in and if that environment is not ah, what would you say, bringing out the best in them well then *(inaudible)* and there's some young people you'd just love to take out of the environments that they're living in but that's not that's not ah feasible so it's not. I think it's paramount I think having a good relationship with the families and the families having the confidence that you're here to help, you're not here to judge, you're not here to put them down, you're here to help them and you're doing that so I think that's, that's important. *(27.35)*

CI: Yea, and am, *[pauses]* have you heard about young people's experiences of asking for help with other services like say maybe the more statutory services, the formal ones?

YW1: Yeah and I don't want to be harsh you know, it comes down to perception, you know, young people perceive that they're going to get help in a certain place and when they don't get that help and it's because that agency might not have the capacity to deliver that help am, we're talking in my cases, CAMHS and Jigsaw have been prominent and not helping young people.

CI: Yeah

YW1: You know I've ended up having cases where they've been to CAMHS, they've been to Jigsaw, they weren't able to help them and ah, some of them cases I was able to manage myself and it was a listening ear exercise basically and not much more than that and other cases I had to find them more expert help *(28.30)*

CI: Yeah, so I suppose you're hearing when young people get to you that they may have had a negative experience and that's why they're at you sometimes

YW1: Yeah

CI: Yeah I get you but again it's down to what that young person's perception and need was of the service?

YW1: Yeah

CI: So it doesn't always match for them

YW1: Doesn't always match for them no, doesn't always match for them but then we could ask questions as well of the services, maybe you see every service is made up of a group of individuals and there's potentially fantastic individuals within every service but *[pauses]* could they all be fantastic or can we all be

fantastic, that would be tough even for a large service *(29.13)*

CI: Mmm and every service has their own policy and approaches and ethos and you know things like that and obviously you're working in youth work because that ethos agrees with you

YW1: Yeah it does

CI: You know, yeah I get what you're saying, it is a, so for young people who are coming here maybe it's more suitable for them?

YW1: Yeah

CI: Well I suppose then I'm thinking, naturally enough and I might be a little bit biased in myself as well in thinking that, but it sounds like the youth service is designed around that sort of youth-led approach then that seems like more appealing to young people or, you know?

YW1: I, I, I'm

CI: Than the clinical sort of which is designed more in the adult services?

YW1: I would be inclined to think that it's down to that ah, control factor, they're empowered, they empower themselves when they seek help here, when they seek help elsewhere I don't think they have the same degree of control or power like you know especially if someone is going to be writing prescriptions or you know

CI: Yea, so, if you could, these are more closing questions now coming to me, so it's more like if you can imagine, as a professional with all of your experience now, the ideal mental health care for young people, what would it look like?

YW1: That would likely be a non-stigmatised building that does more than just mental health. Young people could be going in for getting a CV done, young people could be going in for anything positive that a young person would be getting done in their life, even grant applications, or whatever, it would be maybe a multi-service building that they can also go to for mental health appointments without being stigmatised, that would be free of charge, that would be without waiting lists, no doors closed approach, that would ah, *[pauses]* maybe have a degree of experience and staff members, you wouldn't be going in and getting fobbed off, you know, ah whatever issue a young person brings to the table, that's their issue, it might be a small issue in someone else's mind but it's still a huge issue in their mind and at least treat it with the respect that it deserves, ah *[pauses]* ask me the question again then to re-focus it.

CI: Naw, like I'll re-phrase it for you but no I mean like everything you're saying is quite actually answering the question so far but, so what do you think are the most important features of a youth mental health service? I think you've probably said some of them there

YW1: The most important features, *[pauses]* that it's not clinical, that it's open, accessible, warm, friendly, welcoming, that it's ah *[pauses]* non stigmatised I've already said that

CI: Yeah *(32.08)*

YW1: Yeah that it offers, that it offers ah appropriate facilities as well, you know that there's rooms that the conversation is not going to be heard, it's going to be confidential, it's not going to be interrupted, it's going to be comfortable. Yeah I had something else in my mind before you asked that question as well that was

CI: Imagining the ideal mental care, that was the question

YW1: I had something else in mind as well in relation to practitioners

CI: I was about to say as well is there anything else specific about the people working there, the practitioners that you think for young people, 14, 15year olds to walk into a building, what person should meet them?

YW1: I have a perception you know, right now at the minute I'm beginning to go grey, will I be as appealing for a young person to sit down and have a conversation with when I'm totally grey? I don't know, I don't want to be ageist towards myself either

CI: But there's something in it that you're

YW1: Pause there, pause it a minute there.
[Tape is paused, interviewee had some questions they were concerned about and wanted to ask without being recorded]

YW1: I had I had ah some kind of thing I had on practitioners

CI: Well it's I think

YW1: Fucking lost it now

CI: Is there something there you're getting about like a relatability or something because you're talking about you being too old or sort of a disconnect, is that what you're worried about or

YW1: It wasn't a worry I had it was something that exists with practitioners now at the minute

CI: Is it about the way we look, is it about the way that the practitioner?

YW1: Right, right, it's going back right, right, are you ready to go again?

CI: Mmm

YW1: What's the question there now again, repeat that question?

CI: The ideal mental health care for young people

YW1: The ideal mental health care, well when we're talking about idealism you know and maybe why our mental health is an ideal at the minute you might have to go back into the school and what school is about and what it's for and my mindset for school and education right now at the minute, the socialising aspect of school and education is way more important than the academic aspect of school and education and I think that academics have a lot to answer for here because academics that are successful in academia maybe don't understand what academia was like for other people and there's a big disconnect there, because, and I'm going to put this in ah, what would you say, local slang terms, these academics they carry their heads under their armpits because it's the most important part of them. Their head is not on, where it should be, on their shoulders because they're disconnected from young people who aren't academic, if that makes sense, and don't have an understanding of the social background that these young people are coming out of and that's like a big, big part of an issue that's going on maybe because not too many young people growing up in a, a poor socio-economic background end up being doctors or practitioners that end up working with people, that make sense? *(35.17)*

CI: Yeah

YW1: Had that in my mind so I did

CI: Absolutely it's important you say it

YW1: I know it's totally going away from that question but I think it relates to the question, it relates to the whole research as well I think, that's what I'm getting

CI: Well young people spend so much of their lives in school and often schools are where mental health problems are first actually encountered as well and, you know, I mean I don't know about yourself, but you, I know I definitely find that when young people go back to school, they're not calling you during the summer holidays looking for support, they're calling you when they're under pressure at school, you know so I mean I think absolutely that school does play such a major role in being a teenager and the social life of school as well as the academic life, yeah no it is all tied in and it's something that obviously in Ireland we don't really have very specific school services for mental health do

YW1: We don't really

CI: No we don't

YW1: And when we're talking about the subject of school teachers go to school from 4 to 12 and then go to secondary school till 17 and then they go to college till they're 22 to 23 and then they go back to school and maybe actually have no concept or maybe I'm wrong saying that, but most of them, the majority of

them will have no concept of what it's like for a young person that can't identify with school and academia.

CI: Yeah. So is there anything else you'd like to say, you haven't had the opportunity to say or any recommendations or suggestions?

YW1: Not right now, but I'll probably be thinking and pondering all day today and I'll be thinking to myself I wish I had said this and I could have said that. Is there any scope in this research for me to contribute afterwards?

CI: I will check out with my Supervisors if there is, absolutely!

YW1: You can ask your Supervisors and maybe I could put it back in writing or whatever *(36.56)*

CI: I will yeah, I will double-check.

YW1: That would be nice if we could make progress on facilitation

CI: Because obviously like when you're in the middle of an interview and you're thinking about things it always, I know myself even from taking part in research, you do later on be like, oh I just had an idea, wouldn't that be good or, so I will definitely clarify, I'm having a meeting soon with them about like the if anyone wants to follow up with an email or something or some idea, definitely I'll check that out

YW1: Yeah

CI: Am, because of that process what we've talked about has now affected you and you'll go and think about it and I'll go think about it and so it would be good to see if there's anything

YW1: If I recommended that you ah were to ah interview someone else

CI: Well yeah

YW1: I would I would like you to interview Dr. XXXXXXXXXX

CI: Right

YW1: Is that it is that it

CI: Well you see my remit is what's important at the moment is that I have to, it's the am, it's not the private services at the moment

YW1: Well XXXX is lecturing and a youth work degree, Masters as well and he's also a practising Psychologist and takes on cases

CI: We'll look into it definitely. Thanks so much for everything.

YW1: You're very welcome

CI: That's very good, thank you for taking part in my research it's just so important to hear practitioner's opinions so thanks for your honesty and everything.

- Interview End -

Appendix 13

CI: So, I suppose what, just to get the kind of conversation going, like, what does mental health mean to you?

CATHY: To me, um, I suppose it can be healthy or unhealthy, it's just the way our minds go, we could be thinking really really well and living a good life and happy or we could be struggling with our mental health meanign that we're going through some kind of phase or depression or something like that there *(0.25)*

CI: Yeah

CATHY: Everybody has it! *[laughs]*

CI: Yeah! That's a fair statement yeah. What do you think its like to be a young person in Irealnd today woith a MHP?

CATHY: Umm, it's getting better I have to say but from past experiences when I was a young teenager there was a lot of stigma about it and um, I dunno, it was hard to come forward with stuff, you might say something like I'm feeling shitty a wee bit of attentuion, not attention in a bad way! *(0.55)*

CI: Yeah of course

CATHY: But you want to feel loved by somebody you know, it's a natural thing

CI: Yeah

CATHY: And you'd get put down for it becayse they're like stop being so attention seeking, stop looking for ways to get praise or something, so you find it harder and harder the more you go into your mid teens, and then when you're in them and things are going on, it's a lot harder to come forward with them then coz you're pushed back, because of your experiences coming into your teenage years, um, so coming out to an adult or something like that is a lot harder becayse you don't want to be shamed by an adult saying "don't talk about that" so it's more, it's not even like society, it's just a process you go through and just you have to learn that it's okay to chat about it but thankfully now there's a lot more, there' a lot more services saying it's alright, talk to your friends, tlakt o family, so it's getting better thankfully! *(1.55)*

CI: Yeah! So in a way what you're describing, if I was to put it in a different like perspective

CATHY: Yeah like simple!

CI: No no what you said is like bang on, I'm just trying to make sure I understand you, is like you've to almost, you're sort of feeling your way, is it okay to talk? Is it not okay to talk? Then you have to learn it IS okay to talk! *(2.10)*

CATHY: Exactly! *[laughs]*

CI: So you have to unlearn the stigma?

CATHY: Yeah exactly, you're kinda brought up with it so you're trying then to phase out of it.

CI: So when did you first begin to expereince some problems with your mental health?

CATHY: I have always experienced problems, from a very young age, like 7 years of age, I remember just wanting to hurt myself, either throwing yourself down the stairs out of the house, just something, just there was always something itching at me, just I wasn't feeling right, and of course you never know what it is you just think you're a crazy little kid throwing yourself down the stairs but then that carried on through and got worse as I got older *(2.56)*

CI: Yeah, and um, the two questions linked in with that is how long did it take you to realise, you said you felt like a crazy little kid,

CATHY: Yeah! *[laughs]*

CI: How long did it take for you to realise that I should ask someone for help?

CATHY: Um it wasn't until I was 16 that I was told I should get some help

CI: Right

CATHY: So that came first, so it was kinda like, na I'm too cool for that like but they way that it went was, I was taken to the GP, and now the GP I have is very clsoe minded and said everything is in your head, aw you're only doing this to act out on your parents, it's all to do with you, get yourself sorted and I was like, shit it's all my fault, you know what I mean? So then they referred me to the, I forget the name of it *(3.47)*

CI: [FORMAL YOUTH MENTAL HEALTH SERVICE]?

CATHY: Naw, maybe?

CI: [FORMAL YOUTH MENTAL HEALTH SERVICE]? Child and Adolsecent Mental Health Services?

CATHY: maybe? Somewhere down in Ballyraine?

CI: Yes! everyone calls them [FORMAL YOUTH MENTAL HEALTH SERVICE]

CATHY: Ah right

CI: It stands for Child and Adolsecent Mental Health Services

CATHY: Oh okay

CI: It's in Ballyraine, some people call it Rossan College

CATHY: Oh yeah! It's there too

CI: Because it's beside Rossan College, so you went down there? *(4.11)*

CATHY: Yeah

CI: And what age where you at this point?

CATHY: 16 and it was absolutely dreadful, I suppose coming in from a defensive persepctive, it's my fault I need to be on the defence here, you know trying to protect yourself , it's just human to do, am basically, I sat in a room this person had a clipboard and was ticking boxes and that just made me feel worse, aww they don't even care, I'm just here for them to tick boxes so they can push anpother one off the list or whatever you know, so it was more like a defence mechanism I was going through, but my own, not my own doing, but it was the place I was in at that time so I don't feel, ah, that [FORMAL YOUTH MENTAL HEALTH SERVICE] worked for me because of the way I was kind of entered into it, it wasn't voluntarily done either *(5.00)*

CI: Okay, that's really interesting because I do hear you still talking about this is your fault that [FORMAL YOUTH MENTAL HEALTH SERVICE] didn't work but i am curious to know that there were some things that obviously didn't help with that?

CATHY: Oh yeah

CI: You didn't want to go?

CATHY: Yeah *[laughs]*

CI: So there's no volunteering

CATHY: Yeah *[laughs]*

CI: and there's a clipboard

CATHY: Yeah *[laughs]*

CI: So what else kept the barriers up, lets reframe it, rather than it's all your fault

CATHY: Oh yeah! *[both laugh]*

CI: Let's look at how did the service help remove barriers or keep the barriers up?

CATHY: Um

CI: Or that person you were working wtih, do you know what I mean?

CATHY: Yeah, I only went there twice

CI: Okay

CATHY: Because I had this thing, I didn't want to be there

CI: Yeah

CATHY: And it was mainly a clipboard the whole time, because of course they have to go through an assessment before you're actually put through to anybody, so it was more the assessment phase that put me off, the whole um clipboard in front of you, do you feel like this, do you feel like this, just kinda crossing things off the list rather than asking, well how are ya? *[laughs]* you know? Trying to put words in your mouth rather than you coming across as what you feel

CI: So you didn't feel you could talk or express? Is that what you're saying? *(6.14)*

CATHY: Not as much, not in the assessment phase anyway, um so because of that I didn't go back

CI: Well you said you had a second one, was the second one still an assessment

CATHY: Oh yeah it was still kind of an assessment thing

CI: So you never got to speak to anyone?

CATHY: No! I didn't! *[laughs]*

CI: So how did that whole experience make you feel about asking for help again?

CATHY: It put me off completely because I was like is this all it is? You're sitting in a room with someone ticking boxes, that's not going to help, you know what I mean? And of course you're going through you're own stuff um oh I don't need help either, you're trying to convinve yourself you don't need it either, they weren't giving the right support, not saying that, I'm trying to put it in the right way, um

CI: Say it inwhatever way you feel, it's fine *(7.03)*

CATHY: It's more, they didn't whenever I am referred to this place of course they were given a note by the GP, which was coming across as an angry teenager who is acting out

CI: So they were, treating you from the GP's referral notes?

CATHY: Yeah basically, which was done by my mother rather than me! So I was an angry teenager who was lashing out, so they were kinda looking at that more than what is actually wrong with her? Coz I'm not an angry person generally, *[laughs]* so, um, they weren't looking beyond the, right she's just mad, is it bipolar? is it something else? is it just depression, what's going on here? They were going by that, instead of is this wee girl okay?

CI: Not asking you were you okay?

CATHY: Yeah, basically, yeah

CI: Did anyone ask you are you okay?

CATHY: No *(7.58)*

CI: Or what you would like to do?

CATHY: Genuinely no. Actually not.

CI: Did anyone um tell you, your options?

CATHY: Um, thinking back, like I know for a fact no one asked me if I was okay because I kept that with me from that, from that, but I can't remember what other questions, I was just like ugh

CI: So that actually stayed with you? *(8.21)*

CATHY: Yeah that one wee thing, nobody actually asked me if I was okay

CI: How did that affect you then?

CATHY: Um it was just then I went to this service and they didn't care, you know what I mean? It's a free service, of course they're just trying to get as many people in and out as possible, diagnose them and push them on,but that was my thinking behind it at the time, so yeah *(8.50)*

CI: That's how it felt for you?

CATHY: Yeah 100%

CI: And that's how it felt bieng 16 and in that position?

CATHY: Yeah, uh hmm

CI: Right so, umm, just looking through here, I was going to say like, were you satisfied with the experience?

CATHY: Ugggh *[laughs]*

CI: That's a loaded question *[laughs]*

CATHY: No not really at all, no

CI: And did it match your expectations, did you expect all that to happen when you went there? *(9.12)*

CATHY: Um, I don't know what I expected, uh, just I suppose, a Freudian scene where you had to lie down on a couch! *[laughs]* and liek talk about yoru feelings, even something a wee bit more um *[pauses]* personal than what it was, you know, rather than just sitting on a hard seat and just staring at this person like an interview *[laughs]*

CI: Staring at a clipboard! Being interviewed? That's a good word. What did you need from that person?

CATHY: Probably to ask, are you alright? What's going on? And just be told you know you're a teenag.. no I didn't want it normalised what I was going through, at the time, I didn't want someone to say aww it's just a phase and you'll grow out of it you'll be fine *(10.00)*

CI: Because you at that point had spent nearly ten years of your life dealing with this

CATHY: Oh yeah!

CI: So it's most of your life, not at the phase

CATHY: And no one would have known at this point either, but that's, especially adults especially family, and then they're like it's just a phase you'll grow out of it but in your own mind you're like no it's not! I know it's not!

CI: So you knew, so what were the core things you needed from that person in [FORMAL YOUTH MENTAL HEALTH SERVICE]? Let's say.

CATHY: Just to listen more than anything, and realise it's not a phase, it's something that has been going on for a long long time but I didn't feel comfortable to actually come out with it, on my own

CI: So you needed to feel more comfortable?

CATHY: Yeah

CI: I don't want to put words in your mouth

CATHY: No no! I defintiely needed to feel more comfortable

CI: And how could they have made you feel more comfortable? (10.49)

CATHY: I don't know, coming back to the clipboards, making it a bit more personal, before doing all the paperwork, having just an introducatry conversation and you know coming across as friendly and helpful wanting to help I think is the thing, rather than going straight to, right we need to tick off some boxes here, you know?

CI: Yeah

CATHY: Just something like that

CI: Absolutely

CI: Cause you're, a lot of young people can be in that position where they are distrustful right?

CATHY: Oh god yeah!

CI: I mean we're talking about teenagers and if you're dealing with something for a long time by yourself. Is there any, I was going to ask you what suggestions you would make but you've already given a few, is there any more on top of that, you know, in terms of that, if there is that distrust? or What can help with that?

CATHY: To help with it? Even from coming here something as simple as I'll make you a cup of tea, straight away you get a comfortable feeling

CI: So did you ever speak to a youth worker here? *(11.51)*

CATHY: I did yeah,

CI: You did?

CATHY: I did yeah,

CI: And so what was, going back to all those questions we just asked about the other services, what was it like then to come to the youth service here and speak to a youth worker?

CATHY: It was a lot more comfortable because I was coming here with friends before, and it was a very welcoming place, all the youth workers were friendly especially, should I name names are not name names?

CI: If it is awkward for you to not say it then it is better for you to say it or like

CATHY: just as a conversation goes I don't want to be like oh this person

CI: that's what I'm saying if it interrupts with your thought process then just say it because this is a confidential conversation anyway so just go for it

CATHY: Yeah, so [youth worker] would have always been in there, just having a conversation, just to see how you were without giving you the all, sit down and what's wrong with you, she would be like 'you look different today?' or 'you look nice today' are just something, even little compliments like that, but in a more confidential surrounding it is hard to get that basis with somebody, but even just your looking a bit down today I will put on the kettle, something as simple as that

CI: Noticing?

CATHY: Yes noticing, because you would feel like they actually care, they are actually noticing stuff so, they know

CI: Yeah I can imagine what you're saying in the sense of, you are there time after time, is it? So were you coming here for a while?

CATHY: Yeah I think I started coming here when I was, um, 15 initially? And that was kind of in and out but I did not really know anybody, then when I was 16 I started coming here a bit more

CI: So how long would you have known the youth worker before you talked

CATHY: Before I talked, a good year and a half, two years

CI: So how important was that?

CATHY: Very important, I suppose, you know, having known the person that you are going to open up to is a big thing for a teenager, I really do but in a, not in a, because you know they won't judge you, you know their personality, you know that they do actually care, it's about getting that trust with a young person more than anything, um, so it was a good year and a half, but that's not knowing that I wanted to talk at the same time, I just trusted this person, I did not know that I wanted to talk to them until, you know, because the first couple of times she offered me a cup of tea and a sitdown, I was like no *[laughs],* I'm not going to do that, I'm not going to talk *[both laugh]* I'm here to get away from everything, I'm here to have fun, so it takes a while I think, I think it's hard to break that barrier actually with teenagers because they are too cool *(14.45)*

CI: It is a big thing though, talking to people about personal things across the board, I think it is fair to say, in life, you know, that's why these questions are important to figure out, well, you seem to have, from what you are describing, a positive experience with your youth worker in that sense

CATHY: Definitely yeah

CI: And so, and that's not biased because you were here based off, you are describing this process

CATHY: Oh yeah

CI: Where it was a year and a half to build up to that

CATHY: Oh yeah, and whenever it did, after the [formal youth mental health service] didn't work, I did go to [youth worker], and I'm not saying it was all sunshine and rainbows chatting to her either, em, we agreed to meet once a week as well, but whatever process that she went through there was a lot of handouts, and filling out these handouts and that's what was every week, and I was like uh, I don't want to go in and fill out more handouts and more handouts, and I'm sure in theory these would have worked perfectly but going into a room while she did her own kind of work and I was sitting down, then chatted to her the odd time about what it was and that there

CI: Yeah, what did you need from her then that you didn't get?

CATHY: At that point, ugh, not to be bad *[laughs]*

CI: It's fine

CATHY: I just needed more attention

CI: You needed more attention

CATHY: Sometimes you just need more attention *[laughs]*

CI: Everyone needs attention *(16.16)*

CATHY: Yeah but you would have got that outside of this one are a week, you would have got it like talking to her in there and having a craic with you but understandably she was busy at the same time you know

CI: So a little bit more attention and what would that attention have been like for you, so I was going to say, were you offered any choice in what we would say, an intervention? As in treatment, so you would have, correct me if I'm wrong, you didn't want to do handouts

CATHY: No not really

CI: You wanted to...

CATHY: Uh, even if it was handouts just been brought through the process of it

CI: You just wanted one on one talking, interaction and attention?

CATHY: Yeah *[laughs]*

CI: Yhat is perfectly fine, and so that was sort of, no excellent, and so were you satisfied with your experience in the youth service then?

CATHY: As a whole yeah, but of course there were things I didn't like *(17.18)*

CI: And it is important to talk about it because it helps, um, it helps us understand what works, were you ever asked in the youth service or in [FORMAL YOUTH MENTAL HEALTH SERVICE], do you want to do this? or do you wanna do something else?

CATHY: No, never *[laughs]*

CI: Okay just checking!

CATHY: I just had to think there, did they? No definitely not!

CI: Okay so how do you think the youth service is helpful for young people?

CATHY: Oh it gives them a place to, to gain that trust before having to come forward like, you can come here with your friends and have fun but those services are there whenever you feel you are ready to go forward with them, you know, which is a big thing

CI: It sounds like you're more describing, the option?

CATHY: Yes, I suppose thinking on it, this is just mean now talking, but I think it is very important that the person wants help because if somebody does not want help they are going to be pushed in these directions like, the [FORMAL YOUTH MENTAL HEALTH SERVICE], where you're not happy and even if it is helping one person it is not going to help the other, so there needs to be some sort of comfortablity going into the situation and not just being thrusted into it

CI: So it should be voluntary

CATHY: Definitely, yeah, but even made feel voluntarily without tricking them, if you know what I mean

CI: I think I understand

CATHY: It is hard to explain

CI: Maybe emphasising how involuntary it is?

CATHY: Exactly

CI: Is that what you mean?

CATHY: Emphasising or I was just thinking about this recently for some reason, I'm trying to think what it was, um, *[pauses]* I don't know, kind of more emphasis on passing about, it has to be your choice, just as you said just more emphasis on its voluntary but it works, you know, so it's your decision to go into it, but it will help as long as you are open to it, do you know what I mean?

CI: Right so it's really about having a conversation?

CATHY: Yes

CI: Maybe a few times? And re-emphasising? Is that what you mean? I am just trying to get my head around it

CATHY: Just dropping hints *[laughs]*

CI: I don't want to be picking up on something or putting words in your mouth *(19.51)*

CATHY: No no

CI: It's, so yeah service provision, did you go to any other, did you go to the adult services at all? With the doctor? After the youth service and the [FORMAL YOUTH MENTAL HEALTH SERVICE]? And you were fed up?

CATHY: Oh I did, I will list them out don't worry! [Both laugh] I'll write them all down! Did you ever hear of [private counselling services]?

CI: Yes

CATHY: I've been there, I have also been to college counselling, twice actually, and then also through doctors to get prescriptions for antidepressants, so I have gone through all those

CI: So have some good experience

CATHY: Yes that's a good way to put it!

CI: You are a wealth of knowledge on the topic *[both laugh] (20.39)* Um, so overall then, am, I suppose the [private counselling services]is for, it's for, it's private isn't it? And it is for young people?

CATHY: Yeah I was lucky enough that I was able to get into it, yeah

CI: It's sort of our respite care place? Isn't it?

CATHY: Yeah

CI: And then you have your school counsellors. So when you reflect back then over, I suppose your experiences in the [Private healthcare], were they helpful?

CATHY: All very helpful, the woman who runs it XXXX, is lovely, really really positive kind of person, um, she brings a different kind of aspect to it, is not all about um counselling and all, it's more about trying to redirect your brain from thinking about the bad stuff that you're going through, it's more thinking, well yeah what you're doing, what happening to you is real and I feel so sorry for you and it's so hard, but look at all this good stuff going on to, so that was more trying to change, getting out of the habit of bad thoughts, more than anything, redirecting your mindset and that helped **a lot** *[with emphasis]. (21.58)*

CI: So with me so would that be just more like some practical work?

CATHY: Yeah

CI: I'm just thinking, there was the assessment in [FORMAL YOUTH MENTAL HEALTH SERVICE], that didn't get any further, there was the worksheets in the youth centre and now I'm thinking you've got someone sitting and giving you some practical work on how to work with your thoughts?

CATHY: Yeah it was basically going through mindfulness and meditation techniques and stuff like that, it was, it was like an exercise more than anything just a mental exercise just going through different processes whenever the anxiety patterns come back, recognise them and try to stop them, basically

CI: And that was helpful?

CATHY: Very helpful yeah *(22.39)*

CI: Um, and I suppose were you offered then a type of intervention? Were you offered what you wanted to do?

CATHY: Um, no, not even! *[laughs]* it wasn't even an offering, at that point it was voluntary to go to, [Private healthcare], um cause the anxiety problems got just really heavy as they do and it was just insomnia, depression everything so you're like, this is really shit, I now feel that I am ready to go and get some help so I kind of went in there with a positive attitude to change at the same time so *[laughs]*

CI: So you were in a position, that's what you're talking about, the voluntary aspect?

CATHY: Yeah

CI: And the wanting to make a change?

CATHY: Wanting to make a change yeah

CI: And again, what did you need from the person? The lady you worked with

CATHY: Angela

CI: Yeah what did you need from her?

CATHY: Probably just the lesson though, she never picked up a pen and paper, if she did, it was for me to write goals in life more than anything, um, she talked quite a bit but she also listened and explained things that was going on and also explained different experiences that she had also, obviously no names are anything, it was all confidential, but different experiences and her own experiences, which was another big thing, I know you don't want to tell your experience to everybody, but she said well I went through this and I went through this, and I can tell you, it gets better, you just have to want to do it and you just have to exercise like you would physically, like your mind! *[laughs]* so, she gave exactly what I needed at the time. *(24.42)*

CI: Did you know you needed that at the time?

CATHY: No, not to the extent that it was, it was more holistic than I thought was going to be!

CI: And so, in what way do you think is that service is helpful for young people D' Exeter house?

CATHY: The only thing is, I was lucky that I was able to go to it, because it is expensive, I was very privileged that I could go, it's great for young people in the way that it does, break that circle of anxiety you know? But am, it's it's not readily available to young people at the same time, and young people themselves definitely would not be able to afford it.

CI: I suppose it's like it would be interesting to know how you can take the care that is provided and bring it into other services

CATHY: Yeah exactly! *[Laughs] (25.32)*

CI: That, well that's why we are trying to explore all aspects of help. Okay, was that anything that could improve the service in [private counselling services]do you think?

CATHY: Um, improve *[thinks]* I suppose the one thing I didn't like about it because I am nosy, is am, of course I would have been referred, as well as wanting to go so she would have had private conversations with me mum, so at the time, like paranoia, like what are they talking about? And still to this day I don't know and I don't care any more, but back then I was like, what are they talking about? I suppose just that paranoia coming through.

CI: How important is it though when you are young?

CATHY: Oh you need to know! *[Laughs]*

CI: that you know that adults, are having conversations about you, does that have impacted all in anyway?

CATHY: It's a bit uncomfortable, you're kind of like, shit what are they talking about, are they talking about something that I don't know? They must be because they are doing in private, so it kind of, it brings about faults as well, especially with young people, or someone who has kind of, a paranoid nature, like

CI: So basically a lot of teenagers?

CATHY: Exactly! *[Laughs] 26.47*

CI: No, it's just because trust is so hard to build when you are a teenager

CATHY: Yeah

CI: It can be, especially around anything that is very personal, so I do wonder how that impacts trust, um, knowing that people are talking about you, even if it can't be avoided

CATHY: Yeah exactly!

CI: So what, what's the result of that I am just trying to understand. So, you've been through quite a few different pathways then, I suppose what I'm interested in as well is that, um, you kept looking for help?

CATHY: Yeah definitely

CI: Even though you had a negative experience with the very first time with the doctor and then with [FORMAL YOUTH MENTAL HEALTH SERVICE], eh, a fairly positive experience in the youth centre but you, then you went back to the Dr route, or the consellor route in college, so what sort of like, how to explain this, or I'm trying to find my own words here, it's like, like how did that not put you off? That's what I'm trying to understand, you had a negative experience with the official services let's say, you didn't know in the youth service that you were doing mental health work

CATHY: Yeah exactly *[laughs]*

CI: So, um what motivated you to go forward and asked for help again?

CATHY: Em trust built with adults as I got older, especially after coming to the youth service which was a big thing

CI: Okay, that's interesting so building trust here had an impact?

CATHY: In the future? Yeah, um, because I used to be so shy and of course my own symptoms kept getting more severe and severe and when you are in an uncomfortable situation you want to get out of it, but because I gained confidence here to talk to adults it helped go to counsellors, it helped go to the doctor and be able to chat about it freely, and am, and I was lucky I had a good group of friends in college as well who were supportive as well, so just, because when you have kinda mental illness tendencies, not necessarily a mental illness, um it's very easy to fall back into that rut, but knowing you can go back and talk to someone is a huge help and it even gets you through some of those anxieties as well, okay I'm feeling shit now, but it's okay I can go and talk to someone tomorrow!

CI: Even knowing there is help?

CATHY: Yeah exactly, it makes a big big difference *(29.22)*

CI: so I have some questions around that no culture family environment, like you know, so he did tell your family and friends you are looking for help?

CATHY: Um yeah, friends probably a wee bit more, family I would have kept a lot kinda more secret just like, I'm not feeling well I want to go chat to someone, um, but of course the Irish family being "what's wrong with you?!" *[accusatory manner]* you know that kind of way? *[Laughs]* Ah sure there's nothing wrong with you, that kind way, you just need a good night sleep or something like that!

CI: How did your friends respond?

CATHY: Um, sometimes, well most times actually sorry, they were very supportive but still in the back of your head you are like shit and I burdening them like with this kind of information? They have their own problems and I know about their problems, um, and I don't want to be putting any more stress on them, so like, I was like I need to talk to someone who is getting paid to do this!

CI: A professional basically! *[Both laugh]* do you think culture has a role to play in young people's mental health?

CATHY: Um

CI: Irish culture, like you said

CATHY: Um, does that include like social media? Our culture in general?

CI: Yeah yeah, what ever

CATHY: Yeah definitely, I think there's too many em, to put it in a weird way, there's too many variables been posted that kids can can overthink, they see too many possibilities, so the mind can't focus, which I think is a big contributor to overthinking and anxiety and everything, so with social media you are hearing about what this 13-year-old experiences was in a certain situation and then you think that your relating to that, and then you're thinking oh shit, I'm like that, and then you hear about

another one in England and you're like oh shit, I'm like that too! So there's too much going on, yeah there's too many variables these days.

CI: Yeah you're searching for identity and your options are too varied?

CATHY: Exactly,

CI: Which means it becomes more diffused and it is just harder to be yourself

CATHY: you don't know how to be yourself

CI: Um, do you think young men are women experience different barriers when they are looking for support for the mental health? *(31.37)*

CATHY: Um, I suppose, there is always that kind of age-long thing about a man not wanting to come forward and that it easier for women, em I don't think, there is a difference obviously yeah definitely, but there is not that much it is still very hard for a woman to come out about certain things as much as it is for a man to come out about other things, you know, someone told me one time the worst thing that you experience is the same as the worst thing another person experiences, like regardless of the variation in seriousness, you know? If a person feels that they can't come forward, it's the same as a woman coming forward about something else, and it's just kind of, I think it's kind of level in some ways.

CI: Yeah, have you heard about other people's experiences of being in the?

CATHY: Yeah, oh well, in?

CI: Like of going to, asking for help for the mental health

CATHY: Oh yeah, am

CI: What were they like?

CATHY: Well, like myself, we wouldn't got into it too much, if we were chatting or gossiping about it it would have been like 'oh you're one she's a while hippy' or something *[laughs]* you know she's lovely, but she's a while hippy, and wouldn't be serious stuff because I think we kept that to ourselves you know, the serious kind of aspects of it, it was more gossip than anything

CI: So there wasn't anybody describing very good experience are a very negative experience?

CATHY: Actually sorry now that you say it, um, a friend of mine's brother, who went through a lot in the past couple of years, um, he went, he was in institutions in, down the country, let's say and, whatever happened they were saying that he, the young fella he was 15, and they were saying that they were going to put him into an adult unit, and they want they weren't listening to what he was saying, this is a [FORMAL YOUTH MENTAL HEALTH SERVICE] situation too that this went through, am wasn't listening to what he was saying, was diagnosing him with two different things every time he went in, blamed the parents, which was a big one, wanted to put into an adult institution, and I don't know the complete ins and outs, because of course it was none of my business, whatever happened there wasn't right, like the counsellors were giving out the parents and, because I knew the parents as well, I was friendly

with them and it was putting them under more stress, and putting the young fella under more stress as well that he did not know how to react to this *(34.25)*

CI: How does it impact you when you hear stories about other people that are negative?

CATHY: It's awful, you just kind of just want to help! Like, I just want to help you like

CI: Would it encourage or discourage you hearing a positive or negative mental, a positive experience or a negative experience, with it encourage or discourage?

CATHY: Would definitely discourage, that avenue of [FORMAL YOUTH MENTAL HEALTH SERVICE], another bad, bad experience you know so it would be just like you know, if I knew someone I would definitely not recommend [FORMAL YOUTH MENTAL HEALTH SERVICE]! *[Laughs]*

CI: So from your experience or observation what makes it difficult or easy for young people in Ireland to access mental health care? So accessing of the care, what is not like? *(35.11)*

CATHY: I think it's, it's well advertised these days, um, there's of course there's Pieta house which is something you can do on your own when you feel that you want that help and you are like right I need that help now and phone like and that's great. The only thing, that I've noticed with young people is that, they don't like to admit that they have something up around their own friends especially if they haven't given anything away. I was teaching somebody one time, and they were quite obviously quite anxious about everything that was going on, and their friends, they were kind of opening up and they were doing classes with me and they were enjoying it and their friends just kind of barged into the class, and I was like right? Okay, and am, I was like we're having a class here so you know let's go, out you go, and the wee girl just got up and left with them, like there's my friends, fuck this class you know, what's going on here I'm just going to leave my friends, I'm too cool for all this craic, I think it's a social thing that would stop people, I'm just rambling I don't even know if I making sense at the minute *(36.30)*

CI: no, what you're saying is that there is a peer influence in whether you would go or not?

CATHY: Exactly

CI: Okay, and am,

CATHY: Especially if they are present are in the near area you know, in the same building

CI: So what made it easy for you to access services?

CATHY: Am, I am privileged enough that I was able to afford to go to...

CI: So money?

CATHY: Yeah, I don't want to sound like, I am not the richest person ever

CI: No but it is what it is

CATHY: Yeah, I was able to

CI: Some money can help if you go private

CATHY: If you can go private yeah

CI: Okay, but in terms of like I suppose, I'm just thinking actually, very very quickly, you um, you were talking there about, did you say you went to counselling college university as well?

CATHY: Yeah

CI: So is there, given all the questions I have asked, not to be too repetitive or annoying you, but am, but would, I suppose looking at that service to review it was the anything you can add into this conversation that am, that you got in that service that was positive or negative?

CATHY: Am, thankfully the college that I was with positive wise, we went through that assessment, they were very helpful in the assessment, you know they were quite sympathetic and empathetic in the original assessment and then you were put onto someone else, and you were sat in a cosy office and you were just sat and cry and you felt comfortable and again there was no clipboard there was no paper it was just talking nothing was recorded they just wanted you to sit there and be like this is the shit that's going on, help you unload everything that's going on, because they know, especially in college you have so much going on, and I was still, I suppose I had just hit 20, so I was coming out of teenage years and I was like oh *[overwhelmed]* what is this new world? So the just wanted to unburden everything that was going on and for that situation it was perfect so *(38.43)*

CI: So you got everything you needed from the person?

CATHY: Basically yeah [laughs]

CI: Qas there anything else that you might have needed from the service?

CATHY: No that point I just needed someone to sit there and let me rant more than anything and to say it's all right

CI: So you describe the physical location is having a good impact

CATHY: Yeah it was a nice kind of office, it was a wee bit wary in getting there because it was and in a different campus that I did not know, but I suppose that was good actually because, you're not meeting people that you know sitting at the counsellors office, so I suppose that was good but the just brought you in and nobody knew you, and I just sat with this fella and let it all out, just let it all out *(39.27)*

CI: Earlier you were saying for teenagers it's important to know someone and to trust someone before you talk to them?

CATHY: Yeah

CI: And now you're describing to me that you went to a stranger?

CATHY: Yeah I know *[embarrassed]*

CI: Listen there's obviously a reason for both, so in your younger years did you need more trust?

CATHY: Yeah definitely in the younger ones, I suppose being able to chat to adults at that point I was in I was 20 so it was easier.

CI: So you had already

CATHY: I had gone through the motions on multiple occasions so right I know what I need from you just sit there and let me talk

CI: It's an interesting process I am seen you describe as like, you had to learn how to trust an adult and through the youth service you did

CATHY: Yeah

CI: And that ability then made it easier to walk in at university level and go, and walk into an office and the like I know what this is about

CATHY: Yeah! *[Both laugh]*

CI: I know how this works

CATHY: Exactly

CI: That's very interesting I think isn't it? Even just the different needs between you at 16 and you are 20.

CATHY: Yeah

CI: One person, and the varying needs, I think it is just critical to understand all of these aspects you know

CATHY: Because age does play a big part, you're not the same person that you are 16 and 20, or even 10 or even at seven, whenever it first started whatever, you're not the same person so you have different needs and somebody at 20 could have the same needs as somebody at 16, it's hard to get that balance, you just have to, I suppose have a conversation and assess them without them knowing they're been assessed, just have a conversation and see what they're about and go from there more than anything

CI: On an individual level thing?

CATHY: Yeah, and in all that hard we have so many people who need help

CI: What do you think are the most important features that a youth mental health care service should provide? Were talking that age range 15 to 25 or you know 12 to 25 that, what we think of as youth today not just that teenage years, like were talking youth and adolescents, young adults the whole thing, what do you think would be the most important features thinking about know what we talked about the physical environment the person you're talking to all that kind of stuff,

CATHY: Oh I don't know *[laughs]*

CI: You have wonderful experience, if you were designing it what would you make sure was the most important features?

CATHY: Um, I don't know, just some form of comfort, in a way not necessarily cushions, comfortable environment more than anything, um friendly people is huge, someone to be friendly to you when you walk in a door can change your day, to say oh that's a nice top you have on, I used to play this game whenever I was working in a restaurant in Dublin, somebody would come in with a big huff on their face and I knew they were going to be difficult, so I would be like 'oh your hair is just gorgeous'and straightaway there happy as Larry, they sit down, they don't open your mouth about anything that is wrong, you're playing mind games but it works!

CI: You gotta do what you gotta do. So, what you are emphasising there is that friendliness and the welcoming. And what about like, I think you've discussed a lot of this already so it's just trying to summarise and bring it all together at the end so what about in the interaction between the two people what is important there *(43.12)*

CATHY: Um, letting them know what's going on, basically just helping them, saying this is about you, and I will help you through every process that you are going through, but you need to tell me what's going on because I can't help you unless you tell me, so, letting them know that it's on them but you are there for them

CI: So just that support?

CATHY: Yeah exactly

CI: And based on your experience would you go to a professional mental health service again?

CATHY: Yeah definitely if I was to get back to that point yet

CI: Well that's great, I'm glad to hear that the variety of experiences have been encouraging anyway, that even the negative ones didn't hold too much influence in the long run and it's a shame that that sometimes has to happen, that you have to feel about in the dark, to get to where you want to go

CATHY: Yeah!

CI: Is there anything else that you would like to say that you have not had the opportunity to say that you were thinking about? *(44.16)*

CATHY: Eh, no I don't think so, me being me I would always encourage artistic activities to be done with in mental health because that's the area I want to go into, and and I think it's important to get them active as well as having that setting where you're talking about your feelings getting them into activities that take them away from what's going on?

CI: So would activities have been helpful for you do you think at 16, 17?

CATHY: Oh definitely, the peer education group, the mental health awareness group, uh everything everything, that was going on I was nearly part of, because it was great it would take you away from everything, you are concentrating on something else and it was brilliant

CI: So it's almost like outside of the mental health with your professionals and your one-to-ones, there should be things

CATHY: Yeah definitely, but give them the option if they are ready

CI: Options when they are ready? Any other recommendations you have suggestions you would like to make?

CATHY: Um, no, I think that's kind of it!

CI: Thank you so much, you've been amazing, to share all that those experiences, I'm really delighted that you came in here and did this and I hope, how was the experience for you talking about it?

CATHY: It's good, gotten a lot more comfortable talking about it because I am trying to help other people, it's fine I've been through this to it's okay, basically yeah

CI: Thank you so much, it's been absolutely brilliant, I'm going to stop interview here now

- **INTERVIEW END -**

Appendix 14

Liam:

1.-3.:

mental health in general is analogous to physical health and should be treated in a similiar manner

4-6:

MHP are a part of my life and I accept this as part of who I am. I find life confusing and I need guidance from others. I believe only some people are like me.

7-8:

Mental health is less stigmatised now but I would have self-stigmatised through labelling myself.

9-14

I have a vulnerability to sadness, certain slips in my life made that worse. It only became a 'problem' when it was constant or 'real'.

15-20

There are generational differences: Our generation is feeling more existential dread and so we are more aware of MHP, this allows us to be more open about it.

15-20: Dismissive of offers of help as 'nice' but can't help larger existential threats.

21-23 Our generation have more issues than previous

25 Young people speak out about MH more because of the platform of social media, which has pros & cons

26 If everyone shares dark thoughts then that increases awareness

27/28 Absolute horror at climate change. (Catastrophic thinking - no one can help)

Older generations used religion and alcohol to cope with mental health which has had negative effect.

31 Cynicism about peoples mental health. (→ Contradiction from the beginning)

32: Alcohol was not working with the coping and only lead to more emotional outburst and so the next/only option was to ask

35. for help or else it would end in suicide.

35 Supportive family, friends

35 Personal responsibility - taking control 'I' who 'I' talked to

37. Patronizes the doctor - doesn't think they are equipped 'blah blah'

Doctor is not trained for MH

39 Doctor approach medication 'fixing' segue onto experience

40-41 Experience with medication, CBT made the difference

41-45 'Training' instead of 'counselling'

46-55 Experience of CBT was positive in providing coping strategies and this may be due to being older and being very low

56-57 It's harder to deal with MHP as a young adult than as a teenager

58-59. Different needs in youth

61-64 You need to take responsibility for your MH and care

66-67 Desire to have some substance support. because he fell out of control.

67-69 Friend supported/referred to a counsellor.

75-76 Cost of counselling

77-79 Expectations of what counselling was from media

80-81 Feels like previous expectations would be met if he went to a psychiatrist

feels reluctant to admit that talking is good for you but emphasises how it really does work allowing you to sort out confusing

84 thoughts through someone else listening to you.

86 Personal characteristics of the counsellor and how these are tools she used

* Theme emerging of moving between feeling a loss of control and order/autonomy/responsibility.

90. Begins to communicate 'needs' - to have his thoughts, him, heard

Listening to yourself can give you an

95 opportunity to work through problems.

96 Professional help can ensure security/safety.

97-99 Informal, personal characteristics of helper

100-103 Environment

105-107 Importance of relationship

108-111 Awareness is increasing and it is common to have a MHP and look for help.

112 - Existential horror brought back in

114 Discusses how CBT helped, but taking control
| of life circumstances, regaining balance and
119 power helped -
120 Powerful statement about future plan to deal
with MH/P.
123 MHP are ubiquitous, especially anxiety
125 Provides guidance for others
-127
128 labelling self-stigma and humour
→130 Discussion about the transitional age 16-25
133 Continuation of care is crucial
Distancing language.
Benefit of having youth work services,
difficulty of building a relationship with
145 a college counsellor
Addendum:
147-153 : Defeated, hopeless, dystopic future
and hyperbolic language as a reason for a generation's
mental health. Very candid and very fatalist.
156-162 : Real external threats, global - effect
of climate change & globalisation
161-166 : Creative dystopic future that only the
rich can ~~get out~~ survive? retreat?
167-177 : A sense of hopelessness at trying, anger at
the wider economic structure, something deep &
personal going on here projected globally.

178 A lot of horror and fear about the future - not enough
belief in self to cope or succeed
183 Discussion on the impact of gender, race and
the challenges of others - associating with those
he perceives as marginalized, virtue signalling.
Very pessimistic end to an interview that
had previously ended well - did he sabotage
191 the end by making an addendum?

Themes? Thoughts?

Powerful - powerlessness
Control - chaos
Autonomy - needing others
Decisiveness - confusion
Substances - labelling - self-stigma
hopelessness - hope

Appendix 15

Interview: Liam

PI8: Well like I'm saying just that, you know, I have been dealing with it since I was 18 but I really only made progress to try and you know deal with it and act on it in like maybe the past three or four years maybe put an effort into it, you know when it starts, like everyone, like back when I was younger everyone you know, there were the platitudes, you know 'if you need someone to talk to you' you know all that kind of stuff is very, very helpful but I think it has become more prominent now whether that is because as a generation we are all kind of dealing with this constant existential dread or whether people have always just been like this and are becoming more aware of it now, I think it is much easier to bring up in general context than it would be to even five, ten, five years ago, I think.

CI: It's a really interesting point that you are kinda making up there, that I have come across before, and it would be, you know, that I've come across in interviews before and it would be people are saying that comparing something before like and now, you know what I mean? They are saying like basically umm, the older generations versus the younger generations, did they have it worse, there is that intergenerational discussion, um, do you think it's harder now for young people than it was maybe 20 or 30 years ago?

PI8: I, so in terms of intergenerational difference, and I'm not sure if like, it's very hard to say whether one generation has it harder than the other because you only really know from your own perspective and the perspective people share with you, I do think you know, there, there are a lot of issues, um, that people are dealing with today and like I think, there's are a bunch of reasons why it's becoming kind of like the, so I am losing my train of thought here, but I think the prevalence of young people speaking about mental health more so than the older generations, where, um, is due to quite a few factors number one, um, the introduction of social media kind of, has given everyone an external monologue, like you know, even some dark personal stuff, people are willing to share that out to the entire world, that's good in some ways you know, if that help people be able to process, you know if everyone is doing that then the, the recognition of it is going to shoot up and then, you know, it's a dying planet, there is this constant fear of living in the end times, that apocalyptic anxiety, always there in the background but the older generation did have a tough, I would not have liked growing up in Ireland in the 70s or 80s, but they just have different methods of dealing with it, go say your confession and have a pint, job done, *[laughs]* so that's why they are very well-adjusted now *[sarcastically]* (6.25)

CI: I take it you don't think they are very well-adjusted now?

PI8: I mean is anyone? *[Both laugh]*

CI: Okay so when you did decide to ask others for help, like were you hesitant at all in looking for help?

PI8: I mean, so it took me a while to like get there I had been struggling with quite some time, so I would have the occasional drunken breakdown with friends where like, you know, just one whiskey too many and all the walls breakdown, a blubbering mess, and you know that happened more and more frequently when I was going through some really bad stuff, and then eventually I just hit the stage where I thought if didn't get some help, then em *[pauses]* I was living on borrowed time, it was eventually going to catch up with me so when I eventually made the decision, um, people who I talked to it about were completely supportive *[pauses]* you know friends, family all wanted the best for me, like I went originally went to the doctor about it you know *[pauses]* their heart is in the right place and bless them they are trying to keep up with things but they are pretty much not trained for that sort of thing, the doctors are trying to fix physically what is wrong with you, so it was basically like here some meds and if you want these people might be able to speak to you about it and you know the meds were, I've taken many different strains, of

Interview: Liam

CI: I'm going to start with em a couple of introductory questions, just to get us, get the conversation rolling

PI8: Yeah

CI: Em, what is your understanding of the term mental health?

PI8: Amm, it's kind of like, you know, it's a wide definition but at it's most basic term, it's, as it says it's your mental well-being like that can have multiple different aspects to it but like it's just, yanno, it's mental health, it's the equivalent of like actual health, you don't need to necessarily have like terminal cancer but you know if you've got a cough for a while you should probably get that, taken a look at, and you are, um

CI: What does it mean to you personally?

PI8: What does it mean to me, well like in my context as someone who has, had some mental health issues on and off for years and years, now it's just, it's a fact of life you know? Some people are, just need a bit of like cheering up and touching base every now and again, the mind is a terribly confusing thing and it's good to get some context and perspective from the outside every now and then, I suppose.

CI: And so what is it I suppose you are touching on that a little bit, like to be a young person in Ireland today, I say today, in the past as well, in your experience, in your lifetime, with the mental health problem? *(1.41)*

PI8: I mean, just from umm representation wise, I think it's getting a lot better, it's much more topical now everyone at least has a basic understanding of what it is, umm, you know I did refer to myself as crazy for quite some time *[smiles]* and it is not exactly the best term for it but

CI: So at what age would you have first began to have some difficulty with your mental health?

PI8: Uh, I would say probably late teens? Umm I don't know when it begun specifically but I have always been like, kinda prone to sads for as long as I can remember and have been prone to the occasional downswings but like constant kind of, you are recently re-occurring thing, it probably really picked up at 18 or 19.

CI: Okay *(2.30)*

PI8: Not like, out of nothing, just out of the ether, it was some specific life circumstances that I was in, that kind of lead to it festering and growing

CI: Yeah, and so, am, you're describing being 18, those teenage years where it is starting to escalate, you've been in that situation with your mental health for about six years?

PI8: Yes

CI: And so you have seen changes over those years?

PI8: Yes

CI: So what impact, you're saying it's a bit better now?

Interview: Liam

antidepressants now and some were better than others but the biggest thing I've had, to make a proper impact on me was six months of CBT training *(7.57)*

CI: Right,

CBT Training *[both laugh]*

CI: Training?

PI8: Counselling

CI: Yeah

PI8: I mean, it is kind of training I suppose

CI: You are absolutely right

PI8: You are finding new ways to deal with it yourself

CI: And did you find that effective? *(8.08)*

PI8: I did, like I was doing all the textbook kind of

CI: Can I just ask you a question about that, a curiosity, do you feel CBT would have been helpful for you if you were younger?

PI8: Maybe, um, like maybe if I had have known about, like you know, all the various ways that your mind can play tricks on you, catastrophizing, and all that kind of stuff at an earlier age I would have been more prepared to deal with it but I think, you know, going in at a low moment, kind of took down all the barriers that I may have put up, you know, if someone pointed out (name **redacted**) this is what you're doing, I was in a spot where I could say yes, this is what I'm doing, where as you know, if I was younger, and I had the like you know, folly of youth, I would have just ignored it but

CI: I'm just curious because from 16 to 25 there is such a difference, in sort of, there's a couple of life stages in there really isn't there, it's different being 16 than it is being 22, and 22 is different to 25

PI8: Yes definitely *(9.08)*

CI: So am, I was just curious about that, because I do hear people say that CBT helped them, but later

PI8: Yeah it's, like it gives you the tools to deal with it and they try to teach you how to do that but I do think that you do need some amount of life experience and like, and the ability to know your own head, that you don't **really** get as a teenager, because other than like, like I have said, before I got properly, properly depressed I had low moments and I had my sads, but like that's much easier to deal with when you're young than an older teenager, because you have no responsibilities or anything like that, if you're feeling sad you can go play some video games *[laughs]*

Interview: Liam

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Interview: Liam

and hang out with your friends, at 16 it'll be okay but when you are older like 18, 19, like your first trying to find your feet in the world, am, you don't necessarily have the support base that you had for like all the years up to that, it can be rather overwhelming

CI: Yeah, so do you feel there is a difference then between the needs of a young person in say the teenage years versus early adulthood years? *(10.24)*

PI8: Yeah, absolutely, I think you know, teenagers should be given some kind of training in it but yeah, like I said it would probably help recognise what my mind was doing at the time what I *[pauses]* I think, you, you can teach people all you want and like give them the tools to work with but like you're going to need to figure out how those tools work for yourself, like with as much training, eh, counselling that you can get, the ball is a bit at least in your court, when you are older and more, more emotionally mature, it definitely helps with that.

CI: Sometimes I think also, maybe also just with the, you know with the part of the brain that gets developed last, is all around understanding decisions and risk-taking

PI8: Yeah! *[Both laugh]*

CI: I'm just curious about that, the more I do these interviews I'm starting to hear some things that I am like hmm, I wonder?

PI8: Yeah course like when you're young you're going to live forever, nothing is going to slow you down

CI: So um, when you went your counsellor, am, what was the experience like? Going to, because obviously you did kindly and was successful so I'm trying to track that, so in order to get the counselling, did you get referred, private?

PI8: So ah, I went to the doctor initially because this was at peak, peak depression, I did feel I needed some kind of chemical aids to kind of balance me out a bit and allow me to do that, but I wasn't referred to the practitioner that I ended up using from a doctor it was from a friend who had previously used them I believe.

CI: Okay

PI8: They kind of, like, pointed me in the direction, like made the introductions and from there

CI: And how important was it that a friend referral?

PI8: I mean, it was important in that like the friend had some experience with it knew like what I was getting into whereas the doctor just gave me a list of, here's a psychiatrist, the next they will see you is in like two months, or there are people out in other places who will give you other opportunities but yeah I think if the doctor recommended me a CBT counsellor *[pauses]* I wouldn't have felt any different than I had have going in with a friend, because I knew I had problems that I needed to sort out and being made aware of CBT I recognised that that was what I needed whether publicly by a doctor or privately by a friend, I think as long as I was there doing it, it doesn't matter how I got turned onto it.

CI: And did you pay for it was a free? *(13.22)*

Interview: Liam

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Interview: Liam

and that chequeboard of all the various things they do, I think I ticked everyone, and like having that context, like oh! this makes sense, that really helped *(16.44)*

Cl: So what's, you, you could have just went and told some randomer on the street all your various neuroses so what was it about that person that made you feel, dare I say safe to go right here is all the crazy, as you put it

PI8: Well they were professional, it was their job

Cl: Okay

PI8: Um, and again very nice very supportive made me feel very completely welcome, and like it wasn't as kind of formal as I was expecting, umm after the first session or two, it descended into a bit of a freewheeling chat, which I think was nice, sorry have lost my train of thought in this conversation

Cl: I'm just looking for water the characteristics what are the qualities of the individual that made this work, or the qualities of the environment as well, or the therapy, so you have described the therapy for me and um I don't think you're as bothered about the environment as much as you have not brought it up, was the environment a good environment?

PI8: Um, it wasn't really as much of an issue, we were working in a local youth centre, and am she just took me aside and took me into a back room and just two chairs, intimate space, like am, secluded enough, intimate, free to chat

Cl: So was a good environment?

PI8: Yet a good environment, you know I, it was at good environment but I don't really think the environment affected my decision-making one way or another *(18.24)*

Cl: So it's more about, correct me if I'm wrong, I'm just trying to get my head around it myself, what I'm hearing from you really is it was about the skills you were taught and the professional and kind manner in which the individual taught them

PI8: Yeah

Cl: They were priorities for you

PI8: Yeah, yeah, there was an openness and a warmth there that really made it easy to open up

Cl: You're sort of describing that as you go on, you are even starting to just chat, get to know each other a bit

PI8: Yeah yeah, you know obviously it's a very kind of personal thing and the relationship you have with your counsellor whether it's CBT counsellor or a psychiatrist is going to happen impact on you and, just really warm really friendly and made it very easy to just vent I suppose

Cl: Yeah. So what role do you think culture has in young people's mental health?

Interview: Liam

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Cl: Yeah. So what role do you think culture has in young people's mental health?

Interview: Liam

PI8: Um, again like I said earlier in the interview it is becoming much socially acceptable to talk about it and I do know *[pauses]* at the time I think I was the only person I do my immediate circle of friends who had gone to any kind of counselling but it's been, I think I finished a year, a while ago and in that year I have been speaking to some other friends and they have started on it themselves, so whatever is going on whether it's like the increased recognition of it or like the push to get people to start talking it seems to be working

CI: That sounds very positive

PI8: I mean the world is ending to have to have some positivity somewhere *[both laugh]*

CI: I wasn't aware, but the world is ending? Soon? *(20.21)*

PI8: I mean, I've got 10,20 years?

CI: From experience, I suppose, would you be likely to go for help again?

PI8: Absolutely, yeah, yeeah, so I did six months of CBT and then I continued on antidepressants afterwards and I just kind of like you know, to keep me on an even keel but shortly after that, I moved out of home, I got, left Ireland for a while and moved to London and found a new job, met my girlfriend at the time and like, you know, I was prone to low moods and depression from a young age, but it was specifically the circumstances of my life at the time were the primary cause of it snowballing to what it did, and you know, I needed some recovery after that, like mental rehab, but once I got that and was back on an even kilter, moving circumstances and things generally tending to get better made me able to live my life and be able to deal with it to the point where slowly over a course of months I started weaning myself off the antidepressants, and now if I ever, if that like vicious internal monologue ever starts coming back I know what it is and I know where it's coming from and how to deal with it if I need to.

CI: That's very positive, um, I'm going to like closing question, I'm going to run a few questions by you, and put a few questions into one

PI8: Seven *[both laugh]* blue! *[Both laugh]*

CI: First of all, this is an opportunity, if there is anything you would like to say about mental health or about young people getting help, if you have any recommendations or suggestions, now is the time to say it *(22.22)*

PI8: I think in this day and age it's very, very rare for someone to not have something, whether it is minor or major, that is bothering them, whether they are aware of it consciously or not you know, there is a low-lying constant anxiety kind of everywhere and if you want of those very, very few people who does not think that they need it, good for you but most people probably will at some stage and you know, if you feel yourself starting to get down it's best to kind of deal with that now and acknowledge that that's happening, because I didn't do anything for years and if a couple of decisions had not gone the way they did, I may not be here doing this interview right now *[pauses]* so

CI: So you are a believer now in the mental health services

PI8: Yeah absolutely, I am half functioning now *[both laugh]* solely because that

Interview: Liam

Cl: You're up to half! *(23.33)*

Pl8: I'm up to half!

Cl: Sounds like you're functioning very well

Pl8: I would describe myself as that I was half functioning two years ago and I was a ball of neuroses held together by substance abuse

Cl: Okay

Pl8: So progress *[laughs]*

Cl: You got to where you needed to go

Pl8: Yeah

Cl: I'd say you're functioning very well from what you have described so you shouldn't be so hard on yourself! Um, if I was to get you to list, this is the final question, the most important features of a youth mental health care service, now that would span I am looking at the 12 to 25 age range, current services ended 18 for young people, as soon as you turn 18 year into an adult system, so if we were to look at youth mental health care for the actual age range of youth 12 to 24 or 25, you can even just list me some additives if you'd like *(24.25)*

Pl8: I think, like I think cutting off the care at 18 moving you into a different bracket that's not a good idea because you are not a fully formed person yet and your brain is still developing, like , huge different changes in like your emotional well-being.

Cl: It's a transitional

Pl8: It's a transitional point like you know, I was pretty much the same person I was 18 that I was at 16 but I was a completely different person at 21 and a completely different person at 25 so I think the big, like that gap between 18 and 25 is when most people will have the biggest issues with it and probably the biggest amount of work needs to be done, like you know there are younger teenagers who are you know, who have mental health issues but that's, and again I'm not an expert but I assume that's much more clinical and serious, like you know, when you're in young adult hood, late teenage years you are still forming and just being shoved off into an adult bracket when you are not really there yet is not a great idea, as it is a continuation from like, if mental health is something you are aware of and something that people talk about from a young age and as you get older you start accruing responsibilities and worries and doubts, if the same services and the availability that was there when you were younger is still there I think it would have a much bigger impact *(26.08)*

Cl: So do you think, like, are you saying to sort of link in with services that you had when you were younger when you are older would be, is that it?

Pl8: Maybe I don't know, I tend to speak and then my mind catches up with the sentence once I'm done talking but am, I think, *[pauses]* like I went to a youth club as a kid and we had a drop-in centre you could go speak to people when you needed to, and after that, when I went off and went to college you had the college counsellor, but like, they have thousands of people and there is only certain time so you can't necessarily get

Interview: Liam

the ease of access and like the relationship that you may have necessarily build up with those people so I think it's like a continuity from like the late teenage, early adulthood years would be preferable (27.07)

CI: I understand, thank you very much for your interview and how was the interview, was it okay?

PI8: Yeah, it was fine *[both laugh]*

CI: Okay that's good I'm just going to stop recording now, okay, one second, once I figure out how to open up the phone

Addendum

CI: Just to rerecord here as just as this interview had ended you said there was something you wanted to discuss that you hadn't, so were just going to do a couple of minutes, you were talking about this idea of apocalyptic anxiety is it? *(0.17)*

PI8: Yet well there's definitely a less kind of am, shocking phrase for it but that's just something I kind of put together by myself but like its constant low-level worry for me that you know the way things are going climate change, the rise of horrible global inequality and the international fascist movement, ah things are getting pretty bleak and pretty dark and maybe it's just me and I'm just a big political junkie, I could eat all this stuff up so I am worrying about it more, but it is something that I am very, very concerned about and you know, the planet is on fire and the Nazis are back so think I'm pretty justified being a little bit concerned that, it's kind of, you know I've done all this progress and I'm feeling a lot better about me personally but I don't have much hope for the future, things are going to get rather bleak and as much progress as I make and as much better that I feel now that is always in the back of my mind *(1.29)*

CI: Okay

PI8: Kind of low level anxiety

CI: So you have this external anxiety coming in about the actual planet you're living on?

PI8: Yeah!

CI: And do you think it's…

PI8: When you look at all those kids, millions of kids were protesting a couple of days ago for climate change, you know, I think that's going to have a big impact going forward when nothing gets done, but all these children who from the ages of, as soon as they are old enough to have a basic concept of what is going on and to fight against it and to not make any progress on that is going to lead to some horrible bitterness for a lot of people *(2.08)*

CI: Do you think is that something then that is it different from years ago?

Interview: Liam

PI8: Yeah, and of course I don't know if this is just like due to the increased globalisation and social media and the fact that everybody is aware of everything that is going on now, I definitely think it is a worry that is going to affect, that is beginning to affect my generation and will probably have an impact on the next generation below me who have spent their entire lives dealing with constant, like climactic climate issues *(2.40)*

CI: So it's not maybe just like a threat of, you know Hitler or, going back to the I'm thinking of the 30s, were people would have heard on the radio that the threat of a particular individual, this is more of a planetary threat?

PI8: This is a systemic global issue, that

CI: That is beyond your individual capacity

PI8: It is beyond my individual capacity and you know, I live in London so that is a hotspot for it but like we could always move back to Ireland and not have to deal with the fascists but the planet is on fire and sea levels are rising and weather patterns are going up so there's no real place that you can safely retreat from it unless you are rich.

CI: Okay, tThat's a whole other conversation, but I think that's an important point and I am glad to get the recorder back out for that, as am, it is obviously a massive elephant in the room

PI8: Absolutely, it is, you know everyone should be doing their very best to keep their mental health in order but the world is going through some

CI: So if you're a young person and let's say you're having mental health problems how does that global impact on top of your mental health problems?

PI8: Well there is the there's an element of hopelessness about it like, you know from my own perspective, I have dealt with it and tried to get my own internal house in order, but as much as that helps and as much good as you do, *[pauses]* I don't personally see things getting better and I only see that anxiety increasing the longer this goes on *(4.20)*

CI: So as a young person you're thinking your life ahead of you career, job, family

PI8: Oh I'm never going to have like a career, job, family, I've had plenty of discussions with people of my generation about like the lunacy of the idea of owning a house, the staple for generations, like you getting summer now, you're on the property market, I can't get a house unless I move back to Donegal, all of my friends who have had to leave Ireland for fucking economic reasons are, unless they move back are not going to own a house

CI: That's a massive difference isn't it, that independence of owning your own home

PI8: It is absolutely, like you know, renting is stressful and like you know, just dead money being poured away, and like you know, previous generations would do that for 10, 15 years maybe but by mid 30s you have a house, a kid, you have a stability that my generation, other than a very, very tiny select amount, who have mostly inherited their wealth, are not going to have that stability and again with mental health awareness

Interview: Liam

becoming more prevalent and with people being more willing to talk about it not having that kind of, rose tinted, you know your house your picket fence, your kids running around

CI: A future to follow?

PI8: Yeah a future to lead to, I think that will obviously have an impact on you and I don't know if that's just me over worrying or I've really don't think I'm alone in having this kind of anxiety

CI: Possibly not *(5.56)*

CI: It's am, it's something that when you're in this situation, forced to rent when you don't want to or your sort of, what you're describing the inability to grow up almost isn't it?

PI8: It is and you know I got very kind of lucky, in the fact that I am a heterosexual white guy *[both laugh]*

CI: Is that helpful?

PI8: It is! As much as I've been dealing with, I started life in easy mode, and like you know I have like, privilege or like there are certain things I am never going to have to deal with but if I was like a minority of any kind in this day and age along with all the anxiety, never going to own a house and the planet, **there are people who want you dead** in leading governments around the world and not to get too personal but my girlfriend is a Muslim American woman, and I know that that fact alone is causing her a lot of stress alone to the point that she never wants to move home again and that's heartbreaking you know and she is someone who is so much more together and well-adjusted than, stable, than I am you know and that's something that she has to deal with *(7.21)*

CI: Yeah, so it's these factors of sometimes young people's mental health is not just vanity of youth there is real issues external to them that make it even more difficult to go through even the more normal life things

PI8: Yeah

CI: Is that what you're getting at is well?

PI8: I think yeah an absolutely, unless you purposely have your head in the sand, and purposely choosing to put your head in the sand it's kind of almost impossible to not be at least sort of aware of growing issues like this *(7.56)*

CI: Okay, is that all you would like to say?

PI8: Yes

CI: Okay thank you once again and I want to stop recording, when I get the phone open.

Interview: Liam

- **INTERVIEW END** -

Appendix 16

Aine2

While there has been a decrease in stigma and a general improvement in societal acceptance towards MH, there are still some significant problems with the systems in place for young people when they are looking for help. Now there is a ubiquitous narrative of 'it's okay not to be okay' or 'just talk to someone' but Aine doesn't feel like this is good enough and that there is very little support after asking for MH support.

Counsellor 1 Memo 1

Young people can be in a situation where they are 18+ but still live at home and remain financially dependent on their parents. This can impact their developing autonomy and cause problems not only developmentally but in the parent-child relationship, where young people want more autonomy but due to financial dependence, linked in with wider economical situations, can't 'bite the hand that feeds them'. This can cause depression and other mental health problems for young people.

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Memos

Name	Codes	References
Focusgroup2	0	0
Gerard1	0	0
Joseph1	0	0
Laur4	0	0
Laura1	0	0
Laura3	0	0
Laura5	0	0
Liam1	0	0
Liam2	0	0
Memo 1 - Pastora	0	0
Memo 1 Pastoral	0	0
Rachel1	0	0
Rachel2	0	0
Rachel3	0	0
Rachel4	0	0
Robert1	0	0
Thomas1	0	0
Thomas2	0	0

Rachel3

When a young person is told they are not meeting criteria for service use because they are too unwell and are re-referred on again, this can have terrible consequences, firstly the young person can internalise a belief that they are not able to be helped, which is dangerous, and that there is no one who can help them, and that all the professionals are just waiting for something like a suicide attempt because what other options are there? It can trigger or exacerbate feelings of shame and sadness at the situation.

Appendix 17

Summary table of quantity of codes

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Files

Name	Codes	References	Modified On	Modified By	Classification
02YId	189	231	12/07/2020 14:19	LL	Youth Interview
03YId	605	615	12/07/2020 14:19	LL	Youth Interview
04YId	436	462	12/07/2020 14:19	LL	Youth Interview
05YId	205	223	12/07/2020 14:19	LL	Youth Interview
06YId	532	544	19/07/2020 15:10	LL	Youth Interview
07YId	422	436	12/07/2020 14:19	LL	Youth Interview
08YId	222	228	12/07/2020 14:19	LL	Youth Interview
09YId	519	529	21/07/2020 19:44	LL	Youth Interview
10YId	344	348	12/07/2020 14:15	LL	Youth Interview
11YId	236	238	12/07/2020 14:16	LL	Youth Interview
12YId	438	440	12/07/2020 14:16	LL	Youth Interview
13YId	267	269	12/07/2020 14:16	LL	Youth Interview
14YId	331	333	20/07/2020 15:36	LL	Youth Interview
CS1	362	362	29/09/2020 11:35	LL	Counsellor
CS2	468	472	29/09/2020 11:35	LL	Counsellor
FG1d	298	303	19/07/2020 16:55	LL	Youth Focus Group
PC1	362	362	18/10/2020 21:08	LL	Pastoral care
PC2	544	544	16/01/2021 13:08	LL	Pastoral care
PYW1	396	396	29/09/2020 11:34	LL	Youth Worker

Example of initial code in transcript

02 Youth Worker

Name	Files	References
Approach of helper	0	0
Approach of Formal Services	0	0
Annoyed that other services do not protect confidentiality		1
Appointments with formal services can have long gaps		1
Being told you are too unwell for a service exacerbates MH		1
Believes engagement would be lower if there were administr		1
Formal service culture is restricted and inflexible		1
Formal services are not person-centred services		1
Formal services are under-resourced		1
Formal services can have reputations of being siloed or work		1
Formal services do not have YP at the core of their work eth		1
Formal services have closed door policies		1
Formal services protocols and environments are clinical and		1
If young people return to a service they will meet new staff		1
Inconsistency in staff employment		1
Lots of respect for the workers in formal services		1
Low opinion of community MHS		1

YW2: Well, well they're kind of getting the best of both worlds because, you know, they're getting, you k that youth work approach as well as, am so you know, maybe their appointments with Formal MHS are, there's more breaks, with us there's not so they will get it as long as, if it's once a week they feel they ne Formal MHS is once a month, so then we have them you know for them so they feel like they're getting opportunity to sit down, and a lot of young people will literally sit down for that hour and will not breathe, they were thinking all week and they have no one else to talk to and they just, literally you just are there

CI: So if there, I'm just thinking, I'm putting it out there, sort of devil's advocate, hypothetically, if what y providing care in a mental health capacity for a young person while they're waiting on their mental healt going to Formal MHS and AMHS?

YW2: *[pauses]* I don't know, that's the answer. Well I suppose, what's the point? *[long pause]* I don't kn blasé about it

CI: No absolutely

YW2: I, I don't know is it a thing that we have become, you know, not confident in what we provide that that what it is? Am I don't know and I am not, I am genuinely

CI: No, listen you don't have to have the answers I was just, it's an observation as you're speaking the seems like when you re-frame it that's what's happening, you're providing mental health care while waiti

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02 Youth Worker — Search Project

Name	Files	Refer
Approach of helper	0	0
Approach of Formal Services	0	0
Annoyed that other services do not protect confidentiality		1
Appointments with formal services can have long gaps		1
Being told you are too unwell for a service exacerbates MH		1
Believes engagement would be lower if there were administr		1
Formal service culture is restricted and inflexible		1
Formal services are not person-centred services		1
Formal services are under-resourced		1
Formal services can have reputations of being siloed or work		1
Formal services do not have YP at the core of their work eth		1
Formal services have closed door policies		1
Formal services protocols and environments are clinical and		1
If young people return to a service they will meet new staff		1
Inconsistency in staff employment		1
Lots of respect for the workers in formal services		1
Low opinion of community MHS		1

Annoyed that other services do | PYW2 | Believes engagement would be

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and I, or text, they can ring me, they can contact me through the breakout messaging, whatever way, if they want to get me they can get me and there's also, you know, the Breakout...

CI: So they don't have to go through a receptionist to get to you?

YW2: Not at all, not at all, absolutely not, they wouldn't if they did, they wouldn't ring me if they did *(27.1*

CI: So, that's, just what you were saying there about confidentiality, your face just changed when you st something that you take seriously, would I be

YW2: Massive

CI: Okay tell me more about that

YW2: *[Sighs]* I suppose it actually annoys me sometimes, because some services talk about confidentia talk within eachother and you know, everybody and yeah and I suppose maybe it is to do with the LGBT because it is so important *[with emphasis]*, it's not even, like if anyone knew it, like you know, if you see they're pretending that they're not LGBT, they're just there as an ally for a wee while, you know some pe when they understand that listen no one is going to say outside when you meet them outside, they're gc somewhere else, I tell them every single week I say it in the group.

CI: So you would reinforce confidentiality regularly

YW2: Yes

In | Nodes | Code At | Enter node name (CTRL+Q)

LL | 297 Items | Codes: 448 References: 448 | Read-Only | Line: 234 Column: 45 | 100%

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Folders

Files — Search Project

Name	Codes	References
PC2	544	544
PC1	362	362
FG1d	298	303
CS2	468	472
CS1	362	362
14YId	331	333
13YId	267	269
12YId	438	440
11YId	236	238
10YId	344	348
09YId	519	529
08YId	222	228
07YId	422	436
06YId	532	544
05YId	205	223
04YId	436	462
03YId	605	615
02YId	189	231
01YId	639	715

04YId

Click to edit

CI: So when did you first begin to expereince some problems with your mental health?

CATHY: I have always experienced problems, from a very young age, like 7 years of age, I remember just wanting to yourself down the stairs out of the house, just something, just there was always something itching at me, just I wasn't you never know what it is you just think you're a crazy little kid throwing yourself down the stairs but then that carried as I got older *(2.56)*

CI: Yeah, and um, the two questions linked in with that is how long did it take you to realise, you said you felt like a c

CATHY: Yeah! *[laughs]*

CI: How long did it take for you to realise that I should ask someone for help?

CATHY: Um it wasn't until I was 16 that I was told I should get some help

CI: Right

CATHY: So that came first, so it was kinda like, na I'm too cool for that like but they way that it went was, I was taken I have is very clsoe minded and said everything is in your head, aw you're only doing this to act out on your parents, i yourself sorted and I was like, shit it's all my fault, you know what I mean? So then they referred me to the, I forget the

CI: [FORMAL YOUTH MENTAL HEALTH SERVICE]?

CATHY: Naw, maybe?

Coding Density

LL | 21 Items | Linked | Codes: 436 References: 462 | Read-Only | Line: 1 Column: 52 | 100%

Appendix 18

Focused codes

Help-seeking for MHP Data.nvp - NVivo 12 Pro

01SchoolPC

Name	Files	References	Created On	Created By	Modified On	Modified By
Approach of helper	0	0	19/10/2020 09:15	LL	18/09/2020 10:24	LL
Approach to confidentiality	0	0	19/10/2020 09:15	LL	19/10/2020 14:57	LL
Available and accessible	0	0	19/10/2020 09:15	LL	19/10/2020 15:00	LL
Checking	0	0	19/10/2020 09:15	LL	03/10/2020 15:35	LL
Liassing and advocating	0	0	19/10/2020 09:15	LL	19/10/2020 15:04	LL
Managing confidentiality	0	0	19/10/2020 14:56	LL	19/10/2020 14:56	LL
Providing connection and care	0	0	19/10/2020 15:02	LL	19/10/2020 15:03	LL
Supporting help-seeking	0	0	19/10/2020 14:56	LL	19/10/2020 14:59	LL
Working under direction	0	0	19/10/2020 14:58	LL	19/10/2020 14:58	LL
Friends and family	0	0	19/10/2020 09:38	LL	19/10/2020 09:38	LL
Ensuring parental consent	1	1	06/10/2020 17:26	LL	06/10/2020 17:26	LL
Friends and family are important for Y	1	1	06/10/2020 17:30	LL	06/10/2020 17:30	LL
Friends can ask GC to approach a frien	1	1	06/10/2020 17:29	LL	06/10/2020 17:29	LL
Friends can initiate the HS process for	1	1	06/10/2020 17:27	LL	06/10/2020 17:27	LL
Parents need to know of YP's MHP wh	1	1	18/10/2020 20:44	LL	18/10/2020 20:44	LL
Gender	0	0	19/10/2020 09:15	LL	03/10/2020 14:55	LL
Boys regularly use the GC service	1	1	18/10/2020 20:24	LL	18/10/2020 20:24	LL
Good male role models encourage ma	1	1	18/10/2020 20:22	LL	18/10/2020 20:22	LL

LL 225 Items

Help-seeking for MHP Data.nvp - NVivo 12 Pro

05Robert - FC

Name	Files	References	Created On	Created By	Modified On	Modified By
Core needs of mental health care	0	0	22/07/2020 22:07	LL	29/08/2020 13:23	LL
Confidentiality and professionalism is important	1	1	08/06/2020 16:26	LL	08/08/2020 21:49	LL
Consistency is important in MH care	1	1	08/06/2020 16:22	LL	08/06/2020 16:22	LL
Ensuring enough time is important	1	1	08/06/2020 16:03	LL	08/06/2020 16:03	LL
Feeling that you have time to express yourself as you need	1	2	08/06/2020 16:02	LL	08/06/2020 16:02	LL
Genuine concern and care is very important	1	1	08/06/2020 16:29	LL	08/06/2020 16:29	LL
Needing to offload to someone	1	1	08/06/2020 16:06	LL	08/06/2020 16:06	LL
Not feeling pressured or like a number	1	1	08/06/2020 16:01	LL	08/06/2020 16:01	LL
Reassurance if you have to wait for an appointment	1	1	08/06/2020 16:27	LL	08/08/2020 21:50	LL
The power in relationships was balanced	1	1	08/06/2020 15:59	LL	08/06/2020 15:59	LL
Timely response to help-seeking	1	1	08/06/2020 16:01	LL	08/06/2020 16:01	LL
Trust is important in a rapport	1	1	08/06/2020 16:20	LL	08/06/2020 16:20	LL
Experience of help-seeking	0	0	22/07/2020 16:08	LL	29/08/2020 13:22	LL
Managing mental health	0	0	08/08/2020 21:52	LL	29/08/2020 13:22	LL
Perspective on culture and society	0	0	22/07/2020 22:20	LL	29/08/2020 13:23	LL
Role of services	0	0	22/07/2020 16:04	LL	29/08/2020 14:04	LL
Role of the GP in mental health care	0	0	22/07/2020 16:05	LL	29/08/2020 13:55	LL
The role of friends in supporting mental health problems	0	0	22/07/2020 16:00	LL	29/08/2020 13:21	LL

LL 129 Items

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  - 05Robert - FC
  - 06Laura - FC
  - 07Joseph - FC
  - 08Jamie - FC

01Aine - FC

Search Project

Name	Files	References	Created On	Created By	Modified On	Modified By
Autonomny and decision making	0	0	23/07/2020 17:40	LL	29/08/2020 14:01	LL
Coercion	0	0	24/07/2020 17:25	LL	09/08/2020 14:37	LL
Feeling coerced into treatment	1	1	06/06/2020 18:32	LL	24/07/2020 17:26	LL
Involuntary participation in a programme	1	2	04/06/2020 11:27	LL	04/06/2020 11:33	LL
Exclusion	0	0	09/08/2020 14:37	LL	09/08/2020 14:37	LL
Being excluded from MH care decision making	1	1	04/06/2020 20:20	LL	24/07/2020 17:25	LL
Being part of the care plan meetings when possible	1	1	07/06/2020 17:35	LL	09/08/2020 14:37	LL
Having treatment taken away because of MH problem	1	1	04/06/2020 20:21	LL	04/06/2020 20:21	LL
Instructed where to go and what to do	1	1	06/06/2020 18:34	LL	24/07/2020 17:23	LL
No choice in intervention	1	1	06/06/2020 18:32	LL	06/06/2020 18:32	LL
Others making decisions about you	1	1	06/06/2020 18:34	LL	24/07/2020 17:25	LL
Wanting to know what decisions others are making abou	1	1	07/06/2020 17:35	LL	07/06/2020 17:35	LL
Being LGBT and managing help-seeking	0	0	23/07/2020 15:23	LL	29/08/2020 13:04	LL
Core needs in a mental health service	0	0	23/07/2020 15:25	LL	29/08/2020 13:08	LL
Experience of assessment and diagnosis	0	0	23/07/2020 15:32	LL	29/08/2020 13:08	LL
Experience of being referred	0	0	23/07/2020 15:32	LL	29/08/2020 13:08	LL
Experience of help-seeking	0	0	23/07/2020 15:30	LL	29/08/2020 13:07	LL
Experience of medication	0	0	23/07/2020 15:34	LL	29/08/2020 13:07	LL

LL 404 Items

Help-seeking for MHP Data.nvp - NVivo 12 Pro

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Paste, Cut, Copy, Merge (Clipboard) · Properties, Open, Memo Link, Add To Set, Create As Code, Create As Cases (Item) · Query, Visualize (Explore) · Code, Auto Code, Range Code, Uncode (Coding) · Case Classification, File Classification (Classification) · Detail View, Sort By, Undock, Navigation View, List View, Find (Workspace)

Quick Access
- Files
- Memos
- Nodes

- Youth Codes
  - 01Aine - FC
  - 02Gerard - FC
  - 03Rachel - FC
  - 04Cathy - FC
  - 05Robert - FC
  - 06Laura - FC
  - 07Joseph - FC
  - 08Jamie - FC
  - 09Claire - FC
  - 10Andrew - FC
  - 11Richard - FC
  - 12Thomas - FC
  - 13Erin - FC
  - 14Liam - FC
  - 15Focusgroup - FC
- Relationships

05Robert - FC

Search Project

Name	Files	References	Created On	Created By	Modified On	Modified By
Experience of help-seeking	0	0	22/07/2020 16:08	LL	29/08/2020 13:22	LL
Discovering a mental health problem	0	0	22/07/2020 15:58	LL	22/07/2020 15:58	LL
It took a while to recognise that I had a MH problem	1	1	08/06/2020 15:56	LL	08/06/2020 15:56	LL
MH problems emerged in teenage years	1	1	08/06/2020 15:54	LL	08/06/2020 15:54	LL
Noticing a considerable change in behaviour	1	1	08/06/2020 15:57	LL	08/06/2020 15:57	LL
Experience of going to service for the first time	0	0	22/07/2020 22:11	LL	22/07/2020 22:11	LL
Anxiety around expectation	1	1	08/06/2020 16:01	LL	08/08/2020 11:28	LL
Going to a service and being introduced to support wor	1	1	08/06/2020 16:00	LL	08/06/2020 16:00	LL
I was nervous but that is normal	1	1	08/06/2020 16:00	LL	08/06/2020 16:00	LL
Keeping real feelings back from others	1	1	08/06/2020 15:55	LL	08/06/2020 15:55	LL
Lack of knowledge about MH services available	1	1	08/06/2020 15:57	LL	08/06/2020 15:57	LL
Looking to parent to initiate help-seeking	1	1	08/06/2020 15:57	LL	08/08/2020 21:54	LL
People who are more introverted may find help-seeking har	1	1	08/06/2020 16:26	LL	08/06/2020 16:26	LL
Practical or logistical reasons that impact help-seeking	0	0	22/07/2020 16:09	LL	22/07/2020 16:09	LL
Evening opening hours for school age people would be	1	1	08/06/2020 16:14	LL	08/06/2020 16:14	LL
Having to leave school for appointments can be stressfu	1	1	08/06/2020 16:14	LL	08/06/2020 16:14	LL
Youth service has more accessible opening hours	1	1	08/06/2020 16:15	LL	08/06/2020 16:15	LL
Very distressed and not knowing what to do	1	1	08/06/2020 15:55	LL	08/08/2020 21:57	LL

LL 129 Items

Type here to search · 8°C · ENG · 16:53 02/12/2021

Appendix 19

Concepts and categories

Help-seeking for MHP Data.nvp - NVivo 12 Pro

File | Home | Import | Create | Explore | Share

Paste | Cut | Copy | Merge | Clipboard | Properties | Open | Memo Link | Add To Set | Create As Code | Create As Cases | Item | Query | Visualize | Explore | Code | Auto Code | Range Code | Uncode | Coding | Case Classification | File Classification | Classification | Detail View | Sort By | Undock | Navigation View | List View | Find | Workspace

- Quick Access
  - Files
  - Memos
  - Nodes
- Helper Concepts
  - 1. The Helper
    - Approach of helper
    - Reflecting on helping rol
  - 2. The Young Person
    - Role of friends
    - Role of parents
    - Role of school
    - Society and culture
    - Understanding of YP
  - 3. The Service
    - Experience of other servi
    - Ideal MHS
    - Own service thoughts
- Youth Concepts
- Case Classifications
- Notes

Approach of helper

Search Project

Name	Files	References	Modified On	Modified By	Classification
The helping role	0	0	05/01/2021 18:59	LL	
Understanding of MH	0	0	05/01/2021 18:46	LL	
Time	0	0	05/01/2021 18:20	LL	
Rapport	0	0	05/01/2021 18:20	LL	
Protocols and administration	0	0	05/01/2021 18:46	LL	
Interventions	0	0	05/01/2021 18:55	LL	
Endings	0	0	05/01/2021 18:57	LL	
Confidentiality	0	0	05/01/2021 18:20	LL	
Boundaries	0	0	05/01/2021 18:46	LL	
Autonomy and decision maki	0	0	05/01/2021 18:26	LL	
Approach to support	0	0	05/01/2021 19:00	LL	

LL 276 Items

Help-seeking for MHP Data.nvp - NVivo 12 Pro

File | Home | Import | Create | Explore | Share

Paste | Cut | Copy | Merge | Clipboard | Properties | Open | Memo Link | Add To Set | Create As Code | Create As Cases | Item | Query | Visualize | Explore | Code | Auto Code | Range Code | Uncode | Coding | Case Classification | File Classification | Classification | Detail View | Sort By | Undock | Navigation View | List View | Find | Workspace

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    - Ideal MHS
    - Own service thoughts
- Youth Concepts
- Case Classifications
- Notes

Role of parents

Search Project

Name	Files	References	Modified On	Modified By	Classification
Parents	0	0	05/01/2021 18:22	LL	
Supporting parents	0	0	05/01/2021 18:22	LL	
Source of problem	0	0	05/01/2021 18:26	LL	
Pressures	0	0	05/01/2021 18:45	LL	
Parents managing information	0	0	05/01/2021 18:26	LL	
Parents in counselling	0	0	05/01/2021 18:45	LL	
Parental presence	0	0	05/01/2021 18:26	LL	
Parental MHL	0	0	05/01/2021 18:26	LL	
Over-involvement	0	0	05/01/2021 18:45	LL	
Managing parents	0	0	05/01/2021 18:26	LL	
Initiating HS	0	0	05/01/2021 18:45	LL	
Importance of role in MH HS	0	0	05/01/2021 18:22	LL	
Difficult relationships	0	0	05/01/2021 18:45	LL	
Connecting with parents	0	0	05/01/2021 18:22	LL	
Having to put pressure on parents who don't engage	1	1	05/01/2021 18:20	LL	
Engaging parents on a more equal level	1	1	05/01/2021 18:20	LL	
Coercion	0	0	05/01/2021 18:26	LL	

LL 118 Items

Help-seeking for MHP Data.nvp - NVivo 12 Pro

File | Home | Import | Create | Explore | Share

Quick Access
- Files
- Memos
- Nodes
- Helper Concepts
  - 1. The Helper
    - Approach of helper
    - Reflecting on helping rol
  - 2. The Young Person
    - Role of friends
    - Role of parents
    - Role of school
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    - Understanding of YP
  - 3. The Service
    - Experience of other servi
    - Ideal MHS
    - Own service thoughts
- Youth Concepts
- Case Classifications
- Notes

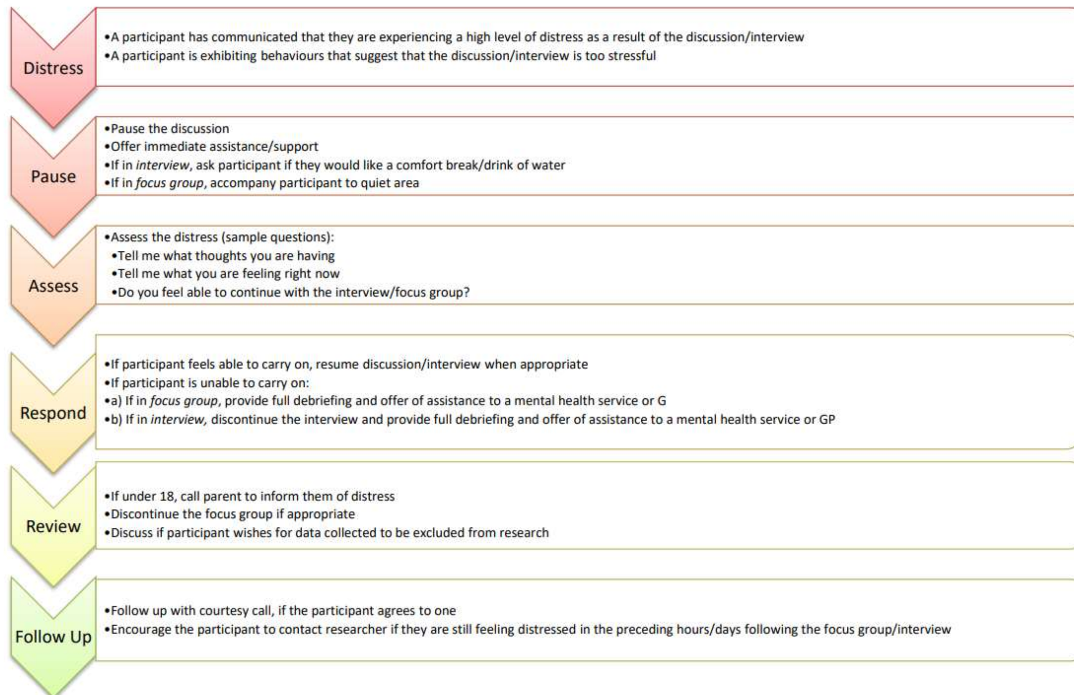
Ideal MHS

Name	Files	References	Modified On	Modified By	Classification
Ideal MHS	0	0	05/01/2021 18:27	LL	
It would be be helpful if parents did not have to stay on	1	1	05/01/2021 18:27	LL	
Inability to self-refer is a problem	1	1	05/01/2021 18:27	LL	
Ideal youth MHS	0	0	05/01/2021 18:46	LL	
Idela MHs may offer other modes of support	1	1	05/01/2021 18:46	LL	
Ideal MHS would utilise technology to support YP fo	1	1	05/01/2021 18:46	LL	
Ideal MHS is flexible	1	1	05/01/2021 18:46	LL	
Ideal MHS is confidenital	1	1	05/01/2021 18:46	LL	
Ideal services	0	0	05/01/2021 18:44	LL	
Trust and confidence are core to MHC	1	1	05/01/2021 18:30	LL	
Ideal MHS would have accessibility	1	1	05/01/2021 18:44	LL	
Ideal MHS would have a drop-in element	1	1	05/01/2021 18:44	LL	
Ideal service would allow YP to chat to someone without	1	1	05/01/2021 18:27	LL	
Ideal service is accessible	1	1	05/01/2021 18:27	LL	
Ideal MHS would allow for drop-in	1	1	05/01/2021 18:27	LL	
Ideal MHS would allow access to care without parental c	1	1	05/01/2021 18:27	LL	
Ideal MHS for YP	0	0	05/01/2021 18:32	LL	

LL 43 Items

Appendix 20

Distress Protocol for Interview and Focus Group Discussion on Mental Health



Adapted from Draucker, Martsolf & Poole (2009) *Developing Distress Protocols for Research on Sensitive Topics*