

**Young People's Understanding of
Mental Health and Mental Illness:
A Focus Group Study**

**for
Greater Glasgow NHS Board**

**by
Scottish Health Feedback**

**SCOTTISH
HEALTH
FEEDBACK**

The logo for Scottish Health Feedback, featuring a stylized, hand-drawn ear shape to the right of the text.

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*Scottish Health Feedback
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SUMMARY

This qualitative research study exploring the concepts of mental health and mental illness was carried out between August and December 2002 and involved exploring the opinions of around 60 young people aged between 12-18 years in Glasgow. The Glasgow Stigma Strategy had recommended all children and young people attending school should participate in a programme of mental health activity and before starting this programme in schools, Greater Glasgow NHS Board Health Promotion Department (Mental Health) wanted to explore these concepts with young people. They commissioned Scottish Health Feedback to carry out twelve focus groups with a range of young people in five different schools and two youth and community groups. The study involved males and females as well as young people from ethnic minorities and from a range of socio-economic backgrounds.

Main Findings

- Eleven single sex focus groups and one mixed group took place, involving 25 females and 35 males from four different parts of Glasgow. Sixteen participants were from ethnic minority communities
- 'Mental health' was an elusive term largely associated with the mind "not working properly", resulting in widespread confusion with mental illness as well as physical and learning disabilities
- Some young people did have a concept of mental health as about the "state your mind is in", and as encompassing both positive and negative states
- Females and older males from more affluent areas were the most articulate about the meaning of mental health
- They felt more comfortable talking about physical health because this was more familiar and "better known" to them
- Mental health was rarely perceived as positive, although some older teenagers of both sexes and some young females did sometimes associate a "healthy mind" with 'good health'
- Clearly young people of all ages had a lot to say about mental health problems in particular but rarely had the language. They were well aware of some of the most common causes or risk factors that could affect young people's mental health
- The most common problems they identified for young people were not fitting in with peers, the responsibilities of being a young carer, problems with family and other relationships and pressure to achieve at school
- A specific issue raised by males from ethnic minorities concerned the pressure they felt from their families to do well and the effect this had on their mental health when they didn't do so well
- Males perceived a key difference between mental health problems and mental illness as having personal control and the ability to choose over mental health problems, but not mental illness

- Knowledge of mental illness was generally poor, although some older teenagers, especially females had a broader knowledge. What knowledge they did have had been gleaned from television and films, and only sometimes from family or friends.
- Mental illness was confused with learning disabilities, including downs syndrome - over half the groups believed that downs syndrome was a mental illness
- There was widespread confusion over the statement 'people are born with mental illness', with only one group of 16-18 year old females not believing this to be true
- The term 'mental illness' invariably conjured up images of violent or dangerous people, hospitals, straight jackets and padded cells
- Males in particular believed it possible to tell that someone was mentally ill just by looking at them, but more commonly it was that the person behaved differently than 'normal'
- Both males and females highlighted abnormal or "weird" behaviour as an obvious sign of mental illness
- It was appreciated by a minority that it was not always possible to tell if someone is mentally ill
- There was an appreciation of the stigma of mental illness, which was why it was difficult for young people to discuss mental health problems and why they might not get the help they needed
- Participants were extremely ignorant of a range of mental illnesses, including schizophrenia even though they had heard of them
- Support and treatment for mental illness was predominantly understood from a medical model emphasising the role of "doctors, psychiatrists, and pills"
- Young people were largely ignorant of the help and support that might be available for young people with mental health problems and believed this to be inadequate
- Participants did not recognise schools as addressing mental health issues in any systematic or strategic way. Rather it was down to the individual interests and motivation of individual teachers
- Views were mixed about the role of schools in promoting mental health – some thought their job was about academic education only, while others took a broader view of schools' potential for enhancing mental health
- Although the supportive role of teachers was recognised in helping pupils with mental health problems, there were strong fears about confidentiality which might deter young people from seeking help
- There was perceived to be untapped potential for peer educators in raising awareness of mental health problems and illness and providing experienced support
- What was clear from participants' comments was that teachers had a major influence on the mental health of young people, both positively and negatively.

Mental Health

As with other research, it was found that young people, especially those under 14 years, struggled with the term mental health, and attached mainly negative connotations to either health or illness if preceded by the word 'mental'. As one 16-18 year old female commented, the word 'mental' was "quite a powerful word", which was "disturbing" because it brought to mind institutions and other negative associations. While there are dangers in trying to over-generalise the views of such a broad range of young people, an overall finding was that mental health was an elusive and unhelpful term for young people. The implication of which might be as argued by Sellen (2002), that perceptions of mental health and mental ill health require fundamental review.

Despite this, there was a clear appreciation of the dangers of certain events such as bereavement, of the problem of not fitting in with peers, of pressure caused by other people or school work and so on and their impact on individual's state of mind. In addition, there was a basic understanding of personal resilience and the impact of encouragement on mental health. What these findings show is a pressing need for even the most basic awareness raising about mental health and dispelling some of the myths arising from biased reporting or portrayal of mental health problems in the media.

Mental Illness

Knowledge and understanding of mental illness and its causes was poor overall. Opinions ranged from limited stereotypes of "psychos" and images of schizophrenia as "split personality" to more sophisticated understanding of the unseen nature of mental illnesses. Older females knew most about mental illness. Many of the same words and phrases as had been identified under mental health appeared again under mental illness and there was often confusion with learning disabilities. Overall, mental illness was perceived as "extreme" and as a negative state. People with mental illnesses were perceived as deviant, as looking and behaving differently and it was predominantly associated with "white jackets", "padded rooms", psychiatrists and "Victorian mental hospitals". There was widespread confusion as to whether a person could be born with a mental illness, and even those who disagreed believed some people to be genetically predisposed to mental illness.

Not surprisingly, given the prevailing myths and stereotypes about mental illness, participants associated treatment and support for mental illness with "doctors, medicines and pills", psychiatrists, hospitals and "padded cells": none it has to be said were thought of as particularly hopeful or optimistic. Even when participants came into contact with people with mental illness in their community, they perceived them as "wierdos". They knew something about talking therapies and were familiar with the notion of child psychologists but did not believe there to be much by way of support for young people suffering mental health problems or illness. Treatment was linked with special schools and sometimes with helplines such as Childline and the Samaritans. The most significant factor seemed to be with the anonymity and confidentiality afforded by these when young people needed most of all to talk, which is further evidence of an awareness of the stigma of mental illness.

The Role of Schools & Teachers

Not surprisingly perhaps, schools and teachers did not appear to be directly involved in addressing the subjects of mental health or illness. They were doing this only cursorily and as ad-hoc inputs, which depended upon the interests of certain teachers rather than a strategic approach by the whole school. Participants felt that schools and teachers had a mainly negative impact on their mental health but they also recognised the benefits of having supportive teachers and of classroom environments that were positively encouraging. They did not consider it sufficient only to have input on stress and how to deal with pressure when exams were looming. While some were doubtful that schools and teachers had any role in promoting mental health when their proper domain was teaching and education, there was a contrasting view that they should be centrally involved. Their role in promoting mental health had yet to be explored and there was suggested to be untapped potential for peer education in raising awareness and providing empathetic support.

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The Research Team

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The focus group data were analysed and this report written by Julie Ridley.

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1. Introduction

1.1. Background

This report presents and discusses the research findings from a focus group study exploring young people's perceptions of 'mental health' and 'mental illness'. In keeping with national strategy and the national priority afforded mental health within NHS Scotland, Greater Glasgow NHS Board (GGNHSB) had identified the need to tackle stigma as a local priority. Research has shown that the impact of stigma because of mental health problems or illness can have far reaching consequences for individuals' lives and life choices, and can create barriers to seeking help. By way of tackling this, the Glasgow 'Stigma Strategy' recommended all children and young people attending school participate in a programme of mental health activity.

Before starting this programme in schools however, the Health Promotion Department (Mental Health) sought to explore what kinds of issues there might be around mental health and illness for young people and commissioned Scottish Health Feedback, an independent research company, to carry out focus groups with a range of young people in Glasgow. There were two main aspects to the research: first it would seek to look at how young people thought about their own and other people's 'mental health'; and second, it would examine their understanding of 'mental illness' including any preconceived or prejudiced attitudes. It was envisaged that this research would therefore contribute to subsequent actions within schools to develop mental health promotion programmes.

1.2. Research on young people's perspectives

Previous research exploring young people's perceptions of mental health has found that while they appear comfortable with discussing everyday issues that affect them and can easily identify factors that cause them stress as well as coping strategies, they relate negatively to the term 'mental health' (Scott Porter Research & Marketing Ltd, 2000). Recent work with young people from ethnic minority communities about their mental health needs (Sellen, 2002) further suggested that the separation, mainly by health specialists, between mental health and mental illness is not something most young people can make sense of, and confirmed a mainly negative connotation with the word 'mental.' In relation to mental illness, Grafton (1994) showed that age rather than personal experience or social background influenced knowledge, except in respect of the common misunderstandings about downs syndrome and schizophrenia.

However, while the language of mental health eludes young people, the issues surrounding mental health remain salient to them. Recent work for the SNAP report for instance dispels the common myth about childhood and young adulthood: although widely assumed that youth equates with health, a succession of statistics is "putting this assumption seriously under challenge" (Scottish Executive, 2002). Statistics from the Accounts Commission Scotland, NHS Information and Statistics Division, the Scottish Office and the Scottish Forum for Public Health Medicine suggest that up to 20% of 14-15 year olds are likely to have significant mental health problems; and that the symptoms of manic depression, schizophrenia (in males) and eating disorders are most likely to first appear in the 15-25 year age range. At any one time 125,000 young people in Scotland will have a mental health problem severe enough to interfere with their day-to-day life and up to one in three males and two in five females report some form of psychological distress, including feeling stressed, an inability to concentrate, feeling depressed or losing sleep.

Qualitative studies with young people show they can readily identify a number of mental health problems that affect them including issues around school performance, issues to do with family and home life, issues around their self esteem, self-perceptions and self-concept, and issues about their future employment and life prospects (SNAP, 2000). Studies also highlight a difference in the perceptions of young people compared to adults when discussing emotional health. A recent survey for 'the big step' of young people leaving care in Glasgow found that mental health was a key health concern for 'looked after' young people, but that this was in terms of problems with family and peer relationships or where they lived, emotional health, and what contributed to whether they felt 'good' or 'bad' about themselves (SHF, 2001). In another survey, young people identified the state of family relationships, acceptance or rejection by peers; and the behaviour of teachers as the most important factors affecting their emotional well-being (SHF, 1998).

A major study of nearly 2,000 young people in Scotland has provided an important insight into the variety and complexity of the emotional experiences of teenagers and how they relate to the whole subject of 'mental health' (Gordon & Grant, 1997). Rather than focusing directly upon the topic of 'mental health' to gather young people's perspectives, the researchers set out to obtain a snapshot of the feelings and emotional health of mid-adolescent males and females in Glasgow. Scanning the literature in the field suggests there is a growing body of work including the above studies, which has explored aspects of emotional and mental health. There is less that focuses specifically on young people's attitudes to and views of mental illness. This research sought to contribute to this body of knowledge in directly exploring young people's reaction and understanding of both mental health and mental illness.

1.3. Research aim & objectives

The main aim of the study was to explore young people's perspectives on mental health and mental illness, and in doing so to be able to inform school based interventions that would promote better understanding of mental health issues among young people. The commissioners had specified that the research objectives were to:

1. Explore young people's understanding of mental health: the terms used to describe it, the factors that determined both mental health and illness;
2. Gauge young people's perceptions of mental illness
3. Explore young people's understanding of the risk factors or causes of mental health problems and mental illness
4. Explore the attitudes of young people towards those suffering from or experiencing mental health problems and/or illness

This study was essentially exploratory and should be read in this way. It involved studying in depth, the perspectives of a relatively small number of young people (60 individuals) between the ages 12-18 years living in the Glasgow area. It should in no way be taken as representative of all young people, but rather as providing an insight into the range of views that will exist within the youth population of today.

1.4. Research design & methods

As the main aim of the study was to explore young people's perspectives, a qualitative research design was adopted. The main method was focus groups held in a range of settings to reflect the ages, gender, socio-economic backgrounds and ethnicity of the youth population of Glasgow. The age group targeted was young people between the ages of 12-18 years attending secondary schools or participating in youth and community groups.

1.4.1. The focus groups

Twelve focus groups involving 60 young people, were carried out during August-September 2002. Single sex groups were arranged in five different secondary schools and mixed gender groups with two existing youth groups that met through community organisations. Experienced facilitators of both sexes led the groups according to whether it was a male or female group. The focus group discussion was structured around four main topics, but was otherwise open-ended to encourage a free flowing discussion around the main concepts of mental health and mental illness. The four main topics of discussion were:

1. Young people's interpretation of 'mental health' and the factors that influence mental health and create problems
2. What the term 'mental illness' provokes for young people
3. Young people's experiences and knowledge of mental illness and the support and treatment available
4. Misconceptions and prejudices

The focus group topic guide was drafted in collaboration with the Health Promotion Department (Mental Health) commissioner and the focus group facilitators, who were both experienced in health promotion as well as in working with young people. The guide also drew upon existing training and awareness raising packs about mental health developed by the Department of Health, 'Mind out' and others. However, such guides were only helpful up to a point as the challenges of gathering information for research about young people's perceptions of mental health and illness had some important differences with awareness raising exercises. It had also been decided to abandon the idea of opening the discussion with a quiz along the lines of that used by Grafton (1994) in his talks to secondary school pupils given there would be a wide range of young people of all ages and abilities included in the research, and no opportunity to right any misconceptions that might emerge.

At the start of each focus group, we used a standardised questionnaire about health (Ewles & Simnett, 1995) asking participants to identify what being healthy meant to them. Their responses were used to start the discussion about different aspects of health including mental health. The questionnaire had 18 items such as 'enjoying being with my family and friends' and 'feeling at peace with myself'. The exercise required participants first to identify the six items of most importance to them and then to prioritise these (see Appendix 3). The facilitators summed participants' scores to gauge whether they had identified physical or mental health items as being the most important. Later in the focus groups, common misconceptions about mental health problems and illness were explored by asking groups to discuss statements such as 'people are born with a mental illness', and 'you can't recover from mental illness'. As it was still possible, despite the most skilful facilitation, that some young people might have been vulnerable after discussing such topics, the facilitators circulated contact information about 'Breathing Space', a telephone helpline for young people, to all participants.

1.4.2. Sampling

The sample recruited represented the range of age, gender, socio-economic background and ethnicity of young people across the GGNHSB area. Four local authority areas were selected to ensure participants were recruited from the required groups. The schools represented a geographical spread and, as far as possible, schools in both deprived and more affluent areas. This included two school in the Glasgow City area one each in East and West Dunbartonshire and East Renfrewshire. This was thought to ensure the range of variables among the sample required in the Research Brief given that access was via schools rather than postcode areas.

Certain schools within Glasgow were known to have large multi-cultural catchments, which ensured that at least two of the focus groups comprised young people from ethnic minority backgrounds. It was imperative that the demands on each school and Local Education Departments (LED) were minimal. A maximum of 8-10 pupils per secondary school in each of the four areas, and, apart from Glasgow City, only one school per LED were approached. Recruitment into the focus groups was via the Head Teachers or relevant year heads of department as advised by each school. In previous research, Scottish Health Feedback had found that with young people, small single sex groups are particularly effective, especially if clearly focused around specific issues and when participants form a friendship network. Head Teachers or the designated Teacher invited young people of specified ages and gender to take part within friendship groups. In total 48 pupils took part in 10 focus groups with between 4-5 pupils in the following age groups:

12-13 years	4 groups
14-15 years	4 groups
16-18 years	2 groups

In addition, two groups involving a further 12 young people aged 16-18 years (mixed gender) were arranged with two different youth and community organisations. It had taken some time to locate suitable groups of older teenagers through community organisations as the majority operated drop-in facilities rather than organised groups. The membership of such groups also tends to fluctuate. For instance, we had to recruit another group at short notice because all of the participants from a group of unemployed young people in the required age range had all found jobs or college places.

In practice, there were 6 all male groups as one of the community groups turned out to be all male, 5 all female and 1 mixed group. Group size had varied between 4-6 participants, and a total of 25 females and 35 males took part in the research. Three groups comprised young people from ethnic minority backgrounds (two school groups and one community group). Focus group participants were therefore broadly in line with the plan laid out in the original proposal. The final sample of 60 was a mix of ages from 12 years to 18 years; males and females, different social backgrounds and ethnic origin. Because the strategy had been to recruit friendship groups as far as possible, most participants were known to each other and while considered to have been the most effective strategy, this may have had unintended effects upon the data generated.

1.4.3. Methodological challenges

Group participants found engaging with the main subject matter of mental health extremely difficult, even though this was introduced at the start of each group in a general way through the health questionnaire. As with research into lay perceptions of positive mental health (Masters et al, 1995), methodological difficulties were experienced in trying to access concepts

of mental health or mental illness from young people. Often participants stated that they had not really thought about the issues in any depth and that taking part in the study had forced them to attach some meaning to the terms sometimes for the first time. For the facilitators, it became an issue whether they should address misconceptions, especially the common misconception that down's syndrome was a mental illness, which was resolved by being reminded of the aims and objectives of the research to explore current perceptions rather than raise awareness.

"What being healthy means to you" questionnaire was found to be a useful opening for the vast majority of groups, all that is except the younger groups (12-13 years) of both males and females. Younger teenagers (12-13 year olds) were the most difficult to engage even with the general topic of health and struggled most to find the right words to explain their views. Understandably, older teenagers had more references points such as relationship problems and the pressure or stress of exams and were therefore more articulate in their views. There were in fact few differences according to the broad variable of social class: the most significant being between the sexes or in terms of age.

Research involving schools and young people always raises a number of practical and conceptual issues, for instance, access and timing of the research and the methods of data gathering to be used. Issues of content and scope must also be addressed to ensure that the study remains relevant and grounded in young people's experiences and interests. Carrying out focus groups in schools presented a number of practical challenges. These included established arrangements becoming chaotic in the face of more pressing events for the schools such as instances of bullying or dealing with excluded pupils. This sometimes resulted in shortened periods for the focus groups, and may have affected some individuals' application and concentration.

When involving pupils in a potentially sensitive area such as discussing mental health and mental illness, it was important to consider the consent of parents. This was achieved through a process of passive consent by providing leaflets summarising information about the study and requesting that any parents who did not wish their son or daughter to participate in the research contact the appropriate Teacher.

1.4.4. Data analysis

All of the focus group discussions were tape-recorded (with the consent of participants) and then fully transcribed. In one group, the facilitator had to reassure participants several times as to how the tapes would be used by the researchers. Young people were assured of confidentiality by the facilitators and this has been taken into account in the presentation of these results. Opinions or quotations have not been ascribed to particular school or community groups, only usually by age and sex. Only where variables such as socio-economic background appeared to have some influence, is this referred to. The transcripts were analysed by the researcher using N5 software package, which supports qualitative analysis. The analysis was thematic, but was also driven by the key topics under study and the structure of the focus group discussion and this has influenced the structure of this report.

It is perhaps worthy of note that in this report we have tried to present young people's views as far as possible to how they were presented to us. Some views were strongly expressed, and with others, the shortness of reply left what they said open to interpretation. It should be remembered that this analysis has been carried out from an adult perspective and as such might be open to scrutiny by young people. Wherever possible in this report, we have used quotations to illustrate as these often speak for themselves.

2. 'Mental Health'

2.1. Introduction

This Section reports on the findings about the participants' perceptions of 'mental health'. It explores the ways they spoke about and related to the term 'mental health', what they understood by it, whether or not the young people participating in the research could relate to a positive notion of mental health, and what they thought were mental health problems and what caused them. Finally, we explore what young people said about the distinction between mental health and mental illness.

2.2. An elusive term

The words generated under 'mental health' included among other things, 'illness', 'spazzy', 'psycho', 'mental', 'weakness', 'loonies', and "handicaps". The same words appeared on the lists under 'mental illness'. On a more general level, it was about "the way you think", "how you feel", "outlook" or "state of your mind and how it affects you". Rarely was it suggested that mental health was a positive concept. Frequently, participants identified specific mental illnesses such as schizophrenia, depression or bulimia under the umbrella of 'mental health'. Four of the groups thought that taking drugs, "junkies" and "alcoholics" were linked to 'mental health'. Some mentioned paedophiles, prostitutes and other groups. Appendix 2 provides a full list of the words identified by each focus group. This finding echoes a recent reflection by a young person attending a mental health seminar (Campbell, 2002) in which the author asserted that teenagers are "positively repelled" by the phrase. Campbell suggested that different terminology was needed to engage young people more meaningfully in any future debates.

For the minority who perceived mental health as about the "state your mind is in and how it affects you", this state could be both positive (happy and content) and negative (depressed). While it would be true to say that females (particularly 16-18 year olds) had the most sophisticated understanding of mental health, one group of 14-15 year old males stated that mental health was to do with "how you feel", "what you do", "how you do it" and "why you do it". Implicit in the majority of responses though was an association with the mind "not working properly". It referred to thoughts and to how people "worked inside". Given this general perception, it is perhaps unsurprising that this led to an assumption that "not being right" as well as being visibly disabled (an example given was people with down's syndrome), fell under the umbrella term of 'mental health'. Sellen (2002) found no difference between young men's and young women's conceptualisation of mental health and in this study too, the spectrum of views were expressed across the sexes.

2.3. Understanding of mental health

During the focus groups, participants were asked to consider what the term 'mental health' meant to them, and to share the words or images they associated with it. This pointed up that young people in this age range (both male and female) did not often use, and so did not easily relate to, the term 'mental health'. Instead, they used words such as 'stress', 'pressure', 'state of mind', 'mentally disturbed', 'depression', and 'disability'. While some certainly did associate the term 'mental health' with a state of mind, this was usually negative and it was hard for participants to pin down its meaning with confidence. This supports the findings of Sellen (2002), who commented:

"Young people are interested in their mental health needs, but they struggle to find an appropriate framework to 'hang' that interest on. They find words like 'emotional' or 'psychological well-being' too cumbersome and medical. And they are worried about offending their peers if they use the word 'mental'" (page 26)

When participants were asked to prioritise the key factors that being healthy meant to them from the standardised questionnaire (Ewles & Simnett, 1995), it was found that many were more comfortable talking about aspects of physical health because this felt "better known" to them. This was especially true of 12-13 year old females and males up to 15 years. Just three groups, a mixed group, a group of 16-18 year old females and one group of 14-15 year old males had prioritised mental health items over physical health. The results from the other five groups showed that they considered a mix of physical and mental health factors as relevant to being healthy.

Participants often confused mental health with disability but most especially with down's syndrome. While confusion over the terms was a common finding across all teenagers in the study, it was particularly marked within the younger groups (12-14 year olds) and in the groups in school that were in lower socio-economic areas. This is a similar finding to Grafton (1994), that is knowledge of mental health and illness tended to increase with age. The following extract from a group with 12-13 year old males illustrates:

Participant 1: Like mental health is when like, if you've got something, maybe something wrong with you or stuff like that.

FACILITATOR: WRONG WITH YOU HOW?

Participant 1: Well, say if you've got learning disabilities.

Participant 2: You might be like a wee bit psycho, once you've been brought up wrong or something.

When a search was performed across the data for all instances where participants had specifically used the term 'mental health', it was found that few of the participants ever used the term directly, and that 'mental health' appeared most in the facilitators dialogue when trying to elicit young people's views. Participants had struggled to find what they felt was the appropriate language to express their views as well as to feel sure they knew what it was:

"Before we came in here, we were like - what are we going to say about mental health, what do we know? And someone said - Alzheimer's." (16-18 year old female)

Another young person gave the following story from her family experience as she tried to relate to the term:

"My granddad had a stroke and sometimes he gets confused, he gets mixed up with people's names, sometimes he'll call me by my sister's name. Before my gran died, she had dementia, she got confused about a lot of things, and she used to fall down the stairs and stuff like that. She'd get confused." (14-15 year old female)

Participants attributed the general understanding of mental health as negative to the way it was portrayed by the media, even when it was supposed to be helpful, for example:

"I saw this advert ages ago, it was about MENTAL HEALTH, and it says there was a helpline and all that kind of stuff, but there was like no hope, there was like no positive thing at the end of this advert. All it showed was this one person, I can't remember where, then it just went blank, and there was the black screen and the white phone number, the helpline basically, and that's it. (Mixed group, 16-18 year old)

The Mental Health Foundation (1999) observed that because the word 'mental' has been seen almost exclusively in negative terms, when it is linked with 'health', the result is often confusion. The research findings would seem to support this assertion:

"The word 'mental' just kind of makes you think - illness and depression and schizophrenia." (16-18 year old female)

2.3.1. Can mental health be positive?

Even though five of the groups had in fact identified some positive words or associations with 'mental health', one group of older teenagers reflected that in general, mental health did not tend to be "seen as good". Participants had found it arduous to distinguish between positive mental health, mental health problems and mental illness. Where it was expressed, a positive mental health was thought to be a positive mental outlook, being "open minded", having a "happy state of mind", "peace of mind", about being "mentally confident" or more neutrally, it was about "the way you think".

None of the descriptions were particularly extensive, which suggests that participants struggled when explaining what they understood by positive mental health, as well as the fact that as a group, they rarely considered mental health in this way. Research that has focused on lay perception of positive mental health (Masters et al, 1995) concluded that part of the problem in accessing concepts of positive mental health is because many people view thinking and talking about it as detrimental to maintaining positive mental health. Masters et al concluded this might explain why respondents had been reluctant to explore what they either took for granted or deliberately ignored.

Having said that, older teenagers of both sexes, but also some younger females, were able to identify with positive mental health as an aspect of good health, for example:

"To be a healthy person I think you have to have a healthy mind"
(16-18 year old female)

"If you're not happy inside how can you be happy on the outside?"
(14-15 year old male)

In describing good or positive mental health, they asserted that it was important to be physically healthy, to feel secure in oneself, to have good self-esteem, to be self-confident and to adopt a positive approach to life. Among older participants, especially 16-18 year old females but also males of the same age from schools in more affluent areas, there was some notion of 'good health' as a combination of good physical and mental health. Further when pressed by the facilitator to prioritise either physical or mental health, good mental health had come out on top:

"If you're mentally happy yet disabled then you're still going to be happy. If you're still happy with yourself then you can go on there where as if you're unhappy then you may lose the will to live." (16-18 year old male)

One group suggested that 'mental well-being' might be a more positive term:

"Wellbeing is a better term than the health part, because you think mental health and mental illness, and you say mental wellbeing and you don't necessarily think of mental institutions, extremes, neurosis, psychologists and so forth." (16-18 year old male)

While this should not be taken as consensus that the term 'well-being' would be acceptable to or would encompass positive mental health for all young people, it does recognise, as do the Scottish Public Mental Health Alliance (2002), its potential for a less distorted term that retains largely positive connotations and with a broad application across individuals and communities.

2.4. Causal or risk factors

Even though participants had found it incredibly challenging to relate to the terms 'mental health', they found it relatively easy to pinpoint various reasons why young people might not 'feel at peace' and what the impact of this would be on their lives. In other words, while they found the terms themselves difficult, the issues such as eating disorders, bullying, and especially not fitting in with peers, were very salient to them. Other research has found it easier to focus on young people's feelings (SHF, 1998: Gordon & Grant, 1997).

A major issue for young people was that of "fitting in" and the distress caused by not fitting in and being "slagged" or bullied as a result. Previous research has found that feeling accepted or rejected by their peer group is of huge importance to young people discussing emotional health (SHF, 1998). They might not fit in because "someone says something bad about them" or because of an aspect of their appearance, the clothes they wear, the colour of their skin or their weight (too thin or fat). It was specifically highlighted that some young people might not be able to afford the "good gear (clothes)" that so often provides acceptance among peers:

*"People that don't, like their mum and dad don't have much money- they don't get the same clothes and everything as everybody else, then people might slag them."
(12-13 year old female)*

Secondly, relationships could be problematic, causing distress and potentially leading to smoking, problem drinking and drug taking. Specifically they talked about domestic and family problems, as well as problems with girlfriends/boyfriends and within friendships. Not having many or even any friends, and feeling left out was a problem and could lead to loneliness and isolation. Friends were recognised as providing vital support and by just being there were a safety mechanism, a listening ear as well as someone that "could help you".

Other significant problems participants identified as commonly experienced by young people and causing mental health problems concerned being bullied or abused. This was closely linked with not fitting in as discussed above. "Failing at something" at school and a lack of encouragement was suggested as a cause of stress generally. This is looked at more specifically in Section 4 in relation to the way that schools and teachers cause or support the promotion of mental health.

It was also suggested that being a young carer, with responsibilities for a disabled parent or sibling, or a parent who had problems with drugs or alcohol caused mental health problems for young people:

"Maybe, if your mum works all the time to try and get money, and then maybe someone has to look after their little brothers and sisters so they can't go out to play."

Young people from an Asian community in one of the focus groups cited pressure from families to do well academically as a significant source of stress to them:

"It's either like, I don't know, in Asian communities and that, you're wanted to be

something, like doctors or lawyers, engineers. That's some sort of pressure as well."
(Mixed group, 16-18 year olds)

This pressure was perceived by the males as more of a problem for them than young females in this culture. However, there were equal pressures on females such as being expected to perform well in the domestic arena.

There was a view that any young person might be susceptible, although those experiencing problems or major changes at home such as moving home or divorce, unemployment, and who came from poorer backgrounds would be most affected. It was suggested in one group of older teenage males that certain people were "more susceptible to stress than others" because of their "nature". This was attributed to "the way they think", in other words, to their approach to life. Further the same group of 16-18 year old males who raised this point felt that some people were able to "build up barriers" or were more resilient while others clearly were not. They felt that "younger people these days were less disciplined" and this was at the heart of the problem. This was not however a conclusion that arose from any of the other groups.

2.4.1. Impact of mental health problems

The young people in the research had no difficulty in identifying how 'not feeling at peace' with oneself could lead to low self-confidence and a multitude of other problems and harmful behaviours. They identified that having low self-esteem might lead to "losing the courage to make new friends" and to making young people susceptible to bullying. They would also be more likely to do "bad stuff" like deliberately harming themselves and to develop eating disorders:

Participant 1: One of the girls who's in our class, she's got like scars on her arm, she's obviously hurt herself. She thinks its fun but...

Participant 2: I said "why do you harm yourself?" She said - say you got dumped by your boyfriend and you were upset but then you got in a fight then you would forget about it and you start wanting to get in fights.

Participant 1: Physical pain overcomes your mental pain, that's why they do it.

They also perceived an obvious link between these problems and behaviours such as vandalism, drinking, smoking, and drug taking. As with previous research carried out by SHF (1998) exploring young people's perspectives of emotional health, participants were acutely aware of how rejection by peers could have serious consequences for individuals, including attempting suicide.

2.5. Difference with mental illness

As has already been argued, participants found it difficult to separate out the concepts of mental health and mental illness. Before taking part in the discussions, most had perceived them as inseparable. They admitted at times to "just guessing" at its meaning because it was "really hard" to define mental health and they were unused to talking about it. It was often only when the facilitators introduced the two terms and then asked participants to compare what they had said about each, that it was realised there might be a difference. Ordinarily, young people considered these as "different names for the same thing" and as one participant commented:

*"It's only in a situation like this that you would differentiate between the two. If you asked someone straight, they would consider them to be the same thing."
(16-18 year old male)*

There was some appreciation that mental health and mental illness might be part of a "big chain" or a continuum, and that mental illness encompassed a broad range of conditions some of which appeared more serious than others, for example:

*"With mental health, like, I'm not saying it's not like brain damage isn't as bad as being in a mental house and places like that. Just some of the stuff, in mental health you are able to stop for instance being cheeky and hurting other people, like you are able to stop being that way but, in mental illness, you might not be able to stop being a weird kind of person, stop having imaginary friends and things like that."
(12-13 year old male)*

According to males up to 15 years, the one significant difference between mental health and mental illness was that it was possible for someone with a mental health problem to choose to change and to be more in control than with severe mental illness, which was characterised by a lack of personal control:

"Stress isn't a disease cos you can cure it" (14-15 year old male)

With this way of thinking, mental illness was something that could not be controlled nor prevented. It was more serious than mental health problems: it was an illness with "proper names". Some believed people to be born with mental illnesses and unable to do anything to alter the course of events. However, mental illness might also happen suddenly and unpredictably:

"It starts to show and it just occurs one day and becomes mental health. Just one day they're normal, the next day they just have a mental health". (12-13 year old male)

The suggestion was that mental health problems were almost self-indulgent - "you bring it on yourself by your surroundings and the way you live." In responding to a question about whether males or females were more affected by mental health problems, a 12-13 year old male asserted mental health affected females, while mental illness tended to affect males more. While interesting and perhaps worthy of further exploration, this was not a prevalent perception.

2.6. Summary

As with other research, it was found that young people, especially those under 14 years, struggled with the term mental health, and attached mainly negative connotations to either health or illness if preceded by the word 'mental'. As one 16-18 year old female commented, the word 'mental' was "quite a powerful word", which was "disturbing" because it brought to mind institutions and other negative associations. While there are dangers in trying to over-generalise the views of such a broad range of young people, an overall finding was that mental health was an elusive and unhelpful term for young people. The implication of which might be as argued by Sellen (2002), that perceptions of mental health and mental ill health require fundamental review.

Despite this, there was a clear appreciation of the dangers of certain events such as bereavement, of the problem of not fitting in with peers, of pressure caused by other people or school work and so on and their impact on individual's state of mind. In addition, there was a basic understanding of personal resilience and the impact of encouragement on mental health. What these findings show is a pressing need for even the most basic awareness raising about mental health and to dispel some of the myths arising from biased reporting or portrayal of mental health problems in the media.

3. Mental Illness

3.1. Introduction

This Section presents the findings about the concept of 'mental illness'. We explore the kinds of terminology young people in the research used in referring to mental illness; what they understood by and knew about mental illness; what their ideas were about the causes of and risk factors for mental illness; and what they thought of the treatment and support available for people, especially young people with mental illness. Finally, we examine some misconceptions about mental illness and look at how common these were among the research participants.

3.2. Terms for mental illness

As discussed in the previous Section, the majority of participants did not tend to separate out the concepts of mental illness and mental health. It was therefore not surprising to find many of the same words or phrases listed under 'mental illness' as had been listed under the umbrella term 'mental health' (See Appendix 2). There was also little distinction between mental illness and "handicapped people", especially with learning disabilities. Some identified physical disabilities such as "people in wheelchairs", epilepsy or serious head injury under mental illness, while one group listed HIV and AIDS and another, euthanasia.

They were most familiar with depression as a mental illness, although some considered this under mental health. Seven of the groups specifically mentioned depression as a mental illness and others included schizophrenia, stress, eating disorders, dementia, as well as drug and alcohol problems. There was no discernible difference between males and females of all ages, although younger males (12-13 years) were the least well informed. The overall interpretation was of mental illness as "extreme" and a negative state of mind, which was outwith the understanding or experience of the majority of participants.

People with mental illnesses were stated to be "crazy", "mentally disturbed", they were "psychos", "spazzy" and some thought they were "perverts". People with mental illness were sometimes thought to have "no control over their actions", were in need of intensive help, and frequently "suicidal". Associations with the term 'mental illness' were "white jackets", "padded rooms", psychiatrists and "Victorian mental hospitals". Two groups of males (12-13 yrs and 16-18 yrs) from ethnic minority communities also identified "terrorists", George Bush, Saddam Hussein, Tony Blair, the World Trade Centre, under 'mental illness', showing how easily young people's mental health can be affected by external events. Their reaction was a reflection of the impact of such traumatic and divisive events on young people's sense of self and identity especially in a multi-cultural society.

3.3. Understanding of mental illness

Overall, there was a limited knowledge of mental illness among participants, that is, of what causes mental illness and how it manifests. Those who had the most sophisticated understanding and were most likely to highlight depression and other illnesses were the older females (16-18 year). Closer analysis of the transcripts revealed diversity in the knowledge of members of the same group, who sometimes contradicted each other. Opinions ranged from limited stereotypes to a more sophisticated understanding of the unseen nature of many mental illnesses and knowledge about specific illnesses such as eating disorders and depression.

The majority stated that they had gained their knowledge from the portrayals of mental illness in television soap operas such as *Emmerdale Farm*, and films, most notably *"A Beautiful Mind"*, *"Girl Interrupted"*, *"Me, Myself and Irene"* and *"Don't Say a Word"*. Family members who either had experienced mental illness or worked with people with mental illness, and some teachers (particularly religious education teachers) were an influential source of information for a minority.

3.3.1. Stereotypes

According to Sullen (2002), newspapers quite often "sensationalise articles by the inappropriate use of psychiatric terms", and the images of people suffering psychiatric disorders are invariably negative. This would seem to be borne out by the responses of young people in this study. A survey recently found that for most people television, radio and newspapers are the main source of information about issues relating to mental health and that most of it is totally misleading (Scottish Executive, 2002). This finding might explain why, in the main, focus group participants of all ages and sex tended to identify stereotypical appearances and behaviour of people with mental illness, or as they put it, the "extreme cases".

"Extreme reactions, that's probably the easiest way to tell." (16-18 year old male)

The words 'mental illness' invariably conjured up images of violent and dangerous people, long stay hospitals, strait jackets, and a "place with padded rooms". Few appeared to have any direct experience of mental illness among family members, peers or even of community care projects. Some were aware of community-based projects, but this had not made mental illness any more accessible or comprehensible to them:

"I ken a, in my street there's a mental house, I stand there and I see a lot of weird people there, and whenever I hear them going mental I always think of these really weird people." (12-13 year old male)

A recent evaluation of peer educators' impact on raising awareness about mental health (Penumbra, 2001) concluded that stereotypical views come not only from the media but also from school. Although teachers did sometimes address mental health issues during social education sessions, focus group participants did not identify this as having happened in any formal way in any school included in the research. More will be said about perceptions of the role of teachers and schools in Section 4.

3.3.2. Appearance

Males in particular, but not exclusively, believed there were clear visual clues that evidenced mental illness. This could be linked to the confusion between mental illness and learning or physical disabilities as the following extract from one group shows:

FACILITATOR: IS IT POSSIBLE TO TELL BY LOOKING AT SOMEBODY WHEN THEY'RE MENTALLY ILL?

Participant1: Sometimes, can see in their eyes as well

FACILITATOR: AND HOW DO THEIR EYES LOOK?

Participant 1: Sort of all stone.

Participant 2: Sometime you can tell like maybe if they swagger and things like that.

Participant 3: And one man who's got downs syndrome sort of...because like you think they're four but they're sixty or something. They can't talk, so it's easy to do.
(12-13 year old males)

At school, those who were mentally ill included those who had what was called a 'mad teacher', another term for a learning support teacher, and this served to mark such pupils out as different. Even older teenagers thought it possible to tell someone was mentally ill by their mannerisms or gait:

*"Like their legs may be different, like different shapes, they may walk different."
(16-18 yr old male)*

Other older males in the same group suggested people with mental illness had "weird faces" that were "not the original shape" or that they "might foam at the mouth". In contrast, younger females (12-13 year old), suggested that while it was not always possible to tell if someone was mentally ill, people who were depressed sometimes "couldn't be bothered" about their appearance and that this might give clues about their mental state. There was also visual evidence when people "cut up their arms" or had deliberately self-harmed.

One group of 14-15 year old females suggested that people who were mentally ill wore "funny clothes" or dressed inappropriately:

"You see them walking in the street and they like pick up things and they wear stuff that's not like appropriate for like, it's a really hot day and they've got a jacket, hat and scarf and stuff like that" (14-15 year old female)

3.3.3. Behaviour

While not all the young people believed that one could just tell by looking at someone's appearance per se, they might believe it possible to tell by the way someone behaved or by "the way they walk and talk" that they were mentally ill. People with mental illness were described as "not behaving normally", "acting differently" or "acting weird", for instance:

"They wouldn't interact with people the same way as how you and I would. They would maybe talk different or maybe walk or do something in particular that would stand out and you could tell." (14-15 year old male)

They might be generally less inhibited in the way they interacted with others:

FACILITATOR: AND WHAT SORT OF THINGS WOULD THEIR BEHAVIOUR BE?

Participant 1: How they confront people.

FACILITATOR: HOW WOULD SOMEONE WHO WAS MENTALLY ILL CONFRONT SOMEONE?

*Participant 2: They would ask them stuff that no-one else would ask them.
(16-18 year old, mixed group)*

There was evidence from personal experience that mentally ill people behaved differently:

*"My mum got on the bus and there was this man who got on the bus and he got off at Levendale...and he was dancing and things, and singing at the bus stop"
(14-15 year old female)*

Two groups of 12-13 year old males both highlighted instances where they had noticed someone talking to "an imaginary friend" and cited this as evidence of mental illness. To most therefore, there were clear overt signs that someone was mentally ill, even if it was not possible to tell just by looking at them.

3.3.4. A more complex picture

A minority had an awareness that mental illness described a multitude of illnesses of varying degrees of seriousness that affected the mind, and also that it was often hidden and the symptoms could be less visible. It was suggested that some people with mental illnesses "kept themselves to themselves", preferring to disguise their mental illness on account of how others might react. In contrast to the 'extreme mental illness' described above, some mentioned "wee bits of mental illness" that might be less obvious or visible for example:

"Like someone who usually talks a lot, and if they stop talking then people ask them 'what's wrong?'." (16-18 year old, mixed group)

"You don't always know because somebody could be desperately trying to cover it up. They're trying to be happy and not tell anyone that they're ill." (14-15 year old male)

Because there was a stigma to talking about mental illness, it was possible that a mental health problem might go undetected "until it was too late". It was believed that only those who knew someone well would be able to perceive the subtle changes, such as the person becoming quieter, less confident, more withdrawn, as "not making an effort" at school or as not sleeping.

One group of 16-18 year old females reflected that the fear of talking about mental health issues because of what other people might think was why it was not always possible to know when a person had a mental health problem. They thought it might feel to the person with a mental illness as if "everyone is going about their life" and they might be unable to tell anyone about their mental health problem or illness. Some people with mental illness, such as the mathematician portrayed in the film "A Beautiful Mind" were "really intelligent but psycho", thus suggesting that some people seem to be able to pass off their mental illness while others' behaviour is less tolerated or acceptable.

3.3.5. Common types of mental illness

The main types of mental illness that they were familiar with were schizophrenia, eating disorders, depression and psychopathic disorder. A few also talked about other things such as panic attacks, anxiety, and obsessions. Familiarity however, did not necessarily equate with accurate knowledge of mental illnesses.

3.3.5.1. Schizophrenia

Although four groups, two male and two female, specifically identified schizophrenia as a mental illness or mental health problem, their knowledge of it was scant and sometimes inaccurate:

"It's split personality, it's like you could be happy one minute and you could just freak out the next" (14-15 year old male)

"People that have it are mad....they have delusions maybe. They're in a totally different place than they really are" (16-18 year old, mixed group)

Knowledge of schizophrenia had been gleaned from television and films and the idea of "split or dual personality" was prevalent. For instance, the film "Me, Myself and Irene" was stated

to be about:

"A poor nice guy who wouldn't think of hurting anybody and the next minute, he'd just try to do stuff that the other person wouldn't think of, just changes completely."

For the 12-13 year old male who mentioned this film, it was believed impossible to be able to tell if someone had schizophrenia when speaking to them on the telephone but possible if face-to-face as it was likely they "would change within ten minutes".

3.3.5.2. *Eating disorders*

The majority of participants had heard of the eating disorders, anorexia nervosa and bulimia. Both males and females accurately associated these disorders with "worries around food", with wanting to conform to a "model shape", and as something that particularly afflicted females:

"Everywhere you look there's advertisements with skinny people. It just makes people think that if they're not like them then they're different and they need to be skinny and stop eating. They look in the mirror and their mind sees a big fat person."
(14-15 year old female)

It would be true to say that eating disorders were generally perceived as a female problem. Interestingly, younger males (up to 15 years) tended to include obesity and over-eating as mental health problems, though not necessarily a mental illness. The distinction being that it was possible for a person to control over-eating but not if they thought they were fat when in fact, they were not.

3.3.5.3. *Depression*

'Depression' was commonly highlighted, even when describing low mood rather than a clinical condition. Like 'stress', the word 'depression' was familiar to most and one they could relate to more easily than either mental health problem or mental illness:

"Something happened in my life and ever since that day I've been depressed. I can't say it but if I were to say you'd understand." (16-18 year old, mixed group)

Participants in a group of 14-15 year old females believed that people who were depressed might "do something to hurt themselves or other people" or might commit suicide or take drugs.

3.3.5.4. *Psychopathic disorder*

Four groups, equal numbers of male and female, specifically mentioned psychopaths under mental illness. People who were psychopaths were often portrayed as "serial killers" but a 16-18 year old male in one of the groups commented:

"I know for a fact that psychotics don't experience emotions in the same way normal people do, but it doesn't necessarily make them criminals. There are psychotics who are lawyers, politicians....then you get the other end of the spectrum where people don't see the value of human life." (16-18 yr old male)

Once again, there was an indication that this knowledge had been gleaned from television and films.

3.4. Causal or risk factors

Factors that appear to trigger mental illness were only partially understood. There was for instance, awareness among some participants that lifestyle changes including adolescence, bereavement or job loss could precipitate mental illness. The following quotation referring to social circumstances or adverse life events such as abuse or bereavement in relation to mental illness was more unusual:

"A lot of murderers they might have a bad childhood they could like for example their parents could be abusing them by hitting them or whatever, taking their stress out on them and then like because of that they grow up to be not good human beings. They just grow up to be violent."(14-15 year old male)

It was suggested that males generally bottled up emotions and that not being able to express emotions could lead to mental illness as the following exchange between two older teenage males (16-18 years) illustrates:

Participant 1: *Number one: we're teenagers, number two: we're boys, it's really hard for us to let emotion out. We don't sit crying at each other.*

Participant 2: *I cry.*

Participant 1: *Not with each other - you don't cry with me.*

Participant 2: *When I'm depressed I have a fag, when I'm more depressed I have some coke, when I'm more depressed I have some hash, I'm too depressed I get pissed, at one point I was going to commit suicide.*

The clearest link between adverse social circumstances was with bullying or not fitting in and as this leading to depression, and ultimately for some to suicide attempts. At least one group of 14-15 year old males considered this a potential problem for all young people.

3.5. Support & treatment

Doctors, psychiatrists, and psychologists were thought to be the main sources of help for people with mental illness. Although social workers and learning support teachers were mentioned, this was in relation to pupils with 'special needs' or learning disabilities. More especially, participants were ignorant on the whole of what might be available for young people and the model of treatment and support described invariably related to adult services. Treatment for mental illness was understood mainly in relation to medical diagnosis and treatment or "doctors, medicines and pills". Understandably, treatment and support for mental health problems was not considered appropriate in schools.

"They should be dealt with, extra-school, out of school. Although the school should support any decisions or things that are made out of the school, but the school should not deal with problems outside." (16-18 year old male)

The predominant 'medical model' of treatment led to the belief that support and treatment mainly happened within specialist clinics and hospitals with "padded rooms", even though few had any idea, and might be sceptical, about what happened inside these clinics:

"Think it's 'just tell me your problems and I'll come out with a conclusion' maybe" (16-18 year old mixed group)

It was suggested by one group of older females (16-18 years) that treatment within what they identified as 'mental institutions' did "not give any hope, people don't really go there to get

better". Medication could be "a good thing" but would not necessarily cure mental illness. What they thought was needed were increased opportunities for "talking it through", better education but it would take time to change the balance of care. In fact, several participants felt that people who were mentally ill mostly needed "people to listen" and to understand them. A group of older teenagers highlighted the importance of getting help to rebuild self-esteem and self-confidence when suffering from various mental health problems. Some were familiar with professionals such as child psychotherapists and psychologists who were thought to help by using "techniques to get at their feelings, and try and change them". However, some of the young people were sceptical about this:

Participant 1: *There are child psychologists, I know that the Americans, a lot of American children are on drugs like Ritalin and things like that*

FACILITATOR: WHAT DO YOU THINK A CHILD PSYCHOLOGIST WILL DO?

Participant 2: *Overcharge*

Participant 1: *I always consider that they tend to over analyse things, except in some cases it's not always true but today it's like what we were saying about the Americans, people are too tempted to just like go get drugs or get counselling.*

Childline and The Samaritans were mentioned as possible source of 'listening support', when the informal support networks of family and friends failed to provide the support needed. The importance of Childline was that it was felt to be anonymous and respected confidentiality. However, there was perceived to be a general lack of treatment available for young people with mental health problems: a perception that is borne out by recent research under the Scottish Need Assessment Programme (Scottish Executive, 2002).

Young males (12-13 years) suggested that it could be stigmatising to admit to mental health problems and "might be embarrassing" to seek help in the first place. While not a common perception, some 14-15 year old males were aware that young people with mental health problems or illness were moved to 'special schools'. While this may have been because they confused learning disabilities with mental illness, this fact is borne out by evidence that children with emotional and behavioural difficulties too often end up in special schools (Pearce, 2002).

In terms of what was actually needed to help young people with mental illness, a group of 16-18 year old females considered it a pre-requisite that those supporting young people should be able to empathise with the person from their own experience:

"Like it's reassuring, if someone's had anorexia then they know there's hope for them, and they can overcome it. I think that's quite encouraging."

3.6. Misconceptions

As part of the focus group discussion, facilitators introduced several statements exploring popular misconceptions about mental illness from Grafton's (1994) questionnaire and other training materials. Participants were asked to state whether they considered each statement as true or false and to discuss their views. It should be noted that there was not time in every focus groups to cover each statement and where a statement was discussed by relatively few participants, this is highlighted in the text below.

3.6.1. 'People are born with mental health problems'

There was widespread confusion as to whether people were born with mental illness, with the majority first agreeing with the statement and after some debate, making a distinction between different kinds of mental health problem or illness. The common distinction they made was between being born with a disability such as downs syndrome or brain damage (which many believed to be the same as mental illness) and illnesses such as eating disorders or depression:

Participant 1: *Sometimes you can develop them, if there's something wrong with your life, somebody died in your family, you can get all depressed.*

FACILITATOR: *OK, SO SOMETIMES YOU CAN DEVELOP THEM IF THINGS GO WRONG IN YOUR LIFE, SOMETIMES YOU'RE BORN WITH THEM.*

Participant 2: *You can be born with like, disabled or retarded, you might have a mental problem because of that, because through your life you could be worn down, and you could be more at risk of developing mental problems because you're not used to it.*

Participant 3: *A baby doesn't get born with anorexia, you develop it.
(16-18 year old males)*

Similarly, a group of 14-15 year old females commented:

Participant 1: *Sometimes that's true and sometimes it's not*

FACILITATOR: *WHAT'S THE DIFFERENCE?*

Participant 1: *People with depression and stuff like that – they're not born with that, it's events that happen, they develop that but other things, like Down's, people are born with that.*

Participant 2: *They just have to live with it.*

FACILITATOR: *ANY OTHER EXAMPLES OF THAT, THINGS THAT YOU'RE BORN WITH AND THINGS THAT YOU'RE NOT BORN WITH?*

Participant 1: *You're not born with anorexia or bulimia.*

Participant 3: *You're not born with a, like a stroke, you're not born with that, that's like after effects, like a stroke.*

Out of the 12 groups, only a group of 16-18 year old females unanimously disagreed with the statement, and even then some doubts were expressed:

FACILITATOR: *I'D LIKE TO KNOW WHAT YOU THINK OF THESE STATEMENTS, WHETHER YOU THINK THEY'RE TRUE OR FALSE OR IF IT'S SOMEWHERE INBETWEEN. 'PEOPLE ARE BORN WITH MENTAL HEALTH PROBLEMS'*

All: *false*

FACILITATOR: *WHY DO YOU THINK THAT'S FALSE?*

Participant 1: *It's a result of a lack of support or issues, something that's happened to you in your life....*

Participant 2: *Maybe your upbringing.*

Participant 3: *Or work*

Participant 4: *Mind you, you could say, that it could run in the family, genetics. So then you are born with it.*

Participant 2: *Alzheimer's*

There was a common belief in the possibility that some people were genetically predisposed to mental illness, for example:

FACILITATOR: I WANT TO KNOW WHETHER YOU AGREE WITH IT OF DISAGREE WITH IT. "PEOPLE ARE BORN WITH MENTAL HEALTH PROBLEMS"

(All disagree, except one)

Participant 1: Could be...

Participant 2: It's something that happens to you, or you've experienced which makes you.....

Participant 1: No, no,do you not believe in genetic information – different moods. Do you not believe in genes? From your parents....the moods go on.

FACILITATOR: YOU DON'T AGREE WITH THIS STATEMENT THEN?

Participant 3: To a certain extent, 80/20 I suppose, 80 that's false, 20 that's true. (16-18 year olds, mixed group)

Further, some held the misconception that mental illness could be caught from parents who themselves were mentally ill.

3.6.2. 'You can't recover from mental illness'

Only three of the focus groups, all female groups, discussed this statement. All were overwhelmingly positive about the potential for recovery. Both groups of 14-15 year old females were of the opinion that there were things individuals could do to help themselves but because they believed some people were 'born with mental illnesses' or disabilities, not all mental illnesses lent themselves to recovery. It was not possible for example, to recover from or as they put it to "get rid of" of downs syndrome or dementia.

3.6.3. 'Anxiety is a mental health problem'

This statement was discussed in only two of the female focus groups and received only passing attention. One group of 12-13 year old females thought anxiety was not a mental health problem, as they argued anyone can feel anxious, and the other group of older females (14-15 years) agreed with the statement as one person had picked up information about anxiety disorders from a television programme.

3.6.4. 'Depression is a mental health problem'

Four focus groups, two female groups, one male group and one mixed youth group gave an opinion on whether depression was a mental health problem. All but one group of younger females agreed with the statement and commented that depression could lead onto serious problems such as deliberate self-harm and suicide attempts. The group of 12-13 year old females responded that they did not know whether depression was a mental health problem. Participants generally believed that depression was something that can affect anyone including young people, and that people coped with it by taking drugs, smoking and drinking alcohol to "forget and calm themselves down about all the bad stuff". While this might make it easier for some, it was reflected this "might also make the problems worse".

3.6.5. 'Down's syndrome is a mental illness'

Half of the focus groups (4 female: 2 male) identified down's syndrome as a mental illness, an opinion linked to age rather than gender: both younger females and males (12-13 year olds) tended to hold this opinion. The reasons given for including down's syndrome under mental illness included:

"I think when the person's got down's syndrome then their brain doesn't work as well as everybody else's" (12-13 year old female)

"Because your born with it and you can't help it really, yeah basically it's just with you for the rest of your life" (12-13 year old male)

One group of 16-18 year old males also identified downs syndrome as a mental illness.

3.7. Summary

Knowledge and understanding of mental illness and its causes was poor overall. Opinions ranged from limited stereotypes of "psychos" and images of schizophrenia as "split personality" to more sophisticated understanding of the unseen nature of mental illnesses. Older females knew most about mental illness. Many of the same words and phrases as had been identified under mental health appeared again under mental illness and there was often confusion with learning disabilities. Overall, mental illness was perceived as "extreme" and as a negative state. People with mental illnesses were perceived as deviant, as looking and behaving differently and it was predominantly associated with "white jackets", "padded rooms", psychiatrists and "Victorian mental hospitals". There was widespread confusion as to whether a person could be born with a mental illness, and even those who disagreed believed some people to be genetically predisposed to mental illness.

Not surprisingly, given the prevailing myths and stereotypes about mental illness, participants associated treatment and support for mental illness with "doctors, medicines and pills", psychiatrists, hospitals and "padded cells": none it has to be said were thought of as particularly hopeful or optimistic. Even when participants came into contact with people with mental illness in their community, they perceived them as "wierdos". They knew something about talking therapies and were familiar with the notion of child psychologists but did not believe there to be much by way of support for young people suffering mental health problems or illness. Treatment was linked with special schools and sometimes with helplines such as Childline and the Samaritans. The most significant factor seemed to be with the anonymity and confidentiality afforded by these when young people needed most of all to talk, which is further evidence of how aware they were of the stigma of mental illness.

4. Promoting Mental Health at School

4.1. Introduction

In this Section, the findings about how the participants perceived the role of schools and teachers in promoting mental health are discussed. First, their comments about the current level of input in schools are discussed. Next, in analysing what the participants said in relation to the statement 'schools and teachers have nothing to do with mental health', we look at the impact, both positive and negative, that school and teachers were thought to have on young people. Finally, we present participants' ideas about the preferred role of schools in promoting mental health.

4.2. Current school input

"It's something that's not really talked about" (16-18 year old female)

The above quotation was fairly typical overall. What emerged was that there was rarely any specific input on mental health or illness in schools, although there had been some coverage of related issues such as bullying. This finding echoes what recent commentators had dubbed a 'policy blind spot' when it comes to promoting mental health in schools (Pearce, 2002), that is, a bias towards physical health and educational achievement within school life. While mental health is covered to an extent, more attention tends to be given within school to issues around alcohol, drugs, smoking, disability issues, bullying, child protection, sex and relationships.

While not addressing the subject directly, some participants highlighted one-off inputs by individual teachers. This had been as part of social education or religious education classes mainly, while in one case the science teacher had addressed the impact of exam pressure and stress:

"In R.E. we had one about like family and moods and everything" (12-13 year old female)

Typically, they stated "we'd just have a discussion about it in class". However, a follow up question to one group by the facilitator as to whether such discussions had been helpful, was met with a resounding "not really". At the other end of opinion:

"It was about mental confidence and physical confidence and all that because we were saying about pop stars and stuff like that but why they thought they were physically confident and that they were confident" (12-13 year old female)

Which might suggest there was something about the approach taken by the teacher that determined success or otherwise.

4.3. 'Schools and teachers have nothing to do with mental health'

The key reason for asking this question in the focus groups was to find out if young people could first identify a role, and second what that role should be, for schools and teachers in addressing mental health and illness. It should be remembered that in answering this question, the predominant view of mental health as about problems and illnesses would have coloured young people's responses.

While there was widespread agreement that schools and teachers had a significant input into mental health, this was not in the way intended by the question: for the participants, schools and teachers had a lot to do with mental health because they were often a major source of stress and a cause of mental health problems because "they put pressure on you". There was passing mention of a positive side and the support given by for instance, guidance teachers. Schools and teachers had a mainly negative impact on young people's mental health.

4.3.1. Negative impact

On one hand, teachers were perceived as putting pressure on pupils, but also as victimising or labelling individual pupils to the detriment of their self-confidence and self-belief. The approach and attitude of teachers to pupils was a critical factor. The unsolicited view from participants generally was that teachers could "pick on" certain individuals in ways that humiliated or "put you down", or they were guilty of paying more attention to some pupils and in the process, neglected others:

Participant 1: Or there might be like a teacher who victimises one of his pupils, like might not like his pupil, or might not like his pupil's big brother, might have a problem with his big brother, so he takes it out on this pupil.

FACILITATOR: DO YOU THINK SCHOOLS AND TEACHERS CAUSE MENTAL HEALTH PROBLEMS? OR ARE THEY THERE TO HELP YOUNG PEOPLE DEAL WITH MENTAL HEALTH PROBLEMS?

Participant 2: Both, because some teachers cause it, well they don't cause it primarily, but they help it to develop, but some teachers support and things like that, with one to one, they try to make it, they try to help.

FACILITATOR: WHAT DO SOME TEACHERS DO AT SCHOOLS THAT CAN CAUSE MENTAL HEALTH PROBLEMS? HOW DOES THAT COME ABOUT?

Participant 1: There might be somebody, like say in PE, that's really slow, they could be doing laps, the teacher instead of encouraging them, could be like 'hurry up, my gran does faster laps'. (14-15 year old males)

Teachers affected mental health in a negative way. While a more common view among male participants of all ages, it was by no means exclusively a male issue. Some females could identify instances when teachers had made them "feel stupid" or had "bullied them". For example:

"Puts you down, get told we're going to fail exams and stuff, and you don't feel good about that subject." (14-15 year old female)

Pressure and stress of exams not only at school but pressure from parents to do well, was having a detrimental impact on young people's mental health. It was only in relation to the subject of exams that the notion of stress and how to deal with it was raised in schools:

"All they talk about is stress, exams, I mean that's just, you're being stressed out because the actual word "exam" just stresses you out. And the only time they talk about it is when exams are coming up." (16-18 year old, mixed group)

Not everyone found stress and pressure as having a negative effect:

"A slight amount of stress can keep you going, you don't want to be sitting there relaxing all day, you need to worry a bit. This school does very well in the exam results, I'd say, yes, it's because they do put people under pressure to do well, and I'd

say that kind of stress is a good thing." (16-18 year old male)

It was hinted that racism affected how supportive teachers were to black and ethnic minority pupils:

Participant 1: *Well, see the thing is that when they say they'll be here to help and that...*

Participant 2: *They forget to put in the back, only if you're white.*

Participant 3: *That is so not true*

Participant 1: *That is so true.*

Participant 4: *It depends which the teacher is.*
(16-18 year olds, mixed group)

This suggests that the experience of racism within school, even within one group of young people from an ethnic minority background, was mixed. It does indicate that teachers' attitudes are a major influence on young people and how supported they feel at school.

4.3.2. Positive impact

On the positive side, there was also a perception that some teachers did recognise when pupils were suffering from stress and went out of their way to help them to cope better. Some considered teachers to have a definite role in helping develop and support pupils so that mental health problems were prevented in the first place, but also to help them when they did have problems:

"If they find something you are good at and it could make you feel better, or they could help you work on the problem you've got" (12-13 year old female)

Guidance teachers were cited as a possible, if limited, source of support in difficulties but again issues around confidentiality were strongly expressed and it was doubted that they would confide in teachers in all instances as:

"Sometimes you don't want people to find out." (14-15 year old female)

The implication being that confiding in one teacher would mean that a young person's problems would be broadcast in the staff room. In one school, younger females commented that they would not confide in their guidance teacher as "our guidance teacher's a man". In other schools this did not seem to be the case and pupils were linked with guidance teachers of the same sex.

In the face of criticism, facilitators prompted for whether there were teachers who did support pupils with mental health problems and who encouraged and promoted mental health in a general way. Participants gave a few examples. A group of 14-15 year old males were clear that a 'good teacher' was one that lets pupils know when they have done well and encouraged them to continue doing well or to do better, and conversely if they did something wrong, a supportive teacher always gave them another chance.

4.4. Preferred role of schools

Participants held conflicting views about how they saw the role of schools and teachers in promoting mental health. Some were sceptical about schools having any role whatsoever in promoting mental health. Within one group of older teenage males (16-18 years), there was a narrow view of school as "to teach people or to give people education" while in contrast,

was a view that the atmosphere created within classrooms was the responsibility of teachers and that this had a direct impact on pupils' well-being and thus their ability to learn. The way teachers related to pupils was of vital importance in promoting, or not promoting mental health, a view endorsed by Young Minds (1996):

"A teacher is in a key position to promote the mental health of his or her students through teaching, establishing clear rules, providing encouragement and setting a good example. The teacher can also do a great deal to help those with problems..." (p42)

Another theme to emerge was that it was just not the "done thing" to talk about mental health issues at school. Again this alluded to the perceived stigma of mental health problems or illness and the private and personal way most people dealt with such problems. There was a perception that it was "very personal" and "some things you just keep to your home life". By doing more to tackle issues around mental health and illness, some thought schools could increase understanding and reduce the stigma of mental illness:

"You could help some people that were ill. Like if you don't know a lot about them then you feel like they've a problem, if they're messed up you could realise you could do something to help them, they've got feelings and stuff. (14-15 year old male)

"Then you wouldn't judge a person; you'd get to know how they feel. You wouldn't be judging people and that, like you don't know anything about it but just judging instead of knowing why they're like that" (14-15 year old female)

A minority view was that young people themselves would be the best sources of support with mental health issues especially if they have experienced problems, and some suggested that tackling issues within small groups of 4-6 young people as in the focus groups would be an effective approach. An evaluation of the impact of peer education programmes in raising awareness of mental health issues (Penumbra, 2001) would seem to support this view. It found peer educators had helped to significantly change attitudes and increase young people's understanding of mental health issues. They also concluded that few teachers had received specialist mental health training.

4.5. Summary

Not surprisingly perhaps, schools and teachers did not appear to be directly involved in addressing the subjects of mental health or illness. They were doing this only cursorily and as ad-hoc inputs, which depended upon the interests of certain teachers rather than a strategic approach by the whole school. Participants felt that schools and teachers had a mainly negative impact on their mental health but they also recognised the benefits of having supportive teachers and of classroom environments that were positively encouraging. They did not consider it sufficient only to have input on stress and how to deal with pressure when exams were looming. While some were doubtful that schools and teachers had any role in promoting mental health when their proper domain was teaching and education, there was a contrasting view that they should be centrally involved. Their role in promoting mental health had yet to be explored and there was suggested to be untapped potential for peer education in raising awareness and providing empathetic support.

5. Discussion and Reflection

This research has highlighted a major confusion in the minds of young people about the terms mental health, mental health problems and mental illness, which should perhaps not be surprising given that current professional use of these terms is often inconsistent. It has in fact been difficult to be consistent even within this research report in an attempt to reflect the different nuances of meaning attached to these words. In some contexts, mental health problem is used to encompass mental illness but in others, it is used to imply a continuum of difficulties from less severe mental health problems that can affect anyone, to more severe mental illnesses that affect a minority of people (sometimes referred to as severe and enduring mental illness). Whether or not, 'mental health' is acceptable to professionals, it is certainly not a term that is common currency among lay people, especially young people and its association with problems and illness strongly suggest it is time for a fundamental rethink about the terms used. As suggested by young people in this study and the Scottish Public Mental Health Alliance (2002), it is perhaps time for other terms such as well-being to be considered.

Many young people in this study confused mental health with learning and physical disabilities, making an uninformed assumption that having an unusual or different appearance was enough to label someone as having a mental health problem. Further, they attached largely negative interpretations to mental health problems and mental illness and while it was considered acceptable to talk about being under stress or feeling depressed, it was less acceptable to admit to having a mental health problem or mental illness. As long as such narrow perceptions go unchallenged, mental health will not receive the important attention it deserves in any community health strategy. As Sellen (2002) argues, it would seem to be a huge task to reclaim the importance of promoting and achieving mental health:

"The pursuit of physical well-being is perceived as an everyday and positive activity. Yet the pursuit of mental well-being is understood quite differently – as an activity reserved for those who are mentally ill or for adults with a professional interest in mental health. Or alternatively, as a highly self-indulgent pastime for adults who can afford the time and money to pursue their inner selves in therapy." (Sellen, 2002, p27)

The young people in this research demonstrated that among the youth population there is a wide spectrum of views and knowledge on mental health and illness, a view not entirely reflected by other research. A survey for Mind out (2001) for instance has suggested that young people are more likely to have ill-informed or discriminatory attitudes on mental illness than the general public. The wider spectrum of views and knowledge among the 60 participants in this study perhaps offers some optimism and a stronger basis for future programmes of health promotion.

While there has been a focus on drugs and sex education with young people in schools, mental health appears to have been a neglected area. This is clearly changing albeit slowly, as this research found evidence of some helpful approaches being taken by individual teachers and schools. However, the misinformation and prejudices found in this study provide strong argument for more direct and focused action with young people within schools. While there is much to be commended about schools' approach to tackling bullying and how to deal with stress specifically, there is little to commend their approach to mental health per se.

On a final note, it should be acknowledged that this is a key area of current policy and practice development in Scotland. Indeed the purpose of this study was to ensure that the planned programme of action in Glasgow was firmly rooted in young people's perceptions

and language. A recent conference "Mind the Gap" organised by Children in Scotland in association with Penumbra and the national programme to improve the mental health and well-being of Scotland's population further brought together professionals from education and other fields and concluded that:

- Schools need to adopt a whole school or holistic approach rather than an individual approach
- Schools need to be places where teachers as well as pupils can be mentally, emotionally and socially healthy
- Development and promoting resilience should start from an early age
- Teachers need support to promote mental health.

(Children in Scotland, 2002, p16)

In developing such an approach, it will be important to listen to the voice of young people as expressed in this and other research and to tailor the approach accordingly.

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6. References

- Campbell L, (2002) Mental health, *Children in Scotland* November, p13.
- Children in Scotland (2002), *Children in Scotland Magazine*, November 2002.
- Department of Health, (2002?), *Talking about it. Promoting Mental Health in Schools. An Education Resource*, Southampton: Meridian Broadcasting.
- Ewles, Simnett, (1995), *Promoting Health. A Practical Guide*. 3rd Edition, London: Scutari Press
- Gordon J, Grant G (Eds), (1997), *How We Feel. An Insight Into the Emotional World of Teenagers*, London: Jessica Kingsley Publishers Ltd.
- Grafton P, (1994), *Mental Talk: Two Years of Talking to Secondary Pupils About Mental Illness*, Paisley: Renfrewshire Association for Mental Health
- Health Education Authority, Bliss, (1996), *Positive Steps: Mental Health and Young People. Attitudes and Awareness Among 11-24 year olds*, London: Health Education Authority.
- Masters H, Pavis S, Cunningham-Burley S, (1995), *Lay concepts of positive mental health and how it can be maintained*, Pilot Study Report,
- Mental Health Foundation, (1999), *Bright Futures. Promoting children and young people's mental health*, London: Mental Health Foundation.
- Mind Out (2001), *Change your mindset. An activity pack for youth groups about discrimination and mental health*, London: Mind Out for mental health
- Pearce J, (2002), *Must Do Better*, *Community Care* 12-18 September 2002, pp34-35.
- Penumbra, (2001), *The Impact of the Peer Education Programme in Raising Awareness of Mental Health Issues. Borders Youth Project Young People's Voice 1998-2001*, Edinburgh: Penumbra.
- Scottish Executive, (2000), *Well? Mental Health and Well Being in Scotland, Well?*, September 2002.
- Scottish Executive, (2000), *Towards a Healthier Scotland*, Edinburgh: Scottish Executive.
- Scottish Executive, (2000), *Our National Health: A plan for action, a plan for change*, Edinburgh: Scottish Executive.
- Scottish Executive, (1997), *A Framework for Mental Health Services in Scotland*, Edinburgh: Scottish Executive.
- Scottish Health Feedback, (2001), *A study of the health needs of young people with experience of being in care in Glasgow, for the big step*, Edinburgh: SHF.
- Scottish Health Feedback, (1998), *A Study of the factors affecting the emotional health of young people in Craigmillar, for Lothian Health Promotion Department*, Edinburgh: SHF
- Scottish Needs Assessment Programme (SNAP), (2000), *Mental Health Promotion among Young People*, Glasgow: Office for Public Health in Scotland.

Scott Porter Research & Marketing Ltd, (2000), *Young People and Mental Well-Being – A Qualitative Research Report*, Edinburgh: Health Education Board for Scotland.

Sellen J, (2002), Getting Started – opening a dialogue with young people, *Young Minds Magazine* 61, pp24-27.

The Scottish Public Mental Health Alliance, (2002), *With Health in Mind – Improving mental health and wellbeing in Scotland: A document to support discussion and action*, Edinburgh: Scottish Development Centre for Mental Health.

West P, Sweeting H, (1996), "Background, Rationale and Design of the West of Scotland 11 to 16 Study", Working Paper No 52, Glasgow: Glasgow University Medical Sociology Unit.

Young Minds, (1996), *Mental Health in Your School: A Guide for Teachers and Others Working in Schools*, London: Jessica Kingsley Publishers

Young R, Sweeting H, West P, (2000), "The West of Scotland 11 to 16 Study. Basic frequencies of the 15 year old (S4) sweep.", MRC Social & Public Health Sciences Unit Working Paper No 2, Glasgow: Medical Research Council.

Appendix 1 Focus Group Topic Guide

Topic guide to explore young people's perceptions of 'mental health' & 'mental illness'

Introduction

The main purpose of the focus groups is to explore how young people (aged 12-18 years) perceive 'mental illness' and the extent to which, they believe mental illness is something that might affect young people like themselves or not. Alongside this, it is to see what, if anything, they understand by the umbrella term 'mental health', and whether they relate to a notion of positive mental health with mental health problems and mental illness as part of a spectrum. The research will inform school-based interventions to promote better understanding of mental health issues in young people.

GGNHSB identified four key research objectives. These were to:

1. Explore young people's understanding of mental health: the terms used to describe it, the factors that determine both mental health and illness;
2. Gauge young people's perceptions of mental illness
3. Explore young people's understanding of the risk factors or causes of mental health problems and mental illness
4. Explore the attitudes of young people towards those suffering from or experiencing mental health problems and/or illness

There are no 'right' and 'wrong' answers; we just want to find out what they think and what the terms evoke for them.

Explain that the research involves 12 focus groups – 10 in school settings and 2 in youth organisations in Glasgow.

Give usual reassurances about confidentiality and privacy and set the ground rules for the group.

4 Key topics to address:

1. Young people's interpretation of 'mental health' and the factors that influence mental health and create problems.
2. What the term 'mental illness' evokes for young people.
3. Young people's experiences and knowledge of mental illness and the support and treatment available.
4. Misconceptions and prejudices.

What we would like to cover under each of these topics is as follows: -

1. Understanding of 'Mental Health'

Using the Ewles & Simnett questionnaire, start out by exploring what 'being healthy' means to young people. The purpose is to use a 'non-threatening' way to lead into the subject of 'mental health' as well as one that has an element of participation. (Scribe to record results on flipchart as instructed by facilitator). Draw on the results to suggest they have identified health in either predominantly physical or mental health terms. Move on to asking more directly how statements from the questionnaire relate to mental health. For instance, you could ask –

- What happens when a young person is not at peace with himself or herself? *(To find out about their understanding of mental health problems)*
- Why might this happen? *(Identifying causal factors)*
- Is this something that could happen to any young person? Why? *(How common mental health problems are)*

Next, I'd like you to ask participants to brainstorm all the words and images evoked by the term 'mental health' and for the scribe to record this on a flipchart. Use these words to stimulate discussion. The object of the exercise is to encourage them to be as honest as possible, emphasising that this is not a test and that the most important thing is to find out what they think.

2. 'Mental Illness'

We need then to explore in a broad way what the term 'mental illness' evokes for young people and the kind of associations it has for them (both positive and negative). A way of introducing the topic would be to say 'We've been exploring mental health now I want you to think about what 'mental illness' means to you'. The following questions might be helpful:

- How do you know if someone is mentally ill? *(Exploring if they have ideas about the appearance and behaviour of people with mental illness)*
- Can you tell they're mentally ill? How?

On a flipchart have the words 'Mental illness' written at the top and ask participants again to brainstorm what these words evoke for them, ask them to think both of the images and words that spring to mind. Again, it's about encouraging young people to be as open and honest as they can. Ask them to shout out all the words they know, even if they seem negative and emphasise that we will not be judging them and are only interested in hearing what they think.

To round off this exercise, it would be useful to put the 2 flipchart sheets side by side and ask participants whether they found it easy to do, what's different about them and whether it's easy to tell the difference.

3. Experience & Knowledge of Mental Illness

The third area we want participants to explore is what they know about mental illness and its treatment and support. First, ask what they know about different types of mental illness. Ask them if they can name any and if they can, what they know about these illnesses. If they're unable to think of any, introduce illnesses such as anxiety, depression, schizophrenia, paranoia etc and find out whether they've heard these terms and what they know. It is of interest whether young people consider depression or eating disorders such as anorexia or

bulimia as mental illnesses or whether they tend only to identify illnesses such as schizophrenia. It is important to know what words they use as well as their general understanding. A key source of information outside personal experience will be soap operas and Big Brother.

A sub topic concerns finding out what they know about support and treatment for mental illness. Many think of hospital treatment as typical so it will be interesting to ask about what they know about treatment options and especially about what's available for young people.

4. Exploring misconceptions

Finally, to examine common misconceptions around mental illness, I'd like you to focus a discussion around the 2 statements below. Ask participants if they agree or disagree with them and why. These will (hopefully!) encourage different viewpoints to be expressed that can be probed in more depth.

- People are born with mental health problems
- and
- Schools and teachers have nothing to do with mental health

[If after all this you still have time, you could introduce other statements such as:

- You can't recover from mental illness
- Anxiety is a mental health problem
- Depression is a mental health problem
- Down's syndrome is a mental illness]

Finish by asking whether mental health and mental illness are topics that have been covered at school.

Follow up support

It is possible that despite the most skilful facilitation that some young people might still be vulnerable after this discussion. It will therefore be important to offer a contact point so that they can ask about anything from the discussion that they'd like to know more about or that has raised issues for them. GGNHSB will supply cards with a telephone number for Breathing Space. These can be distributed at the beginning or end to everyone.

Appendix 2: Terms used by participants to describe mental health and mental illness

Focus Group 1 – Mixed youth group, 16-18 years

Mental Health

Illness
Stress
Depression
Anti-social
Pressure
Peer Pressure
Education
Smoking
Taking drugs
Try to commit suicide
Getting sick of everything

Mental Illness

Depression
Disability
Shouldn't be ignored
Disability allowance
Pain
Not being able to do much
Euthanasia
Assisting suicide

Focus Group 2 – 12-13 year old females

Mental Health

Stress
Anger
Depression
Drinking
Drugs and Drug Abuse
Fighting
Confused
Upset
Lonely
Unhealthy
Smoking

Mental Illness

Depression
Upset
Confused
Need psychiatric help
Need a lot of help
Pills
People in white jackets
Medicines
Home help
Mental home

Focus Group 3 - 14-15 year old females

Mental Health

Being happy or depressed
State your mind and how it affects you
Brain haemorrhage
Stroke- confusion
Dementia – confused

Mental Illness

Schizophrenic people
People whose minds don't function properly
Depression
People who are not right in the head
Try and hurt themselves

Group 4 – 12-13 year old males

Mental Health

Brain Damage
Autism
Learning Difficulties
Not Being Right in the Head
Cheeky
Hurting Other People
Way You Think

Mental Illness

Levendale
Place with padded rooms
Mental house
Weird house
Walks strange
Imaginary friend

Focus Group 5 – 16-18 year old females

Mental Health

Depression
Unhappiness
Not content
Just ill
Low self-esteem
Unmotivated to do things
No confidence
Long term thing

Mental Illness

Depression
Schizophrenia
Eating Disorders
Mental Institutes (Levendale)
Isolation
Suicide

Focus Group 6 – 14-15 year old females

Mental Health

Disturbed people
Depressed
People need more attention
Moody
People with disabilities

Mental Illness

People have accidents and recovering
Traumatized
Stress (cause)
People look different
People call you nasty names
People make fun of them
Mongol,
Spazzy,
Psycho
Brain damage
People scared because they are different
No control over their actions
Dementia – old people.

Focus Group 7 – 12-13 year old females

Mental Health

Open minded
Doing Stuff in PSE
People who have got mental illness
Mentally confident
Anorexia
Bulimia
Alcoholic
Drug Dealers
Folk who take drugs- Junkies
Paedophiles
Prostitutes

Mental Illness

Dumb- Brain doesn't work
Psychos
Disabled People
Handicapped people
Anorexia
Bulimia
Junkies
Drugs
Alcohol

Focus Group 8 – 14-15 year old males

Mental Health

Brain
Working inside
How you feel
What you do
Hospitals
What's happening
What you do
How you do it
Why you do it
Mental pleasure
Thoughts
Games
Memory
Holiday
PlayStation
Entertainment

Mental Illness

Why people are different
Paranoid
Weakness
Disability
What they do for pastime
Why they are like that
Depression
What other people think about them
Feel sad for them
Advantage
Not being able to see
Paralysed

Focus Group 9 – 12- 13 year old males

Mental Health

Crazy
Dizzy
Mental institutions
(Shaky)
(Demented people)
(Mental people)
Mental hospitals
Mental illness
Ambulances
Murderers
Terrorists
Straitjackets
(Psycho killers)
Gas chambers
Psychotic

Mental Illness

Diseases
Crazy (Illnesses)
Brain damage
Drugs
(Hospital)
Hitler
George Bush (he likes war)
Terrorists
Psycho
Saddam Hussein
Tony Blair
Wild dogs
Flu's and colds
World Trade Centre

Focus Group 10 - 16-18 year old males

Mental Health

Peace of mind
Depression
Eating Disorders
Neurosis
Lunacy
Shrinks – Psychologists
Stress
Victorian mental home/hospital
Care in community
Extremes
Schizophrenia

Mental Illness

Lunacy
Stress
Schizophrenia
Victorian Mental home/hospital
Extremes
Neurosis
Depression
Psychologists
Eating Disorders

Focus Group 11 – 14-15 year old males

Mental Health

Disabled
Emotions
People who can't look after themselves
How capable you are
Depression
Outlook
Being happy
Schizophrenia
Limits on what you can do
Learning difficulties
Paranoid about weight
Stress

Mental Illness

Schizophrenia
Dyslexia
Autism
Wheelchairs – how people might feel
Diane P
Tourettes
Alzheimers
Depression
Bulimia
Anorexia

Focus Group 12 – Mixed group (male only) 16-18 years

Mental Health

Illnesses
Loonies

Handicaps
Psychos
Alcoholics
Drug addicts
Junkies
Way brought up
Abused
Spotty
Fat
Too much money
Spoilt
Rich kids –no pals
Strength
Lot of strength to get through it
Physical strength
If homeless need strength to get through it
Wee uns in Africa starving

Mental Illness

Handicap
Pensioners – getting old, forgetting, not looking after themselves
Psychos – killing people, get away with it
Disturbed mind
Seeing someone killed – dream about it
Diseases – Aids/HIV
Obese
Disabled – People in wheelchairs
Brains not functioning
Perverts – child abusers/lifers
God told them to kill them
black/ethnic people, get brainwashed

APPENDIX 3 – Ewles & Simnett (1995) Questionnaire – What does 'being healthy' mean to you?

WHAT DOES 'BEING HEALTHY' MEAN TO YOU?

<i>For me, being healthy involves:</i>	Column 1	Column 2	Column 3
1. Enjoying being with my family and friends	_____	_____	_____
2. Living to a ripe old age	_____	_____	_____
3. Feeling happy most of the time	_____	_____	_____
4. Having a job	_____	_____	_____
5. Hardly ever taking tablets or medicines	_____	_____	_____
6. Being the ideal weight for my height	_____	_____	_____
7. Taking regular exercise	_____	_____	_____
8. Feeling at peace with myself	_____	_____	_____
9. Never smoking	_____	_____	_____
10. Never suffering from anything more serious than a mild cold, flu or stomach upset	_____	_____	_____
11. Not getting things confused or out of proportion - assessing situations realistically	_____	_____	_____
12. Being able to adapt easily to big changes in my life such as moving house or a new job	_____	_____	_____
13. Drinking only moderate amounts of alcohol or none at all	_____	_____	_____
14. Enjoying my work without too much stress	_____	_____	_____
15. Having all the parts of my body in good working condition	_____	_____	_____
16. Getting on well with other people most of the time	_____	_____	_____
17. Eating the 'right' foods	_____	_____	_____
18. Enjoying some form of relaxation or recreation	_____	_____	_____