

“Nobody has ever asked me that”

*Reimagining mental health care through collaborative research
with young people from New Zealand.*

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For Rae

Abstract

The past decade has represented a remarkable turning point for youth mental health around the world. Notably, awareness has increased of the challenges facing traditional youth mental health services and the need to address these. However, historically, little attention has been turned to the voices of young people themselves and the role they may play as active participants in the process of renewing and rejuvenating mental health services. While an international body of literature is growing which attends to young people's perspectives on improving mental health care, relatively little research which collaborates with young people has been conducted within New Zealand. The research described in this thesis aims to address this gap in our theoretical and clinical understanding by working with New Zealand's young people to envision a mental health system which truly works for and with them.

This study involved eight participatory workshops conducted in six locations across New Zealand. Ninety-four young people ranging in age from 16 to 25 participated in these. The workshop methodology was inspired by participatory action research and incorporated a series of mixed-medium activities including surveys, focus-group style discussions, responses to prompts, creative work, and presentations.

A thematic analysis was conducted on the transcriptions of these workshops which explored how young people envisioned their ideal mental health service. The results of this analysis were split into two broad categories: firstly, participants' preferences regarding mental health professionals and secondly, mental health services themselves. There were five themes related to young people's ideal mental health professional. These were: a clinician with whom they shared a background; who is friendly; professional; respectful; and responsive to their individual needs. Seven themes were identified which related to young

people's ideal mental health service. These themes were: a place that is comfortable; accessible; welcoming; embedded in the community; holistic; adaptable; and youth focussed.

The young people who participated in this study articulately described their visions for mental health care. The results of this project demonstrate that young people can be empowered to contribute to novel, creative, and germane solutions to the problems facing youth mental health care. Additionally, these results may be effectively incorporated with research informed practices from around the world to recommend changes to the practices of both mental health clinicians and services in New Zealand which could improve the engagement of young people in services. This supports a future for collaborative service design both within New Zealand and internationally, which draws on the expertise of young people and research informed best practice.

Contents

Abstract	iii
Contents	v
A note on structure	1
Chapter One: Introduction and Literature Review	2
Introduction	3
Literature review	8
Mental health: A global challenge	8
Youth mental health: An unprecedented need.	10
Youth mental health in New Zealand: A global mirror	12
Youth mental health care and practice: An international predicament	13
Rethinking youth mental health care: A matter of need and urgency	25
Youth perspectives on mental health care: The missing piece	27
The current study	29
Summary	32
Chapter Two: Methodology	34
Epistemological Framing	36
Qualitative methodologies	39
Empowering and critical methodologies	42
Participatory Action Research	44
Research Design	46
Workshop Process	49
Reflexivity	55
Conducting the Study	58
Recruitment	58
Workshop details	60
Participants	61
Ethics	63
Reflections on the workshop method	65
Data-Analysis	69
Transcription	69
Thematic Analysis	72
Rigour: Assuring quality in qualitative research	73
Summary	75

Preface to Findings	76
Chapter Three: Findings.....	78
Methodology	85
Findings	89
A shared background: Someone like me	89
Friendliness: Someone I connect with	91
Professionalism: Someone who protects my space	93
Respect: Someone who treats me as an equal	95
Responds to the individual: Someone who works in the right way for me	96
Discussion	99
Conclusion	107
Chapter Four: Findings.....	109
Methodology	117
Findings	121
A place that is comfortable	121
A place that is accessible	123
A place that will welcome me	125
A place that is embedded in the community	127
A place that treats us holistically	129
A place that is adaptable	130
A place that is youth focussed	133
Discussion	134
Conclusion	139
Chapter Five: Discussion	141
Clinical and Service Implications	153
Future research directions	165
Strengths and Limitations	166
Conclusion	168
Final thoughts	175
Acknowledgments	179
Appendix One: Workshop Materials.....	182
Appendix Two: Recruitment Materials.....	188
Appendix Three: Participant Information and Consent Forms	193
References.....	202

A note on structure

The body of this thesis contains two articles prepared for submission for publication to academic journals. In order to prevent a significant overlap of content, some relevant literature is not reviewed in the introductory section of this thesis and is instead included in the introductions to these papers. For ease of reading, I have signified when this has occurred by referencing the appropriate chapter to refer to for greater detail on this material. Similarly, each of these papers contains its own discussion section in which the findings described in that paper are critically evaluated in relation to both psychological theory and past research. Given the inclusion of these papers, there is some inevitable repetition of content as I draw together the findings from both articles in the final discussion chapter later in this thesis. This discussion expands upon these papers and considers broader implications of the research project presented in this thesis.

Chapter One:

Introduction and Literature Review

Youth mental health and practice in New Zealand and around the world.

Whāia te hauora hinengaro kia puāwai ai te hauora tangata

There is no health without mental health.

Introduction

In February 2019, a Facebook frame reading *I Am Hope* went ‘viral’ in New Zealand (NZ Herald, 22 February 2019)¹. For almost a month, even the most casual social media user was shown dozens of images framed with this phrase while those not online heard news of the campaign through radio promotion and mainstream media reports. This was a fundraising effort produced by the Key to Life Charitable Trust and their Gumboot Up NZ initiative, a charity which raises awareness of youth mental health challenges (I Am Hope, n.d.). Each time the frame was used, a large New Zealand bank donated to their fund providing financial support for young people to seek mental health treatment. Requiring very little time investment from each participant, the mere minutes to update a profile picture, the campaign was enormously popular and raised hundreds of thousands of dollars for the charity. Certainly, the contributing organisations who ultimately made these donations could have done so without any need for the Facebook frame. But the act of creating a meaningful sign of activism on their social profiles appealed hugely to the sentiments of young people, allowing them to adopt an identity as an active and empowered participant in a growing movement towards improving mental health treatment in the country.

While the *I Am Hope* phenomenon took New Zealand mainstream and social media by storm, this viral campaign was not born in a vacuum and its success was not the impetus for a change in public sentiments in New Zealand regarding youth mental health. Rather, this represented a growing shift which had developed over the past five years towards burgeoning public awareness of and concern for the state of youth mental health in this country. It would be impossible to pinpoint a single moment which could represent this transformation in attitudes towards youth mental health, as this was not the result of any one identifiable event

¹ See the New Zealand Herald Article, 22nd February 2019, for a review of the frame’s rise in popularity and impacts as discussed throughout this paragraph.

or person. Rather, awareness of youth mental health both in New Zealand and internationally has been the product of tireless campaigning and years of effort from government organisations, professionals, parents, and young people themselves seeking to disseminate the knowledge of how deeply young people around the world are struggling. Yet, if I was to select the moment when public attention in New Zealand squarely surged towards youth mental health I, like many others, would refer to the 2017 statement by Sir Peter Gluckman, the Chief Science Advisor to the New Zealand Prime Minister, regarding youth suicide. In his statement following the announcement that New Zealand's youth suicide rates were the highest in the OECD (UNICEF Office of Research, 2017), Gluckman emphasised the need for urgent action regarding our youth suicide rates (Gluckman, 2017).

Greater attention is now being turned to how we can meaningfully address these issues since bringing them to public attention. To this end, in 2018 the New Zealand Government held an Inquiry into Mental Health and Addiction which revealed numerous issues and shortcomings in mental health treatment across population groups, including for young people (Paterson et al., 2018). This in part instigated the 2019 Wellbeing Budget put forward by the Labour-led Government, which promised millions of dollars of increased funding for youth mental health care – particularly primary services. While representative of a significant change in both social perspectives and actual government policy, questions remain as to how we can harness the current political and social attention to youth mental health and foster meaningful change to the actual health and wellbeing of New Zealand's young people (Menziez et al., 2020). Indeed, youth mental health in New Zealand can still be described as a 'silent pandemic' (Menziez et al., 2020).

This thesis describes an attempt to capture what young people want from mental health services in New Zealand, with the aim of improving our understanding of how to enhance youth mental health care. It draws from a series of participatory action workshops

held with 94 young people around the country aimed at generating young people's perspectives on ideal mental health service design, and presents findings illustrating young people's vision for the mental health services and practitioners with whom they would like to work.

I begin this thesis by grounding it within my own journey both as a student and a training clinician, which I believe provides important contextualisation for both this project and my process as a researcher. I conducted the research described in this thesis as a component of my Doctorate in Clinical Psychology. I entered this doctoral program as a young woman with a passion for working with other young people, which stemmed from my background as a clinician in peer support services and my experiences with mental health challenges faced by myself, my friends, and my family. I myself had positive experiences with receiving mental health support as a young person, and I became interested in why it was that many of the young people I worked with and knew personally had such negative experiences within mental health care. This personal interest led me to consider what needed to be done to create a system in which all young people felt heard, respected, and understood.

As such, this research project was motivated by a desire to improve our understanding of young people's perspectives of mental health treatment. However, I sought through this research to not simply describe what young people perceived as lacking about their treatment, an area which has already been thoroughly researched around the world. Rather, I hoped to contribute to a growing movement highlighting how services can be adapted to better address the needs of young people. That is to say, this research aimed to move beyond considering what young people *do not* want in mental health services, towards proposing alternative approaches to care which are consistent with their priorities.

I came to this research with my own experience as a clinician, support person, and as a young person with my own history of treatment. As such, it was essential to remain reflexive of how my perspectives coloured the process of research, including my selection of this topic. I was particularly conscious of the need to appreciate young people's capacity to take an active role in their mental health care and to step into leadership positions, and to avoid the pitfalls of positioning myself as the 'researcher' and them the 'researched'. I will refer throughout this thesis to the practices integrated into the research to ensure this process remained rigorous and trustworthy. At times, I will use the first person personal pronoun 'I' to refer to myself. I have done this as it is crucial to the process of reflexivity – the important practice of acknowledging my positioning and presence within the research (Finlay & Gough, 2003). In doing this, I hope to acknowledge the multiple roles I carried throughout this research project. I seek by doing this to highlight that this research, like all research, is not independent of people but inherently tied to my role as researcher. Additionally, the avoidance of personal pronouns can evoke a false sense of objectivity and mistakenly convey that in order to be valid, scientific research must be void of human influence (Webb, 1992). I also, at times, use the third person personal pronoun 'We' when the decisions described are not only my own, but also involve the perspectives and advice of other members of the research team. This will particularly occur in Chapters Three and Four which present the findings of this project, as the process of conducting qualitative analysis is inherently collaborative and these chapters contain publications that were co-authored with my supervisor.

Additionally, to help illustrate the perspective from which I operated throughout this project, at the start of each chapter I have included whakatauki. Whakatauki are proverbs for Māori people, the indigenous people of New Zealand, and an important part of my own heritage. I have selected each whakatauki with the intention of making visible my positioning

and mind-set at each stage of conducting this research and writing this thesis. By including these, I hope to continue acknowledging my role within this project and my orientation as a young researcher and practitioner in the field of mental health. The use of whakatauki also positions this thesis within the place it was conducted, Aotearoa New Zealand, providing context and grounding.

Literature review

In order to provide a context for the research, this introductory chapter considers the realities of youth mental health and its care both around the world and in New Zealand. I focus particularly on the short-comings of conventional mental health care for young people, and turn attention to strategies for improving engagement with and outcomes of treatment for young people. I then situate the research project conducted and presented in this thesis as rooted in a growing international movement seeking to centre the voices of young people in decisions about their own treatment and care. This project will draw on this body of literature to explore the perspectives of New Zealand's youth on how mental health services could be improved.

Mental health: A global challenge

Mental health presents a substantial challenge in all world regions, including both developed and developing countries (Whiteford et al., 2013). Data from the Global Burden of Disease Study (2019) has found that in the past five years, global deaths and days living with disability as a consequence of mental health difficulties have continued to increase steadily. The impact of mental disorders on the global population amounts to millions of lives affected each year, a number which does not even begin to account for lives impacted by mental health problems which do not meet the criteria for a diagnosable mental disorder (Goldman & Grob, 2006).

In the past few decades, interest in improving population health through preventing and treating mental ill-health has increasingly become an area of public health concern (Whiteford et al., 2013). However, while interest has grown, mental health services continue to lag behind need in all regions of the world (World Health Organisation, 2019). In acknowledgment of this international need, in 2019 the World Health Organisation launched

a special initiative to improve mental health care around the world, which follows on from their previous mental health action plan (World Health Organisation, 2013). This project focusses particularly on mental health care in developing countries, however, no country has achieved acceptable standards of mental health care (World Health Organisation, 2019). As Shekhar Saxena, former director of the Department of Mental Health and Substance Abuse at the World Health Organisation stated: “When it comes to mental health, all countries are developing countries” (Davies, 2018). This quote highlights that no country has a ‘world-class’ mental health system and all are in need of attention (Davies, 2018).

This global situation is mirrored within the New Zealand population, with estimates that at least half the New Zealand population will experience difficulties with their mental health during their life (Kessler et al., 2007). A national survey of mental health estimated that the 12-month prevalence of diagnosable mental illness in New Zealand was 20.7% (Wells et al., 2006). This amounts to an extremely significant proportion of the population impacted by mental ill-health each year, demonstrating the necessity of rapid, high-quality work to decrease this rate and lessen the negative impact of mental health around the country. This impact is considerable, with anxiety and depressive disorders the ninth and tenth most prevalent causes of disability and death in New Zealand, thus amounting to a significant portion of New Zealander’s days living with disability (Institute for Health Metrics and Evaluation, 2019). Alongside anxiety and mood disorders, New Zealand also has high prevalence rates of other mental health challenges, including substance use and eating disorders (Wells et al., 2006). Unfortunately, it is not possible to determine whether there has been a significant change to these rates in recent years as there has not been a large scale mental health survey conducted in New Zealand since this study.

Youth mental health: An unprecedented need.

The mental health of young people is of particular concern globally. In comparison to other age groups, adolescence and young adulthood are the peak periods of onset for mental health challenges (Coughlan et al., 2013), with particular spikes in the prevalence of mood disorders including depression (Eyre & Thapar, 2014). Most mental health challenges that may impact a person throughout their life including mood disorders, anxiety disorders, substance use, and psychotic disorders emerge during a person's youth (de Girolamo et al., 2012). Age of onset is earliest for phobias and impulse control disorders, with onset in late childhood and early adolescence, while substance use, psychosis, anxiety, and mood disorders all have an average age of onset in a person's late teens to twenties (Kessler et al., 2008).

One in five young people will experience diagnosable mental health challenges without even accounting for the many more who will experience 'sub-threshold' mental distress (Kieling et al., 2011). This amounts to millions of young people whose lives are significantly impacted by mental ill-health. Data from the World Health Organisation suggests that mental health challenges are the most significant contribution to the burden of disease on children and young people worldwide (Erskine et al., 2015). Globally, mental and substance use disorders account for a quarter of all years living with disability for young people, and in high-income countries are the leading cause of disability for young people (Erskine et al., 2015). This research suggests that in developed countries, more young people are affected daily by poor mental health than by any physical illness.

This crisis in youth mental health should be of enormous concern for both moral and ethical reasons and for the significant impact it will have and continue to have on the lives of the young people affected, their families, and their broader communities (Patel & Farmer,

2020). Perhaps the most concerning outcome of poor mental health for youth is that mental distress that emerges during youth is not restricted to a person's early years. Around half of all lifetime mental health problems will have had their onset by a person's mid-teens, and by age 25, more than three-quarters of all lifetime disorders will have begun (Kessler et al., 2008; McGorry et al., 2007). That is to say, the majority of lifelong mental ill-health will begin in a person's youth. Adolescent mental health difficulties significantly increase the risk of being diagnosed with a mental health challenge in adulthood, and most adult disorders have a first episode in adolescence (Eyre & Thapar, 2014). At least 60% of those who experienced an adolescent episode of mental ill-health will experience at least one more as an adult (Patton et al., 2014). As such, poor mental health for young people not only causes immense pain during youth but for many young people can lead to a lifelong struggle with their mental health, which will contribute to the burden of and days lost to disability as they reach adulthood.

Poor mental health impacts lives not only through the immense personal psychological pain of mental ill-health, but also through its impacts on many other areas of a young person's life. Mental ill-health commonly results in days away from formal education and work, which has enduring implications for a young person's growth and development (Kieling et al., 2011). Poor mental health in young people is also linked to several other concerning outcomes, including lower educational achievement, substance abuse, violence, and poor sexual health (Patel et al., 2007). These outcomes suggest that youth mental health has a significant impact on a country's future workforce (Kieling et al., 2011). It is crucial that youth mental health is taken seriously and not dismissed as expected, problematic teenage behaviour. The concerns of youth are genuine and can have long-term impacts on their lives and communities (Summerhurst et al., 2017).

Youth mental health in New Zealand: A global mirror

The landscape of youth mental health observed worldwide is reflected within New Zealand and our population of young people. While the broader public is increasingly acknowledging and turning attention to this, poor youth mental health in New Zealand should not be considered a new phenomenon. Large samples of New Zealand youth surveyed in the past two decades, beginning with a survey of secondary school students in the 2000's, found high levels of mental distress among young people (Coggan et al., 2003). Te Rau Hinengaro, a national survey of health conducted in the 2000's, established that within New Zealand, the twelve-month prevalence of mental health challenges is highest in younger age groups, particularly in young Māori (Baxter et al., 2006). Findings of a high prevalence of mental distress among youth have been replicated since the early 2000's. The Youth'12 survey of New Zealand secondary students found that at least 13% of young people experienced depression (Clark et al., 2013). This study of New Zealand secondary students revealed high distress rates, with close to a quarter of young people having self-harmed, 15.7% having experienced suicide ideation, and 4.5% having made a suicide attempt (Adolescent Health Research Group, 2013). The most recent data from the Youth'19 survey found that rates of depression had increased since 2012 to 23%, with rates of 'good emotional wellbeing' falling to 69% of young people (Fleming et al., 2020). This would suggest that as close to a third of New Zealand's young people are experiencing mental distress of some kind.

These high rates of mental ill-health and distress, including high levels of self-harm and suicidal behaviour, are profoundly concerning (Fleming et al., 2020). This is particularly true when considering the international body of literature suggesting these mental health challenges can persist throughout a persons' life. This has also been found in New Zealand, with the median age of onset for lifetime mental health challenges which may persist across the life course being 18 years (Browne et al., 2006a). The Christchurch Health and

Development Study also found a significant association between the extent of a young person's depression from ages 17 to 18 and their later rates of depressive disorders, anxiety disorders, suicide ideation, and suicide attempts as an adult (Fergusson et al., 2005). This also suggests there is need to address youth mental health in New Zealand if we wish to change the course of mental health across the lifespan.

While the youth mental health situation in New Zealand has been well documented over the past several decades, findings continue to emerge which suggest youth mental health in this country may be further deteriorating in recent years. Some studies have suggested a significant increase in low mood, depressive symptoms, and self-harm for young people aged over 16 since 2002 (Fleming et al., 2020). Additionally, at least one in five young people with mental health challenges have struggled to access help when they sought it (Fleming et al., 2020). Increased attention to this has brought a cry for action to improve these statistics and a call for accountability to address why it has taken so long for significant action to be taken. In particular, questions have been raised about the nature of mental health care and support for young people across the country. These questions have often drawn on the international body of literature and discussions about mental health treatment for young people worldwide.

Youth mental health care and practice: An international predicament

In high-income countries, limited access to high-quality mental health services is a very concerning issue (Patel et al., 2007). This is particularly true for young people, with the overwhelming majority of young people's mental health needs going unmet without access to appropriate care and treatment (Patel et al., 2007). In fact, despite all findings which suggest young people aged 12-25 are in greatest need of mental health intervention, this group has the most inadequate service access of any age group (McGorry et al., 2013). Given the attention being turned to the extent of youths' mental health challenges, many are likely alarmed to

learn that so few young people have their mental health needs met. Many factors contribute to this. This includes factors within young people, like low mental health literacy and engagement, and service factors, including poor accessibility and inappropriate care models. In this section, I review some of these issues. Many of these will be described in greater detail in Chapters Three and Four.

Issues with traditional youth mental health services: Poor engagement

One commonly described issue with traditional mental health services is that these may not be adequately acknowledging and responding to the challenges of engaging young people with services. It has been reported that potentially as few as one-fifth of all young people with a diagnosable mental health disorder will seek professional help (McGorry et al., 2013), and those with a diagnosable disorder represent only a small portion of young people experiencing mental distress. Poor help-seeking behaviour among young people has also been reported to be a significant issue in New Zealand specifically, with one study finding 82% of students with significant mental health problems had not sought help from a professional like a general practitioner (Mariu et al., 2011). This is an unacceptably low level, and we must question what aspects of traditional mental health services may be contributing to this (or, alternatively, in what way services may be able to promote improved service engagement). This may not be something we can understand without feedback from young people themselves, who can act as informants as to why engagement with professional services remains limited.

Past research has suggested some issues that may contribute to limited engagement in services for young people. It has been suggested that young people may be less likely to engage with mental health care when the services available to them are perceived as unsuitable to meet their needs or irrelevant to their lives (Summerhurst et al., 2017). This is

consistent with other research which has demonstrated that young people can be deterred from seeking help to address their mental health problems when there are no youth-specific services available (Cosgrave et al., 2008). Therefore, to effectively engage young people, services may need to address the ways in which they are designed and perceived in order to be considered more relevant, useful, and consistent with youth values. This issue has been a topic of extensive discussion for several decades. In 2005, Rickwood et al. stated that Australia needed to identify effective mental health services that young people would use and which could meet their real needs in order to prevent mental health problems continuing to be an obstacle for young people. It may be time for New Zealand to similarly consider how our services can adapt to the priorities of young people.

However, encouraging young people to reach out for help when they need it is an extremely complex issue (Coughlan et al., 2013). Help-seeking is a complicated action which involves taking the personal feeling of psychological distress and translating it into the interpersonal process of seeking help from others (Rickwood et al., 2005). Help-seeking is a style of approach coping and is considered an adaptive and effective coping strategy (Rickwood et al., 2005). While young people do seek help, a frequent research finding is that, rather than engage with professional services, young people may be more likely to seek help from their friends and families (Cosgrave et al., 2008; Rickwood et al., 2005). To improve youth mental health outcomes, services may need to consider the reasons young people prefer not to seek professional help. Several factors may influence this decision, the most commonly reported being concerns about confidentiality, with young people often concerned that formal help-seeking will result in their parents being alerted to their concerns (Booth et al., 2004; Gulliver et al., 2010).

It is young people themselves who may be able to inform us as to how these barriers impact them and their engagement with professional services, as well as how this could be

improved. While some research has explored why young people do not engage with services, significantly less has sought to describe how services can *promote* youth engagement. For example, understanding is limited as to how a service can convey that it is relevant to young people and meets their needs although this is clearly important (Summerhurst et al., 2017). Therefore, a key element of improving youth mental health care may involve improving our understanding of how services can work to enhance their appropriateness for the young people they intend to support.

Issues with traditional youth mental health services: Limited understanding

Young people can be under informed about mental health and what it entails, despite increasing pressure on them to take responsibility for their own emotional wellbeing (Rickwood et al., 2005; Wyn & Harris, 2004). Some research has suggested that young people can struggle with limited mental health literacy which may make it very challenging for them to understand where and how to seek help (Rickwood et al., 2005; Rickwood et al., 2007). This research has identified that many young people report feeling uncertain about what mental health challenges may benefit from professional support (Cosgrave et al., 2008). Researchers have suggested this may be a function of young people's emotional competence, a skill which develops during youth. This is defined as the ability to recognise and interpret distress and possess the language to explain this to someone else (Rickwood et al., 2005.) As such, young people may not understand some challenges, struggle to communicate them to others, or understand where to access support. This may be particularly relevant in contexts like New Zealand, in which the mental health system is complex and can require a lot of support to navigate effectively (HealthNavigator, 2020).

If young people struggle to understand when and how to seek support for mental health, this may impact their likelihood of engaging in mental health treatment. Some

research has suggested that increasing the visibility of services and improving young people's understanding of the supports that are available to them might improve their engagement with mental health treatment (Perera et al., 2019). However, we have little understanding of whether young people in New Zealand perceive lack of understanding or knowledge to be a barrier to engaging with mental health services, particularly since the rise of awareness raising campaigns in the past few years which may have impacted youth mental health literacy.

Issues with traditional youth mental health services: Inaccessibility

While young people can have challenges recognising distress and engaging with services, the unacceptably high rates of untreated mental distress among youth are not solely caused by young people 'failing to access' services which are available to them. There is also a legitimate shortage of these services, with young people remaining the most underserved population for mental health treatment (Patel et al., 2007). Youth mental health services face immense pressure to respond to increasingly high levels of demand for care (Coughlan et al., 2013). Indeed, it may be irresponsible to increase the demand for these organisations by promoting mental health awareness and literacy without addressing their limited capacity to meet this greater need (Cosgrave et al., 2008). Unfortunately, long waitlists and lack of ability to quickly access treatment have been suggested to be among the most significant barriers to treatment for young people and may often prevent them from receiving the help they need (Buston, 2002; Houle et al., 2013; McCann & Lubman, 2012a; Summerhurst et al., 2017).

Even with the influx of funding in New Zealand over the past two years, low capacity continues to be a substantial issue. It was reported in late 2020 that wait times for mental health services for young people in Auckland, the largest city in New Zealand, had reached six weeks for suicidal young people (McConnell, 2020). This did not consider the months-

long wait lists for those not considered ‘urgent’ priority – typically those who have not attempted suicide. In one South Island region, waitlists had reached three and a half months in these cases (Meier, 2020). In early 2021, waitlists for young people in Auckland exceed five months (Truebridge, February 2021) with personal communications suggesting they may be even longer². This lack of availability is likely to be a significant barrier to appropriate treatment for young people in New Zealand and does not appear to have been adequately addressed by the increases in funding which have occurred.

However, the limited accessibility of mental health care may not only relate to long waitlists and limited capacity, but to many other factors of a service which may make it challenging for young people and families to attend treatment. One such factor may be continued reliance on face-to-face delivery models in a few limited clinics, which can be inaccessible and have limited capacity to provide care, particularly to rural populations (Boydell et al., 2014). This challenge has particularly come to attention during the Covid-19 pandemic of 2020, during which mental health services have needed to rapidly reconsider their delivery models in order to continue operation with national lock-downs in place. It has been suggested that one approach to making therapy more acceptable may be an online format (Nelson et al., 2003; Read et al., 2009). This is consistent with findings that some New Zealand young people prefer services that are accessible over the phone, text, or online (Gibson & Cartwright, 2014). However, we currently do not have a clear understanding of what young people in New Zealand would consider an accessible service and the extent to which they perceive these factors as impacting upon their engagement.

² Through my clinical work in child and adolescent mental health care I have corresponded with the Intake Team at the Kari Centre, Auckland’s youth mental health service. This statement is based on email correspondence with this team from December 2020 to February 2021.

Issues with traditional mental health services: Inappropriate models of care

However, improving youth mental health care is not simply a case of increasing the accessibility of services or growing the mental health workforce to improve its capacity to meet this need. Increasing the availability of existing services alone may not be an adequate solution to this crisis in youth mental health care. In addition to there being too few mental health services for young people, some research has identified that those that are available may be struggling to appropriately serve the mental health needs of their target population at far higher rates than other mental health services (McGorry et al., 2007). Indeed, researchers have suggested that traditional mental health services may have limited efficacy with young people (French et al., 2003). Some researchers have claimed that this amounts to widespread neglect of the mental health needs of youth by existing services (Kieling et al., 2011).

In much of the world, the design of traditional mental health services has made it challenging, if not impossible, to access publicly funded mental health care if a young person's psychological distress does not meet the threshold for a mental health disorder (Cosgrave et al., 2008). However, it has been well established that a dual-factor approach may be a more effective way of preserving mental health in young people. This involves prioritising not only the absence of mental illness but also promoting subjective wellbeing (Antaramian et al., 2010; Suldo & Shaffer, 2008). Some research has suggested this may be the most effective way to prevent illness and vulnerability for young people, who are likely to respond better to a more holistic approach to mental health that does not solely focus on eliminating negatives (Anae et al., 2002). Unfortunately, when a system is so overwhelmed that it is only capable of offering treatment to the most unwell for the period in which they are unwell, this approach is not possible. Services often function with such limited capacity that they must prioritise symptom reduction without the capacity to build resilience and long-term wellbeing in their young clients (Coughlan et al., 2013).

With this in mind, this thesis is written from the theoretical perspective that mental health refers not simply to the absence of mental illness, but rather to the presence of a state of emotional and behavioural wellbeing (World Health Organisation, 2013). As such, the phrase ‘mental health’ is often used to refer broadly to the spectrum of wellbeing which exists between severe mental illness and complete mental wellbeing, with all people falling at some point across that spectrum (Westerhof & Keyes, 2010). Mental ill-health is most commonly represented by a diagnosis with a major mental illness, as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (American Psychiatric Association, 2013) or the International Statistical Classification of Diseases, 10th Edition (World Health Organisation, 2016). However, mental health problems may not always be diagnosable or most accurately captured by these conceptualisations of disorder (Goldman & Grob, 2006). As such, throughout this thesis I will often refer to ‘mental health’ ‘mental ill-health’ and ‘mental distress’, to signify that I include in my understanding of those who need psychological support those with any form of psychological and emotional struggle, including those without a diagnosable ‘mental illness’.

To effectively address long-term wellbeing for young people, we may need preventative strategies that go beyond the traditional disease model of mental health (Kieling et al., 2011). This illness focus, which is very dominant in the western world, focuses on a few traditional clinical perspectives and leaves little space for innovative approaches, even those which have been established as beneficial to clients (Anae et al., 2002; McGorry et al., 2007). Indeed these more traditional services, such as publicly funded not for profit child and adolescent services, are more likely to adhere to traditional practices and resist updating approaches despite findings suggesting that these may not be the most effective with young people (Schoenwald et al., 2008).

A closely related issue with conventional youth mental health approaches is that effective treatment is often not initiated until several years after the onset of mental distress for a young person (de Girolamo et al., 2012; Kessler et al., 2008). Early onset of mental health problems in adolescence or youth has been associated with extended periods without treatment, as well as poorer clinical and functional outcomes related to that delay (de Girolamo et al., 2012). However, many youth mental health services worldwide may withhold treatments until symptoms are severe and functional impairments have occurred (McGorry et al., 2008). There are often delays to treatment due to extreme wait times and strict restrictions regarding service criteria, resulting in only providing care to those whose needs are most severe – often at the ‘crisis point’ or even later (McGorry et al., 2013). However, the unavailability of treatment until symptoms have become severe and often very complicated to treat is an unacceptable failure of care and must be addressed (McGorry et al., 2008). For example, subthreshold symptoms of depression during adolescence have been linked to the same outcomes of increased risk of later depression in adulthood as a diagnosed major depression (Fergusson et al., 2005). This suggests that to promote mental health in young people and prevent life-long implications of mental health challenges, we should not only attend to those at the extreme end of the spectrum of mental ill-health. This approach may be obscuring a population of youth who could equally require strong mental health support or risk life-long consequences (Fergusson et al., 2005).

By contrast, the early detection and treatment of mental health challenges when these first occur in adolescence or young adulthood has been shown to relate to better long-term outcomes (Wright et al., 2006). Intervention at younger ages may reduce the severity and persistence of mental health challenges and prevent secondary disorders (de Girolamo et al., 2012). Early intervention may be especially crucial to reducing the lifetime impact of mental health challenges in youth (Kessler et al., 2008). Despite findings supporting these

approaches, around the world and in New Zealand early intervention is often only publicly funded for psychosis treatment, which severely limits services' ability to create long-term, lasting change for most young people experiencing mental distress (McGorry et al., 2008). It may be important to improving the mental health outcomes of young people in New Zealand to consider the potential of early intervention approaches and whether these are considered relevant to young people.

Issues with traditional mental health services: Developmentally inappropriate

Perhaps the most pressing and substantial issue with traditional mental health services lies in findings suggesting these may be unsuitable for young people's unique developmental needs (Coughlan et al., 2013). It is typical in most countries of the world for child and adolescent services to provide mental health intervention for young people up until a cut-off point – commonly either 16 or 18 years old – with adult services then becoming responsible for care (Coughlan et al., 2013). For public services in New Zealand, this cut off point is at age 18, with the exception of early-psychosis intervention teams. As a result of these policies, mental health care for adolescents is embedded in child services often with the same physical environment and carers (McGorry et al., 2007).

This is concerning because of the seemingly arbitrary nature of the decision to transfer care. There is no clinical reason for 18-year-olds to be treated separately from 17-year-olds (McGorry, 2007). Currently, we have very limited understanding of how adolescent mental health challenges are influenced by the transition to adulthood (Eyre & Thapar, 2014). Indeed, in the developed world, the transition from adolescence to adulthood is becoming increasingly variable (Coughlan et al., 2013). This period for young people in developed countries is increasingly referred to as ‘emerging adulthood’³, a time from a person's late

³ While the concept of emerging adulthood is used in this paragraph to illustrate why a clean line between paediatric and adult mental health services does not reflect the reality for young people in New Zealand, this

teens to mid-twenties defined by identity exploration and self-focus during which many are caught between the worlds of childhood and adulthood (Arnett, 2007). This developmental conceptualisation is a shift away from traditional, binary views of the transition between adolescence and adulthood (Arnett, 2007), such as traditional notions of development proposed by Erickson (1968), with the process of identity formation continuing for significantly longer than these theories have suggested. Indeed, it is intuitive to those who work with young people that the process of reaching adulthood – generally defined as financial independence, independent decision making, and taking responsibility for most personal decisions – does not occur overnight at the age of 18 (Arnett, 2007). Particularly in the past decades, this time has emerged as a distinct developmental period with its own specific needs and challenges. However, it has been largely ignored by services with young people typically treated as purely adolescent or purely adult with age alone considered an overly simplified marker of complex and varied development (Arnett, 2007). This widespread practice of ending adolescent care at 18 is based on traditional notions of the age of adulthood which are now outdated, and are reinforced by funding structures that make it impossible for child and adolescent services to care for anyone outside of their scope.

In direct opposition to this clear division between adult services and those which deal with children and adolescents, a growing body of research has begun to suggest that young people may be better treated under different frameworks than adults and children (Osuch et al., 2015; Patel et al., 2007; Ross et al., 2012). Around the world, services are emerging which are seeking to address the gap at this transitional period and provide youth-specific mental health care for young people (Hetrick et al., 2017). A review of these services and the literature supporting this practice can be found in Chapter Four. The question of how we

thesis will continue to use the term 'young people' to refer to people of these ages. This is to signify that it is not the sole focus of this period to 'achieve adulthood,' which this title can falsely imply.

define ‘youth appropriate’ treatment is an ongoing one (Hetrick et al., 2017), which perhaps will be best understood through direct consultation with young people themselves. The process of development has clearly changed in the past few decades, and it is important for us to consider how this may impact and change our priorities for mental health treatment. We do not currently know whether young people in New Zealand see a need for youth-specific services such as those found internationally, and whether this would be an appropriate strategy here.

Issues with traditional youth mental health services: Stigma

Another critical issue present in traditional youth mental health services is stigma and shame which can prevent young people from seeking help. This may be particularly challenging within countries like New Zealand and Australia, in which young people may have absorbed broader cultural attitudes and stigma around help-seeking (Rickwood et al., 2007). It is possible that this widespread stigma can result in many young people feeling afraid or ashamed of sharing their experiences with other people (Coughlan et al., 2013). This is not to suggest that stigma only exists outside of services within the general public. Some research has found that young people can be reluctant to seek help due to their perception of how they will be treated in services, with particular fears that they will experience ‘institutional stigma’ (Hefflinger & Hinshaw, 2010). Institutional stigma refers to professionals portraying shame to young people regarding mental health or encouraging low expectations of outcomes (Hefflinger & Hinshaw, 2010). Additionally, professionals may convey to young people that they are not seen as active participants but as ‘helpless’ receivers of care – such as by holding meetings about treatment plans without allowing the young person to attend or making facilities challenging for them to access independently without parental support (Hefflinger & Hinshaw, 2010). This can result in young people holding negative attitudes towards and fears of services due to their treatment by professionals

(Rickwood et al., 2007). This research suggests that it may be important to improve our understanding of young people's interactions with clinicians within services and how these interactions can reduce stigma around help seeking.

Issues with traditional youth mental health services: Culturally inappropriate

A final issue that must be highlighted in traditional mental health services is a lack of culturally appropriate care. Many services may lack recognition of cultural practices, which can result in low engagement from young people and families (Harrison et al., 2004). While this study was conducted in the United States, cultural sensitivity should concern New Zealand services given the number of different cultural backgrounds a young service user may come from – particularly in the large multicultural urban centres like Auckland.

Despite increasingly widespread awareness of these shortcomings, efforts to right this pattern have been too slow to meet the need (Becker & Kleinman, 2013). On the basis of the literature presented, it appears that the current system of care may not be adequately meeting the needs of young people, and this may contribute to why the majority of their mental health needs remain unmet (Becker & Kleinman, 2013; McGorry et al., 2013). It is crucial to reducing the impact of mental ill-health among youth and across the lifespan, that we respond to the too often ignored needs of young people (McGorry et al., 2007).

Rethinking youth mental health care: A matter of need and urgency

The previous discussion highlights ways in which the current mental health system may not be reaching young people in distress, and poses significant challenges facing youth mental health care in New Zealand and worldwide. Some researchers have argued that widespread and substantial transformation to these systems is essential to positively impacting young people's trajectories with mental ill-health (Coughlan et al., 2013; McGorry et al., 2013). However, it is important to understand what change is needed to these systems,

particularly what it is that young people themselves perceive as important targets for change. For example, many researchers, clinicians, and young people have suggested there is a need for innovative responses which challenge traditional approaches to mental health care and replace them with creative, accessible, and youth-friendly services that are empowering and responsive to young people (Coughlan et al., 2013). Indeed, it has been proposed that in order to improve the efficacy of youth mental health care we may need to hold young people at the core of services – listening to and understanding their preferences and being flexible and responsive to their needs (French et al., 2003). The question then remains as to what novel and responsive models of youth mental health care practically look like in any given setting, including in New Zealand. This raises further questions around what we currently know about the desires and beliefs of young people regarding their treatment, and what we must still learn.

A significant step towards transformative youth mental health care change was made in 2013 with the signing of the International Declaration on Youth Mental Health. A group of international professionals wrote this Declaration in collaboration with a group of young people who provided their feedback and thoughts on young people's mental health needs (Coughlan et al., 2013). This Declaration aimed to influence the creation of more youth-friendly services by encouraging traditional services to give way to those where young people were involved in the design and development of the service (Coughlan et al., 2013). This encouraged services to draw on their target population's perspectives to address issues of perceived irrelevance and poor help-seeking (Summerhurst et al., 2017) and provide developmentally appropriate, and holistic care (McGorry et al., 2013). The youth who participated in the Declaration stated that young people want to see a change in the mental health system and are eager to be involved in this process (Coughlan et al., 2013). Indeed, young people have lived experience with traditional services, and they are the experts on their

needs. As such, their perspectives should be invaluable (Coughlan et al., 2013). Particularly given findings which suggest that improving the relevance of services may improve young people's engagement with these (Summerhurst et al., 2017), working collaboratively with young people to improve mental health care seems an important and necessary process.

However, an approach to mental health care which so intentionally positions the voices of young people at its forefront may be uncomfortable and unusual to those who have practiced in traditional child and adolescent mental health services, which tend to be paternalistic and dismissive of young people's capacity for agency (Coughlan et al., 2013). Rethinking the design of services is a complex task that cannot be completed internally without services challenging how they position young people, shifting from victimizing perspectives to considering their right to agency and capacity for empowerment and growth (Coughlan et al., 2013). To construct services that build upon young people's independence and respect their needs as a group, young people need to be allowed to be full and equal participants in the development of services despite the discomfort this may cause clinicians (Rickwood et al., 2007). Participation is not only a necessary but an essential component of creating services capable of rising to the challenges facing global youth mental health care (Simmons et al., 2020; Rickwood et al., 2007). As such, if we are to consider how we can respond effectively to the 'silent pandemic' of youth mental health in New Zealand we must turn attention to considering how young people can participate in that response.

Youth perspectives on mental health care: The missing piece

A growing body of literature has emerged which aims to address this need by centring young people's voices at its core, particularly young people's attitudes to and perspectives on help-seeking and youth mental health services. This research looks beyond what has not worked in traditional service design towards exploring creative alternatives, which may be

the essential ingredient for designing effective youth services. Simply looking at what does not work can only develop services insofar as to reach an acceptable level but may be insufficient to design high-quality services. In order to achieve this, international research has suggested we must prioritise young people's perspectives on their care (Coughlan et al., 2013).

This research proposes that young people may prefer more informal delivery of mental health services and that these relaxed approaches could be associated with improved, sustained engagement with treatment (Shandley et al., 2010). The physical environment of services may also be an important factor, with some young people reporting they are more likely to engage with a service when it is easy for them to access, has a pleasant and clean physical environment, good location, a positive and friendly atmosphere, and youth-friendly branding (Coughlan et al., 2013). Further literature which offers the perspective of young people on service design is offered in the introduction to the article which constitutes Chapter Four of this thesis.

Another area in which youth perspectives may be valuable is in guiding the practice of clinicians who work with young people and who can inform a young person's decision to continue treatment or disengage. Some research has identified that this is an area where young people, including young people in New Zealand, like to have agency, particularly over whom they work with and how they work with that person (Gibson & Cartwright, 2013). Many features of a clinician's style may make young people more likely to sustain treatment and improve their outcomes. These features include strong communication, acceptance, empathy, a youth-friendly approach, and being non-judgmental (Biering, 2010; McCann & Lubman, 2012a). A detailed review of young people's perspectives on mental health clinicians is provided as part of the article in Chapter Three.

Additionally, existing research indicates that young people have strong preferences regarding the models of treatment they receive. Some research has suggested young people highly value talking therapy as treatment (Buston, 2002; Houle et al., 2013; Jordan et al., 2012; Leavey, 2005; McCann & Lubman, 2012a, Summerhurst et al., 2017). However, it has also been noted that many young people may prefer medication for their treatment (Farmer, 2002; Leavey, 2005; McCann & Lubman, 2012b). By contrast, there are other young people who may avoid help-seeking in order not to take medication (Bluhm et al., 2014). As such, young people might prefer having access to multi-disciplinary services that offer a range of clinicians and approaches including both talking therapy and medications (Scott et al., 2009). This may allow youth to engage with the treatment approaches that are most consistent with their values and beliefs about mental health and therefore increase the likelihood they will continue to seek and engage in treatment. This also highlights that we cannot expect youth perspectives to be entirely homogenous, and within the broad category of ‘young people’ there are likely to be many varied and contrasting perspectives.

The current study

The body of literature exploring the short-falls of traditional mental health services and the potential for collaboratively designed mental health services to address these gaps continues to grow internationally. Across the developed world a number of services have emerged in response to this body of literature which seek to address these challenges and meet the high level of need. Such services have emerged in countries including Australia, Canada, the United Kingdom, and France with some existing long before the surge in literature in this area and merely expanding as need has grown (Hetrick et al., 2017). A detailed review of these services is included in Chapter Four. New Zealand’s youth mental health system is increasingly falling behind other regions of the developed world in the

quality of services it provides to its young people and only limited research and clinical work has been conducted in this area in New Zealand. For example, while Youth One Stop Shops have existed in New Zealand for several decades, and do involve young people in ongoing collaboration regarding the design and practice of the services, the scope of these to treat mental health needs is limited and they exist in few locations (Bailey et al., 2013).

Additionally, a recent study conducted in New Zealand explicitly explored young people's treatment preferences and identified that their priorities include maintaining control, having a friendly relationship with their counsellor, being listened to, and having highly accessible services (Gibson et al., 2016). While an important foundation, this project was not intended to provide an opportunity for young people to creatively express their vision for mental health care in New Zealand. Additionally, while international examples of services have been a positive step for the countries where they have been developed, creating an effective youth mental health system in New Zealand is not as simple as copying other approaches that have been effective in different contexts. An important element of developing effective mental health services is ensuring these are culturally appropriate and responsive to the local community and we do not know if the preferences of young people in New Zealand will align with youth values identified in international literature. It is therefore essential that we work collaboratively with New Zealand's youth to hear their voices and allow them to have a seat at the table in these discussions of how we can improve their mental health care.

Given the level of youth mental health need and findings suggesting that New Zealand's approach to youth mental health care may be outdated by international standards, it is time to prioritise working collaboratively with young people to change the landscape of our youth mental health services. With the increase in funding for public mental health care made available under the new Wellbeing Budget, it is critical that these funds are spent on services that will effectively work for their target population. While increased funding may contribute

to improved accessibility of services, it is clear from this review that limited access is just one of many issues which may be contributing to the poor outcomes of traditional youth mental health care for young people. Taking this approach alone may result in sinking funds into services which are fundamentally unable to meet the actual needs of young people. As such, we must accompany increased funding with a substantial reconsideration of the nature of youth mental health care in New Zealand. In particular, we must focus our attention on improving youth engagement with treatment and increasing the services' capacity to meet the needs and priorities of youth.

On the basis of the current body of literature and these identified gaps in knowledge, three research questions were identified for this project.

Firstly: How do young people in New Zealand envision ideal mental health care for themselves and their peers? There is scope to expand upon our current knowledge of young people in New Zealand's preferences by allowing them to creatively explore solutions outside what they have already been exposed to. We do not know whether young people in New Zealand would value novel solutions, and what these would look like for them.

Secondly: Are the priorities and ideals of young people in New Zealand consistent with the perspectives of young people which have been identified in international research? Given the rapid development of a literature base for this area, it would be extremely beneficial for the work of updating New Zealand's youth mental health system to understand whether the views of young people here are consistent with those of other young people around the world.

Lastly: Can the ideals of New Zealand's young people be incorporated into a model of proposed change to mental health care in New Zealand? It is not currently known what kinds of solutions young people might propose and whether these could, feasibly, contribute to

practical suggestions for change which could be applied to the New Zealand mental health system. It is hoped that this project can shed light on the capacity for youth to contribute to these discussions and thereby the potential role young leaders may play in shaping our future of youth mental health care.

Having discussed the context from which this project emerged, including the international challenge of youth mental health and the short-comings of conventional care models for mental health treatment in young people, I now move to describing the structure of this thesis. In Chapter Two I will discuss the methodology employed in the study which was conducted: a collaborative workshop model. This chapter begins by discussing the theoretical underpinning of this methodological approach including social constructivism and participatory action research. I then move to describing and detailing the research method and study design. In Chapters Three and Four I present the findings of this research in two parts. In Chapter Three I present the workshop participants' attitudes to mental health clinicians, with particular attention to their ideal vision of a counsellor with whom they would like to work clinically. In Chapter Four I detail the workshop participants' visions for mental health services that capture and respond to their needs, wishes, and hopes. In Chapter Five, I discuss the implications of this project including the contributions of this research to the field of youth mental health care and treatment. This includes an exploration of the implications of this project and the potential applications of these results to tangibly progressing mental health care for young people in New Zealand. Lastly, I discuss some of the particular challenges of conducting research of this kind and of generating change within established clinical settings.

Summary

Around the world, attention has been drawn to the challenge of youth mental health and how many currently available services to support young people may not be appropriately addressing their mental health needs. In response, a movement has developed which emphasises involving young people in service design and the process of informing clinical practices in youth mental health treatment. At present, there has been limited collaborative work conducted in New Zealand with young people which aims to meet this need and inform understanding of what young people are seeking from mental health treatment. The present project aims to address this and answer the research question: what do young people in New Zealand ideally want from their mental health care?

Chapter Two:

Methodology

Straight to the source: A workshop approach to collaborative service design.

Hapaitia te ara tika pumau ai te rangatiratanga mo nga uri whakatipu

Foster the pathway of knowledge to strength, independence, and growth for future generations.

With this research project, I aimed to explore the ways in which young people envisioned their ideal mental health system. I begin this chapter by describing the underlying epistemology within which this research was conducted, a social construction paradigm. Following this, I discuss the influences of qualitative methodologies, critical psychology, and community psychology upon informing my methodological approach. I then detail the methodology utilised in addressing my research questions, a novel workshop approach conceptualised within a participatory action framework. I then describe the method of data collection and explain the specific analytical approach employed. Lastly, I attend to important ethical considerations for this project and how I ensured rigour throughout the process of the research.

This study was related to a broader, inter-disciplinary project involving professionals within the School of Psychology and Department of Anthropology at the University of Auckland known as *The Mirror Project* (see The Mirror Project, n.d.). This project intends to explore the world young people inhabit, with particular focus on improving understanding of the psychological challenges they face, how these impact them, and how the support services available to them can be improved to better address their needs and priorities. *The Mirror Project* also seeks to address the privileging of adult and professional perspectives on youth mental health service development, which has historically silenced the voices of young people. In this way, *The Mirror Project* seeks to hold up a mirror to how young people see themselves and identify what they feel will work best for them.

This specific doctoral research project stemmed from the broader aims of *The Mirror Project*, along with the theoretical context outlined in this chapter. This project was developed to sit alongside previous work conducted in *The Mirror Project*, and to contribute to a greater body of literature seeking to unpack and improve understanding of youth mental health treatment.

Epistemological Framing

All psychological research is positioned within a specific set of assumptions and beliefs which the researchers hold about the nature of knowledge and reality. That is, the research's epistemology and ontology respectively (Crotty, 1998). While all research is grounded in this way (Merleau-Ponty, 1945/1962), traditional scientific practice including mainstream psychological research rarely acknowledges this (Denzin & Lincoln, 2003). It is essential that psychological research increases the frequency with which we disclose, describe, and critically discuss the epistemological grounding for our research (Darlaston-Jones, 2007). As such, I begin this chapter by discussing the guiding epistemology for this project. My aim here is to not simply provide a description of my research methods but to detail the complete research pathway from theoretical and epistemological positioning through to the final methodology as has been encouraged as good practice for all psychological research (Crotty, 1998).

Psychology and mental health research are often dominated by positivist approaches (Breen & Darlaston-Jones, 2010; Gergen, 1985; Leahey, 1992; Michell, 2003; Rosenau, 1992). Positivism refers to a broad collection of research epistemologies which aim to produce universal laws which can be applied to all people through a process of experimentally testing hypotheses and making deductions based on these experiments (Leahey, 1992; Patton, 2002; Rozeboom, 1960). In mental health research, the dominance of positivism has stemmed from medical science and the medical model of mental health (McCann, 2016). However, positivist mental health research does not often attend to people's subjective experiences of mental health challenges and treatment (Walker, 2006). In this thesis, I focus upon developing our understanding of what young people want from services with the aim of improving their engagement in treatment. In order to develop such services

which are acceptable to young people, we must conduct research which allows us to access young people's priorities for mental health treatment (Coughlan et al., 2013). In researching young people's views, we are likely to benefit from approaches which do not seek universal truths but recognise that these are part of a subjective meaning making process (Edley, 2001). An approach which prioritises subjective meaning and recognises that there may be a range of alternative perspectives on a phenomena is likely to better fit the specific aims of this project (Patton, 1990). It is important to explore young people's unique perspective on mental health services, recognising that this may be different to that of adults, including professionals, researchers and parents.

While it is important to recognise that young people's subjectivity informs their views of mental health, it is also vital to place these views in social context (Edley, 2001). A social constructionist approach recognises that our perceptions are shaped by the social contexts we operate within (Gergen, 1999). That is, our experience of reality is not objective but related to the environment in which it is developed – particularly the historical, cultural, political and social norms which operate within and impact on all lives (Berger & Luckman, 1966). Social constructionism also highlights the impact of power, and how this can influence whose perspectives become dominant and are given weight in society (Gergen, 2001). For example, in the case of youth mental health care, while the literature on youth perspectives of mental health care suggest there are alternative ways to define 'good' mental health treatment, there is a dominant, privileged view of treatment which has shaped how services and clinical treatment typically look. Dominant perspectives are often reflective of the priorities of those in positions of power, particularly white professionals and policy makers (Rose & Kalathil, 2019). The privileged position and power of the dominant narrative can discourage the exploration and expression of other approaches, which can make it challenging to become privy to alternative constructions (Gergen, 2001).

This epistemological position aligns well with the present research questions. In this study, I recognise that young people’s views on mental health care are likely to differ from dominant narratives of mental health treatment on the basis of the international literature regarding youth perspectives on mental health services. Yet, young people’s position of relative disempowerment within society may make it challenging to express these beliefs as it can be very challenging to express alternative narratives when power is operating (Gergen, 2001). As such, it is important in this research project to consider how to design a project which explores these beliefs and creates a space within which young people can challenge dominant views on mental health.

Social constructionist research holds the possibility that there are always alternative ways of understanding a phenomena, and that multiple truths can exist at the same time within the same context (Gergen, 1999). As such, social constructionism has in the past been criticised as being less ‘scientifically rigorous’ than positivist approaches which seek to ‘prove’ theories and reject null hypotheses (Gergen, 2001; Patton, 2002). However, social constructionism oriented research can follow empirical methodologies, such as the systematic gathering and analysing of data which are key components of the scientific method (Robson, 2002). A critical consideration here is the purpose of research – this project does not seek to identify a single, objective truth and thus, inability to produce knowledge of this kind is not viewed as a limitation of this project. Instead, this approach allows us to engage with multiple ways of understanding and interpreting mental health care and, most importantly, challenge currently constructed notions of how treatment can and should look. Additionally, a social constructionist approach to research allows us to acknowledge how our conceptualisations of young people, mental distress, and mental health care are not objective realities but a version of reality which has been shaped and created over time by socio-cultural norms, discourses,

and power. This is essential for questioning current practices and how young people are positioned within these, as well as for proposing alternatives to these traditional approaches.

Qualitative methodologies

Given these priorities within this project, it was important to implement a methodology with the potential to provide space for young people's voices to be properly heard and acknowledged, allowing their perspectives on mental health to emerge. Research which seeks to examine young people's perspectives on mental health has often drawn on qualitative methodologies, including focus groups and interviews. This has been driven by recognition that qualitative methodologies which ask open-ended questions of participants produce rich data, particularly a depth of knowledge which provides meaningful insights into the perspectives of young people (Hennessey, 1999). In this way, qualitative methodologies can allow us greater depth of understanding than quantitative approaches such as rating scales or close-questioned surveys which typically prioritise breadth of knowledge (Hennessey, 1999). Qualitative approaches also allow us to see and embrace the context which contributes to a participant's views (Kogstad et al., 2014). Qualitative research aims to understand people and their interpretations of their experiences and can acknowledge that knowledge is situated within particular socio-cultural contexts, a stance which aligns well with a social constructionism epistemology (Liamputtong & Ezzy, 2005; Creswell, 2008). Indeed, qualitative research can allow an emic view of the areas being studied, that is, it may allow us to explore the perspectives of insiders as opposed to occupying a position as the outsider looking in (Bryman, 2001). This can lead to detailed, in-depth explorations from smaller sample sizes generating rich and nuanced data (Merriam, 2002).

However, there are several limitations of traditional qualitative methodologies which may impact the potential for these research designs to effectively answer the current research

questions. Surveys can limit the responses of participants and confine them to the expectations of the researcher, an ineffective method for research such as this that intends to access perspectives young people may hold of which researchers are unaware (Morgan, 1996). Interview designs can also tend to produce fewer ideas and novel topics, which is again not suited to a research project which will benefit from generating many varied ideas (Morgan, 1996). Focus groups then emerge as a suitable candidate, due to the greater depth and breadth of material they tend to generate compared to other qualitative methodologies. However, the risk remains that in focus groups participants can tend to converge on similar responses, which may be of particular concern with socially motivated young people who may tend towards peer agreement on controversial topics (Morgan, 1996).

An important consideration in evaluating the potential for qualitative methodologies to answer the research questions laid out in this project is the understanding that traditional qualitative approaches may not necessarily address the power which operates on and constrains young people (Parker, 2007). Qualitative methodologies can result in participants reproducing narratives they have heard from others without paying critical attention to them particularly when those participating have traditionally had less power (Kitzinger & Wilkinson, 1997). This posed a challenge for this study, in which I aimed to support young people to explore their own perspectives of mental health care and not simply reproduce what they had already experienced or witnessed in treatment.

Additionally, power can operate within qualitative research in ways which may constrain young people's responses. In the past, it had been stated that sharing their stories can position young people as experts and empower them to share their experiences (Goodley, 1998). However, the general aim of qualitative methodologies including interviews and focus groups is for information to pass from the participant to the researcher (Calder-Dawe & Gavey, 2019). This parallels broader issues within psychological research of exploiting the

knowledge of the researched to benefit and serve a purpose to the researcher (Prilleltensky, 1997; Smith, 1999). This is a particularly important issue to consider in research involving young people, who are often already disempowered socially and are likely to be very attuned to power discrepancies within research (Ginwright & James, 2002). In particular, young people are often disempowered in relation to adults who are more likely to dominate conversations and have their voices prioritised (Hinshaw, 2005). These power dynamics are often reproduced in the research environment and can greatly impact the process and outcomes of research if not addressed (Chung & Lounsbury, 2006). For example, the perceived and actual power of the researcher impacts upon what is considered ‘important’ in the research and analysis process (Gaventa & Cornwall, 2006). The researcher often occupies a position of assumed expertise, for example, they set the agenda for discussions (Brinkmann, 2007). Given that power dynamics are closely affected by factors like the perceived age, education, and authority of others, it is very difficult (if not impossible) to foster an equal power dynamic between research participants and researchers (Kelly & Vlaenderen, 1996). As such, it is important to consider how to prioritise collaboration within research and consciously consider the impact of power. That is, we should consider not only whether we are conducting research *on* or *with* young people but also how power is enacted at all levels of research including that in which young people have a voice (Hunleth, 2011; Wyn & Harris, 2004).

This issue was of great concern due to my desire to position young people as collaborators in the process of the research itself. As such, I aimed to develop a qualitative methodology which critically considered the impact of power on young people within society and mental health treatment, and also addressed the issue of power within research itself. In this way, I hoped to ensure young people were respected and encouraged to become active collaborators in the design of services (Rickwood et al., 2007).

Empowering and critical methodologies

Designing a methodology capable of reaching this goal required me to look beyond traditional qualitative research methodologies. One approach which explicitly acknowledges the impact of power is critical psychology, a field within psychological research and practice which sits in contrast to dominant approaches, with a particular focus on the shortcomings of mainstream psychology (Parker, 2007) and the potential for psychology to effect political action and social justice (Austin & Prilleltensky, 2001). Critical psychology prioritises acknowledging and holding alternative narratives and approaches which may differ from the current dominant cannon of positivist science, such as those which are fundamental to indigenous world-views (Nikora, 2006). Indigenous world-views often do not align with mainstream psychological research, particularly as this does not embrace issues of social justice which are essential to the post-colonial⁴ indigenous experience (Bhatia & Priya, 2018). As such, critical psychology-informed research may be well suited to research conducted with indigenous populations, which is vital for research in New Zealand where partnership with Māori people is an inherent requirement (National Ethics Advisory Committee, 2020).

In developing this project, it was appropriate to draw upon some aspects of critical psychological approaches in addressing the specific research questions described. The focus of critical psychology on eliciting alternative narratives, particularly those which sit in opposition or resistance to mainstream frameworks, aligns well with my aim of hearing the perspectives of young people that may lie outside of traditional perspectives on mental health and its treatment. In this project, I aimed to allow possibilities for participants to express

⁴ Here, the phrase post-colonial is not used to suggest that colonisation is a historic event which is not currently on-going. Rather, post-colonial is used to specifically refer to the social, political, and cultural impacts of colonisation on an indigenous population (Ashcroft, 2012).

alternative views in order to avoid simply reproducing dominant narratives of mental health care. In being influenced by critical psychology, I aimed to allow for explicit consideration of the ways in which young people's views may differ from what they had experienced or heard about services in the past (Coughlan et al., 2013). Additionally, the capacity for political and social activism alongside research is a key component of critical psychological work and is essential to this research project and its aims of creating conversations and meaningful change in youth mental health service delivery in New Zealand. While this research does not follow other critical psychologists in deconstructing the language of psychology, it does aim to create a space within which young people can challenge the dominant views and hierarchies that operate through the mental health system.

Another area of psychological research and practice which acknowledges the potential for research to challenge the constraints of power is community psychology. Community psychology is a field of study founded in the 1960s which was then grounded in socially progressive research and action, oriented towards promoting mental health and wellbeing within the community by working directly with those living with mental health challenges (Prilleltensky & Nelson, 2009). Community psychology holds at its core that research should be meaningful and empowering to the community it researches (Jason et al., 2004), a positioning which aligns well with the research questions laid out in this project which sought to empower the young people with whom this research was conducted. The key impetus of community psychological research – often described as community collaboration with the motivation of social justice (Kelly, 1971) – holds at its core that researchers should work within communities to promote actions which benefit those people.

However, it has been noted that, over time, there has been a 'stalling' within community psychology with a reduction of emphasis on topics of key concern to communities (Townley et al., 2018). It has been noted that some current research in

community psychology is not actively highlighting the perspectives and priorities of those who are struggling (Kidd et al., 2018). However, there has been an increase in qualitative community psychology projects grounded in alternative orientations to positivism (Prilleltensky & Nelson, 2009). One approach within community psychology which I believe is particularly pertinent to this project is a movement towards incorporating participatory methodologies into community psychology which are action focussed and driven by community engagement (Kidd et al., 2018; Kral & Allen, 2016). True participatory methodologies involve working collaboratively within a community to advance action in areas where they face challenge (Fals Borda, 1991). In order for this to be done successfully, participatory community research requires researchers to approach their work with humility and respect for community perspectives (Rahman, 1991). This scope aligned well with the research questions laid out in this project, as I aim within this project to consider possibilities for change in care and treatment for young people.

Participatory Action Research

The specific methodological approach of participatory action research aims to reduce health inequities through involving the same people who are affected by a health problem in the researching of it (Braum et al., 2006). In the tradition of other community psychological approaches driven by an empowerment agenda, participatory action research seeks not only to understand but to improve the lives of communities with whom we work (Braum et al., 2006). However, participatory action research also seeks to be empowering of communities being researched and to offer them greater control over their lives (Minkler & Wallerstein, 2003; Grbich, 1999). A key component of participatory action research is its attention to power and intention to blur the lines between researchers and researched, allowing the researched to share the role of researcher (Braum et al., 2006). Participatory action research is also inherently linked to social constructionism and acknowledges that we cannot remove our

understanding from the context in which it arose (Braum et al., 2006). Importantly, participatory action research also actively questions the use of pejorative terms to define communities as problematic, including views of young people as delinquent or victimised (Torre et al., 2012).

This approach very closely aligns with the specific aims of my research project, particularly for its explicit focus on questioning traditional, paternalistic approaches to mental health research which may position research participants as disempowered and in need of scientific expertise to help them (Braum et al., 2006). The strength of this approach lies in its acknowledgement of the expertise that people, including young people, gather through day to day experience of mental health challenges, providing support to others, and help-seeking (Braum et al., 2006). I would posit that this approach also aligns closely with the developmental priorities of young people, who often seek to differentiate themselves and form identities throughout their youth (Erickson, 1968). While young people are often disempowered in society in terms of both the legal and social power they possess (or do not) (Ginwright & James, 2002) many young people will resist this position and seek to assert their growing agency through their voice and potential for action (Munford & Sanders, 2015). Participatory action work with youth overtly aims to empower young people to step into leadership and activism roles, advocating for progress and change in areas that affect their lives (Brydon-Miller et al., 2003; Ozer, 2017). Indeed, research of this kind may promote healthy youth development (Suleiman et al., 2019). As such, this approach to research is particularly notable for its potential to add benefit to the lives of participants through offering them experiences of empowerment (Akom, 2011). In this way, employing a methodology influenced by this framework in the present research project could enable young people to take on a role of expert informants on their experiences of and perspectives on mental health care. This aligned very well with the aim of this project to allow young people to express

alternative narratives and perspectives on mental health treatment than those which may be dominant. Additionally, research has suggested that participatory action research can be used effectively to engage young people in intervention design (Suleiman et al., 2019).

Importantly, the influence of participatory action research allowed me to develop a methodology which aimed to resist disempowering tendencies in research and redefine the potential to work collaboratively with youth. In this way, I was able to conduct a project which explicitly prioritised youth agency and empowerment.

Research Design

I then faced the challenge of devising a methodological process rooted in this epistemological framework with the capacity to answer the research questions. In doing so, I drew upon several components of participatory action research. Firstly, I sought to place the experiences of young people at the centre of the research and highlight their knowledge and perspectives throughout. This is an essential component of participatory action research (Braun et al., 2006). This focus upon youth perspectives is key to re-positioning young participants as collaborators rather than subjects of the research process which, as described earlier, was an essential aim of this project.

I also sought to integrate the emphasis on creative approaches present in participatory action research (Veale, 2005). Creative approaches in research can help to unlock alternative sources of knowledge and can encourage young people to engage with different ways of thinking about both the challenges they face and the ways these can be addressed. As such, it was essential to identify ways in which to integrate creative expression and problem solving into the methodology.

I also drew upon the field of critical psychology, and sought to include opportunities within the methodology for young people to critique traditional mental health services should

they wish to. Given that it can be challenging for those who are disempowered to critique dominant perspectives (Gergen, 2001) it was important to find ways to integrate moments which allowed for this throughout the research process to ensure young people had opportunity to share negative experiences or challenge the practices currently in place.

This left me with the need to devise a methodology which centred youth voices, employed creative approaches, and provided opportunities to critique current traditions. In considering how to consolidate these priorities into a research methodology, I was inspired by the dynamic socio-cultural methodology developed by Calder-Dawe and Gavey (2019). This methodology prioritised empowering young people to expand their knowledge and identify their own novel solutions to issues of sexism. This methodological approach was rooted in participatory action research, and aimed to ‘de-silence’ the voices of young people and allow them to explore new ways of understanding and interpreting their experience. While this project explored young people’s experiences of sexism, I believed there were a number of ways I could draw from this methodology to develop an approach to studying mental health service design.

The first key element of this research conducted by Calder-Dawe and Gavey (2019) which I drew upon was its employment of a workshop design. In their workshop, young people engaged in problem-posing and creative exercises including socio-drama approaches to exploring the issues they faced. This was followed by individual interviews, and their analysis did not incorporate the experience of the workshops themselves. This presented an opportunity, as engaging in multiple activities within a workshop draws on the benefits of various qualitative approaches and addresses some of their respective limitations. For example, a workshop could integrate opportunities to privately share knowledge that might be considered undesirable or unpopular among peers alongside activities which prioritise publicly exploring and collaborating on socially shared knowledge. This balance has the

potential to encourage critical thinking among participants which is crucial for problem solving and identifying solutions rather than simply reporting on past experiences. For these reasons, the methodology employed in this research was formed around a workshop process incorporating multiple activities and creative practices.

There were a number of key differences between the workshop process I developed and that employed by Calder-Dawe and Gavey (2019). These adaptations were made to devise a unique process suitable to studying this project's particular research questions. Notably, while both research projects were conducted with young people from New Zealand, the context within which the young people in Calder-Dawe and Gavey's (2019) study and those in the present project sat was very different. Calder-Dawe and Gavey (2019) note that they conducted their research at a time when cultural perspectives regarding sexism and feminism were such that in order to conduct research on young people's experiences of these they needed to expose participants to new ways of knowing and defining those experiences. By contrast, our research emerged at a time of significant public attention towards youth mental health and its treatment. As such, the present workshop process developed for this study did not need to allocate significant time to expanding participants' ways of knowing prior to beginning a 'data-gathering' process. Rather, as the participants in this study had likely been exposed to many ways of thinking about mental health within their lives (through personal experience, education, awareness raising campaigns, peer groups, social media, and many more) it was preferable for these specific research aims that I engage with their perspectives as they stood at the beginning of the research project. This also avoided the risk of 'ventriloquism' – a process by which the researcher inserts their perspective into the research and thus overtly changes the perspectives of participants (Fine, 1992). This would result in young people simply reproducing more 'dominant' perspectives imposed by another

person in a position of power, a researcher, and not allow them to share their subjective perspectives.

By not requiring this period of initial knowledge sharing, I was also able to substantially reduce the duration of the workshop. Calder-Dawe and Gavey's (2019) research required a significant time investment from their participants – with workshops lasting either one or three days and follow up interviews conducted following the conclusion of these. This time burden was essential for their research aims and specific focuses. However, it was felt that the present project could be strengthened by requiring just one point of contact with young people of a shorter duration. As such, I aimed to reduce the time taken by this process to ensure that as many young people as possible would be able to participate and to facilitate 'buy-in' from schools who may have been more willing to engage than if the project had required a greater investment of student time. The duration of the final workshop procedure, outlined in the following section, was between two and three hours dependent on the size of the participant group. This length of time maximised potential to engage in a meaningful workshop process with participants while minimising the risk of distress and emotional burnout from discussing potentially upsetting content for a prolonged period of time.

By drawing on these influences, a unique methodology was developed which aligned with the theoretical and epistemological underpinnings of this project and the research questions posed at its outset.

Workshop Process

The final process I developed followed a participatory action research informed approach of focusing initially on providing opportunities for young people to formulate their own questions and issues regarding their experiences of and perspectives on current mental health care, before moving to allowing them the space to envisage a solution to those

problems. In this section, I outline the actual research process and the phases included in the workshop procedure along with the rationale and purpose for including each phase. Specific materials used in the workshops, including surveys and newspaper prompts, are provided in Appendix One.

In developing the protocol for this project, I began by adapting Calder-Dawe and Gavey's (2019) principles for collaborative research to suit the specific research questions. These principles were: creating a space in which participants are safe, supported, and encouraged to voice their perspectives; inviting participants to reflect on their own experiences without insisting they do so; working directly with the experiences and perspectives that participants bring in order to focus the research on those issues which are important to them; including diverse catalysts for reflection and action, such as opportunities for creative expression; and attending to the potential impact of the workshops by including playful and hopeful activities alongside more serious ones. These are referenced throughout the following description of the stages of the protocol.

Phase One: Setting the scene. At the beginning of the workshop, participants were invited to respond to a short survey. The purpose of this stage was to ground the workshop in opportunities for private reflection and ensure participants opened the session with their own perspectives and experiences at the forefront. This was one way in which I sought to minimise the potential for peer influence to prevent young people sharing their own perspectives. This survey also allowed for the possibility of comparison between start and end surveys, and determining whether there were significant differences between these.

The survey involved a series of short questions. These began with demographics, including age, gender, sexuality, ethnicity, involvement in work and education, and past experience with mental health services. All questions were left open ended, allowing

participants to identify themselves however they chose. It then included a series of open ended questions intended to gauge participants' initial perspective on mental health services before they had been influenced by the discussion in the group. These questions were: 1) How do you think mental health services for young people are doing right now? 2) If you could change one thing about mental health services, what would you change? and 3) What could a mental health service do to make you more likely to choose to attend it, if you needed to?

After the survey was completed and all participants were ready to begin, a round of introductions was completed. The purpose of this portion of the process was to begin attending to power dynamics that are often present between researchers and participants. In this way, the introductions were intended to foster an environment of 'mutual sharing' in which participants understood they were in a position to ask questions and participate openly with the researcher. This was particularly important for those workshops conducted in schools. I began by introducing myself with my name and background. As a young person within the age range of the participants, this introduction often aided rapport building. At this stage, I also included an explanation that more opportunities would be offered at the conclusion of the workshop to ask more about my background and perspectives. Participants were then invited to share their name, pronouns, and why they chose to come along to the workshop.

Following these introductions, participants received reminders regarding confidentiality and voice recorders, including that I was unable to delete their individual data from the transcripts should they chose to leave a session.

Phase Two: Centring participant experiences. Phase two followed a traditional semi-structured focus group style discussion, in which participants responded to a series of

prompts. These prompts were: 1) What do young people want from a mental health service? 2) What is the best thing a mental health service could do to engage young people? and 3) What is the worst thing a mental health service could do for young people?

The discussion which followed each prompt was semi-structured, and I prioritised following the threads of conversation brought forward by participants. This approach was chosen in accordance with Calder-Dawe and Gavey's (2019) principle of prioritising the concerns of the participants within the project. During this focus-group style discussion, many participants opted to share personal stories of their own experiences. In this way, participants targeted key issues in relation to mental health and mental health care which were rooted in their own personal experiences and desire for change. Importantly, these prompts did not explicitly encourage the sharing of personal experience, allowing individual participants to share as they felt comfortable to.

By beginning with a group discussion of this nature, I was able to centre at the core of the workshop the experiences participants had prior to the workshop, and allow them to begin occupying the position of 'expert informant'. This stage varied in duration depending on the openness of the group and the size, as regardless of group size I aimed for each participant to make at least one unique contribution to the discussion.

Phase Three: Opportunities to critique. Following the conclusion of the focus-group style discussion, the workshop then transitioned to an activity. In this activity, participants read a prompt – a newspaper article written in a national newspaper regarding a new publicly funded youth mental health service in New Zealand. This article is included in Appendix One. Participants were first asked to read the article and take note of any points they agreed with, disagreed with, questioned, or to which they felt any strong reaction. Participants then

reflected on the article as a group. Several participants annotated articles with highlighting, questions, and written responses.

The purpose of this activity was to begin the process of linking the personal experiences and perspectives described by the participants to broader socio-political issues including the funding of services and government priorities for mental health care. Additionally, this allowed participants the opportunity to attend to and critique the dominant discourse of mental health care in New Zealand at the time of their workshops, and address the ways in which the solutions proposed by those in power may not necessarily align with their needs. By drawing attention to these particular discourses, this opened the participants up to greater critical reflection on the ways in which the care being offered meets or does not meet their perceived needs.

Phase Four: Creative problem-solving. The next stage of this workshop protocol involved inviting young people into a space of creative thinking and problem-solving. Participants broke into small groups of two to five participants and were asked to work together as a team to develop their design for their ideal mental health service for young people, which would address the key issues they had highlighted or any others they felt were important to them.

Participants had the freedom to respond to this prompt however they chose. The majority of groups engaged in creative processes including drawings, mind maps and word clouds about the type of experience they would like participants to have. Others created diagrams or wrote descriptions.

Throughout this process, I would move throughout the room providing answers to questions and posing questions to participants when they felt stuck or were running short of ideas. Prompts I gave included: Where would you want this to be? How much should this

cost? What does it look like? How do you want people to feel when they go here? At no point did I provide feedback or advice on aspects of the response when asked.

This activity was designed to be the heart of the workshop experience, and aimed to highlight hopefulness and motivation for change. It also intended to encourage creativity and excitement. Given the lively nature of this activity, it tended to take the majority of the time in the session. In some workshops conducted around mid-day, participants were offered pizzas and drinks throughout this activity. For workshops conducted at other times these were offered at the end of the workshop.

Phase Five: Crafting socially shared knowledge. Following their small group creative process, participants then presented their service design to the wider group. Groups chose to present in a variety of ways including having a single person speak, a number of speakers, and passing around their images. Each group explained the decisions they had made throughout their design process, why these choices were made, and what they felt they had addressed through their design. After each small group presentation, the broader workshop group were invited to provide feedback. The purpose of this approach was to encourage the social sharing of knowledge, and allow the full group to come together to bridge their perspectives and debate differences. Group members would often engage in hearty debates, highlighting the complexity of the issues faced and the challenges of care. In this way, the workshop not only elicited initial reactions and responses but encouraged young people to be critical of those ideas and consider the strengths and weaknesses of each approach.

Phase Six: Private reflection. Following this group discussion, participants were invited to respond to a concluding survey. This included two final questions: what is your ideal vision for youth mental health services? And was there anything you would like from a mental health service that was not discussed in the focus group?

The purposes of these questions were to ensure participants were afforded opportunities to share the final conclusions they had drawn individually in response to the social sharing process, along with a chance to privately share and reflect upon any priorities they had. Given tendencies towards peer agreement among young people due to their priorities of social acceptance, this opportunity was important to maximise chances for participants to share perspectives they may have felt would not be as socially acceptable or which they had publicly acquiesced to public opinion on whilst maintaining an independent private belief. This significantly strengthened the methodology beyond a single focus group by allowing these opportunities to share thoughts that may not have been publicly vocalised.

Phase Seven: Returning knowledge. At the conclusion of the workshop, participants reflected on their experience. They were thanked and provided a Koha (a donation of money offered as a thank you) along with a certificate of participation acknowledging their role as a contributing researcher and youth leader. Participants were then offered the opportunity to consult with me and ask any questions they had which had arisen throughout the process. Many participants asked about my experiences and perspectives, how to seek help for friends, and the process of studying and pursuing a career in psychology. At this stage, I focused on providing open and honest answers about my perspectives and offering any expert knowledge they sought to help restore the experience of mutuality through the research.

Reflexivity

While no research can ever be entirely without the influence of the researcher and their perspectives, it is particularly important within qualitative research to acknowledge the position of the researcher and how their presence can impact the research process (Farvid, 2010; Potter & Edwards, 2001). This is a process known as reflexivity, by which researchers consider their influence on the research conducted (Morrow, 2005). The position of the

researcher influences the project from its inception and the selection of the subject, through this process of research design and delivery, to analysis. As such, I will now consider the influence of my position as researcher on the process of designing and conducting these workshops. Later in this chapter, I will turn attention to reflexivity regarding the analytic process.

Reflexivity during the process of data collection is important for acknowledging how the presence of the researcher impacts upon the kinds of information gathered. For example, the researcher could influence the kinds of narratives gathered in a qualitative project through what they might unconsciously (or consciously) encourage participants to express (Russell & Kelly, 2002; Watt, 2007). The researcher's presence can also impact upon what is considered 'important' in the research process (Gaventa & Cornwall, 2006). As such, it was crucial to keep a reflexive record of my experience with each workshop. This involved noting to myself the emotions I experienced during the workshops, any changes made to the standard procedure, and why I believed those changes had been made. For example, in one workshop, I chose to completely separate myself from participants during the final creative process. I had noted that I chose to do this as I felt participants were often deferring to me and asking my opinion on their suggestions. In the recording of this workshop this was noted, with comments such as "what do you think?" appearing in the transcript.

As this vignette alludes to, it is particularly important when completing research with young people to consider the impact of power within the research, and the privileged position the researcher occupies. Research conducted with youth must acknowledge the impact of the power imbalance between adults and young people (Chung & Lounsbury, 2006; Claveirole, 2004). At the time of conducting this research and facilitating the workshops, I was myself a young person (aged 22-23), within the age range of the participants. There were both strengths and weaknesses to my age and position within youth culture. Firstly, this was often

very beneficial for rapport building and helped to foster a more ‘mutual’ culture. Several participants, particularly in schools, commented that they felt they could “relax more” because I “was not, like, a teacher.” I myself was able to understand much of the language used including slang and references to popular culture and social media sites.

However, while being embedded within youth culture and sharing experiences may have afforded me a greater depth of appreciation for the realities of the participants’ worlds and have offered a shorthand for communication, there were also weaknesses to my age in relation to participants. It was particularly essential that I not insert my own perspectives on youth culture, mental health, or mental health treatment into the research process.

Additionally, it should not ever be assumed that simply by occupying the same age bracket as participants that this eliminated any and all power differential present in the research process.

Power also relates to the perceived education and authority of others, and the position of researcher is inherently one of power (Kelly & Vlaenderen, 1996). Indeed, being a younger

person may have introduced other power differentials and emotional responses for

participants. For example, several participants stated ‘admiring’ my career path – which may have impacted their conduct in workshops or their willingness to offer feedback. In some

cases, participants recognised an extended social connection to me, such as volunteering for the same organisation or having mutual friendships which may also have contributed to this.

While I did not allow any young people with whom I had directly worked or who I regularly socially interacted with to participate in the study, these more extended connections could not

be eliminated. This was an essential driver of the decision not to offer any of my personal or professional advice and perspective until the conclusion of the ‘data-gathering’ process of the

workshop so as not to unduly influence the process. In this way, I attempted to reduce the

potential for participants to seek to align their perspectives with my own. However, I cannot

eliminate the possibility of unconsciously encouraging particular responses within workshops

entirely and, as such, will continue to overtly acknowledge my position throughout this research.

Conducting the Study

I will now turn to describing the details of conducting this study including ethical considerations, recruitment, the participants, and the analytic procedure.

Recruitment

Recruitment was conducted by reaching out to young people through social media, public advertisements, schools, universities, and community youth organisations. A sample of the text used for initial contact is included in Appendix Two, along with the advertisement distributed to both organisations and participants. This advertisement called for any young people aged 16-25 with interest or experience with mental health to participate. This language was chosen to appeal to not only participants who had been involved in the mental health system themselves, but also those who had elected not to be involved for a range of reasons including the barriers earlier described, those who had been declined from care, those who had sought informal help, and those who had been involved in supporting peers. Participants were only to be excluded if they were outside of the specified age range, the language for which is included in Appendix Two, with arrangements in place for supporting participants across the spectrum of mental distress who might have participated.

The process of recruitment was initially slow. At the beginning of the project, recruitment was conducted by contacting organisations including schools, sports clubs, and youth support organisations within the community and requesting they advertise workshops open to all which would be conducted at third party settings. The purpose of this had been to reduce the emergence of undue pressure or overt power dynamics by conducting workshops in formal settings such as within a person's workplace or school. However, this procedure

had very little efficacy and was extremely slow. A handful of participants were recruited via social media through a number of organisations who posted the advertisement. This group completed the pilot workshop together. These participants all commented that they would have felt as able to attend the workshop had it been held in a space they frequented.

Additionally, several participants who had responded to the advertisement and were expected to attend the initial workshop did not do so. Several stated challenges organising transport to the location of the workshop as a contributing factor to this.

As such, it was decided to consider organising workshops directly with community organisations and schools to determine if this would increase engagement with the research process. This new procedure was advertised via email and later through social media to enormous success, with dozens of schools and community groups contacting to request a workshop be arranged. The interest in these workshops was such that the number of workshops was capped at eight with an original estimated total of 80 participants. This was significantly greater than the original intended number of 25 participants, and capacity did not exist within the scope of this project to continue conducting these workshops at the rate at which they were requested. While some groups at this stage requested to advertise and distribute information to their young people without hosting a workshop themselves, due to the level of interest it was decided to only proceed with organising workshops directly with community groups and schools who could host these. However, the high degree of interest clearly indicated the passion among young people and those who work with them for conducting work of this kind. While capacity within the scope of this project limited engagement in this way, interest would have been sufficient to conduct several more such workshops.

When workshops were to be conducted at a school, several teachers opted to advertise the workshop directly to students whom they felt would be interested and who met the

criteria for participation. This tended to include students in psychology classes and those receiving support from school counselling services. These young people then decided whether they wished to participate in the project or not.

Workshop details

A total of eight workshops were conducted in six different localities across New Zealand, including both high density urban areas and lower population townships of both the North and South Islands. The local population size of locations in which workshops were conducted varied from less than 40,000 to over 1.5 million. On occasion, multiple workshops were held within a township or city, and some townships in which workshops were conducted were close together. This was in part to manage the process of research by reducing travel requirements. Workshops varied in size significantly, from three to 26 participants.

Several of these workshops were completed at secondary schools. The participating schools ranged in decile from three to nine, with a mean of six. The decile system is a crude measure of socio-economic level on a scale from one to 10, with one representing the greatest socio-economic deprivation (Ministry of Education, 2020). This is used within New Zealand to provide a rough estimate of the socio-economic status of students within a school, and primarily informs resource allocation and funding for schools (Ministry of Education, 2020). As such, our participants were slightly skewed towards higher socio-economic levels. This may be a result of better resourced schools in higher decile areas having greater potential to divert time and energy from regular school activities to offer an opportunity such as this. However, the decile system has been heavily criticised for its rudimentary measurement system and is not considered a reliable indicator of socio-economic deprivation (PPTA, 2013).

The workshops which were not conducted in secondary schools were based in community organisations or universities with participants recruited from a range of collaborating community organisations and local tertiary education centres. The number of these workshops conducted was fewer, in part due to the rapid and strong interest in the opportunity from secondary schools. However, conducting some workshops in these settings was essential for enabling young people who had left school to participate in the workshops.

I facilitated all workshops which were completed in this project. All workshops were recorded using multiple recording devices placed around the workshop rooms, with one recorder assigned to each ‘small group’ of participants who worked together on the creative project.

Participants

Across the eight workshops, 94 young people fully participated. A total of 96 young people completed consent forms and participated in the workshops, however two did not complete their final survey and so were not considered to have fully completed the workshop. Each of these participants left the workshop early to participate in other activities. No participant requested to leave the workshop due to no longer wishing to participate in the research. This was considered validating of the decision to shorten our workshop approach, as it significantly increased the number of young people able to participate in the workshops.

The average age of our participants was 17.77, with a range of 16-25. Our participants were able to self-identify their gender on their initial survey. A total of 80% of the workshops participants identified as young women, 19% as young men, and 1% identified as non-binary. Young people who identified as ‘male’ were grouped with men, and those who identified as ‘female’ were grouped with women. I did not request young people to identify their gender identity as cis or transgender.

In total, 16% of participants identified themselves as being a member of the LGBTQIA+ community. Identities I included in this category included gay, lesbian, pansexual, and queer with the majority of people within this community self-identifying as bisexual. National estimates of the youth rainbow population rely on young people describing themselves as bisexual, gay, or lesbian which totals 6.2% of young people 16-25 across New Zealand (Statistics New Zealand, 2019a). As such, this study is significantly over-representative of the LGBTQIA+ community, which may be related to allowing young people to self-describe their sexuality. Given that young people with rainbow identities are more likely to experience mental ill-health, this is a strength of our sample (Statistics New Zealand, 2019a). It should also be noted that 10% of the sample did not disclose or self-identify their sexuality.

Participants were also invited to self-identify their ethnicity. 68% of participants identified themselves as Pakeha, a term which refers to New Zealanders of European origin. I included in this category all young people who identified themselves as New Zealand European, Pakeha, or white. 15% of young people identified themselves as Māori, the indigenous people of New Zealand. As participants were able to include multiple ethnic identities, several who described themselves as Māori also described themselves as Pakeha. These participants were counted in both categories. 10% of participants identified as Asian of mixed origins, a category that included young people from China, the Philippines, Malaysia, Singapore, and several other Asian nations. 6% identified as Pacific Islanders, including those who identified as Samoan, Tongan, and Cook Island Māori. Additionally, 9% identified themselves as other ethnicities including international students. These young people had origins from the Middle East, South America, and Europe. Many ethnicity groups were slightly underrepresented in this sample with the exception of ‘other’ ethnicities. The degree of underrepresentation varied from between 1-5% (Statistics New Zealand, 2019b). While the

percentage of underrepresentation may appear small, this should nonetheless be seriously considered, particularly for Māori and Pacific Islander young peoples whom are overrepresented in mental ill-health statistics and underrepresented in professional treatment services.

57% of participants in these workshops had used mental health services before. In this project, I sought not only to include those with direct experience in services but also those who had supported friends and family, those who had been engaged in informal support, those unable to seek professional support, and those who had elected not to seek support due to perceived or actual barriers to help-seeking. A small number of students were included who were academically interested in mental health and did not disclose personal experience, typically students in psychology classes. Many of those students spoke to wishing to pursue careers in help-seeking and several already worked in the area as volunteers. These students were often leaders, driving towards meaningful change within their communities. Additionally, while a small number of these students did not disclose personal experience, a majority of those interested in psychology academically did disclose personal experience with mental ill-health.

Ethics

Ethics approval was granted for this project by the University of Auckland ethics committee on the 3rd of August 2018, for a period of three years (reference number 021731). A number of specific ethical considerations were taken in designing and implementing this research project. These particularly included the process of informed consent, the importance of maintaining confidentiality, and consideration of the potential for distress within participants given the sensitive nature of the material which was discussed in workshops.

Ensuring participants give informed consent to participate is an important aspect of research with young people. In the case of this study, this included ensuring young people were not coerced into participating, particularly when workshop recruitment was conducted in schools. Language was included in participant information sheets to ensure participants were aware their participation would not impact upon their schooling, and teachers were encouraged to remind their students that participation was completely voluntary. Additionally, young people in this study received a koha in acknowledgement of their participation. Some concerns have been raised in the past about the potential for these ‘rewards’ for participation to ‘incentivise’ participation in a way which can become coercive (Rice & Broome, 2004). As such, I took care to position the koha as a ‘thank you’ in the participant information and advertisements for participation.

In recognition of the sensitivity of the research, it was important to prioritise establishing the safety of participants. There was potential for young people to become distressed when discussing this content as many young people have strong emotional connections to this topic, particularly when discussing their own or their peers’ traumatic experiences with services. This is an important consideration with all qualitative research which involves discussing lived experiences, particularly with people who are already vulnerable (Clandinin, 2006). As such, throughout this process it was important to provide a safe environment for participants by maintaining an open and accepting stance, as well as attuning to and calmly responding to any distress which emerged (Josselson, 2007). All young people were provided with the details of where to seek help or support following workshops should they need it. In cases where workshops were organised directly with schools or community organisations, the organisation contact person was also provided with this information and advised to contact the researchers if any issues arose. Some participants did become distressed through the process, and I drew upon my experience as a training

psychologist and peer support worker for young people to support them throughout the workshop to engage safely. These young people were debriefed at the conclusion of the workshop and safety checks were completed in all cases. Workshop conversations were monitored for content suggesting distress, and procedures were in place to support young people who were considered in need of services or intervention on the basis of conversation.

The issue of confidentiality was also an important consideration in this project. There was potential that the young people who participated in this study would be familiar with each other. Given the nature of conversations within the workshops, it was also possible that young people might disclose personal and private information during workshops. Young people were encouraged to keep information disclosed within workshops confidential, but care was taken to remind participants both in the written information provided and the preamble to the workshops that I could not guarantee others within the workshop would not share information they had heard during the session outside of the workshop. A consideration of maintaining confidentiality through the process of transcribing and analysing data will be provided later in this chapter.

Reflections on the workshop method

Prior to moving to a discussion of the process of data analysis, I include a broad reflection upon the process of conducting these workshops. This includes considering both the feedback of participants and the kinds of knowledge produced through this approach.

Participant feedback.

Participants' feedback was sought formally at the conclusion of the first workshop conducted, at which stage the methodology was considered a pilot. This was not a formal evaluation of the procedure, rather an opportunity to shape and refine the methodology if needed based on feedback and experience. Participants were asked to write comments at the

conclusion of their final survey. This feedback was positive, with all participants expressing that they found the process enjoyable, with participants describing the session as “honest, supportive, relaxed, and focussed.” Interestingly, participants also commented on the process as validating, noting that they felt welcomed to share their genuine views and past experiences. As this participant reported “I felt very listened to and validated with my opinions and experiences.”

Across other workshops, participant feedback was shared informally at the conclusion of the workshop. Participants were asked to describe how the experience had been for them, and what they felt at the end of the process. In addition to endorsing feeling engaged, participants described feeling energised and eager for change. One participant stated, “We want to collaborate together” after the workshops with continued conversations and work within their communities. Some discussed working together to improve mental health awareness within their communities, such as one group who discussed how they could work to improve a mental health focussed event at their school. This feedback was also shared by teachers who had helped to arrange workshops, who expressed their students had been actively seeking opportunities within their school environments to facilitate and encourage change.

Other participants described feeling a sense of unity, community, and solidarity with their fellow workshop participants. Many reported this discussion with peers was the highlight of their experience: “It’s been really cool seeing everyone’s ideas....everyone’s talking way more than I thought they’d be.” Importantly, several young people also commented that the structure of the workshop helped them to feel more comfortable than they typically would in these environments: “I’m usually very shy but I felt very comfortable to share my ideas and experiences through this calm and open environment.”

Some participants also directly reflected on what enabled them to feel comfortable through the workshop process. As one queried: “I wanna know why this environment with these people, why does it work in this environment, why are we all comfortable talking with each other?” Participants particularly commented on being outside of a formal classroom, even when at school, as enabling them to feel comfortable: “If we were to do this in a classroom it would be awkward.” Others commented that this was related to the specific peers who chose to attend: “It’s the people that chose to do it. We all chose to be here.”

Others explicitly related this to my position as a researcher, as one said “Jess was very kind and inclusive.” This feedback was typically related to either my age or status as an unknown external person. As this participant stated: “You’re young and you’re not a teacher at our school. Cause usually for me I’d be like, oh I don’t like you I don’t want to do this. But you’re not from here.”

No critical feedback or points to change were raised. This does not necessarily mean there were no issues with the methodology and that all participants had a positive experience. It is possible that, if the experience was viewed positively by their peers, participants felt pressure to indicate their own experience had been positive. Additionally, while participants were reassured I would not know which person wrote any feedback provided, they may not have felt able to share criticisms directly.

Encouragingly, the feedback provided by participants suggested that they found the process empowering and energising. This was a key aim of this project and of designing this specific research methodology, and based on the feedback provided this approach was successful in incorporating practices to facilitate this throughout the workshop. Additionally, the response described by participants including feeling energised and driven to take action closely resembles definitions of catalytic validity, a process that describes research as having

validity when it energises its participants and helps them to re-focus and orient themselves to key issues (Lather, 1986).

Knowledge gained and shared.

An additional aim of this methodology was to achieve a wide breadth of responses whilst also gaining a depth of knowledge. This goal was overwhelmingly achieved, which presented both a strength and a challenge. There was enormous analytic potential for this project given the sheer quantity of data gained – amounting to over 200,000 words in total. This included both the transcripts of workshop discussions and presentations, written responses to surveys, and written remarks from the group creative processes and the newspaper prompts. For the purposes of this project, there was only scope to analyse all data together and not to compare the types of information gained from each activity and their individual contributions to the overall knowledge output of the workshop process.

Informally, it was observed that one strength of the mixed-methods workshop approach was the capacity to engage different participants across activities. For example, some participants were very verbal and made many contributions during group discussions. However, several of these participants wrote very short and limited responses in response to surveys or newspaper prompts. Other participants who were quieter in discussions often contributed more on written surveys and prompts, or drew images during the creative activities. Some participants appeared to have limited participation before writing nuanced and reflective final responses, or drawing an image to correspond with their group presentation whilst other group members spoke. In this way, this methodology appeared to allow participants to find comfortable ways in which they could make their own individual contributions.

Exploring alternatives

With this research project, I sought to develop a methodology which would not only allow but actively encourage our participants to step beyond mainstream narratives and perspectives of youth mental health and its care. The capacity to do this was somewhat limited by the condensed workshop timeline, which was a trade-off made to maximise the number of participants. However, despite this, participants were still able to effectively critique and respond to dominant discourses including those regarding their role as young people, youth mental health, and the treatments currently offered to them. It is likely that participants were primed for this by alternative discourses they have been exposed to, particularly those circulating online, and by their own extensive personal experiences which many acknowledged. Additionally, many participants may have self-selected for the opportunity to comment on the existing system and contribute to its change and development. As such, having limited time to explore dominant narratives and consider alternatives to them did not present as a significant barrier to the efficacy of this approach. Overall, young people were able to provide detailed, nuanced, and intelligent comments on their experiences, critically consider the relation of their individual experiences to systemic issues, and develop novel, creative solutions addressing their key concerns.

Data-Analysis

Transcription

At the completion of these workshops, data was gathered and consolidated. This involved transcribing in full the records from each of the eight workshops, including recordings taken from small-group activities. All workshops were transcribed by myself. This occurred for practical reasons, as the nature of the workshop recordings resulted in overlapping voices and conversations picked up across multiple recording devices present in

the room. The nature of these recordings therefore would have made it very challenging for a transcriber not present in the workshops to determine the flow of conversation through and across the devices used for recording (a total of four spread across the room to pick up conversations from, at times, large numbers of participants). These transcripts included only the actual words spoken by participants, with no reference to length of pauses, tone, or emphasis. Analysis of this kind was both beyond the scope of this project and somewhat impractical given the number of voices present in each workshop, which often overlapped. Participants were not offered the opportunity to review their transcripts. This was decided as, while this can be a useful way of restoring power to an interviewee following an interview, it was not feasible to allow each workshop participant to edit their individual contributions. It would have been near impossible to determine who had contributed what to the conversation. Additionally, I could not remove aspects of the conversation without altering the context and thereby meaning of other participants' remarks.

The written responses to surveys as well as written responses to the creative-group activity and newspaper prompt were then also added to the transcript to create a complete data-set for the project. This amounted to over 700 pages of data. This did not include images drawn during the creative small-group portion of the workshop, however these images were often described by their groups with the descriptions included in the transcripts. While analysis of the images themselves would be an interesting and engaging project, this was beyond the scope of this thesis.

Prior to analysis, all identifying information was removed from the transcripts. This included references to locations, schools, and individual people as well as removing specific information which could identify regions or schools. Finally, peer group conversations were removed (including conversations about weekend plans and upcoming events) as these also had potential to be identifying. These conversations were often present as the recording

devices remained on for the duration of the workshops, including while participants entered and while breaking for food.

While it is common practice in qualitative research to employ pseudonyms by which to refer to participants, these were not used in this analysis. The essential reason for this was that it was not possible, as due to the style of recording and number of voices present on each recording it was often very difficult to track voices across the workshop and thereby determine precisely which participant had made which comment. As such, to assign pseudonyms would be to falsely build an individual based on assumptions and estimations of their identity. Along with not including pseudonyms, significant identifying data was removed perhaps to a higher degree than may be necessary in international research. Given the size of New Zealand, without stringent de-identifying practices it can be very easy to identify organisations and the people associated with them, thereby risking exposing the identity of participants (Tolich, 2001). As such, details including names of teachers, friends, school subjects, the structure of buildings, and national location were altered when included. When participants' ethnicity or sexuality was explicitly referenced or provided necessary context for a quotation, it was ensured that no other identifying information surrounding the quotation could be triangulated to identify this person. While every step possible was taken to avoid identifying any participants, it is important to note that each participant attended a workshop with between two and 25 other young people. Each participant's consent form requested they maintain the confidentiality of their peers, however it cannot be guaranteed that this took place and the possibility remains that a young person may reveal sensitive information regarding another participant or may recall the participant who made a particular remark during the workshop. This unfortunately is an unavoidable consequence of research of this kind, and was made explicit to participants in the participant information they were provided with prior to signing their consent forms.

Thematic Analysis

The complete set of data was then analysed using a thematic analysis approach, employing Braun and Clarke's (2012) framework for thematic analysis which was chosen as a flexible approach that can accommodate different epistemologies and theoretical priorities. This approach to analysis involves identifying themes that reflect important trends in the data relevant to the research question. The analysis process began with immersion in the data and the full data-set was read several times. Following this, I made note of interesting comments and initial patterns that were emerging. After this initial immersion, the process of analysis began by defining two key lines of analysis to pursue: young people's perspectives on and ideals for mental health clinicians and for mental health services. Relevant extracts under each category were removed from the master document and formed into two new documents containing all comments related to mental health clinicians and all related to services. This was an inclusive process, with some passages included in both documents if they related to both areas. These two broad areas were selected for their relevance to the research aims and the specific question this project sought to answer. There was a significant portion of the data which was not further analysed but which provided further interesting information on young people's perspectives.

The extracted statements were then tentatively grouped into overarching categories that related to similar subjects using NVivo software for support given the large amount of data available. These overarching categories were then refined and shaped into themes. These themes were reviewed by myself and my supervisor until it was felt they accurately reflected

the data. The themes for each category were developed independently of one another, and are presented separately in Chapters Three and Four.

To ensure trustworthiness of the analysis, the themes were discussed, reviewed, and refined by myself and my supervisor at each stage of the analysis to ensure consensus and increase fidelity (Hill, 2015). Examples that illustrated each theme were extracted for inclusion in the analysis chapters of this thesis and any remaining identifying information in these was removed. In these analysis chapters, descriptors such as ‘many’ and ‘a few’ were used to indicate how frequently themes or specific ideas within a theme were addressed by participants but are not intended to imply the possibility for statistical generalisation which was not an aim of this research.

Rigour: Assuring quality in qualitative research

As has been acknowledged throughout this chapter, qualitative analysis inherently entails subjective decision making. This has often led to criticisms of qualitative research as lacking validity and reliability (Liamputtong & Ezzy, 2005). However, qualitative research is fundamentally different to quantitative approaches and should not be evaluated according to the same standards of quality as quantitative approaches (Bailey, 1996; Lincoln & Guba, 1985). For example, the aim within qualitative research is to develop depth of understanding rather than to generate universal, generalizable findings (Merriam, 2002).

While some researchers have attempted to develop criteria for ‘good’ qualitative research, the notion of these criteria continues to be contentious in the field of qualitative research (Sandelowski & Barroso, 2002). This may in part be due to qualitative research being a wide and varied field, covering a range of subjects, methods, and theoretical approaches to research which do not necessarily share unifying principles (Rolfe, 2006). It is therefore important to prioritise transparency and reflexivity in qualitative research (Yardley,

2008). Transparency involves intentionally making visible the process of research and opening this up to scrutiny, a process which can make qualitative research more trust-worthy (Bailey, 1996). As such, throughout this chapter I have documented in detail the various influences upon this project, the methods used, and the analytic approach chosen. It is hoped that this process will afford those who may read this research the opportunity to make their own informed decisions regarding the applications of this research and its findings to contexts which are relevant to them (Morrow, 2005).

Reflexivity is regarded as an important criteria for establishing the quality of qualitative research (Morrow, 2005). It has been noted that the interpretation of data in qualitative research is always impacted upon by the researcher and their worldview (Denzin & Lincoln, 2003). I conducted this research from my position as a student on a doctoral clinical psychology program and trainee psychologist, as well as my position a young person who fits in the age range of the participants. Given my professional positioning, it was important to resist and challenge tendencies to confine the accounts of participants into dominant narratives of mental health and its treatment. Additionally, it was important to be attentive to how my own perspectives and experiences as a young person could influence me through the process of data-analysis. This involved carefully documenting responses to the data and to the workshops, highlighting times I felt challenged or that my personal experience varied from that described by young people, and reflecting on these issues throughout the analysis. Supervision with my supervisor, a researcher and psychologist with significant experience of working clinically with young people, was also an opportunity for reflection on and challenging of my views. This helped ensure fidelity, that is, ensuring the themes developed most accurately reflected the words and sentiments of the workshop participants (Hill, 2015).

Qualitative approaches are gaining acceptance as potentially rigorous and valuable methods of conducting research (Creswell, 2008). This is particularly true in fields related to health care broadly and clinical psychology specifically, in which qualitative research is increasingly seen as offering valuable contributions to the field (Baum, 1995; Rhodes, 2011). In this way, an important signifier of the value of qualitative research is its potential for *transferability*, that is, the potential for findings to be applied beyond the research setting (Lincoln & Guba, 1985). Given the relatively large sample size and attempts made to clearly document the groups from which our sample drew representatively, it is believed these findings do have the potential to be transferred to broader understanding of some groups of young people within New Zealand.

Summary

This study draws upon the fields of social constructionism and participatory action research to inform its exploration of young people in New Zealand's ideal vision of mental health care. A novel collaborative workshop process was employed with 94 young people across eight workshops around the nation. This approach was intended to allow young people to occupy a position of agency and explore creative solutions to perceived problems without simply reproducing dominant understandings of youth mental health care to which they may have been exposed. These workshops were analysed using thematic analysis, which allowed a depth of understanding of the words and ideas put forward by the participants. This approach to research allowed for a rich exploration of a complex issue with a traditionally disempowered population.

Preface to Findings

Chapters Three and Four of this thesis present the findings of this research project. Each chapter details a different component of the qualitative analysis conducted, with Chapter Three focusing on findings related to young people’s ideals for mental health clinicians and Chapter Four highlighting findings which represent young people’s ideals for mental health services. Each of these chapters is written as a journal article prepared for submission in different journals, both of which are currently under review.

Chapter Three presents “Rethinking the role of *the all-knowing gods of mental health*: What young people want from their mental health clinicians.” This article describes the results of this project that pertained to participants’ perspectives on mental health clinicians, including counsellors, psychologists, psychiatrists, and more. This chapter begins by reviewing the existing body of literature that has explored young people’s attitudes to and desires for their mental health clinicians. It then moves to situating the current project and its potential to contribute to this area, before briefly reviewing the relevant details of the methodology for this specific area of findings. The qualitative analysis regarding participants’ ideal mental health clinician is then presented, before concluding with a discussion of the relation between our outcomes and both current research and developmental theory.

Chapter Four presents “Building *somewhere that you want to go*: What young people want from their mental health services.” This chapter details the results that address young people’s ideals for mental health services. It begins by providing an overview of mental health service design for young people, both in New Zealand and internationally, and providing the context for this research. It then recaps the relevant details of the research methodology. The bulk of this paper provides the results of the qualitative analysis of the workshops related to young people’s ideals for mental health services. The conclusion of this

paper considers the relation between these results and those of past research, and considers the similarities between the proposed service and those existing internationally.

It is important to note that, while these chapters are separated for the purpose of presenting findings, the areas of mental health clinicians and services were not presented separately or in isolation throughout the workshops. Both topics were woven through all activities of the workshops, and are inherently linked in complex and varied ways. In the reality of clinical work, it is impossible to untangle the impacts of clinicians on the services within which they work, and vice versa. The purpose of dividing the results of this project in this way is not to artificially impose a false divide between these, but rather to ensure the appropriate findings and discussion is available to the audience who would most benefit from reading and understanding the results. As such, Chapter Three is aimed at an audience consisting of clinicians and mental health practitioners who work with young people while Chapter Four is intended not only for other researchers in the area of service design, but also for those in management positions of existing youth mental health services who have the potential to influence change in this area.

Chapter Three:

Findings.

Rethinking the role of *‘The all-knowing gods of mental health’*:

What young people want from their clinicians.⁵

Ahakoia te momo mate, whakanuia tangata

Regardless of illness, people deserve dignity

⁵ This chapter is a lightly edited version of a co-authored paper prepared for publication in a peer-reviewed journal. This paper has been submitted to Child and Youth Services Review.

Young people globally are in great need of acceptable and accessible mental health treatment due to their high incidence and prevalence of mental health problems (McGorry et al., 2007). However, youth aged 12-25 have the poorest engagement with treatment of any population group (McGorry et al., 2013). While this is a complex issue, it should be particularly concerning to mental health clinicians that even after accessing mental health treatment, young people have very high drop-out rates (de Haan et al., 2013). There are several reasons young people may disengage from treatment. However, many drop out of therapy because of dissatisfaction, including dissatisfaction with their clinician (O’Keeffe et al., 2019).

While poor engagement of youth in mental health treatment is associated with a number of factors, findings have suggested that the clinician, their style of working, and the therapeutic alliance are powerful factors in determining whether young people will engage with treatment. Young people’s engagement in treatment is closely influenced by their counsellor (Atzil-Slonin et al., 2015; Berry & Greenwood, 2015, Duppong Hurley et al., 2015; Fernandez et al., 2016) and young people often report counsellor qualities as one of the most helpful aspects of their treatment (Griffiths, 2013; Lynass et al., 2012; Ness et al., 2017). By contrast, young people who drop-out of services are more likely to report a poor therapeutic alliance (Garcia & Weisz, 2002; Hawley & Weisz, 2005; O’Keeffe et al., 2020), with those who do not like their therapist’s approach or who have issues in their relationship being most likely to drop out without expressing their dissatisfaction directly to their clinician (O’Keeffe et al., 2019). As such, if we intend to improve young people’s engagement with mental health treatment, there is scope to focus on factors within the control of individual clinicians including counsellors. Counsellors can be empowered to improve their relationships with young people, in order to reduce drop outs and improve engagement.

Clinician factors and adult outcomes

Most research into the impact of clinician characteristics and the counselling relationship has focused on adults (Lambert & Barley, 2001). Beutler et al. (2004) have conceptualised clinician characteristics that impact outcomes as falling within four domains – observable traits, such as age, sex, and ethnicity; observable states, such as training and experience; inferred traits, such as personality style and therapeutic approach; and inferred states, such as the therapeutic relationship with a client. In adult research, findings vary as to the impact of gender, ethnicity, and age of clinician on outcomes (Beutler et al., 2004; Blow et al., 2007). Similarly, results vary as to what type of training and experience improve outcomes (Beutler et al., 2004). Friendliness is consistently associated with good outcomes (Beutler et al., 2004), but results vary as to the impact of other personality traits (Blow et al., 2007). While many of these other domains may produce varied results, some research findings suggest that ‘inferred states’, particularly the therapeutic alliance, may be most strongly associated with outcomes (Horvath & Bedi, 2002; Orlinsky et al., 2004; Wampold, 2001). A recent meta-analysis of studies which reported correlations between therapeutic alliance and treatment outcomes reported that the therapeutic alliance is positively related to outcomes of treatment, above and beyond client or clinician characteristics (Fluckiger et al., 2020). As such, the therapeutic alliance has often been suggested to be the most important factor in sustaining engagement of adults (Beutler et al., 2004). Positive regard, genuineness, collaboration, warmth, sensitivity, and good communication are all key factors in building therapeutic alliance for adults (Cooper, 2004).

Clinician factors and young people

By contrast, significantly less research investigating the impact of clinician factors on engagement and outcomes has been conducted with young people. In order to improve young

people's engagement with clinicians we need greater understanding of this (Donald et al., 2014), particularly as young people's needs from their counsellors are likely to be different to adults given their different developmental priorities (Sauter et al., 2009). However, this body of literature is growing. For example, observable traits may be more impactful for young people than adults and appear to directly relate to inferred states including the therapeutic alliance, with research suggesting that gender and ethnicity matching can improve the therapeutic alliance, decrease drop-outs, and increase likeliness of completing treatment for young people (Wintersteen et al., 2005).

Youth perspectives on engagement with clinicians

Traditionally, research into client/clinician relationships has not attended to the client's experiences of and perspectives on their own treatment but relies on independent ratings of quality of relationship or clinician perspectives (Bury et al., 2007). For young people, this research often relies on parent and clinician reported outcomes (Roose & John, 2003). Historically, mental health clients have often been perceived as unable to accurately comment on their own relationship with clinicians due to factors like their mental state (Bohart et al., 2002); insight (Elliot & James, 1989), and 'distorted' views (Macran et al., 1999). However, research has identified that client perceptions of therapy correlate better with treatment outcomes than the views of professionals (Bohart & Tallman, 2010; Busseri & Tyler, 2004). Additionally, it has been found that accommodating a client's preferences into the therapeutic relationship is correlated with decreased drop outs and improve outcomes (Swift et al., 2018). Therefore, considering client's perspectives on what clinician factors they value in treatment is likely to be an effective way of improving engagement.

Even less research has been devoted to understanding young people's perspectives on working with clinicians (Gibson et al., 2016). This is likely to be related to traditional

conceptualisations of young people as a ‘difficult’ group who lack the motivation and insight to comment on their experiences (Biever et al., 1995; Sommers-Flanagan & Sommers-Flanagan, 1995; Trepper, 1991). These historic attitudes that young people are incapable of making decisions about their treatment have lingered (Prout, 2007; Lack & Green, 2009; Zirkelback & Reese, 2010) and relate to beliefs that young people are immature and irrational in comparison to adults (Alderson, 2013). However, young people’s reported relationship with their clinician correlates closely with their treatment outcomes (Shirk & Karver, 2003) suggesting youth perspectives too are valuable and should be considered. It has been repeatedly noted that clients bring their own values, beliefs, experiences, and culture to therapy (Gelson & Carter, 1994) and this includes young clients. Additionally, the United Nations have set the precedent that young people should have the right to express their views about services provided to them (The United Nations, 1989, Article 12). As such, it is important that we prioritise hearing and understanding young people’s perspectives on the clinicians they work with.

The body of literature seeking to explore what young people value from their clinicians is developing. Young people have consistently indicated that the relationship with their counsellor is of significant importance to them when seeking mental health treatment (Bury et al., 2007; Gibson et al., 2015). From the research that has been conducted, the most common factors which young people report improve their engagement with clinicians include being listened to (Bury et al., 2007; Freake et al., 2007; Gibson et al., 2019); experiencing a genuine connection (Bolton et al., 2003; Gibson et al., 2016); feeling accepted without judgment or stigma (Binder et al., 2011; Everall & Paulson, 2002; Hefflinger & Hinshaw, 2010; Hollidge 2013); having their autonomy respected (Binder et al., 2011; Gibson et al., 2016); a less hierarchical relationship (Bacha et al., 2019; Binder et al., 2011; Bury et al., 2007; Everall & Paulson, 2002; Gibson et al., 2016; Lavik et al., 2018); a more informal and

friendly relationship (Binder et al., 2011; Everall & Paulson, 2002; Gibson et al., 2016); a sense of control and choice in their own care (Gibson et al., 2016), which may be particularly significant for young men (Doherty et al., 2017); trust (Lovgren et al., 2019) particularly regarding confidentiality (Booth et al., 2004; Freake et al., 2007); and empathy and care (Bacha et al., 2019; Binder et al. 2011; Everall & Paulson 2002; Henriksen, 2014; Hollidge 2013; Lavik et al., 2018). More supportive clinicians with strong communication, clear acceptance, empathy, and non-judgmental attitudes are valued highly (Biering, 2010). Youth also indicate a preference for youth-friendly clinicians who understand their worldview (Lavik et al., 2018; McCann & Lubman, 2012b) and who are not perceived as patronising (Freake et al., 2007). Young people also have a preference for multi-disciplinary teams, and the opportunity to work with a range of different professionals with different expertise (Scott et al., 2009).

Research into young people's priorities for their counsellors is consistent with what we might expect their priorities to be on the basis of developmental literature. Adolescence is widely accepted to be a key stage for identity development, and is associated with a growing desire for independence and autonomy (Erickson, 1963, 1968; Habermas & Bluck, 2000; Klimstra, et al., 2010; Kroger, 2003; Marcia, 1966; Schmitt et al., 2008). As a result of this, young people are sensitive to attempts to control them (Everall & Paulson, 2002) but tend to hold very little power (Hinshaw, 2005). Indeed, young people are less likely than other clients to have control over their engagement with mental health services, and are most often treated in services designed for and focused on adult priorities (Karver et al., 2005). The disconnect between the priorities of young people and their adult clinicians could contribute to challenges engaging young people in treatment, including high drop-out rates (Block & Greeno, 2011). It is likely that respecting young people's priorities will aid the formation of a strong therapeutic relationship, in order to allow young people to truly engage in and become

active participants in therapy (Oetzel & Scherer, 2003). This means reconsidering the ways in which we give voice to young people's perspectives (Duncan et al., 2006; Kelley et al., 2010) and providing more opportunities to explore the complex issue of agency for young people in a system which often provides them with little power (Spencer & Doull, 2015).

The New Zealand study

Given the clear value in hearing young people's perspectives on clinicians for improving their engagement and decreasing drop-outs, it is important that research considers their voices (Gibson et al., 2016). While this research body is growing both around the world and in New Zealand, much of the research that has been conducted thus far in this area has utilised traditional qualitative methodologies to determine what was helpful or unhelpful for young people with experience in mental health treatment about their clinician. There are a number of issues with traditional qualitative methodologies, including tendencies towards to peer agreement within focus groups, lack of depth to answers on surveys, and limited perspective taking in individual interviews (Morgan, 1996). Additionally, when research consists of commenting on past experiences it is rooted in current practices and limits participants to commenting on what has already being done, positively or negatively, in this area. As such, past research into young people's perspectives on clinicians has not allowed them to explore creative or novel ideas for how these relationships could be improved. This project seeks to step beyond having young people comment on their experiences, and open up possibilities for active participation and creative ideas of an ideal counselling experience in order to move beyond current perceptions of what the role of counsellor entails.

In this study, we apply a novel methodology intended to elicit more creative solutions to avoid participants 'recreating the wheel' based on what they already believe to be possible. As such, we integrate traditional qualitative methodologies with participatory approaches

such as those used in critical empowerment research in the broader social sciences. One such methodology is a collaborative workshop methodology, piloted by Calder-Dawe and Gavey (2019) which aims to empower young people to develop solutions to problems that affect them and to improve their skills. In this way, the research process is intended to not only elicit information but also to be mutually beneficial to participants themselves in a process that is empowering to the youth who are involved.

This study was conducted in New Zealand, an island nation in the South Pacific. New Zealand has a young demographic, and the primary ethnic groups are Pakeha people (also known as New Zealand European, people who are descended or recently immigrated from Europe), Māori people (the indigenous people of New Zealand), Pacific Island people (people originating from islands in the Pacific), Asian peoples (consisting of recent immigrants and descendants of earlier settlers) and other immigrants, most commonly from Africa, the Middle East, and South America (Statistics New Zealand, 2019b). New Zealand young people have high rates of mental ill-health and often have poor service access (Clark et al., 2013).

This study utilises this collaborative workshop methodology to explore New Zealand young people's views on the clinicians they would most like to work with when engaging in mental health treatment.

Methodology

Participants

94 participants between the age of 16 and 25 with an interest or background in mental health participated in eight workshops across New Zealand. Participants responded to an advertisement calling for young people with personal experience or passion for mental health. While not all participants identified as service users (57% had been involved with mental

health services) this study sought to also include those who may not have accessed services due to barriers including their preconceived notions of counselling, as well as those who had supported others with mental health challenges.

Workshops were conducted in six different localities across New Zealand, including high density urban areas and townships of both the North and South Island. 80% of participants were young women, 19% were young men, and 1% were non-binary. 68% of participants were Pakeha, 15% Māori (indigenous people of New Zealand), 10% Asian, mixed origins, and 6% Pacific Islanders. 9% were immigrants or international students from the Middle East, South America, and Europe. The ethnic diversity of the group closely resembled the diversity of New Zealand (Statistics New Zealand, 2019b) with a slight underrepresentation of most groups.

Data gathering

A qualitative methodology was chosen to answer our research questions for its potential to elicit greater depth and breadth of response from participants. A unique workshop design was developed specifically for the purposes of conducting this research. It was important for our specific research questions to utilise creative methods in order to create more possibilities for our participants to see beyond the conventional social construction of the role of ‘clinician’ to new possibilities of what this role could look like.

This method drew on critical empowerment work, such as the methodology utilised by Calder-Dawe and Gavey (2019) with the intention of empowering young people to be in a position of agency and ensuring they mutually benefit from the research process. This methodology enabled young people to proactively consider solutions to the problems they see, rather than focusing on their past experiences or the problems they see alone. This method was also developed to overcome issues inherent in other qualitative methodologies,

such as reducing the power imbalance between the researcher and the young participant (Punch, 2002), tendencies to peer agreement within focus groups, lack of depth to answers on surveys, and limited perspective taking in individual interviews (Morgan, 1996). Additionally, this form of data gathering enables social sharing of knowledge consistent with the aims of this research (Willig, 2008).

The workshop method incorporated individual surveys at the beginning and ending to elicit initial thoughts and any responses to the topics discussed which participants might not express openly for any reason, such as fear that these ideas would be considered socially undesirable. A group discussion typical of a focus group then occurred, in which young people responded to questions about their experiences of and goals for clinicians. This was followed by an activity in which young people responded to a prompt – a newspaper article about a proposed new mental health service. Lastly, participants engaged in creative group projects in which they worked in teams to design an ideal mental health service, including the ideal clinicians with whom they would like to work, which they then presented to the full group. It was noted that, in addition to addressing some challenges of qualitative research and eliciting nuanced and creative ideas, the mixed methods utilised in the workshops also allowed different participants to ‘shine’ in different activities, with some very vocal in discussions, others writing more, some annotating their newspaper articles, and others drawing services. Workshops lasted between two and three hours depending on group size and were facilitated by the lead author, a training psychologist and doctoral candidate. The size of the focus group varied from three to 26 participants.

Data analysis

The thematic analysis took a theoretical, deductive approach which sought to identify themes in the data related to our specific research question (Braun & Clarke, 2012). The data

was analysed using Braun and Clarke's (2012) framework for thematic analysis, which involves identifying themes that reflect important trends in the data relevant to the research question.

Data was transcribed, including transcriptions for each small group, and combined with written survey answers. Prior to analysis, all identifying information was removed from the transcripts. The analysis began with immersion in the data and the full transcripts of the focus groups were read several times. All statements that related to young people's attitudes to or ideals for clinicians and mental health professionals were then extracted. These statements were then tentatively grouped into overarching categories that related to similar subjects using NVivo software for support given the large amount of data. These were then refined and shaped into themes. These themes were reviewed by both researchers until it was felt they accurately reflected the data.

To ensure trustworthiness of the analysis, the themes were discussed, reviewed, and refined by both researchers at each stage of the analysis to ensure consensus and increase fidelity (Hill, 2015). Examples that illustrated the beliefs of participants within each theme were extracted from the transcripts. Any remaining identifying information included in the examples was removed. Descriptors such as 'many' and 'a few' were used to indicate how frequently themes or specific ideas within a theme were addressed by participants but are not intended to imply the possibility for statistical generalisation which is not appropriate in this kind of qualitative research.

Reflexivity is regarded as an important criteria for establishing the quality of qualitative research (Morrow, 2005). The first author is of mixed Māori and European heritage. She is a student on a doctoral clinical psychology program and a young person within the age range of our participants. The second author, a South African migrant to New

Zealand, is a researcher and psychologist with experience of working clinically with young people. Given our professional positioning, it was important to resist and challenge tendencies to confine the accounts of participants into dominant scientific explanations or notions of professionals, particularly our own ideals within our practice, and to pay attention to the different and novel ideas young people were proposing.

Ethical consideration

Ethics approval was granted by the University of Auckland Ethics Committee. The researchers recognised the sensitivity of the research and care was taken to establish the safety of participants. Workshop conversations were monitored for content suggesting distress, and procedures were in place to support young people who were considered in need of services or intervention on the basis of conversation. Participants were also provided with contact information for support services should they need it.

Findings

Five themes were identified through the thematic analysis. These themes are presented separately for the purposes of the analysis, however they are not conceptually or theoretically independent. These themes are best considered synergistically; it is the combination of these ideas, and the overlap that exists in the space between them, that best represents the participant's perspectives on the ideal professional with whom they would like to work.

A shared background: Someone like me

Across the workshops, young people consistently expressed a desire to work with mental health clinicians with whom they have shared experiences and identities. Participants expressed how this can provide a sense of being implicitly understood. As one participant

stated: “We want diversity in them, with a range of background knowledge and experience similar to what we have.”

Within this theme, participants spoke about several types of experience and identity which they would like to share with their professionals. The most common of these was a shared cultural background with their professional. Young people reported that this gives them a sense the professional will understand their cultural upbringing and their family dynamics better. One young person described it like this:

Your background and your religion has a lot to do with who you are and where your problems are based from so if you have a counsellor that’s tailored to you then that will help you way more to open up cause they’ll understand about cultural things.

This need was particularly expressed by participants from minority ethnicities in New Zealand, particularly Pacific Islander and Māori participants, with agreement from their peers of other cultural backgrounds. One young Māori woman particularly drew attention to the ways in which cultural competence alone is not an acceptable alternative to culturally matched professionals, stating:

You can be a Pakeha [Non-Indigenous] person and go to different courses and things like that and you know, learn your mihi [formal greeting] and things like that, but at the same time it's not the same experience. And so I think it's really important to have Māori counsellors, specific counsellors, counsellors from different ethnicities all over so that we can understand the culture My ideal counsellor would be like a Māori, young Māori woman ... because it would make me feel comfortable to talk to them because I could feel like they can relate to me.

Young people also reported a desire to work with professionals with whom they shared lived experience with mental illness. They particularly emphasised how this can help

them to feel understood, and increase feelings of safety. As this young person stated: “Counsellors with personal experience can be great as well because they can kind of understand what you’re going through. Like, they’ve gone through similar things to you.”

Participants spoke about a need for more potential for sexuality and gender matching among the professionals they work with. Young LGBTQ+ participants emphasised how training alone is not enough to educate a professional without the shared identity about what that experience is truly like, similar to discussions about cultural matching. They also spoke about the desire to see professionals of different gender identities, including both gender matching to men and women and the option to work with transgender or non-binary professionals.

Young people who participated in workshops emphasised the need for clinicians they see as sharing a background with them.

Friendliness: Someone I connect with

Participants spoke about the need to connect with their professionals in order to work with them. Most participants spoke of a desire to have a more relaxed, friendly relationship with their professionals. For many, this meant knowing more about their professionals and having a stronger sense of their personality, interests, and background – rather than seeing them as just a “name and a title.” One participant put it this way: “I feel like the more casual it is the more you take from them... Like, I take more advice from my friends than a counsellor so if the counsellor’s your friend then I can take more on.”

Many of these young people pointed out that these relationships would take time to build, but described how more relaxed relationships would help them to feel more comfortable, and could reduce power dynamics and feelings of intimidation. As this

participant shared: “It’s less of like a power thing. It’s more like, I guess we could be friends if we wanted to even though they’re your counsellor. It’s like, I could see you as a friend.”

Participants spoke about how age could be a factor that helps them connect with professionals, particularly younger professionals whom they might perceive as more relatable due to being closer in age to them. This young person put it as: “I feel like... other people might not understand the things that teenagers are going through whereas like younger people might because they’re around a similar age to us.”

Some participants expressed discomfort about working with professionals who were much older than them due to feeling they do not understand them and might have old-fashioned judgments of them. As this participant said: “It’s just a bit awkward and uncomfortable, especially if you’re like 20 years younger than the person who’s talking to you. Like, I just feel like old people have that belief that like, you know, self-harming’s attention seeking.”

However, to contrast this perspective, many participants also spoke about how they might connect more with older professionals. One young person stated their ideal age for a professional was over 40 because: “You know that they have a lot more experience in their life and can be, you know, wiser.”

Finally, participants spoke about the importance of humble professionals who would be able to admit when they were not the right fit for them, and could be honest about what they know and do not know. One described it as: “They can be honest about this... rather than ‘we are the all-knowing gods of mental health and everything you are experiencing is distilled into this word and will be handled like this.’”

Across the workshops, young people emphasised the importance of working with professionals whom they connect with, which could be related to their style of relating, friendliness, age, and humility.

Professionalism: Someone who protects my space

Young people expressed their need to work with professionals who they believed were capable of keeping them safe and effectively treating them. For some participants it was important to have the safety provided by professional boundaries. While a sense of connection was valuable, some participants explained that they wanted to feel they could focus on their own needs rather than the person they were speaking to. That is, the distinction between working with a ‘friendly professional’ and a ‘friend’. As this participant put it:

Professionalism is extremely important ... if your counsellor’s telling you about their day and their work, it’s like I don’t really care, this is meant to be about me. But like it sounds selfish but like that is what you’re paying for and that’s what you’re going for.

Some of these participants described how they appreciated the stance of a professional who can give more objective advice: “I think that if you make a counsellor basically become your friend, your friends are more likely to not tell you the complete truth of what they think of a situation.”

Many participants extended this balance between friendliness and safety from a professional to the issue of confidentiality. This participant spoke about the importance of both a relaxed connection and professionalism in creating a safe space: “If people want to see a therapist it needs to be a chill environment where you can feel safe, where they’re not going to give away your secrets.”

Many participants shared their frustration with policies around confidentiality and parents being notified about risk, noting how restrictions around confidentiality had prevented them from being honest with clinicians. For several participants, there was frustration with not understanding what information will be kept confidential or not. One expressed “I don’t know, where is that line? Like, it’s not really clear.” For many, it was felt that there was need for greater transparency about bounds of confidentiality. In general, young people who understood the legal bounds on confidentiality were the most accepting of the occasional need to break confidentiality.

However, the greatest frustration for young people around confidentiality was feeling as though it was breached unnecessarily and unprofessionally, outside of situations where there were safety concerns. Situations like these were the majority of breached confidentiality experiences described. Many described having teachers told the content of their visits to school counsellors. One described an experience: “They tell you it’s confidential and then they go around telling everyone and it’s like ‘I thought this service was confidential!’”

Young people expressed how, for them, professionalism would include transparency and sharing their interpretation of events and their justification for treatment. As one participant put it: “They can inform and explain rather than tell you. You can see the reasoning behind what they’re saying and that comes with a respect that you deserve to know.”

Many participants spoke about their desire to work with professional and competent clinicians, who they trusted to adhere to professional practices like boundaries, confidentiality, and transparency.

Respect: Someone who treats me as an equal

Young people across the workshops expressed a need for clinicians who are respectful of them and their experiences. Underlying this desire were a substantial number of negative experiences around disrespectful and patronising clinicians.

Young people expressed how respectful clinicians would take them and their experiences seriously. Many participants described interactions with professionals who did not believe their problems, blamed them for situations they had been through, or told them to “just get over it.” Many adolescent participants particularly pointed out how they felt their problems were dismissed because they were teenagers. Older participants who had experienced mental health services both as a teenager and as a young adult also noted this and reflected on how their experience in mental health services had changed, with one stating:

I’ve noticed a difference from being most recently in the past year compared to being in it when I was 15.... They really treat you differently in the sense that you don’t deserve to know what’s going on with you and you don’t really deserve to know what [they’re] thinking about. ... and I felt like I was being belittled or patronised or disrespected and there’s no worse feeling.... I’ve realised they’re kind of reinforcing that vulnerability rather than empowering you.

Other young people spoke about how being respected as a young person includes not being ‘babied’ or patronised by clinicians. These young people described times when they had sought mental health treatment and were offered models that felt like they were designed for much younger children. As this participant states:

A lot of counsellors’ kind of use similar treatments to how they would like a child. Like a ten year old. Like, one lady like got a bunch of little Lego characters and shit

and told me to like put them in places around me... I saw like a lot of the same things being used as when I was like six.

Participants described a respectful clinician as listening, believing them, and “really soaking up what the person is saying and just taking it in and thinking about it.”

Young people also described the importance of being compassionate, stating that they “should be validated” by their clinicians. This stood in contrast to many young people’s experiences of questioning the compassion of their clinicians. As one said: “It’s almost like they see the patients as more of like a pay check maybe.”

Participants expressed a desire to feel respected by their clinicians, through validation and compassion as opposed to being patronised.

Responds to the individual: Someone who works in the right way for me

Young people across the workshops outlined how their ideal clinician would be someone who works in a way that aligns with their personal beliefs. Young people spoke passionately about their desire for having options and some kind of agency in choosing their support. For many, this meant being able to engage with their preferred type of clinician. Participants expressed desire to be able to choose whether they worked with a range of clinicians including counsellors, psychologists, psychiatrists, occupational therapists, speech language therapists, nurses, and peer support workers. For some young people, there was a perception that they were not being offered treatments to properly address their needs. One participant described her experience like this:

When I did counselling it was like, just every week instead of what was meant to be happening, like dealing with the feelings I was having ... it was like, ‘you know what will make you happy? Let's make cupcakes this week!’ and it was like ‘Can we talk about my trauma?’ And it was like ‘No! We're gonna make cupcakes!’

These participants often expressed a need for more therapeutic approaches that they perceived as helping them more directly. Several participants expressed frustration that they had not been offered treatment options including cognitive behavioural therapy and dialectical behaviour therapy, such as this young person who said:

There was this type of therapy... CBT or something. Cognitive behavioural therapy. Yeah, I think that would be helpful. Because my psychologist talked about it but we never got to it or she never really even explained it to me so I had to like research it myself.

Other participants by contrast described seeking alternative ways to interact with their therapists, such as by expressing themselves through crafts and music, when they found talking too uncomfortable. As one said: “I reckon there needs to be alternative ways of mental health as well if that makes sense. Like there can’t just be sitting down and talking to someone because some people just don’t express like that.”

Overall, these participants spoke about a desire to work more collaboratively with their clinicians, being offered choices, and having a say in treatment planning. One put this as: “You are not obliged or forced to do anything. You are in control of this whole process”

For many other participants, having agency over therapeutic decisions meant having the option to choose whether or not they would take medications, having their options properly explained to them and presented in collaboration with other therapy models. As one participant described:

They might say an option is to take medication as well... but you don’t have to. Everything comes with the support that this can happen but you don’t have to because you’re still a human being and you should still feel as though you have agency, no matter what age you are.

For many participants, it was important that the professionals working with them consider their treatment individually. As this participant put it:

Young people sort of get put into like a homogenous group. We're all young people, since we're all the same age we all think exactly the same, but like that's just not true at all. There's people with different political beliefs, different upbringings, everything like that. And so there's sort of not really one method that can cure every one of their, you know, mental health problems.

For other participants, part of the value of being professional meant that clinicians had specialist knowledge in particular areas of mental health. For these participants, there was often a feeling that a more specialised clinician would be more educated and focussed on the problems of particular concern to them. As this participant described

I reckon... it should be different counsellors that study different like departments. So it's more personalized to go to not just one counsellor that you know, knows a bit of everything. If you've got one specific problem you've got a specific person that can help you.

Participants were eager for individualised therapy approaches that take into account their unique needs. One young person described how they felt professionals could meet this need:

In my opinion, a good counsellor... should be able to foresee this, should be able to see the sort of things that would benefit an individual case because everyone's unique and certainly some strategies will be more effective on them than others. Others may really just benefit from talking and others might benefit from more getting out and doing things. And that just fits into a whole there's no one size fits all kind of rule.

Young people who participated in workshops emphasised the importance of working with clinicians who respect their unique needs and values in the treatment planning process.

Discussion

This analysis identified five themes that describe the ideal mental health professionals young people would like to be able to work with. These themes were a clinician with a shared background, who is friendly, professional, respectful, and responds to their individual needs. The significance of these results is bolstered by the consistency between our findings and other research that has been conducted with young people. This study reinforces those findings and offers a framework which combines disparate research across fields relating to different kinds of mental health professional.

The need for gender and ethnicity matching between mental health professionals and clients has been raised in a number of studies, and it has been found that for young people gender and ethnicity matching can improve the therapeutic alliance and increase likelihood of completing treatment, thus reducing high rates of drop-outs among young people (Wintersteen et al., 2005). While gender matching has often been seen as a stronger preference among young women than men, it may also be valued by younger males (Cooper, 2006). Some research has suggested that young people value clinicians who are similar to them in age, gender, and experience as this improves relatability (Clark et al., 2018). Research investigating the impact of ethnicity matching on therapeutic outcome is varied, with one meta-analysis identifying small impacts of ethnicity matching on outcomes for most people and an overall decline in preference for ethnicity matching among adults in recent decades (Cabral & Smith, 2011). The importance of ethnicity matching to young people specifically could be related to the importance of identity formation during this stage of development for young people. Interdisciplinary research has identified that ethnic identity

formation is a complex and important process for young people, particularly of minority ethnicities, and that the experience of an ‘othered’ ethnic identity can impact a young person’s sense of agency (Jensen, 2011; Umana-Taylor et al., 2014). As such, reducing the feeling of ‘othering’ and creating opportunities for identity formation within the therapeutic alliance by ethnicity matching may increase a young person’s sense of empowerment and of being understood rather than othered within their treatment.

Despite the importance of ethnicity matching to young people and its potential benefits to their therapeutic outcomes many regions including New Zealand face the challenge of having few mental health professionals from minority ethnicities, who are also often overrepresented in the mental health system. In order to meet the desire for gender, ethnicity, and sexuality matching among young people it is important to consider how training programs can contribute to increasing the number of professionals of minority ethnicity and sexuality moving into the workforce. Given that under current circumstances ethnicity, gender, and sexuality matching will often not be possible, it may also be important for clinicians to consider turning attention to the ways in which they may not be the ideal therapist for their young client, to acknowledge this, and seek supervision and consultation with others who hold these identities.

Very little research has evaluated if there is any impact on therapeutic outcomes from working with professionals who have lived experience with mental health. This may be due to traditional professional boundaries, which discourage clinicians from sharing this kind of experience with their clients. There may be room to evaluate whether, even without disclosing experience to clients, there is a difference in outcome for professionals with and without their own lived experience.

It has been well established that young people prefer to work with professionals who they perceive as approachable, compassionate, warm, friendly, and authentic (see Plaistow et al., 2014 for a review of such studies). These traits are typically depicted as important for how they facilitate the process of building rapport, or a relationship, between client and clinician. While clearly a priority for young people, this should also be a priority for professionals given frequent findings suggesting that rapport is a key component in effective youth mental health care (Garcia & Weisz, 2002; Hawley & Weisz, 2005; Ross, 2013; Mooney, 2016). This study provides additional support to the finding that this is highly valued among young people, and that friendliness and a relaxed environment may be key to engaging some young people in treatment.

However, focussing on building a connection with a client can often be misperceived as unprofessional due to misconceptions of a false dichotomy between connection and professionalism. Young people in this study demonstrated that they do not value connection or professionalism in isolation from each other, but rather would prefer to work with a professional who is equally capable of connecting with them and conducting themselves professionally. This includes someone who is experienced and capable of holding their needs, who maintains confidentiality, informs them of their plans, and can clearly articulate what they are doing and why. This is consistent with the results of a meta-analysis suggesting that a key desire for young people is to have information about what their professionals are doing and why (Plaistow et al., 2014). It is also consistent with other studies demonstrating that young people value experienced and competent clinicians (Robinson, 2010) and clinicians with boundaries and integrity (Binder et al., 2011). When considered together, young people's desires for clinicians who are both friendly and professional show that it is not sufficient for young people to feel a rapport with their clinician. They also need to have faith that their professionals have the competence required to adequately treat them, and trust that

they will adhere to professional practices like boundaries and confidentiality. Rather than perceiving professionalism and connection as two ends of a dialectic, it is important to consider how professionals can embody both of these practices.

One way professionals may integrate this into their work with clients can be to allow young people to establish the kind of relationship they would like to have and meet them in their need. For example, if a young client sets a tone of more relaxed communication, a professional might consider how they can meet this in a way that still allows them to respect professional boundaries such as by sharing some of their interests, professional background, or sense of humour, or otherwise engaging in a more relaxed style. If a client prefers more professional boundaries, rather than assuming they would prefer to be more relaxed given their youth, it may be more appropriate to prioritise professionalism that demonstrates professional competence and consider why they might be in need of reassurance of this.

One particular area of practice where professionalism and connection can appear to contrast is around confidentiality. Young people have continually raised their concerns about confidentiality (Booth et al., 2004), and these challenges will be very familiar to all clinicians who work with young people. What may surprise clinicians is that young people in our study were understanding of the need to breach confidentiality when this had been explained to them fully and they were aware of the ‘line’, even if they did not like this need. What young people struggle with the most is feeling their clinicians are unprofessionally or unnecessarily breaching confidentiality. This is consistent with research finding that young people with poor experiences of therapy often report that processes involved in treatment were not properly explained to them (Lavik et al., 2018; Von Below, 2020). There is room to navigate confidentiality professionally while still building connection. By practicing transparently, professionals can empower young clients and position themselves as allies to them on their

journey to better mental health. One direction professionals could pursue is ensuring they are informing their clients of their expectations and bounds around confidentiality.

A respectful professional is someone who is perceived as validating and who takes their client seriously. This is distinct from someone who a client connects with, as a young person may build rapport with a professional who then does not take them seriously. Additionally, many clinicians who focus on professionalism may not prioritise respecting their young client's perspective. Desires for respectful clinicians who take their young clients seriously and listen to their perspectives align with findings that young people are often deterred from help-seeking due to fears they will be judged by their mental health clinicians (Hefflinger & Hinshaw, 2010). Other research has identified that young people have had the most positive experiences of counsellors who are seen as listening and understanding rather than dismissing or patronising (Crocket et al., 2015; Lynass et al., 2012; Robinson, 2010). Respectfulness is a piece that can tie together both professionalism and connection, and can aid clinicians who find each way of relating more naturally to them.

There are clear links between a young person's desire to be respected by their clinicians and both the developmental stage of youth and sociological views on what it is to be a young person in society. The desire for increased autonomy is a well-established aspect of development for young people, as they begin to deepen their identity formation both as individuals and group members (Smetana, 2011). By contrast, in many contexts around the world, young people are often positioned as relatively powerless with limited control over their lives such as decisions about their health (Hinshaw, 2005). In psychological research, young people are often characterised as difficult, unmotivated, and incapable of making decisions about their own care (Biever et al., 1995; Lack & Green, 2009; Prout, 2007; Sommers-Flanagan & Sommers-Flanagan, 1995; Trepper, 1991; Zirkelback & Reese, 2010). When young people are disrespected, they are further disempowered at a developmental stage

when they are most sensitive to their desire for agency. As such, it would follow that young people would prefer to work with clinicians who respect and build up their growing autonomy rather than undermining them or treating them as children. Additionally, research has indicated that autonomy among young people can predict greater psychological wellbeing (Inguglia et al., 2015). As such, mental health services that prioritise the autonomy of youth may promote wellbeing in and of themselves, irrespective of the added benefit of reducing drop-out rates and promoting service engagement. By positioning themselves as non-judgmental, compassionate, and open by taking their clients seriously, not minimising their experiences, and considering for themselves why they may struggle to take some clients seriously, professionals could improve outcomes for their young clients and reduce disengagement.

Research has also established that young people are eager for opportunities to participate in their own care (see Robinson, 2010 for a review). For many young people, this can enable them to take more control of their care and feel as though they are helping themselves (Svanberg & Street, 2003). While professionals might be concerned about young people's capacity to guide their own care, studies have demonstrated that young people can be effective participants in care planning particularly when professionals focus on identifying communication methods that work for their clients (Smith & Callery, 2005). It may be time to rethink the role of professionals who work with young people as dictating care decisions for their client based on professional opinion or service demands. Allowing young people a voice in decision-making may not only aid their engagement, but also improve their outcomes. Clinicians may achieve this by considering how to involve their clients in an age and ability appropriate manner. For example, if considering multiple therapeutic models they may consider presenting these and the rationale for each approach to a client for their perspective. If inappropriate to consult a client in this way, professionals could consider

clearly explaining their decision as to how to approach therapy including why there is no other option available to the young person. It may also be helpful for clinicians to consider how young people in our study highlighted the benefit of ‘small’ choices, such as where to sit and how to start a session, and how these may also help to build empowerment in therapy.

Across the workshops, it was clear that young people who have experienced mental health services have rarely worked with professionals in this way. Poor experiences with clinicians may be related to a number of issues out of the control of individual professionals. These include training and the demands of services. As such, many young people have had poor experiences with clinicians and may therefore take more time to build trust and be more sensitive to issues with new clinicians with whom they engage. It is important for clinicians to consider how they can help address these concerns and past experiences for clients.

Nevertheless, as mental health professionals, there is room to consider how our behaviour can shift to be more in line with the needs of young clients, and from where any resistance to this change may come. Many professionals may already be incorporating several of these principles or may see easy behaviour changes they can make. Others may feel resistance to these principles or see great disconnect between the perspectives of young people and how they have been trained to practice. While some may feel that, as experts, clinicians’ practice is fundamentally correct, and should not be adjusted to suit clients, it is critical for the wider profession of mental health professionals to reconsider this attitude. A more efficient and engaging service requires professionals who are willing to be flexible and adaptable to the unique needs of the population they serve, and who can hold this flexibility alongside their training. Mental health professionals can and should be able to uphold high standards of professional behaviour while also adapting their behaviour and attitudes to better address young people’s needs.

Many countries around the world are reconsidering their mental health systems broadly, or youth mental health systems more specifically. Even when widespread change is not underway, many individual services are increasingly recognising the need to alter practice to better serve the needs of youth. While widespread systemic, cultural, and structural change is needed in many mental health services it can often feel insurmountable, unachievable, and expensive. This can leave services trapped in traditional, unhelpful patterns of care while they juggle the challenge of establishing how to address these needs. This study demonstrates how changes to the practices of individual mental health professionals within these services, or even in private practice, may improve the engagement of young people and thereby their outcomes. Many of these practices can be implemented quickly and individually, while others might require conversations with management, but few should require substantial and expensive structural changes to services. These changes should not be considered an alternative to broader system change, but a supplement to this and an option that services can integrate quickly even before undergoing larger scale change.

Particularly interesting is that, when given the freedom to identify any features that could improve their engagement, young people often focused on characteristics of clinicians. This should empower clinicians to be confident their practice can substantially impact a young client's engagement and likely also their outcomes.

Limitations

While this sample was diverse and reflected many groups from around New Zealand, these results may not be truly reflective of the perspectives of all young people. In particular, Māori and Pacific Islander young people who were underrepresented in this sample and are overrepresented in mental health statistics may have different needs for their professionals

(Bennett & Liu, 2018). Their opinions may need to be investigated in an additional study building on this research.

This sample was also gender imbalanced, as is unfortunately common in some mental health research (Woodall et al., 2010). However, young men in New Zealand do experience mental ill-health (Adolescent Health Research Group, 2013). As such, it may be necessary to consider developing unique methodologies for gathering the perspectives of young men that are more able to engage them in research.

Conclusion

Awareness is rapidly growing of the poor mental health experienced by many young people around the world, and how this is not only impacting their health and wellbeing in the short term but also their individual development and contributions to the economy as they move into adulthood. Despite greater awareness and increased understanding that the current mental health system is not sufficiently meeting the needs of young people, less attention has been paid to factors that clinicians can control which may contribute to limited service engagement, high drop-out rates, and poor outcomes among young people. Less research still has focussed on the perspectives of young people themselves as to how they believe professionals can work better with them. This is an area in need of greater energy and increased research. This study seeks to fill some of that gap, by providing a set of principles for professional practice based on the perspectives of young people who participated in a series of workshops about the youth mental health system. Based on this study, young people seek to work with professionals with whom they share a background, who they connect with, who are professional, who respect them, and who work in a way that is adapted to them. By incorporating some of the practices we recommend, mental health professionals can align their practice more closely with the needs of young people. This can improve the engagement

of young people in their service in a way that is relatively inexpensive and low demand compared to structural or systemic changes to services.

Chapter Four:

Findings

Building '*somewhere that you want to go*':

Conducting collaborative mental health service design with New Zealand's
young people.⁶

Tungia te ururua, kia tipu whakaritorito te tipu a te harakeke

Burn off the undergrowth, so that the new flax shoots may grow.

⁶ This chapter is a lightly edited version of a co-authored paper prepared for publication in a peer-reviewed journal. This paper has been submitted to the Journal of Environmental Research and Public Health.

It has been well established that around three quarters of lifetime mental ill-health will have onset by age 24 (McGorry et al., 2007). Given this, it is clear that youth mental health should be an important priority for not only moral and ethical reasons but for the significant burden it places on health, families, communities, and economies across the lifespan. However, access to good quality mental health services is poor both around the world and in high income countries like New Zealand (Becker & Kleinman, 2013; Browne et al., 2006b; Patel et al., 2007). Despite having the highest incidence and prevalence of mental ill-health, 12-25 year olds have the poorest service access, highlighting the immense gap between need for and engagement with mental health services among young people (McGorry et al., 2013). This has been called a crisis in care as the majority of young people with mental health difficulties do not have their needs met (McGorry et al., 2011).

Barriers to help seeking

Several factors contribute to poor mental health service access among young people. These include both internal and external barriers. External barriers are features of a service that can prevent young people from accessing care, with most research into external barriers identifying cost, hours of operation, inaccessible location, and fragmented and confusing services as key barriers to help seeking among young people (Anderson & Lowen, 2010; Settapani et al., 2019; Adolescent Health Research Group, 2003). Internal barriers are factors within the young person that prevent them from seeking help from formal services. These include fears about confidentiality, not feeling comfortable with services, lack of knowledge about both when to seek help and how to seek it, discomfort and shame with seeking help, and perceiving that clinicians will have negative, discriminatory, or patronising attitudes to them (Anderson & Lowen, 2010; Booth et al., 2004; Boydell et al., 2014; Cosgrave et al., 2008; French et al., 2003; Garland et al., 2005; Hefflinger & Hinshaw, 2010; Rickwood et al., 2005; Rickwood et al., 2007; Summerhurst et al., 2017; Adolescent Health Research Group,

2003). Historically, most research in this area has focussed on ways in which service practices can negatively impact engagement with considerably less research investigating young people's beliefs about what services should do to reduce the barriers and improve their engagement.

One critical barrier to engagement is that young people are less likely to engage with services they perceive as irrelevant to them (Summerhurst et al., 2017). This is both an internal barrier, driven by beliefs among young people that services are not appropriate for them, and a structural external barrier, as traditional services are rarely designed for young people and therefore are often unsuitable for them (Cosgrove et al., 2008; Coughlan et al., 2013; Kieling et al., 2011; McGorry et al., 2007). At present in New Zealand, as in many other countries, youth mental health care is split between child and adolescent services for 12-17 year olds and adult services for 18-25 year olds, with some exceptions such as Early Psychosis Intervention Teams. Child and adolescent services are overwhelmed with long waitlists and high demand (Moore & Gammie, 2018). As such, while there are many barriers to engaging in these services, these are hidden by the extreme level of need with an additional four young people in need of services for everyone who engages (McGorry et al., 2007). Despite their level of need, young people over 18 often do not meet criteria for adult services which often focus on long-term mental health clients (McGorry & Mei, 2020). Both child and adolescent and adult services are often not developmentally sensitive to the needs of young people (Hetrick et al., 2017) and are rarely evaluated in research (McGorry & Mei, 2018; McGorry et al., 2020). This has continued to be the case despite widespread consensus that young people require different treatment approaches to either children or adults (Asher et al., 2019; Corace et al., 2018; Fusar-Poli, 2019; McGorry & Mei, 2020; Roche et al., 2019). For example, it has been noted that most mental health systems rely on young people accessing services through primary health care (Tyler et al., 2017) despite findings that young people

are often reluctant to engage with primary health care (Tylee et al., 2007). This lack of suitability to the target population could contribute to these services having poorer engagement and outcomes than any other mental health services (Coughlan et al., 2013; Kieling et al., 2011; McGorry et al., 2007), but it is difficult to determine exactly how as these services are so rarely evaluated (McGorry et al., 2020). It is clear that the traditional model of youth mental health care is not adequately meeting the needs of young people (McGorry et al., 2013).

Youth specific services

Many have argued that to address this unmet need we must respond with wide-spread, transformative change which reconsiders traditional services in favour of services that are empowering, inclusive, responsive, accessible, creative, and youth-friendly (Coughlan et al., 2013; McGorry et al., 2013; McGorry et al., 2007). A common response to this need for change around the world has been to move towards youth-friendly services, designed specifically with young people of age 10-25 in mind.

The World Health Organisation have defined youth-friendly services as services that are accessible, acceptable, and appropriate to young people (World Health Organisation, 2012). A number of principles have been proposed for youth-friendly services that align with this definition. These include that services should be accessible in terms of location, cost, wait time, and referral process; that they be acceptable by being safe, informal, youth-friendly, non-stigmatising, confidential, and collaborative; and that they be appropriate by offering integrated and holistic care, ‘evidence-based’⁷ practice, and early intervention (Anderson & Lowen, 2010; Fleming & Elvidge, 2010; Social Policy Evaluation and Research

⁷ While the term ‘evidence-based’ is often used to refer to clinical treatment models which are supported by research, it is used cautiously in this thesis to acknowledge the ways in which the term might suggest there is a single ‘best’ approach to clinical practice (Lakeman, 2008).

Unit, 2015; Stewart, 2020; Tylee et al., 2007). It has also been proposed that services should be sustainable, through being adapted to and embedded in the community, and effectively managed (Rickwood et al., 2015; Stewart, 2020).

A number of services have emerged around the world with the intention of filling this gap for youth specific care in accordance with some or all of these principles (Hetrick et al., 2017). One example is Australia's Headspace (McGorry, 2007). Headspace was specifically created as a response to the need for more youth-friendly, accessible, and effective services for young people and provides high quality, research informed treatments to young people 12-25 years old (McGorry et al., 2007). There are numerous other well-established international examples including Jigsaw, in Ireland (McGorry et al., 2013); Maison des Adolescents, in France (Benoit et al., 2018), YouthCan IMPACT and ACCESS Open Minds, in Canada (Abba-Aji et al., 2019; Henderson et al., 2020); and other programs in The Netherlands (Leijdesdorff et al., 2019); the United Kingdom (Heavens et al., 2020; Vusio et al., 2020); and more (Hetrick et al., 2017). New Zealand currently has Youth One Stop Shops, a youth specific integrated health care service with numerous locations. While these are not specifically mental health services, many clients would not access mental health care without the support offered through this service (Communio, 2009). This service sees a high portion of indigenous Māori youth, and a significant number of their clientele have complex needs (Bailey et al., 2013). These services all tend to be conveniently located, 'youth-friendly', low cost, and focussed on offering timely appointments with assurances of confidentiality and privacy (Hetrick et al., 2017).

These youth-specific services have demonstrated their efficacy in a number of ways. Across services reviewed by Hetrick et al. (2017), 52-68% of young people saw a reduction of symptoms, suicidal ideation, and self-harm along with an improvement to function. Youth One Stop Shops in New Zealand found that 58% of those most in need of help and 52% of

those with some difficulties improved after being under the service (Bailey et al., 2013). Research into Headspace identified that awareness of services significantly improved in a seven year period, addressing a common barrier to engagement (Perera et al., 2019).

However, in their review of youth-specific services, Hetrick et al. (2017) note that there are no unifying principles or standards for youth services, the details of service design are often poorly described in the research, and there is currently no single ‘best-practice’ example of youth-specific services.

Youth participation in the design of mental health services

One component that is common to most youth-specific services internationally is youth participation in the planning, design, and delivery of the mental health service (Halsall et al., 2018; Hetrick et al., 2017). Youth participation has been proposed as a means of improving engagement among young people by ensuring that services clearly respond to and relate to their needs and preferences (Woodhouse, 2014). Youth participatory design incorporates young people as active participants in their own care, and challenges professionals to reconsider their view of young people, shifting from disempowering and paternalistic attitudes to respecting young people’s right to agency (Coughlan et al., 2013). Youth participatory research builds on the notion that in order to create services that meet the needs of young people, young people must be allowed to be full and equal participants in the development process to ensure it truly responds to them (Rickwood et al., 2007). Working collaboratively with young people in this way can serve the important role of facilitating youth empowerment (Hughes et al., 2017).

Many services have involved young people in the development process (Heavens et al., 2020; Henderson et al., 2020; Malla et al., 2019; McGorry et al., 2013) with Hetrick et al. (2017) identifying that Jigsaw, Headspace, NZ YOSS, Foundry, and ACCESS Open Minds

all explicitly involved young people not only in the design process but in on-going evaluation of the service. In the Headspace model, youth participation is expected at all levels including in their own care and in on-going service development as well as high-level service design, delivery and evaluation (Rickwood et al., 2019). It has been noted that this kind of involvement not only ensures that services are more relevant and appropriate to the population they are seeking to serve, but that it facilitates youth-friendly and stigma free culture of care (McGorry et al., 2014) and may be more cost-effective (Hamilton et al., 2017). Many findings suggest that involving young people in the process of service design is a key component to developing effective youth mental health services which address many of the identified barriers to help-seeking for young people (Al-Yateem, 2020; Halsall et al., 2018; Hetrick, 2017; Mei et al., 2020; Porter & Lee, 2013; Settapani et al., 2019). It is particularly notable that some research has suggested that collaboratively designed services have the potential to engage minority young people who are traditionally underserved by conventional mental health services (Rickwood et al., 2014).

As such, despite findings which have suggested these existing services are effective in engaging and treating young people, it would not be sufficient to simply adopt the headspace model *as is* around the world. Youth participation is likely to be a key component in the success of these models, and we cannot assume that youth populations around the world are homogenous with common needs and priorities. It is therefore important to balance research-informed service design with local adaptations (Hetrick et al., 2017). It is critical for designing responsive and appropriate youth services to not recreate existing services, but to draw on the literature, methodologies, and approaches employed in service design around the world to inform the process of collaboratively developing services for specific communities and youth populations. These services have great potential to be adapted for different settings by employing a co-design process (McGorry, 2019).

The New Zealand study

In New Zealand, there is significant scope to expand the provision of youth-friendly, collaboratively designed services for young people. While there has been some acknowledgement of the importance to include service users in the design of services, this has not been specifically applied to young people (Cunningham et al., 2018). Youth One Stop Shops have been highlighted as an example of the benefits of increasing funding for primary mental health services (Cunningham et al., 2018). However, commentary on this model's success has rarely acknowledged the role of youth engagement or noted that no other primary mental health service for young people in New Zealand aims to provide youth-friendly services informed by youth perspectives. Youth One Stop Shops are also not explicitly mental health services, and have limited capacity to meet high and complex mental health needs (Bailey et al., 2013). As such, this research seeks to determine whether the process of collaboratively designing mental health services can be expanded upon and effectively applied with New Zealand young people to determine how mental health services might better serve their needs.

While many methods of collaborative design have been explored in past research, there is scope to move beyond these. Traditional methods of involving young people in service design often rely on surveys, interviews, and focus groups. Each of these methods has limited capacity to elicit creative solutions and novel ideas that move beyond young people's pre-conceptions of what services can be. For example, tendencies towards to peer agreement within focus groups, lack of depth to answers on surveys, and limited perspective taking in individual interviews (Morgan, 1996). In this study, we applied a novel methodology intended to elicit more creative solutions to avoid participants 'recreating the wheel' based on what they already believe to be possible. As such, we integrate traditional qualitative methodologies with participatory approaches such as those used in critical empowerment

research in the broader social sciences. One such methodology is a collaborative workshop methodology, piloted by Calder-Dawe and Gavey (2019) which aims to empower young people to develop solutions to problems that affect them and to improve their skills. In this way, the research process is intended to not only elicit information but also to be mutually beneficial to participants themselves in a process that is empowering to the youth who are involved. This approach was used effectively by Calder-Dawe and Gavey (2019) in a similar population of young New Zealanders to discuss the challenging topic of sexism. As such, it is believed a similar model could be used to safely investigate the challenging topics of mental ill-health and support.

In this study, we bring together methodologies inspired by both critical empowerment research and youth agency work done in collaborative youth mental health service design around the world. We use this methodology to explore New Zealand young people's views on creating services that serve their needs and are more likely to engage them in their time of need.

Methodology

Participants

94 participants aged 16 - 25 with an interest or background in mental health participated in eight workshops across New Zealand. Participants responded to an advertisement calling for young people with personal experience or passion for mental health. While not all participants identified as service users (57% had been involved with mental health services), this study sought to include those who may not have accessed services due to barriers and those who had supported others.

Workshops were conducted in six different localities, including high density urban areas and townships of both the North and South Island. 80% of participants were young

women, 19% were young men, and 1% were non-binary. 68% of participants were Pakeha, 15% Māori, 10% Asian, mixed origins, and 6% Pacific Islander. 9% were immigrants or international students from Asia, the Middle East, South America, and Europe. The ethnic diversity of the group closely resembled the diversity of the New Zealand (Statistics New Zealand, 2019b) with a slight under representation of most groups and slight over representation of recent immigrants and international students. While the level of underrepresentation is very small, this should nonetheless be seriously considered, particularly for Māori and Pacific Islander peoples who are overrepresented in mental ill-health statistics.

Data gathering

A qualitative methodology was chosen to answer our research questions for its potential to elicit greater depth and breadth of response from participants. A unique workshop design was developed specifically for the purposes of conducting this research. This method drew on critical empowerment work, such as the methodology utilised by Calder-Dawe and Gavey (2019), with the intention of empowering young people to be in a position of agency and ensuring they mutually benefit from the research process. This method was also developed to overcome issues inherent in other qualitative methodologies, such as reducing the power imbalance between the researcher and the young participant (Punch, 2002), tendencies to peer agreement within focus groups, lack of depth to answers on surveys, and limited perspective taking in individual interviews (Morgan, 1996). Additionally, this form of data gathering enables socially shared knowledge consistent with the aims of this research (Willig, 2008). This methodology enabled young people to proactively consider solutions to the problems they see, rather than focusing on their past experiences or the problems alone.

The workshop method incorporated individual surveys at the beginning and ending, to elicit initial thoughts and any responses that might not be expressed by participants, for example due to concern these would be considered socially undesirable. A group discussion more typical of a focus group then occurred, followed by an activity in which young people responded to a prompt – a newspaper article about a proposed new mental health service. Lastly, participants engaged in a creative group project in which they worked in teams to design an ideal mental health service which they then presented to the full group. It was noted that, in addition to addressing some challenges of qualitative research and eliciting nuanced and creative ideas, the mixed methods utilised in the workshops also allowed different participants to ‘shine’ in different activities, with some very vocal in discussions, others writing more, some annotating their newspaper articles, and others drawing services. Workshops lasted between two and three hours depending on group size and were facilitated by the lead author, a training psychologist and doctoral candidate. The size of the focus group varied from three to twenty-two participants.

Data analysis

The data was analysed using Braun and Clarke’s (2012) framework for thematic analysis, which involves identifying themes that reflect important trends in the data relevant to the research question.

Data was transcribed and combined with written survey answers. Prior to analysis, all identifying information was removed from the transcripts. The analysis began with immersion in the data and the full transcripts were read several times. All statements that related to young people’s attitudes to or ideals for mental health services were then extracted. These statements were then tentatively grouped into overarching categories that related to similar subjects using NVivo software for support given the large amount of data. These were

then refined and shaped into themes. These themes were reviewed by both researchers until it was felt they accurately reflected the data.

To ensure trustworthiness of the analysis, the themes were discussed, reviewed, and refined by both researchers at each stage of the analysis to ensure consensus and increase fidelity (Hill, 2015). Examples that illustrated the beliefs of participants within each theme were extracted from the transcripts. Any remaining identifying information included in the examples was removed. Descriptors such as ‘many’ and ‘a few’ were used to indicate how frequently themes or specific ideas within a theme were addressed by participants but are not intended to imply the possibility for statistical generalisation.

Reflexivity is regarded as an important criteria for establishing the quality of qualitative research (Morrow, 2005). The first author is of mixed Māori and European heritage. She is a student on a doctoral clinical psychology program and a young person who fits in the age range of our participants. The second author, a South African migrant to New Zealand, is a researcher and psychologist with experience of working clinically with young people. Given our professional positioning, it was important to resist and challenge tendencies to confine the accounts of participants into dominant scientific explanations or notions of mental health services, and to pay attention to the different and novel ideas young people were proposing. Similarly, given our cultural backgrounds it was important to focus on participants’ words rather than making assumptions about what this might mean within specific cultural contexts.

Ethical considerations

Ethics approval was granted by the University of Auckland Human Participants Ethics Committee. The researchers recognised the sensitivity of the research and care was taken to establish the safety of participants. Workshop conversations were monitored for

content suggesting distress, and procedures were in place to support young people who were considered in need of services or intervention on the basis of conversation. Participants were also provided with contact information for support services should they need it.

Findings

Seven themes were identified through the thematic analysis that reflect the kind of mental health service young people want. This is a place that is comfortable, accessible, welcoming, embedded in the community, holistic, adaptable, and youth focussed. It is the combination of these themes that most accurately reflects the wishes of the young people who participated in our workshops – none of these themes in isolation would be sufficient for designing a youth-friendly mental health service.

A place that is comfortable

Across our workshops, young people described the kind of mental health service they would like to attend as a comfortable space in which they could feel safe and relaxed. As one young person put it, they sought a space “where [young people] feel like they can be honest and at ease and not like they’re in an asylum”.

Participants spoke to aspects of design that could increase comfort. For several, this meant reconsidering the clinical space, which had often been experienced as uncomfortable due to features like dim lighting, plain design, or classical music. As this young person said: “It was just like, kind of a dark room with weird ambience like a weird ...and not like bright and happy.”

Instead, young people described the ideal service as more relaxed and informal spaces with brighter colours and lighting, and more unconventional furnishings including giant bouncy balls, comfy couches, and bean bags. Many young people spoke about the balance

between making a space fun and engaging for them without being too childish or feeling too young. This young person described it like this:

I don't want to say like make it look like a kindergarten, but you know like make it a really happy place to be with lots of colours and stuff. Because a lot of the places you go they literally look like a hospital room or like a business office and you always think of the scenes in like movies where they're lying down on the couch with the clipboard and that's really not inviting.

Several young people's ideal service offered options outside of the traditional 'two chairs and door' model, where they could do activities while speaking with their clinician. Examples including playing games, weighted blankets, or playing with stress balls or fidget spinners. This young person described how different approaches might work at different times:

Some days you don't want to talk about your feelings but you want someone to just chill out with. And sometimes you do want to talk about your feelings! So... like a chill room and a professional formal room. So, the Chill Zone ... if you just want to come in after school and you've had a bad day and you just want to watch some Netflix with your counsellor, maybe you want to play some board games, maybe you want to play with the stress ball while you're talking or you know listen to some chill beats. And there's some bean bags. And then this is the formal zone, with the chair and a couch and a glass of water because it's formal, there's not too much going on and there's not many distractions. But it's a place where you can get down to business because sometimes that's what you want.

Many young people wanted a space to be more reflective of youth culture. For example, a space playing popular music, having posters for upcoming events, or having Wi-

Fi: “For young people it would be like kind of reflective of like pop culture or things that they can kind of relate to. So like, nice colours and like photos and posters and stuff for upcoming events.”

For other young people, their desire was for a relaxed and soothing service with an attractive and calming appearance, often including plants:

I was thinking like a tranquil environment. So, to me that would be like water fountain thingies and like really calm like nice music. So like, something that’s really just relaxing so you can just really exist in the moment.

Many young people spoke about how they would want to feel welcomed into this space from the time of arriving in the reception. One group described this feeling of welcoming as treating you “as if you’re house guests”, such as by offering food and drinks.

Finally, young people spoke about hoping to see more of their clinician’s personalities within the spaces they work, forgoing bland furnishings and generic offices for personal spaces that could show them more about the person they were working with. One group member, who had experienced this in a private service, described it like this:

Like in some private clinics the doctor’s office is a bit of a reflection of themselves. But in public service you’re in a very bland room which can kind of make you feel like you’re in an asylum. Which is not an atmosphere you want to be feeling ever. It also gives you a sense of the personality of the person you’re dealing with, like you’re dealing with a person you’re not dealing with a name, a title.

A place that is accessible

Young people who participated in our workshops consistently expressed their desire for services that are more accessible to them. For many, location was a key issue in

accessibility with many wanting more local services. This group from Auckland spoke about the need for services around the city rather than in one central area where many might not access them: “It would be within easy driving distance to people. Maybe one in each like major area. Like one in south, west, central, east. Like the most densely populated areas or around where students are.”

Other young people emphasised the importance of these locations being spaces regularly frequented by young people, like malls, similar to the model for Family Planning in New Zealand. They spoke about how this can be less awkward for them:

It needs to be somewhere a lot of teenagers go, so it’s like natural for them to go.

Like at a mall. Like family planning or some stuff.

Other participants, particularly in smaller towns, proposed novel solutions to the difficulty of more distant services. Many proposed services on popular public transport lines, such as trains or popular bus routes. Others proposed shuttles that young people could book spaces on. However, several proposed mobile clinics that could attend their schools or visit their towns. These were often based on the popular dental nurse vans which visit New Zealand primary schools to conduct annual dental appointments free of charge to students:

We talked about mobile vans. So, like you know how we have like the dental van that comes to school? So like having maybe something similar so then more people, like it’s less of an intense approach than going to talk to the counsellors...so people coming to your school like somewhat regularly like you do with the dental van, they come like every few months.

In addition to being physically accessible, young people spoke of the need for services with accessible cost. Almost all young people expressed a desire for free services for youth,

with some suggesting a very cheap service or a sliding scale based on personal income rather than parental income. This group decided:

Free through all school and then cheaper for like five years after uni. Because they might still be experiencing stress, you know, getting their life sorted trying to find an actual job. But free services available to like, school attendees and universities.

A place that will welcome me

Young people across our workshops described their ideal service as a place that they will be welcomed to if they make contact. Many compared this to services where they had reached out for help only to be turned away.

For many, this meant decreasing the wait times for services, most often to a week. Several participants spoke to how long delays between making contact and receiving appointments are harmful to young people who may wait until their challenges are acute to even reach out. As this participant said:

I want it like, to be able to actually talk to someone one on one when you need to [should be] much easier, because I know one of my friends that like literally had to wait for like 6 months before she got a place to talk to someone and by that time it was like... got a bit too far.

Several participants spoke about how a service that was easy to get in contact with would be perceived as more open to them. For many participants, this was as simple as having email addresses available or operating a phone line including emergency helplines. Other participants had more novel ideas for how to get in touch with the service, including via social media:

I think social media. And then there could be someone managing the reception desk that just gets in the messages from social media and like a computer system that filters through it because I imagine there could be quite a lot.

Several groups proposed using apps to make contact with services or for triaging:

Having like a free app that people can get... like you could go onto this app and just discuss how you're gonna feel and then the people that run like the reception can have a look and try to get you to talk a little bit more about what you kind of need and then they'd like guide you to where you need to be [within the service].

Many young people spoke about changing the approach to referrals to not rely on professional referrals: "Maybe a way of going so they can feel like they don't have to see their GP if they're not providing the right support or recommendations for them."

Several participants spoke about peer referrals as a way into services for young people who are struggling to ask for help themselves. This participant described an idea where young people could contact a service about a friend they were worried about:

Like, if you're not in a position to engage directly, someone you know might be able to come to them with a concern and they can get in contact with you so that they can outline what support they can offer.

Others spoke about how a welcoming service would be one with which the initial contact was not intimidating or stressful, such as when meeting with psychiatrists as first point of contact. Young people spoke about the ideal service as a space where they did not feel stigmatised for asking for help. This young person phrased it as: "Something more like, you can approach them without it feeling like you've got something wrong with you."

A place that is embedded in the community

In our workshops, many young people spoke about their ideal mental health service as embedded and visible within their communities rather than a siloed space for therapy only.

For many, this included increasing visibility and awareness of services:

I think the big part is raising the awareness of it. Because I know lots of people might not know about the services or they might not think they're eligible or like at the level that needs to go talk to someone about what's going on.

Ideas for how this could be done included advertisements using posters, television shows, social media, and painting billboards or buildings. As this young person put it:

It needs to be easily visible, like advertising. Cause if I'm walking around and then like I see a poster about like mental health or whatever and it has like a phone number, an address, an email or whatever then I can just you know email them, call them, go there, get help. But if there's nothing to advertise it then I don't know where the hell I'm gonna go and then it just becomes like, well no one can get help because they don't know where to get help.

Several young people spoke about how this advertising should be done with the input of young people to ensure it appeals to them as potential service users. This young person said:

If there was like a young person who was in charge of advertising on social media, rather than a 30 year old being like 'hey, kids, you wanna nae nae on down to the counselling office and we'll help you out.'

Many participants extended this beyond simple visibility to active presence within the community, such as by speaking about the service at local schools or through presentations to

the broader community. Others spoke about how services could hold events for the broader youth community in an area, rather than exclusively providing services for mental health treatment. This group proposed this:

I think it would be really cool to see like events where it was a combination of like, if we did young people it could be open to anyone. People struggling with mental health and then people who are not to create that awareness. Just like, events open to the public.

Some young people spoke about a desire that these services could be involved in training other professionals who interact with them, including their teachers, parents, and health professionals, to help them know how to talk about mental health and what help to offer:

It doesn't have to train the teachers to be really good to provide counselling, but maybe to spot like 'oh, maybe this student's not doing really well' and then maybe reach out and see if the student needs help. If we educated teachers on mental health then they'll be more aware of it and they can actually play a part, so you can actually help them in a school environment. And if the students are outside then it could be family, friends, professionals... so it's like the inside out everywhere kind of thing.

Lastly, young people also spoke about how services could be involved in providing information that is readily available to young people about mental health and services, particularly information that can be found online. As this young person said:

Even if you google stuff it doesn't really come up with everything. And then you have to google another keyword and it's like, I don't know. Like everything about counselling feels so outdated, they need to update everything...Like, easier to navigate through them. I've tried and it's just like all this tiny ass print all together

and there's just this ugly photo in like this ugly green background and it's really overwhelming.

A place that treats us holistically

Many participants in our workshops described their ideal mental health services as holistic, considering multiple aspects of a person's mental health including physical health, social health, and spiritual health: "I think mental health has got a few aspects which is like physical, mental, social, and I think one is spiritual. So I think it's more the integration that would actually help."

Several participants particularly emphasised their desire for a space within the service to engage in activities to support their physical health such as by having a gym within a service. Others proposed having healthy cooking classes, particularly for young people moving out. This young person said:

I guess for me, I'm someone that prefers like really practical stuff. Like I love exercise and I feel like that's a huge part of mental health and staying well so that's something I would like to see in the mental health services.

Other participants spoke about the importance of a mental health service that also promotes social wellbeing, particularly through providing recreational spaces for young people to interact with one another. This group emphasised peer support as a way to serve this purpose: "You could just like, have someone creating a space where young people going through mental health can come together and support each other and just like hash it out."

Many participants sought services that provided more opportunities for spiritual wellbeing, however this looked to them. Some young people suggested having workshops for traditional healing practices that service users could participate in. For many participants, this was as simple as having clinicians from different faith backgrounds available:

I wonder if we can include like a chaplain or some kind of person with a faith background. Because I feel like sometimes with mental health services they don't really acknowledge people's faith in their system. Especially because like, some churches people go to might also have a stigma around.

For others, spiritual health meant access to spaces where they could feel at peace and a sense of calm. This often meant yoga rooms or garden spaces. As this participant said:

We wanted to include a rooftop garden because some people feel quite closed in when they're in a room, so if they were able to have a bit of a good view and just fresh air then they can feel more at peace to talk about issues.

Some young people's ideal mental health service also incorporated online options, discussing how this could be helpful given the amount of time young people spend online: "I can see the counselling services online and you can just chat with a counsellor sometime. And I think it's really helpful."

A place that is adaptable

Many young people in our workshops' ideal mental health service would be able to adapt to their individual needs. These included options for group and individual therapy, or to bring friends to sessions. Many of these young people found talking therapies awkward and unhelpful for their specific needs:

Mental health is very different to any other kind of service that could be like provided to us. Because say like at a hospital you can just be prescribed to the same drug as everybody else and you probably have the same results. But if you're in mental health and you just have the same thing told to you, like it'll probably be far less effective because it's all individual and it just doesn't work to like fit everyone into the same kind of box.

Many suggested offering different treatment approaches that could be designed to serve their individual needs:

In the end, you'd have an outline of at least two different strategies so you don't feel boxed into one thing. And if they suggest a medication they should always have another option.... Whether it be cognitive behaviour therapy, dialectic behaviour therapy, occupational therapy, they can suggest these things as well but not saying you're going to have to do all this. Just, this is what I recommend as a starting point and your treatment plan will be refined along the way.

Many participants described an ideal service as offering diverse clinicians including occupational therapists, speech language therapists, counsellors, nurses, psychologists, and psychiatrists. Participants hoped that these clinicians would offer different models of work beyond traditional counselling:

I would prefer to see them putting money into occupational therapists and training them up to help people. Because I know that with the team of specialists that I worked with the person that was most helpful for me was my OT because she did like really practical things with me.

Other young people spoke how options could include specific therapy models like Mindfulness, Cognitive Behaviour Therapy and Dialectic Behaviour Therapy to manage significant mental health problems and trauma. Some of these young people spoke about how the assistance they had been offered was not sufficient to fully address their needs:

Cognitive behavioural therapy, like I've heard of it. I would've liked to have that available. Cause yeah [they] were like 'you should do cognitive behaviour therapy' and it's like, where am I going to go to do it? Because they can't do it.

One group proposed an approach to an adaptable service that could involve young people being involved in tailoring their own treatment plan. Under this model, young people could sign up for a range of programs recommended by their clinical team: “There could be like a rotation of programs. Like you go inside the app and you find that there’s like set events or like counselling methods that you could sign yourself up to for a certain amount of time.”

Some participants spoke about desiring more specialised clinicians with specific skills that could be tailored to the areas of concern for them. Other participants disagreed with this, emphasising the high chance of multiple issues. However, others described feeling that their clinicians were not specialised to understand what they really needed. This young person described it like this:

It should be different counsellors that study different like departments. So it’s more personalised to go to not just one counsellor that knows a bit of everything, if you’ve got a specific problem you’ve got a specific person that can help you.

Young people reported that their ideal mental health service would be flexible with them about the degree to which they would like their family involved. This participant expressed:

There’ll be some people out there that don’t want their parents involved, or they might want to be there when they’re talking to their parents, or they might not want to be. OR they might want their parents to only know certain things. And they can ask you ‘are you comfortable with us sharing everything or are there certain things you want us to leave out?’

Additionally, young people who participated in our workshops spoke to the need for services that can adapt to be more culturally responsive, by being respectful of the mental

health needs and challenges of different cultural groups. This participant put it simply: “Like, the services should be culturally sensitive.”

As our workshops took place in New Zealand, many participants both Māori and non-Māori emphasised the need for services that are understanding of Māori cultural needs. As this participant said:

I heard that not many services are being provided for Māori.... It'd be really good if they had services provided to them that it's open to them, and since they have cultural differences so... it's part of the therapist's plan to make that service open for them, make it a bit more approachable, and follow their roots, follow their traditions and customs.

Others stated that all cultures present in New Zealand should be included and have responsive services. These participants made reference to how different attitudes to mental health may make it challenging for immigrants, with specific mention of young people from the Pacific, China, India, or Asia more generally, the Middle East, and Africa. As this young person said: “I think all the cultures that are residing in New Zealand should be included because they would have different ideas for how a psychologist should be. Especially now that New Zealand is becoming more diverse.”

A place that is youth focussed

The young people who participated in our workshops emphasised their desire for a service that is youth focussed and tailored to the needs of young people. The specific age limit proposed ranged from a minimum between 11 and 16, with the age limit either at 20 or at 25. The most common age grouping was 13-25. Specifically, many participants spoke about the need for youth-specific services that were distinct from child services. This

participant stated: “You obviously can’t treat a five year old the same way you would treat a 16 year old.”

Participants gave examples of being talked to like a baby, and how they would prefer a service where they were treated like an equal. Similarly, they emphasised that this service would not treat young people like adults: “You have like a targeted youth program specifically for young people, because let’s say it’s open to the adults for example, then you will have more specific targets. Obviously adults have stress of like, adult issues.”

Other aspects that young people emphasised in their ideal service was that it would be a transparent and honest space, that puts you at a more even playing field rather than feeling that there is a significant power imbalance between the young person and the clinician.

Some participants emphasised how a youth responsive service would not stigmatise young people or suggest that they should not be struggling because of their age, or assume their problems are age-related and will pass. This young person stated an ideal service should be: “Somewhere they can seek help without feeling judged, like ‘you’re young why do you have all this stress?’”

Finally, participants noted that services should be responsive to the perspectives of young people, such as with suggestion boxes for young people to report what they would like from the service.

Discussion

This study identified seven themes that describe the ideal mental health service for the young people who participated in our research. These themes were a place that is comfortable, accessible, welcoming, embedded in the community, holistic, adaptable, and youth focussed. These findings are consistent with a large body of international research into

youth preferences for mental health services, and additionally offers a guideline for how these principles could be applied to services in the New Zealand context. This research also offers a methodology which could be used in other cultural contexts to adapt best practice principles for services to fit the needs of a local population.

A number of general principles for successful youth health services have been defined in research. These include that services be youth-centred and holistic; accessible in location, hours, referral process, timeliness, and cost; that they be informal non-stigmatising environments; provide recreational or drop in space; that they be integrated into the community; confidential; research informed; staffed by welcoming and youth focused clinicians, and that young people should participate in the planning, delivery and evaluation of services (Anderson & Lowen, 2010; Fleming & Elvidge, 2010; Social Policy Evaluation and Research Unit, 2015; Stewart, 2020; Tylee et al., 2007). These principles align very closely with the ideal mental health service proposed by young people in our study, with all of these emerging in some way across these themes. This supports the relevance of these principles, as they have been identified in a very similar form in this independent sample of young people not exposed to these ideas prior to participating in this research.

In their 2017 paper, Hughes et al. proposed a set of 10 principles for youth mental health services which outlined best practice. These included acknowledging and incorporating the full continuum of response into the service; employing ‘evidence-based’ practice; easing the process of accessing services; having a youth-friendly approach; being empowering of young people; providing developmentally appropriate care; prioritizing most at-risk young people; collaborating with other services; being sensitive to families; and providing holistic care. Several of these ideas emerged in our study, however others were not present. While our sample emphasised the importance of family needs, holistic care, empowering, developmentally appropriate services with a youth-friendly approach, easy

access, and research informed practice, they did not discuss prioritizing high-risk youth or covering the spectrum of care in one service. This may highlight that for this sample of young people, many felt their needs had been neglected due to not being ‘severe’ enough and as such most emphasised the importance of early intervention over care for the most ‘severely’ unwell. Another explanation may be that some young people did not have experience with the full spectrum of severity.

While these international principles for youth specific services have been proposed, researchers have highlighted the importance of balancing international standards with local adaptations, to ensure services are relevant to their specific target populations (Hetrick et al., 2017). Importantly, our findings also share a number of similarities to ideas that were highlighted in a 2020 review of stakeholder feedback on child and adolescent mental health care in a New Zealand district health board (Stewart, 2020). These consistencies included that stakeholders believed treatment outcomes for young people would improve with more active involvement of family and clients, individually tailoring treatment plans, and including multi-disciplinary staff trained in treatment to offer multiple models of care. They also emphasised accessibility through affordability, convenience, and timeliness; acceptability through being youth-friendly, confidential, and respectful; appropriate care, through a developmentally appropriate and research informed focus; and sustainability, through being embedded in the community. These results again share a high degree of theoretical similarity with the results of this study, which is particularly significant for how this demonstrates congruence between the ideals of other stakeholders and those of young people. This demonstrates that our findings are not only consistent with international practice standards and principles for youth-friendly services, but with the beliefs of an independent sample of local youth mental health stakeholders.

Indeed, it has been noted that these models for youth-specific services that are emerging around the world have the potential to be adapted for different local contexts through the process of co-design (McGorry, 2019). The value of local co-design may lie in allowing researchers to specifically tailor the application of these principles to the needs of the local community. This also addresses the challenge identified in Hetrick et al. 2017 review that research often poorly describes what these principles look like when applied in practice to the design of a youth-specific service. For example, what does a youth-friendly service that is comfortably and attractively designed actually look like? While one service might be designed in an appropriate ‘youth-friendly’ style for their setting, this might not be considered a comfortable environment to all young people around the world. While these principles might clearly illustrate a guiding framework for services, they do not often offer the detail and practical examples of how these can be applied in practice to specific communities of young people.

Young people in this study did identify a number of clear and practical ways that a service could be designed which also align with these principles. For example, in order to be accessible, services should consider having a presence on social media and options for self-referral online or through apps. To be comfortable, services should offer relaxing spaces playing popular music, with games and activities to enjoy like pool tables and video games. To be holistic, services should include a range of therapeutic modalities delivered by a multi-disciplinary team, and should include spaces to work out, learn practical skills like cooking, and complete both individual and group therapy. For our participants, ‘youth-focused’ care included care delivered by clinicians specialised in work with young people who provide treatments adapted for their developmental stage, rather than treatments designed for younger children or adults. This finding is particularly significant as ‘youth-friendliness’ is generally poorly defined in literature on youth-specific services, with even the consistent practices

across services (e.g. ‘bright and comfortable’) providing little guidance to those seeking to design services as to how a service can practically become more ‘youth-friendly’ (Hawke et al., 2019).

The results of this study suggest that while principles of youth-friendly services may be consistent internationally, the detailed guidance of how to apply these principles in a specific local context should come directly from the community. Young people were easily able to express their desires in a clear, practical way that could be applied to the design of a service. As such, rather than attempting to consult a body of research for detail that is not present on specific design qualities, service designers would better spend their time conducting their own co-design workshops to elicit the specific practical ideas of young people in their community. The design process should therefore be rooted in adapting international best-practice principles to a practical and specific design which is developed in collaboration with the local community. This workshop method is one proposed methodology by which this could be done, which worked effectively with our sample to elicit detailed and helpful responses.

This approach is consistent with the core common value of all youth-specific services, which is to include the voices of young people (Halsall et al., 2018; Hawke et al., 2019; Hetrick et al., 2017). To simply reproduce an internationally designed service in a new context with different young people would directly oppose this value by neglecting the specific voices, goals, and needs of local youth. Indeed, it is likely that services are more successful when well-adapted to the specific needs of the local community (Rickwood et al., 2015). Youth culture is rapidly changing and flexible, and can look very different around the world. As such, there can be no single image of what ‘youth-friendly’ would look like in all contexts and there is likely to be a lot of variation in young people’s preferences (Watsford & Rickwood, 2015). Above all else, services should continue to prioritise the preferences of the

young people accessing the care they provide and should remain adaptable as their desires and needs adjust.

Limitations

As noted in this paper, in order to be truly youth-focussed, services must include the voices of their target population in their design process. This sample was diverse and reflective of many groups from around New Zealand, but was slightly under-representative of some key demographics including Māori and Pasifika young people. Our sample is also under-representative of men, which is unfortunately common in some mental health research (Woodall et al., 2010). This could relate to limited help-seeking among men and reminds us of the importance of male-focussed psychological research (Smith et al., 2018). As such, further research exploring the perspectives of these groups would be important to designing a service that is truly reflective of the needs of New Zealand's young people.

Conclusion

Around the world, youth-specific mental health services are emerging as a potential solution to the problem of low engagement of youth in mental health services despite high need. A number of international principles have been proposed based on these existing models which describe the qualities of a youth-focused mental health service. In this study, we utilised a novel methodology to explore the preferences of young people in New Zealand regarding mental health service design. We identified a high degree of similarity between the perspectives of the young people in our independent sample and research found internationally (Hughes et al., 2017). We also demonstrated that when given opportunities to explore creative ideas young people are able to give detailed and nuanced descriptions of specific and practical ways in which services can become more youth friendly. As such, all services for young people should involve youth voices in their design process as they are

clearly capable of being involved in this way. The methodology laid out in this paper may be one effective way of hearing and incorporating youth perspectives.

Chapter Five:

Discussion.

Meaningful contributions, room for growth.

Nahau te rourou, naku te rourou, ka ora ait e manuhiri

With your basket of knowledge, and my basket of knowledge, the people will prosper.

The research presented in this thesis explored the vision of young people in New Zealand for a re-imagined youth mental health system, including both the clinicians with whom young people would ideally seek to work and the services these professionals would work within. The findings of this project provide valuable insights into the perspectives of young people as to how mental health services and clinicians within New Zealand can improve their appropriateness and acceptability for youth. In this discussion, I review these findings with reference to the research questions laid out at the inception of this project. Following this, I turn to the broader clinical implications of these findings with reference to current mental health practice within New Zealand. Later, this chapter will acknowledge some of the limitations of the current study and discuss directions for future research.

This study has identified that young people in New Zealand have clear and specific ideals for youth mental health care, including the services they would like to be treated within. In conducting the analysis of the workshops, seven key themes emerged which collectively captured the perspectives of participants regarding their ideal mental health service. The first of these was that a service should be comfortable. Participants described their ideal service as a space within which they could feel relaxed and safe, and detailed specific features that could contribute to this feeling. These included balancing bright colours with a calm environment, popular music playing, posters for upcoming events, quirky furnishings such as bean bags, activities including games and fidget toys, and utilities like WIFI and having food and tea available. Drawings of the service often also included plants and outdoor spaces. This finding is consistent with past research, which has found that the physical environment of services is important to young people who often value services with a friendly atmosphere and youth-friendly image (Coughlan et al., 2013). However, the findings of the present project offer additional value as it has been noted that it is challenging to elicit from research what a ‘youth-friendly’ design actually looks like in practice (Hetrick

et al., 2017). The findings of this project offer a clear description of youth-friendly design from the perspective of young people in New Zealand, and suggest that young people can provide clear and informative examples that could be incorporated into service design.

Young people also described their ideal service as accessible in terms of location, such as by being on public transport links or in spaces frequented by young people, and cost, by being free or very low in price. These findings were consistent with past research which has found that accessibility issues including cost and location are among the most significant barriers to care for young people (Buston, 2002; Houle et al., 2013; McCann & Lubman, 2012a; Summerhurst et al., 2017). Given that this has been identified as a barrier to service engagement, it is understandable that young people would seek to address this barrier in their ideal service design. Interestingly, young people in this study did not emphasise technology as a solution to accessibility issues for rural areas, but did propose novel solutions including mobile clinics that could visit their townships. One possible explanation may be that the framing of the question ‘How would you design your ideal mental health service?’ led young people to primarily consider physical, offline options.

The ideal mental health service described by the participants in this study would be welcoming to young people throughout their experience, starting from the first point of contact. This included making services easy to contact such as via social media, website, or phone, reducing wait times, and allowing more open referral pathways, including self-referrals. This was consistent with past findings, as long wait lists have often been highlighted as a key barrier to access for young people (McCann & Lubman, 2012a; Summerhurst et al., 2017). Workshops in this study were completed both before and after the introduction of the Wellbeing Budget in New Zealand, which aimed to reduce waitlists by increasing the availability of earlier interventions (Treasury New Zealand, 2019). As the

budget changes had yet to be implemented, these findings do not reflect the concerns of young people following the increase in mental health funding. However, news reports would suggest that waitlists remain as long, or longer, than at the time of this project (McConnell, 2020; Meier, 2020) suggesting this is likely to remain a key concern of young people in New Zealand.

The ideal service for young people in this study was also described as being embedded within their communities, with a high degree of visibility and a focus on conscious awareness raising through advertising (with youth input into campaign design). Young people also described how they would like services to engage with the community through presentations, hosting broader events open to the public, and providing training to the broader community. These young people spoke of the need for services to actively work to improve young people's knowledge of services including when to seek help and how to access it. Past research has demonstrated that lack of knowledge can be a significant barrier for young people in help-seeking (Cosgrave et al., 2008; Rickwood et al., 2005) and participants in the present study saw this as an important target for services. Given that some studies have found that improving understanding of services can promote engagement (Perera et al., 2019) this may be an area on which services within New Zealand could focus. Additionally, this kind of community immersion could contribute to reducing stigma by normalising mental health and allowing services to demonstrate they are safe spaces. This is important given that stigma is another barrier to help-seeking which has been frequently identified in past research (Coughlan et al., 2013; Hefflinger & Hinshaw, 2010; Rickwood et al., 2007).

Participants highlighted that their ideal service would offer holistic treatment, considering them as a full person. This would include promoting physical wellbeing (through fitness options and healthy living skills), social wellbeing (through recreational spaces), and

spiritual wellbeing (through respecting and engaging with traditional healing practices). International research has suggested that the most appropriate model for care for young people may be the promotion of holistic mental wellbeing as opposed to the absence of mental health challenges (Anae et al., 2002; Antaramian et al., 2010; Suldo & Shaffer, 2008). Our findings also suggest that mental health services for young people in New Zealand would benefit from looking beyond the illness focus, although this can be very challenging given the limited capacity of services (Coughlan et al., 2013). Importantly, this is consistent with Māori frameworks of wellbeing such as the Te Whare Tapa Wha model, which emphasises the importance of holistic wellbeing for mental health (Durie, 1998).

Central to the perspectives of young people who participated in this study was that services be adaptable to their needs. For example, some participants reported finding talking therapy uncomfortable, while others hoped to be offered specific treatments like cognitive behavioural therapy. This is consistent with past findings that young people's preferences for treatment are varied (Leavey, 2005; McCann & Lubman, 2012b). However, the findings of this project did highlight that some young people had preferences for alternative treatments, which has been referenced less frequently in the literature. This suggests that these alternative treatments, such as spiritual healing practices, may be particularly salient to this sample of young people or within current New Zealand youth culture. However, the general perspective that participants hoped to work with diverse teams who could offer multiple different treatment modalities and be flexible with their values is consistent with past findings (Scott et al., 2009). Importantly, Māori and Pacific young people particularly emphasised wishing services would be responsive to their cultural needs by incorporating traditional customs and beliefs, as well as by ensuring the service was approachable to Māori youth. This is consistent with the commonly articulated perspective that Māori people are actively seeking culturally responsive and appropriate frameworks of mental health that acknowledge their

values and perspectives on wellbeing (Durie, 1998; Rangihuna et al., 2018). This finding adds support that this is an important priority for young Māori, and that youth services would benefit from incorporating cultural perspectives.

Finally, participants reported that within their ideal mental health services they would receive care that was youth-friendly, specifically care that had been tailored to their developmental needs. Young people emphasised that youth-friendly care would require services to not treat them as children, but see them as capable of exercising agency and receiving transparent and honest communication. It has long been a concern of youth mental health research that young people are treated within child or adult services, which are each considered developmentally inappropriate for many young people (Coughlan et al., 2013; Osusch et al., 2015; Patel et al., 2007; Ross et al., 2012). However, given the average age of this sample was under 18, it is perhaps not surprising that they focussed upon the unsuitability of child services for meeting their mental health needs as most would not have experienced adult mental health care at the time of their participation. The perspectives of these young people were consistent with those identified in past research, including that they felt it was inappropriate to be treated in the same physical environments, by the same clinicians, and with the same models applied to much younger children (McGorry et al., 2007). This does not align well with the values of young people, and suggests it may be important for engagement to consider youth-specific treatment models.

Interestingly, these seven themes which were identified in this project share many similarities with the 10 principles for youth mental health services proposed by Hughes et al. (2017). Both these principles and the present findings suggest that mental health treatment for young people should include highly accessible, youth-friendly services which offer holistic care including empowering and developmentally appropriate models, and which incorporate

research-informed practice. However, a particularly notable finding from this project was the level of detail in participants' descriptions, including clear and specific recommendations which could be followed in the development or redesign of a service. While these general principles for youth mental health service design and delivery have been supported by some empirical research, the greatest challenge facing the application of these is the lack of specificity regarding how they could be applied in clinical practice (see Hetrick et al., 2017). This is an important concern given findings which suggest that the challenges of translating research into clinical practice can be a reason for poor uptake of and adherence to research-based recommendations (Sullivan et al., 2008). Further, other findings suggest that we must adapt clinical practice to fit local contexts in order to see the best outcomes (Cabassa & Baumann, 2013). The results of this study suggest that the process of local co-design can add significant value to the development of services, consistent with past statements that this process can transform research into relevant and appropriate clinical practice (McGorry, 2019). These findings suggest that we may be able to meet the challenge of the lack of specificity of research-based recommendations through conscious collaboration with young people. In this way, we can involve youth in the process of translating broad principles identified through international research into tangible decisions and practices, which are culturally responsive and appropriate to them, their needs, and their given environment.

While this research was aimed at investigating the way that young people might design a youth mental health service, it became clear that a good relationship with a clinician was one of the most important aspects of the ideal service for our participants. Indeed, their discussions focussed so heavily on this subject that it was chosen as the focus of the analysis contained in Chapter Three. This occurred even though, as described in the workshop process outlined in Chapter Two, none of the specific prompts posed in the workshops I conducted directly asked young people to describe their experiences with or hopes for clinicians. Rather,

young people themselves consistently raised the topic of clinicians as an essential component of services across every workshop held. This is in line with past research regarding barriers and facilitators of engagement for young people, which has found that a young person's relationship with their clinicians is imperative in sustaining engagement with treatment (Radez et al., 2020). These young people have made clear that in addressing the design of mental health services we must not only consider the practices of services themselves, but also those professionals who operate within them. These cannot be seen as separate entities to be addressed independently but as inherently interlinked and correlated components of a young person's overall experiences with and expectations for mental health treatment.

Five themes were identified through the analysis that described the participants' ideal mental health clinician. The first of these was that young people hoped to work with a clinician with whom they shared a background. Many young people highlighted how if they shared a background with their clinician they would be more likely to feel they would be understood. Importantly, this finding was particularly emphasised by diverse young people who participated in the project including LGBTQ+ participants and Pacific Islander and Māori young people. The question of gender and ethnicity matching clinicians and clients has been addressed frequently in the research, with varied and inconsistent findings (Cabral & Smith, 2011; Cooper, 2006; Clark et al., 2018; Wintersteen et al., 2005). The findings of this study suggest that for some young people in New Zealand, particularly Māori, Pacific Islander, and LGBTQ+ young people, sharing a background with their clinician is highly valued. These young people expressed that this could improve the feeling of relatability, which is consistent with some past research with young people (Clark et al., 2018).

The second theme identified by participants, that clinicians should be someone friendly with whom they feel a connection, is particularly important when considered

alongside the third theme, that participants ideally hoped to work with professional, highly competent clinicians who would protect their boundaries and respect their space. Past research with young people has often identified that they value friendly and informal approaches from clinicians (Binder et al., 2011; Everall & Paulson, 2002) and this has been found specifically with young people from New Zealand who identified that they preferred to have a relationship with their counsellors which more closely resembled a friendship (Gibson et al., 2016). Yet, it has also been found that young people value experienced and competent clinicians who respect boundaries (Binder et al., 2011; Robinson, 2010). While clinical practice is often torn between the two clinical approaches our findings suggest that young people are not only aware of this challenge in clinical practice but attend to it themselves, and have nuanced individual beliefs regarding desirable clinical conduct. Overall, young people are seeking clinicians who can be warm and supportive whilst still maintaining their professionalism, and who have the experience and ability necessary to adequately address and treat their concerns.

Participants in this study described the importance of being treated respectfully by clinicians, highlighting how they hoped to be taken seriously and not patronised. A respectful clinician was described as someone who believed them, validated them, and showed compassion. For many young people, this ideal was contrasted against experiences within services in which they felt invalidated, judged, and powerless. This is consistent with findings that young people are often discouraged from help-seeking by fears of judgment (Hefflinger & Hinshaw, 2010). This was also very consistent with findings of other studies which have identified that young people have the most positive experiences of clinicians who are perceived as compassionately listening as opposed to dismissing or patronising them (Crocket et al., 2015; Lynass et al., 2012; Robinson, 2010).

Lastly, participants described wanting to work with clinicians who could be responsive to their individual needs. Importantly, this theme shares a number of similarities with another finding within this broader project, that services should be flexible and adaptive to a client's needs. This theme was important to include in both the service and clinician based analyses for the frequency with which it emerged and the weight placed upon it by participants. In relation to clinicians, young people particularly emphasised hoping that clinicians would tailor their treatment to their specific values and allow them to exercise agency over therapeutic decisions. This is consistent with extensive past research that young people are eager to take part in their own care (Robinson, 2010; Svanberg & Street, 2003). This appears to be an important priority for young people in New Zealand.

The findings of this study in relation to mental health clinicians are consistent with past research, which has suggested that youth-friendly and appropriate clinicians are key components of youth-specific services (Hetrick et al., 2017). The findings of this project add to this existing knowledge by clarifying and expanding understandings of how youth-friendliness can be defined in clinical practice in New Zealand. Additionally, these findings suggest that we cannot consider youth mental health services without considering the fundamental importance of the therapeutic relationship for young people. The ideal youth mental health service cannot simply adhere to the design and service-level practices suggested by the young people who participated in this project but must also employ clinicians who practice youth-friendly care.

In this discussion, I have considered a number of past studies which have explored young people's perspectives on mental health services and clinicians. These projects have contributed to building our understanding of young people's priorities for mental health care and how services and clinicians might promote better engagement with mental health

treatment among young people. However, the majority of these studies employed traditional qualitative research designs, such as surveys, interviews and focus groups. For example, headspace - a youth specific specialist service that prioritises being responsive to young people - utilises surveys to gather feedback of young people's experiences in care (Rickwood et al., 2015). A past study of young New Zealander's perspectives on mental health care utilised interviews to explore experiences these young people had during mental health treatment (Gibson et al., 2016). Each of these approaches has important value in this field of study. For example, surveys have the scope to elicit feedback from a large number of young people, and interviews can allow opportunities for the detailed sharing of deeply personal and emotional experiences. However, when it comes to exploring solutions for improving mental health services for young people, these approaches often come with trade-offs. Surveys do not allow for in depth exploration of creative ideas that young people may hold while the individual nature of interviews may limit young people's ability to question and consider multiple creative solutions and alternative perspectives (Morgan, 1996). The workshop methodology I employed in this project may provide an approach to research in this area which opens us up to greater exploration of novel solutions with young people, through drawing on creative exercises and mixed-method activities. Importantly, in this study I found that a varied, collaborative workshop can be effectively conducted within a short time frame suggesting that there is scope to incorporate similar methodologies into many future research projects. Additionally, this method may provide a clear outline for how research in this area can be conducted in a way which allows young people to take ownership of their experiences and find their own creative solutions in a participatory manner. This is significant, as even when work in this field has been collaborative – such as in examples of collaborative service design – studies rarely describe in detail how this collaborative process was conducted or what the design looked like in a way which could be replicated (Hetrick et al., 2017). In this

way, this methodology may provide an avenue for advancing our ability to work collaboratively with young people to explore their perceptions, experiences, and ideas.

Youth is a period of time in which young people develop not only their own personal identity, but also their capacity to have and to exercise agency in areas which affect their lives (Erikson, 1968; Strack et al., 2004). The findings of this study demonstrate that young people in New Zealand have the ability and capacity to be not only involved in but leaders of nuanced and sophisticated conversations regarding their mental health needs and care, contrary to historic perspectives of young people's ability (or lack thereof) to contribute to care decisions (Prout, 2007; Lack & Green, 2009; Zirkelback & Reese, 2010). This is consistent with international work highlighting the potential for youth leadership and collaborative work between young people and professionals in youth mental health care (Coughlan et al., 2013). Researchers in this area are increasingly recognising that young people are not passive, but have the potential to be strong critical thinkers and problem solvers (Wilson et al., 2008). The inclusion of young people as active participants in decision making and as future leaders in the field should not only be considered their legal right (The United Nations 1989, Article 12) but also an approach which adds significant value to research in the field of youth mental health. This study provides further support to the perspective that young people's contributions should not be an afterthought of service development or youth mental health research more broadly, but an essential driver and component of the research we conduct.

In considering the research questions I had posed at the beginning of this project, I believe several of these were successfully addressed by this research. In response to the first question, the findings of this project did describe young people in New Zealand's ideal vision of a youth mental health service and features of a service that could most effectively engage

them in care. The findings of this research contributes to a clear vision for a youth mental health system which prioritizes the preferences of young people. In response to the second question posed, this project suggests that the visions of young people in New Zealand for mental health services may be broadly consistent with much of the existing international body of literature regarding young people's preferences for mental health care. The findings of this study did support past research and provide further support for the existence of some broad international principles for youth mental health care. Most notably, this consistency between the present findings and past research suggests some of the international research regarding appropriate youth mental health treatment may be relevant to the New Zealand context. Yet, these findings also highlight that we should continue to consider individual differences and particularly the preferences of Māori young people for culturally appropriate care. Therefore, these approaches from around the world could be tentatively considered in discussions about evolving the nature of youth mental health in New Zealand.

Clinical and Service Implications

After reviewing these findings and their relative contributions to the broader field of youth mental health care, I now turn to the final research question posed at the commencement of this project. That is, the issue of the feasibility of integrating the perspectives and ideas of these young people into tangible proposals for change to youth mental health care in New Zealand. I now critically consider how these findings could lead not only to a *theoretical* impact on a body of research, but also their potential to impact upon the lives of young people by contributing to evolving practice and care in New Zealand's youth mental health sector.

It is important to consider how to apply the knowledge offered by these participants into generating meaningful change. The potential to motivate action is an indispensable

purpose of all participatory action research. Social constructionism as a framework for research also centres the interrelation of social action and knowledge, acknowledging that the potential to drive action can be an important motivator for research (Burr, 1995). The findings of this project make clear that young people in New Zealand do see the potential to make change to the mental health system in this country, and have exciting and clear visions of how this could look. As such, it is important to consider the changes which were suggested by participants in order to truly acknowledge and honour their contributions to this work. In this section, I aim not to provide a conclusive answer as to a precise method or approach which could see these practices ‘rolled out’ within New Zealand, nor do I suggest the ideas presented here are the sole route to which the present findings could be effectively integrated into improving clinical practice and outcomes. Rather, I offer some of the ideas proposed by the young people with whom this work was conducted in order to address the question which often plagues research of this kind – *what happens next?*

When reviewing the priorities and ideals discussed by the participants in this study, there appears to be a significant gap between the current youth mental health system and what young people are hoping to experience in their care. Throughout the workshops young people provided several examples of current practices they had experienced which were directly opposed to their wishes for mental health care. At present, New Zealand’s youth mental health system is complex and layered, involving nationally funded tertiary, secondary, and primary care alongside numerous non-governmental organisations, some of which operate under national contracts while others are independently funded or charitable organisations (see HealthNavigator, 2020 for descriptions of the services described in this paragraph). Governmental services include limited hospital and residential care options, community child and adolescent services, and primary care - typically counselling offered through general practitioners, school counsellors, or contracted organisations. Some young

people are also eligible to access specialist support with government funding in certain circumstances, such as following sexual violence. Given the mixed funding sources, employers, and intentions of these services, it is perhaps logical that the experiences of young people in our study were varied and did not reflect any unifying principles of youth mental health care.

However, while much of the current system appears to be removed from young people's priorities for mental health care, there are several examples of services which, were they to be introduced to and adapted for the New Zealand context, may align with many of the ideals proposed by our participants. One type of service which the findings of this project would suggest may be relevant in New Zealand is 'youth-specific services' (Hetrick et al., 2017), which are discussed in detail in Chapter Four of this thesis. These have demonstrated high rates of efficacy and are among some of the most studied services available for young people anywhere in the world (Hetrick et al., 2017; McGorry et al., 2020). Interestingly, a model resembling youth-specific specialist care clinics was frequently proposed by the young people who participated in these workshops. This may suggest that this approach could be desirable to young people in New Zealand, in addition to being supported by an international body of literature.

If we were to consider the possibility of introducing youth-specific services in New Zealand, the findings presented in this thesis could provide an excellent blueprint of a model for youth-specialist care in New Zealand. The key components of this are presented in Chapter Four, in the discussion of participants' ideal mental health service. Generally, participants desired a stable service specifically designed to provide care for pre-teens, adolescents, and young adults. This service would be attractively designed, featuring plants, pleasant colours, and posters. It would integrate multiple spaces including traditional and

non-traditional therapy rooms, recreational areas, outdoor spaces, and rooms for work with other professionals such as gyms and kitchens. It would include options to work with many different kinds of professionals and peers. This service would provide young people with clear information and choices about their treatment, including regarding the involvement of family and friends. The services would be welcoming and easy to be referred to, such as through self-referral, with clear advertising. Finally, once engaged, services would be low cost or free with processes in place to improve access such as offering transport or being close to transport lines.

In considering the feasibility of this model in the New Zealand context, I consider one international example of a youth-specific service: headspace. Headspace is both the name of Australia's National Youth Mental Health Foundation, founded in 2006 after the Australian Federal Government recognised the need for urgent reform to the youth mental health system, and the name of the centres this foundation has developed (McGorry et al., 2007). Headspace centres are specialist youth primary care services which offer treatment to 12-25 year olds, which were first introduced with 10 centres in 2007 before being scaled in 2018 to a national network of 110 centres (Rickwood et al., 2019). The headspace centre model is the largest national implementation of youth friendly primary care worldwide (Rickwood et al., 2019). It has been continually reviewed and refined over its history and is in line with the World Health Organisation guidelines for youth services and the principles for youth mental health services (Hughes et al., 2017; Rickwood et al., 2019).

The headspace model aims to provide young people with care that is accessible and responsive to their needs (Rickwood et al., 2014). These were both important priorities for the young people who participated in the present study, who spoke of a desire for services which were not only accessible but also appropriate to them. Importantly when considering

its relation to this research, the headspace model is focused around the participation of young people (Rickwood et al., 2019). The service was not only developed with youth interests at its core but continues to prioritise remaining relevant and being responsive to young people (Rickwood et al., 2019). It does this by frequently collecting data regarding youth satisfaction with the care they have received (Rickwood et al., 2015) and also collects data on the satisfaction of family and friends (Nicholas et al., 2017). The headspace model also prioritises ensuring widespread awareness of the service (Rickwood et al., 2019). Awareness was another priority of the young people who participated in this present study, who often spoke of the need to increase public awareness of the services available for support. Additionally, headspace aims to offer research informed practice through its collaboration with Orygen, the National Centre for Excellence in Youth Mental Health, and focuses on providing developmentally and culturally appropriate treatments particularly in collaboration with Aboriginal and Torres Strait Islander populations (Rickwood et al., 2019). The findings of this study suggest that such cultural awareness would be critical to a youth-specific service developed in New Zealand. Treatments which are informed by research and are culturally responsive were described as important elements of the ideal service by the young people who participated in this research. Lastly, headspace aims to support holistic youth health through four streams - mental health, physical and sexual health, alcohol and other drugs, and vocational support (McGorry et al., 2013). Holistic care was a theme which emerged in the findings as being important to the young people who participated in this research. This suggests that the headspace model may have the potential to closely align with the priorities of New Zealand's youth.

Introducing a model similar to headspace would not only be consistent with many of the priorities set forward by the young people who engaged in this study, but would also be supported by research findings which have demonstrated their efficacy. Research, including

both internal and external reviews, has shown that not only are headspace centres frequently accessed (Hilferty et al., 2015) but satisfaction rates among clients are high (Nicholas et al., 2017) and outcomes are good (Hilferty et al., 2015; Rickwood et al., 2015). The headspace model is often perceived as a very strong example of a youth-specific service and, in recognition of its success and the positive response from the community, has received extensive funding from the federal Australian government (Hetrick et al., 2017; Rickwood et al., 2019).

While the headspace model is very strong, it does have its limitations. Headspace centres may struggle to maintain their focus on primary care and intervention due to ongoing resourcing challenges which result in high levels of unmet need for more severe mental ill-health (Purcell et al., 2011). In order to help meet this need, headspace centres do not turn away those who are more severe, thus extending their scope beyond a traditional primary care service (Rickwood et al., 2019). Additionally, headspace centres have been criticised for ‘detracting’ from the work of traditional community-based child and adolescent mental health services particularly by those who work within these services and are resistant to change (Looi et al., 2019). However, this push-back appears to be a result of resource envy (Brooks et al., 2011). This often stems from a false belief that services are competing for funding to offer the same services rather than perceiving the introduction of new services as a tool for contributing to improved community wellbeing for a shared target population (McGorry et al., 2020).

The headspace model is a sizable commitment which the Australian government made in acknowledgement of the extent of the crisis in youth mental health care (McGorry et al., 2007). As such, it is a large-scale response to a large problem, which has required significant input of funding and has fundamentally redefined the process of mental health

care for thousands of young Australians (Rickwood et al., 2019). The commitment required at a national level to proceed with change on this scale is significant, and if we were to seek to form our own equivalent model this would be a sizable, long-term project requiring extensive and wide-spread support from policy-makers, health care officials, treatment providers, young people, and their families. However, the headspace model does indicate that this approach could be successful here based on its significant success in Australia (Rickwood et al., 2019).

The frequency with which youth-specific service models emerged in the present research would suggest that this approach is highly desirable to young people in New Zealand and would likely align well with current attitudes and perspectives of youth. It is important to note that interest in youth-specific services is very appropriate, as young people are developmentally distinct to both children and adults. It is not consistent with modern knowledge regarding youth development to attempt to treat young people in the same services with the same approaches as either children or adults. Youth-specific services are therefore likely not only to be acceptable to young people but also appropriate for providing high quality care. The findings of this study suggest youth-specific services could function well in New Zealand, particularly if they operate from holistic, culturally informed frameworks, are highly accessible, and attractively designed.

In this thesis, I have also referred to Youth One Stop Shops, which have a few locations around New Zealand (Bailey et al., 2013). One Stop Shops share many similarities with the vision expressed by participants in this project, most notably their ‘youth-friendly’ approach to offering care. As such, those young people who are able to receive care from these services may be more likely to perceive their treatment as appropriate and relevant. Indeed, those participants in our study who had experience with Youth One Stop Shops spoke

positively of these, with their most common criticism being that these do not have enough scope to support major mental illness – a limitation these services are themselves aware of (Bailey et al., 2013). As such, on the basis of the present findings, introducing youth-specific services designed in collaboration with local youth populations may be an effective approach to service development and quality improvement in youth mental health care in New Zealand. Such services would require appropriate funding, however, funding streams for services like Youth One Stop Shops in New Zealand are limited and may not acknowledge the many aspects of the holistic care offered, an additional barrier to implementing these recommendations (Garrett et al., 2020).

While youth-specific services were the most commonly discussed suggestion raised in the workshops conducted, young people proposed other creative solutions to evolving mental health care alongside this. For example, several groups of young people who participated in our research proposed that a solution to improving the accessibility of mental health services and young people’s engagement with these could be a mobile clinic. This model was independently proposed by multiple groups of young people and positively received by others with whom they shared this idea. These groups often specifically referenced dental nurse vans, a successful and established public health practice in New Zealand which involves a mobile van visiting schools across New Zealand to conduct annual dental appointments free of charge (Moffat et al., 2017). Young people’s experiences with the dental vans may make this a comfortable style of service engagement for them in comparison to reaching out to new service providers.

When groups proposed mobile clinics they emphasised the benefits of youth-specific services being mobile and able to visit areas which might otherwise be challenging to access. This is consistent with some past research, with mobile mental health services having been

used successfully to deliver treatment programs in rural areas, regions with particularly low utilisation of traditional services, and developing countries (Fernandez, 2017; Fils-Aime et al., 2018). To this end, mobile mental health clinics for young people might be a feasible approach to improving engagement for those in particularly hard to access areas. This may be important in New Zealand's regions, and indeed this proposal was made in workshops which were held outside of major metropolitan areas. These regions of New Zealand often rely upon child and adolescent services in nearby centres, which can be very challenging to access particularly for young people who may not be able to drive or have their own transport. This inaccessibility may leave young people reliant on school counsellors and family doctors for local treatment. This fails to acknowledge that young people have very poor engagement with primary care, particularly through family doctors, and as such targeting traditional primary care is unlikely to be effective in improving youth mental health treatment access (Tylee et al., 2007). Unlike accessing primary care through school counsellors or family doctors, mobile clinics are not inherently associated with schools or family which may allay concerns regarding confidentiality, a key barrier to help-seeking for young people (Booth et al., 2004). One region visited which did have a specialist youth primary care service did not propose a mobile option. This suggested this approach may be a perceived solution for those young people who do not believe they are likely to have access to a local, fixed youth-specialist service.

The discussion of these specific international models is not intended to suggest that there are no youth-friendly services available in New Zealand. Some non-governmental organisations have involved and continue to involve young people collaboratively in their processes and actively seek to offer specialist youth care. I have already discussed Youth One Stop Shops which have some locations around New Zealand (Bailey et al., 2013). Another leader in this area is Youthline, a national network of youth development services which aim

to improve the support of young people across New Zealand (Youthline, 2013). Youthline has been extensively involved in youth leadership promotion not only within their services but also within other organisations (Youthline, 2013). For example, Youthline has worked with the Ministry of Youth Development and with District Health Boards to promote youth engagement and share the perspectives of young people (Youthline, 2013). While these organisations work to promote youth friendly care and are, in many ways, consistent with the ideals of the participants in this study, it may be appropriate for New Zealand to question whether it continues to be appropriate to rely upon a few ‘good actors’ to provide this standard of care. These services have not been prioritised in budgets and often have a limited mental health mandate (Bailey et al., 2013). As such, it may be important to encourage other organisations to consider whether their services can incorporate more youth-friendly practice.

The young people in this study did not solely speak of the need for change within services but also of how clinicians themselves could improve their youth-friendliness in practice. It may appear a more straightforward task to promote youth-friendly practices among clinicians in line with the present findings as opposed to developing new services, as this does not require the funding or socio-political motivation of developing an entirely new service (Adams et al., 2009). However, resistance from professionals can be a significant barrier to changing practice within existing mental health services (Brooks et al., 2011; Gupta et al., 2017; Laker et al., 2014). Clinicians may lack motivation to implement changes (Laker et al., 2014; Lau et al., 2016). However, this is not only an issue of motivation. Change can often be perceived by clinicians as disrupting a status quo, and it can be very challenging for clinicians to find their ‘new normal’ when they are required to adjust their practice, particularly if they have learnt habits over a long and established career (Gupta et al., 2017). They may be concerned about their autonomy and independence as practitioners (Lau et al., 2016). Additionally, clinicians may not agree with or feel confident in the new practices,

believing they are unimportant, irrelevant, or that they will not be effective (Brooks et al., 2011; Laker et al., 2014; Lau et al., 2016; Lugtenberg et al., 2009). This can often stem from mistrust of those who have suggested changes, typically academics whom clinicians may perceive as removed from the realities of everyday clinical practice and lacking understanding of the nature of their practice (Sandstrom et al., 2015). This can result in tension between the ‘imposed’ changes and what clinicians perceive as relevant ‘on the ground’ (Brooks et al., 2011). This may be particularly challenging for clinicians who perceive their experiential expertise as more helpful than recommendations which can be made based on research (Sandstrom et al., 2015). As such, clinicians may be more resistant to changes if they are complex ideas proposed by researchers with little history with or knowledge of the service (Brooks et al., 2011).

If I was to attempt to apply the present findings into guidelines for professionals about how to conduct youth-friendly clinical work in New Zealand, many of these barriers may present themselves. As a researcher operating within a hierarchical system in which young people often struggle to make their voices heard, many clinicians may not perceive myself as researcher or the young people I collaborated with as capable of commenting upon ‘appropriate practice’ or give guidance about working with young people. Additionally, as this study presents the perspectives of young people, clinicians may be resistant to adapting their practice to reflect the wishes of young people if they hold traditional, paternalistic ideas of the role of young people in clinical practice. For example, clinicians may hold beliefs that young clients, particularly teenagers, are not capable of commenting on their care in a way which is meaningful (Bohart et al., 2002; Elliot & James, 1989; Macran et al., 1999). This could prove a particular challenge in feasibly integrating the recommendations of the young people who participated in this research into action. The importance of working with young people as mental health consumers cannot be overstated and this has been increasingly

recognised by an international emphasis on developing and evaluating services in consultation with young people (Coughlan et al., 2013). Indeed, the World Health Organisation (2012) has reported that it is essential for youth mental health services to be appropriate and acceptable to young people. Youth consultation may be an important approach to improving the efficacy of mental health services for young people, and it has been identified that young people are more likely to engage with services they perceive as relevant to them (Summerhurst et al., 2017). As such, adapting or developing services on the basis of co-design with young people may be an approach to service design we should prioritise in the future of mental health care.

However, historically, change within New Zealand has been slow and limited in the domain of hearing the voices of young people. For example, the Youth Development Strategy Aotearoa was first introduced in 2002 and includes recommendations for youth participation in services (Ministry of Youth Affairs, 2002). As noted earlier, the majority of mental health services and particularly publicly funded services within District Health Boards have not introduced this model or integrated any other recommendations from this strategy. As such, effectively generating change to perceptions of the role young people may play in service development is likely to be an ongoing, long-term process which cannot be driven by any single project.

In the past, those seeking to generate change to mental health systems have often thrust a ‘passive’ role upon service users and their families, neglecting to include them in conversations about improving services (Sederer, 2009). However, this project contributes to a movement which acknowledges that those who use a service should be prioritised in conversations about how they can improve. Indeed, not involving service users has been shown to prevent and slow the process of service improvement (Brooks et al., 2011) whereas

by including service users there is significantly more potential for changes to be successful (Coughlan et al., 2013; Sederer, 2009). As such, the project described in this thesis may be uniquely positioned to contribute to meaningful, sustainable, and successful change to our youth mental health system in New Zealand.

Future research directions

While this project did provide many useful insights into young people in New Zealand's perspectives on mental health care, there is scope to build upon this research. Here, I will discuss a few specific research directions which I feel would be beneficial for informing the conduct of collaborative research with young people and motivating realistic and sustainable action on the basis of these findings.

While it was beyond the scope of this project to conduct a full-scale review of the proposed methodology, it would be beneficial to conduct research exploring whether collaborative research of this kind does significantly improve the quality of research into young people's mental health preferences. This should consider the experiences of young people who engage in collaborative methodologies such as the one illustrated in this project. For example, further research could explore whether youth report feeling more validated and empowered after completing research rooted in collaborative methodologies than if they had participated in traditional qualitative methodologies such as interviews, surveys, or focus groups. The complete dataset of this project was significantly greater than could be explored within the scope of this project, and could be utilised for example to explore the relative contributions of each workshop activity and whether these mixed methods truly added value to the research project.

Additionally, it may be particularly important to conduct research which engages mental health professionals, including clinicians and managers, in a process of reviewing the

findings of this study. Incorporating input from treatment providers along with consumers can improve the uptake of change and promote positive perceptions of new initiatives from all groups (Green & Aarons, 2011). This acknowledges that the participation of professionals is essential to understanding how change can realistically occur in any setting (Park et al., 2014). Indeed, it is often clinicians who have the specific knowledge of their services which inform understanding of how changes could practically be integrated into their services (Lakeman, 2013). Enabling clinicians to be involved in adapting changes to best fit their specific context may also improve the sustainability of new practices (Cabassa & Baumann, 2013). In this way, a new research phase of professional consultation could be entered into, through which professionals' attitudes to youth ideals could be explored, establishing common ground and discrepancies, and potentially identifying informed avenues for promoting growth in existing mental health services and with experienced clinicians.

Strengths and Limitations

I have described in this discussion the unique strengths this methodology may bring to the field of collaborative service design with young people. The specific research design employed in this study allowed young people to creatively explore and express their solutions, while occupying positions of expertise throughout the project. This is a significant strength to this project as young people were able to not only describe their experiences and the problems which they see in youth mental health care, but also consider novel solutions for these. Additionally, for a qualitative project of this kind, the sample size employed here was relatively large allowing for the consideration of many young people's views. For example, 63 participants were involved in a recent study which explored young people in New Zealand's perspectives on mental health care (Gibson et al., 2016) whereas this study included 94 participants. Lastly, this sample included both young people who had used mental health services and those who had not – a very important demographic to consider in

research of this kind given the enormous documented barriers to help-seeking and the importance of informal mental health support to young people. In this way, I was able to explore the views of those who might traditionally be excluded from research of this kind and consider how services could improve engagement with those who had not engaged before.

As in all research, this project has some specific limitations which should be considered when interpreting findings and particularly when considering their generalisability. Earlier in this thesis, I have acknowledged that the sample of participants included in this study has some limitations. Notably, this sample underrepresents a few key demographics which are particularly important to consider in mental health research. Firstly, this sample is under-representative of young men, who are often underrepresented in mental health research (Woodall et al., 2010). As such, it may be particularly important to consider why it is that mental health care and research continue to underrepresent young men and how these can become more appealing and engaging to this group in particular. Similarly, this sample was under-representative of Māori and Pacific Islander peoples. While the degree of under-representation was small according to the latest available statistics (Statistics New Zealand, 2019b) this should still be noted given that Māori and Pacific young people are overrepresented in mental health services (Ministry of Health, 2021). As such, while our sample may be only slightly under-representative at a societal level, the level of under-representation may be greater compared to the true numbers of Māori and Pacific young people struggling with their mental health (Ministry of Health, 2021). As such, it is important to be careful about extrapolating these findings to these particular groups. Given that there are some challenges engaging men and Māori and Pacific Islander youth with research and services, it is important to consider how we can engage these groups in studies which are designed with the express purpose of engaging them in appropriate, collaborative work. This was beyond the scope of this project, but is very important work. It is important to note in this

vein that the goal of qualitative research of this kind is not to identify ‘universal’ generalisable principles which we suppose to apply to all young people (Merriam, 2002). Even within the scope of this project some specific priorities emerged which appeared, at face value, to hold greater value for Māori and Pacific young people than to others who participated – including culturally informed models and the presence of culturally matched clinicians. There is capacity to expand upon this project with detailed, collaborative work with these key groups.

It should be noted that the emphasis of young people who participated in this research on the development of youth-specific services could be a consequence of the specific research questions. In the research workshops, I asked young people to describe their ideal service and did not direct them to ‘fix’ existing services. This framing may have unduly suggested to young people that their ideal service ‘should’ be an entirely new service. It should also be noted that, while integrating new services into our mental health system may fill gaps in services and increase engagement, this does not imply that introducing a new service should be a substitute for addressing the issues with existing services. It is likely to be essential if we wish to see significant and sustainable change to our mental health statistics and outcomes that we consider how we can implement change and incorporate the perspectives of young people at all stages of the youth mental health system and at all levels. This was, however, beyond the scope of this project.

Conclusion

In drawing this thesis to a close, I would like to end with a consideration of some of the broader aims of this project, including the challenges of motivating change in an established health care sector and in conducting activism oriented research.

At the opening of this thesis, I described the unique socio-cultural context from which this study emerged, a period of considerably greater attention towards the challenge of youth mental health and the need to address the issues facing youth mental health care. Against this backdrop, in their attempts to address poor youth mental health, New Zealand governments have prioritised a significant increase in funding for conventional mental health services, particularly under the Wellbeing Budgets of 2019 and 2020 (Treasury New Zealand, 2019, 2020). The current approach of the New Zealand government focuses upon ‘strengthening’ existing programs through greater funding with the aim of increasing service availability (Treasury New Zealand, 2019). However, the New Zealand government has not expressed interest in novel solutions or changes to the mental health system, and indeed the report following the Mental Health Inquiry commented that there would be no value to changing the mental health system (Paterson et al., 2018). These statements suggest the New Zealand government currently perceives youth mental health as a ‘tame problem’, a challenge which is easily solved with a conventional solution, when it is truly a ‘wicked problem’, which can only be addressed through innovation beyond traditional approaches (DeGrace & Hulet, 1998).

While a positive step in the right direction, the findings of the present study would suggest that increasing availability may be a necessary but not sufficient strategy for addressing the ‘silent pandemic’ of youth mental health in New Zealand. It has been identified that although increasing funding may appear a tempting and straightforward solution to the complex challenge of mental health care, for its potential to improve the accessibility of services and address low availability, it is not sufficient to ‘close the gap’ when mental health services are not adequately meeting the needs of their target population (Mahomed, 2020). Our findings suggest that these conventional services may not be meeting young people’s needs, as the young people in this study discussed many changes they would

like to see in mental health services beyond increased availability. Further, some international research would suggest that conventional approaches to youth mental health treatment have not been effective in altering the trajectory of youth mental health and low rates of service use from young people (McGorry et al., 2013). It may be that, if we wish to significantly improve mental health outcomes, services must meaningfully improve their suitability for youth and address poor engagement and retainment of young people in treatment (Summerhurst et al., 2017).

Additionally, while change to mental health services may be seen as an expensive solution, the cost of failing to take action is significantly higher in the long term (Jenkins et al., 2011). Costs for care mount and grow as young people go on to more intensive services or continue to require support throughout adulthood due to receiving limited or poor quality treatment as a young person (Knapp et al., 2011). It has been demonstrated that governments can actually save money in other areas such as welfare and incarceration by fronting the cost of more expensive mental health services, as has occurred in the United Kingdom with the introduction of the Improving Access to Psychological Therapies (IAPT) program (Zala et al., 2019). In this project, young people suggested many potentially low cost solutions including minor adaptations to clinical practice which may have the potential to positively improve engagement with services, and thereby treatment outcomes, without considerable cost.

It appears that international calls to prioritise solutions beyond increasing funding to services designed with little attention to the perspectives of young people may be relevant to the New Zealand context (McGorry & Mei, 2018; McGorry et al., 2020). Given how slow rates of mental health improvement have been when policy has focused upon increasing access, it may be important to consider the potential for radical change to mental health care

(Chaves & Moro, 2009). The findings of the present study suggest that increasing funding for a youth mental health system which has not been designed to be responsive to or appropriate for young people may never adequately meet the needs present within the community.

Therefore, while the New Zealand government's interest in improving mental health treatment for all people is notable and should be acknowledged, it is likely we may not see a significant shift in mental health outcomes for young people without systemic changes to the nature of mental health care in New Zealand.

There has been a long-standing tradition within the discipline of psychology of activism and change-oriented research. In particular, this thesis has drawn upon influences from the fields of critical and community psychology, two sub-disciplines which emphasise the role psychological research can play in challenging disempowering conventions and improving the lives of people around the world. In these and other research canons, numerous projects have sought to foster meaningful progress to mental health care with the aim of improving the lives of vulnerable groups, including young people. Through this project, I have gathered knowledge with the potential to positively impact upon the mental health treatment of young people within New Zealand. However, it has been well documented that there is a significant gap between what research has identified as good practice in mental health care and what truly occurs in clinical practice (Woolf, 2008). The traditional status quo of health systems can be incredibly powerful, and creating sustainable and impactful change to conventional practices is an immense challenge facing all researchers who intend to improve outcomes. This has been referred to as a "quality chasm" due to the low rates of improvement to clinical practice around the world despite a growing body of research suggesting possible approaches to improving care (Sederer, 2009). Indeed, some have stated that there have been few cases of successfully adopting and implementing change to mental health services (Proctor et al., 2009) while others have found that only

around a third of recommendations for care based on research are routinely followed (Mickan et al., 2011). Unfortunately, it is well documented that change and growth can be perceived as extremely threatening to mental health systems which may delay change even when it is suggested to be useful and important by researchers and the populations who are served by services (Brooks et al., 2011).

On the basis of this history, I feel it is important to acknowledge that I hold no illusions about the challenges present in pursuing change within long-standing services and systems of care. I am acutely aware that researchers who seek to answer inherently political questions about the nature of psychology and mental health treatment are often viewed as too political and self-righteous, and that many believe work of this kind is entirely unnecessary (Fyer et al., 2004; Sullivan, 2008). However, I hold that work which considers the impact of findings upon its populations of interest is serving one of the key tenants of psychological research: the importance of relevance (Rosnow, 1981). It has long been recognised within psychology that it is important to consciously consider whether the research we conduct can helpfully improve the lives of the people with whom we work (Rosnow, 1981). In this project, I was specifically guided by collaboration with young people, and those who participated in this research proposed a number of changes to mental health care which they perceived as necessary and important. As such, I believe it is relevant in the final pages of this thesis to note how, in the spirit of community psychology and participatory action research, I intend to work towards amplifying the voices and perspectives offered to this project by participants. In this way, I hope to return some of the investment offered by my young collaborators towards actions with the potential to benefit them and their peers.

To this end, I have identified three key targets to which I hope to disseminate the findings of this project. These include existing youth mental health services, political actors,

and young people themselves. I have selected these targets on the basis of research suggesting that the most effective approaches to implementation involve consulting at all levels – with patients, providers, managers, and policy makers to implement change across domains and motivate both systemic change and national policy (Green & Aarons, 2011).

Disseminating knowledge to youth mental health services involves providing information regarding the results of this research directly to the managers and clinicians currently working within youth mental health services across the country. This may have significant benefit, as it has been shown that informing and educating professionals can improve the uptake of changes recommended in research (Brooks et al., 2011). Addressing key concerns that professionals may have about change through clear communication may promote better uptake of new practices (Brooks et al., 2011). Additionally, providing training can also improve professional response to changes (Forman-Hoffman et al., 2017; Lau et al., 2016; Pilgrim & Sheaff, 2006). While one of the most effective approaches to incentivising change in clinical practice is pay (Forman-Hoffman et al., 2017; Garner et al., 2012), the resourcing required for this is likely to make it impractical. In order to meet this need, I am currently in the process of developing presentations on the findings of this study to deliver to audiences of mental health care professionals, including both a presentation for clinicians integrating the findings concerning young people’s ideals for clinicians and a presentation for service managers and leadership based upon young people’s ideals for services. This is important as most findings would suggest that to maximise the likelihood of adopting new practices in a service, change must be promoted at all levels, including management (Maganabosco, 2006; Sullivan et al., 2008). Interest has already been expressed by multiple services within New Zealand in hearing these findings, suggesting that there may be potential to disseminate knowledge in this way.

The next key target for knowledge dissemination is political actors. One particular challenge when communicating about mental health treatment with political groups is that the impacts and costs of mental ill-health exist over significantly greater timescales than those traditionally considered by policy makers (Knapp et al., 2011). Poor mental health policy has long-term impacts on communities and economic productivity, but changes to a mental health system may not result in immediate, pronounced change to these outcomes (Burnell, 2018). Rather, the process of developing and improving a mental health system that has greater capacity to meet the needs of its target population is a long game – and politicians who prioritise making changes may no longer be in office when progress is made (Jenkins, 2013). As such, for disseminating information to political actors to have any impact, it may be important to share this knowledge with representatives across the political spectrum. Fortunately, this has been facilitated by a governmental initiative to form a cross-party working group on Mental Health and Addictions (Alexander, August 2019). As it is, New Zealand may be in a particularly unique political position in which all major political parties acknowledge the significant need to address mental ill-health (Alexander, August 2019). In order to disseminate the findings of this project to this group, a formal report is being prepared for presentation. This report will highlight the benefits of innovation in our youth mental health system including the importance of incorporating the voices of young people in service design. Members of parliament across party lines have already been approached regarding this project. These conversations have indicated receptiveness to reviewing such a report within the cross-party working group on mental health and addiction and have generally suggested an interest in considering alternative approaches to youth mental health care.

Finally, I would like to consider some ways in which these findings can be disseminated to young people themselves. An inherent component of participatory action

research is the returning of power to the population involved in the project (Braum et al., 2006). As such, I see it as important to discuss these findings with young people themselves. One approach which may support this would be producing a webinar explaining the results of this study. This can contribute to ensuring young people receive the benefits of the time and energy they contributed to this project.

However slow progress may be and however many barriers may be present, the change young people spoke of in this project should not be considered impossible or infeasible. Many countries who had previously been reluctant to advance change in mental health care have begun this process. For example, in recent years, the United Kingdom's government has reported their increasing focus on the mental health needs of young people (NHS England, 2015) with an emphasis on providing child and adolescent mental health services which are modernised and higher quality (UK Government, 2017). Since this time, there have been cases of services reconsidering their approach to care for young people. For example, Camden, a borough of London, entirely redesigned their child and adolescent mental health services between 2016 and 2018 (see Lidchi & Wiener, 2020 for a detailed description of this process). Initial findings have suggested that these changes have effectively improved the efficacy of these services with the potential to improve outcomes for the young people and families who access this service (Lidchi & Wiener, 2020). The outcomes of this study suggest that widespread, systemic change within a region is not only possible but could potentially be undertaken within a relatively short timeframe with a significant improvement in outcomes.

Final thoughts

Just as I started this thesis with a reflection upon my role and position within this research, I would like to end by considering how this has shifted throughout the process of

conducting and writing this project. As a training clinician, I now hold significantly greater knowledge of and experience within the mental health system than was available to me at the time this project was conceived. I have a great appreciation for the immense challenge it would be to generate change in the youth mental health system of New Zealand, and there have been times over the years it has taken to complete this project where I have not felt as hopeful as the young participants with whom I have worked. As Goodwin and Pfaff (2001) would say, I had invested a significant amount of emotional labour into this research which was, and is, closely tied to my identity. The toll of work of this kind can be heavy and I, like many others, have found that work intended to shift long held patterns can cause an enormous impact on our emotional wellbeing (Driscoll, 2019). It has been well established that activists are prone to burn out and often feel overwhelming pressure from the sense of urgency for the changes they seek to see made (Cox, 2011). I have been acutely aware of how this has affected me and my role within this work. I must be honest that I, like many others (Cox, 2011), have felt disheartened and disappointed with how challenging change can be and how high a hill there is to climb. Indeed, I have often felt myself pulled towards the ‘culture of martyrdom’ which many activists identify (Gorski & Chen, 2015) in which I feel a pressure to continue dedicating increasingly greater time and energy to work in this area. At times throughout this project, I have struggled with apprehension regarding the scale of ideas which were presented by the young people who participated in this project and my awareness of how challenging these ambitions would be to reach even in our current climate.

However, at these times, I found it most important to return myself to the words of the participants. As in all qualitative research, it was essential that I continue to ground myself in the hopefulness and optimism of my participants, and ensure that in this project I honour them and do not allow my own worries to cloud the perspectives they offered to me. Through focusing my energies on the words of my participants, I have found inspiration to

continue engaging in activist research. Like many others (see Klar & Kasser, 2009) I have found activism a fulfilling and meaningful exercise which has contributed positively to my studies and wellbeing. Indeed, I have now moved to a position in which the weight of the significance of this work is no longer simply a source of stress but also a source of pride which has motivated me, as it motivates many others engaged in activism (Jasko et al., 2019). Like many others across disciplines, I have found my resilience has been at its highest when my activism was not conducted in a vacuum but in collaboration with those within my community – in this case, other young people passionate about mental health (Edelman, 2020). In this way, I have felt strengthened to resist the burn out and sense of isolation which causes many activists to drop out of their work (Cox, 2011). In order to do this, I have drawn on a body of research which has demonstrated it *is* possible to sustain activism long term, with proper attention to its impacts on us and how to avoid burn out (Rettig, 2006). I have developed and now occupy a position of enormous respect for the discipline and practice of psychology, and a deeper understanding of how critical, community-based research can inform practices in mainstream settings which do, ultimately, also seek to serve and benefit young people.

I emerge from this project a firmer advocate and fiercer activist than I entered it and, ultimately, it has been the hopefulness and passion of the young people who collaborated with me on this project that has continued to motivate me and which has fuelled my desire for change. I am consistently reminded that this is not ‘my’ research: it is the product of 96 young people, including those who left their workshops early, and it was each of their words which ultimately pushed me to not only complete this project but to pursue a future in activism oriented research. Like many of my participants, over the course of conducting and writing this research I myself have aged out of the category of ‘young people’. However, my

aspirations for a youth mental health system which genuinely works for and with all young people only continue to grow.

Acknowledgments

Ehara taku toa i te toa takitahi, engari kē he toa takitini

My success should not be bestowed onto me alone, it is not that of the individual but of the collective

Before anything else, I have to acknowledge my *why* for this thesis: the 96 young people who committed their time and energy to collaborating on this project with me. I am grateful for each and every participant who offered their stories, their time, and their passion to this process. I hope throughout my career as a researcher and clinician to have the honour of continuing to work with such bright, passionate, and empowered young people.

Even before meeting the young people who participated in this research, I had been fortunate to work with some truly exceptional young people during my time volunteering and working as a clinician to young people. This work is what grounds me and reminds me every day why I do what I do.

At the outset, I dedicated this thesis to my grandmother Rae. Her journey with mental health throughout her life has been a constant reminder to me of why we must prioritise compassionate and respectful mental health care. She was and is the strongest person I have ever known.

Now for the *how*. Firstly Kerry: thank you for making this possible. You have been exactly the supervisor I needed and I am grateful for how you both pushed me to follow my wildest ideas and kept my feet squarely on the ground. Thank you for all your mentorship and support in the past four years and for believing I could do this.

I don't see this thesis as the culmination only of my doctoral degree – but the result of 20 years of schooling and education. There are many other educators who were hugely influential on me, too many to name here, but I'd like to particularly acknowledge a few. Liz Peterson, thank you for all your support of me over the years for which I am so grateful. To Nigel George, thank you for showing me I *could* do this and I don't need to overthink so much.

To all of the teachers, board members, and staff of organisations who took a chance on me and this research project, thank you for giving me the opportunity to make this research happen. I could not have done it without your efforts.

There is of course also the matter of funding, and my thanks extend to the University of Auckland for supporting me throughout my doctorate and this project.

While the practicalities of the research might seem the most obvious *how* to consider here, there are countless people whom I could not have completed this without. Firstly, the Consult Liaison Team at Starship Hospital, thank you for all your nurturing over the past year. Liz, thank you for all your support, faith, and work in guiding me to being the best clinician I can be. Laura, you are a role model to me and I am so grateful to have had your guidance this past year. Kath, thank you for being the most compassionate and flexible manager I could have hoped for. And Chris, thank you for all of the office rants which have kept me sane throughout this write up.

My Hannahs, who have been by my side for the past decade, I will be eternally grateful for your support and love. Diver, thank you for being with me through all the messy phases of this research and write up. Follows, I can only hope that proof-reading this was less tedious than attempting to coach me through Year 12 math and Latin. Louise, the hardest working person I know, you inspire me to always reach for my best. Sylvia, thank you for all the much needed distractions – both food and music. And Kristin, I quite literally could not have completed this thesis without you. Thank you for being my other half for the past four years.

To Jack, you are a jack of all trades: my proof reader, emotional rock, and favourite sounding board. Thank you for making it possible for me to finish this and for always managing to bring joy into my life even in the most stressful of times.

I never could have reached this point without the influence of my entire family, my many cousins, my aunts and uncles, and my other grandparents – Rex, Walter, and Joyce. Ben, I hope you know how much your grit and compassion are a constant reminder to me of what all young people are capable of. Rebecca, I am so lucky to have had you and Kate to pick up the abandoned pieces of my

life when I dedicated my time to writing this. Dad, I hope one day I can repay you for the hours you spent combing through this thesis by following in your footsteps in working to help all New Zealanders access the health care they deserve. And lastly to Mum. I spent most of my teenage years desperately trying not to become you – but I am filled with pride at the comparison now. I hope that in my lifetime I can make a fraction of the difference you have made throughout your career – and that I can learn your knack for tracking down even the most dramatically misspelled in-text citations.

Appendix One:
Workshop Materials

Questionnaire

Age:

Gender:

Ethnicity:

Sexuality:

Are you at school or University? Yes No

If yes, what year are you in?

Are you working? Yes No

If yes: Casual Part time Full time

Do you have any past knowledge or experience with mental health services? Yes No

If yes, what is that experience? E.g. past engagement, family engagement.

Q1. How do you think mental health services for young people are doing right now?

Q2. If you could change one thing about mental health services, what would you change?

Q3. What could a mental health service do to make you more likely to choose to attend it, if you needed to?

Q4. What is your ideal vision for youth mental health services?

Q5. Was there anything you'd like from a mental health service that wasn't discussed today?

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Government announces \$10.5m mental health pilot for 18-25-year-olds

23 Jul, 2018



Associate health minister Julie Anne Genter leads mental health youth pilot.

[By: Emma Russell](#)

The Government has announced a \$10.49 million mental health pilot offering free counselling to 18- to 25-year-olds will start in December.

It comes as part of the Greens' pre-election pledge to fund free counselling for anyone under 25.

Associate Health Minister Julie Anne Genter said, while Labour had a plan to roll out better support for under 18s through school nurses, this initiative focused on targeting those who had left school and were still at risk.

The funding for the programme was provided in the 2018 Budget. Today, a tender opened for all mental health providers to make a proposal that would decide who and where this pilot should be run.

"The healthcare provider that wins the tender will be responsible for working closely with the Ministry of Health and local healthcare providers, whether that's the district health board or primary health organisation."

She said the Ministry of Health would be monitoring the progress.

Genter said the programme was likely to operate in a contained geographic area and would be looking to target the most at-risk communities.

"Eventually a much larger programme will become nationwide for all 18- to 25-year-olds but this is the first step in developing the model and compiling the evidence from a New Zealand perspective," Genter said.

In New Zealand around 75 per cent of all lifelong cases of mental illness started before people turned 25.

Genter said New Zealand's mental health services had been in crisis for a long time and the public health system had not provided early intervention - "particularly for that age group who have left home".

"Those young people don't have the money to pay for a private psychologist and the public health system doesn't respond until things have gotten very serious and critical.

"When someone is willing to hurt themselves that's when they get intervention so what this programme is aiming to do is to ensure that support is there earlier."

She said the Government had been looking at a UK model that showed high success rates through early intervention and support for young people by providing free counselling.

"It showed that by being able to access that early intervention and support, people were able to get better and tragedies were avoided."

Putting it out to tender was about looking at how best to roll out a similar programme in New Zealand.

"We do have a higher youth suicide rate and a different health system, and particular high need communities like Māori and Pacific [peoples] that will be different to the high needs communities in the UK."

In 2016, 4940 20-year-olds sought appointments, but a third of them had to wait longer than three weeks after being referred to a mental health specialist.

Genter has said suicide was preventable, not inevitable.

"We have to break the assumption that there's nothing we can do.

"Government has a very important role to play in protecting and empowering families and communities, so that they don't have to suffer this type of loss."

This comes after figures, released to the *Herald* under the Official Information Act, showed at least 11 university students had died by suspected suicide in New Zealand since 2015.

Another study based on the same time period also showed 56 per cent of New Zealand tertiary students considered dropping out because of stress, anxiety and depression.

It prompted the New Zealand Union of Students' Associations, which commissioned the Kei Te Pai Report, to claim tertiary students are failing to reach their potential because of the mental health crisis.

The tender will close on August 17.

WHERE TO GET HELP:

If you are worried about your or someone else's mental health, the best place to get help is your GP or local mental health provider. However, if you or someone else is in danger or endangering others, call 111.

If you need to talk to someone, the following free helplines operate 24/7:

DEPRESSION HELPLINE: 0800 111 757

LIFELINE: 0800 543 354

NEED TO TALK? Call or text 1737

SAMARITANS: 0800 726 666

YOUTHLINE: 0800 376 633 or text 234

1.3 Workshop materials: Participation certificate example



Appendix Two:
Recruitment Materials

What do young people want mental health services to be like?

My name is Jess Stubbing. I am a clinical psychology doctoral student in the School of Psychology at the University of Auckland wanting to find out what young people want New Zealand's mental health services for young people to be like.

If you are:

- Aged 16-25

-Interested in mental health services (*whether or not you have personal experience*)

- Wanting to help other young people struggling with mental health problems

We want you to tell us what you want from services so we contribute to the development of better mental health services for young people around the country.

Email Jess at jstu736@aucklanduni.ac.nz for more information.

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2.2 Recruitment materials: Email scripts

2.2.1 *Initial contact with schools and organisations*

Kia Ora,

My name is Jess Stubbing, I am a doctoral candidate in psychology at the University of Auckland conducting research which explores young people's perspectives on mental health interventions. I'm looking for groups of young people that would be interested in participating in workshops. I am currently looking for organisations to collaborate with so we can give this opportunity to as many young people around the country as possible.

The workshops are designed to be exciting opportunities for young people to share their perspectives and to work together in teams to design their ideal mental health intervention. It's an engaging and fun session, designed to be collaborative and innovative and to allow young people to have a say over the direction mental health services should be taking.

I think it would be a great fit with your organisation's vision and a good opportunity. I would love to be able to speak to someone in your team about the possibility of holding a workshop with you, to explain more about the research and discuss how this could work. If this would be possible, please get in touch with me.

Nga mihi,
Jess

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2.2.2 *Response to expression of interest: Individual participant*

Kia ora,

Thanks for expressing interest in our research! I've attached a copy of our participant information sheet for you to read. You're welcome to ask any questions before deciding whether to participate or not.

If you would like to participate, there is a consent form attached for you to complete. If you don't have access to a printer you can also fill it out on the day of your workshop. You can then let me know which of the following locations and dates would be most suitable for you to take part in a workshop.....

If you do not wish to participate in this research, you do not need to respond to this email. Thank you for your interest!

Ngā mihi,

Jess Stubbing

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2.2.3 Response to expression of interest: Organisation or school

Kia ora,

Thanks very much for getting in touch via [social media/email]

My name is Jess Stubbing, I am a doctoral candidate in psychology conducting research that looks at young people's perspectives on mental health interventions. I'm looking for groups of young people that would be interested in participating in workshop to help us know how they think youth services should be designed.

The workshops are designed to be exciting opportunities to learn about mental health, and to work together in teams to design their ideal mental health intervention. It's an engaging and fun session for young people, designed to be collaborative and innovative. It's a great way for young people to contribute and share their ideas.

I've attached an information sheet with more details about the research, but the key is that it takes two hours (or up to three if a large group sign up) and can be completed either in or outside of school time. All young people will receive \$40 koha as a thank you and food is provided.

Let me know if you have any questions, or if you'd like to give me a ring and discuss the research.

Ngā mihi,
Jess Stubbing

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2.2.4 Participant or organisation to be excluded

Kia ora,

Thank you for expressing interest in participating in our research. Unfortunately, we are only looking for participants aged 16-25/we have reached capacity for our workshops and you will not be able to participate.

Thank you again for your interest.

Ngā mihi,
Jess Stubbing

Approved by the University of Auckland Human Participants Ethics Committee on 3rd August 2018 for three years. Reference number 021731

Appendix Three:
Participant Information and Consent Forms

PARTICIPANT INFORMATION SHEET
School Principal

Project title: What do young people in New Zealand want mental health services to be like?

Name of Supervisors: Dr Kerry Gibson, Dr Susan Cowie

Name of Student Researcher: Jessica Stubbing

Researcher Introduction

My name is Jessica Stubbing. I am a student training in Clinical Psychology in the School of Psychology at the University of Auckland. I am supervised by Kerry Gibson and we are working on a project on how young people want mental health services in New Zealand to be designed.

We would like to request your permission to share information about this project with young people in your organisation and to request their participation in the research.

Project Description

Most mental health services for young people in New Zealand were developed by adults without talking to young people about what they want from services. We are hoping to recruit young people who want to help us develop understanding of how young people want mental health services for them to work. We would like to use this information to help develop guidelines for mental health services for young people that young people themselves helped us create.

We are looking for around 50 participants who are between the ages of 16 and 25 to take part in this research. We are hoping to recruit a small number of participants from your organization.

Project Procedures

If any of the young people in your organization agree to take part in the research they will be asked to participate in a workshop that will last 2 hours. In the workshop they will be asked to take part in a number of activities. These activities include answering questions individually, participating in a group discussion, and designing their ideal mental health service with other workshop participants. Some questions we might ask include: What do young people want from mental health services? What is the best thing a mental health service could do for young people? The workshop will be recorded.

They will also be asked if they agree to take part in the next phase of the research. If they agree, after all our workshops have been completed they will be sent a copy of the guidelines for work with young people that we come up with based on all the workshops. They will then be invited to provide feedback on those guidelines.

If they are interested in taking part in this study we will ask them to first fill out a consent form.

Future use of data and data storage

We would like to write up the research findings so that we can learn more what young people want from mental health services, so services can help young people more. When we write this up we will use quotes and examples from the workshops but we will make sure that nobody can identify participants or the organisations. We will develop this into a series of guidelines for how mental health services could work with young people.

All researchers are obliged to keep the transcribed workshops as well as the consent and information forms. We will keep consent forms in a locked cabinet in the School of Psychology for 6 years and will then destroy them. The transcripts will be also be kept for 6 years in a locked cabinet, separate to consent forms so that nobody can identify participants or any schools from transcripts.

Right to withdraw from participation

It's up to you to decide if you want your organization to be involved in this project or not. Each participant will also get to decide for themselves whether or not they want to take part and should not experience any pressure to do so. We seek your assurance that young people's participation or non-participation will not affect their relationship with the organisation. Even if they do agree to be involved they can change their mind at any time.

If participants are over 16 they do not have to ask their parents' permission to take part in this research but they are very welcome to discuss it with their family/whanau if they prefer. We would be happy for individual participants to inform their parents to ensure there are comfortable with the young person participating. We would be happy to help answer any questions they may have about the research.

Confidentiality and Anonymity

The researchers will not tell anyone which participants or organizations have taken part in the research or give out any information about them. If young people in your organization participate in the workshop, other people who participated will know they participated and what they said. We cannot guarantee that they will be participating with people they don't know, and they may have known other participants prior to the workshop. While we will ask everyone to respect the other group member's confidentiality we cannot guarantee that they will. The workshops will not require young people to share personal information.

If they give us feedback on the guidelines, their feedback and information will be kept confidential by the researchers

What's in it for you?

The organization will have an opportunity to contribute to creating guidelines to improve mental health services for young people. This is an area important to young people's wellbeing and also helpful to those in your organization who are concerned with these issues.

Participants will have an opportunity to share what is important to them, which is important for young people but will also hopefully be a useful and interesting process. They can contribute to helping us help other young people who may be struggling.

We will send the organization and individual participants a copy of the findings once the study is complete if you would like this.

Are there any risks involved in taking part in this research?

It can be difficult to talk about mental health and mental health services. If it does upset a participant to talk about it, we can talk to them about getting support. If we are worried that they are at risk, we will take steps to keep them safe – even if that means breaking our confidentiality agreement.

So what do you need to do next?

If you are prepared to allowing your organization to be involved in this research, please complete the Consent Form attached.

The student researcher is:

Jessica Stubbing

Email: jstu736@aucklanduni.ac.nz

The primary investigator is:

Dr Kerry Gibson

Email: kl.gibson@auckland.ac.nz

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For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland Office of the Vice Chancellor, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 83711.

Approved by the University of Auckland Human Participants Ethics Committee on 3rd August 2018 for three years. Reference Number 021731

PARTICIPANT INFORMATION SHEET

Young People

Project title: What do young people in New Zealand want mental health services to be like?

Name of Supervisors: Dr Kerry Gibson, Dr Susan Cowie

Name of Student Researcher: Jessica Stubbing

Researcher Introduction

My name is Jessica Stubbing. I am a student training in Clinical Psychology in the School of Psychology at the University of Auckland. I am supervised by Kerry Gibson and Sue Cowie and we are working on a project on how young people want mental health services in New Zealand to be designed.

Project Description

Most mental health services for young people in New Zealand were developed by adults without talking to young people about what they want from services. We are looking for participants who want to help us develop understanding of how young people want mental health services to work. We would like to use this information to help develop guidelines for mental health services for young people that young people themselves helped us create.

If you are interested in mental health services and are between the ages of 16 and 25 you may be able to take part in this research. We are hoping to recruit around 50 participants to take part. If you are interested, get in touch and we can let you know if there will be a workshop taking place in your area.

What will taking part in the research involve?

If you take part in the research you will be asked to participate in a workshop that will last 2 hours. In the workshop you will be asked to take part in a number of activities. These activities include answering some survey questions individually, participating in a group discussion, and designing your ideal mental health service with other workshop participants. To guide the discussion we will ask you questions like: What do young people want from mental health services? What is the best thing a mental health service could do for young people? The workshop will be audio-recorded.

Once all the workshops have been completed you will be sent a copy of the guidelines for work with young people that we come up with based on all the workshops for you to provide your feedback on those guidelines

If you are interested in taking part in this study we will ask you to first fill out a consent form.

What will happen to the focus group material?

We would like to write up the research findings so that people can learn more what young people want from mental health services, so services can help young people more. When we write this up we will use quotes and examples from the workshops but we will make sure that nobody outside the workshop can identify you. We will develop this into a series of guidelines for how mental health services could work with young people, and if you'd like to you can sign up to provide us feedback on those guidelines a few months after your workshop.

The researchers are obliged to keep the transcribed workshops as well as your consent and information forms. We will keep your consent forms in a locked cabinet in the School of Psychology for 6 years and will then destroy them. The transcripts will be also be kept for 6 years in a locked cabinet, separate to your consent forms so that nobody can identify you from transcripts.

Who gets to decide if I do the research?

It's up to you to decide whether or not you want to participate in this study. If you saw this advertised at school or at a community group, you are under no obligation to that group to participate or not. If you saw this advertised at school, your School Principal has given an assurance that participation or non-participation will not affect student's learning or relationship with the school. Even if you do agree to be involved you can change your mind at any time. Because you are taking part in a group discussion we cannot remove any contributions you have already made to the discussion, but you can leave the workshop room whenever you choose.

If you are over 16 you do not have to ask your parents' permission to take part in this research but you are very welcome to discuss it with your family/whanau if you prefer. We would be happy to help answer any questions you or they have about the research.

Will it be confidential and anonymous?

The researchers will not tell anyone that you have taken part in the research or give out any information about you. If you participate in the workshop, other people who participated will know you participated and what you said. We cannot guarantee that you will be participating with people you don't know, and you may have known other participants prior to the workshop. While we will ask everyone to respect the other group member's confidentiality we cannot guarantee that they will. The workshops will not require you to share personal information.

Some of the workshops might be transcribed by a professional transcriber. They will sign a confidentiality form to ensure they keep your feedback and information confidential. If you give us feedback on the guidelines, your feedback and information will be kept confidential by the researchers.

What's in it for you?

We want this to be a collaborative research process – you will be able to share what is important to you and your community. We hope that the workshop will be interesting, useful, and that you may learn more about mental health services in New Zealand. You will also be helping us help other young people who may be struggling and need help. If you'd like, we will send you a copy of our findings from the research when we are finished.

We will also give you a \$40 voucher if you take part, and there'll be pizza at the end of the workshop. If you give us feedback on our guidelines, you'll go in the draw to win a \$100 voucher.

Are there any risks involved in taking part in this research?

Mental health is a sensitive subject and if it does upset you to talk about it, we can talk to you about getting support. If we are worried that your safety is at risk, we will take steps to keep you safe – even if that means breaking our confidentiality agreement. If this did occur, we would make sure to discuss all the options with you.

These are some numbers of people you can contact if you're distressed:

Youthline: Free call [0800 376 633](tel:0800376633) or text [234](tel:234)

Lifeline: Free call [0800 543 354](tel:0800543354) or text [4357](tel:4357)

So what do you need to do next?

If you think you would like to take part in this research or would like to hear more about it then please contact **Jessica Stubbing** at jstu736@aucklanduni.ac.nz

The student researcher is:

Jessica Stubbing

Email: jstu736@aucklanduni.ac.nz

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Approved by the University of Auckland Human Participants Ethics Committee on 3rd August 2018 for three years. Reference Number 021731

**CONSENT FORM
School Principal**

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project title: What do young people want? Designing mental health services in New Zealand?

Names of Researchers: Jessica Stubbing, Kerry Gibson, Sue Cowie.

I have read the Participant Information Sheet and have understood the nature of the research and what my school is required to do. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to allow information about the research project to be distributed at my school.
- I agree that some of the young people who are part of my school can participate in this research.
- I understand that they will be asked to be part of a workshop lasting about 2 hours and to provide feedback on the guidelines written based on these workshops.
- I understand that potential participants will be free to decide if they wish to participate in either of these activities or not.
- I understand that I am free to withdraw my schools participation at any time if I am concerned about the process.
- I give my assurance that participation or non-participation will not affect the student's learning or relationship with the School.
- I am aware that the researchers will provide me with a report on the research findings.
- I agree that the research may be published in academic articles and conference presentations at the researchers' discretion.
- I wish / do not wish to receive the summary of findings, which can be sent to me by email at _____

Name _____

Signature _____ Date _____

Approved by the University of Auckland Human Participants Ethics Committee on 3rd August 2018 for three years. Reference Number 021731

CONSENT FORM

Young Person

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project title: What do young people want? Designing mental health services in New Zealand?

Names of Researchers: Jessica Stubbing, Kerry Gibson, Sue Cowie

I have read the Participant Information Sheet and have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to take part in the workshop and to review and comment on the guidelines that are developed through this process.
- I understand that the workshop will run for about 2 hours.
- I understand that I can withdraw from any part of the research at any time without providing a reason for this.
- I understand that I am free to leave the workshop at any time without giving a reason, but am aware that I cannot withdraw contributions I have already made to the discussion.
- I understand the researchers will keep information confidential.
- I agree to keep personal information about others in the group confidential.
- I understand the researchers cannot guarantee that all the participants will keep any information I share confidential.
- I agree to be audiotaped.
- I wish / do not wish to receive the summary of findings, which can be emailed to me at the email address below
- I give permission for my workshop contributions to be quoted anonymously in publications arising from this study.
- I understand that the transcript from the workshop will be kept for 6 years after which it will be destroyed

Name _____

Signature _____ Date _____

Please send the findings to email _____

Approved by the University of Auckland Human Participants Ethics Committee on 3rd August 2018 for three years. Reference Number 021731

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