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R. Woolfson, L. Woolfson, L. Mooney, Donna Bryce

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Young people's views of mental health education in secondary schools: a Scottish study

R. Woolfson,* L. Woolfson,† L. Mooney* and D. Bryce*

*Renfrewshire Educational Psychology Service, Paisley, and

†University of Strathclyde, Glasgow, UK

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Correspondence:

Dr Lisa Woolfson,
Department of
Psychology, University of
Strathclyde, 40 George
Street, Glasgow G1 1QE,
UK

E-mail:

lisa.woolfson@strath.ac.uk

Abstract

Background This exploratory study used mixed methods to investigate young people's preferences in the delivery of mental health education and to investigate possible age and gender differences.

Method Information was gathered about the delivery of mental health education in three secondary schools. Nine pupil focus groups were carried out to identify key themes which were then further developed and administered through questionnaires to a larger sample of 773 pupils.

Results Gender and age differences were found in young people's preferences about who should deliver mental health education, and what, when, where and how this should be delivered.

Conclusion Mental health education should reflect the needs of young people. Age and gender preferences should be considered when designing these programmes.

School mental health education is high on the government's agenda in the UK (Department for Education and Skills 2001) and in Scotland (Scottish Executive 2004) where the present study took place. Weist and Murray (2007), building on the World Health Organization's 2001 definition, viewed school mental health education as a continuum that includes prevention, identification and intervention in emotional and behavioural problems as well as promotion of social and life skills.

Thus, there is potentially a wide spectrum of programmes that may be delivered, ranging from selectively targeting pupils viewed as at increased risk of an emotional or behavioural disorder, e.g. eating disorder prevention (Stewart *et al.* 2001), to a universal focus targeting every young person in the school by promoting health and general well-being or problem prevention (Pfeiffer & Reddy 1998; Graeff-Martins *et al.* 2008), as in the present study. A universal programme might focus, for example, on prevention of substance abuse (e.g. Perry *et al.* 2003), on prevention of behaviour problems [e.g. Greenberg *et al.*'s (1995) PATHS programme], or on general health promotion (e.g. Patton *et al.* 2003). Recent studies have indicated

gender and age differences in children's knowledge, understanding and concern (Burns & Papee 2006; Williams & Pow 2007; Fox *et al.* 2008), suggesting that these may need to be taken into account in designing effective curricula.

The general trend in acknowledging the views of the consumer in service development is now recognized as extending to children and young people (UN 1989; Dorrian *et al.* 2000). It has recently been recommended that Child and Adolescent Mental Health Services involve young people in service development (Claveirole 2004; Street 2004; Gilliland *et al.* 2005). Therefore, consulting with children is not simply a preferred model, but is now a requirement placed upon professionals.

Nevertheless, many mental health education studies have not examined young people's opinions (e.g. Jiang *et al.* 2001; Desocio *et al.* 2006), but have typically carried out consultations with service providers such as directors of services and professionals rather than young people themselves (Van Hoof & Hansen 1999; Weist *et al.* 2000, 2005; Wyn *et al.* 2000). On the other hand, Armstrong and colleagues (1998) worryingly reported that the young people consulted in their study viewed

school-based mental health education as having little significance because of poor-quality information and adult lack of expertise. Experiential learning (Pinfold *et al.* 2003) and personal testimonies (Pinfold *et al.* 2005) were viewed as more relevant.

The current exploratory study thus aimed to identify young people's preferences in relation to the delivery of mental health education in schools, and to investigate whether there were gender or age differences in this.

Methods

Participants

A purposive sample of three secondary schools was selected from a possible 11 in a West of Scotland local authority and invited to participate. These schools were selected in order to represent the following criteria:

- geographical area (one from each of three separate areas of the local authority);
- size of the school population (representing smaller and larger schools);
- religious denomination (one denominational and two non-denominational schools);
- socio-economic status (ranging from lower to higher socio-economic status).

The present study's audit of procedures at the level of school management indicated that each school carried out most of its mental health education within Personal and Social Education (PSE) classes with class teachers usually delivering the material although external providers were occasionally recruited to deliver classes on exam stress, relaxation, worries, self-esteem, depression, psychology and general mental health awareness. Schools were asked to identify mental health topics they covered. These included alcohol and drug awareness, sexual health, bullying, body image, eating disorders, feelings, assertiveness, managing stress, promoting self-esteem, mental illness. Related school visits were sometimes organized. A range of teaching methods was reported, e.g. videos, workbooks, group discussions, practical classes and seminars from external professionals. All three schools also offered targeted support groups for pupils experiencing specific difficulties (e.g. bereavement, bullying). The focus of this study is however on universal mental health programmes for all pupils, rather than these targeted programmes.

Procedure

Stage 1 – focus groups

The use of focus groups is viewed as particularly appropriate for exploratory research where little is known about an area, often then followed up by quantitative methods from a larger sample (Stewart *et al.* 2007). This use of mixed qualitative and quantitative methods where quantitative methodology is used to develop findings from qualitative data (Greene *et al.* 1989) was employed in the present study. Furthermore, triangulation of data gathered by both qualitative and quantitative methods is thought to strengthen the findings (Tashakkori & Teddlie 1998).

Three focus groups were held in each school: Secondary Year 1 (S1) and Secondary Year 2 (S2) (aged 11–13), Secondary Year 3 (S3) and Secondary Year 4 (S4) (aged 13–15), and Secondary Year 5 (S5) and Secondary Year 6 (S6) (aged 15–17). Age groupings were chosen to optimize group cohesiveness and compatibility (Stewart *et al.*, *op. cit.*). Therefore, nine focus groups with young people were held with the purpose of exploring the groups' views on their school's current mental health education curriculum.

All pupils at these three schools, who had received mental health education in the previous 12 months, were eligible to participate in the focus groups. Participants were randomly selected from a list of these eligible pupils, with selection weighted to ensure a balance of male/female participants. Prior to inviting the young people to participate in focus groups, parents were contacted by letter and asked to discuss the focus group with their child in order to seek their consent. Consents were also obtained from parents and from head teachers.

Within each participating school, 10–12 pupils were invited to attend each of the three age-banded focus groups held in that school, with the aim of obtaining an optimal number of between six and eight participants per group (Krueger & Casey 2000). Pupils were not required to explain why they declined to become involved in the study. It was not established whether there were any significant differences between those who declined and those who participated. Some pupils were unable to attend on the day owing to ill health, medical appointments, class tests, change of timetable. Thus, 44 pupils (21 girls, 23 boys) participated in the nine focus groups (see Table 1). Each group lasted approximately 1 h. Focus group questions are presented in the Appendix. Two members of the research team moderated each group; discussions were recorded, transcribed and then tapes were erased. Discussion transcripts were analysed independently by two members of the research team and key themes were identified (Robson 1993).

School	Secondary 1/2			Secondary 3/4			Secondary 5/6		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
A	3	2	5	3	1	4	2	2	4
B	3	4	7	3	3	6	1	2	3
C	2	4	6	4	2	6	2	1	3

Table 1. Focus group composition

Table 2. Gender and year group of pupils completing questionnaire

	S1	S2	S3	S4	S5	S6	Total
Girls	86	88	74	44	66	38	396
Boys	67	82	65	62	61	33	370
GNI*	0	7	0	0	0	0	7
Total	153	177	139	106	127	71	773

S1, Secondary Year 1; S2, Secondary Year 2; etc.

*GNI: gender was not indicated for these pupils.

Stage 2 – questionnaires

A 26-item questionnaire was then devised that expanded on themes emerging from the focus groups with the purpose of investigating preferences in more detail and exploring possible age and gender differences. Respondents were asked to indicate their views on each statement, using a 5-point Likert scale for which responses ranged from 1, 'not at all important', to 5, 'very important'. There were also open-ended questions to identify additional topics and make further suggestions. The questionnaire was initially piloted with 36 pupils and minor changes were made following this. Analysis confirmed that the alpha reliability of the 26-item questionnaire was 0.81, indicating good reliability. In the next stage, a further 847 pupils comprising randomly selected whole class groups from the three participating schools (24% of the pupil population of the three schools) were invited to complete questionnaires by distributing them to these pupils in whole class groups and advising them to leave the questionnaire blank if they did not wish to participate in the research. A total of 773 young people completed questionnaires. Forty blank questionnaires and 34 spoiled questionnaires could not be included in the study. Table 2 describes the year group and gender of participants.

Results

Stage 1 – focus group data

The main themes which emerged from focus group discussions are presented below with illustrative quotes and the year group of the respondent:

- *Mental health education can be delivered effectively by both school staff and external professionals.* Preferences here seemed to vary according to topic and to individual teacher qualities. Groups also suggested that it may be useful to hear from people who have been directly affected by mental ill health.

If they teach you other subjects, then you'll probably know them better and you'll be able to talk to them better. (Secondary 3/4)

It might be a bit weird... because you know a teacher and then we've never really talked to (the teacher) about anything like that before. (Secondary 1/2)

The teachers they don't know what they're talking about, so it would be better with somebody that knew what they were talking about. (Secondary 5)

- *Importance of location.* Focus group participants indicated that the teaching environment is an important aspect of mental health education. They preferred to receive lessons in a specific, suitably decorated classroom. Additionally though they stated that external trips could provide a useful environment for learning.

I think it would be good if we had like a classroom just for PSE, because like in that way we could like decorate it and stuff and it could always be that way. (Secondary 1/2)

... the science place you see like lungs... it's all black from smoking. (Secondary 1/2)

- *Preferred groupings.* When learning about mental health, the size of the class group was viewed as important. Focus group participants disliked whole year group delivery, as they often felt inhibited by large groups.

... if it is smaller groups you'd be less intimidated to say something. (Secondary 1/2)

Not whole year assembly. (Secondary 3/4)

- *Active engagement.* Participants identified various methods currently used in school to teach mental health education, some of which they find useful (videos, posters, group work with friends, practical workshops) and some of which they do not find as engaging (copying from the board, passive listening to someone talk).

When you're watching a video and it's like about bullying or something you see how other people got over it, when

Table 3. Questionnaire results: personnel and location

Mental health education should be taught . . .	Not at all important	A little important	Not sure	Important	Very important
By someone you are familiar with (e.g. teacher, school nurse)?	66 (8%)	121 (16%)	186 (24%)	309 (40%)	91 (12%)
By someone employed only to teach PSE (instead of a teacher of another subject)?	146 (19%)	121 (16%)	211 (27%)	182 (23%)	113 (15%)
By someone who has personal experience of the topic (e.g. someone who has had a mental illness)?	98 (13%)	101 (13%)	153 (20%)	247 (32%)	174 (22%)
In a classroom only used for mental health (PSE) lessons?	205 (27%)	163 (21%)	181 (23%)	156 (20%)	68 (9%)
In whole year group assemblies?	265 (34%)	168 (22%)	201 (26%)	110 (14%)	29 (4%)
In your usual class groups (roughly 20–30 people)?	79 (10%)	142 (18%)	190 (25%)	294 (38%)	68 (9%)
In small groups (5–10 people)?	130 (17%)	151 (19%)	211 (27%)	184 (24%)	97 (13%)
On school trips to relevant places (e.g. hospitals, health centre, science centre)?	98 (13%)	93 (12%)	160 (21%)	215 (28%)	207 (27%)

PSE, Personal and Social Education.

it's something like that, and it's better than listening to a teacher. (Secondary 1/2)

When we were doing smoking we made like a poster and that was quite good. And just now we are doing drugs, so we are making a little brochure thing and I think that's quite good as well. (Secondary 1/2)

- *Curriculum coherence.* Some had found their mental health education to be somewhat repetitive. Consequently, it was suggested that mental health education might be carried out only in the early secondary school years, although others felt this knowledge should be expanded in subsequent years.

I think most of the stuff should be done earlier like the alcohol and the smoking and the drugs, because it's becoming a sort of a common thing where it's like young people, our age and even younger. (Secondary 1/2)

I've seen the same video about eight times about the girl that took ecstasy and died. (Secondary 5/6)

Some stuff can be repeated, but stuff maybe that's more complicated that you didn't really get in first year or you'd forgotten about. (Secondary 5/6)

- *Useful content* included knowledge, prevention and coping with depression, eating disorders, sexual health problems, self-harm, autism, ADHD, dementia and schizophrenia.

We don't know what to do if you get it. It would help reduce stigma because people might think once you've got it you can't get cured. (Secondary 3/4)

They could teach us about the long term effects. We already learn about it with anorexia, but not with things like dementia or schizophrenia. (Secondary 3/4)

Should be taught how to prevent it. (Secondary 3/4)

Stage 2 – questionnaire data

A questionnaire was designed to examine the focus group themes in more detail. Pupils' questionnaire responses are pre-

sented in Tables 3–5. For analysis we collapsed the two categories 'not at all important' and 'a little important' on the left of the table into one category that broadly reflected 'not very important' and we collapsed the two categories 'important' and 'very important' on the right of the table into a single category that reflected 'important'. A similar process was carried out with the different 'useful' categories in Table 4. Two-tailed z-tests of proportions were then carried out to establish the significance of the difference between proportions of pupils rating each item as 'important' compared with those who viewed it as 'not very important', and between 'useful' and 'not very useful'.

Main themes

Table 3 shows that respondents viewed it as important for mental health education to be delivered by someone they are familiar with such as their class teacher ($z = 11.16, P < 0.001$) and who has personal experience ($z = 11.52, P < 0.001$). There was no significant difference in the proportions of young people viewing it as important or not important that the mental health educator was someone employed to teach this subject alone in the school. From Table 3 too, it can be seen that most young people felt that it was important to teach mental health education through school trips to relevant places such as a hospital or science centre ($z = 12.01, P < 0.001$). Within school, young people thought it important to learn about mental health in their usual class group ($z = 7.40, P < 0.001$). They saw it as not important for teaching to take place in a specially designated room within the school ($z = -7.53, P < 0.001$), or in whole year assemblies ($z = -15.49, P < 0.001$). Learning about mental health within very small groups evoked a mixed response from pupils.

From Table 4, it can be seen that young people identified a variety of techniques that they felt were useful when learning about mental health related issues, including listening to

Table 4. Questionnaire results: curriculum delivery

How useful is it to be taught mental health education . . .	Not at all useful	A little useful	Not sure	Useful	Very useful
Listening to someone talking about the subject?	49 (6%)	127 (16%)	112 (15%)	371 (48%)	114 (15%)
Reading information in books/leaflets?	94 (12%)	221 (29%)	149 (19%)	255 (33%)	54 (7%)
Discussing things in groups?	28 (4%)	89 (11%)	95 (12%)	367 (48%)	194 (25%)
Writing down information from the board?	191 (25%)	229 (30%)	147 (19%)	158 (20%)	48 (6%)
Using role-play exercises?	87 (11%)	112 (15%)	204 (26%)	215 (28%)	155 (20%)
Watching videos about the subject?	22 (3%)	74 (10%)	80 (10%)	349 (45%)	248 (32%)
Designing posters (e.g. about bullying)?	92 (12%)	121 (16%)	124 (16%)	265 (34%)	171 (22%)
Participating in group work with people you know?	25 (3%)	61 (8%)	105 (14%)	342 (44%)	240 (31%)
Participating in group work with people you don't know?	217 (28%)	202 (26%)	188 (24%)	120 (16%)	46 (6%)
In practical lessons?	35 (5%)	64 (8%)	179 (23%)	252 (33%)	243 (31%)
Each school year?	60 (8%)	95 (12%)	156 (20%)	299 (39%)	163 (21%)
From primary school age?	118 (15%)	145 (19%)	152 (20%)	201 (26%)	157 (20%)
From the start of secondary school?	44 (6%)	79 (10%)	128 (17%)	318 (41%)	294 (38%)
Later in secondary school?	126 (16%)	106 (14%)	131 (17%)	217 (28%)	193 (25%)

Table 5. Questionnaire results: curriculum content

How important is it to learn . . .	Not at all important	A little important	Not sure	Important	Very important
How to prevent a mental health problem arising (e.g. learning study techniques to avoid stress during exams)?	24 (3%)	33 (4%)	99 (13%)	260 (34%)	357 (46%)
How to deal with a mental health problem if it arises (e.g. learning relaxation techniques to overcome stress)?	17 (2%)	46 (6%)	97 (13%)	272 (35%)	341 (44%)
The facts about mental health problems (e.g. learning what stress is, how many people suffer from it)?	28 (4%)	63 (8%)	125 (16%)	318 (41%)	239 (31%)

people talking about the subjects ($z = 15.89$, $P < 0.001$), group discussions ($z = 22.76$, $P < 0.001$), using role-play ($z = 9.02$, $P < 0.001$), videos ($z = 30.58$, $P < 0.001$), designing posters ($z = 11.49$, $P < 0.001$) and practical activities ($z = 20.71$, $P < 0.001$). They viewed it as useful to participate in activities with familiar people ($z = 25.47$, $P < 0.001$), and not useful to engage in group work on mental health education with people unknown to them ($z = -13.27$, $P < 0.001$). They also felt that writing information down from the board was not a helpful technique ($z = -11.09$, $P < 0.001$). Respondents expressed mixed views on the usefulness of reading information from books alone (no significant difference between proportions rating this as 'useful' or 'not very useful').

The data in Table 5 show that young people felt it was useful to learn about mental health at every stage of development from primary school ($z = 10.49$, $P < 0.001$), the start of secondary school ($z = 24.90$, $P < 0.001$) through to late secondary school ($z = 9.19$, $P < 0.001$). The majority of young people also felt that it is useful to receive mental health education during each school year ($z = 15.94$, $P < 0.001$). Comparing across these choices, the start of secondary school was however considered to be the most useful time to receive mental health education, with less people expressing a preference for the primary school

stages ($z = 13.42$, $P < 0.001$) or late secondary ($z = 10.80$, $P < 0.001$). From Table 5, it can be seen that young people considered it important to learn about mental health from a variety of different angles, including preventative techniques ($z = 28.72$, $P < 0.001$), coping strategies ($z = 28.20$, $P < 0.001$) and factual knowledge ($z = 24.02$, $P < 0.001$).

In addition to the general issues of mental health information, prevention and coping strategies, young people also suggested specific mental health education topics. Topics mentioned by five or more pupils are given below in Table 6.

Effects of gender and year group

Questionnaire responses were analysed separately for effects of gender and year group using analysis of variance (ANOVA). Significant gender differences were found with girls viewing it as more important as boys that mental health education being delivered by a special PSE teacher ($F = 9.86$, $P = 0.002$); by someone who has personal experience of mental illness ($F = 13.77$, $P < 0.001$); in small groups ($F = 11.10$, $P = 0.001$); with a focus on prevention ($F = 6.13$, $P = 0.013$); through practical activities ($F = 9.36$, $P = 0.002$); and delivered each year ($F = 20.61$, $P < 0.001$). Additionally, boys viewed it as more

Table 6. Questionnaire: suggested topics

Topic	Boys	Girls	S1	S2	S3	S4	S5	S6	Total
Mental ill health	12	18	7	2	4	2	9	6	30
Stress	9	21	8	7	7	2	4	2	30
Eating disorders	1	14	4	2	0	1	5	3	15
Drug/alcohol misuse	10	4	6	3	1	2	2	0	14
Sex education/pregnancy	7	4	1	3	1	1	0	1	7
Self-harm and suicide	0	6	0	1	0	2	2	1	6
Abuse	0	6	2	3	0	0	1	0	6
Bullying	3	3	4	2	0	0	0	0	6

S1, Secondary Year 1; S2, Secondary Year 2; etc.

Table 7. Questionnaire items showing year-group differences

Question	ANOVA	Difference
1. familiar	$F = 3.80, P = 0.002$	+1/2,4
4. personal experience	$F = 2.72, P = 0.019$	+1/2
5. specific classroom	$F = 3.65, P = 0.003$	+1/3,5
6. whole year learning	$F = 7.39, P < 0.001$	-5/all
9. class trips	$F = 2.81, P = 0.016$	+1,4,5
10. preventative strategies	$F = 2.50, P = 0.029$	+6/4
11. practical techniques	$F = 10.61, P < 0.001$	+5/2,4 + 6/1,2,3,4
12. factual information	$F = 4.80, P < 0.001$	+6/1,2,3,4 + 5/4
13. listening to someone	$F = 6.46, P < 0.001$	+1,6/4 + 1/2
14. reading information	$F = 4.58, P < 0.001$	+1/2,4,5,6
16. writing information	$F = 4.31, P = 0.001$	-5/1
17. role-play exercises	$F = 3.40, P = 0.005$	+2/3,5
18. watching videos	$F = 2.96, P = 0.012$	+2/6
19. designing posters	$F = 0.67, P < 0.001$	+1/4,5,6 + 2,3/5
22. practical class activities	$F = 3.87, P = 0.002$	+6/1,2,3,4
23. learning each year	$F = 5.99, P < 0.001$	+1/2,3,4,5 + 6/4
24. learning in primary	$F = 5.60, P < 0.001$	+1/2,3,4,5
26. learning late secondary	$F = 7.55, P < 0.001$	+6/1,2,3,4

Figures in the *Difference* column illustrate the direction of preference, the year group expressing that preference, and with whom they are compared. For example, '+1/2,4' means that Secondary Year 1 found this item more important than Secondary Year 2 and Secondary Year 4.

important than girls that mental health education should not be delivered through whole year assemblies ($F = 6.99, P = 0.008$).

The effect of year group on responses to each question was similarly analysed using one-way ANOVAs, and statistically significant results are shown in Table 7. Where the *P*-value of the ANOVA was found to be significant at or beyond the 0.01 level, *post hoc* Tukey HSD Tests were used to determine where differences occurred. This higher level of significance was set for both the gender and the age analyses to correct for possible type I errors.

- S1 pupils thought it was more important that mental health education was taught by someone they already know (compared with S2 and S4), by someone with personal experience (compared with S2), in a specifically designated classroom (compared with S3 and S5), on class trips (compared with S4

and S5), and more usefully taught through listening, reading, and designing posters in primary school (compared with S4, 5, 6).

- S6 pupils viewed it as more important that preventative (compared with S4) and practical strategies (compared with S1, 2, 3, 4) were used and to receive factual information (compared with S1, 2, 3, 4) and to learn during every school year until late secondary (compared with S4).
- S5 pupils particularly disliked receiving mental health education in whole year groups (compared with all other year groups) and in lessons which involve writing down information (compared with S1).

Discussion

Young people are able to participate effectively in a consultation process which examines their views about how mental health education should be delivered. This concurs with Gabhainn and colleagues' (2007) finding that young people should be considered as stakeholders in health-promoting schools. The present study's participants expressed clear views on key areas, namely that a familiar person should deliver this education; that it should be delivered at every stage, within usual class groupings, through talks, discussion, role-play and video, and should include preventive as well as reactive techniques, with some differences in priorities indicated according to age group and gender. Each of these aspects impacts upon their experience. Taking these views into account will enable this education to be tailored to the self-identified needs of young people and have an impact on the overall ethos of the school, identified as an important factor in a health-promoting school by West (2006). Indeed as education is only one part of the health-promoting schools model, such consultation may also be usefully extended to other elements in the model.

In planning mental health education, school staff should consider the gender differences which emerged from this study. Many issues surrounding mental health education are regarded as important by both genders, but are especially important for

girls. For example, depression (Petersen *et al.* 1991), eating disorders, (Patton *et al.* 1999) and self-harm (Lewinsohn *et al.* 2001) are particularly salient for girls because of increased prevalence, while the subject of alcohol and drug misuse is particularly salient for boys. Where significant differences were noted between responses from male and female participants, the girls were usually noted to have more positive views about mental health education than boys. This finding is consistent with previous research (Williams & Pow 2007) which noted that boys were 'less likely to want to know more about mental health issues and twice as likely to think that they had already been given enough education' (p. 10).

Additional differences emerged across year groups. For example, compared with some of the other year groups, S1 pupils have a strong preference to be taught mental health education by someone whom they already know and learn about mental ill health from someone who has personal experiences of mental health problems. Some year groups express stronger preferences about the developmental stage at which mental health education should begin. Interestingly pupils in S1, who had only recently completed their primary school education, express a significantly stronger preference for mental health education to begin in primary school. If practically possible, mental health education providers should build these year-group preferences into programme planning.

On the basis of the findings of this study, it may be suggested that – from young people's perspective – an effective mental health education programme in school might have some, or all, of the following features:

- delivered by a range of people with thorough knowledge of the subject;
- interactive techniques;
- delivery in class groups;
- school trips to appropriate facilities;
- wide variety of topics;
- taking account of gender and year-group preferences;
- involving young people in planning.

Caution should be exercised, however, in drawing firm conclusions from this study, given that data were gathered from three secondary schools only. Furthermore, there was a lower number of participants than anticipated owing to the research coinciding with the exam period in schools. Research timescales need to take into account the demands of the school year. While it might be possible to generalize the results to the larger school population, at this stage they should be viewed as potential suggestions only.

It is important to ensure that consultation is not purely tokenistic. Young people have cited this as a deterrent to participation in consultation exercises (Stafford *et al.* 2003). To avoid tokenism, implementing findings is essential. Future research could evaluate the impact of a programme that takes into account the suggestions made by young people through such consultations.

Conclusion

This study demonstrates that listening to pupils can provide a starting point for improvements in mental health education. Although some of the ideas regarding mental health education, which were developed by the participants in this study, are current practice in some schools, they are not consistently applied. The study's results suggest that consideration of these suggestions could make mental health education more effective and could provide a more enriching learning experience for pupils.

Key messages

- Adolescent mental health is a significant concern worldwide
- Mental health education should reflect the needs of young people.
- The study found developmental and gender differences in Scottish young people's preferences for delivery and content of mental health education
- Consulting with young people helps ensure mental health education is relevant to pupil needs and preferences
- Professionals should take more account of young people's age and gender when designing mental health education programmes

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Appendix

Key questions for focus groups:

- What is the school's current mental health education curriculum?
- Who should deliver mental health education?
- How should mental health education be delivered?
- Where should mental health education be taught?
- Were there topics not covered that may have been helpful?
- Were the classes delivered at an appropriate time?
- What other aspects make mental health education effective?