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Exploring parents' understanding of their children's mental health and wellbeing. From experience to discourse.

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THESIS

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Declaration

This thesis is being submitted for the award of Doctorate in Applied Educational Psychology. I declare that it is my own work and does not include material that is the work of others without acknowledgement, that I have consulted all materials cited, and have not submitted this assignment for any other academic award.

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JUNE 2021

Overarching Abstract

This thesis explores parents' views, experiences, and constructions of children's mental health and wellbeing.

Chapter 1: A meta-ethnographic, systematic literature review was conducted to synthesise findings of six studies which had explored the experiences of parents whose children had accessed mental health services. Findings demonstrated support for common understandings in help-seeking and access literature in mental health. The synthesis highlighted the expectations, assumptions, and anticipated consequences of constructing problems as mental health difficulties. Connections were drawn with the possibilities made available in community-based and partnership working in universal services.

Chapter 2: Provides an ethical and methodological consideration of the empirical project presented in Chapter Three. The relationship between findings from the literature review and the empirical project is discussed and the methodological process is considered in depth. This includes consideration of the philosophical assumptions related to a discourse analysis methodology and consideration of ethically important moments which arose in carrying out the research.

Chapter 3: An empirical study focused on understanding parents' construction of wellbeing as a concept. A discourse analysis methodology was used to explore how wellbeing is constructed in conversations amongst parents. Participants were interviewed virtually in pre-existing pairs and the discussions then analysed. The discursive constructions and wider discourses considered in this analysis were explored from the perspective of power, positioning, and possibilities for action in universal services when developing approaches to practice. Particular consideration was given to the possible contribution of educational psychology.

Chapter 4: Provides a reflective and reflexive account of the research process and outcomes and what this means for me as a trainee practitioner and researcher. The implications for my own professional practice as a future EP are considered and possible next steps in EP research and practice more generally are explored.

Cross referencing is used throughout the thesis. These links are indicated by text in ***bold italics***.

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I would first like to thank the participants who took part in my study during such a chaotic and challenging time for everyone. I truly value your time and your insight.

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Dad.

You taught me to care, to look outside of myself, to see what was happening and to believe in change. I hope that runs through this piece of work and through all that I try to do. Losing you at the start of all this was the hardest thing. I wish I could have talked with you about the things I was learning. One more time, pool and a pint perhaps, putting the world to rights. But the values you instilled in me got me through.

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Chapter 1: What are parents' experiences of their child's access to Mental Health and Wellbeing support?

Abstract

Changes in responsibility and approaches for meeting the Mental Health and Wellbeing (MHaW) needs of Children and Young People (CYP) have been introduced through recent guidance and legislation. The guidance indicates shared responsibility for parents, families and communities as well as those in a variety of professional roles across children's services. This review systematically explores and analyses existing research literature regarding parents' experiences of their Child or Young Person (CYP)'s access to support for MHaW.

A meta-ethnography was undertaken on six papers to generate a line of argument synthesis. The outcome of this process suggests three areas of interest. The dominance of administrative factors and the influence of differing cultural assumptions and expectations in initiation and continuation of access to CYP MHaW support reinforces existing findings and theory related to help-seeking and existing literature reviews in the area. In addition, it is suggested that the approaches outlined as facilitative in these accounts can be synthesised as representing community-based practice and partnership with parents. As such, the Fostering a Facilitative Fit model is proposed and explored.

It is concluded that effective, multi-agency work with parents and families which aims to work preventatively and responsively for better CYP MHaW must be embedded in and constructed in partnership with the community it wishes to serve.

Following examination this study will be submitted to
Educational and Child Psychology and therefore it is presented
in the style of papers typically published by this journal.

1.1 Introduction

1.1.1 Mental Health and Wellbeing

The terms ‘mental health’ and ‘wellbeing’ are conceptually diverse. Mental health as a concept is often discussed in the context of its absence - mental illness, or as a specific sub-field of health services. These contexts offer well established constructs whereby a mental disorder is defined as:

> “…a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions”
>
> (ICD 10; World Health Organization, 1992, p. 5).

The term mental health is widely used and in more generalised definitions, it is often considered alongside the notion of wellbeing. The World Health Organization (WHO) frames mental health as being largely defined by the presence or absence of a state of wellbeing:

> "Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."
>
> (WHO; 2013, p. 6).

These terms are seen alongside each other in social research and policy. Both are present in legislation and policy documents across the Department of Health (DoH) and Department for Education (DfE) including ‘*Transforming Children and Young People's Mental Health Provision: A Green Paper’* and *‘A system mapping approach to understanding child and adolescent wellbeing’ (DoH & DfE; 2017; J. Smith & Hamer, 2019)*. In these documents, the notion of wellbeing is framed, either implicitly or explicitly, as being a continuum representing a degree of ‘resilience and ability to thrive’ (J. Smith & Hamer, 2019, p. 2). The implication is that, in the absence of a diagnosable mental disorder, a person’s position on this continuum establishes their mental health status.

Despite their conceptual overlap, it seems these terms offer a broader spectrum of meaning when presented together. As such, in this review, the phrase Mental Health and Wellbeing (MHaW) will be used. The inclusion of both terms in this phrase is intended to acknowledge the complexity of the concept of mental health and the nuanced experiences which can be better understood when the variance in meaning across these two terms is established. For example, a person can be diagnosed with a mental disorder but still have experiences across the wellbeing spectrum. Similarly, experiencing periods of poor wellbeing can be considered a healthy response to challenging situations.

1.1.2 Mental Health and Wellbeing in Context

The above exploration of MHaW accepts conceptually diverse interpretations of psychological health and acknowledges the importance of coping and connection in the context of a fruitful life. Historically, discourses about mental health were comparatively narrow and the history of psychological diagnosis and treatment presents a problematic picture of socio-politically driven categorisation of behaviour, unusual or unacceptable to those in power, as mental illness (Maracek & Hare-Mustin, 2009) leading to the oppression of those who did not fit culturally defined constructs of normality.

Dominant narratives about MHaW often position difficulties at an individual level. Whilst the value of intervention at a family and community level has been demonstrated (Carlson, Armitstead, Rodger, & Liddle, 2010; Goodkind, LaNoue, Lee, Freeland, & Freund, 2012), this is largely from the perspective of a support mechanism for an unwell individual. It has been suggested that narrow, clinical perspectives, particularly in relation to CYP, could result in the lack of consideration of environmental factors or ‘ignoring the wider influences and causes of rising demand, over-medicalising our children along the way’ (DoH, 2012, p. 6). As psychologists, we should be acutely aware of the risk of pathologising difference and consider any ‘clinically recognisable set of symptoms’ in context and through the lens of its social construction (Maracek & Hare-Mustin, 2009; Mills, 2017).

Notwithstanding this position, experiences of psychological distress are evident, if different in presentation, across cultures, often as a response to the specific demands and challenges of a given society. Therefore, providing support to mediate distress, social exclusion and long-term disadvantage to the best of our ability within existing systems is of clear importance.

1.1.3 Children's Mental Health and Wellbeing

The complexity of interacting experiences and inter-dependent social systems in CYP's lives is widely established in theory and research (Bronfenbrenner, 1977, 1986; Kelly, 1966; J. Smith & Hamer, 2019) and it is thought that characteristics and changes at any point in these systems can have a chain of impact across other parts of the system and on CYP lives (Bronfenbrenner & Evans, 2000; Turner, Randall, & Mohammed, 2010).

MHaW difficulties as currently understood often emerge in childhood (DoH, 2012; Public Health England, 2016; (PHE)) and several such environmental influences have been associated with poor CYP MHaW. These include factors such as family functioning, parent mental health, and policies and approaches in school settings (Brown, 2018; PHE, 2016; Ryan, Jorm, Toumbourou, & Lubman, 2015).

Child and family factors further interact with wider social issues such as economic austerity, which impacts the availability of universal and targeted support across communities, disproportionately affecting groups considered to be vulnerable and compounding disadvantage (Lambie-Mumford & Green, 2017; WHO, 2013). These factors, and related MHaW difficulties, are further associated with a number of poor long term social outcomes (PHE, 2016).

The provision of MHaW support services can be considered a feature of the social systems which positively influences CYP MHaW and facilitating access to MHaW support for CYP can be considered of importance to all who seek to improve outcomes for CYP and who claim a social justice agenda.

1.1.4 Access to Services

The problem of access in the context of MHaW services has a long history. There have been a number of initiatives over time attempting to identify gaps and facilitate greater equality of access for various populations (DoH & DfE, 2017; Steele & Roberts, 2005).

Inequality at national and international levels, has led to a rights-driven perspective of access highlighting the importance of availability, accessibility, acceptability and quality of services (WHO, 2016). Somewhat condensed definitions of these concepts of access are outlined in ***Table 1.***

Table 1: Condensed definitions denoting service accessibility.

Accessibility	Available, known about, easy to reach, affordable
Acceptability	Belief that the proposed support is fit for purpose, cultural acceptability, initial experiences and related attrition.

Research regarding access to services often examines service and service user characteristics to consider influences on both initial entry into a service as well as ongoing service engagement (Anderson, Howarth, Vainre, Jones, & Humphrey, 2017; Becker, Buckingham, & Brandt, 2015; Oh & Bayer, 2017; Taylor, Kaminer, & Hardy, 2011). This dual notion of access is adopted in this review.

Access in Context

Narratives in health and education guidance and legislation appear to prioritise CYP’s MHaW (Brown, 2018; Department of Health, 2012; DoH; Public Health England, 2016; PHE). However, these publications continue to indicate that the overall prevalence of problems relating to CYPs MHaW is increasing (PHE; 2016), and that the funding and resources needed for services to respond to demand, continues to be lacking (Brown, 2018; Care Quality Commission, 2018; CQC; DoH; 2012).

It has been suggested that as few as 25% of CYP whose difficulties meet the criteria for a MH diagnosis currently access any type of formal support (PHE; 2016). Ongoing austerity-driven policy, and predictions of significant emotional and economic impact from the Coronavirus pandemic, mean that the problem of access to MHaW support will be of continued importance (BPS, 2020; The Children's Society, 2020).

The Role of Parents[1]

Parents and primary caregivers are influential actors within the social systems in a CYP’s life. They shape the environments CYP grow up in, their earliest relationships, and the interactions amongst existing support systems. The importance of parental engagement in the universal services their children access has been emphasised in policy and guidance for education and health services (DfE, 2014; DoH & DfE, 2017; Lamb, 2009; Young Minds, 2014) and recognised as being of value in achieving

---

[1] The term parents is inclusive of all primary caregivers; however literature in this area has indicated that access models may not be applicable to corporate parents due to existing relationships with services.

positive treatment and intervention outcomes (Beveridge, 2004; Koch, 2018; Sime & Sheridan, 2014). It has also been suggested that the development of partnership with parents is vital if services are to generate inclusive, easy to reach sources of support (Day, 2013; Todd, 2007).

The role parents play in their CYP's access to targeted MHaW support can be explored through consideration of help-seeking literature. This body of research offers descriptions of elaborate processes thought to precede or influence an individual's action in contacting MHaW professionals (Rogler & Cortes, 1993; Srebnik, Cauce, & Baydar, 1996). Process driven and behavioural models of access to CYP MHaW services have provided increased understanding of likely barriers and facilitators. Targeted attempts to adapt such service characteristics to improve access have had some success (Benway, Hamrin, & McMahon, 2003). Later adaptations of help-seeking models have proposed more dynamic networks of influences than is suggested by the notion of a linear process (Shanley, 2008; Stiffman, Pescosolido, & Cabassa, 2004). Such dynamic networks are aligned with the notion of CYP MHaW as being ecologically complex.

Help-seeking literature is dominated by quantitative research. Whilst environmental factors and individual experiences are given greater weight in more recent iterations of such processes (Shanley, 2008; Stiffman et al., 2004), they are still largely considered from an individualistic perspective. Social, cultural and environmental influences are considered for the role they play in individual help-seeking decisions such as a parent's comparison of their CYP with others in their social circle (Logan & King, 2006). Some attempts have been made to explore experiences of service users qualitatively, adding richness to models of access and quantitively established demographic associations (Reardon, Harvey, Young, O'Brien, & Creswell, 2018).

Empirical studies exploring data-driven associative network models and qualitative experiences of access to MHaW services tend to examine experiences of a specific system, intervention or population (Bevaart et al., 2014; de Haan, Boon, de Jong, & Vermeiren, 2018; Thurston, Phares, Coates, & Bogart, 2015; van Vulpen, Habegar, & Simmons, 2018). As such, findings related to service development may not be applicable or generalisable to other systems and services. Where experiences are so context specific it could be considered more appropriate to broaden the investigative lens and consider the phenomena from a conceptual rather than a narrow, analytical perspective.

A systematic review and synthesis of qualitative data would allow for conceptualisations of access experiences which go beyond demographic associations and experiences of specific systems. In this review, I explore research which may offer insight into how parents, as key decision makers, experience the accessibility and acceptability of MHaW provision for CYP.

1.2 A Systematic Literature Review

Relevant literature was first identified through systematic searching of bibliographic databases (PsycInfo, ERIC and Scopus). Final searches were undertaken in January 2020. Whilst systematic searches are not always indicated in the processes outlined for qualitative reviews (Boland, Cherry, & Dickson, 2014), the approach has been adopted by qualitative researchers (Atkins et al., 2008) and could be seen to offer additional rigour in accessing relevant data in a narrow field of interest. Through consideration of terminology evident in relevant literature and initial search results (see ***Appendix 1***: Development of Key Termssearch terms were generated to reflect the following key concepts:

- Parents/Caregivers
- Access/Barriers and Facilitators
- (Child) Mental Health Services/Support
- Children and Young People

The results were initially screened by title. A large number were excluded given limited relevance to the review question. Hand-searching followed, including direct searching of journals of relevance to the subject area and the scanning of identified papers' reference lists. Papers were then exported to bibliographic software (EndNote) for further screening.

Much of the research identified attempted to make associations between measurable characteristics of parents and families and the nature of their engagement with mental health services (Nanninga, Reijneveld, Knorth, & Jansen, 2016; Ofonedu, Belcher, Budhathoki, & Gross, 2017; Ryan et al., 2015). There was limited literature available which elicited experiential accounts from parents regarding the process through which they choose whether to engage with mental health support. I chose to undertake a qualitative review to synthesise the accounts that were available.

Following a systematic process guiding development from general to specific research questions (Punch, 2006), I generated a research question which could offer insight relevant to the specific phenomena and context I was interested in (see ***Appendix 2***: From Research Interest to Research Question). I posed the following question for a systematic review:

What are parents' experiences of their CYP's access to MHaW support?

1.2.2 Systematic Synthesis of Qualitative Research

The review question required the consideration of perspectives and experiences of access to CYP MHaW services reported directly from parents. A qualitative review was considered appropriate as such research is concerned with how people see and understand their world (Strauss & Corbin, 1998). Having considered possible approaches (Barnett-Page & Thomas, 2009; Boland et al., 2014), a seven-step meta-ethnography (see ***Table 2***) was chosen to provide a systematic structure to the review (Noblit & Hare, 1988).

Table 2: Seven Steps of Meta Ethnography

	Description from Noblit and Hare (1988)
Stage 1	Getting started
Stage 2	Deciding what is relevant to the initial interest
Stage 3	Reading the studies
Stage 4	Determining how the studies are related
Stage 5	Translating the studies into one another
Stage 6	Synthesising translations
Stage 7	Expressing the synthesis

Systematic syntheses can provide structure in the consideration of qualitative research beyond the rigour of completing of a series of tasks, facilitating the generation of comprehensive and generalisable theory whilst adding richness to bodies of quantitative evidence (Atkins et al., 2008; Britten et al., 2002). It was intended that undertaking a meta-ethnography would provide a rich picture of parent's experiences, synthesising the interpretive elements of the existing research to produce a novel, 'holistic interpretation' (Noblit & Hare, 1988, p. 10).

The following sections outline the meta-ethnographic process to generate an interpretive representation of parents' experience of access to CYP MHaW support.

1.2.3 Deciding what is relevant to the initial research interest

Initial scoping and screening identified a limited number of studies with direct relevance to my review question. As such, fairly broad inclusion criteria were applied when screening abstracts. These were:

- Parent/caregivers of children/adolescents were participants
- Parent/caregiver views were directly reported
- Study was published in English in a peer-reviewed journal
- Focus on access (barriers and facilitators) to children's mental health support

Existing Reviews:

During the screening process, I identified existing literature reviews in my area of interest. These papers could not be included in my own review as they were not empirical studies, but it was important that I scrutinise them further (see ***Table 3***) to

Table 3: Consideration of existing reviews

Review Identified:	Differences to current review:
Ryan et al. (2015) Parent and family factors associated with service use by young people with mental health problems: a systematic review.	Only quantitative data reviewed – aim to examine associations between parent/family characteristics and CYP service-use.
Anderson et al. (2017) A scoping literature review of service level barriers for access and engagement with mental health services for children and young people.	Inclusion of existing reviews. Inclusion of policy and initiative overviews. Inclusion of quantitative studies.
Reardon et al. (2018) What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies.	Nearly half of the included studies (20/44) presented only quantitative data. More than half of the 22 qualitative studies were undertaken ten or more years ago. Inclusion of studies targeting specific populations of both CYP and parents. Inclusion of studies which focussed on access issues related to specific group membership e.g. ethnicity.

ensure the value of the current review. One of the key clarifications related to the consideration of rich qualitative data from the perspective of parents.

Selecting Full Text Papers

To identify papers for inclusion in the review, I considered the **P**opulation, Phenomena of **I**nterest and the **Co**ntext (PICo), an approach recommended for reviews of qualitative evidence (Boland et al., 2014). This process (see ***Appendix 3***: Considering Inclusion and Exclusion Criteria using ‘PICo’), led to slightly adapted criteria with which to scrutinise initial search results (see ***Table 4***).

Table 4: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
Parent/caregivers of children/adolescents were participants.	*Population is specific (i.e. purposively sampled from specific ethnicities or groups)*
Study provides data related to access [initial or continued] to children’s mental health support/services.	*Views expressed relate only to a specific program of support*
Parent/caregiver views [of the above] were reported *qualitatively.*	Views expressed relate to experiences from the perspective of specific group membership
Study was published in English in a peer-reviewed journal.	

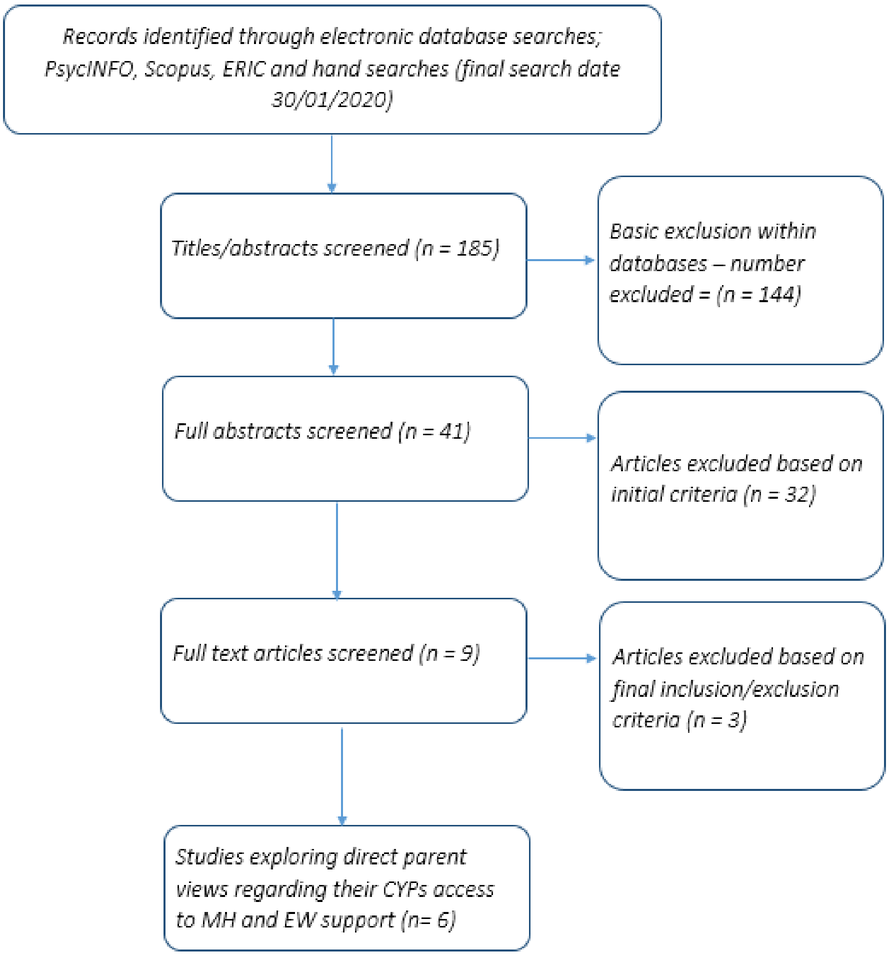
Quality Assessment

A further criterion often applied in selecting papers for systematic review is that of quality. I considered using formulaic quality assessment tools but in the context of the papers available these approaches seemed philosophically incoherent as they are largely adapted from quality assessment approaches in a realist paradigm (Tanggaard, 2013). Further, the limit in the quantity of data which was appropriate for my research question meant that for a meaningful review to be possible, the transparency of a methodological audit trail (Carcary, 2020) established for consideration of inclusion more broadly served as an appropriate assessment of quality in this review.

Reading possible papers:

Following application of these inclusion and exclusion criteria to the search results, nine papers were further explored. Variations in conceptual interpretation of terms such as access, wellbeing and experience resulted in some inclusion and exclusion criteria feeling quite subjective. To arrive at a final decision, it was necessary to examine the data available in the context of its relevance to the review question. This would not be considered standard in systematic searching but was aligned with Noblit and Hare's (1988) purposive approaches and in later iterations of meta-ethnography where systematic approaches were adopted and advocated (Atkins et al., 2008). This process resulted in the identification of six papers for review (see ***Figure 1***)**Error! Reference source not found.**.

Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)



1.2.4 Reading the studies

Repeated reading of studies develops familiarity with their content and detail. This immersion allowed me to understand the context of the data needed to note the concepts and interpretive metaphors evident in the studies (France, Ring, & Jepson, 2016; Noblit & Hare, 1988). The demographic information established here, including participant information, methods of data collection and research is available in **Appendix 4**: Demographic Information**.**

Repeated reading also supports the in-depth consideration of the studies to consider what could constitute data for synthesis. Sometimes, I was unsure how to categorise some of the data. I found there was limited guidance about what constituted an 'interpretive metaphor', which seemed a relatively subjective term. I found it helpful to consider the notion of first and second order constructs attributed to Alfred Schutz (see; Atkins et al., 2008) to better understand and organise my data (***Table 5***).

Table 5: Construct definitions

First order construct	Constructs that reflect participants' understandings, as reported in the included studies (usually found in the results/findings section of an article).
Second order construct	Interpretations of participants' understandings made by authors of these studies (and usually found in the discussion and conclusion section of an article).
Third order construct	The synthesis of both first and second order constructs into a new model or theory about a phenomenon (generated in this review).
Reciprocal translation	The comparison of themes across papers and an attempt to match themes from one paper with themes from another, ensuring that a key theme captures similar themes from different papers
Line of argument synthesis	The development of a new model, theory or understanding by synthesising and interpreting first and second order themes found in the text.

The key differentiation here was whether information was descriptive or interpretive. There were some cases where themes identified by authors appeared to be descriptive, offering little interpretation. I questioned whether these themes, or concept labels should be considered second order. On considering the processes of empirical, qualitative data analysis which often includes a theming process, I was reminded that interpretive analysis represents a single read of the data and that the labelling themes is inherently interpretive and influenced by the theoretical and philosophical positions of a researcher. As such, I concluded that they should be considered second order data under the definitions I was using. The first and second order data extracted from the studies can be seen in **Appendix 5**: Data Extraction.

1.2.5 Determining how the studies are related

This stage of the meta-ethnography required me to determine how accounts presented in the studies fit together. Noblit and Hare (1988) suggested three ways studies under review might be related (see ***Table 6***).

Table 6: Three ways studies might be related; adapted from Noblit & Hare (1988)

Reciprocal	The accounts can be directly compared – themes can be matched or added together.
Refutational	The accounts oppose or contradict each other.
Line of Argument	The accounts are dissimilar to the extent that the themes cannot be added together but are sufficiently related to contribute to a synthesis which generates a line of argument.

I examined the second order data extracted from the studies in more depth to consider what themes, ideas and concepts were present in each of the studies and how they were related and relevant to the review question. This led to the identification of nine key concepts across the six papers based on my interpretation (see: **Appendix 6**: Key Concepts Map). At this stage, I chose not to assign labels to these concepts as I felt the meaning would need to be further constructed through the following translation process.

As I compared key concepts, it seemed the accounts were largely reciprocal. These decisions are a ‘key judgement call’ (Noblit & Hare, 1988, p. 81) and should be made in light of all contextual information. As the studies had different foci, and in some cases only sub-sets of the data were used, it could be considered more appropriate to conduct a line of argument synthesis. France et al. (2016) suggest that the two need not necessarily be viewed separately and that a line of argument is an important part of a reciprocal translation, going beyond the synthesis of translations.

At this stage, I assumed that the studies could be taken together as a reciprocal translation whilst acknowledging the possibility that, following translation, a synthesis of the studies could be taken together to represent a line of argument.

1.2.6 Translating the studies into one another

To move from descriptive relationships between the studies towards translation, I examined the identified concepts in greater depth. I scrutinised the second order data from across all six studies within each concept, further examining the meaning I was extrapolating from those evident in the data. For some of the concepts, when looking at the data from across the studies together, there were second order constructs which fit better with other concepts which had emerged as dominant in other studies. In addition, some second order constructs, which hadn’t been prevalent enough in individual studies to be considered key concepts, emerged as being of greater importance when viewed across all studies. The result of this process was the construction of eight key concepts which were interpreted as being important in response to the research question. These were:

- **Stigma and Family Context.**
- **Mental Health Awareness and Problem Perception.**
- **Expectation and Experience of Services.**
- **Response from Others.**
- **Administrative Factors.**
- **Relationships and Communication.**
- **Positioning of Parents.**
- **Community Engagement**.

Detail of the 2nd order data contributing to this construction is presented in ***Table 7***. The papers have been numbered for ease of presentation. The papers corresponding to these numbers are:

Paper 1: Baker-Ericzen, Jenkins, and Haine-Schlagel (2013)

Paper 2: Boulter and Rickwood (2013)

Paper 3: Cohen, Calderon, Salinas, SenGupta, and Reiter (2012)

Paper 4: Crouch, Reardon, Farrington, Glover, and Creswell (2019)

Paper 5: T. Smith, Linnemeyer, Scalise, and Hamilton (2013)

Paper 6: Walter, Yuan, Morocho, and Thekkedath (2019)

Table 7 also indicates the number of times these concepts were considered to be present in each paper, indicated in brackets in each cell.

Table 7: Key concepts across papers after translation.

	Paper 1	**Paper 2**	**Paper 3**	**Paper 4**	**Paper 5**	**Paper 6**
Stigma and Family Context	Parents feeling overwhelmed by CYP symptoms and problems (1).	The nature of the problem, the impact this is having on the CYP and family and capacity to cope (7).	Concerns about current and future MH stigma leads to reluctance in help-seeking – delayed until crisis point (7).	Cultural differences in perceptions of presenting behaviour and concerns about stigma and repercussions of engagement with the system (5).	Extent of problem impact (crisis) in the family and awareness of services/ agreement amongst caregivers about service access (6).	Concerns about stigma and labelling makes service access last resort (5).
Mental Health Awareness and Problem Perception.		Level of knowledge, awareness and experience of CYP MH mediator of uncertainty re: problem severity and need for help (4).	Uncertainty about presenting behaviour/ problems as symptoms and about the support available led to uncertainty about help-seeking (11).	Uncertainty related to the nature of the problem and level of knowledge/ familiarity with systems of support (6).		Level of understanding about MH in early childhood and accessibility of information about services (5).
Expectation and Experience of Service	Lack of confidence/ frustration with the treatment available and perception of treatment as ineffective (5).	Availability of specific outcomes (diagnosis) and perception of service as inadequate or ineffective (6).	Disagreement between parents and professionals about appropriate treatment (4).		Perception of treatment as not acceptable or insufficient (3).	Selectivity regarding services parents will use (1).

Response from Others	Level of acceptance and validation mediating sensitivity to blame and judgement (4).	Level of validation (or initiation) OR judgement/blame/ dismissal in family and initial service responses (7).	Initial service responses which validate severity of need and present concrete options OR ambivalent/dismissive responses (8).	Level of validation (or initiation) OR judgement/blame/ dismissal in family and initial service responses; perception of role of professionals in universal services (9).		Inconsistency in parent and professional perception re: severity of need [dismissal] (1).
Administrative Factors	Level of co-ordination in service systems (2)	Level of accessibility responsiveness of services and parent capacity to persist and negotiate multiple contacts (5).	Administrative barriers re: qualification for services, delays for appointments (lack of resources) and repeated attempts to access services (7).	Administrative barriers re: qualification for services, delays for appointments (lack of resources) and co-ordination of services (7).	Administrative barriers re: availability, timeliness and convenience of appointments (resources) and co-ordination of services (11).	Frustration that CYP MH is not addressed in general early childhood systems and with availability, complexity and timeliness of support (13).
Relationships and Communication	Feeling blamed/ignored by therapist – lack of practical support, and clarity/ transparency in communication (4).	Insufficient practical and emotional support and lack of trust/rapport between CYP and therapist (5).	Clarity of communication (language and literacy) and explanation of complex processes (4).	Relationship development at initial contact (comfort levels) and ongoing communication and contact (5).		Positive and continuing relationships and need for effective communication ad information sharing (4).

Positioning of Parents	Value differences and misunderstandings about the possible outcomes of treatment – a need for hope and to feel like part of a solution (6).	Sense of guilt and responsibility led to diagnosis seeking and relief. Importance of empowerment and hope in any direct involvement (4).	Uncertainty about role in CYP's treatment and time and capacity parents have to engage (3).	Time taken to listen, acknowledge possible barriers, address concerns and develop shared understanding and expectations amongst parents and professionals (10).		Need to take on an advocate role to access and navigate care (1).
Community Engagement	Value connection to those with shared experiences (1).	Nature of 'informal' support available (1).	School and universal services as key locations for connection to others with similar experiences. Positive constructs of the role of professionals in these settings within a community (6).	Importance of relationships with and role constructs of professionals in universal settings at a community level. Opportunities for peer support during and after service access and for ongoing 'informal' community support and resource access (10).		Professionals in schools and community health centres key in initial access. Value of community-based resources allowing single-point of access and peer support for parents (8).

1.2.7 Synthesising the translation

Synthesis requires the production of innovative or novel insight that goes beyond the interpretation of each study (Noblit & Hare, 1988). Through translation and consideration of the eight concepts and the relationships between them, three dominant third order constructs were developed. These are:

Cultural Context,

Systems and Processes and

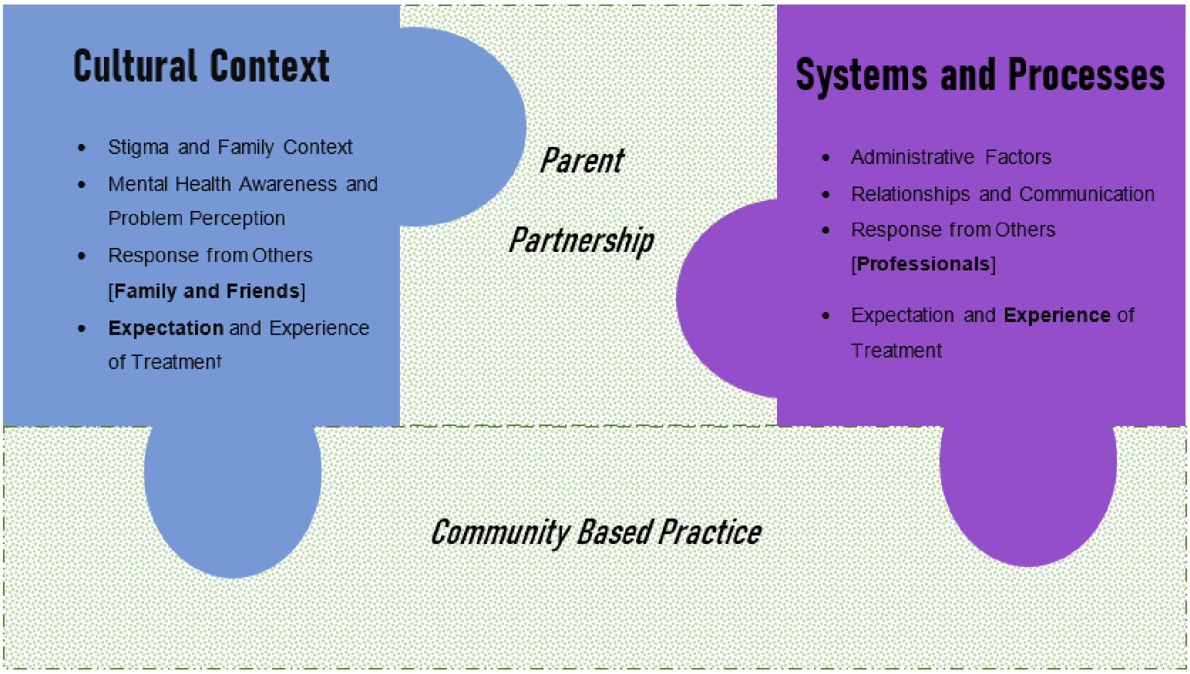
Approaches to Practice; Community Engagement and Parent Partnership.

The finalisation of these third order interpretations also allowed a line of argument to become clear regarding the interaction amongst them

1.2.8 Expressing the synthesis

Visual methods have been used to express the line of argument synthesis (see ***Figure 2***). Developing this was helpful for me in refining my own understanding of the interactions at play. Exploring visual expressions which did not seem representative led to consideration at greater depth and, as a result, a more developed line of argument.

Figure 2: Fostering a Facilitative Fit



The metaphor of puzzle pieces was chosen to represent the notion of fit between service and service users. There were several characteristics of access which were consistently identified by parents in first order data. Consideration of second order interpretations across the studies demonstrated that these characteristics were not simply features which should be present or absent in an accessible system but were important in terms of the fit between the culture and family context of possible service users and the makeup of the systems of support available.

As such, the expression in its entirety represents a MHaW service whereby a fit between service and population is fostered through values driven practice underpinned by principles of community engagement and partnership with parents and families.

Strengths and Limitations

It is important to consider the outcomes of this review in the context of its relative strengths and limitations. The use of a meta-ethnographic approach provided an appropriate and helpful structure to review the literature available based on my question regarding parents' experiences. The systematic approach provided rigour and transparency in the production of a novel interpretation (Noblit & Hare, 1988). However, the theoretical generalisability of the line of argument is somewhat undermined by the limited amount of data available for synthesis.

1.3 Discussion

This systematic literature review was undertaken to address the research question; ***'What are parents' experiences of their CYP's access to MHaW support?'*** The Fostering a Facilitative Fit model was created to represent the line of argument synthesis. In this section the context and meaning underpinning the third order constructs and their interaction is explored in greater depth.

1.3.1 Systems and Processes

The key concepts constructed as relating to systems and processes are closely aligned with existing literature relating to parent-facilitated access and some of the more tangible influences on this process outlined in help-seeking research. These associations and additional points of note from the process of synthesis are presented in ***Table 8.***

For the most part, the influences at play here related to a parent’s initial decision to seek help or not, to continue the pathway to professional support and/or to continue to engage with the service provided. The line of argument presented here suggests that these influences are complex and interact with one another. For example, frustration relating to waiting list delays was moderated by frequent, effective contact (Baker-Ericzen et al., 2013) and the type of response given by professionals was experienced differently depending on the existing relationship or perceived position within social hierarchies (Cohen et al., 2012; Crouch et al., 2019).

In the context of the reviewed studies, these interactions can be framed as influencing access in relation to delay, possible attrition and a risk of disguised compliance. All parents involved had ultimately made the decision to access professional services; however, it could be speculated that in some circumstances the factors which led to these delays could also result in a decision not to seek or access support at all.

The complex, interactive experiences evident in the data which relate to systems and processes are aligned with complex models of service access (Shanley, 2008). The line of argument developed in this synthesis suggests that beyond this process driven understanding there appear to be key, underpinning socio-cultural influences on how the systems and processes are experienced.

Table 8: Key concepts underpinning Systems and Processes

	Key points from synthesis
Administrative Factors *“Just keep pushing … keep phoning, keep on at the doctor until you do get [the support].” Crouch et al. (2019, p. 496)* *“It is hard to schedule appointments when you are in crisis. Help seems too far away”.* T. Smith et al. (2013, p. 82)	Discussion of system and process features was prevalent across all papers. Parents described experiences of frustration regarding administrative limitations and barriers in gaining initial access to a MHaW service. This is in line with much of the help-seeking and access literature which has identified issues such as waiting times and convenience of appointment times as barriers to access (Stern et al., 2015). A further frustration, evident across four of the six studies, related to the level of co-ordination of children’s services more broadly. The other two studies included reference to a requirement for parents to make frequent contact which led to increased demand on families. Experiences such as this increase the likelihood of disengagement part way through the help-seeking process (Reardon et al., 2018).
Relationships and Communication *“They’ve listened to her, I think, and then if I’ve got questions, they’ll answer my questions as well. You know I have the option of either going in with her or not”.* *Boulter and Rickwood (2013, p. 137)*	The experience of systems and processes was also represented in talk about relationships and communication in five studies. Some of these characteristics related to tangible factors such as the frequency and nature of formal communication including issues of language and readability in written communication (Cohen et al., 2012) and extended periods of time without contact following initiation. Others related to emotional responses both in relationships between a CYP and their therapist and between parents and professionals. References were made to characteristics such as rapport or comfort levels in three studies. Relationships which facilitate ongoing access are likely to provide relational support for parents and children. Here it is important to acknowledge the influence of individual practitioners as a key feature of the system. It has been suggested that the skills, knowledge and experience of practitioners is a key influence in shaping the service pathway that a CYP will follow (Stiffman et al., 2004). This seemed to be the case in the experiences presented in these studies as it was important that practitioners could adapt their role and interactions to the needs and expectations of the individual and family.

Response from Others: Professionals *So yes, just that validation, I guess, was probably the first most important thing".* *Boulter and Rickwood (2013, p. 137)*	The importance of relational characteristics was further demonstrated in discussions of professionals' responses relating largely to initial contact. There appeared to be a vulnerability to feelings of blame, judgement and dismissal, prevalent across four studies and evident in one other. This vulnerability could delay or discourage ongoing engagement when not met with responses which accepted and validated a parents' concerns. The decision to open a conversation about MHaW (and thus begin to explore possibilities for support) is made more difficult by the anticipation of these negative responses. As such, initial professional responses can be a key facilitator or barrier to access. This point of initial contact is acknowledged as being important in existing models of service access (Shanley, 2008; Stiffman et al., 2004).
Experience of Treatment *"I feel like she has been on a lot of medication and I haven't seen any results"* *T. Smith et al. (2013, p. 82)*	A further relevant aspect relating to systems and processes was parents' practical experience of engaging with a service and their perception of their CYP's experience and progress. The acceptability of a service is known to impact ongoing treatment engagement (Boulter & Rickwood, 2013; Stern et al., 2015). Parents discussed their thoughts about the support and/or treatment on offer in all the studies. The strength of feeling about acceptability varied and related to aspects such as: use of medication, appropriateness of family therapy, and the capacity of clinicians/therapists to address complex needs. In five of the six studies, it was evident that the nature of the treatment or support on offer for their CYP was not what parents expected and this impacted their perspective. In some cases, there were instances of unresolved disagreements about treatment. Such disagreements about the appropriateness of treatment approaches can influence access through attrition or disguised compliance.

1.3.2 Cultural Context

Culture is defined in the Cambridge online dictionary as: “The way of life, especially the general customs and beliefs, of a particular group of people at a particular time” (Cambride University Press, 2021). In this instance, cultural context is used in acknowledgement of dominant understandings of MH in wider society, and in nuanced cultural narratives and assumptions which are often evident in smaller groups or associated with cultural identities. These associations and additional points of note from the process of synthesis are presented in ***Table 9***.

It was evident across the papers reviewed that several more tangible experiences affecting accessibility were influenced by underlying constructs of MHaW difficulties. Cultural constructs of MHaW contribute to real and anticipated stigma towards those who are identified as needing MHaW support as well as social norms regarding service use and acceptable treatments for presenting difficulties. Where these cultural constructs were barriers to service access, the impact of negative experiences relating to systems and process would be more significant. For example, where cultural constructs of MHaW need positioned help and support within the family, and use of professional services was frowned upon, parents would be particularly vulnerable to experiences of dismissal, blame or judgement if they did reach the point of active help-seeking. In these cases, responses which were validating and empathic would be of particular importance. This was represented particularly well in Walter et al. (2019, p. 182):

> “. . . a lot of parents have to face that [mental health disorder] stigma with themselves primarily and then move on from that, which makes it hard . . . you are kinda try to win a war with your child for so long, figuring out what should I be doing . . . try to keep it [child’s mental health disorder] in my house because you would perceive that as weak or unusual when you go and seek out mental health counseling (sic) . . .”

It is helpful to frame the interactions at play in service access as being a function of complex cultural constructs relating to MHaW and service use. This line of argument supports an ecological understanding of CYP MHaW whereby the influence of wider social systems and constructs are acknowledged and proactively responded to.

Table 9: Constructs underpinning Cultural Context

	Key points from synthesis
Stigma and family context *". . . when you start to talk about mental health, some people are afraid even to go, like "oh, nobody see me here."" Walter et al. (2019, p. 182)* *"You put up with it for a long time and then there's a point when you break … when you refer yourself to CAMHS or to anybody you waited till the last minute, till you can't cope." Crouch et al. (2019, p. 495)* *"My husband thinks he doesn't need it [recommended treatment]". T. Smith et al. (2013, p. 82)*	Parents directly discussed concerns about stigma as influencing the process of gaining access to MHaW support. The possible repercussions related to the constructs of MHaW in the community with some indications that naming a mental health need or seeking professional MHaW support could result in stigma within the family and in the wider community. Concerns about stigma were particularly evident in samples with low socio-economic status, recruited from urban community support and non-white demographics (see papers 3 & 5). For the most part these reservations become less of a concern due to the escalation of problem presentation or impact on the family. Parents weighed up the anticipated harm of labelling and stigma with their perceived ability to cope with the problem themselves. In some cases, this led to a significant delay in the CYP's access to services until the problem escalated to crisis point. Whilst the parents in these studies had reached a point at which the impact on the family had outweighed their concerns about stigma, it can be extrapolated that some parents may not make the decision to start a conversation about mental health if the fear of stigma outweighs other considerations. Barriers such as this could impact access to both informal and professional support as in some cases the stigma and negative repercussions which were anticipated existed within the family and immediate community.
Mental Health Awareness and Problem Perception *". . . you don't see anything about mental health in a doctor's office*	The individual decision (made by parents) to start a conversation about mental health was one involving several culturally dependent factors. When reflecting on the process leading to these decisions, parents indicated that MHaW awareness and cultural constructs of MHaW within the community had influenced the likelihood that they would perceive a problem as being possibly related to their child's MHaW. The extent to which conversations about children's MHaW were normalised within cultural discourses and the

or pediatric offices. You don't see anything about it." *Walter et al. (2019, p. 181)* *"I don't think there are very many people who can associate this sort of behaviour with anxiety. Often it will come across as disruptive behaviour."* *Crouch et al. (2019, p. 494)*	level of knowledge and awareness of common presentations of MH difficulties influenced this problem perception. In some instances, parents directly associated a lack of education and awareness about the symptoms and behaviours associated with MHaW difficulties as delaying their CYP's access to services as they did not, as parents, know what this might look like. Where there is a difference between service and community constructs of difficult behaviours and experiences parents may not know that there are services available to support with a given problem. To seek MHaW services, parents must construct a problem scenario as being related to a mental health need. In some research this notion is referred to as problem recognition (Bevaart et al., 2014; Thurston et al., 2015). This language seems problematic in that it assumes that parents are aware of construct definitions in MHaW services and of the support that is available in order to *recognise* it as such a problem (Logan & King, 2006).
Response from Others: Family and Friends *"My friend's husband said he can't be [anxious or depressed], so I just kind of brushed it off."* *"[The GP] said it's okay we've seen this before, you're not on your own, there is help"* *Crouch et al. (2019, pp. 494-495)* *"When I asked the school about my son, they said he was*	The decision to share thoughts or suspicions that a CYP may be experiencing MH difficulties with others involve a weighing up of the nature and impact of the problem and anticipated repercussions. These conversations are often initiated in immediate social systems; the likelihood that parents would then seek support from services was further influenced by the responses from informal support networks such as family and friends as well as those from professionals in universal services with whom there was an existing relationship. Like the influence of responses from mental health professionals, these responses from informal support networks could validate and reinforce or blame and reject the emerging construction of need as relating to MHaW. This then impacts the likelihood that targeted MHaW support would be sought. Professionals in universal services had a particular role in shaping these constructs. Teachers and General Practitioners (GPs) in some cases were positioned as knowledgeable and experienced in issues of CYP development and more generally as

immature. They didn't want to give me a referral to get him tested. I think schools need more training… I had to wait so long because the school just thinks he's immature." *Cohen et al. (2012, p. 301)*	sources of help. This position of influence on parent's constructs of their child's needs meant that responses could directly facilitate or impede access (Reardon et al., 2017). In some cases, existing relationships and role constructs meant that contact with these professionals reinforced or even initiated problem constructs as being related to MHaW in interactions that were perceived as helpful and non-judgemental. Conversely, any experiences of dismissal or judgement could derail these emerging constructs and delay access through discouragement of further help-seeking.
Expectation of Treatment *"She needs inpatient treatment; they just give her meds".* *T. Smith et al. (2013, p. 82)* *"… once the diagnosis was made it was kind of 'well off you go, you've got your diagnosis' off you go now and try and deal with it".* *Boulter and Rickwood (2013, p. 137)* *"It's a leap of faith because you're engaging with an organisation you know very little about, so it's making that choice without having all the information."* *Crouch et al. (2019, p. 497)*	The fit between expectation and experience of treatment is evident in notions of acceptability. The importance of this acceptability is supported in this synthesis as disagreement or dissatisfaction about treatment options was prevalent (4/6). The line of argument suggests that parent's perspectives of the support available was influenced by the expectations they had when choosing to engage. Existing constructs of service demand shaped perspectives of treatment approaches as being driven by convenience and lack of resources – particularly in relation to medication. In other instances, parents found approaches to be too generic compared to the specialist treatment they might have expected when engaging with a MHaW service and specifically on receipt of a diagnosis Expectations for treatment could be considered from the perspective of hoped for outcomes which are also influences by cultural contexts. If the class and culture of parents are aligned with professionals, there is an increased likelihood that hoped for outcomes will be the same. However, where there is misalignment parents and professionals may be working toward different outcomes and perceive success differently. The constructs of expectation seemed to interact with MH awareness and problem perception. Where knowledge of problem presentation and information about service availability were not evident in existing settings relating to CYP's health development, parents' expectations could only be shaped by culturally constructed assumptions about the availability and nature of MHaW support available to them.

1.3.3 Approaches to Practice

The line of argument constructed in this synthesis highlights the importance of recognising the influence of cultural context in shaping the narratives, knowledge, assumptions and relationships underpinning reciprocal interactions in MHaW access experiences. In the studies reviewed, approaches whereby professionals worked in partnership with parents as community members to openly navigate and mediate possible barriers positively influenced access and engagement. In this section, I will briefly outline the notions of community engagement and parent partnership as facilitative approaches in a culmination of this line of argument.

Community Based Practice

Experiences which could be characterised as relating to community-based practice were evident in five studies but particularly prevalent in three. In some instances, this related to the practical benefits of local services. Community based practice provided a single point of contact and source of information about CYP MHaW and the support available. This moderated some of the system and process barriers relating to demands on parents. The information provided in these contexts was relevant to and based in the local area (so embedded in influential cultural discourses) and could mediate barriers relating to awareness and problem perception by prioritising visibility for MHaW issues and normalising discussions in universal contexts about a CYP's MHaW experiences**.**

In the studies where issues of community engagement were evident, the importance of connection with others with similar experiences was valued (Walter et al., 2019). This connection was constructed as informal support, peer support and connection and was indicative of the isolation parents can experience when navigating challenges relating to their CYP's MHaW. These connections could mediate barriers relating to responses from family and friends as parents with similar experiences can provide supportive and validating responses as social equals both in the help-seeking process and in navigating treatment and post-treatment experiences.

Community based practice also played a facilitative role in the likelihood of a validating response from professionals. Professionals in these contexts have opportunities to develop relationships in the community and to establish themselves in role as helpers and supporters for the wider family and as such being in a position to provide responses that parents consider validating. The opportunity to access MHaW support through a community access point could be a significant mediator in relation to stigma and family context as it can allow access to support at an individual and family level without the need to navigate stigma concerns associated with the use of MHaW services. Working at a community level to provide education and awareness raising could also challenge stigmatising belief systems at a social level.

Establishing such approaches would require change at a wider systems level through the implementation of principles for effective community-based practice. Carter, Swedeen, Walter, and Moss (2012) demonstrated how such approaches could include locally based action research projects and partnership with families to develop education and awareness about CYP MHaW that was culturally sensitive, providing clarity and transparency in relation to available services and a space for open consideration of possible choices for local families.

Such strategies are aligned with perspectives in community psychology aiming to optimise liberation and empowerment for community members. Such approaches can be embedded in approaches to prevention and early intervention in educational psychology (Nelson & Prilleltensky, 2010; Prilleltensky, Peirson, & Nelson, 1997).

In EP practice, some of these community-based actions could include:

- Promotion of multi-agency working in children’s MHaW support to promote consistency in professional narratives and development of culturally considered language.
- Promote and or provide collaborative adult learning spaces within the community to develop awareness of children’s MHaW and support available.
- Development of working groups and research projects in partnership with a wide range of interested community members.
- Preventative and development work in schools based on locality working which allows EPs to be visible to parents, families, and all school staff.
- Developmental work with key school staff who work closely with parents such as teaching assistants and pastoral leads to promote the importance of accepting, legitimising and empathetic language in communication about need.

Parent Partnership

One key concept in translation and synthesis related to the positioning of parents in the initiation and continuation of their child's MHaW treatment. This concept was evident in five accounts and the way parents were positioned constituted either barriers or facilitators to their child's access. Taken together, these accounts support a line of argument in which parent partnership is a facilitative approach in promoting access to CYP MHaW support.

In literature about inclusive education, the notion of partnership has been constructed to characterise ways in which services can better engage with parents and families to optimise accessibility and inclusion. In traditional models of engagement, similarly to some early help-seeking literature, there has often been a focus on parent and family characteristics and in establishing categories of 'hard to reach' parents (Crozier & Davies, 2007). A partnership perspective places the responsibility on professionals to reach all members of their community and to promote trust, collaboration and respect (Lamb, 2009; Mortier, Hunt, Leroy, Van de Putte, & Van Hove, 2010; Todd, 2007).

Interestingly, positioning of parents was considered particularly influential in the study where participants were parents with lower socio-economic status. This could reflect findings in partnership and engagement literature suggesting the existence of tacit assumptions in the nature of parental involvement that are predicated on the social behaviours of the majority and aligned with that of professionals (Day, 2013; Levine-Rasky, 2009).

Partnership literature acknowledges the influence of socio-cultural norms and social power in the established practices for parental engagement with services for CYP. Such practices could be considered of greater importance in the context of services for MH support specifically due to the discursive complexity of MH as a construct in wider society. Partnership provides a space for deconstruction and mediation of the impact of real and anticipated stigma on access to services.

Approaches to Practice Summary:

Barriers to access for CYP MHaW support which have been long established, and are reflected in the reviewed studies' findings, have often been understood from a within-child perspective in a system which assumes that MHaW services should aim for high levels of identification, diagnosis and access to professional intervention. However, many barriers to access and engagement are underpinned by the real and anticipated stigma which would be associated with such service use and diagnostic labelling and with the inability of public services to provide the high cost, individual treatment approaches which might be expected as a result.

The way services are constructed and positioned within a community is likely to have a significant impact on access. Whilst there will be circumstances in which targeted, individual treatment is required (and sought by service users), this should occur in the context of a graduated, multi-agency approach to community wellbeing. Such approaches, by nature of their partnership with community members are also increasingly likely to be acceptable to those who choose to use them.

1.4 Conclusion

This review's outcomes could be seen to demonstrate the problematic nature of an individualistic approach to MHaW, particularly in relation to prevention and early intervention. Such constructs contribute to the continuation of established barriers to engagement related to uncertainty and apprehension in help-seeking based on dominant belief systems and assumptions across communities.

Support systems in which communities and professionals collaborate in genuine partnership allow for the nuances in sub-cultural narratives and family contexts to be better understood and actioned in the co-construction of accessible and acceptable systems of MHaW support.

School leaders and education professionals within Local Authorities (LAs) will be faced with the challenge of creating or re-structuring their approaches to CYP MHaW. The recent introduction of new multi-agency teams and a senior MHaW role in school could be constructed as an opportunity to do so by enhancing or developing community-based practice and partnership with families across agencies through existing relationships and practical accessibility in schools.

Chapter 2: Methodological Considerations

2.1 Introduction

The following chapter outlines the transition from the systematic review to an empirical research project. This is followed by a critical exploration of the philosophical assumptions underpinning the methodological approach. Finally, I reflexively explore key ethical considerations in line with the research paradigm.

2.2 Systematic Literature Review to Empirical Research

The meta-ethnography outlined in Chapter 1 constitutes my initial engagement with the experiences of parents who had accessed existing systems of MH support. The synthesis of findings from six studies generated a framework for understanding these experiences and the positive opportunities they elucidated.

Following the synthesis, I was curious to explore the unseen or intangible elements which seemed to underpin the experiences shared by parents and seemed related to the assumptions and constructs regarding MH in their culture. Considerations of culture are often concerned with the explicit practices and beliefs of a group of people. In this case, I felt it was less about “The way we do things around here”, and more about “The way we know/understand things around here”. It seemed there were systems of understanding about MH that were not necessarily explicit but were contributing to a number of aspects of parents’ initial and ongoing access to support.

The impact of delays to access described by parents had significant emotional resonance for me. Hesitance and anticipation of problematic responses in personal and professional sources of support meant that problems sometimes had to escalate to crisis level before a family would seek support. This highlighted a need for preventative approaches particularly ones facilitating early access to holistic support. This resonated with my burgeoning interest in community psychology and principles of prevention, promotion, and empowerment for social justice (Prilleltensky, 2001).

This perspective directed my interest to the notion of wellbeing. It was a concept that seemed to span policy and literature about promoting good MH and preventative approaches but it remained ill-defined (Watson, Emery, Bayliss, Boushel, & McInnes, 2012). Understanding the implicit constructs and assumptions about wellbeing in communities would be an essential first step in facilitating partnership for the development of new systems of MH and Wellbeing support in universal services.

2.3 Philosophical Stance

To consider the methodological and ethical characteristics of the empirical research, I shall outline my philosophical assumptions before going on to reflexively consider how these contribute to the research process (Darlaston Jones, 2007; Guillemin & Gillam, 2004).

2.3.1 Philosophical Assumptions

I consider myself to be ontologically relativist, assuming that what is to be known about the world is constructed through language and experiences, and that attempts to find out about the world are explorations of individual representations and not of an objective reality (Burr, 2004). From an epistemological perspective though, I find this relativism to be somewhat problematic. The social world cannot helpfully be understood through infinitesimal individual representations, and people's lives, experiences and personhood are shaped by systems of power, however socially constructed we might believe them to be.

This tension has been explored by researchers across the epistemological spectrum (Doucet & Mauthner, 2002; Fletcher, 2017) and could be understood in the context of Bhaskar's various levels of reality within critical realism (Fletcher, 2017; Parker, 1992). For me, research embedded in social systems, such as health and education, can helpfully contextualise accounts and experiences through a social constructionist lens but is remiss if it does not acknowledge the influence of established systems of power. As such, I feel that macro-constructionism best represents my epistemological position.

Macro-constructionism is explicitly concerned with the power structures and systems in society which delineate the language and linguistic resources available in the construction of these social phenomena (Burr, 2004; Willig & Stainton Rogers, 2017). It has been suggested that the assumptions underpinning this position are problematically deterministic in the context of social constructionism and that this way of understanding discourse fails to account for individual agency and the active construction of social phenomena (Burr, 2004). These claims to determinism can be challenged in this research through the specific approach adopted. A focus of the adopted method is to provide space for the development of alternative constructions which challenge those privileged by such systems. This facilitates a focus on positive possibilities related to ways of being made available for various subjects.

2.3.2 Methodology

A methodology underpinned by social constructionism rejects the traditional paradigm of scientific research when exploring complex social phenomena. In this study, I did not intend that an objective truth be established or tested through the research process. It was my intention that the research outcomes contribute to a socially conscious construction of wellbeing as an influential construct. To develop and implement wellbeing approaches which are appropriate for a community, it is important to establish a collaborative and critically considered understanding of what is, and might be, understood by wellbeing.

The specific methodology adopted in this study could be considered a macro-constructionist Discourse Analysis (DA). There is established coherence between macro-constructionism and DA in relation to Foucauldian philosophical origins (Burr, 2004; Parker, 1992). I considered it a particularly appropriate approach to address my research aims due to the consideration of the discourses constructing wellbeing (the intangible influences on beliefs and actions) and the notion that a particular discourse makes available certain possibilities for human subjects (possibilities for action in context). DA provided an established conceptual and methodological framework to explore the systems of meaning constructing an object in the talk of a group.

2.4 Ethics, Rigour and Validity

This study was approved by Newcastle University’s Ethics Committee following an enhanced ethics assessment. Processes of ethical approval are an important aspect of research: safeguarding participants and providing a catalyst for reflexive thinking in the process of planning an empirical project. Reflexivity is increasingly established as an essential tool in considering the rigour, validity and ethicality of research in an interpretive paradigm (Guillemin & Gillam, 2004; Yardley, 2017).

I will consider some moments in the research process which seemed ethically important (Guillemin & Gillam, 2004) and consider how these moments might further enhance my future sensitivity in the planning and carrying out of research and for practice (explored further in ***Chapter 4***: Reflections and Projections***)***.

2.4.1 Intention and possible impact

In education and health contexts, it could be argued that all research is a political act; simply by choosing one area, participant pool or question I am exercising political power (Gillies & Alldred, 2002). So, it is essential to be transparent about the intentions underpinning these choices and to consider their possible impact throughout the research process (Dodgson, 2019; Gillies & Alldred, 2002).

My intention in undertaking this empirical research was to consider the constructions of wellbeing evident in talk among parents in the context of wider systems and the discourses dominant in policy and practice in children's services. This intention was shaped by my experiences working with CYP in the area of MH and Wellbeing and my awareness of the increasing dominance of a mental health discourse in policy (Watson et al., 2012). In undertaking a discourse analysis, I hoped that the influences shaping discussions and perspectives about wellbeing could be critically considered and various alternatives to MH discourse could be considered for the action possibilities they make available.

Acknowledging and stating these intentions was a helpful step in ensuring the research process was sensitive to context (Yardley, 2017). Awareness of the likely influence my familiarity with the research area and psychological theory more broadly would have on my engagement with the participants increased my sensitivity to this in the interviews and allowed me to make considered choices in the moment.

It was also important to consider the sensitivity of the subject matter more broadly and the possible impact of the discussions in interviews on participants. To safeguard the participants, a debriefing process was embedded into the closing stage of the interviews. I provided the participants with signposts to key sources of information and support and invited them to contact me for further support if needed. This verbal debrief was followed up with a summative email.

2.4.2 Adapting to virtual methods – a changing project

Due to the restrictions in place in response to the Coronavirus pandemic, there was a point in the planning of this project where a shift had to made to online platforms.

This shift required amendments to the project proposal and a renewed focus on ethical considerations.

There is an emerging research base relating to the use of audio-visual software when conducting interviews and focus groups in research (Daniels, Gillen, Casson, & Wilson, 2019; Tuttas, 2015). I will consider some of the key areas in the context of my research.

Practicality and accessibility

One factor of relevance relates to the physical location of participants. Some advantages in terms of accessibility have been explored in the context of reaching participant groups (Daniels et al., 2019) which could be applied here as the context of school closures and working from home have meant that demands on parents' time are greater. However, flexibility in location must be balanced with concerns regarding the lack of control over the participants' physical environment including practical issues such as childcare, unexpected visitors or background noise which could better controlled for in a purposefully arranged location.

This also raised issues of privacy and confidentiality (Daniels et al., 2019; Lobe, 2017) as I could not be aware of what was happening away from the camera. Issues of privacy and confidentiality may arise in in-person research, especially in a busy school environment, but in face-to-face contexts it is possible to register these risks and respond accordingly. In response to these issues, clear expectations were established with participants prior to the interviews.

The balance of flexibility and convenience was illustrated in my research when one of the participants joined on their phone from their van. The flexibility of the online platforms meant that he was able to join despite a bustling household, but it raised questions regarding his comfort and the influence this might have on the construction of an interview space that encouraged interaction in an already challenging virtual space. For this participant though, joining from the van was comfortable and the use of pre-existing participant pairs (see ***3.3*** Method) also meant the response to some connection issues was jovial and easily navigated. Should I use virtual methods again in the future it will be important to maintain sensitivity to this balance and explore possibilities explicitly with potential participants to work out what is best for them.

Data Generation

A barrier when working virtually is the ability to create an environment which encourages participation and interaction. Daniels et al. (2019, p. 2) found that “the nature of the online environment had the potential to produce detached statements from participants as opposed to interactive exchanges”. As well as the nature of spoken communication, it is important to consider the broader communicative environment. Social context cues and non-verbal behaviours are presented as essential to the development of shared understandings in online research environments which require interaction (Lobe, 2017).

Characteristics of the online environment such as courteous turn-taking have been described as an advantage in research (Daniels et al., 2019) as it can prevent the loss of meaning where participants talk over each other. However, the uncertainty as to whether another person is speaking is likely to impact the dialogic development which could add richness to the meaning being constructed. This suggests that virtual settings could be limiting in group interviews. The use of pairs in which the participants knew each other went some way to mediate this limitation. When there are only two others who might wish to speak, the participants had less social information and non-verbal communication to process which could minimise the need for an organisational approach such as the courteous turn-taking described above. More broadly, recent experience of consultation as a Trainee Educational Psychologist (TEP), requiring collaboration, had enhanced my ability to facilitate a positive online environment.

2.4.3 Doing Discourse Analysis

The approach to analysis in this study is embedded in the overall methodology. DA is a deconstructive enterprise exploring the conditions of possibility for a given construct. There are several ways to undertake a DA linked to philosophical positions and ideological underpinnings (Burr, 2004; Willig & Stainton Rogers, 2017). Undertaken from a macro-constructionist perspective, the analysis is focused on the way objects are constructed in local and specific settings. Attention is drawn to the relationships between discourses and institutions and the legitimisation and power afforded to particular discursive constructions as a result (Arribas-Ayllon & Walkerdine, 2008).

In a number of these approaches, a DA is often carried out on naturally occurring text and talk, such as policy or pre-existing transcripts of conversations. If this text is not readily available in a targeted area of interest from a specific perspective (such as parents talking about CYP wellbeing), there is an established precedent for the use of interviews to generate text for analysis (Arribas-Ayllon & Walkerdine, 2008).

Moreover, if I were to attempt data generation that could be considered naturally occurring, I would have to try to create, or gain access to, a natural environment and attempt to observe objectively. This process is not aligned with a constructionist epistemology as it would involve positioning myself as objective in the research process (Darlaston Jones, 2007). However, one element of the design which was intended to facilitate a more naturalistic environment was the use of dyadic interviews in pre-existing pairs. It was intended that this would allow the participants to explore meaning and experience in their shared role as parents despite a relatively strange situation. In this context my direct involvement in the development of the discussion was minimised in comparison to that of an individual interview exchange (Morgan, Ataie, Carder, & Hoffman, 2013).

Analysis

The analytical approach undertaken in this research was predominantly underpinned by the methodological procedure for Foucauldian Discourse Analysis outlined in Willig (2013, p. 131) which provides six sequential stages for analysis. Alternative approaches for DA were explored including methods of analysis that were more detailed and those which were less practicable but driven by a greater understanding of the conceptual underpinnings of DA (Kendall & Wickham, 1999).

Whilst both perspectives on DA were used as tool for methodological criticality and reflexivity in the research process, Willig's (2013) approach was selected to allow for methodological adaptation within the broader, less prescriptive stages. With some adaptation, this process was aligned with my research purpose in the explicit emphasis placed on the interactions amongst discourses and practice. This is in line with suggestions in the methodological literature which question the value of sequential methods (Tanggaard, 2013) suggesting there is no one agreed approach to undertaking DA (Burr, 2004; Parker, 1992; Willig, 2013). The implication is that DA from a macro-constructionist perspective is more importantly related to a particular philosophical lens.

Elements of the adaptation were also developed in research supervision and in additional supervision from a colleague in the university who was familiar with DA as an approach. This facilitated the supported exploration of the application of DA principles with the data generated and the initial interpretive ideas. It has been suggested that the exploration of possible interpretations through supervision can demonstrate thoroughness in analysis and interpretation (Barbour, 2001). The variation in this method enhances the need for clarity and transparency in the research process (Yardley, 2017). A detailed record of the analytical process, including the reasons for the adapted or repositioned stages is outlined in ***Table 10.***

Table 10: Adapting and undertaking the discourse analysis

Stages from Willig (2013)	**Process undertaken**	**Notes**
Stage 1: Discursive constructions Identify how the discursive object (DO) is constructed by participants.	Instances in which the discursive object (DO) was being constructed in the data were identified in the transcripts. This was also the first stage in considering how the DO was being constructed. This stage of the process is referred to in Parker (1992, p. 6) as finding “pieces of the discourse”. A process of collation and synthesis was undertaken which involved the recognition of patterns of meaning in the language use within and across the transcripts. This contributed to the identification of particular discursive constructions as being consistently deployed in the construction of wellbeing in the data.	Labelling or coding meaning patterns in the text was not a linear process. The exploration of the interpretive repertoires, discursive constructions and discourses was undertaken cyclically through a critical lens, including consideration of the conversational context of what was clearly present but also what was absent and implicit (Tanggaard, 2013).
Stage 2: Discourses Locate discursive constructions within wider discourses.	The discursive constructions were then located in the context of wider discourses (see ***Appendix 10***: Discursive constructions and initial discourse identification***).*** As part of this process, I found it helpful to consider the assumptions made about the	Some of the wider social discourses were themselves enmeshed and interrelated and the process of interpretation here is a representation of the power and influence of the researcher in this study.

<table>
<tr><th>Stages from Willig (2013)</th><th>Process undertaken</th><th>Notes</th></tr>
<tr><td></td><td>DO (both explicitly and implicitly) when it was constructed various ways.
These patterns of meaning and related assumptions were then connected through a process of reflective free association (explored in supervision) to wider social discourses (Parker, 1992).</td><td>Cycles of critical reflection and returning to both the data and to methodological texts was intended to provide rigour in this process.</td></tr>
<tr><td colspan="3">Stage 3: Action Orientation - what is gained from constructing the object in this particular way?
This stage as it is outlined in Willig (2013) has been adapted in this process as the discussion is not a personal account and action orientations are more helpfully considered in the context of the wider system than for the participants themselves in this particular instance. Additionally, the purpose and context of an interview will likely disrupt patterns of deliberate discursive action which might have particular implications for an individual in naturally occurring conversations. Action orientation was considered more systemically in stages 4 and 5 in explorations of positions and possibilities.</td></tr>
</table>

Stages from Willig (2013)	Process undertaken	Notes
Stage 4: Positioning Consider how the discourse constructs subjects as well as objects and how it makes certain positions available.	Throughout the analytical process, a research journal was used to take notes of some of the action implications that seemed to be implied when particular discourses were deployed in the context of the data. Consideration was given to various subjects in the context of wellbeing as a discursive object with an initial focus on the implications for parents. Focus was shifted however to the explicit consideration of implications for roles and responsibility within systems of power. This process was undertaken through various theming and mapping processes whereby the constructions were considered through a contextual, historical lens and in relation to the institutional and systemic contexts of particular relevance (see **Error! Not a valid result for table.**	It is in this section (and those that follow) that the macro-constructionist perspective was particularly overt and the principles from more conceptual approaches to FDA (Kendall & Wickham, 1999; Parker, 1992) were interwoven into the analysis. This included consideration of the rules and patterns of what can be said, and by whom, based on the context in which a discourse or discursive construction came to be. It was also important to acknowledge the power I have as a TEP (outside of the research context) in my positioning as being able to make or privilege new statements or alternative discourses as a psychological professional often positioned as expert.
Stage 5: Practice A systematic exploration of the ways in which	This stage was undertaken as a "So what?" factor in the context of this applied educational psychology research and was undertaken largely as described by Willig (2013).	This section is mostly represented in (***Table 14:*** Summary and consideration of discourses constructing wellbeing in interviews with parentsand explored in depth in the discussion section.

<table>
<tr><th>Stages from Willig (2013)</th><th>Process undertaken</th><th>Notes</th></tr>
<tr><td>discursive constructions and the subject positions contained within them open up or close down opportunities for action.</td><td>This exploration allowed consideration of opportunities for action in relation to wellbeing in the context of the dominant discursive constructions presented. The positioning of parents, professionals, and children as subjects was varied depending on the discourse constructing wellbeing.</td><td>Exploring the possibilities for future practice based on the ways of being made available, or not, for different possible subject positions. Combinations of discourses was also of interest here – most were often interacting.</td></tr>
<tr><td colspan="3"><u>Stage 6: Subjectivity</u> - Tracing the consequences of taking up various subject positions for the participants' subjective experience (thoughts feelings etc).

The subjectivity stage was not adopted in this research to prioritise the consideration of the possible consequences for practice in universal services explicitly. This was decided as the analysis was not based on a personal account and the research purpose related to diversifying the constructs of wellbeing which shape approaches to wider practice.

In the discussion section of the empirical project, the notion of subjectivity as tracing the consequences was adapted to extend the consideration of systems and power. The possible subjective experience of various stakeholders has been considered in the discussion through the lens of existing conceptual frameworks and possible action outcomes.</td></tr>
</table>

2.4.4 My role as a researcher

Undertaking DA from a constructionist epistemological position, particularly in the context of an empirical research project, precludes the separation of the researcher from the research (Parker, 1992; Willig, 2013). I played an active role in the interview process and was the author of the constructs shared as an analysis outcome.

In using an interview structure, the researcher is consistently present in the discursive space. In planning and directing interviews with participants, I made decisions about the subject matter and structure of the interviews without input from the participants. The participants were also recruited through my TEP role in the LA; all this influences my position in the interview process. ***Table 11*** Table 11: Position as an insider, outsider and in the space-between.demonstrates some key points from a consideration of Dwyer and Buckle's (2009) ideas about the multiple positions occupied by a qualitative researcher as being insider, outsider and in the space between, within the perspective of my research.

There are various positions regarding the value of insider and outsider research. In some circumstances, undertaking outsider research could be considered ethically questionable due to the assumption and exertion of power over participants (Gillies & Alldred, 2002; Willig, 2013). It is important to acknowledge the value of insider research, particularly in relation to vulnerable or marginalised groups whereby access and openness can be ethically and sensitively facilitated (Dwyer & Buckle, 2009). Yet, as Gillies and Alldred (2002) argue, constructing insider research as the only ethical, qualitative approach could ultimately lead to the exclusion or invisibility of certain social experience, limiting explorations to demographically oriented research outside of a qualitative paradigm.

As Dwyer and Buckle (2009) suggest, in this research I think that I largely occupy the space between. There were aspects of my personal and professional context which positioned me as an insider, whilst in relation to the research purpose I was explicitly an outsider. One aspect of the space-between which was interesting in the interview was the shared experience the participants and I had of being parented as adolescents. This was heightened by a shared sense of class identity in one interview which I felt further developed the dialogue.

Table 11: Position as an insider, outsider and in the space-between.

Insider	Space-between	Outsider
I was known to the participants by the point of the interview based on my position as TEP within the LA and in the process of arranging the interviews in a changing environment (adapting to virtual). Similar age-range, culture and ethnicity as participants.	Shared experience of being parented which was sometimes talked about in the interviews in relation to comparison and change in social context. Skills and experience in facilitating a reflective space for discussion.	I am not a parent of a CYP aged 11 – 14 (or at all). I am not local to the area and am not a member of the local community. Analysis and interpretation – conducted without input from participants and based on my knowledge and experience of the research area.

Interpretation

An aspect of qualitative research which can be an ethical burden in relation to power and positioning is the level of interpretation applied to data - the content of the parents' conversations in my case. It could be said that any interpretation of a participant's account is an exertion of power and assumption of superiority to a certain extent (Willig, 2013). However, in the context of conducting DA this exertion of power is explicitly exercised with a moral pursuit in mind and with the intention of facilitating change within systems of power (Graham, 2018). To problemetise interpretation through a lens of power without consideration of an ultimately democratic aim could be considered somewhat reductive. This claim brings with it an acknowledgement that I am the author, not discoverer, of the interpretations offered as an outcome of this research and in itself this reading of the data has been constructed by discourse (Willig, 2013).

Interpreting the participants' accounts in the context of wider social discourse risks positioning them as either passive instruments of the system or as actively manipulating constructions for their own ends (Burr, 2004; Hanna, 2014). This is a particularly difficult process where topics could be considered sensitive (Hanna, 2014). I was uncomfortable making direct attributions regarding the use of discourse for personal subjective ends, having initiated the conversation for research purposes. The adaptations to the process outlined above removed elements of the process that were specifically related to the subjective positioning for individual participants. In this context, locating the discourses and subject positions in wider social discourses and systems of power allowed me to consider the possible consequences of the naturalisation or resistance of particular discourses more broadly and contextualise this for future practice.

2.5 Conclusions

Undertaking qualitative research in a relativist paradigm required extensive application of critical and reflexive thinking to ensure ethical quality and rigour. I was struck by the complexity of cycles of analysis and reflexivity required throughout the process to feel comfortable making interpretive judgements and tentatively applying these to practice. This reflexive thinking will be further extended to consider implications for me personally and as practitioner in ***Chapter 4***: Reflections and Projections***.***

Chapter 3: Making Sense of Wellbeing: An Analysis of Parental Discourse about the Wellbeing of Children and Young People

Abstract

Issues of mental health and wellbeing are often considered a social problem and as such have been the subject of various political policies over time. Recent policies in health and education continue to position wellbeing as closely related to mental health and as somewhat removed from other key policy objectives related to equality and SEND.

In an education context, the promotion of wellbeing as a preventative measure for mental health is increasingly prevalent and schools are considered a valuable site for such approaches. Variations in meaning when talking about wellbeing can contribute to miscommunication and misunderstanding in the context of multi-agency and community-based practice perpetuating barriers to support.

Social discourses about wellbeing contribute to public perceptions of health and behaviour and shape the actions of those who seek to measure, understand, and promote wellbeing. Such discourses reflect conflicting ideologies which are embedded in policy, culture, and practice in education systems. The dominant discourses in education and community settings contribute to the construction of wellbeing and, as such, the type of approaches which are valued.

This study seeks to better understand the discourses which are drawn upon in the construction of wellbeing in parents' conversations about their children's wellbeing. An adapted Foucauldian Discourse Analysis was carried out to explore the dominant discourses constructing wellbeing in conversations amongst three pairs of parents. These discourses are presented and implications for ways of being for various social actors in relation to the wellbeing of children and young people are considered in the context of conditions of possibility in educational psychology practice.

Following examination this study will be submitted to Educational Psychology in Practice and therefore it is presented in the style of papers typically published by this journal

3.1 Introduction

The aim of this empirical research project was to explore how the conceptually diverse notion of wellbeing is constructed by discourse in researcher-guided conversations with six parents about their children. In this introduction, I will briefly review the wider context of the research area before establishing the rationale for the current project in the context of Educational Psychology practice.

3.1.1 Current Context

There is an established acceptance in research and policy that the Mental Health (MH) and Wellbeing of Children and Young People (CYP) is an area of importance and ongoing concern (Brown, 2018; DoH & DfE; 2017; Weare, 2017). There has been an upward trend in the number of CYP experiencing psychological distress in England and groups considered socially vulnerable are at greater risk (DoH & DfE; 2017; Sadler et al., 2018).

Various aspects of existing systems (including academic reform in schools and the impact of economic austerity on public services) have resulted in a significant gap in MH provision (Florian, 2014; Hennessey & McNamara, 2013; Public Health England, 2016) leaving children and families without the necessary support.

Ideas about mental health have become increasingly diverse and there has been a paradigm shift towards positive constructs of what it means to be mentally healthy (Weare, 2017). This shift has contributed to the concept of wellbeing becoming increasingly dominant in the way individual CYP's psychological and emotional experiences are understood (Watson et al., 2012; Weare, 2017).

3.1.2 Wellbeing in Policy

The concept of wellbeing is embedded in policy and guidance aiming to promote good MH experiences and address service gaps in CYP's MH support (Brown, 2018; DoH & DfE; 2017). In this context, schools have been positioned as playing a key role in the promotion of CYP MH and Wellbeing (DoH & DfE; 2017).

The specific nature of this role is difficult to characterise as the way CYP's wellbeing and related provision are constructed in policy and guidance in education varies (Spratt, 2017). This is notable in the apparent discord between policies for Special Educational Needs and Disabilities (SEND) and in those explicitly targeting MH and

Wellbeing across universal services (DfE, 2014; DoH & DfE, 2017). Across these two policy areas, wellbeing can be seen to be varyingly constructed as an issue of environmental adaptation and inclusion and as a subjective, individualistic factor in CYP MH status. These constructions co-exist in school policy and culture and lead to high levels of interpretation in the way school systems and staff construct roles in supporting CYP wellbeing (Monkman, 2017; Spratt, Shucksmith, Philip, & Watson, 2006). A range of approaches and initiatives is evident in schools (Brown, 2018; Spratt et al., 2006; Watson et al., 2012) and EPs may be asked to contribute to school strategies for wellbeing in various ways (Fallon, Woods, & Rooney, 2010; Zafeiriou & Gulliford, 2020).

Partnerships for wellbeing

The MH and Wellbeing provision made available in schools is considered key in the mediation of access issues relating to wider services gaps (J. Smith & Hamer, 2019). As a universal service based in the community, it is thought that there is far reaching potential for prevention and early intervention within existing school structures (N. Thomas, Graham, Powell, & Fitzgerald, 2016).

These apparent advantages assume a universality in engagement with school across communities which is not reflected in research (Levine-Rasky, 2009). Patterns of engagement between school and parents influence access to resources to meet the needs of children (Grove & Fisher, 1999; Riddell, Brown, & Duffield, 1994) and it has been established that schools are harder to reach for some families (Crozier & Davies, 2007; Day, 2013; Sime & Sheridan, 2014). Hidden expectations based on the prevalent culture and social class of school staff constitute significant barriers to collaborative relationships for some parents and families (Levine-Rasky, 2009). Often, this leads to the further exclusion of groups considered socially vulnerable, undermining the possibility that school-based approaches can mediate issues of access.

In a related literature review (Edwards, unpub), it was suggested that some barriers to engagement with MH services were underpinned or compounded by ideological incoherence across communities and agencies. Community-based practice was effective where collaboration with families facilitated a genuine partnership built on a shared understanding of experiences and hoped-for outcomes (Todd, 2007).

The development and implementation of new systems of support which separate MH and Wellbeing from other constructs of need (DoH & DfE, 2017) necessitate the consideration of wellbeing as a construct and how it can be understood in the context of universal services. Variations in discourses which construct meaning across policy can limit the potential for effective multi-agency working and engagement with communities as the ideological and discursive juxtapositions confuse meaning and undermine shared understanding (Gaskell & Leadbetter, 2009).

3.1.3 Discourse

Discourse can be understood as relating to the active construction of objects[2] through language in a social context (Willig, 2013). Discursive constructions are thought to be reflective of wider ideological positions whereby patterns of meaning in language use, construct an object from a particular perspective (Parker, 1992; Spratt, 2017). The way an object is constructed within a discourse impacts the ways of being available for social actors and has implications for power and positioning within social systems.

Discourses can be privileged to the extent that they permeate societal assumptions and a construction can be assimilated as a common-sense understanding of a concept (Arribas-Ayllon & Walkerdine, 2008). Further, the systematic construction of objects in the context of a particular discourse will ‘reproduce and transform the world’ in its ideological light (Parker, 1992, p. 5). As such, discourses can be both systematically deployed and privileged to serve a particular agenda, and unintentionally propagated in the common sense language that is embedded in ways of talking about an object (Spratt, 2017).

Discursive constructions of wellbeing in education

The conceptual ambiguity of wellbeing as a construct and its position at the border of health and education policy has led to a “web of discourses which seem to converge around the concept of wellbeing.” (Spratt, 2017, p. 13). It is an attractive construct which has come to represent positive aspirations for CYP (N. Thomas et al., 2016).

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[2] The term object in discourse analysis generally refers to a concept or idea that is being constructed by the discourse.

However, the various discourses constructing wellbeing are underpinned by differing ideologies which consequently impact these aspirations.

Discursive exploration of wellbeing constructs in education tends to focus on policy. Policy development is an expression of power and is influential in privileging particular discourses - delineating what is possible in a given context (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013). In her consideration of discourse in education policy in Scotland, Spratt (2017) suggests that two competing ideologies are particularly dominant. Described as ‘welfare liberal’ and ‘neo-liberal’ these ideologies relate to the way social justice is understood. These competing ideologies are also relevant in the competing policy objectives in England, as outlined earlier (see also; Callaghan, Fellin, & Warner-Gale, 2017).

Neo-liberal ideologies in education value economic possibility and the notion of personal responsibility (Sugarman, 2015). Social justice is understood as equal opportunity to acquire personal, social and financial resources for success (Sugarman, 2015). Such ideologies contribute to constructs of wellbeing which are individualistic and aligned with theoretical perspectives from positive psychology such as Seligman’s (Diener & Seligman, 2018; Seligman, 2011) whereby subjective wellbeing is broken down into measurable characteristics supporting personal action for improvement. Individualistic constructs of wellbeing are aligned with a wider health discourse and this is evident in policies for MH and Wellbeing which draw on increasingly pathological language and isolate MH from other areas of need (Callaghan et al., 2017). This contributes to the assumption of a need for individual intervention and expert support/treatment in practice (Monkman, 2017; Spratt et al., 2006).

Welfare liberal ideologies in education derive from a position of state responsibility where schooling is valued as a public good and a site for social integration and community development (Spratt, 2017). In this context, wellbeing can be understood as relating to systemic, environmental, and relational experiences, largely constructed within an equality discourse. Such constructs could be associated with perspectives in community psychology whereby ideas about collective wellbeing are explicitly aligned with constructs of social justice and the recognition of wider social problems and inequalities as primarily constitutive of poor wellbeing experiences. In the context of such constructions, the common sense action to promote wellbeing is the equitable redistribution of resources within communities and in society as a whole (Nelson, 2013).

A further construct of interest is the notion of recognition as a way of understanding human dignity and as such the achievement of wellness (Honneth, 1992). Honneth (1992) proposes a tripartite construction of recognition experiences (love, rights and solidarity) as being fundamental to experiences of self-confidence, self-respect and self-esteem. This focus on relationship to the self has led to suggestion that recognition is excessively individualistic and does not sufficiently account for distributive injustice (Fraser, 2001). However, the notion of recognition is fundamentally inter-subjective. One of the strands in particular – solidarity – highlights the importance of collective action for resistance and Honneth (2004) has proposed recognition as a theory which could offer an overarching constructive of both distributive and individual constructs of justice.

As an interventionist approach to address a social problem of inequality, SEND policy and related ideals of inclusion are largely constructed in a welfare-liberal ideology (UNESCO, 2009). It has been suggested though, that the dominance of neoliberal discourses of personal responsibility in education as a whole has individualised constructs of inclusion to an extent that no longer aligns with a wholly inclusive ideology (Lindsay, 2007; G. Thomas & Loxley, 2007).

Theories of wellbeing such as those offered by Roffey (2015) acknowledge and address some of the environmental and societal influences on wellbeing, with a focus on relationships and connection in a school community. Yet the dominance of ideas about risk and resilience at an individual level demonstrates the continued positioning of a wellbeing state as within an individual. This could be considered reflective of the discursive confusion of promoting wellbeing in practice whereby welfare liberal and neoliberal ideologies co-exist in the discourses constructing wellbeing in theory and policy.

The varying constructions evident within wellbeing discourse reflect different philosophical assumptions and ideological positions. The constructs of wellbeing used by EPs in their practice privilege particular ideologies in school contexts and can have a significant impact on the pursuit, subjective experience, and measurement of wellness in context.

3.1.4 The Current Study

If wellbeing approaches in school and elsewhere are to avoid perpetuating existing inequalities of access, steps should taken to understand how wellbeing is constructed across communities. Developing an understanding of the discourses constructing wellbeing can contribute to a shared understanding which is rooted in ideology and driven by shared values. This can facilitate genuine partnership in the development of systems of support for wellbeing as a preventative MH strategy.

The aim of this study is to understand the discourses which construct wellbeing in conversations amongst parents and to consider the possibilities for positive action made available in the context of these discursive actions.

The study addresses the research question:

How is wellbeing constructed by discourse in parents' talk about their children?

Initial identification of discourse is further scrutinised to consider:

- ***What power relationships are perpetuated by the discourse and what positions are available?***
- ***What opportunities for action intervention and change are available?***

3.2 Methodology

This study adopted a methodology rooted in a social constructionist epistemology. Social constructionism claims that reality is actively constructed and interpreted by individuals based on the meanings available to them in their social context (Burr, 2004; Willig, 2013). It is a research paradigm concerned with how individuals are constituted by the social world.

A focus on the wider discourses which contribute to the construction of wellbeing reflects an acknowledgement of systems of power in the construction of social phenomena. This reflects a macro social-constructionist perspective. Where micro social constructionism privileges the influence of individual experiences and linguistic tools in the construction and interpretation of the self and the social world (Burr, 2004), macro social constructionism is concerned with the power structures and systems in society which delineate the language and linguistic resources available in the construction of these social phenomena (Burr, 2004).

3.2.1 Discourse Analysis

Macro social constructionism is closely associated with discourse analysis (DA) as a research methodology and has been heavily influenced by Foucauldian philosophy. Such philosophy promotes the importance of understanding the historical origins of constructs, particularly in relation to the systems of power at play, in understanding their ongoing social influence (Burr, 2004; Willig & Stainton Rogers, 2017).

This study adopted a method which could be considered a macro-constructionist discourse analysis with a particular focus on possibilities for positive action as a specific outcome of the research process (see ***3.3.6*** Analysis section for detail).

3.3 Method

This research was conducted in a large rural Local Authority in the North East of England. The Educational Psychology service in this LA is involved with a Mental Health Trailblazer Project which implements the guidance and expectations outlined in recent policy for MH and Wellbeing in education (DoH & DfE, 2017). This research was not associated with the Trailblazer Project, but the Project was influential in shaping the original research focus.

3.3.1 Ethical considerations

This study was approved by Newcastle University's Ethics Committee following an enhanced ethics assessment and adhered to the standards outlined in the BPS Code of Ethics (2014). Participants were informed in writing of the aims and purposes of the research, their rights as participants, how and where their data would be stored, and relevant contact information (see ***Appendix 7***: Information sheets and consent form).

Procedural ethics alone cannot account for the ethical undertaking of qualitative research. A critical consideration of ethicality can be found in ***Chapter 2***: Methodological Considerations.

3.3.2 Recruitment

The participant group chosen for this study was parents/carers of children and young people between the ages of 11 and 15. This age group was selected as it has been identified as a period in which concerns regarding wellbeing are likely to manifest (PHE; 2016). Additionally, concerns regarding wellbeing in education are particularly evident in the secondary phase of education (Public Health England, 2016; Sadler et al., 2018). I chose to exclude parents of children who had accessed targeted MH support as their constructs of wellbeing would likely be more heavily influenced by health discourses than others.

Participants were recruited through purposive, snowball sampling. Electronic posters were shared via school SENDCOs and local parent groups with a request for expressions of interests via a secure university affiliated email address. Detailed information sheets were shared with those who expressed interest followed by consent forms for those who subsequently requested them. These participants then identified others who may be interested in the project. It is important to note that the snowball approach resulted in quite a homogenous participant group who could broadly be described as white middle class.

Table 12: Demographic information for participant pairs.

		Demographic Information	Pair
Interview 1	Participant 1 **'Andy'**	Male 50+ Partner in home 3 Children - 1 in age range.	Fathers of teenage girls whose children are friends. Established friendship between the participants.
	Participant 2 **'Ben'**	Male 50+ Partner in home 1 child (in age range)	
Interview 2	Participant 3 **'Clare'**	Female 40+ Partner in home 2 Children (1 age range).	Mothers of children in early adolescence who are sisters in law.
	Participant 4 **'Debbie'**	Female 40+ Partner in home 2 Children (1 in age range).	
Intervi	Participant 5 **'Ewan'**	Male 40+	Married couple and co-parents to a teenage daughter.

		Partner in home 2 Children (1 in age range).	
	Participant 6 **‘Faye’**	Female 40+ Partner in home 2 Children (1 in age range).	

3.3.4 Participants

The participants were six parents (who all met the criteria outlined above) from a suburb in the North East of England. They were interviewed across three sessions in pairs based on pre-existing relationships (see *Error! Reference source not found.*).

Whilst the interview context and influence of my role as a researcher precludes the possibility of a naturalistic discussion among participants, the decision to undertake paired interviews was taken in the hope that talk amongst two people would allow for a more natural development of the discussion than in an individual interview (Morgan et al., 2013). Through the process of snowball sampling outlined above, I was able to identify existing connections between the participants. This made it possible to conduct the interviews with pairs of participants who had a pre-existing relationship. I thought that these pre-existing pairs could increase the likelihood of discussions underpinned by the discursive resources which would usually be employed in their conversations (Morgan et al., 2013). I discussed this with the participants who all indicated that they would be comfortable being interviewed in the pairs suggested.

3.3.5 Interviews

Transcripts for analysis were created in unstructured interviews of approximately an hour in late November and early December of 2020. As a result of Coronavirus pandemic related restrictions, the interviews were carried out virtually using video-conferencing software. The software facilitated the secure audio-visual recording of the interviews which I then transcribed.

The context of the pandemic also meant that there were national and global conversations about wellbeing taking place at the time of the interviews which were more prevalent in mainstream media than might usually be the case. Whilst the subject of the pandemic came up in some interviews, I did not judge it to be significant in shaping the underlying discourses.

The interviews were open in structure. All were initiated by a question inviting the participants to talk about what they thought might be meant by wellbeing. The interviews were then led by the responses of participants and questions were open and based in curiosity, reflecting and drawing threads together for further discussion. If further prompting were necessary, I would use generic prompts such as “do you have any thoughts about school and wellbeing?” (see ***Appendix 8***: Interview Prompts).

3.3.6 Analysis

The study’s approach to analysis is embedded in the overall methodology. DA is a deconstructive enterprise which explores the conditions of possibility for a given construct. When undertaken from a macro-constructionist perspective, the analysis is focused on the ways in which objects are constructed in local and specific settings. Attention is drawn to the relationships between discourses and institutions and the legitimisation and power afforded to particular discursive constructions as a result (Arribas-Ayllon & Walkerdine, 2008).

The analytical approach undertaken in this study was predominantly underpinned by the methodological procedure for Foucauldian Discourse Analysis (FDA) outlined in Willig (2013, p. 131) which provides six sequential stages for analysis. Some aspects of this procedure were omitted and/or adapted to best address the research purpose in the context of the data (R. Parker, 2013).

In this study, the adapted approach to analysis was considered ultimately not Foucauldian as the focus in relation to the consequences of various conditions of possibility was on systems and not individuals. In a FDA, the analytical stages relating to action orientation and subjectivity (see ***Table 13***) suggest that the researcher considers the possible gain and impact on subjective experiences for the individuals providing the accounts based on their deployment or avoidance of particular discourses (Arribas-Ayllon & Walkerdine, 2008; Willig, 2013). In this study, consideration of action orientation and subjectivity related to the broader, systemic consequences of discursive dominance on social actors in a CYP’s life.

The process undertaken is outlined in ***Table 13***. This adaptive approach is in line with the methodological literature which suggests that there is no one agreed approach to undertaking DA (Burr, 2004; Parker, 1992). Further, it is suggested that when conducting DA from a macro-constructionist perspective greater importance should be given to the application of a particular philosophical lens (Carabine, 2001). For a detailed methodological consideration of the analytical approach, including reasons for the omission of some of Willig's stages, see ***Chapter 2***: Methodological Considerations**.**

Table 13: Adapted Discourse Analysis Process

Stage 1 - data driven	
Stages from Willig (2013)	**Analytical approach**
Stage 1: Discursive constructions Identify how the discursive object is constructed by participants.	A process much like coding in which instances where the discursive object was being constructed were identified in the data. This included collation across the three transcripts. Initial notes were made in relation to the patterns of meaning and assumptions in these discursive constructions.
Stage 2: Discourses Locate discursive constructions within wider discourses.	The discursive constructions which had been tentatively identified were located within wider social discourses such as health and environment discourses. This was not a linear process and the exploration of the patterns of meaning, discursive constructions and discourses was undertaken cyclically.
Stage 3: Action Orientation	Largely incorporated into Stage 4 regarding possibilities for action within systems.
Stage 4: Positioning Consider how the discourse constructs subjects as well as objects and how it makes certain positions available.	The discourses and related constructions were considered in relation to the subject positions made available when wellbeing was constructed in this way. Consideration was given to various subjects in the context of wellbeing as a discursive object. Explicit consideration was given to the implications for roles and responsibilities within systems of power.
Stage 2 - reflexive process	
Stage 5: Practice A systematic exploration of the ways in which discursive constructions and the subject positions contained within	This stage was undertaken as a *"So what?"* factor in the context of this research. The exploration was carried out systematically through the process of writing the discussion section of the study. Questions relating to power and positioning and possibilities for action were considered in the context of wider literature.

them open up or close down opportunities for action.	This facilitated the explicit consideration of opportunities for action in relation to wellbeing in the context of current practice in existing systems.
Stage 6: Subjectivity	Considered in the discussion based on the possible experiences of various social actors not those of the research participants themselves.

3.4 Discourses

In this section, the outcomes of the first stage of analysis are presented (see ***Appendix 9***: Mind-mapping and exploration of possible discourse***, Appendix*** 10: Discursive constructions and initial discourse identification ***and Appendix*** 11: Patterns of meaning and interpretation of dominant discourses constructing wellbeing for initial identification of contributing discourses). In presenting the meaning constructed from the data it is important to consider my role. The macro-constructionist epistemology underpinning this discourse analysis precludes the separation of the researcher from the research. The meaning is interpretive and framed in the context of my knowledge, experience, and philosophical assumptions. The wider discourses considered dominant in constructing wellbeing across transcripts are presented in ***Table 14.***

I have presented the discourses in tabular form so the relationship between the discourse in the interview and the broader power and positioning implications can be considered alongside each other. It is also important to note that the quotes used are not intended to be a demonstrative representation of the discourse. The construction of a discourse as being dominant was based on some instances of isolated discursive construction but also on the overarching patterns of meaning within and across the interviews. Individual examples cannot represent the totality of this, and the quotes have been used as an illustration of this meaning.

Table 14: Summary and consideration of discourses constructing wellbeing in interviews with parents

Wider Social Discourse: Mental Health	
Patterns of meaning: trauma, illness, breakable, functional, mechanical, pre-determined, biological, neurological.	
Deployment in interview:	**Power and positioning implications:**
Health discourses were mostly drawn upon early in the interviews as the participants were directly trying to explain how they understood wellbeing as a concept. This included suggestions of an overlap with MH and the use of mental health constructs to distinguish the two constructs from each other. *“I think mental health generally doesn't, is more about basic functioning… and wellbeing maybe is a more erm positive or bonus kind of looking at it.”* - **Andy** I wonder if the use of health discourse here is a result of the conceptual knot that seems to exist around wellbeing in policy (Spratt, 2017). Discursive resources of health may have offered a sense of clarity in providing an ‘answer’ to a difficult question. In one of the transcripts, there was further use of physiological and health-based terms during the interview. *“…when it's an emotional injury, the expectation that I think one way we as a family do that is, I think we're aware of that and we take that as something that needs to be helped and healed.”* **– Faye**	The wider systems in which this discourse has developed include the development of the National Health Service and as a state-based healthcare system. Review of MH support in this context has led to calls for parity of esteem for MH and physical health treatment and support (DoH, 2012). This could be seen to position experiences of emotional and psychological distress as aligned with physical ill-health and as such individualised, pharmaceutical responses are considered the common-sense treatment approach (Callaghan et al., 2017). When wellbeing is constructed through a health discourse, it is understood as an individual and pathological problem. CYP and their families are positioned as passive recipients of care as patients or clients. In this context, the power and capacity to intervene is positioned with an appropriate professional. Parents are positioned as unable to intervene due to the speciality of intervention assumed to be required and CYP can become the centre of problematic family circumstances (Boulter & Rickwood,

These discursive actions may also reflect the strong association between mental health and wellbeing in current health and education policy – entering wider social discourses through news media outlets and public facing organisations. *“Yeah, I think my immediate thought would be somebody's mental health, just because that just what I would naturally jump to in my mind.”* – **Debbie**	2013). Professionals in universal services may feel similarly disempowered in such contexts as they don’t consider themselves as having a clear role in addressing difficulties which may be considered symptomatic of mental ill-health (Monkman, 2017). Associated action - Promote recognition of MH need in families and schools. - Increase access to targeted MH support for all. Diagnosis and treatment of identified CYP.
Wider Social Discourse: Environmental	
Patterns of meaning: environmental, socioeconomics, stressors, risk and resilience factors, context bound	
Deployment in interview:	**Power and positioning implications:**
This discourse was dominant across the interviews whereby CYP’s wellbeing was constructed as being a product of various environmental factors such as financial position, parent mental health and social position/status. *“I think of our mental health. I think of the mental health of our parents and beyond. I think of children's exposure to social media, life experiences, we've got bereavement in my family…”* – **Faye**	CYP are most often still positioned as passive when wellbeing is constructed by a social determents discourse (Darling, 2007). There is a strong sense of inevitability in the description of circumstances that would undermine CYP wellbeing and to a certain extent CYP were positioned as victims of circumstance. There is some variation in the subject positions available in the context of such discourse for parents and responsible adults. Particularly in discussions of family and community circumstances where parents can be blamed for instances of poor wellbeing, a

"…in a family context, I mean, part of me was thinking, well, it kind of depends on how much food is on the table… that's good for your wellbeing isn't it. And equally when it's not? It's not, you know" – **Ben**

This relates to discursive constructions whereby wellbeing is characterised as relating to systems of psychological functioning that are determined by various experiences delineated by environmental conditions. These discourses were mostly used in negative constructions of wellbeing – allowing participants to offer explanations for individual experiences of wellbeing outside of health and mental health discourse. At times though, participants spoke of characteristics of the environment that were supportive of their efforts to provide a positive family environment for their children's wellbeing.

"… and also to just check in emotionally. I mean for example, homework can be a massive frustration... I find myself getting stressed… My children know how to push my buttons. And when I get riled, I get loud, I know I get loud, and I get high-pitched and I talk really quickly. And [partner] will actually come in and he'll say, 'Stop, I'll take this.' And that gives me time to kind of go, step away" – **Debbie**

There was an overlap here with sociological and psychological discourses including narratives of learned behaviour and wellbeing as an outcome of

discourse which can be tracked to policy (Department for Communities and Local Government, 2016). These families can be interchangeably pitied and vilified but both circumstances constitute an element of othering (Crossley, 2018).

This variation in positioning contributes to a sense of discord in relation to power and responsibility when wellbeing is constructed by this discourse. This could be seen to reflect differing ideologies regarding the responsibility of the state. Power and responsibility could be placed with public officials who have a responsibility to uphold a certain standard of living, or with individual parents to overcome circumstance.

The systems in which psychological discourses have developed are historically related to measurement and understanding of individual differences as the consequences of experiences which could be considered psychologically harmful. This is also represented in SEND policy whereby categories relating to behaviour considered to be challenging have over time become increasingly constructed through the psychological lens of Social, Emotional and Mental Health (SEMH) needs (Department for Education, 2014).

risk and resilience factors. Wellbeing was recognised in these scenarios through physical manifestations of difficult feelings such as challenging behaviour. *"…there were people who were in their class, who would be seen as, from problem families or troubled kids. And they would take great pains to look after them. [Child] would come home from school, and she would talk about poor [classmate], you know, and his troubles kind of thing… and it kind of, and that was, that felt like that was their attitude. You know, that they were slightly more troubled? Not 'bad' or whatever…"* – **Ben** At times this discourse constructed wellbeing as somewhat collective. Participants spoke of their own childhood and patterns of parenting replicating each other in families whilst also talking about intergenerational experiences of social problems affecting communities of people. *"My dad just keeps coming out my mouth. I can't help it you know, it's all the time"* – **Andy** *"I think just about basic life skills as well, because there's lots of kids… [not] being able to use a knife and fork or knowing how the washing machine works. One of these things that for many children, unfortunately, because of their family situation, that's not open to them."* – **Ewan**	Power is also given in such a scenario to those with specialist educational or psychological knowledge. Providers of expert advice and or therapeutic intervention to heal or fix the damage done to a CYP – notably, including EPs. Where wellbeing is constructed by a social determinants discourse alongside one of personal growth, there can be a sense of positioning power and responsibility with the young person to overcome such challenges. In such instances, there is a possibility for CYP to be heroized as an overcomer of adversity/exception to the rule. This could be seen to reflect a neoliberal ideology of personal responsibility which then shifts responsibility for social problems away from those with political power (considered further in the ***Development*** section). <u>Associated action</u> - State based intervention in social disparities (link with rights discourse). - Adaptation and intervention strategies to mediate impact. - Wellbeing support for targeted groups/individuals. - Diagnosis and psychological support for identified CYP.

Wider Social Discourse: Rights	
Patterns of meaning: policy, rights, need, systems, dependent, expected, freedom, safety, liberation, platform for growth	
Deployment in interview:	**Power and positioning implications:**
This discourse was at times deployed alongside the notion of social determinants in relation to ideas of freedom and safety as being necessary for wellbeing and in recognition of certain social circumstances as limiting personal freedoms and opportunity. It was most often evident in discussions which centred on school. School was seen across the interviews as a site to meet the varying needs of CYP and families. There was also an increased sense of collective or community-based constructs in the context of this discourse. *"…there's quite an economic strata sort of middle-class lot right the way through to sort of, say working class, but it's, it's workless class isn't it. And now there's that there is quite an influx of immigrants for a better word that that live in, in [the area], and then yeah, always been included as well."* – **Ben** School was also identified as a space where a collective approach could be advantageous but could also be problematic if approaches were essentially nominal.	There was a particularly direct relationship with positionality in some of the deployment of this discourse. Both power and responsibility were given to professionals in schools as being enactors of policy and as providers in the context of need. The historical context of rights discourse stems back to post war notions of anti-oppression and equality and is often aligned with a welfare-liberal ideology (Spratt, 2017). Power and responsibility are positioned with the state and relevant professionals (such as those in schools) to ensure rights are protected. In this context, there is the possibility for children to be positioned as democratic subjects who are active in the enactment of their rights or as passive recipients of adult legitimisation and support. Young children are constructed as particularly vulnerable in this context and adolescents are seen to have increasing responsibility to act as democratic subjects in their own best interests over time. Parents are positioned as responsible for understanding levels of independence that are appropriate and recognising a balance between freedom and protection.

"… having an ethos that's, what's the word, not imposed, that's too authoritarian. Not 'we're doing this' and just identifying with an ethos, but actually living it."– **Ewan** At some points in the text, discussions of safety and freedom were constructed alongside narratives of developing independence. Wellbeing was then constructed as being a product of appropriate levels of autonomy and agency and expressions of identity – taken from a position of safety. *"But at the moment it's that balance between, she also needs to know that if there is a real problem, the grown up will step in, that she doesn't have to carry all of this on her own, and actually we are big enough and grown up enough to manage this for her if needs be."* – **Debbie** *"… in terms of wellbeing, surely that's a reflection of the fact that they feel genuinely confident enough and trouble free. To be able to think about, you know, what to put on the wall in the bedroom and all the rest of it or, you know."* – ***Andy***	The notion of a right to expression of identity is reflected in theories of recognition which underpin some constructs of social justice (Honneth, 1992) and contributes to the possible positioning of CYP as democratic subjects as they move away from adult care. The combination of generalised expectations in equality and standards of living and expectations of individual recognition reflect considerations of social justice as parity of participation in social life (Fraser, 2001). Associated action: - Legal responsibility of the state outlined in policy. - SEND and Safeguarding procedures in schools. - Democratic systems in schools – collective action. - Targeted awareness raising for protected groups. - Individual campaigns for recognition. - Claims of inequality/lack of access at an individual level.

<table>
<tr><th colspan="2">Tentative discourse identification: Development</th></tr>
<tr><td colspan="2">Patterns of meaning: skills and strategies, commodity, construction, learning, self-care, earned, capacity,</td></tr>
<tr><td>Deployment in interview:</td><td>Power and positioning implications:</td></tr>
<tr><td>A discourse of development was identified based on constructions of identity, personal growth, and the acquisition of a range of skills.

These constructions varied according to the context in which they were deployed and tended to be discussed in the context of school or home. At times the discourse was evident in talk about the explicit learning of skills and strategies to promote, protect or reinforce wellbeing.

<i>“So you know you’re always, you know, trying to look after your wellbeing… all those good intentions that will make you feel better”</i> – Ben
<i>“… looking at trying to get coping mechanisms in them, how do they deal with this challenge, and supporting them through that and trying to help them develop good or more healthy coping strategies.”</i> - Faye

Conversely, a lack of consideration for holistic development was problematic for wellbeing, particularly in a school context.

<i>“…making happy humans, it's almost secondary. It's just not as important [as] the academic side of it. I think we've got it backwards.”</i> - Faye</td><td>A discourse of development and personal growth could be aligned with notions of choice-based self-improvement – something you work on and choose to pursue. These ideas have developed in light of neoliberal ideologies of entrepreneurship of the self and personal responsibility (Sugarman, 2015). These ideas are evident in policy discourse and more broadly in education and can lead the positioning of responsibility for wellbeing on CYP themselves.

Spiritual discourse of finding oneself was sometimes used alongside a developmental discourse which has implications for the possible appeal of neoliberal ideology. The notion that personal choice and effort is appealing as it suggests wellbeing/happiness can be gained through the effortful deployment of skills.

Developmental discourse could also be seen to have strong association with psychology and Piagetian stages of development (Piaget, 1932), as well as notions of the self (self-esteem, self-confidence, self-awareness etc) which have become assimilated into the way we talk about ourselves. This could be seen to differ from entrepreneurship of the self (Sugarman, 2015) to a certain</td></tr>
</table>

It was most evident in the constructions of growth, identity development and confidence across various aspects of life, often in the context of a developing an individual identity. *“... the opportunity, having the opportunity to do these things, because how do you find out you're good at something without the opportunity to try it? And if you are not a kid who perhaps succeeds in the classroom academically, and you might not be much cop on the sports field, maybe your thing in life will be live action role play or the computer coding club, and finding those like-minded kids...”* - **Clare** *“I’ve seen that over the years and that's quite painful to watch at times you know, but you just encourage them. And it's almost like that’s their own journey you can’t do too much for them.”* - **Andy** *“… she refused to race for the school or anything else in case she lost, because her perception was, because she was the small quirky one who could run really fast, and she thought her whole identity would fall apart. She was wrapped up in it.”* - **Ewan** There was also a sense of future looking in some of the constructions: developing skills, strategies, confidence, and clarity of identity towards good wellbeing in the long term.	extent as interests and strengths are not necessarily constructed as related to acquisition or employment. Developmental discourse could be seen to open up possibilities for change more broadly as the notion of development in and of itself implies ongoing change. There are less individualised positions, as the notion of a stage of development would imply that there may be collective or shared experiences with collective responses. There is a possibility within this discourse for power and responsibility to be given to the CYP themselves or shared amongst a number of actors. Parents could be positioned as responsible for cultivating rewarding experiences and/or recognising and challenging a lack of opportunity. School and other systems of support for this age group might also be positioned as responsible depending on the interaction amongst discourses. Associated action: - Age-appropriate curriculum developing autonomy. - Enrichment approaches in curriculum development. - Involvement in diverse array of activities. - Values/interest driven support (person centred/strengths based).

“I think it puts him [in] very good stead because he's got a very strong sense of self and what he wants and who he is and now he's striking out and he's going off to college. He can make those choices” – **Clare** The discourse of development had strong associations in the interviews with discourses of care and philosophical notions of intangible experiences of happiness and with ideas about identity, values, aspiration and possibilities being discovered in adolescence.	
Tentative discourse identification: Recognition	
Patterns of meaning: love, care, respect, safety, parity, identity, connection, community, responsibility, transactional, interaction	
Deployment in interview:	**Power and positioning implications:**
A discourse constructed as recognition was prevalent across all transcripts. Wellbeing was constructed within this discourse as positive emotional experiences of love and connection and also as facilitating a variety of positive experiences more broadly through shared experiences and reciprocal relationships (respect and solidarity) (Honneth, 1992). Some of the constructions were familial in nature; including the importance of unconditional positive regard and of developing trust and parity of esteem.	The power and positioning implications of a recognition discourse seem to be particularly context dependent. Notions of belonging and connectedness have become increasingly prevalent in school contexts and tend to be more one sided in the positioning whereby staff are positioned as meeting the needs of CYP and providing a particular type of environment. More general and familial constructs, related to care, nurture and support varyingly lead to adults as a willing caregiver and/or as part of a wider community of shared responsibility with CYP and other adults.

"I think that contributes to their wellbeing as well, because they know they're in an environment where they're trusted and believed." – **Clare** *"… they loved us without any real conditions at all... there's people out there who'll just do anything for me and I just, I can go through life knowing that"* – **Andy** This was often constructed in relation to emotional openness and availability as an important relational quality and as a characteristic of modern parent-child relationships. *"I have an emotional lexicon that my dad definitely never had. They just didn't have the language for emotional communication… so you know, that opening up emotionally of societies has been a good thing as far as I can see."* - **Ben** Wellbeing was constructed by a recognition discourse across various types of relationships, and friendships were constructed as a relational space of particular value in adolescence. *"… she's got a good friendship group where I think she feels very secure"* – **Debbie**	Friends and community members (as well as parents) are positioned as possible role models and co-regulators or learners. Relational space is seen as providing safety to have and seek other positive experiences and experiment with identity. The notion of various community members (CYP and adults) as a source of mutual connection positions multiple subjects as having collective responsibility for each other's wellbeing and relates to ideologies within community psychology as well as ideals rooted in moral philosophy of recognition (Honneth, 1992). In some of these constructions there was an alignment with a rights discourse from the perspective of collective responsibility. Community members were positioned as being responsible for acts of recognition and support for each other for the benefit of their wellbeing and that of others.

"… when [child] had finished isolating, lockdown had happened proper… and that lack of physical contact started really showing in her mood. As soon as they were able to mix. It was like a light coming on again." – **Ben** Recognition discourse was also evident in conversations about school and the wider community in ideals of safety, connection and reciprocity. *"… all about connecting with the school, connecting with the teacher, the kids that were in that group. It was really well done."* – **Clare** *"… it's almost a wider sense of that as well, that it's just not things that I want for her, when it's like... I don't know, valuing kindness and telling her it's not just for her benefit. I just think there's something there about more of that community and that... It's almost a group feel, looking out for the vulnerable and I don't know"* – **Debbie**	Associated action: - Relational approaches to wellbeing intervention. - Community based practice across schools and other services – broaden scope of relationships. - Collective wellbeing promoted in a democratic context - Principles of recognition and distribution in constructs of justice.

3.5 Discussion

This study adopted a Discourse Analysis methodology to explore how wellbeing was constructed by discourse in conversations among parents. In my reading of the data, the discourses most dominant in constructing wellbeing were mental health, environment, rights, development, and recognition.

The interaction amongst discourses and the variability in the way they were deployed in these interviews could be seen to reflect the discursive complexity of wellbeing indicated in explorations of policy (Spratt, 2017). Developing understanding of the discourse at play in parental constructions can offer a helpful insight into ideologies underpinning perspectives of wellbeing in communities and can highlight opportunities for shared approaches towards positive change for CYP.

As outlined in ***Table 14***, constructions embedded in each of these discourses had related implications for the power, positioning and possible actions for various subjects. These implications, or conditions of possibility, delineate the likely action orientation that would follow in a common-sense manifestation of these constructions in a given context.

3.5.1 Inter-dependent discursive construction

A point of interest developed through analysis of the discourses in the text was the way in which interactions between discourses served to further open up, or close down, the conditions of possibility made available by a discourse alone. Except for the MH discourse, which was mostly independent in its deployment, the discourses were often drawn upon together or alongside each other in the thoughts and experiences shared by participants – having implications for the conditions of possibility.

One aspect of these interactions which I found to be of interest was the overarching impact of a recognition discourse. Patterns of meaning associated with this discourse were evident across the interviews and seemed to frequently serve to broaden the possibilities for positionality and responsibility. The notion of recognition implies the presence of a positive relationship and is aligned with ideas of care, respect and solidarity which would serve to suggest a joint, or collective responsibility – although there were some of instances of disempowerment (in the context of need as pre-cursor to rights) where the child was positioned as cared for without the advantage of voice or choice.

From the perspective of possible partnerships for wellbeing, construction by a recognition discourse also created conditions in which parental and familial roles were attributed more equitable importance as those of professionals and CYP themselves. Connections to familial ideals such as unconditional love positioned parents as being able to change or challenge the direct environment but also to redefine assumptions and constructions about CYP and their wellbeing experiences. Professionals, particularly psychological professionals were afforded this position within many of the discursive contexts.

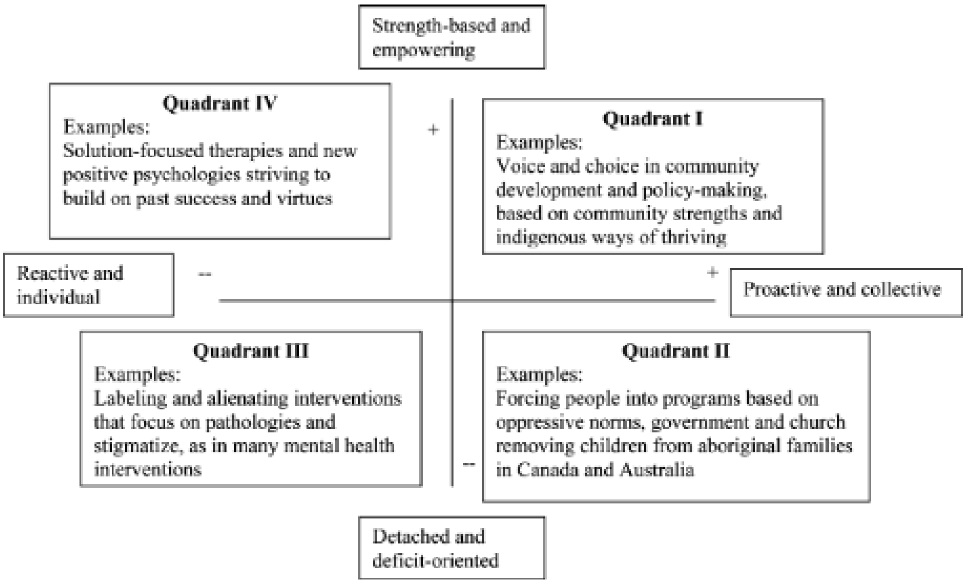
The notion of recognition as an important construct for wellbeing is gaining increasing attention (Fraser, 2001; N. Thomas et al., 2016) and has been previously explored in an education context (N. Thomas et al., 2016). In the interpretation of the discourse constructing wellbeing offered here, the notion of recognition has the potential to conceptualise wellbeing in a way that recognises the importance of social justice and collective responsibility in understanding CYP and family experiences either in its own right (Honneth, 2004) or through the provision of an overarching ideological bridge (Fraser, 2001).

3.5.2 Implications for Practice

When wellbeing was constructed by discourses of environment, rights or development alongside a recognition discourse, the related possibilities for positioning and action were aligned with a conceptual model of wellbeing proposed by Prilleltensky (2014). This model is based on constructs of wellness and social justice that are participatory in nature promoting individual, relational and collective wellbeing through key principles of competence and engagement. In this model Prilleltensky proposes that practice that is Strengths-based, Preventative, Empowering and Community based (SPEC) is facilitative of wellness and fairness (see ***Figure 3***).

The opening up of positions and possibilities when wellbeing was constructed by a recognition discourse made available SPEC practices that could be considered effective in challenging social exclusion and facilitating a ‘parity of participation in social life’ (Axford, 2009; Fraser, 2001) for both CYP and their families. In the context of this interpretive exploration, Prilleltensky's key tenets of competence and engagement could be alternatively represented by recognition theoretical constructs of social justice which frame injustice as encompassing both individual and systemic claims to mis-recognition (Honneth, 2004).

Figure 3: Representation of SPEC model; from Prilleltensky (2014)



Through the promotion of criticality regarding discursive action in constructing wellbeing in education contexts, EPs could diversify the conditions of possibility for constructions, positions and related action to support wellbeing for CYP. Our position as psychological professionals imbues us with the power to change the conditions of possibility in the context of many of the dominant discourses and to invite others to do the same. This highlights the importance of challenging dominant discourses within systems of power, recognising our role as EPs in perpetuating particular ideologies and tracing and reflecting on the consequences of this continued dominance. The explicit promotion of recognition discourse in joint work with schools, families and other professionals could open up the conditions of possibility within systems such as education and health. This could provide a more inclusive and open discursive space for families and offer a platform for collective responsibility and action for wellbeing.

Some explicit actions EPs might take include:

- Use their discursive power as psychological professionals to promote the value of relational practices based in core values of recognition. For example, using this language in day-to-day interactions and providing training about recognition as a way of understanding wellbeing experiences.
- Undertake research projects in the communities in which their practice is based to develop understanding of ideologies underpinning conversations about wellbeing in these families.
- Seek opportunities for development work with colleagues across education, health and care to reflect on discursive diversity and similarity in professional policy and discussion.
- Work with school leaders to develop policy relating to wellbeing and similar constructs such as resilience to promote criticality about the language and related ideologies being promoted.
- Promote and prioritise systemic work which acknowledges the importance of collective wellbeing and preventative practices.
- Provide support for teachers and other adults in education to critically consider the consequences of constructing wellbeing within a particular discourse using familiar practices such as supervision or reflecting teams.
- Use considered, open questions to explore how wellbeing is constructed in day-to-day work with school staff and families.
- Use strength-based empowering language based on recognition of individual interests and skills and outcomes that are clear and relevant to those they describe.

Limitations

The circumstances of this research project meant that the participant group was relatively small and homogenous. If circumstances had allowed, I would have sought to adopt a recruitment approach which was itself based on the community; meeting parents in school and providing face to face discussion of the project. Whilst the aim of the research project was not to establish a replicable or singular truth in relation to discourses constructing wellbeing, more data and a more diverse participant group would have provided greater weight and theoretical generalisability to the perspectives outlined.

3.6 Conclusion

Wellbeing as a construct has the potential to offer a space for the critical consideration of contributions to overall wellness which reject individualistic and pathological constructs of these experiences and the restricted ideas of what being well and positive outcomes can look like. Doing discursive work with families as well as making deliberate, ideologically driven choices in our use of language in daily practice can support EP practice, and practice within the systems we support, to position ourselves in Prilleltensky's Quadrant 1 and pursue collective wellbeing.

Possibilities for action and ways of working outlined in SPEC offer an approach to the overall construction of educational practice that can facilitate parity of participation in social (and educational) life. Principles of empowerment and democracy contribute to a way of working with CYP and families that could redefine the rules of power in discursive contexts and facilitate collective action in response to a lack of such parity.

Chapter 4: Reflections and Projections

4.1 Introduction

Researcher reflexivity has been established as a key factor in the measurement of quality in qualitative research (Mockler, 2014; Willig, 2013). Having offered a methodological account of such in ***Chapter 2***: Methodological Considerations, this final chapter provides an opportunity for prospective and retrospective reflexivity (Attia & Edge, 2017) about the outcomes and process of the research which resonated with me both personally and professionally.

4.2 Personal Reflexivity

In their account of personal reflexivity, Palaganas, Sanchez, Molintas, and Caricativo (2017) refer to the idea of two-fold reflexivity as a researcher’s awareness of shaping and being shaped by research. I will use these two concepts as reflections points for my own personal reflexivity.

Shaping

At the outset of this research process, I had some firmly held values about constructs of justice and morality in education and other aspects of public services derived from early life experiences. I was raised in highly political, working-class environment in a former pit village where the impact of national and local politics on day-to-day life was a subject of frequent debate.

I started the project with an explicit (if ill-examined) interest in the notion of social justice and I saw a large part of my role as an EP as challenging practices which undermined this and promoting those contributing to it or mediating the influence of a lack thereof. I considered such practice to be an example of the EP as an agent of change (Pearl, 1974; Roffey, 2015) which could be considered at the core of much of EPs’ work (Eddleston & Atkinson, 2018; Kennedy, Cameron, & Monsen, 2009). This shaped my inclination to explore social problems reported to disproportionately impact those with low Socio-Economic Status (SES) and other groups considered vulnerable. Ultimately, this contributed significantly to my initial engagement with literature relating to access in MH services and interest in non-professional accounts.

I feel inherently connected to the working-class identity of my early life and accept the shaping affect this has on my research in the many decisions I make as a researcher and practitioner. However, it is important to acknowledge that my personal characteristics and position as perceived by others (a white woman in a middle-class profession) will have shaped the nature of the accounts elicited in interview. It is likely that my access to groups who perceive me as different to them – in some way other - would be restricted and my access to groups who recognise characteristics of their own identity in me would be advantaged (Berger, 2015).

I felt this imbalance was further compounded in the context of researching in a dual role as a practitioner in the Local Authority and a researcher associated with Newcastle University. Whilst this could be seen to lend me credibility as a researcher, I was then in a position to decide if and how to describe my dual role when finding participants (Bell & Nutt, 2002) which balanced transparency with alienation. The duality of my role in systems of power alongside my broader social privilege may have limited the scope of the research. Those considering participation will likely perceive me as having particular viewpoints, assumptions and biases based on these positions of power and as such feel that they are unlikely to be represented or understood (Attia & Edge, 2017).

This pattern of problematic access and engagement in the light of insider/outsider research positions can ultimately contribute to the predisposition towards white middle class as an undisclosed standard in research and the preconception of this experience as the norm, and others as minority or culturally diverse accounts (Dodgson, 2019). It is also likely that I am particularly aware of this limitation due to my own discomfort being positioned in this way. My history means that I am uncomfortable being positioned as other in the context of a working-class identity possibly leading me to over-relate to certain aspects of the participants’ accounts in the process of interview and analysis. A heightened awareness of this potential allowed me to recognise this and critically consider the extent to which this connection was productive or reductive in what was constructed in the participants’ accounts (Berger, 2015; Doucet & Mauthner, 2002).

This process of reflexive writing was itself an exposing process and I recognised in myself an attachment to the ideals of objectivity from my previous learning in psychology. I found myself toying with how much to say and at what point in the reflexive journey - wondering how to talk about my hopes for the research without it seeming that I somehow made this appear in the data. It is through reflection that I understood that of course, as the author of the interpretation I did construct it, but that I did so through a structured and transparent process of analysis with a clear and justified purpose (Graham, 2018). A such, the reader can see for themselves the criticality and transparency of the research and judge its trustworthiness and value in their own context (Dodgson, 2019; Yardley, 2017).

Being Shaped

An aspect of this research that has represented a significant change for me has been my engagement with differing constructs of social justice. I now understand that my long-held view of social justice is underpinned by a specific ideology in relation to justice and morality. Previously, I held fervently to a singular construct of redistribution as the only construct of justice that came from a place of fairness and equity and ultimately of goodness. This had led me to a problematic assumption of moral superiority and disbelief at certain political phenomena. I was initially uncomfortable engaging critically with these problematic assumptions and experiencing the dissonance necessary for change - likely due to the intimate connection to my personal and professional values and self-constructs. However, in finding out about research, practice and policy in MH and Wellbeing, and particularly exploring this from a discursive perspective, my assumptions about different constructs of social justice and the ideologies underpinning them has changed.

The ideological origins of policy and practice in public services and assumptions in dominant social discourses act as catalysts for the constructs, positions and common-sense actions that follow (Arribas-Ayllon & Walkerdine, 2008). Constructs of justice in social discourse embedded in ideologies that differ from mine, such as neoliberalism, cannot be considered inherently problematic or unjust based on principled disagreement of what justice should look like. Whilst I still consider redistribution to be vital in the achievement of social justice in society as it stands, the way I position myself in responding to this has been transformed through examination of social justice in the context of wellbeing.

I have come to understand wellbeing and social justice as inherently linked. The right to wellbeing is explicit in a rights-based construct of justice and is emphasised in relation to good health and participation in society (WHO, 2016). Wellbeing could also be constructed as a measure of just, efficacious practice. The process of undertaking this research has led me to think that, in many contexts, constructs of wellbeing and social justice act as interdependently constructive and constitutive of one another.

Constructs of wellbeing, including those which are dominant in psychology and educational psychology, which position wellbeing as an individual characteristic or experience to be actively pursued or achieved through choice are constructive and constitutive of neoliberal constructs of justice. These perspectives prioritise opportunity and recognition at an individual level and could be seen to minimise or dismiss complex systemic influences on engagement with such possibilities or receipt of this recognition (Fraser, 2001).

The complexity of interdependent and interacting ideologies in the school environment can confuse and polarise approaches seeking to promote social justice. The concept of wellbeing could offer a perspective through which the possibilities and limitations in different constructs of justice can be critically examined. The conceptual framework provided by Fraser (2001), though eliciting discomfort for me in some word use, proposes a potentially unifying construct of parity of participation in social life. This, to me, is fundamentally connected to both justice and wellbeing and could provide an ideological bridge between two camps.

I have increasingly come to understand that approaches to change when addressing social problems can be limited when entrenched in political ideologies. If the aim is to *do* social justice, the focus at a community level should be de-politicised and focused on shared values that incite less division (O'Neil, Hawkins, Levay, Volmert, & Kendall-Taylor, 2018; Speight & Vera, 2009). This is not to say that I no longer see my role as including challenge to unjust practice and the practical use of my position and privilege to challenge and contribute to policy. I think I now have a better understanding of my own position regarding social justice and wellbeing but also that of others. In developing this cultural humility (Fisher, 2019) I am better able to accept and engage with different perspectives, promote and warrant approaches I believe to be socially just and to provide effective challenge to those I don't (MacKay, 2006).

4.3 Implications for research and practice

Viewing these complex constructs from this perspective has led me to problematise aspects of EP responses to problems of wellbeing - or of emotional experiences which are problematic in the context of the classroom.

Over time there has been a development of individualism in education, and some disciplines of psychology which promotes the notion of individual success as being represented by learners who are "self-motivated, self-regulated, and self-adapting" (Martin & McLellan, 2013, p. 174). These notions are linked to similarly psychological actions within therapeutic discourses such as the idea of working on yourself as the route to success and actualisation. Particularly relevant in the context of wellbeing, such discourses could suggest that if we have emotional experiences which undermine the possibility for personal advancement – we are to blame (Foster, 2016).

In the context of current school environments, I wonder whether these approaches could be teaching young people to internalise the expectation that they adjust to the unjust (Sugarman, 2015). Perpetuating this in the way that we intervene as psychological professionals could be seen to demonstrate complicity with individualistic ideologies in education and minimise the influence of social determinants within established systems of power. Whilst I have come to accept that differing ideologies cannot be assumed to be problematic on this basis alone, I think that examination of the purpose of education and of psychology's complicity or contribution to the dominance of a particular discourse is essential to embed ethical reflexivity in research and practice.

Psychology is, and always has been, inherently enmeshed in the social, political, cultural and economic systems of a given time. An eagerness to position psychology in neutrality and objectivity can result in an unwillingness to acknowledge historical and ongoing complicity with socio-political agendas and demonstrates a lack of cultural sensitivity and competence. One of the competency statements outlined by the British Psychological Society (2019, p. 17) impresses on trainee educational psychologists the importance that they:

> “Be aware of attitudes to impairment and disability and where relevant, redress influences which risk diminishing opportunities for all vulnerable children and young people including those with SEND and their families.”

If we are to meet this responsibility, educational psychology must interrogate its ongoing relationship to dominant ideological constructs of education and justice in research and practice and critically reflect on whether the profession is only contributing to the continuation of the status quo or also offering up alternative discourses and ways of seeing and being in the social world (Ball, 2010; Gergen & Zielke, 2006).

4.4 Next steps

As I move forward into my first post as a qualified Educational Psychologist, I hope to continue to develop my understanding of my role as a researcher-practitioner.

Principles of quality in qualitative research such as community engagement, collaboration and reflexivity can be applied to all aspects of my practice. Mockler (2014) explored the value of cross-field effects for teachers as practitioner researchers which is process that could also apply to the EP role. In seeing daily practice through a research lens (R. Parker, 2013), and embedding the learning, reflexivity and transformation from research into my approaches to practice (Mockler, 2014), I hope to develop a way of working rooted in community development and a commitment to the possibility of systemic change for the better in public services. Some specific approaches which could facilitate the first steps towards this are outlined in ***Table 15***.

The ideal of a developing community of practice driven by quality, collaborative research and shared values has the possibility of engineering an approach to applied psychology that can respond to the demands of the current system while pursuing a system that is socially just.

Table 15: Becoming a research-practitioner - some first steps.

	Child and Family	**School and Community**	**LA and Systems of Power**
Research	Undertake research with CYP to further develop understanding of constructs of wellbeing. Offer voice and choice through collaborative research projects.	Develop research with communities in relation to social justice and wellbeing. Consider how conceptual frameworks from Prilleltensky (2005) and Fraser (2001) could shape this.	Share and promote research with CYP to further develop understanding of constructs of wellbeing. Offer voice and choice through collaborative research projects.
Research-Practitioner	Consider the language and discourses drawn upon in consultation (in particular personal responsibility narratives) and aim to make available alternative ways of being in relation to how the young person and the problem could be viewed (Frohm & Beehler, 2010; Pearl, 1974). Consider how approaches I have felt aligned with (such as self-regulation and Acceptance and Commitment Therapy) could be problematic in their redirection of responsibility to the young person (Martin & McLellan,	Applying principles of discursive psychology and discourse analysis (Parker, 1992; I. Parker, 2013) can help us to provide a critical understanding of discursive objects within education and educational psychology and corresponding positions and possibilities for action (Spratt, 2017). Provide critical space to deconstruct and reconstruct MH and Wellbeing and other impactful constructs with other professionals – supervision of school staff?	Resisting the construction of EPs as being necessarily positioned only within a SEND context by promoting skills in research and organisational development. Promote constructs of social justice that can have broad appeal and effect – consider evaluation against SPEC (Prilleltensky, 2014). Seek to engage with MH and Wellbeing work across agencies and work with other services with cultural humility (Fisher, 2019) to track the

	Child and Family	School and Community	LA and Systems of Power
	2007). Could they be adapted to a collective strategy to decide on appropriate sharing of responsibilities. Consider the role of advocacy and complex responsibilities in practice – use supervision to reflect. Relational justice – process driven in moments with others. Use understanding and experience to suggest acceptable and accessible ways change might take place. Promoting relational and restorative rather than punitive constructs of behaviour.	Focus on prevention and promotion at a community level when measuring and intervening in wellbeing in school (Roffey, 2015). Change could be achieved through direct work with members of the wider community - both in incidental contact though day to day practice and explicitly in change projects. Critical consideration of common training and school development work we do, and the practices we see, which are associated with psychology (e.g., wellbeing, attachment, ACES etc.). Any knowledge, understanding or construct can be presented in context of assumptions and positioning if we make it an ethical priority.	consequences of linguistic and discursive choices. EPs can contribute to reconstruction through direct involvement and contribution to transformative policy change (Nelson, 2013; Prilleltensky et al., 1997). Nelson's (2013) paper provides an outline of how positions of relative power can be manifested for change. He offers an extensive consideration of the place for psychologists in a form of professional activism to promote community resilience, political awareness and makes use of various aspects of the neoliberal context.

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Appendices

Appendix 1: Development of Key Terms

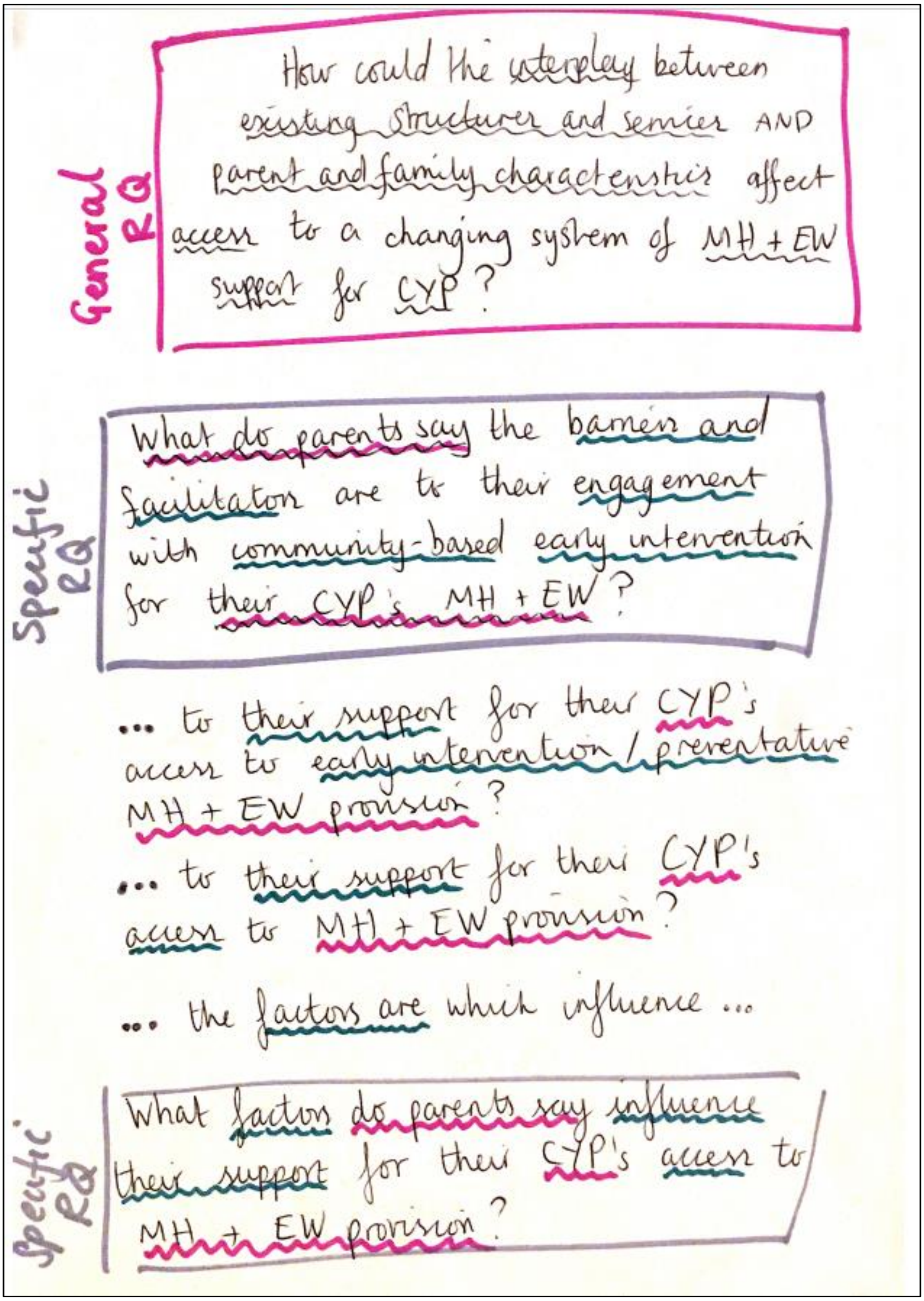
Main Terms	**Synonyms**	**Related Terms**	**Alternative Spellings**	**Controlled Vocabulary**
Parent	Carers Caregivers	Family Parental		Parent*
Parent characteristics	Parental role Parent factors	Family factors Family characteristics	Hyphenated? E.g. parental-role	Combined phrases e.g. “parental role”
Access to	Treatment attendance Treatment Barriers Service Access Barriers to	Help-Seeking Service-use Intervention Participation Involvement Engagement		Combined phrases e.g. “help seeking” “service use”
? Preventative support	Preventative programs Early Intervention Prevention Support	Community-based support Family support? Treatment Child services		
Children	Child Young-people Adolescents	Child’s Teens Teenager		Child*
Mental Health	Wellbeing	Mental Health Problems Mental Health Disorders?	Well-being Behavioral	Combined phrases + Behavio*r*

		Emotional and Behavioural Problems		

? Does this narrow too much at this stage?

? Does this fit with my question?

Appendix 2: From Research Interest to Research Question



General RQ

How could the interplay between existing structures and services AND parent and family characteristics affect access to a changing system of MH + EW support for CYP?

Specific RQ

What do parents say the barriers and facilitators are to their engagement with community-based early intervention for their CYP's MH + EW?

... to their support for their CYP's access to early intervention / preventative MH + EW provision?

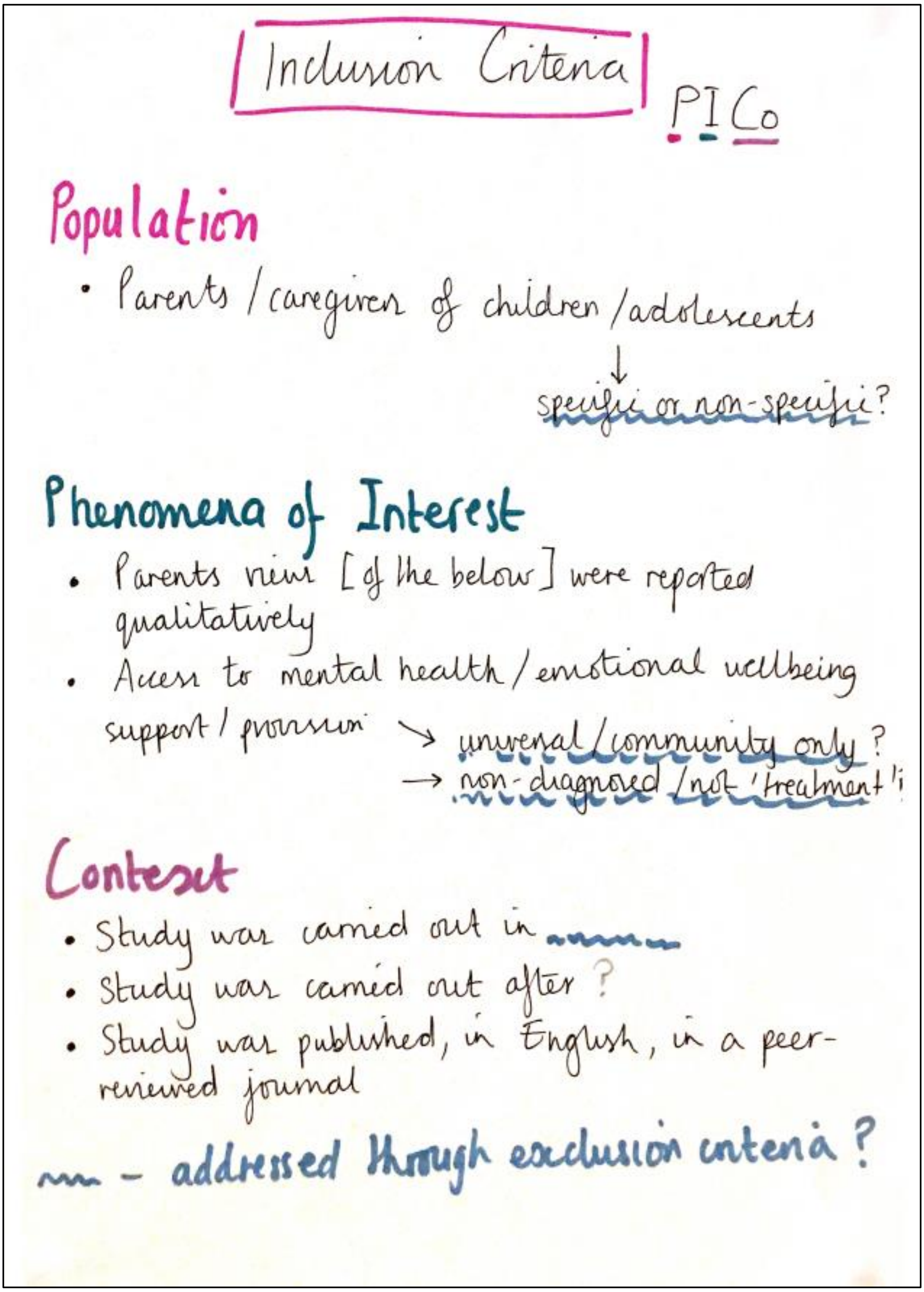
... to their support for their CYP's access to MH + EW provision?

... the factors are which influence ...

Specific RQ

What factors do parents say influence their support for their CYP's access to MH + EW provision?

Appendix 3: Considering Inclusion and Exclusion Criteria using 'PICo'



Inclusion Criteria

PICo

Population

- Parents / caregivers of children / adolescents

↓ specific or non-specific?

Phenomena of Interest

- Parents views [of the below] were reported qualitatively
- Access to mental health / emotional wellbeing support / provision
  - → universal / community only ?
  - → non-diagnosed / not 'treatment'?

Context

- Study was carried out in ∼∼∼
- Study was carried out after ?
- Study was published, in English, in a peer-reviewed journal

∼∼ - addressed through exclusion criteria ?

Appendix 4: Demographic Information

Authors	Participants	Data Collection	Setting
Baker-Ericzen, Jenkins & Haine-Schlagel (2013)	Therapists [n= 26] ***Parents [n=14] of children aged 5 -13 in receipt of treatment for Disruptive Behaviour Problems (DBPs)*** Youths interviews [n=10]	Focus groups and interviews **Focus groups used for relevant data – parents** **Focus groups lasted 1.5 – 2hrs** Participants discussed perceived barriers to effective treatment, the problems with current child outpatient therapy and desired changes to improve MH services. Open ended stimulus questions provided to each stakeholder group (1) their experiences in community mental health services; (2) problems they encounter in participating in treatment, and (3) ways to improve usual care practices All verbal and non-verbal responses were recorded No fixed, a priori hypothesis	USA A metropolitan county in Southern California 6 Large community child MH clinics – selected as clinician recruitment sites because they represent the largest contractors for publically funded, clinic based out-patient care for children in the county. Geographical diversity Race/ethnic diversity (but inclusion criteria had a requirement to be ‘English speaking’.)

Boulter & Rickwood (2013)	15 Parents; 14 mothers and 1 father. Between ages of 25 – 61 Sought professional (school counsellor, doctor, paediatrician, and psychologist) help at any point in time for their child's mental health problems. Nearly all participants were well educated mothers from high socio-economic status. Half had self-reported mental health difficulties.	Aim: '…to gain an insight into parent's experiences of seeking help for their children with mental health problems… an exploration of the whole help-seeking process from the parental perspective..' pg 133 Method – semi-structured interviews. Questions re: parents perceptions of the: a) nature of the mental health problem b) way parents/families coped ***c) types of help sought*** ***d) ways help was sought*** ***e) factors that influenced decision to seek help*** Thematic analysis (Braun and Clarke) undertaken. Four frequency levels reported: General (all or all but one), typical (more than half), variant (more than two but less than half), rare, (two cases).	One location in Australia. Group reported as being particularly homogenous; high socio-economic status.

	Recruitment to saturation of themes.	‘Essentialist or realistic method perspective was applied reporting experiences meaning and reality of participants’ Inductive and data driven – focused on identifying salient themes repeated across and within transcripts.	
Cohen, Calderon, Salinas, SenGupta, & Reiter, (2012)	**24 parents** 22 mothers 13 Parents attended focus groups 11 Couldn’t attend and were interviewed over the telephone. 16/24 parents listed Spanish as preferred language. HFP tends to serve high proportions of Latino families.	Aim: interest in parents perceptions of pathways to care. General research questions: a) How and when did parents make the decision to seek care? b) What type of response did parents receive from professionals? c) What were their impressions of first contacts with specialty mental health clinicians? d) What were their experiences working with health plans and providers in the early stages of referral, assessment and treatment? Focus groups and telephone interviews; two thematic concepts: • Use of literature regarding help seeking	USA – enrolled in a state health insurance program. No access to parents in depth characteristics. Parent education, child’s diagnosis, family income, mental health history

		- An evaluation plan in the contract with the state agency re: satisfaction, perceived quality, timelines and barriers. Interpreters were present where needed. Analysis strategy involved finding instances of pre-determined thematic concepts. Unanticipated thematic ideas were identified individually and discussed as a team.	
Crouch, Reardon, Farrington, Glover, & Creswell (2019)	Parents of 16 children aged 7 – 12 years. Referred to a child mental health service for anxiety (CAMHS). Purposive sampling – varied views and experiences. Majority female and white British.	Aim: to understand families' experiences of seeking help and accessing specialist treatment for difficulties with childhood anxiety. Interviews undertaken until theoretical saturation was reached. Questionnaires completed and returned prior to interviews for demographics and child anxiety scales. Semi-structured, topic-guided interviews over the telephone.	Berkshire Healthcare NHS Foundation. Higher professional 9/15

		(a) recognition of the child's difficulties with anxiety, (b) parents' experiences of seeking both informal and formal help, (c) support families sought and received from different professionals, and (d) families' experiences of accessing CAMHS Thematic analysis approach to data; inductive.	
Smith, Linnemeyer, Scalise, & Hamilton (2013)	63 parents of children admitted to an inpatient psychiatric ward aged 23 - 63. 68% Caucasian; just under half earning under $30,000 OR 52% over $30,000. 25% of children had been in foster or state care.	Threefold purposes: 1. Most commonly reported barriers to outpatient treatment. 2. Relationships between demographics and reported barriers ***3. Explore open-ended responses from parents regarding barriers to outpatient treatment and their recommendations.*** Questionnaire w/extended qualitative questions.	USA Conducted in one Midwestern hospital; retrospective views of outpatient experiences for current inpatients.

	31 participants responded to the 'qualitative' element of the study (this is just under half). - 58% earn over $30,000 Choice to respond could indicate extreme experiences and choice not to could indicate barriers due to written questionnaire.	***a) What other issues have you faced in trying to get the mental health treatment you need for your child?*** ***b) What suggestions would you have that may help parents/guardians to receive the mental health services that are recommended for their children?*** c) Comments about coming to treatment. Mixed methods used – phenomenological methodological approach to identifying themes. Narrative analyses conducted to identify overarching thematic categories.	
Walter, Yuan, Morocho, & Thekkedath (2018)	18 parents recruited from urban community health and early childcare centres.	Aim: to identify predisposing, enabling and need factors that influence engagement and retention of young children in mental health care from parents' perspectives. Towards optimal health outcomes through improved access and retention.	USA; Massachusetts. Chosen due to robust system of care for children with and at risk of mental health [disorders].

		Qualitative interviews conducted using the Gelberg-Anderson behavioural model for vulnerable populations (a model of access to care). Semi-structured interview guide used – qualitative coding conducted. Codes were organised onto existing primary and secondary nodes as indicated by the GAB model.	Providers of health and social services to families. 6 Community Health Centres 3 Early Childcare Centres

Appendix 5: Data Extraction

Paper 1: Therapist, Parent and Youth Perspectives of Treatment Barriers to Family-Focused Community Outpatient Mental Health Service (Baker-Ericzen et al., 2013)

1st Order Data	2nd Order Data
“Usually it was because I was so exhausted from him pushing and pushing I was dead, nothing left.” “I think that really when you are afraid of your own child, of them hurting you and you can’t touch them or they are going to call CPS or tell the therapist, it changes the relationship” “Everything we do is wrong, everything we do doesn’t work with her.” “It drains you it absolutely drains you. Every morning you get up and go ok what phone call am I going to get today?” “And it is a constant struggle with too much help, not enough help and nobody really to guide you”	‘…overwhelmed by their youth’s symptoms and problems’ ‘… frustrated with service delivery [of family focused therapy]’ ‘… not feeling supported by formal service systems’ … feeling blamed and ignored by their therapist’ ‘…feeling dissatisfied with mental health services’ ‘…substantial lack of support for them in addressing their youth’s needs’ ‘… lack of service system coordination’

1st Order Data	2nd Order Data
“I don’t know what these people want me to do – I have done everything they have told me to do.” “It’s not that I’m not being a parent but when you get in front of these people, the teachers, the CPS – you feel like you are one of the kids” “So you’re reaching out to get some help and they come over and slap your hand.” “And that’s been really frustrating and that’s when you just think ‘oh my God why don’t [the therapists] believe me?’” “They would bring things up and I would just feel myself turning red. I always felt like I was having a major hot flash right then and I would just feel like I was being blamed” “They don’t listen they don’t really care what you got to say. All they care about is what they got to tell you”	‘… ineffective treatment strategies’ ‘… feel unimportant and disinterested in their youth’s treatment [as a result of feeling blamed]’ ‘’… did not seem confident in the therapy process’ ‘… dissatisfaction as a significant source of frustration’ Parents are sensitive to judgements – may need open acknowledgement of struggles and efforts in parenting. Feeling blamed and ignored impacts attitude about service delivery this can make them feel uncomfortable and resistant to participation. Need to feel like part of the solution (shared decision making?).

1st Order Data	2nd Order Data
“That is what is so frustrating, sometimes some of these people already have an assessment” “It is very hard when the professionals don’t understand. You know they look at the parents who are tired by the time they get to that point and they just gather the same old information from them.” “We’ve been to therapists who don’t understand at all.” “And you know he wasn’t really saying anything. I was kind of wasting my time” “Yeah and they came in acting like we never tried stupid sticker charts. And they wouldn’t believe me when I said sticker charts, poker chips, whatever you want to use is not going to work.” “And you know sometimes the extreme behaviour problems I don’t think the mental health system is prepared to deal with”	Misunderstandings of process including goals and strategies. Value openness and connection with those who have shared experiences. Need for hope. Parents and therapists have different values in relation to hoped-for outcomes of treatment. Need for acceptance and support. Parents generally perceive their needs as isolated from youth’s therapy. Want to be heard and violated. Clarity and transparency of communication.

1st Order Data	2nd Order Data
"… that is how I feel his treatment is. I feel like the arms are doing something and it is not connected to the head." "And what really bothered me about [therapy] was not only was I wasting my time but my other four kids are sitting out there for an hour. And the drive and all that junk. And it was just a waste of their whole day" "And now you know I have been and talked to four therapists, the police, everybody and no-one has an answer for me for that."	Co-ordinated service systems. Contradiction of family 'scrutiny' in individual therapy approach. Communication strategies which do not convey blame/causation (therapeutic alliance).
General thinking	
Some of the 1st order data which is themed by the researchers as being overwhelmed and frustrated could alternatively be themed together in the sense of powerlessness and/or uncertainty. A sense of the therapeutic context being another area of life where they were made to feel incompetent. The data presented as support for feeling blamed/judged seems to have an increased level of physicality in the description. This makes me question the directionality of some of the researcher's interpretations. It seems like a sense of exposure in this context brought about a feeling of physical discomfort or even humiliation. Could it be that a fear of exposure and ongoing sense of incompetence heightens parent's sensitivity to language and exploration which could indicate blame or judgement? Data regarding dissatisfaction could be seen from the perspective of differing expectations and lack of clarity in communication.	

Paper 2: Parents' experience of seeking help for children with mental health problems (Boulter & Rickwood, 2013)

This data was originally collected from the perspective of help-seeking which is an important element of access – in addition there is information regarding broader experiences which can offer insight into avoidance of attrition.

1st Order Data	2nd Order Data
"It was a lack of coping as parents and… the family being upset all the time" "He was really different that the other children and his behaviour wasn't normal at all. It was too bizarre" "I could relate to it. There was no way I wanted her to go through the things that I went through when I was younger" "She was really upset about her own problems"	Pathways to mental health care …initiation pathways (parent/school) … nature of the CYPs problem (emotional/ behavioural) … contact with multiple services (leading to delay) … dissatisfaction with specialist service provider (following referral) … perception of the service as inadequate or ineffective …capacity for persistence … capacity to negotiate multiple contacts

1st Order Data	2nd Order Data
“It was partly because his grandparents and his teacher said things to us” “That was really helpful to teach her to think things through… it’s certainly given her some strategies and she really enjoyed it” “And then we went to another paediatrician who said that we should be able to manage without medication, but didn’t give us anything that was terribly helpful” “I wanted to get an explanation and the psychologist diagnosed him… it was helpful because I guess I needed confirmation about my son’s behaviour” “So we sort of felt once the diagnosis was made it was kind of ‘well off you go, you’ve	… mother as primary help seeker … nature of ‘informal’ support available Intra and Inter personal influences on help-seeking choices … *concern about impact on family* …desire to alleviate emotional impact (frustration, guilt, stress etc.) … not being able to cope/manage … escalation of problem and related impact …*recognition that CYP was ‘different’* … impact of other people’s concerns …child’s own expression of distress

1st Order Data	2nd Order Data
got your diagnosis' off you go now and try and deal with it" "We finally got a referral, which took a long time and then when we actually went in there, they actually said that she didn't have a serious enough problem to warrant their, help and unfortunately it just sort of went from there" "[the service] was helpful because one of their comments was, if she won't come to see us she obviously needs help, and we'll come out to see her" "So yes just that validation, I guess, was probably the first most important thing"	…suggestions from others (teacher and family)act as a push to seek help sooner … denial of problems in the family network … family members judgemental, critical and dismissive of concerns (help-seeking alone) … *recognition of family 'vulnerability'* … awareness of similar problems in the family Impact of service use experiences on future help-seeking … practical support (fit) …knowledgeable service providers that gave useful strategies and advice …provided insufficient support and information …availability/receipt of diagnosis

1st Order Data	2nd Order Data
“You’re made to feel welcome, you know there’s no judgemental atmosphere in the way that the staff treat you” “It’s also difficult to be told as a parent to go and get more skills when you’ve done all the courses and read all the books you think are reasonable and you don’t know the skills you’re missing” “My daughter managed to actually from a good relationship with her and has a lot of trust in her, which is something she hasn’t been able to do in the past” “I think the psychologist started at the wrong end with her problems. She needed to speak to her more before she started the relaxation techniques. I don’t know. My daughter didn’t feel comfortable with her”	… delays to diagnosis and ‘wrong’ diagnosis led to frustration … explanation of diagnosis … diagnosis was often followed by seeking of informal help (able to name the need identify sources of support) … flexibility, accessibility and responsiveness …emotional support (feeling) … child’s problems validated as real … diagnosis led to relief of guilt and responsibility for child’s problems … feeling of being judged/dismissed/criticised … trustworthy workers with good rapport (safe place)

<table>
<tr><th>1st Order Data</th><th>2nd Order Data</th></tr>
<tr><td>“They’ve listened to her, I think, and then if I’ve got questions, they’ll answer my questions as well. You know I have the option of either going in with her or not”
“I thought that was extremely helpful because it sort of empowered her to take charge of her own problem”</td><td>… empowerment and hope
… support from workers provided relief from burden of responsibility
… inclusion in treatment
Parental education and experience of mental health services decrease uncertainty about child’s problems and increase help seeking.</td></tr>
<tr><th colspan="2">General Thinking</th></tr>
<tr><td colspan="2">Something here about what is perceived as being an arrival at ‘help’. School psychologists referred to as a step towards help. Not as the help itself.
Indication that most seek ‘informal’ help (family and friends, parent support groups, self-help resources) but does this influence access to services?
Theme of inter and intra personal influence links with judgement and blame. Seems the most emotional area.
Mention of stigma and labels in the context of diagnosis – so formal diagnosis is more important than this?
Could this indicate that the concern about being seen as at fault or incompetent as a parent takes priority over concerns about stigma for the child? Is particularly relevant for this participant group?
What is meant by ‘the right mental health care’? Does this just mean the care parents expected? Something here about the importance of mental health education in relation to symptom recognition and available services. Familiarity = recognition.</td></tr>
</table>

Paper 3: Parents' perspectives on access to child and adolescent mental health services (Cohen et al., 2012).

1st Order Data	**2nd Order Data**
“I called because when my daughter was between two to three and a half years old we noticed she had some attention deficit problems. I noticed something was wrong and I took her to the doctor (we had Kaiser at the time). I just felt something was wrong. I took her to see a counsellor; I was so mad because the psychologist said I needed to learn to be a parent. I didn’t think so.” “When I asked the school about my son, they said he was immature. They didn’t want to give me a referral to get him tested. I think schools need more training; they can just refer and maybe it is that he is just immature, but at least give him the evaluation so you can have peace of mind. I had to wait so long because the school just thinks he’s immature.”	Identifying the problem and reaction from others … Nature of the problem presentation (often behavioural) … Difficulty convincing others of problems … Parents unsure of the nature/extent of a problem … Ambivalent/dismissive responses (discouraging OR more persistent) … Knowledgeability of parents (in the face of discouragement) … Teacher/school staff noticing and communicating behaviour problems (validation outside of home?) … School response (major support or frustrating barrier)

1st Order Data	**2nd Order Data**
“I know a lot [now about these issues]. I have time to go to the school. I always send [my son] to the school and they return him to the house because of the behavior. I tell them if he needs one-on-one attention, they need to provide it.” “My child, when he was 3 years old, he had a very explosive temperament. The doctor kept asking what the problem was. I would explain to the doctor that it was a behavior problem. The doctor didn’t want to refer him to a psychiatrist and just wanted to give him medicine. I said no. I felt he needed an evaluation first. I went for help at school.” “...my son was diagnosed with ADHD ...his pediatrician asked [a provider] to do an assessment, months and months after he was diagnosed. I had to wait for five months to get an appointment after his evaluation . . . and the school didn’t want to have him tested with their credentials so I had to write a	… View of teachers/those suggesting MH problem … Persistence over several years to get assistance … Parents attention to CYP need and time to engage with providers … Knowledge about dealing with school systems (social capital) … Qualification for specific targeted services [SEND] The role of the primary care physician. … The nature of early contacts with primary care physician (very effective or frustrating) … Recommendations from trusted professionals (doctor) … Responses which validated … Responses which provided empathy

1st Order Data	2nd Order Data
letter to the [school] board. It took almost two years [for the school to consider an SED evaluation].” “I was told, after I go to the referral, that there was a very long wait list, like 3–4 months. The receptionist I talked to said I need to call the insurance company.” “When they diagnosed my son with ADD, the doctor, the pediatrician, sent him to mental health but they didn’t accept him because they said he didn’t qualify (this was when he was 7). When his behavior was worse, they sent him to mental health and they accepted him.” “Of the five [phone numbers given for mental health clinicians] only 2 called back. They only gave me 20 sessions and only gave me medication. I called to get more sessions. They said no. They said maybe she needs medication. I said no, I don’t want to give	… Responses which present concrete options … Perception of reasons for treatment (medication as a response of convenience) … Explanation of treatment offered by clinicians … fit of advice given with parents’ wishes (could lead to pseudo-agreement and no treatment) The first appointments … delay for appointment with mental health clinician … Professionals’ perception of ‘severity’ of problem and need for intervention (differing to parents) Admin procedures in accessing care … Administrative requirements as barriers to continuing care

1st Order Data	2nd Order Data
her medication. They gave her five more sessions. They said maybe another [clinician] can work well again. They gave me five more numbers. One called back.” “Once I got the right person, things happened very fast.” “My son went to therapy maybe a year, when he was between 4 and 5. But it was difficult because interns would see him, not actual psychologists but people studying to be psychologists. My daughter is with another health plan and they give her another referral and I could put my son with the same doctor. But in June last year was the last appointment and they haven’t called back again to set another appointment.” “My son also stopped taking the medication. Up to now, I don’t know what his diagnosis is. Ever since	… Disagreement with professionals about treatment options [medication] unresolved … Parents familiarity with mental health systems and procedures … Language and literacy of parents … Clarity and communication re: function of admin procedures The treatment process … Direct support for facilitating access … Number of attempts for assessment … Movement between providers/clinicians (discontinuity) … Different professionals with different perspectives (causes confusion about pursuing treatment)

1st Order Data	2nd Order Data
then I don’t go to any other doctor. His academics are at an average, like C’s, but he has a really bad temper and everybody has to please him, whatever he wants everybody has to give it to him. I’m not sure if it’s Autism or he’s just being a bad child. I don’t know how to get him to see a doctor because he [the son] says he doesn’t have anything wrong with him.” “I always look for Latino doctors. They just seem to understand my problem better.” “Sometimes the doctors don’t want to listen to you, just want to listen to the child. My son didn’t speak until he was three years old. They want attention; they’re bored. . . . I had the option of putting my son on medication and I didn’t. One counsellor told me that her brother grew up using medications, and now he’s a teacher and still taking the medication. The other person didn’t take medication and he was fine.	… Assertiveness in the face of professional/system responses … Cultural differences in perception/ understanding of the role of providers Culture, language and stigma … Understanding systems and when/whether to get care … Effective communication of complex ideas (language barrier) … Uncertainty about role in getting CYP to return to care … Stigma about mental illness (cultural factors) … Fears about long term dependence on treatment Parents recommendations … Education about the mental health process

1st Order Data	2nd Order Data
My son, when he gets in trouble, says he wants to see the counsellor. I say no, you don't want to become dependent on the counsellor. You only get coverage until you're 19; you can't always have it." "My son has been to different schools; my daughter has been to six different schools. The schools can't find a good program for her."	… School as a site for education of many groups and services … Opportunities to talk to other parents with similar problems … Consultation with parents re targeting problems and suggesting improvements … Perceptions of severity/urgency influences view of barriers and help-seeking persistence … Provider education about specific populations and culturally defined presentations
General thinking	

Paper 4: “Just keep pushing”: Parents' experiences of accessing child and adolescent mental health services for child anxiety problems (Crouch et al., 2019).

1st Order Data	2nd Order Data
“I don't think there are very many people who can associate this sort of behaviour with anxiety. Often it will come across as disruptive behaviour.”	Parental Recognition … *nature of child’s difficulties* … difficulty identifying problems as symptoms of anxiety
“I thought it was just all the autism thing really, I was not sure what it was.”	… comorbidities hindered ability to recognise anxiety symptoms
“It's been a longer process because we've had to deal with his medical situations, the brain injury … the delay in getting to the GP was mostly because I was caring for my son.”	… addressing co-morbid difficulties as a barrier (medical priorities for example) *… family and friends*
“My friend's husband said he can't be [anxious or depressed], so I just kind of brushed it off.”	… discouragement/dismissal from family and friends deterred professional help-seeking

1st Order Data	2nd Order Data
“It was becoming more and more apparent that there were differences between him and his peer group.”	… comparison to other children and siblings – prompt for recognition and help-seeking
“I've got older children, so I knew that something wasn't right.”	… siblings with similar difficulties impacts the support they access (different needs)
“When you have two children suffering from the same problem, if you start encouraging one to talk about it and the other one isn't ready, it becomes counterproductive.”	*… delay* … when symptoms had always been there, difficult to know when to seek help
“You put up with it for a long time and then there's a point when you break … when you refer yourself to CAMHS or to anybody you waited till the last minute, till you can't cope.”	… help-seeking occurs when most in need/in crisis
	Contact with professionals
“He acts on [my concerns] straight away and that's probably because he knows that I know when [my child's] got a problem.”	*… General Practitioners* … contact with GPs – feeling listened to
“It was nice that someone saw the problems he had and actually took them seriously.”	… contact with GPs – taken seriously

1st Order Data	2nd Order Data
“[The GP] said it's okay we've seen this before, you're not on your own, there is help. It was really reassuring.” “The doctor was brilliant, she referred me straight away.” “He's had his nausea, he's now got a [sick] phobia … we went to the GP because he had a lump in his throat, he can't swallow again … to see that there wasn't actually anything wrong with him and he's got some medication for acid [reflux].” “School are really good, they really do acknowledge that he's got problems and they do try and help him.” “I went into school and they did a referral, so that's where it all began.” “It was quite easy to talk to his teacher, the SENCO, and head teacher, so I think they were very supportive.”	… contact with GPs – trusted judgement … contact with GPs – showed empathy … recognition of need and reassurance that it’s not uncommon … quick responses and referrals from GPs … [GP] skill in differentiating between physical and mental health difficulties *… school staff* … school staff recognising and acting on a child’s anxiety difficulties … providing support in school or referring to specialists … nature of relationships with school staff, starting conversations, accepting/taking advice, seeking and accessing specialists

1st Order Data	2nd Order Data
“[The teacher said] if you feel like you're not managing it, go to the doctors … I hadn't even thought this was something to go to the doctor about before she said that.” “Alex's [anxiety] is such a silent thing and they say he's absolutely fine, they don't really believe it.” “We did bring it up with the school on lots of occasions … but no one believed us because it never happened at school.” “CAMHS wrote back and said your GP can't refer you we've got to go back through the school and then we waited another six months trying to get school on board.” “So first of all I contacted [the autism worker], I knew she was my first call of contact.” “[The paediatrician] then decided that she would do another referral … and that referral has been more successful.”	*… other professionals* … CYP/families with contact with other professionals saw them as a first contact (facilitated access) Reaching CAMHS … meeting service criteria (box ticking as a barrier) *...waitlist* … led to seeking support elsewhere … delay to treatment means treatment is no longer appropriate … peer support whilst on waiting list *… contact with clinicians* ... contact maintained during waitlist period (made process easier)

1st Order Data	2nd Order Data
“She wasn't ticking all the boxes for all the criteria … she was ticking boxes across everything, but not enough in each box.” “When we finally came to have the treatment he basically was over it … so it was a bit of a waste.” “I did take on a private psychologist at one point because CAMHS is just too long to wait.” “We wouldn't go for a re-referral because of the [waitlist] time.” “You could get in contact I suppose with other parents … in that time … more parent to parent support before you get seen.”	… comfort in initial assessment (impacts on perception on subsequent treatment) … recommendations of resources and materials for reference/education … learning and resources led to effective long-term self-help capacities Administrative and non-clinical issues … ‘understand-ability’ of appointment and information letters Funding and resources … empathy and understanding for staff … difficulties seen as due to lack of staff and restricting workload of staff

1^{st} Order Data	2^{nd} Order Data
“She was giving me strategies to try with Lily [during the waitlist period] until I'd had any more information about the course.” “It was very open, we all felt very relaxed in that we could be emotional. It was a really nice environment.” “When I told her we had to go back she was actually looking forward to it.” “Before I went on the CBT course I'd already read the book … and it was very useful.” “She said to me that I could go on certain websites and find out information which is what I did.” “[The waitlist] is the really hard prime bit when you feel very much alone.”	Parental effort *… managing the anxiety* … availability/access to knowledge and strategies to help at home … availability/access to workshops and courses to develop skills to help … availability/access to community support *… persistent help-seeking* … repeated contact with universal services led to access to specialist services … professionals advising parents to ‘push’ Parental knowledge and concerns

1st Order Data	**2nd Order Data**
“Just a mid-wait call to ring up and say ‘I'm just touching base with you again, this is what we expect to be the period of time that you'll now need to wait’.” “[The forms] are not straight forward … is something that's going to put people off.” “I thought, there's no point getting any professional help if we can try and manage it, I did look into CBT and tried it.” “I had started working on everything I possibly could, so I had been on [a workshop], I've had a mindfulness course to help him, there were a whole list of things.” “I wondered whether I could organise a local sort of OCD [children's group].” “We got other people to listen to us through school … [school staff] did start contacting CAMHS to say we really need some help.”	*… uncertainty* … uncertainty about how long they will wait … uncertain how to help while waiting … uncertain about ongoing/continual care (processes for re-engaging) … uncertainty leads to delayed decision making (and access as a result) … uncertainty about the services/support actually available (decision making is more difficult) Concerns … processes for ongoing support after treatment completion

1st Order Data	2nd Order Data
“[The legal professionals] are saying you must still chase the NHS … see if you can get him up on the waiting list.” “Just keep pushing … keep phoning, keep on at the doctor until you do get [the support].” “School asked me to chase it up so I did, then the next thing I know I've got an appointment come through. “I was a bit anxious about how long it would all take … and I still don't know.” “You're just left in limbo because you're not sure … am I saying the wrong thing, am I making it worse.” “I'm not sure how to deal with it if we aren't doing good … am I completely discharged from CAMHS, do I have a contact … I don't actually know.”	… co-morbidity and reluctance to depend on one source of treatment … mental health stigma … concern about being blamed … impact of possible future stigma (records) … families particularly influenced by MH stigma (professional awareness of this) … importance of regular, clear communication w/services during wait times … heightened awareness and understanding of MH difficulties among parents and general population … highly accessible information on the signs and symptoms of anxiety

1st Order Data	2nd Order Data
“The school were saying ‘what can we do to support’ and I was like ‘I don't know.’” “It's a leap of faith because you're engaging with an organisation you know very little about, so it's making that choice without having all the information.” “I did say I'm uncomfortable discharging him because if they decide not to prescribe him [the medication], then we'll be straight back on the pathway again.” “Admitting that your child has a mental health problem is obviously not an easy thing, because it's like what have we done to cause this.” “Daniel's mother is very concerned that the issues don't get recorded in his NHS records because she feels that could have a prejudicial effect on his future employment prospects.”	… clarity and guidance readily available about when CYP might benefit from professional support … highly accessible information about the help-seeking process … highly accessible information about the benefits of available support … directly addressing concerns about negative consequences … professionals well-equipped to identify and refer … development of trusting relationships in universal services … support to access other sources of help (e.g. self-help) … clear regular communication amongst families, specialists and other services involved with families … increased availability and streamlined processes

1st Order Data	2nd Order Data

Paper 5: Barriers to outpatient mental health treatment for children and adolescents: Parental perspectives. (T. Smith et al., 2013).

1st Order Data	2nd Order Data
“I feel like she has been on a lot of medication and I haven’t seen any results” “She needs inpatient treatment; they just give her meds” “Lack of understanding of ongoing behavioural/ emotional/ educational issues relating to my child’s diagnoses” “Lack of faith in the [Registered Nurse] assigned for med[icine] checks” “More in home support and managing behaviours, sibling interactions, hierarchy etc”	Treatment did not meet expectations … pharmocotherapeutic treatment was not sufficient … wavering confidence in providers ability to help … systemic obstacles … communication between caregivers and providers less than expected or desired Access issues … ability to gain timely access to appointments w/MH professionals … need for better office hours compatible with work and school … lack of hospital services and specific professionals (psychiatrist)

“Seems too bogged down in bureaucracy. Patient wellbeing seems secondary. Dr said do no harm rather than patient best interest being the focus” “Anyone qualified to work with problem autistic behaviours is booked for weeks” “It is hard to schedule appointments when you are in crisis. Help seems too far away” “It is hard to schedule appointments when your family is in crisis” “Two sets of parents who disagree” “My husband thinks he doesn’t need it [recommended treatment]” “If their child is talking about doing away with themselves [sic], [you need] to take it serious to	… more than one child in the family needing treatment (separate appointments/treatment) … providers covered by insurance companies (availability) … waiting list delays Family discord/crises … crisis within the family … parents (family) disagreeing about the need for treatment Proactivity and persistence … getting in for treatment … contact numerous providers … make appointments as soon as behaviours emerge

the point of getting your child checked out regardless”	… appointments available more often and at more convenient times
“[A]sk private insurance (if applicable) to assign a case manager to help you coordinate and suggest appropriate treatment options”	Communication issues … parents to seek out information from providers by asking a lot of questions
“Keep going”	… providers taking time to listen to parents
“Stay with it because it takes time”	… within-family/ among caregivers communication (re: treatment?)
“Call lots of places”	Extra services/support needed
“Schedule appointments right away when you see out of control behaviour”	… lack of access to proper care
	… systemic obstacles preventing treatment parents deemed appropriate
“Ask a lot of questions”	
“Follow the plan and be honest”	… ‘unrealistic’ expectations by parents or a lack of ongoing education by treatment professional (re: need for continued treatment)
“[Providers] take time and listen to parents”	

“[Need for] communication among caregivers” “… an after-care program that he desires and is financially able [sic] for the family” “More parent support groups [are] needed” “We need a lot of support” “Right now I feel angry that my child’s psychiatrist from outpatient is not the primary caregiver while she is on the inpatient unit. Too much bureaucracy!”	… need for useful information and greater understanding by treatment professionals regarding the pervasive nature of child’s difficulties … education for all involved caregivers (family?) re: treatment … need for positive relationships with therapist (continuation with the same person) … support/strategies for effective communication aimed at both parents and professionals … political/social issues re: MH as a priority in the state and sufficient funding … clinician persistence in following up on family therapy referrals … educating/ training healthcare providers re impact of family problems (e.g. differing opinions) on access to treatment … MH professionals develop skills and strategies for sufficient and effective education of and communication with parents re: expectations and limitations of treatment

	… taking time to address parents’ concerns and expectations and to describe treatment process … assistance in identifying and devising plans for addressing treatment barriers that emerge during treatment … building stronger alliances with parents early in the treatment process … time during sessions to address parents personal concerns … acknowledging ahead of time that barriers may occur
General thinking	

Paper 6: Facilitators and barriers to family engagement and retention of young children in mental health care: A qualitative study of caregivers' perspectives (Walter et al., 2019).

1st Order Data	2nd Order Data
“.. . it’s like my child is not wrong, my child is not broken, it’s not something going on, so it’s like denial, and if they [parents] don’t accept that, how can they help them? So, I think most of the parents are afraid. And they don’t want anything wrong with their kids. So, one of the first is accepting that there is something going on . . .” “I don’t believe in medication, so he doesn’t take medication. Right now, his biggest problem is executive functioning. We are working with the school and his network of providers to make sure that he can come up with goals and achieve his goals. He has trouble with concentration and focus” “. . . You have to help these babies at an early stage because [by] the time they are teenagers, [or] young adults . . . they [have mental health] problems that no one has addressed.”	Health Beliefs … coming to terms with the fact that the CYP has a mental disorder … selectivity regarding the types of health services they use [willing to use] Knowledge about mental health … difficulty understanding mental disorders in early childhood and distinguishing from other developmental issues … lack of knowledge leads to late screening and to delays in access to help

1st Order Data	2nd Order Data
“I don’t know if it’s part of the research, but people seem to be afraid of science or literature . . . you don’t see anything about mental health in a doctor’s office or pediatric offices. You don’t see anything about it.” “Her teacher was just terrific. I mean she talked to us, she thought something was a little off. And maybe we should think about, you know, having a consultation. So, I think that just kind of supported what we were seeing and demanded our attention at the time.” “The other thing is that we have not told him [son of the participant] that he has ADHD. We don’t want him to feel different or that something is wrong. Even if my daughter [second child of the participant] is going to counseling, she does not have a diagnosis. [Crying]. When [the doctor or other provider] told me she has an ADHD diagnosis, that is different. [Crying] It means I have to put a label to my child and I don’t want that.” “. . . when you start to talk about mental health, some people are afraid even to go, like “oh, nobody see me here.”	… mental health not part of early childhood service delivery system … navigating mental health system as a last resort for parents (initiation a result of prompts from others) … teachers and the school system played an important role in initiation of dialogue about mental health and a catalyst for engaging with services Values concerning mental health and illness … struggled with diagnosing due to concerns about labelling and long term impacts (help without diagnosis?) … stigma associated with mental health limited discussions about need and led to delayed access

1st Order Data	2nd Order Data
“. . . a lot of parents have to face that [mental health disorder] stigma with themselves primarily and then move on from that, which makes it hard . . . you are kinda try to win a war with your child for so long, figuring out what should I be doing . . . try to keep it [child’s mental health disorder] in my house because you would perceive that as weak or unusual when you go and seek out mental health counseling . . .” “. . . just that access and knowledge, like knowing what to do if your child experiences something, like we know what to do if your child has chickenpox. We know what to do when your child breaks their leg. We are not taught as parents what to do if your child has some sort of special mental health need. It’s just not out there.” “I make sure I ask a lot of questions about mental health, about the medications, about behaviors as well as about program options. [The provider did not tell me about] that many program options. I have [to] research them [by] myself. She just says this is the medicine, that is it. But I tell her no, I need to know [more].”	Attitudes towards mental health services … frustration that healthcare system doesn’t proactively address mental health in early childhood … healthcare providers do not discuss mental, behavioural and emotional development ... information not readily available or easily accessible across systems of care for CYP Personal/family resources … perceived barriers to care … difficulty obtaining information about MH services … difficulty finding providers and obtaining *accurate* diagnosis for CYP

1st Order Data	2nd Order Data
“To get a real psychologist, we had to go through a lot. I had to get two appointments for my kid [and] after that I had to go to four therapy sessions with my kids . . . To get to a psychologist, you have to go to therapist first and get therapy.” “. . . the number of hospitalizations proves the severity of the kids. So that’s that. I know we had a lot of argument about this aspect with MassHealth. Because they said, “oh, she didn’t have a hospitalization for the past 12 months. So that means she’s well enough to stay home.” But they didn’t see how much effort we already put [in] at home to keep her healthy, you know . . . some of the parents they actually go to hospital. What do they do? They call ambulance. They said I don’t want to wait in the emergency room, I just call [an] ambulance. And when they call [the] ambulance, they see your kid right away. . . these parents know how to get the service.” “I really feel privileged in the sense that we knew what was going on before all of this happened [with my child] . . . it’s so difficult even if you know . . . how to navigate the system . . . I feel for people because it’s not information that [is] readily available, it’s so difficult to access care .	… ability to negotiate systems of care … lack of timely outpatient care led to emergency room visits to ‘demonstrate’ severity of CYPs condition … complexity in the process of accessing comprehensive care … importance of having a support system which enhances parent’s ability to negotiate and navigate systems … need to be proactive and advocate in order to navigate and obtain care … case manager/conservator/community health worker availability (retention) … provides a single point of contact and an information repository for types of programs available

1^{st} Order Data	2^{nd} Order Data
. . it’s so difficult, I just feel for people because I can’t imagine what they are going through.” “. . . the case manager gives you the recommendations or finds out what [the] issues are, when the doctor may not have the time to go into a lot of what’s going on, the background, the case manager will be able to do that . . . and make those referrals or recommendations.” “The mentor works with [the] child, shows them how to live their daily life without being angry, shows them how to control the anger, control their feelings . . . show them what to do with those feelings. Some kids cannot control their feelings, control their anger, communicate effectively. [Mentors] show them how to communicate effectively with their parents, show them how live the daily life without having meltdowns.” “. . . when I met with them, it was my time like, my relax time. So, we shared, and we know all the parents, they have all the problems like me. We support each other, you know, we share resources, and like,	… parent-peer mentors as key community advocates … community resources (parent and peer support systems in the community) … health service resources … interaction with local schools, early education centers and community health centers (retention) Perceived health; parents knowledge not sufficient to justify access Perception of CYP MH need; inconsistencies with parent perception of need and assessment by providers … lack of providers with expertise in early childhood mental health

1st Order Data	2nd Order Data
relief. After all what you are living, they were confidential, so we were able to talk about anything that worried us, and I’m still going.”	… need of a more comprehensive approach in provision (reduce number and complexity of barriers)
“I go to a neighborhood health center. Ok. Which is great. I am very fortunate to be able to be [connected] at the center for about ten years and I trust that center and it has done a wonderful job in treating me and my family. If I didn’t have that center, I would be elsewhere, but it’s hard to trust people out here with healthcare and understanding your problem . . .”	… benefits of co-ordinated, integrated services such as joint visits … need to fully integrate mental health as a component of the larger system of health care services
“. . .when you have a doctor saying that there is nothing wrong with your child, you know it’s like, no, as a parent you know there is something wrong with your kid. Because it’s like, don’t tell me there is nothing wrong with my kid when you are sitting with him for five minutes and I have him 24/7 . . . I am telling you because when I see him with other 5- and 6-year old, I see something different.”	… single point of contact systems, through integration, continuous provision of care (assessment, planning, referral and monitoring) … case management within the context of families, homes and communities – parents ability to be responsive and supportive
“They need to have more mental health people. At the clinic, there are only three people and sometimes it takes a long time to be seen. By the time they see my child, something could have happened. I don’t	… need for a dialogue about infant and early childhood mental health and prevention within pediatric healthcare services

1st Order Data	2nd Order Data
want to have to call the pediatrician to jump the line, but I know the only way to get the service faster is to call the pediatrician and ask them to connect me to the mental health. That takes a lot of time and effort, time I don't have." "Like we called six or seven different places before we found the place that, first of all answered the phone, second of all got us in right away, and third of all accepted someone who didn't have an insurance. So, we were so frustrated . . . But it's so easy I guess to get so frustrated, and give up after an amount of time because it's just crazy, it took us hours to find a place, and you had to say . . . he is in crisis because you can't just say oh, my child is really acting out, you have to say, my child is in crisis and we cannot control him, and most of them said just go to an emergency room and it's like for someone who is nine years old, that's so traumatizing plus just knowing that there is no, they [providers] are not equipped to deal with someone like that." ". . . the system, needs to be flexible enough to meet family's needs, rather than just look at [the] diagnosis. Because diagnosis alone is, you cannot really fix that. You need to fix the whole system . . . the whole	… school system that is equipped to meet mental health needs and handle crises … providers across early childhood systems equipped to manage emotional and behavioural needs of children to foster social, emotional wellbeing … educational interventions to combat public stigma … engaging in dialogue and combating stigma to facilitate earlier screening and engagement/ retention in care … importance of community resources (e.g. family to family programs) for education and skills development for parents

1st Order Data	2nd Order Data
network, you know, the whole network, one part is broken, the whole thing is broken. If you don’t look at the person’s network as a whole, how are you going to fix the problem?” “I was able to get access to the behavioral help . . . and they are right there with the doctor, right there in the same. Well, the case manager and the doctor they do work hand-in-hand. So, when the doctor walks out and the case manager walks in, and offers services, “do you need help with this” or “this is available, would you like help with this,” “there’s this food pantry here, are you interested?.””	
General thinking	

Appendix 6: Key Concepts Map

Paper 1	**Paper 5**	**Paper 2**	**Paper 4**	**Paper 3**	**Paper 6**
	Problem Context	Impact of the problem (coping)			
Views of treatment	Expectation and experience of treatment	View of treatment (fit)		Perspectives on problem/ treatment	
Parental role and goal of treatment		Inclusion/ involvement	Parent empowerment		
Response from others		Response from others	Response from professionals	Response from others	
	Systemic barriers	Persistence (in the face of barriers)	Service/system ‘accessibility’	Delays and practical barriers	Navigating systems of care
		Knowledge/ experience of mental health	Uncertainty (knowledge)	Knowledge, understanding and experience of parents	Knowledge and access to knowledge re: mental health
Communication and support	Relationship with therapist	Emotional support/ relationships	Relationships (existing and new)		Community based support (relationships)
Communication and support	Communication		Communication	Communication	
			Stigma (perceived and anticipated)	Cultural factors	Values and culture re: mental health

Appendix 7: Information sheets and consent form

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Understanding Children and Young People’s Mental Health and Wellbeing

Participant Information Sheet

My name is Samantha Edwards and I am a Trainee Educational Psychologist. I am in the final year of the Applied Doctorate in Educational Psychology Programme at Newcastle University. I am about to begin my research exploring Children and Young People’s Mental Health and Wellbeing (MHaW). This research is being supervised by Dr Richard Parker, the co-director of the doctorate programme. The project has been approved by the University’s Research Ethics Committee, which means anyone taking part will be fully aware of what the research is about, their part in it and what will happen to any ideas or information they share.

INVITATION

I am inviting you to take part in a piece of research which will explore how Children and Young People’s Mental Health and Wellbeing is understood in your community. I hope that the outcome of this research can contribute to the way services are delivered in the future. The research will involve sharing your views and ideas about what is meant by MHaW, what contributes to childhood MHaW and what could make support accessible and acceptable so that young people are supported.

For this research, I have chosen to speak to parents/carers as they play a key role in the day-to-day support of Children and Young People and can offer a distinct perspective about their children's MHaW experiences.

WHAT WILL HAPPEN?

I will contact you to plan for a virtual interview which may be conducted over telephone or video. We can decide together if this would be better as individuals or in carefully chosen groups. I will negotiate the date and time with you to make it as convenient as possible. In the interview, I will ask some questions about children's Mental Health and Wellbeing to get the conversation going.

During the interview, I might ask additional questions to direct the conversation onto key areas if needed so that you have an opportunity to share your views on various aspects of the subject.

The interviews will last approximately forty-five minutes but could be shorter or longer depending on what you would like to share. The interviews will be video and/or audio-recorded so that I don't miss what has been said. The recordings will be anonymously transcribed so that no-one except me can tell who said what and I will use these transcripts to analyse the data from all the interviews.

CONFIDENTIALITY AND ANONYMITY

The information collected will remain anonymous from the point of transcription. Data will be kept in a secure place that only my supervisors and myself will have access to and will be destroyed in accordance with General Data Protection Regulations (GDPR) and Newcastle University's ethics requirements (i.e. no longer than necessary as stipulated in GDPR).

If we decide that pairs or small groups will be a helpful structure for the interview, I cannot guarantee complete confidentiality and anonymity as there will be other people present and this is outside of my control. To help with this, agreements regarding confidentiality will be established at the start of a group session.

The results of this research will be made accessible to relevant teams at local councils through feedback of findings and may involve the recommendation of possible next steps.

I will also seek to publish this research project in an appropriate journal so that these findings can be shared more widely. All data used in this way will be anonymous.

YOUR RIGHTS

You can of course decide not to be part of this research and you may decide to stop being a part of the research project at any time without explanation. During the interview you have the right to omit or choose not to answer or respond to any question asked.

Once the interview is complete, you have the right to ask that any data you have supplied to be withdrawn/destroyed up until the date of transcription. At this point the data you have provided will be part of a larger data-set and cannot be identified in order to be removed.

BENEFITS AND RISKS

I hope that the information I gather in this research will help me to develop a new way of understanding Children and Young People’s Mental Health and Wellbeing which could influence how early support is developed in the future. It is important to remember that there is no guarantee that the findings of this research will lead to change.

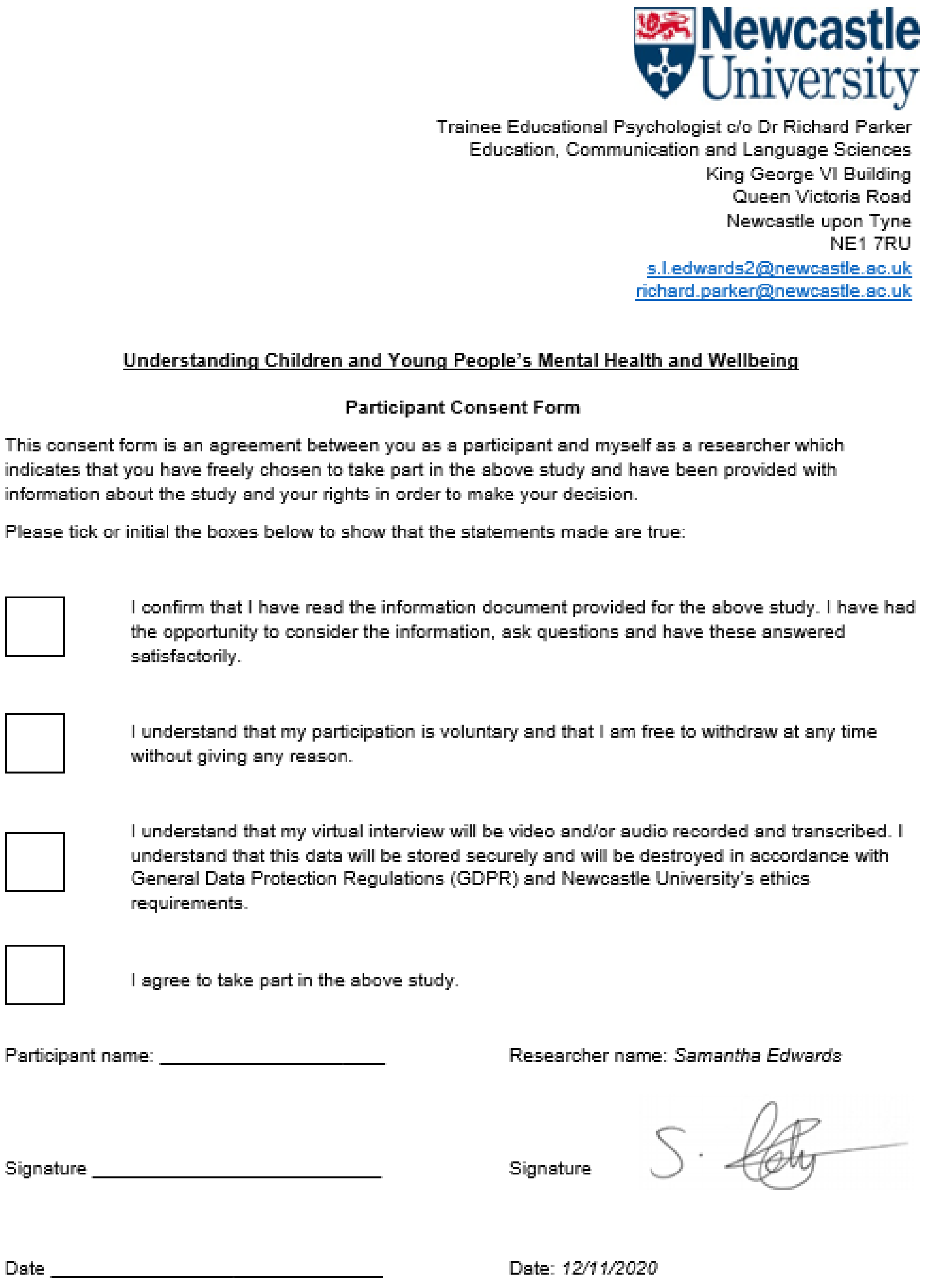
Whilst it is not something I will ask direct questions about, it is possible that the discussions that take place could lead you to discuss sensitive or difficult personal experiences. I will try to make sure that the interviews are as safe and supportive as possible and there will be a process in place afterwards for de-briefing which will include signposting to any additional support that might be needed.

FOR FURTHER INFORMATION

Thank you for taking the time to consider this information and for considering taking part. If you would like to express your interest in taking part, please contact me at the below e-mail address and I will then contact you to discuss this further and to gain your consent for participation.

If you have any questions about this research project at any time then please contact me by telephone on: 07814097366 or by email at s.l.edwards2@newcastle.ac.uk. Alternatively, and in the case of concerns or complaints, contact Dr Richard Parker by e-mail at richard.parker@newcastle.ac.uk.

Consent Form:



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Understanding Children and Young People's Mental Health and Wellbeing

Participant Consent Form

This consent form is an agreement between you as a participant and myself as a researcher which indicates that you have freely chosen to take part in the above study and have been provided with information about the study and your rights in order to make your decision.

Please tick or initial the boxes below to show that the statements made are true:

☐ I confirm that I have read the information document provided for the above study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

☐ I understand that my virtual interview will be video and/or audio recorded and transcribed. I understand that this data will be stored securely and will be destroyed in accordance with General Data Protection Regulations (GDPR) and Newcastle University's ethics requirements.

☐ I agree to take part in the above study.

Participant name: ______________________

Researcher name: *Samantha Edwards*

Signature ____________________________

Signature

Date ________________________________

Date: *12/11/2020*

Appendix 8: Interview Prompts

Possible prompts:

Prompts to encourage continuation or development:

- That’s interesting can you say any more about that?
- What might contribute to that?
- What might that look like?
- How/why might that be important?
- What makes you think that?
- What thoughts do you have about that X?
- Is there something else important we haven’t talked about?
- So, I’m hearing… have I got that right?

Prompts to redirect or initiate if needed:

Do you have any thoughts about **school** and CYP wellbeing?

What are your thoughts about the role **family** plays in CYP wellbeing?

Interchange **subjects** in above prompts with areas not discussed if needed: **individual, community, school, family, wider society**

Appendix 9: Mind-mapping and exploration of possible discourse

WB as within-person and outside of individual control

WB as physiological/mental health
- Functional
- Mechanical

WB as absence of trauma

WB as shaped by circumstances
- Environment
- Subjective

WB as harm undone/fixed

WB as defined by protective factors
- Lack of stress
- Freedom to express
- Lack of pressure

MH / Environment

WB as access to resources
- Relational
- Financial
- Developmentally appropriate

WB as 'breakable'

WB as a product of access/opportunities

Rights / freedom

WB as policy
- Responsibilities

WB as inclusion
- Within systems
- In relationships

WB as having needs met

WB as shaped by others
- Role models
- Harmful relationships
- Supportive relationships

Relationships - recognition?

WB as nurtured by othe
- Communication
- Relationships

WB as receipt of love

WB as community

WB as relationship
- Respect
- Parity
- Absence of condescension

WB as consideration of others

WB as belonging
- Self in others
- Finding your people

WB as liberation
- Openness
- Power/Assertiveness

WB as experimentation/play
- Growth
- Development

WB as opportunities for risk taking

WB as safety
- Supported/protected/trusted

WB as behavioural
- Cycles
- Negative choices

WB as a feeling/positive emotion

WB as fun/joy

Development / personal growth

WB as a light which can go out

WB as something you have

WB as subjective

WB as non-tangible/undefineable

WB as holistic wellness

WB as an internal state

Spiritual? Curiosity?

WB as aspirational - bonus

WB as qualifiable – poor/good

WB as resilience
- Learned
- Nurtured
- Capacity to handle change

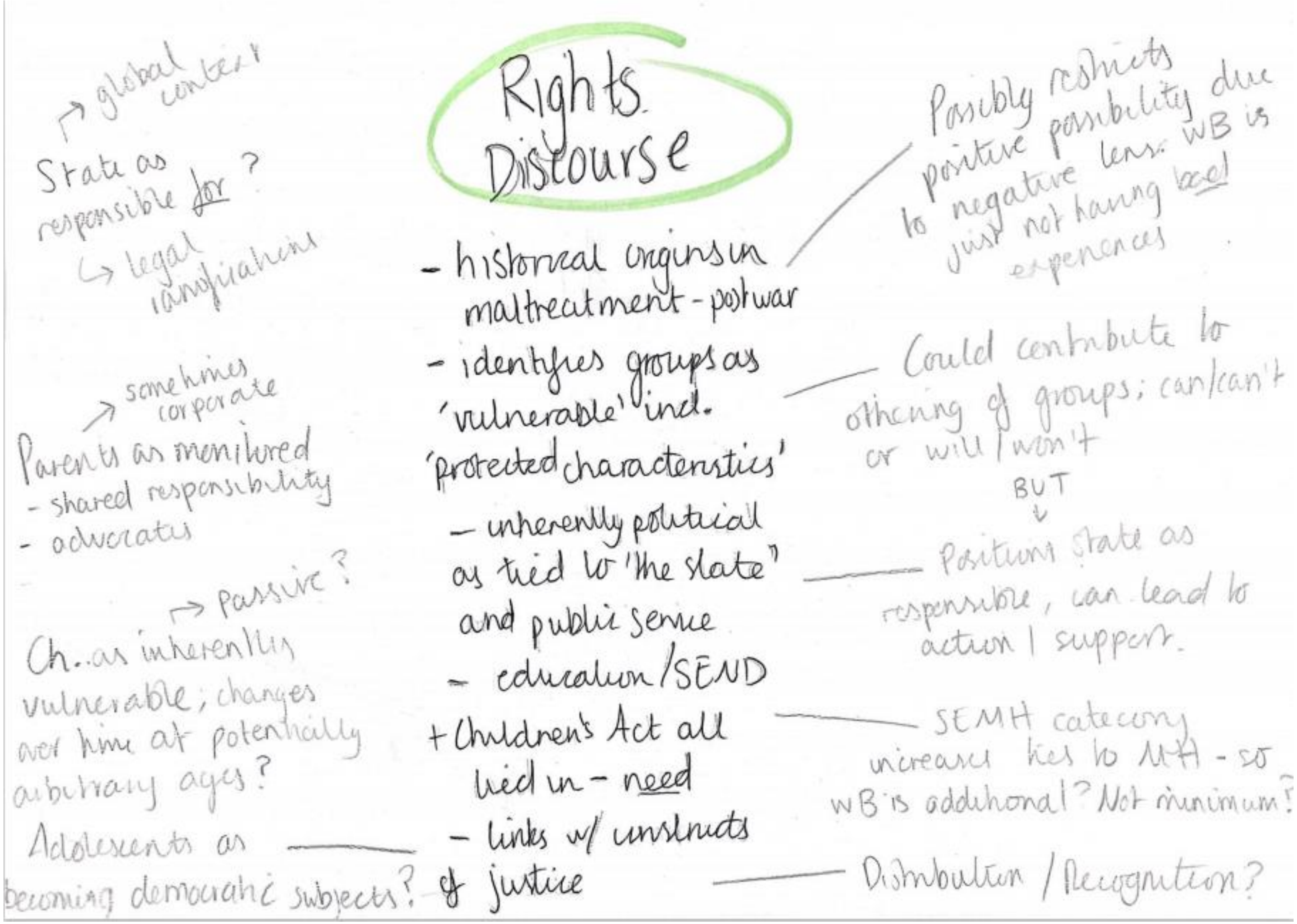
WB as confidence/secure selfhood

WB as growth

WB as something you learn
- A product of knowledge

WB as something you actively curate
- Nurture
- Look after

WB as a product of effort
- Personal
- Professional responsibility



Rights Discourse

→ global context

State as responsible for ?

↳ legal ramifications

→ sometimes corporate

Parents as monitored

- shared responsibility
- advocates

→ passive ?

Ch.. as inherently vulnerable; changes over time at potentially arbitrary ages?

Adolescents as becoming democratic subjects?

- historical origins in maltreatment - post war
- identifies groups as 'vulnerable' incl. 'protected characteristics'
- inherently political as tied to 'the state" and public service
- education/SEND
+ Children's Act all tied in - need
- links w/ constructs of justice

Possibly restricts positive possibility due to negative lens: WB is just not having bad experiences

Could contribute to othering of groups; can/can't or will/won't

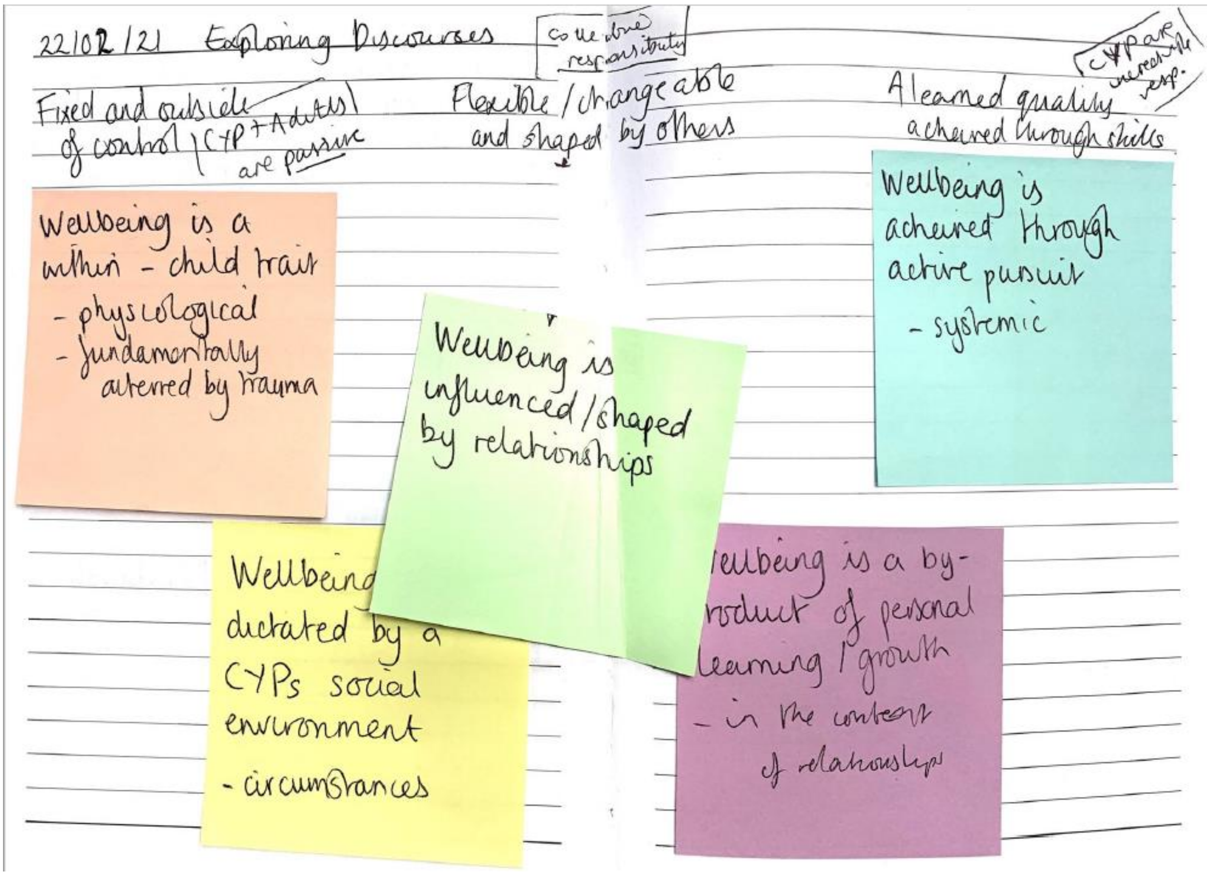
BUT

↓

Positions state as responsible, can lead to action / support.

SEMH category increase ties to MH - so WB is additional? Not minimum?

Distribution / Recognition?



22/02/21 Exploring Discourses

collective responsibility

CYP are increasingly resp.

Fixed and outside of control (CYP + Adults) are passive

Flexible / changeable and shaped by others

A learned quality achieved through skills

Wellbeing is a within - child trait
- physiological
- fundamentally altered by trauma

Wellbeing is influenced / shaped by relationships

Wellbeing is achieved through active pursuit
- systemic

Wellbein
dictated by a CYPs social environment
- circumstances

ellbeing is a by-
roduct of personal
earning / growth
- in the context of relationships

Health/Medical	Economic	Relational	Developmental	Philosophical
Sociological/political	Educational	Belonging	Identity	Spiritual
Outside of individual control Wellbeing as a product of physical health/physiological conditions. A sense that a child is born wellbeing neutral and is then a product of various influences – aligned with trauma discourse (ACES etc.)	Wellbeing as a personal quality/ commodity. Wellbeing in the short term and the long term – sacrifice now if it supports good 'long term outcomes'.	Wellbeing as constructed in the context of meaningful relationships Care/reciprocity - wellbeing as recognition? Recognition Theory?	Some psychological discourse here – linked with economic discourse of working on the self. Somewhat needs driven constructs in relation to developmental stages – adolescence. WB, or absence thereof, as a tool of identity constructions. Used in commodification/ resistance of this.	Wellbeing as positioned within the self. Not tangible and difficult to define. Wellbeing is something that is found or discovered. Gestalt concept – more than the sum of parts. Maybe about how we know?

Appendix 10: Discursive constructions and initial discourse identification

Transcript 1	Transcript 2	Transcript 3
Tentative discourse identification: Mental Health		
Patterns of meaning/interpretive assumptions: trauma, breakable, functional, mechanical, pre-determined, biological, neurological.		
WB as within-person and outside of individual control WB as physiological/mental health - Functional - Mechanical WB as behavioural - Cycles - Negative choices WB as absence of trauma WB as 'breakable' WB as harm undone/fixed	WB as mental health WB as dependent on physical health WB as interconnected/cyclical - How you feel, how you think and act, how you feel.	WB as mental health - healthy thinking and feeling cycles - measurable/quantifiable WB as inherited WB as treatable - Counselling - Therapy WB as within child - functional/chemical responses WB as behavioural - Troubled kids - Challenging cohorts

		WB as a something which can be hidden and shared - Status/diagnosis WB as impacted by trauma - Injury - Ailment
Tentative discourse identification: Environmental/Social Determinants		
Patterns of meaning: environmental, socioeconomics, stressors, risk and resilience factors, context bound		
WB as shaped by circumstances - Environment - Subjective WB as defined by protective factors - Lack of stress - Freedom to express - Lack of pressure WB as access to resources - Relational - Financial - Developmentally appropriate	WB as absence of stress WB as shaped by circumstance - Parent’s education/access	WB as a product of the formative environment - Emotional literacy om the family - Parent knowledge - Professional skill WB as a consequence of environmental factors WB as a product of social status - accumulation of social capital WB as lack of pressure/stress

		WB as absence of stress - Exam/study
Tentative discourse identification: Freedom/Safety		
Patterns of Meaning: freedom, safety, liberation, platform for growth		
WB as liberation - Openness - Power/Assertiveness WB as safety - Supported/protected/trusted WB as experimentation/play - Growth - Development WB as opportunities for risk taking	WB as access to opportunities for exploration/developing interests WB as moving away – exploration WB as feeling/being supported WB as feeling safe enough to take risks - Recognition of possible harm WB as ability to separate from the family – individuate WB as safety and protection WB as freedom and choice	WB as access to diverse experiences and opportunities WB as safety and security WB as safety - Knowing support is available WB as a product of boundaries/safety - Social media - Safety to test/push WB as safety to take risks WB as protection from risk WB as support

	WB as being supported - Support for CYP - Support for parents WB as a product of appropriate boundaries	
Tentative discourse identification: Rights/Policy		
Patterns of Meaning: policy, rights, need, systems, dependent, expected		
WB as having needs met WB as a product of access/opportunities WB as inclusion - Within systems - In relationships WB as policy - Responsibilities	WB as policy - Professional responsibility - Priority - Implementation WB as inclusivity WB as knowledge of support/access to support - Familial	WB as successful implementation of policy/ethos WB as a product of support - School role WB has shaped by the actions of others - School environment/beyond ethos WB as having needs met - By professionals - SEN WB as access to support - From parents

<table>
<tr><th colspan="3">Tentative discourse identification: Educational</th></tr>
<tr><td colspan="3">Patterns of meaning: skills and strategies, product, commodity, construction, learning, self-care, earned</td></tr>
<tr><td>WB as something you actively curate
- Nurture
- Look after
WB as something you learn
- A product of knowledge
WB as a product of effort
- Personal
- Professional responsibility</td><td>WB as resulting from individual characteristics – personality/skill/strength
WB as learning
- Product of knowledge
- Preparation for independence
- Problem solving skills
WB as requiring effort and attention</td><td>WB as a product of cumulative experience
WB as a product of effort/treatment hard work
WB as a product of learned skill
- Scaffolded by school staff
- Accumulated by the individual
WB as a desirable characteristic/ quality
WB as a product of capacity/self-care
- Basic skills (learned)</td></tr>
<tr><th colspan="3">Tentative discourse identification: Development</th></tr>
<tr><td colspan="3">Patterns of meaning: individual differences, character, capacity, motivation,</td></tr>
<tr><td>WB as resilience
- Learned/Nurtured</td><td>WB as feeling competent</td><td>WB as resilience/capacity to cope</td></tr>
</table>

- Capacity to handle change WB as growth WB as confidence/secure selfhood WB as qualifiable – poor/good (something you have) WB as aspirational - bonus	WB as resilience/assertiveness - Values driven - Facing challenges WB as confidence/self-esteem WB as building aspiration/inspiration WB as self-awareness/selfhood WB as facing challenges	WB as emotional resilience - Recognition of risk - Absence of vulnerability WB as establishing identity WB as self-expression WB as an image portrayed - Façade - Social media WB as secure selfhood - To allow vulnerability/risk WB as ability to plan based on risk/reward WB as self-belief - Growth mindset - Feeling competent - Safe to be different

		WB as freedom of choice - Future looking - Pursuit of interest - Values driven
Tentative discourse identification: Care/Relationships/Recognition		
Patterns of meaning: love, care, respect, parity, connection, community, responsibility, transactional, interaction		
WB as shaped by others - Role models - Harmful relationships - Supportive relationships WB as nurtured by others - Communication - Relationships WB as receipt of love WB as relationship - Respect - Parity - Absence of condescension	WB as relational/safety - Supportive adults (school) - Certainty - Capacity to cope with change WB as group identity WB as connection/belonging - Social group - Friendship - Environment WB as finding 'your place' and/or 'your people' - Shared interests - Group identity	WB as meaningful connection - In interaction WB as acceptance/recognition/validation - Or rejection WB as belonging - Group identity - Finding 'your people' - Community/social group WB as respect/authenticity in relationships with adults - Being heard

WB as belonging - Self in others - Finding your people WB as community WB as consideration of others	WB as diverse relationships WB as play/friendships WB as parity of esteem/respect WB as something that is nurtured/developed alongside others - Trusted adult WB as a shared responsibility - Consideration of others WB as positive regard/respect WB as recognition - Trust/respect WB as a product of openness/communication	WB as collective achievement WB as shaped by role models WB as openness WB as collective responsibility/care WB as a product of social success WB as connection/communication WB as community - Shared values WB as emotion management - By parents

Tentative discourse identification: Philosophical/Spiritual		
Patterns of meaning: holism, light, internal, intangible, intrinsic, emotional,		
WB as holistic wellness WB as an internal state WB as something you have WB as non-tangible/undefineable WB as subjective WB as a light which can go out WB as a feeling/positive emotion WB as fun/joy	WB as holistic WB as existing within us WB as unseen WB as a sense of purpose and meaning WB as feelings WB as happiness/comfort WB as relaxation	WB as all encompassing WB/MH as consciously constructed - (Mis) use of diagnostic labels - Identity WB/MH as complex and difficult to understand - Shaped by awareness/policy WB as feelings and emotions WB as fun/joy WB as mood - changeable

Appendix 11: Patterns of meaning and interpretation of dominant discourses constructing wellbeing

Mental Health	**Environmental/ Social Determinants**	**Rights**		**Development**		**Care/ Recognition**	**Philosophical/ Spiritual**
		Rights	**Freedom/ Safety**	**Identity/Personal growth**	**Educational/ Neoliberal**		
Trauma Breakable Functional Mechanical Pre-determined biological Neurological	Barriers Socioeconomics Stressors Risk and resilience factors Context bound	Policy Rights Need Systems Dependent Expected	Freedom Safety Liberation Platform for growth	Individual differences Character Capacity Motivation Purpose	Skills and strategies Product Commodity Becoming Learning Self-care Earned	Love Care Respect Parity Connection Community Belonging Responsibility Transactional Interaction	Holism Light Internal Intangible Intrinsic Emotional