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Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

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Date: 23 August 2024

A research project submitted to the School of Public Health in partial fulfilment of the requirement for the Degree of Master of Public Health, in the field of Rural Health.

Declaration

I, **Nkhluleko Themba Joshua**, declare that this research work on Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school, is my own original work. Any work produced by other authors quoted in this report has been adequately cited. The report is being submitted to the School of Public Health at the University of the Witwatersrand, Johannesburg. It has not been submitted for assessment at this or any other institution.

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Student number: 450258

Signature:



Date: 23 August 2024

Dedication

To **Mphofe Ndlangamandla**. I just want to say that I love you and I miss you. So yeah… ube Safety ntwana yami.

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To my supervisors, Abigail and Nicola. I would like to thank you for the tremendous support and guidance you have given me throughout this process. You continued to restore faith and confidence in my ability to see this through. You were always available and willing to help; you calmed my anxieties and helped me stay focused. It was an honour and an absolute pleasure to be supervised by you, and as your self-proclaimed favourite student, I am eternally grateful.

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Lastly. I'd like to thank Nkhluleko. You stuck it through until the end and I am very proud of you for that.

Abstract

Introduction:

Adolescence is a critical stage of human development where there is a susceptibility to developing mental health disorders. Socioeconomic factors such as poverty predispose adolescents to developing mental health disorders that last into adulthood. The lack of adequate resources for adolescent mental health and poor mental health literacy hinders their overall health. Investigating the views and attitudes of adolescents towards mental health and mental health care services seeks to help identify the existing barriers to accessing health care and providing evidence-based interventions that are socially and culturally relevant.

Objectives: The study objectives were set to assess adolescents' knowledge and perceptions of mental health and mental health services, to assess the mental health challenges experienced by adolescents and to assess the awareness and knowledge of mental health care services among adolescents.

Methods: This study used an exploratory qualitative research method, using an in-depth interview guide to explore the perceptions, attitudes and experiences of mental health and mental health services among a Johannesburg high school. Study participants were recruited using purposive and convenience sampling methods. Participants in the study were aged 13-19 years old. Participants filled in a sociodemographic questionnaire as well as a Patient Health Questionnaire (PHQ-9). The participants engaged in a collage/activity after which the interview guide was implemented.

Results:

The adolescents' overall understanding of mental health was low and varied along a continuum from understanding social well-being to creative and intellectual ability. The adolescents viewed mental health as a lived experience that they should manage on their own. Most of the adolescents had a negative association with mental health. The adolescents experienced a myriad of risk factors including but not limited to rape, bullying, grief, loneliness, and academic stress that affect their mental health. Stigma towards mental health and mental health services remains prevalent among adolescents. The use of stigmatising and dehumanising language among adolescents indicated misinformation and a negative association with mental illness and mental health care services. Knowledge of mental health care services was low, with all but one being able to name a mental health care service. The adolescents had some knowledge about counselling/therapy; however, none had any knowledge of where they could access such services.

Conclusion:

Knowledge of mental health is varied and mental health services is low which hinders access to mental health care. The lived experiences of adolescents greatly inform their mental health and their development. Mental health programmes should be cognisant of their experiences and understanding of mental health, to circumvent the prevailing stigma and bolster mental health information. The inclusion of parents and teachers as stakeholders in school-based intervention strategies should be prioritised to facilitate a conducive environment for adolescents and equip them with the necessary skills to identify and refer adolescents for their mental health struggles. Further research investigating the knowledge and perceptions of adolescents towards mental health is required. This will inform policy and intervention programmes that are culturally and socially relevant.

Abbreviations

ACE	Adverse Childhood Events
CAMH	Child and Adolescent Mental Health
CAMHS	Child and Adolescent Mental Health Services
GMMP	Gauteng Mental Health Marathon Project
LMIC	Low- and Middle-Income Country
MHCA	Mental Health Care Act No.17 of 2002
MHCU	Mental health care user
NGO	Non-Governmental Organisation
NHI	National Health Insurance Bill
NMHCSF	National Mental Health Care Strategy Framework
PHC	Primary Health Care
SDG	Sustainable Development Goals
QIP	Quality Improvement Plan

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Chapter 1 - Introduction

1.1 Background

Adolescence, the ages of 10-19 (World Health Organization, 2014), is a critical stage of human development in which mental health disorders, like depression, anxiety, and mood disorders develop (Kim *et al.*, 2017; Aluh *et al.*, 2018). Adverse Childhood Events (ACE) increase the likelihood of adolescents not finishing school and experiencing emotional distress during adulthood (Ajaero, Nzeadibe and Igboeli, 2018). Childhood adversity which includes sexual, physical, and emotional abuse and neglect, has been strongly associated with depression in South African students attending university (Mall et al., 2018). Responding to the mental health needs of adolescents is an emerging priority and the failure to do so continues to have detrimental effects on their learning and cognitive development (Barry and Jenkins, 2007; Atkins *et al.*, 2010). Some of the negative outcomes seen through this period due to being undiagnosed and untreated include suicidal ideation and committing suicide (Cluver et al., 2015; Aluh et al., 2018).

Some of the signs and symptoms of depression, anxiety, and other mood disorders such as sadness, lack of sleep and concentration issues (Fried, 2017) are less conspicuous and are not always easy to recognise (Waraich *et al.*, 2006). People living with mental health disorders are often stigmatized, which is a barrier to accessing adequate mental health care (Vigo, 2016; Haugen *et al.*, 2017). The stigma is often based on misinformation and results in people living with mental disorders being treated unfairly and not being deemed 'fit' to be integrated into the community (Wahl, 1999; Kakuma *et al.*, 2010). There is a need for evidence-based approaches that serve to not only address mental health issues but also reduce the inequalities that exist as a result of socioeconomic differences within communities (Egbe *et al.*, 2014). Resources are not distributed evenly between communities and across provinces, which leads to disparities in access to resources and services (National Department of Health, 2023). Health policies are still focusing on how to change people's health without addressing the conditions they live in.

The need for mental health services, including those targeting adolescents, is great. The World Health Organization called for increased prioritization of mental health services to meet the growing needs of communities globally (World Health Organization, 2008). It is estimated that mental disorders, affect more than 10% of the population globally, including men and women of all ages (GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 2018) and further affect approximately 14% of the global population (World Health Organization, 2021). The scaling-up of mental health services would entail "deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects to benefit more people and to foster policy and programme development on a lasting basis" (World Health Organization, 2007, pg 180).

South Africa has a world-renowned Mental Health Care Act 20 (Act 17 of 2002), that guarantees that mental health care users are treated without prejudice and are afforded the protection and treatment they need to fulfil a life of self-determination (Republic of South Africa, 2002). Yet despite its excellence, there has been a failure to implement it at levels where it is most effective, especially for adolescents (Vergunst, 2018). This was seen through the tragedy of Life Esidimeni, which highlighted the need for a different approach to providing mental health care. Mental health care users who were receiving care at Life Esidimeni, a psychiatric hospital, were displaced and moved to unsafe and unregulated non-governmental organisations (NGOs), under the guise of deinstitutionalizing mental health and cutting costs (Makgoba, 2017). This led to the death of over 140 patients, due to the ill-informed and poorly executed Gauteng Mental Health Marathon Project (GMMP) (Makgoba, 2017). This tragedy brought to the fore that mental health care is not prioritized and the decisions made around it are ill-informed and do not cater for mental health care users (Makgoba, 2017).

The development and implementation of intervention strategies that tend to adolescent mental health needs are crucial for the prevention of mental disorders and the promotion of mental health. Intersectoral collaborations, including healthcare providers, parents, educators, and policymakers, are pivotal to such strategies' success (National Department of Health, 2023). Policies such as the National Mental Health Policy Framework and Strategic Plan (2023 – 2030) highlight the importance of intersectoral collaborations in the development of the policy but also emphasise inclusion in implementation at all levels (National Department of Health, 2023).

The COVID-19 pandemic has transformed our way of life and way of thinking. The pandemic has had socioeconomic and psychological effects on people globally (Talevi *et al.*, 2020). This has left groups that are vulnerable to psychiatric disorders at the risk of having their mental health status worsen due to the restrictions imposed in attempts to stop the spread of the COVID-19 pandemic (Talevi *et al.*, 2020). Studies reveal that the mental health of adolescents has worsened over the course of the pandemic (Benton, Boyd and Njoroge, 2021). This exacerbates the already existing crisis of adolescent mental health. The precautionary measures taken in the attempt to limit the spread of the Coronavirus such as social distancing, isolation and quarantine have poorly affected the mental well-being of children and adolescents. As a result of forced isolation, children and adolescents faced a higher risk of experiencing depression and anxiety disorder, the effects of which can last up to nine years after enforced isolation has ended (Octavius *et al.*, 2020).

1.2 Problem statement

The ability to recognise some of the signs and symptoms of common mental health challenges such as depression and anxiety among adolescents is limited (Sartorius, 2007; Coles *et al.*, 2016). Limitations in recognising signs and symptoms can result in delays in seeking care which adds to the existing crisis in adolescent mental health care (Gunnell, Kidger and Elvidge, 2018). There is a need to assess the knowledge and awareness of mental health in adolescents to improve their help-seeking behaviour when dealing with emotional distress and provide adequate mental health information on services they have at their disposal.

1.3 Justification

Adolescents are a vulnerable group with regard to experiencing depression, anxiety and eating disorders. Focusing on this group will reveal their knowledge and views of mental health (Sartorius, 2007), but will also highlight what is needed and how to provide evidence-based healthcare by using the available resources. Mental health care is a neglected area of healthcare which affects access (Vergunst, 2018). There is not enough research that explores the views of adolescents about mental health. (Flisher *et al.*, 2012). Knowing the views that adolescents have about mental health will assist in implementing mental health policies in ways that are relevant and more culturally appropriate to them. This should be acknowledged and integrated into future healthcare policy implementation. Because of the uneven expenditure in the healthcare system, there was a need to develop universal health coverage in the form of the National Health Insurance Bill (SA National Department of Health, 2019).

The unequal expenditure in the healthcare system warranted the development of the National Health Insurance (NHI), to achieve universal health coverage (SA National Department of Health, 2019) The new healthcare funding policy aims to resolve the financial issues faced by the public healthcare system but has yet to address the increased number of patients that will be accessing public healthcare services.

1.4 Research Question

What are the perceptions and experiences of mental health among adolescents in a high school in Gauteng and what is their awareness and knowledge of available services?

1.5 Aim

To explore the perceptions, attitudes, and experiences of mental health, and their awareness and knowledge of mental health services among adolescents in a high school in Johannesburg, Gauteng.

1.6 Objectives

The specific study objectives were:

1. To assess the knowledge and perceptions of mental health and mental health issues among adolescent high school learners in Johannesburg, 2023.
2. To describe the mental health challenges experienced by adolescent high school learners in Johannesburg.
3. To assess the awareness and knowledge of mental health care services offered in the community.

The study objectives were chosen to achieve the study's aims and align relevant Sustainable Development Goals (SDGs). Namely, SDG 3 (Good Health and Well-being) under Target 3.4, aimed at reducing premature mortality from non-communicable diseases by one-third through prevention, treatment and promotion of mental health and well-being (United Nations, 2018), SDG 4 (Quality Education) under Target 4.7, aimed at ensuring all learners are equipped with the knowledge and skills to promote sustainable development through education for sustainable development and sustainable lifestyle (United Nations, 2018).

1.7 Literature Review

1.7.1 Prevalence and patterns of mental disorders in South Africa

It is estimated that approximately 2.2 billion of the world's population is comprised of children and adolescents, with almost 90% of them residing in low and middle-income countries (LMICs) (Kieling *et al.*, 2011). Despite there being a large proportion of children and adolescents living in LMICs, there is still very little information concerning the burden of child and adolescent mental disorders in these areas (Mokitimi *et al.*, 2019). Children and adolescents are predominantly affected by mental health disorders, which carry one of the highest burdens of disease going into early adulthood. (Kieling *et al.*, 2011). Approximately 50% of mental disorders occur around the age of 14, however, due to them being inappropriately categorized as a part of the changes attributed to puberty, they often go undetected and untreated (Shorey, Ng and Wong, 2022), which further compounds the existing crisis on adolescent mental health. Depression is the fourth leading cause of illness and disability for adolescents, where mental health disorders account for 16% of the global burden of disease and injury among them (Shorey, Ng and Wong, 2022). It is estimated that the global prevalence of child and adolescent mental health (CAMH) disorders is between 10-20% (Mokitimi *et al.*, 2019). Bansal, Goyal, and Srivastava (2009) noted that 3-9% of teenagers experience symptoms of depression at any point in time, and estimate that the lifetime prevalence of depression is approximately 20% (Bansal, Goyal and Srivastava, 2009).

The number of people living with a mental health disorder is increasing, with many people going undiagnosed for the disorders they have (Kometsi, Mkhize and Pillay, 2020). Mental health disorders in South Africa contribute significantly to the burden of disease experienced in the country (Lund *et al.*, 2012). It is estimated that 16.5% of South Africans experience a mental health disorder, which is not only a representation of the adult population, but for children and adolescents as well (Kakuma *et al.*, 2010). There are no discernible prevalence studies conducted on the wellbeing of children and adolescent mental health in Sub-Saharan Africa, including South Africa (Mokitimi *et al.*, 2019). Kleintjes and colleagues (2006) derived estimates based on international data which established that the number of children that were likely to have a diagnosable mental health disorder was around 17% (Kleintjes *et al.*, 2006; Mokitimi *et al.*, 2019). South African children and adolescents under the age of 17 are at the most risk of experiencing poverty, in a country where approximately 56% of the population live in poverty (Statistics South Africa, 2017; Harrison, Loxton and Somhlaba, 2021). Children and adolescents living in unequal societies have been shown to perform poorly in school because of the socio-economic challenges around them (Najman *et al.*, 2010; Harrison, Loxton and Somhlaba, 2021).

Adversity caused by poverty increases the likelihood of experiencing mental health disorders through increase exposure to violence and diminished potential social support, which worsens health outcomes for those living with mental health disorders (Stansfeld *et al.*, 2017). The lack of access to basic resources correlates with an increased likelihood of developing of mental disorders such as depression, anxiety disorder and post-traumatic stress disorder (Das-Munshi *et al.*, 2016). This leaves those affected by mental disorders vulnerable to suicidal ideation or attempting suicide (Cluver *et al.*, 2015).

Abusive parenting styles by the caregiver or the caregiver having experienced mental health distress themselves increases the health risk for adolescents. These include, but are not limited to, mental and physical health and, behavioural problems (Harrison, Loxton and Somhlaba, 2021). Harrison, Loxton and Somhlaba (2021) posit that abusive parenting styles cause negative emotions such as anxiety and fear which, in turn, increases the vulnerability of adolescents experiencing health risks (Harrison, Loxton and Somhlaba, 2021).

The ability of an adolescent to be resilient when going through any mental health challenges is influenced by a multitude of variables which include intrinsic factors like genetic or cognitive factors but also the interaction between themselves and environmental factors such as family and friends, or the community they reside in and how well they are supported. (Masten, 2015; Harrison, Loxton and Somhlaba, 2021). Positive parenting styles and emotional responsiveness, and the caretaker's level of education, mental health knowledge and positive relationships reinforce the adolescent's ability to be resilient when going through adversity (Kieling *et al.*, 2011). Some behaviours positively affect the resilience of adolescents, such as making a friend and having that friendship sustained over a period of time (Cluver *et al.*, 2015; Harrison, Loxton and Somhlaba, 2021). These positive relationships allow for the adolescent to cope with any stressors.

1.7.2 Adolescent mental disorders

There is a wide gap between the mental health needs of children and adolescents and the resources available to them. This is despite the fact that mental health promotion in children and adolescents has been widely recognised as an important aspect of improving health outcomes for them (Kieling *et al.*, 2011). Adolescent mental health disorders are globally recognised as an emerging issue that requires redress (Benton, Boyd and Njoroge, 2021), and addressing mental health disorders for adolescents is a major health priority, as they are recognised as chronic conditions that begin in the early developmental phases (Kieling *et al.*, 2011).

Approximately a fifth of adolescents in South Africa are suffering from a mental health disorder (Flisher *et al.*, 2012; Das-Munshi *et al.*, 2016). Youth that is disadvantaged materially or through racial

discrimination have less access to health care resources and are susceptible to common mental health disorders including depression and anxiety. The inability to afford basic items acts as an indicator for poor health outcomes later in adulthood (Stansfeld *et al.*, 2017). The interaction between childhood adversities and genetic, cognitive, and psychological factors have been linked with suicidal behaviour among adolescents (Cluver *et al.*, 2015). Socio-economic adversity faced by adolescents has a lasting effect on their mental health, which is worsened by experiencing and witnessing risk factors such as sexual abuse and violence (Harrison, Loxton and Somhlaba, 2021). The high prevalence of exposure to violence whether directly or indirectly through witnessed violence in South Africa affects approximately 80% of adolescents (Humm, Kaminer and Hardy, 2018). Depression and anxiety are prevalent in communities with high rates of poverty and unemployment, which is potentially caused by the lack of social support and overall perception of neighbourhood cohesion (Harrison, Loxton and Somhlaba, 2021).

Mental illness is exacerbated by risk factors such as HIV/AIDS and exposure to violence, where the prevalence of these are high in South Africa (Flisher *et al.*, 2012; Humm, Kaminer and Hardy, 2018), and in sub-Saharan Africa (SSA) (Okumu, Nyoni and Byansi, 2021). The interaction between mental health disorders and risk factors have been found to have an effect that lasts well into adulthood (Flisher *et al.*, 2012; Stansfeld *et al.*, 2017). Cluver, Orkin, Boyes and Sherr (2015) investigated the exposure to multiple ACEs such as food insecurity, losing parents due to HIV/AIDS, loss of a parent due to homicide, and having a parent living with AIDS. They found that the accumulation of ACEs in adolescents is a notable risk factor for the threat of suicide among adolescents (Cluver *et al.*, 2015). Research on mental health disorders for adults has increased, but this has yet to be seen with investigating the mental health disorders for adolescents living in LMICs such as South Africa (Das-Munshi et al., 2016).

Multiple risk factors exist for children under the age of 5 in LMICs, with more than 200 million not reaching their full developmental potential due to exposure to violence, HIV/AIDS, inadequate home care and stimulation, dietary insufficiencies such as iodine and iron deficiency, malaria, and stunting (Kieling *et al.*, 2011). These are some of the further risk factors that have been shown to have poor mental health outcomes for children, adolescents, and adults. Other risk factors for poor adolescent mental health include teenage pregnancy, adolescent parenting and unintended pregnancies (Kieling *et al.*, 2011). In studies done in adult populations, it was found that most mental health disorders occur prior the age of 25 years, often manifesting between the ages of 11 and 18 years old (Patton *et al.*, 2014). This is consistent with Mokitimi and colleagues' (2019) finding that approximately 50-80% of adult mental health disorders appear before people are 18 years old (Mokitimi *et al.*, 2019). The risk of adolescents developing clinical depression is estimated at approximately 34%, which is

substantially more than people aged between 18 -25 years (Shorey, Ng and Wong, 2022). This heightens their susceptibility to mental disorders such as anxiety, eating and mood disorders as well as personality disorders (Shorey, Ng and Wong, 2022).

Depression and stress-related conditions affect close to 20% of the South African youth (Ajaero, Nzeadibe and Igboeli, 2018), and without adequate diagnosis, this not only affects health outcomes, but also has economic and educational ramifications, which manifest as early dropout of adolescents from school and not being able to join the workforce (Ajaero, Nzeadibe and Igboeli, 2018). Mental health disorders affect children and adolescents' ability to learn appropriately in school, and their transition to adulthood and hinder their ability to lead a normal and productive life (Mokitimi *et al.*, 2019). Depression has been shown to have numerous adverse effects for adolescents, which include higher rates of hospitalisation, repeated depressive episodes, susceptibility to substance abuse, psychosocial impairment, and antisocial behaviour (Bansal, Goyal and Srivastava, 2009). Bansal, Goyal, and Srivastava (2009) also cite familial instability, poor school performance, and household abuse as contributors to distress among adolescents.

1.7.3 Perceptions and knowledge of mental health among adolescents

Globally, adolescents have been noted as having a diminished ability to recognize psychological and psychiatric disorders (Coles *et al.*, 2016). This is an indication of poor mental health literacy in adolescents. Mental Health Literacy is "knowledge and beliefs about mental disorders which aid their recognition, management, or prevention" (Coles *et al.*, 2016, pg 57). There is as scarcity in research conducted that explores the views of adolescents on mental health, especially within the South African context. Studies done to test the mental health literacy of adolescents revealed that there is generally a poor understanding in how symptoms of schizophrenia, depression and anxiety manifest and how they can be spotted (Aluh *et al.*, 2018). Some adolescents are able recognise some of the symptoms of a mental disorder in vignettes and questionnaires designed to assess the mental health literacy for depression and anxiety. This, however, does not translate to them recommending professional help from a psychologist or psychiatrist (Coles *et al.*, 2016; Aluh *et al.*, 2018). Many of them suggested that people they recognised as having depressive symptoms should seek help from a counsellor or friends and family (Coles *et al.*, 2016). Friends and family are largely regarded as a good support structure for coping with mental health struggles (Johansson, Brunnberg and Eriksson, 2007; Aggarwal *et al.*, 2016; Aluh *et al.*, 2018). Adolescents are less likely to recognise symptoms of anxiety disorder and even less likely to recommend seeking help from a healthcare professional (Lam, 2014; Coles *et al.*, 2016).

Understanding mental illness is not only based on scientific knowledge but also on cultural and social context. Cultural and social factors play a significant role in the interpretation and management of distress and impairment which changes how mental disorders can be addressed (Kieling *et al.*, 2011).

In a study conducted in Nigeria among adolescents, mental disorders such as schizophrenia are seen as spiritual possessions or connections that require treatment from a traditional healer (Aluh *et al.*, 2018), as opposed to being recognised as a medical condition that can be treated through psychiatric intervention. A South African study investigating beliefs around mental illness, had similar findings where depression was regarded as a psychological condition, and psychiatric illnesses were viewed as bewitchment or *"ukuthwasa"* (Kometsi, Mkhize and Pillay, 2020). Understanding mental illness should expand beyond scientific methods of classifying disease, and include indigenous knowledge of how to identify disease and how traditional methods are incorporated in treating and managing mental illness. Kometsi and Colleagues (2020) assert that individual conceptualisation of mental illness is informed by their world outlook (Kometsi, Mkhize and Pillay, 2020). Due to the lack of a well-developed African language regarding mental health and mental illness, it is important to identify how people identify disease and distress, which will ultimately inform their help-seeking behaviour (Kometsi, Mkhize and Pillay, 2020).

Adolescents have differing views on how they navigate the world around them and what informs their decisions. As such, it is important to understand the ways in which adolescent express themselves and how they understand illness (Johansson, Brunnberg and Eriksson, 2007). In investigating the perception of adolescents in a Swedish community, Johansson, Brunberg and Eriksson (2007) identified some of the ways adolescents express themselves and their experiences of mental health. For them, mental health was an emotional experience that encompassed negative and positive elements to it. Their experiences were both internal, including their ability to self-regulate and cope with their emotions and their level of self-esteem, and relational which involved their relationships with their friends and family, and how they influence their mental health (Johansson, Brunnberg and Eriksson, 2007). Adolescents in the study recognised positive emotions as being happy or being in harmony while viewing negative emotions as being unhappy or feeling hopeless (Johansson, Brunnberg and Eriksson, 2007). Adolescents in a South African study were able to identify loss of appetite, reduced sleep, fatigue, lack of interest in things and poor concentration as some of the signs of someone going through depression (Aggarwal *et al.*, 2016). Adolescent's ability to recognise and articulate their mental health struggles allows for early detection and improved help-seeking behaviour. Exploring adolescent mental health knowledge and awareness can contribute to the knowledge gap in how mental health is conceptualised by young people and it can provide guidance for increasing access to mental health support and services. Programmes such as the Measuring Mental Health Among Adolescents and Young People at the Population Level (MMAPP) Initiative by UNICEF, guide data collection for adolescent mental health, with identifying mental disorders in adolescents, and care-seeking and connectedness as some of the focal points of the initiative (UNICEF,

2023). The MMAPP initiative further identifies the need for cultural adaptation as one of the tenets for data collection in new settings (UNICEF, 2023)Investigating the perceptions of adolescents on mental health can contribute to providing a better contextual insights for data collection and implementation of interventions.

1.7.4 Mental health services

The World Health Organization seeks to promote mental health by establishing new and innovative ways to implement existing policies. The aim is to incorporate task-shifting/sharing as a method to address health care issues without solely relying on conventional, Westernised forms of treatment and care (Kirmayer and Pedersen, 2014). The integration of mental health information into primary and secondary level of education creates an opportunity to provide health care promotion and in turn improve health outcomes through preventative measures (Atkins *et al.*, 2010). In South Africa, mental health care should be provided at a primary, secondary and tertiary level (Republic of South Africa, 2002). At primary level there is little identification and referral to secondary and tertiary institutions of mental healthcare. This is because staff training is still inadequate, primary healthcare providers do not have the requisite time to provide treatment for mental health care users and referral pathways are not well orchestrated nor are they accessible (Lund *et al.*, 2012). The National Mental Health Care Strategic Framework (NMHCSF) indicates that mental health care should be integrated into Primary Health Care (PHC), where most people can gain access to it (National Department of Health, 2023).

At the secondary level, mental health care users are able to access psychotropic medication for treatment in general hospital inpatient and outpatient psychiatric units (Lund *et al.*, 2012). Services such as 72-hour management and observation are still lacking in many areas because there is inadequate infrastructure, insufficient specialist personnel and poor capacity building for primary healthcare personnel (Lund *et al.*, 2012). In areas such as the Western Cape, where training and support is available, it is common practice to circumvent the 72-hour observation period that is mandated in the MHCA, and transfer mental health care users directly to tertiary facilities (Republic of South Africa, 2002; Lund *et al.*, 2012).

At the tertiary level, a phenomenon termed the “revolving door” is seen where patients treated at this level are often re-admitted to the same level of care. This is largely due to inadequate community -based rehabilitation that ought to be provided at the level of primary care (Lund *et al.*, 2012). Failure to establish these primary, community-based facilities overburdens tertiary facilities and does not afford mental health care users the ability to have their mental health challenges taken care of before they become severe. Mental health care services are still faced with several of challenges that stifle mental health care promotion and good healthcare outcomes. Often confronted with barriers such as stigma, lack of availability, accessibility and acceptability of resources, misinformation regarding

treatment effectiveness, poor mental health literacy, cultural beliefs and language barriers (Seedat *et al.*, 2009), and the perceived lack of a need for treatment (Sorsdahl, Stein and Lund, 2012). There is a higher usage rate of general medical services than mental health service by people who require mental healthcare. Nationally, it is predominantly the very ill who get to access specialised mental health care (Seedat *et al.*, 2009)

Mental health care services in South Africa are split into general health services such as hospital-based services and primary health care facilities, and specialised Child and Adolescent Mental Health Services (CAMHS) (Flisher *et al.*, 2012). CAMH resources are still unevenly distributed in an unequal and inequitable fashion by having the majority of the country's services in metropolitan areas (Flisher *et al.*, 2012; Mokitimi *et al.*, 2019). Some areas are without specialist practitioners and this is compounded by a lack of training for generalist workers (Mokitimi *et al.*, 2019). Nationally, only 3 provinces have government-funded specialist service units, located in Gauteng (4), Western Cape (3) and Kwa-Zulu Natal (1) (Mokitimi *et al.*, 2019). The lack of development in CAMH services is worsened by the existing stigma, lack of attention to mental health services, and disregard for the interaction between poverty and mental illness (Mokitimi *et al.*, 2019). There is a need for adequate and equitable distribution of resources across provinces to ensure that mental health care seekers are provided with appropriate care and treatment (Seedat et al., 2009).

Integrating CAMHS into primary health care remains a challenge as facilities at that level are inadequately staffed, and the staff is poorly trained to handle mental health care users (Flisher *et al.*, 2012). Staff shortages in underserviced centers and inadequate training for treating mental health care users result in patients being offered substandard mental health care and having to be restrained physically or pharmacologically (Vergunst, 2018). CAMH is neglected at the policy level, despite the existing burden of CAMH disorders (Mokitimi *et al.*, 2019). The lack of government-funded CAMH services often leads to non-government, non-profit organizations and academic institutions having to provide supplementary assistance to CAMH services (Mokitimi *et al.*, 2019).

The provision of CAMH is particularly low in LMICs including South Africa, and there have yet to be significant changes implemented towards improving this(Babatunde, Bhana and Petersen, 2020; Mokitimi, Schneider and de Vries, 2022). Mental health services designed for adolescents are lacking even where they are available, there is substandard training and preparedness of staff, and a lack of resources availability (James *et al.*, 2018). This impedes the ability to provide effective and adequate mental health care for adolescents when they need it.

There are some positive aspects that have been noted in the provision of CAMH services. Mokititmi and colleagues (2019) investigated stakeholder views on CAMH services. They were seen as having a

"comprehensive bio-psycho-social approach" which entailed giving thorough assessment of the child and family's biological, social, and psychological needs (Mokitimi *et al.*, 2019). The CAMH services described included preventative, promotive, and curative components which were offered at primary, secondary and tertiary levels of care that are available for all children between the ages of 0-18 years old (Mokitimi *et al.*, 2019).

Chapter 2 - Methodology

2.1 Study design

The study design was an exploratory qualitative study using in-depth interviews (IDI) to explore the perceptions, attitudes, and experiences of mental health and mental health services among adolescents in a high school in Johannesburg, Gauteng. The participants filled in a sociodemographic questionnaire (Appendix B) as well as a Patient Health Questionnaire-9 (PHQ) form (Appendix C), before they engaged in a collage/art-based activity. The arts-based methods aimed to assist the study participants with expressing themselves and supported the in-depth interviews (Appendix D). To achieve this I had, precut images from a variety of magazines and newspapers, scissors, coloured pens and pencils, glue, and an A-3 chart for each participant to use. The pre-cut images were a combination of "random" images from magazines and newspapers. The images were of people in groups, alone, cycling, running, eating, doing skincare routines, and depicting various emotions (anguish, happiness, stress, etc). There were also images of houses, cars and other modes of transportation, food, and natural and city landscapes. The images were randomly selected without having a specific purpose for each image. Each participant was asked about their collage and what it represented for them as per the IDI (Appendix D). After this, an interview was facilitated through a questionnaire guide (Appendix D) {see Appendix E for flow chart}. The study allowed me to explore the perspectives of mental health from adolescents and draw insight into their experiences and how they had affected them.

2.2 Study site

One public high school was purposively selected for the study. The high school is a mixed-gendered public school located in Hillbrow, Johannesburg. The school is a culturally diverse, quintile five secondary school (grade 8 – 12), that that uses English as the medium of education for their learners. In 2023 there were 950 learners and 31 teachers in the school (SouthAfricanSchools.net, no date). There are school fees and children whose caregivers cannot afford the fees are not excluded from attending the school. While classified as a quintile five school, this is a misrepresentation of the school, given the community it is in and serves. Hillbrow is a low-income community located in inner-city Johannesburg, CBD. It has a multi-cultural and diverse community with some of its residents being domestic and cross-border migrants (Todes, Harrison and Weakley, 2015). The population growth within the finite space has led to overcrowding and competition for accommodation. The area is characterized by a myriad of factors that contribute to the state of the environment and community. There is a high prevalence of HIV/AIDS, increased childhood neglect, elevated levels of crime and violence, drug trading, unemployment, and homelessness (Todes, Harrison and Weakley, 2015). Other issues that face the area are poorly maintained infrastructure and buildings, littering and pollution, and reduced safety (Todes, Harrison and Weakley, 2015).

2.3 Study population

For the study population, I used the World Health Organization's classification for adolescence, which is the ages of 10 -19 years (World Health Organization, 2014). Because the study site was a high school in South Africa, learners ranged in age from 13-19 years old. Therefore, the population was adolescents, between the ages of 13 – 19 years, who were in grades 8-12 in a high school in Berea, Johannesburg in 2023. As a result of this, learners who showed interest in participating in the study, but were 12 or 20 years old were excluded from the study. Of the total participants, three of them were of foreign descent which added to the diversity of the participants.

2.4 Sampling

For the sampling, I first used purposive sampling to select the desired study population for the study. Purposive sampling involves the selection of participants based on their attributes to get as much diversity as possible. I first went to recruit the learners by introducing myself and the study to them. The learners asked questions when they had any or when they needed something clarified for them. I handed out small slips where they filled in their name, sex, interest in the study [yes/no], age, and their contact details or their parents' contact details. Learners were informed that participating in the study is voluntary and will not have any effect on their academics. The learners were also informed that filling in the contact slip was not necessary if they were not interested in the study. The slips were collected and sorted for positive and negative responses, and then sorted by sex. The contact details of the participants were entered into a Microsoft Excel spreadsheet. After recruitment was done, I called the learners who submitted their contact details to ask if they were still interested in participating in the study.

Convenience sampling was also used for recruiting some of the participants during the period of data collection. While I was at the school, either for handing out and retrieving the participation information sheets and consent forms, some of the learners approached me to state their interest in participating in the study still. This method of sampling assisted because, although there was a high number of learners that provided their details to participate in the study, there were many recruitment issues experienced. These included calls going to voicemail, incorrect numbers being provided (extra digit/fewer digits), wrong numbers, illegible writing, or unavailability for the interviews. Participants that were called and indicated that they were no longer interested in participating in the study were excluded from recruitment. Learners who were still interested in participating in the study collected participant information sheets and consent forms from a teacher who was designated to assist with the recruiting and facilitating the interviews, and from me. After all the necessary consent forms were correctly signed and returned to me, I scheduled a day for an interview session with the learners. In total, 13 learners participated in the study.

2.5 Data collection

Before participating in the interview session, each participant provided written parental consent as well as written participant consent for participants that were 18 years or older and written assent for participants that were 17 years or younger.

I reminded each participant that they could choose to withdraw their assent/consent at any time without giving a reason at any point during the session. This was reiterated to them during the interviews as well if a participant spoke about a sensitive issue such as rape/sexual assault or when they introduced a topic that they initially did not want to talk about such as family. The interviews were conducted on the school premises, where we were provided with a classroom that ensured auditory privacy. The participants were requested to fill in the sociodemographic questionnaire as well as a PHQ-9 form (Appendices B and C). The questionnaire included gender, grade, whether they had siblings or not, who they lived with, age, and how they got to school. Following this, I asked the participant to create a collage of their choice, using the materials provided for them. The participants were told they could write on their collages, to add to how they would like to express themselves.

When participants did not understand the request, I re-explained it to them and got confirmation that they understood before beginning. The activity was not time-based and was not judged in any fashion. The participant was given time to create their collage and encouraged to give their collage a title. The time the participants took to finish creating their collages was around 30-35 minutes. At the beginning of the discussion, I asked the participants to talk about their collage and why they chose the images/writing that they did. The participant talked about their collage and was only interrupted for clarification or if they were not audible. When the participant was finished with their initial explanation of their collage, I asked them to further elaborate on the different parts they spoke about when it was applicable. After the discussion on the collage, I then asked the participants the interview questions as per the in-depth interview guide (Appendix D). During the interviews, I made notes of the conversation to further investigate where I felt there could be deeper insights in their responses. These notes were the basis for the memos created to assist in analysing the data collected. The IDIs were audio-recorded, and the data collected was stored electronically, and prepared for data analysis. The participants could keep the collages they made and when they chose to, I took a picture of the collage which was stored along with the transcripts. Because of the risk of social desirability bias, I tried to mitigate this by reassuring the participants of confidentiality and anonymity (Larson, 2019). Similarly, the risk of recall bias influencing collected data was prevalent and would have to be considered throughout data analysis. To reduce the risk, the interview guide was developed to have questions that were clear and could be easily understood by the participants (Khare and Vedel, 2019).

2.6 Data Management

The recorded data was transcribed verbatim and translated from isiZulu to English when it was necessary. Transcription was done using Otter.ai, which is an online transcription software. I checked all transcriptions against the audio recordings to ensure accuracy and do the necessary translations. The data was de-identified with pseudonyms when a relative's name was mentioned during the interviews. The data was stored electronically and on an online backup system with an encrypted password to ensure that access was limited to myself and the supervisors. Data will be kept for six years, if the results are not published, and two years if published in a scientific journal. After this, the data will be permanently destroyed.

2.7 Data Analysis

The data was analysed, organized and coded using MAXQDA, a data analysis software. The data retrieved was analysed using a thematic analysis approach (Vaismoradi, Turunen and Bondas, 2013). An inductive approach to data analysis was used to understand the perceptions and experiences of mental health and access to health services from the study participants. The codes were generated after a deep reading and re-reading of the transcripts. I created the codes with the aid of my supervisors using two of the transcripts.

Through the coding process, the codes were refined further and collapsed or expanded as necessary. I developed a codebook or coding scheme with definitions to ensure that the codes were mutually exclusive. After I finished coding all the transcripts, I sent the codebook to my supervisors to check if the transcripts had been coded accurately. This was to establish some intercoder reliability for analysing the collected data (O'Connor and Joffe, 2020). Memos were created throughout the process, from the initial reading of the transcripts through the coding process, to draw links across the interviews. The collages were also used when coding the transcript as they helped with providing the needed context of the conversation I had with the participant. I developed themes based on the codes to reflect the patterns in the data. I routinely debriefed with my supervisors on the findings I got from the collected data and how to aggregate the data from across the interviews. Following adequate data analysis and interpretation, the information was compiled for a final write-up.

2.8 Ethical Considerations

The final research protocol was submitted to the Wits Human Research Ethics Committee (Medical) and the Department of Basic Education, Gauteng for approval before beginning recruitment and data collection (M220708) (Appendices F and G). I adhered to the principle of ethical research of human participants. The standard compensation for human studies in South Africa is R150 however, due to

budgetary constraints and concerns about unintended monetary coercion to take part in the research, each participant was reimbursed with R30 Airtime for their time spent in participating in the study.

2.8.1 Informed Consent

Written parental/Guardian informed consent were sought for the learners under the age of 18 years as well as assent from the participants. While participants who were 18 years and older were eligible to participate in the study without written parental consent, the school requested written parental consent for participants 18 years or older, which I adhered to. The participants were given participant information sheets for their parents (Appendix H) and for themselves (Appendices I and J), which provided details of the purpose of the study, the risk involved in participating in the study, the registered counsellor's contact details, the participant's right to confidentiality and contact details of the researcher, supervisors as well as the Wits Human Research Ethics Committee (Medical) secretariat details (Appendices H, I and J). Both the parents and the participants provided signed consent and assent forms for participating in the study (Appendices K, M and O), and consent forms for audio-recording of the interviews (Appendices L, N and P). Each participant was reminded that they were not obligated to participate in the study and that they could choose to stop participating at any point in time.

2.8.2 Confidentiality

I created a study ID for each participant and used it to label the transcript files and identify each participant in the IDIs. The participant was told that should they say a person's name throughout the interview, it would be replaced with a pseudonym to maintain the anonymity of themselves or the person they mentioned. This occurred on two separate occasions where a pseudonym was used to de-identify the data. The interviews were conducted on the school premises and done after school hours. To ensure that the classroom we were assigned to conduct the interviews would not be interrupted and potentially have other learners see the participants, I waited 15-20 minutes for the learners to leave the school grounds before taking the participant to the classroom to conduct the interviews.

2.8.3 Distress Protocol

Due to the nature of the topic and the questions asked, there was a risk of participants experiencing emotional distress because of the study. As such, a distress protocol was formulated for the study (Appendix Q). The research interviews asked participants to reveal personal and sensitive stories about their lives and their experiences. When participants talked about a sensitive topic such as sexual assault or the death of a loved one, I asked them if they were fine to continue and reminded them that they could stop with the interview if they wanted to. In these instances, the participants stated that they were able to continue with the interview. One participant was referred to the registered

counsellor after the interview was conducted because they revealed that they had been raped, have self-harmed and had a previous suicidal attempt. This was shared with my supervisors, who have experience with conducting qualitative research on sensitive topics.

2.9 Researcher Reflexivity

The study design required me to acknowledge any assumptions or preconceived ideas about adolescent mental health and particularly, what adolescents would know and how they would feel about the subject of mental health. Doing this was important because the objective of the study was to have the adolescents speak to the subject as much as they could without being influenced by me. Because of any lack of professional training regarding mental health or adolescents, my engagements with the adolescents were to understand what they were aware of and how their daily experiences have influenced their mental health and not from a diagnostic lens.

Throughout the recruitment phase of the study, I was able to engage with the teachers and learners, which was an opportunity to have more context of their environment and daily lives. While this was helpful and necessary for building rapport with the teachers and learners, it was also important to not have that feed into any potential biases and have certain expectations of how the interview sessions would ultimately go. While recruiting, I did, notice several issues that the school and learners faced such as not having water for two weeks, which led to classes being cut short and, in some instances, classes not having enough desks and chairs to accommodate the number of learners in the class.

The adolescents were very enthusiastic to participate in the study after I had explained it to them, which made it easier to have more potential participants. This was unfortunately hampered by schools having to close because of water shortages, which meant there was less time to call participants as their exams were commencing shortly after. This often led to some adolescents not remembering my recruitment at their school, leading to them being excluded from the study.

As the interviews began, I remained cognizant of the fact that mental health is a sensitive topic, not only because of the stigma that exists but also that our lived experiences inform the state of our mental health and that some of them were adolescents were potentially going to share stories that were personal and traumatic. Being mindful of this helped me to not have visceral reactions to some of their experiences because I felt that would have been discouraging and would not lend itself to what I hoped to achieve with this study. With more interviews, I felt I became more comfortable with interviews and more prepared to make note of some things that I could probe into during the interviews so that I was able to represent what they said accurately. This was helped by listening to audio recordings of the interviews and identifying areas where I could have asked for more insight to be better prepared should something similar come up in a different interview. Additionally, I would

debrief with my supervisors who gave me insight on my findings and how I could improve my interview skills.

Making small talk with the adolescents before the interviews began was a way for me to start talking with them without having our first conversation be about the interview. By asking them about their day and talking about some of their school activities, I was able to have a dialogue that I could use to 'break the ice', but it also helped me gauge how the participants' responsiveness and mood because I was aware that their participation in the study was extra-curricular and was after school hours, after having a full day of school activities. Despite some of the participants expressing that they were tired or my observing their responsiveness in the short conversations, I did not feel like that influenced the interviews and how they answered the questions. I feel as though how I presented the study to adolescents influenced how they were able to respond positively to me and participate in the study. Having a vested interest in adolescent mental health, it is possible that my own biases informed the way I answered questions or my potential demeanour. The participants were open and forthcoming with their views, experiences, and lives. The extent to which they were willing to share their stories was very positive and indicative of a sincere interest in participating in the study.

My findings revealed what adolescents knew about mental health, and while it may not have been fully descriptive and complete, there was some insight into what mental health is and some of the elements associated with it. When participants described mental illness and used stigmatizing language, it was important for me to not only recognize that the intention may not to be harmful but a lack of a vocabulary for what they wanted to say and, to also not harshly judge adolescents for the views they have, especially as adolescence is a vulnerable stage and they can be impressionable to certain things. While doing this as well, I had to remember not to feel the need correct what they were saying because the overall aim is to know what their thoughts and opinions are on mental health, without as little external influence as possible.

CHAPTER 3 - Results

3.1 Description of participants

Thirteen participants took part in the study. The average age of the participants was 15.6 years and ranged from 14 to 19 years. There were three boys who participated and 10 girls. Participants were in grades 8-12, with four participants from grade 9. Six of the participants lived with their mothers, some with siblings or other relatives as well. Five lived with both parents and the remaining two participants lived with relatives including an aunt and a grandmother. According to the PHQ-9, four of the participants scored with moderately severe depressive symptoms, five with moderate symptoms and two with mild symptoms.

Table 1. Participant Overview

Study ID	Sex	Age	Grade	Living arrangement	PHQ- 9 Score
Participant 001	F	17	11	Lives with mother and sister	Moderate depressive symptoms
Participant 002	M	14	9	Lives with Aunt, siblings, and relatives	Minimal depressive symptoms
Participant 003	F	19	12	Lives with both biological parents and sibling	Moderate depressive symptoms
Participant 004	F	16	12	Lives with parents and siblings	Moderately severe depressive symptoms
Participant 005	M	19	11	Lives with parents and	Moderate depressive symptoms
Participant 006	F	15	9	Lives with mother only	Moderately severe depressive symptoms
Participant 007	F	14	9	Lives with mother, aunt, and sibling	Minimal depressive symptoms
Participant 008	F	18	12	Lives with both parents and siblings	Moderately severe depressive symptoms
Participant 009	F	15	9	Lives with both parents and siblings	Moderately severe depressive symptoms
Participant 010	F	14	9	Lives with grandmother and siblings	Moderate depressive symptoms
Participant 011	M	14	8	Lives with mother and siblings	Mild depressive symptoms
Participant 012	F	14	8	Lives with mother and sibling	Mild depressive symptoms
Participant 013	F	14	8	Lives with mother and sister	Moderate depressive symptoms

Six main themes were identified (Table 2) relating to participant perceptions of mental health as well as their experiences. Sub-themes were identified under each theme. These are presented under the subheadings.

Table 2. Overview of research themes

Main Theme	Subtheme(s)
Understanding of Mental Health and Mental illness	Mental Health Continuum: Mental Health and Social Well-being
	Mental Health Challenges
	Mental Health Illness Compared to Mental Health
Perceived Causes of Mental Health Challenges and Mental Illness	Bullying and Peer Pressure
	Trauma
Relationships with Family and friends	Family
	Friends
	Disconnection from family and friends
Knowledge and experiences of mental health services	Knowledge of types of mental health services
	Informal mental health support
Coping mechanisms for adolescents	
Perceived facilitators for good mental health	

3.2 Understanding of Mental Health and Mental Illness

3.2.1 Mental health continuum: Mental and social well-being

The participants' understanding of mental health varied along a continuum. A few of the adolescents had a vague understanding of what mental health is, only stating that it is related to the mind and how it functions, but there was no further understanding beyond that. Some adolescents had a basic understanding of mental health being related to social well-being and having the ability to cope with life challenges. They identified some of the factors that influence good mental health such as being in a '*peaceful environment*', having good eating habits, and exercising.

Mental health was also understood in terms of mental capacity and levels of intellectual functioning, which are *"higher or lower than normal people" (Participant 005. M,19*). Participants described it as the ability to think and make '*good decisions*' and having the ability to regulate your emotions. They also related this to the level of creativity a person has and how they're able to work well with others.

> *"I think mental health is something that has to do with your social well-being and your emotions and, something that has to do with your mind and all that… Meaning like, how you cope with things. Yeah, your social well-being and all that."*
>
> *(Participant 007. F, 15)*

3.2.2 *Mental health challenges*

The consensus on mental health from the participants was perceived as having negative feelings and emotions that were the result of trauma and lived experiences that people go through. Mental health challenges were lived experiences described through how they have felt and the emotions they have throughout their lives. The adolescents highlighted feelings and emotions such as stress, frustration, anxiety, depression, and suicidal ideation. They recognized mental health problems as issues that can be brought about by struggling with academics at school, family dysfunction, bullying, or traumatic experiences such as sexual violence and rape. Participants described how grief, loneliness, and feelings of hopelessness affected them and, in some instances, their peers and how these were their mental health struggles. Most adolescents, however, regarded mental health challenges as something you can cope with without requiring any medical intervention.

> *"What do I know about mental health? I know it's like something everyone goes through and... It's something that happens and like, in a negative way, whereby, like something, sometimes you feel hopelessness and anxiety or depression."*
>
> *(Participant 003. F, 19)*

One of the participants had researched the topic of mental health prior to the interview session. Their knowledge of mental health was swayed by this, and they were able to give a description of mental health that includes both the positive and negative aspects of mental health and the ability to cope with life challenges. Their understanding of the cause of mental illness included a physical illness such as a tumour.

3.2.3 *Mental illness compared to mental health*

The participants made a distinction between mental health challenges and mental illness. Mental health challenges were described as negative emotions they face and live with but were manageable and did not require interventions. Only one of the adolescents recognized depression as an illness that could require medical attention, describing depression as the inability to regulate negative emotions and consistently feeling sad. While expressing grief, sorrow, feelings of hopelessness and not being able to experience happiness were considered emotions and feelings that they could cope with. The perceptions of mental illness were not as varied as those of mental health. The adolescents regarded mental illness as severe mental health disorders that were conspicuous, and that people were born with. Most of the participants understood people with mental illness as requiring medical attention to be cured or treated. They described people experiencing mental illness as exhibiting psychotic behaviours such as "talking to a bottle", requiring institutionalization, and having learning and cognitive disabilities. There was stigmatising language associated with their understanding of mental illness, throughout the interview sessions. The language used was dehumanizing and exclusionary,

describing people living with mental illness as "*not being normal*", "*mentally disturbed*", "*mad*", or "*crazy*" and needing to be in an "*asylum*". Other participants mentioned types of mental illness such as bipolar that needs medical attention. They described bipolar as doing things in excess, not being "*uncontrollable*" and being hyper *(gestured with their hands).*

> *"Okay, so I feel like it's somebody, you usually call that person umuntu ohlanyayo [a person that's crazy]. So, somebody who needs to go to the asylum, somebody who is disturbed mentally. Somebody who, who can't function properly. Which is different from mental health, because mental health a person can be normal, but the mind will have some pains, maybe the mind will have some sorrow, the mind will have different things." (Participant 002. M,14)*

One of the participants understood mental health and mental illness to be the same thing. Mental health for them was individuals with learning disabilities and diminished mental capacity where they described people who "*pick up papers*" and require "*rehab*".

3.3 Perceived causes of mental health challenges and mental illness

3.3.1 Bullying and peer pressure

Based on their understanding of mental health, the adolescents expressed some of the causes of mental health problems throughout their lives. There were multiple factors that they understood as having negative effects on their mental health. Not only did they express factors that were causes of mental health challenges, but also maintained or made them worse. Many of the adolescents listed causes and sustaining factors interchangeably. Bullying was universally noted as one the biggest issues that affects them and other adolescents in their school and community. They mentioned how it has poorly affected their mental health, performance in school, their self-image, and how their relationships with others can be affected. In some instances, the participants mentioned that the bullying had intensified to where they felt angry and depressed, which killed their desire to go to school, and led to suicidal thoughts.

> *"Yeah, I've once been depressed. Yeah, so ezinye iyngane eskolweni [other kids in the school] used to call me "ugogo" [granny] because of my white hair, and that led to depression… That led to depression" (Participant 010. F, 14)*

Similarly, peer pressure seemed to be a major contributor in their lives. The adolescents mentioned multiple ways in which peer pressure can affect them such as changing behaviour and going against a parent's wishes to stay at home because of their friends. In other cases, they referenced how peer pressure could lead to being forced to start taking drugs and alcohol, to remain part of a group. This insight was particularly enlightening as wanting to belong in a group, fitting in, and not being isolated

were also considered to be things that impact your mental health poorly. One participant added that wanting to have material things would lead to someone dating older men to get money and having that be a decision they would only regret later in life.

> *"I think it's peer pressure. Peer pressure is one of the biggest things, especially in high schools. The girl side, girls want perfect bodies, girls want perfect things and everything. On the boys, on the boys side, a boy wants to have everything as is. It is popular to have things like girlfriends, things like abs and muscles. So for boys, it might be popular. And you see, peer pressure is playing a big role in the mental health of people. It's like when I'm in a big role like it is the biggest thing in the school and like, yeah, peer pressure is the thing that you find everywhere in high school."*
> *(Participant 002. M,14)*

3.3.2 Trauma

Many of the adolescents mentioned traumatic events or violent crimes that they considered the cause of poor mental health. They acknowledged how childhood abuse, harassment, teenage pregnancy, neglect, "*being robbed*", or witnessing a murder or kidnapping can be traumatic and have a negative impact on mental health. One adolescent girl described how her stepfather had raped her. Rape as one of the perceived causes of poor mental health challenges, was notably mentioned only by girls, both because of their experiences as well as a fear throughout their daily lives. Girls described daily anxiety and fear as many women and girls are raped in South Africa. The experience impacted the adolescent's schooling and their self-image indicated through blaming themselves and how they could have prevented it. This also resulted in them choosing to be around people and not be isolated to avoid their stepfather. In instances when they could not, they went into their room, self-harmed, and had tried to commit suicide.

> *"I always blame myself ukuthi [that] "Why can't I have a father that will love me and not use me because he has my mother? Why, why me?" So yeah, it's, it's created that thing that I'm not wanted, maybe because I don't have a real father, and this is my stepfather, and my mother is very ignorant. So those things build up in your mind and they tell you wrong things and stuff." (Participant 001. F, 17)*

The adolescent expressed how they felt they were targeted by their perpetrator because they were "*light-skinned*". Colourism and skin tone were noted by some of the girls as an insecurity that affects their self-image and mental health, often comparing themselves to others, wishing for either '*lighter skin*" or clear skin, without pimples. Some of the adolescents also mentioned how wanting popularity, having 'ideal' bodies, and wanting to have material things affected adolescents' mental health. They

viewed self-image and wanting to impress their peers as causes of mental health challenges for other adolescents.

> *"And the picture in the middle of this, I'm not comfortable in my skin colour. Yes. Because I think in my head, I think if I'm a bit lighter, yeah. Or look like that. It's prettier. That's all… Because like, most of my friends are lighter than me. So they'll be like, "Oh, you look good. You look good when you're lighter" and then, it's also like something that I see. Prettier girls have lighter skin and all that. And my mom was, like, "You used to be light when you were little" So I'd like to go back to what was that phrase." (Participant 008. F,18)*[1]

Other factors that were mentioned by the adolescents were chronic illness, adapting to a new school environment, financial stress, experiencing poverty, academic stress, pressure to perform well academically from parents, having no electricity which affects their ability to study, COVID-19, and the rise of fuel prices, as well as being judged because of their sexuality. These affected the adolescents to varying degrees and were sources of anxiety for them.

> *"To me, it was changed our schools and new environment. That would have changed me because right now I'm still adapting to this new environment, environment having a new school. Since last year I was at a primary school now it's kind of hard for me to adapt. And when I got here I kind of like got here in a bad influence, yes. And then also friends, I got to the wrong friends, but now, I decided to stop being friends with them and found better and good friends" (Participant 012. F,14)*

One of the participants mentioned feeling despondent as being a cause for mental health challenges. They attributed a lack of faith, lack of motivation, or inspiration as the cause of having poor mental health that led to teenage pregnancy, '*high suicide rates'*, divorce rates, and anxiety. Some of the adolescents mentioned substance abuse as one of the causes of poor mental illness. Substances such as '*Crystal*', '*weed*', '*marijuana*', '*glue*', '*alcohol*', and '*cocaine*' were noted as substances that can damage your mind and lead to mental illnesses that would require treatment and '*rehab*".

3.4 Relationships with family and friends

3.4.1 Family

Family relationships were noted as being very influential in their lives and participants described how they impact mental health both positively and negatively. Some of the adolescents mentioned how

[1] *Excerpt from the collage section of the interview session.*

they were able to speak to their parents and siblings after having gone through traumatic events and were supported by talking with them about their experiences and getting healthcare services when it was required. Family was regarded by some adolescents as being the most important in their lives and the only people they could trust. Spending time with family and engaging in activities together was a source of joy for them as they could bond with their loved ones. Being able to openly talk to family about their mental health challenges was beneficial to them as they received advice and guidance through their mental health challenges. Some adolescents noted that having a good and positive family environment was beneficial to mental health and provided peace.

> *"I chose to represent family because it's the most important thing in my life, and I have a good relationship with my mother and my brother because I'm currently living with both of them. Yes, that's why I chose family." (Participant 012. F,14)*

Conversely, poor interpersonal relationships within their families were listed as issues that impact their mental health negatively. Issues such as fighting with siblings, being shouted at by parents, being mistreated at home, being overly criticized, and dismissed, and being bullied at home were some of the things they faced and were regarded as detrimental to their mental health. One of the participants mentioned how they sometimes felt alone, even when they were around family and friends, and how they did not feel understood by their family. The adolescents described family dysfunction and poor relationships with family and friends as contributors to developing mental health challenges. Having parents who were divorced, parents who were unable to understand or empathize with them through their struggles, and family members who bullied and shouted at them were some of the issues they regarded as not being a peaceful environment and could bring about unhappiness.

> *"Like, as a person, you make mistakes. So like, being that one particular person in the family who like, always makes mistakes and you know, you feel like they're always against you. They don't try to understand your point. Ya" (Participant 003. F,19)*

Neglect and not getting emotional support from family were mentioned by some of the adolescents as well. A few of the adolescents mentioned that they did not feel they could talk to their family members, out of fear of being judged and misunderstood. One of the adolescents revealed how speaking to their family garnered a negative response which led to them no longer wanting to communicate with them and preferred to cope with any challenges alone. One participant noted how their parents were 'strict' and they felt restricted by not being able to behave in a way a teenager would. For them, wearing black clothing was associated with witchcraft by their parents, and they found that to be limiting because they were someone who liked fashion. One adolescent

acknowledged the loss of loved ones as negatively impacting their mental health, bringing about “pain and sorrows” for them.

> *“I think it starts at home. We know, parents, especially, especially black parents actually, they don't know much about mental health. You know, like when you tell them. Maybe she would like say, like "you moody." and you're like, "I'm not moody, It's just that I'm quiet." and she starts shouting. She starts you know, that thing, like it just, it overwhelms you, it comes and it just, you know, it makes you feel so irritated, you know, Yeah. So frustrated. Like it's boring. Yeah. So I think that's what causes a mental illness.” (Participant 006. F,16)*

3.4.2 Friends

Many of the adolescents noted how friends influence mental health to varying degrees. Some of the adolescents mentioned how they were able to speak to friends about their mental health challenges. The adolescents acknowledged how friends can motivate and inspire each other to make good decisions and be a source of emotional support when going through mental health challenges. The adolescents viewed friends who advised them in a positive light and as having a good impact on their mental health. Some of the adolescents could speak about their academic stresses to their friends and found that helpful when dealing with their stress.

> *“Then for school, I talk to my friends and my friends were like, I should just believe in myself, because if I cannot believe in myself, no one will do that for me… Okay, with my friends, it's kind of like motivated me to do better and change my way of thinking towards my studies…” (Participant 008. F,18)*

Other adolescents’ experiences with friends have been sources of pain for them, citing bullying, name-calling, being taken for granted and being teased as things that occur amongst friendships. A few of the adolescents mentioned how they’ve experienced betrayal from close friends, which has led to them feeling depressed, losing their appetite, falling physically ill and having suicidal ideation. Some adolescents listed situations such as a friend revealing their secrets and being disloyal to them, often leading them to have mental health challenges. They also noted that being “*betrayed*” has led to them having “*trust issues*” and “*feeling unwanted*”.

> *“When I broke up with my ex, it was really bad. I mean, it was a relationship that I really wanted to carry on with, but I just found out that a close friend of mine, okay, wasn't a close friend, because I just considered the person as like family, is now with*

my ex. So I'm like, "You come to my house, we laugh and do this, but at the same time, I'm busy with my ex". So that's how I, everything started this depression, anxiety, and even to, to just eat was a problem, and I got terribly sick. And yeah, just a lot of depression and anxiety came about." (Participant 004. F,16)

3.4.3 Disconnection from family and friends

A few of the adolescents mentioned how they felt disconnected from their friends and family and found themselves isolated at times. The adolescents felt that family members not understanding them and being abrasive towards them, restricted them from being able to communicate with them. Some participants were reluctant to speak to friends about their mental health challenges because they felt their friends could not understand them if they had not gone through something similar. They also mentioned how wanting to be in a group and not be excluded from others often leads to mental health issues and feelings of loneliness. They indicated that when going through mental health challenges, they preferred dealing with them on their own rather than telling their friends and family. One of the male participants stated that they dealt with mental health challenges on their own because men do not speak about their problems to their friends and family.

"Being a man, you don't really tell people what you go through. If you have stress, you don't really tell your friends or your parents or family members at all. So that's what I have done. I have like, bottled up my feelings and emotions, in some situations." (Participant 005. M,19)

3.5 Knowledge and experience of mental health services

The adolescents' overall knowledge of mental health services was very low. Most of the participants were unable to name any mental health care services or facilities that they could contact or access if they needed to. Of the few who mentioned that they had some knowledge of mental services, one mentioned ChildLine[2] and the other mentioned a service for which they had a pamphlet for but could not remember the name of the organization. Only one of the adolescents had had an experience that required mental health services through a social worker and a therapist, where they received counselling and engaged in activities that helped them cope with the emotions and feelings they had. Their knowledge of mental health services was based on their experience, through visiting hospitals and clinics, but they were also unable to mention any specific mental health care services by name.

[2] "Childline South Africa is a non-profit organization that works to protect children from violence and further the culture of children's rights in South Africa" (Childline South Africa, no date)

Barring the one participant who had an experience that needed a social worker and a therapist, none of the other participants had used mental health care services before.

> *"For social workers, it didn't last long. Because I felt like there was nothing they could help me with. But for the hospital, that clinic helped me a lot, because now I could stand any bad thing which will come to me. Similar is the past. So I could talk early and something happened to me, so the counselling really helped me a lot….Yes, I may say it like that, yes we are able to talk about our feelings. Now we're also given some worksheets to fill out. And then we had like things like homework, try to practice something we learned. So…" (Participant 002. M,14)*

A few of the adolescents mentioned "rehab" and hospitals as places where people living with mental health challenges can get help. This was, however, in the context of their understanding of mental illness, which they stated required medical intervention, where people would need permanent assistance and be under constant supervision.

> *"Like different like mental illness, because mental illness is like, people who like... People that stays in like rehab… Rehab. They call it like, those people maybe who are mad like, something drinking alcohol too much, they take him to rehab with drugs" (Participant 011. M,14)*

3.5.1 Knowledge of types of mental health services

Most of the adolescents mentioned the types of mental health care services such as counselling or therapy. They acknowledged that this helps by being able to speak about their feelings and not "bottle up' what they feel. Despite this, there was no knowledge of where they would get these services. These were the only professional services they knew that would be able to provide help for mental health challenges. Some of the adolescents were able to consider some barriers to accessing mental health care. They mentioned the costs, visibility, and access to mental health facilities. These barriers are added contributors to the lack of access to mental health care services for adolescents, which are compounded by the lack of awareness of any services.

> *"I would like, have like a therapist, that doesn't like need money. Because you know sometimes when you want to see a therapist all you think about is like, "Will my parents afford this? Will I afford this?". So having a therapist who's not charging, maybe like the therapist is working for a particular organization or something?" (Participant 003. F,19)*

3.5.2 Informal mental health support

Many of the adolescents identified family and friends as being their first line of help when experiencing mental health challenges. Some of the adolescents stated that family were the only people they could trust to be able to help them through their mental health struggles. One participant mentioned that the betrayal led her to be suicidal, but they spoke to an older friend who comforted them and was able to persuade them otherwise. Other participants mentioned family members gave them coping mechanisms such as "*crying*", to release their emotions and how that helps them when they have mental health challenges. A few participants' coping mechanism was religion-based. They mentioned that prayer and reading the bible when going through mental health challenges often comforted them.

> *"It had to do with friends, okay. And then affected me in a way that I was accused of doing something that I didn't do, at a point whereby I felt like I wanted to commit suicide. But then I spoke to someone, which made me feel a little bit better about myself and told me that it's not worth it. Yes" (Participant 012. F,14)*

3.6 Coping mechanisms for adolescents

The adolescents experienced a plethora of issues throughout their lives and had experiences that affected their mental health. Some of the ways in which they have coped with these mental health challenges has been through speaking with their family and friends, as described in section 3.3.1, who have supported them through their struggles. Some of the adolescents stated that they preferred dealing with any issues they faced on their own. The reasons cited were they feared being misunderstood or judged, some stated that maybe a person might feel embarrassed about their struggles, or that their secrets would not be kept by the person they would confide in. While stating that they did not speak to anyone because it was something men did not do, the male participant's recommendation on what could improve mental health for young people, which was specifically directed to boys, was that they should talk about their feelings and what they go through. This in part, reinforces the notion that mental health challenges can be dealt with alone and additionally that it is a masculine trait to handle any mental health struggles on their own, albeit them recommending seeking help when struggling with something.

> *"I would like to say to mostly boys, because boys like bottling things up, it isn't healthy, physically and mentally to bottle up, to bottle up your emotions and stuff like that. Because once you bottle them up, it will take a bad toll on you in the future. And in the future, it could lead to Alzheimer's and stuff like that. Or unhealthy eating, or stuff like that, yeah. So, for boys don't bottle your emotions." (Participant 005. M,19)*

Many of the adolescents stated that they cope with mental health struggles by engaging in recreational activities such as reading, singing, listening to music, playing sports, watching a movie, being on social media as a distraction, keeping to themselves or being around nature. Other recreational activities included baking, drawing fashion as well as interior design and floor planning. A few of the adolescents mentioned that they keep themselves mentally healthy by exercising and having healthy eating habits and suggested that doing these things are facilitators of good mental health. Some of the adolescents mentioned that they enjoyed going to school because they enjoyed learning. A few of the adolescents mentioned that they enjoyed eating and that food was one of the ways they coped with their struggles. Other adolescents mentioned that they focused on their goals and the things they aim to achieve in life such as being a businesswoman, having a career, getting a degree, starting their own families, being able to buy a house and a car for themselves and their parents. These were motivators for them for wanting to achieve good things but also gave them a sense of hope in their lives.

> *"Okay, so my collage is basically about my dreams and reality. So I'll start with the dreams. Maybe in like 10 years to come, I'd love to like, own a big mansion, you know, like, live in a large house, like live the life you know, the wealthy life and be successful, as well as being independent. Because I like I love doing things on my own. Yeah, I also love nature as well. I feel, whenever like I'm at a nature place, I feel so relaxed and calm. Like everything that just says nature, that is just created by God, it just calms me down." (Participant 006. F,15)*[3]

3.7 Perceived facilitators for good mental health

The adolescents expressed potential remedies for some of the causes of mental health struggles and potential facilitators for attaining good mental health outcomes. These included limiting/stopping some of the behaviours that affect their mental health, such as bullying and grouping themselves according to their skin tones. Having someone who would understand and not judge them for what they are experiencing was noted by other adolescents and they viewed this as a substantial facilitator for improving mental health by having an outlet for their emotions. Interestingly, this recommendation was also made by participants who expressed that they cope with any mental health struggle on their own. While they acknowledged that having a confidant is important, they felt they did not have that for themselves. A few of the participants stated that having a good family

[3] *Excerpt from the collage section of the interview session.*

environment and having their parents still be married was good for their mental health. One of the participants stated that being accepting of each other despite whatever differences people have would also be a good facilitator for good mental health.

> *"Yeah, it is difficult to, and like, sometimes you, when you want to talk to someone you think that they'll only think to their level of perception, having their own opinions and like they are, their opinions might be negative." (Participant 003. F,19)*

Many of the adolescents' recommendations for improving mental health for young people included having organizations that provide professional counselling services, which would allow them to gain access to mental health care facilities when they were needed. These proposed organizations would be in several areas, and they would be assisted without having fees for the services, which could be maintained through fundraising. A few of the adolescents argued that the onus to seek help and follow through would have to be on the person requiring it. They also recommended ways in which awareness of mental health can be improved for young people, through educational programs that are given in schools and community centres. The adolescents proposed that this could be sessional or included into the curriculum through assessments. A few of the adolescents suggested motivational talks, particularly from someone who had gone through adversity and had overcome it. Others suggested giving information through social media and ad campaigns, which provide information on how to spot the signs of someone who is having mental health struggles and have contact details of places they could get help.

> *"Motivating people sometimes might not be enough. And sometimes opening rehabs or hospitals to help people sometimes might also not be enough. And also, building places, let's say like a good environment for people to live in, that for me might also not be enough. Instead, for me, I would leave it to the person. If either they want to change or not… Because if the person doesn't want to change, the person will not change. But if the person really does need help and does want to change, they will do it for themselves because they know why they want to do it. That's what I would say." (Participant 012. F,14)*

Chapter 4 – Discussion

4.1 Introduction

The study sought to investigate school-going adolescents' understanding and perceptions of mental health and mental health services within a community in Johannesburg. Additionally, the study explored the experiences of adolescents in relation to their mental health and mental health struggles. Knowledge of mental health by adolescents was varied and views covered a continuum with a few insights into mental wellness and others discussing challenges. Participants lived experiences influenced their mental health, self-image, and behaviour. The adolescents understood mental illness as being an illness that is congenital, conspicuous, and requires medical intervention. The language used in the description of mental illness was stigmatising and dehumanising. While the adolescents were able to mention types of mental health care services such as counselling, there was very little knowledge of specific types of mental health care professionals, knowledge of facilities, and ways to access any facilities available in their community.

4.2 Understanding of mental health

The adolescents in this study's understanding of mental health was varied, and in some instances limited, and incomplete. There was a basic understanding of mental health in terms of social well-being, mental capacity, and the ability to cope with life challenges. This finding aligns with a Nigerian study investigating adolescent knowledge of depression (Aluh *et al.*, 2018). Renwick and colleagues' systematic review of mental health literacy of children and adolescents in LMICs had similar findings and further reported that adolescents' recognition of mental illnesses varied (Renwick *et al.*, 2022). Adolescents understood that how to cope with life challenges is an integral part of mental health, and as such they not only acknowledged positive mental health but also the ability to manage feelings and emotions when going through struggles. The adolescents perceived that good mental health is fostered by a healthy environment, coupled with a healthy lifestyle including exercising, and eating healthy. Facilitators for positive mental health were believed to include having an upbringing where parents are not separated, and where there are family and friends that provide support and who adolescents can confide in. This is in line with the finding that positive family structures and an active lifestyle can be good for mental health (Kieling *et al.*, 2011; Cluver *et al.*, 2015; Harrison, Loxton and Somhlaba, 2021).

Overall, most of the adolescents had negative associations with mental health. Mental health was understood through the challenges that they experienced and how these affected them daily. This is similar to the findings by Johansson, where adolescents in the study identified mental health as a lived experience (Johansson, Brunnberg and Eriksson, 2007). This was indicated in how the participants shared their stories and emotions, in how they felt frustration, feelings of hopelessness, sorrow,

stress, loneliness, and grief. Many of the participants reported moderate to moderately severe depressive symptoms from the PHQ-9, which supports the qualitative findings of this study. The adolescents showed the ability to recognise and articulate their feelings and emotions, but also the ability to recognise some of the mental health struggles of their peers. This understanding of mental health is similar to Johannson's findings when investigating the perceptions of mental health from adolescent boys and girls. Adolescents in the study described both their positive and negative emotions and related mental health and mental health struggles to their daily encounters (Johansson, Brunnberg and Eriksson, 2007). This study found that having the ability to recognise and describe mental health struggles could influence help-seeking behaviour. The adolescents' ability to recognise and mention any mental health struggles in this study was dependent on them recognising any challenge as something that should be shared with someone else.

The adolescents in this study understood mental health challenges as something they should manage on their own and that did not require any professional interventions. In Aluh and colleague's (2018) research on adolescents' identification of mental health disorders suggest that adolescents have a decreased ability to accurately identify symptoms such as clinical depression and they were also less likely to suggest professional intervention for any mental disorders identified (Aluh *et al.*, 2018). This was confirmed in Renwick's systematic review, which determined that there was poor help-seeking behaviour in LMICs (Renwick *et al.*, 2022). It is worth noting that the studies had set out to identify the adolescents' ability to recognise specific symptoms through vignettes and questionnaires, whereas my study set out to investigate their perceptions of mental health and mental health services and their experiences through interviews.

Many of the adolescents in this study had traumatic experiences that contributed to their mental health such as being raped, being bullied, experiencing colourism, having a chronic illness, academic stress, peer pressure, and experiencing poverty. Experiencing these adverse events negatively affected their mental health, which is consistent with Mall and colleague's findings and the negative effects they have on mental health (Mall *et al.*, 2018). Their experiences affected their mental health poorly, resulting in mood changes, depression, self-harm, suicidal ideation, and a suicide attempt. The unmitigated exposure to adverse childhood events has been found to have detrimental effects on the health of adolescents and can lead to them being susceptible to developing mental health disorders in the future, where suicidal ideation and attempts are potential outcomes (Bannink *et al.*, 2014; Cluver *et al.*, 2015; Aluh *et al.*, 2018). The adolescents also alluded to how their traumas influenced their school progress, a finding that was similar to Harrison, Loxton and Somhlaba's study on how adverse events affect mental health, but also school performance (Harrison, Loxton and Somhlaba, 2021).

4.3 Understanding of mental illness

The adolescents in this study understood mental illness in a less varied manner compared to their understanding of mental health and mental health disorders. Their understanding of mental illness was psychiatric disorders, that people are born with or a result of substance and alcohol abuse, which require medical intervention and institutionalisation. Some participants associated mental illness with having cognitive or learning disabilities. One of the adolescents was able to name bipolar disorder as a mental disorder, where they described the symptoms as being hyper and uncontrollable. The adolescents' understanding of mental illness is aligned with a Western understanding of mental illness. The adolescents in this study did not associate mental illness with spiritual or traditional possessions, in addition to Western forms of understanding, which was contrary to observations made in studies exploring the perceptions of mental illness and mental disorders from adolescents in a Nigerian community and residents in a South African district (Aluh *et al.*, 2018; Kometsi, Mkhize and Pillay, 2020). The studies set out to investigate views on depression and psychiatric disorders such as schizophrenia while this study sought to explore what they understood as mental illness. It is then possible that the study design of this study would not elicit a response that would be similar to the previous studies. This study relied on their existing knowledge and not their ability to recognise and label symptoms from questionnaires and vignettes. This gives insight as to how they acknowledged illness and distress and how they communicate to others.

The adolescents' acknowledgement of mental illness was related to what they have seen, with some describing psychotic symptoms such as 'picking up papers' and 'speaking to a bottle', and others using descriptors such as mentally disturbed, mad, crazy, and not being normal to describe living with mental illness. This was also the case when some of the adolescents described mental illness in isiZulu, using the term "umuntu ohlanyayo" which means "a 'crazy' person". Kometsi and colleagues had similar findings to how people identified disorders such as depression, schizophrenia and alcohol dependency (Kometsi, Mkhize and Pillay, 2020). This is likely informed by the pre-existing stigma and misinformation, or the lack of an adequately developed African language that does not stigmatise people with mental illness (Kometsi, Mkhize and Pillay, 2020), and the lack of promotion of less stigmatising terms. Stigma has been a well-documented barrier to mental health and accessing mental health care (Sartorious, 2007; Kakuma *et al.*, 2010; Sorsdahl *et al.*, 2012), and is further exacerbated by the continued use of stigmatising language and attitudes towards people with mental illness.

4.4 Perceived causes of mental health challenges.

4.4.1 Bullying and peer pressure

The adolescents in this study were able to articulate some of the challenges they faced and how these affected their mental health. One of the most notable findings of the study was that almost all the

adolescents mentioned bullying as being prevalent in their school, whether having experienced it or perceived it to be a cause of poor mental health. van der Westhuizen and colleagues (2023) reported similar findings in their study of adolescents in Belize, Kazakhstan and South Africa (van der Westhuizen *et al.*, 2023). Steyn and Singh highlighted the increased prevalence of bullying in South African schools and the reported causes such as family dysfunction, peer pressure and community violence (Steyn and Singh, 2018). The adolescents described how being bullied led to mental health struggles such as depression, but also affected their poor school performance and resulted in a decreased desire to go to school, caused mood and behavioural changes, and led to suicidal ideation. Similarly, the adolescents in van der Westhuizen and Colleague's research cited the negative effects of bullying on their emotional well-being (van der Westhuizen *et al.*, 2023). The similar results demonstrate the robustness of data obtained through this study. Bullying amongst adolescents has been found to have detrimental effects on their mental health, with similar reported outcomes such as suicidal ideation, poor school performance and depression for those who are experiencing bullying (Bannink *et al.*, 2014; Kim *et al.*, 2017).

The adolescents mentioned peer pressure as being prevalent in their school and community, where some perceived having the 'ideal body' and popularity to be prioritised over academic performance. Some of the adolescents alluded to how the influence of peers could lead to changed behaviour such as being disobedient to their parents or substance and alcohol use to ingratiate themselves among their friends, and this would ultimately lead to poor mental health. This aligns with the finding of Hendricks and colleagues which suggests that, while there is a sociopolitical context to substance abuse in South Africa, peer pressure is an added risk factor among adolescents (Hendricks, Savahl and Florence, 2015). This is further corroborated by the findings of van der Westhuizen and colleagues, where the adolescents alluded to the peer pressure influencing substance use and behavioural changes (van der Westhuizen *et al.*, 2023). Some of the adolescents suggested that peer pressure results in their wanting material things such as phones and extra money, which could potentially lead to them getting it from older men. This observation aligns with some of the views of young women's perceptions on transactional relationships (Ranganathan *et al.*, 2017). Poverty or financial potential gains have been recognised as driving forces towards transactional relationships for young women in South Africa (Ranganathan *et al.*, 2017; Duby *et al.*, 2021). It is worth noting that some of the participants in the study reported active participation in transactional relationships and others had an aversion to them (Ranganathan *et al.*, 2017). The interaction between material things and money was noted differently by some of the adolescents in van der Westhuizen and colleagues (van der Westhuizen *et al.*, 2023), where some viewed the lack of money and material things as isolating to

their peers while others associated having material things and money with positive emotions (van der Westhuizen *et al.*, 2023).

4.4.2 Trauma

The adolescents in the study perceived certain experiences as being causes of mental health struggles. Childhood abuse, teenage pregnancy, being emotionally neglected, experiencing, or witnessing a violent crime such as murder, theft or kidnapping were some of the issues they listed as having a negative impact on mental health. This is in line with some of the perceived causes of poor mental health outcomes by other adolescents (van der Westhuizen *et al.*, 2023). Several studies that investigated adverse childhood events and the detrimental effects they have on mental health reported outcomes such as, but not limited to developing depression, anxiety disorder, mood disorders and threat of suicide (Humm, Kaminer and Hardy, 2018; Mall *et al.*, 2018; Harrison, Loxton and Somhlaba, 2019). With adolescent exposure to violence affecting 80% of adolescents in South Africa (Humm, Kaminer and Hardy, 2018), this increases the chances of them experiencing a mental health disorder. Only the girls in this study mentioned rape and sexual assault as an experience or concern in their lives. This is indicative of different lived experiences for boys and girls which have varying effects on their lives and mental health. South Africa has high reported numbers of rape and sexual assault, with women and girls being affected the most (Devries and Meinck, 2018; Ward *et al.*, 2018), which lead to mental disorders such as depression, anxiety disorder and suicidal ideation (Cluver *et al.*, 2015; Mall *et al.*, 2018). This suggests a need for mental health promotion and prevention programmes that are sensitive to the experiences of boys and girls.

4.4.3 Self-image and self-identity

Some of the adolescents in this study revealed how their experiences affected their self-image and self-identity. Some of the girls cited colourism as being an issue they faced in their school and in their lives. The adolescents described how their peers grouped themselves according to skin complexion and others described having a negative image of themselves and wanting to have a lighter complexion. Anjari astutely described how colourism, as a consequence of racial segregation in South Africa and manufactured beauty standards, affects Black women and women of colour disproportionately (Anjari, 2022). These were similar findings to research conducted by Mbatha (2016) on students from a Cape Town academic institution, where they revealed how colourism affects their lives and inform beauty standards in their communities (Mbatha, 2016). For the adolescents in this study, this was reinforced by their peers and in some instances their parents. Some of the adolescents in this study had concerns about developing pimples on their faces which influenced the way they perceived themselves. Natsuki and Yates reported the high prevalence of acne among young people and further raised concern about its impact on the mental health of the youth (Natsuaki and Yates, 2021). Sexual

orientation and religious belief were mentioned by one of the adolescents to be things that they struggled with and that others may struggle with as well. Having their parents respond negatively to their sexuality demotivated them from speaking about other issues they could have. Facing bigotry because of their sexual orientation at a young age is damaging for adolescents as they are still forming their own beliefs and developing their own understanding of the world and themselves (Francis, 2017; Lamontagne *et al.*, 2018).

4.5 Influence of interpersonal relationships

4.5.1 Positive influence of family

The adolescents in this study were cognisant of the influence of family relationships and dynamics that influence their mental health. Some of them viewed family members as the only people they trusted to be open with about their problems and were the first people they would talk to.

Similar studies reported that adolescents perceived family as their most trusted person to speak to about mental health issues (Johansson, Brunnberg and Eriksson, 2007; van der Westhuizen *et al.*, 2023). This is further solidified by other studies which found that family is an important and primary support structure for adolescents. (Stansfeld *et al.*, 2017; Humm, Kaminer and Hardy, 2018; Magson *et al.*, 2021). Their recognition of this was through their own experiences and perceptions of how family can positively influence their mental health. Some adolescents who had been raped, bullied, or experienced a traumatic event were able to speak to their family and got support and professional help where it was possible for them. Having positive relationships with family members is an essential aspect for adolescents as it could increase the likelihood of them speaking when they are going through struggle because they are confiding in someone they trust and are comfortable with (Harrison, Loxton and Somhlaba, 2021; Courtwright, Le Pard and Jones, 2022).

4.5.2 Negative influence of family

Some of the adolescents in this study had different experiences and relationships with their families. Family was sometimes a source of pain and discomfort for them. They indicated that being criticized and dismissed, being mistreated, and being bullied at home were causes of poor mental health. Family dysfunction such as parents being divorced or separated (Patton *et al.*, 2014), emotional neglect and abuse (Geoffroy *et al.*, 2016; Mall *et al.*, 2018) are noted contributors to adolescents developing mental health disorders, which extend into adulthood (Patton *et al.*, 2014). Additionally, the lack of support and neglect affects adolescent youth's ability to progress or do well academically (Geoffroy *et al.*, 2016; Ajaero, Nzeadibe and Igboeli, 2018). Some adolescents in this study encountered trouble when communicating their struggles with their families, which led to them to not wanting to talk with them about other issues they encountered. Lacking emotional support and not having a confidant introduces an added challenge to addressing the mental health of adolescents. Adolescents having

someone they can talk to, provide them with ways to cope, and seek the necessary professional help potentially alleviates the effects of mental health struggles, and the absence of this, could harm their mental health further (Geoffroy *et al.*, 2016; Harrison, Loxton and Somhlaba, 2021).

4.5.3 Positive Influence of friends

The adolescents in the study revealed how friends had a positive influence in their lives. They had a positive association with friends that were able to motivate them, help them avoid bad decisions and provide emotional support for them. Some of them were able to speak to their friends about their academic stress and get the needed help and motivation, which was a similar finding in other studies (Lesch and De Jager, 2014; van der Westhuizen *et al.*, 2023). Adolescents in other studies noted the importance of friends and in some instances, romantic relationships to their emotional well-being (Johansson, Brunnberg and Eriksson, 2007; van der Westhuizen *et al.*, 2023).

4.5.4 Negative influence of friends

Some of the adolescents in the study had negative experiences with their friends, which impacted their mental health. They cited bullying and name calling, disloyalty and betrayal from former friends, whether they revealed secrets that were shared by them or starting relationships with their former partners. This finding is similar to that of Johansson and colleagues (2007) and van der Westhuizen and colleagues (2023), where adolescents had negative experiences such as bullying from their peers which negatively impacted their mental health (Johansson, Brunnberg and Eriksson, 2007; van der Westhuizen *et al.*, 2023). The adolescents in this study reported several outcomes such as loss of appetite, feeling physically ill, feeling depressed and having suicidal ideation, feeling unwanted, and having trust issues. Adolescents' relationships are an important part of their development, and their interpersonal relationships are influential to their well-being.

4.5.5 Disconnection from family and friends

The adolescents revealed issues they have regarding their relationships with family and friends. Being mistreated and bullied by friends and family, feeling criticized and dismissed, feeling embarrassed or the fear of being misunderstood resulted in the adolescents having less of a desire to communicate their issues and deal with them on their own. The additional lack of a perceived support structure places the adolescents at risk of poorer mental health outcomes. The adolescents in the study preferred being reclusive despite them suggesting that speaking to someone could assist when going through challenges. While they promoted communicating about mental health struggles, they felt they were not able to do the same with their friends or family. Some felt isolated and distant from their family and friends, and even felt lonely while in the presence of others.

4.6 Knowledge of mental health services

The adolescents in the study had very low knowledge of mental health services. Their overall knowledge was limited to counselling or therapy. Adolescents in van der Westhuizen and colleagues (2023) had similar knowledge around mental health services. The ability to recognise and identify mental health struggles should be supplemented with the knowledge of available services that can be accessed and limited knowledge on mental health services hinders the adolescents help-seeking behaviour. One of the adolescents was able to list Childline as a mental health service they could access. The adolescent who had seen a social worker and therapist was only able to list facilities generically such as a '*clinic*' and '*hospital*'. Their perception and experience of the therapist was positive, and they felt that it helped them. Adolescents that mentioned '*rehab*' as a mental health service, referred to them for what they understood to be mental illness. This adds to the existing stigma and misinformation about mental health and mental illness. A finding that is similar to Goodwin and colleague's (2016) study on adolescent views on mental health care services (Goodwin, Savage and Horgan, 2016). Acknowledging mental health facilities as only for people with severe mental illness further limits their likelihood of seeking professional help for mental health struggles as it reinforces the existing stigma around mental health (Goodwin, Savage and Horgan, 2016). The adolescents in the study had minimal knowledge and experiences with mental health facilities and as such, this study was unable to appropriately explore their attitudes towards mental health care services. The findings of this study, however, suggest that there is also a lack of a perceived need to seeking professional help as the adolescents viewed mental health challenges as something they should be able to cope with.

4.6.1 Informal mental health support and coping mechanisms

Many of the adolescents in this study viewed family and friends to be their primary form of support when going through any struggles, and some had confided in them when they had experienced trauma or faced mental health challenges. This aligns with other studies which indicated that adolescents are more likely to confide in someone close to them when going through mental health challenges (Johansson, Brunnberg and Eriksson, 2007; van der Westhuizen *et al.*, 2023).

Some of the adolescents in this study viewed religion as a coping mechanism for them. They alluded to how prayer and reading scriptures gave them consolation when going through mental health challenges. Goodwin and colleagues (2016) noted the influence of religion and prayer among adolescents and young adults on mental health and mental health services (Goodwin, Savage and Horgan, 2016). While religion was mentioned by some of the adolescents as their coping mechanism, they did not indicate that it dissuaded them against mental health care.

A finding of this study was that, while some of the adolescents mentioned school positively and enjoyed coming to school and learning, none of them indicated that they told a teacher nor suggested that speaking to a teacher as a perceived facilitator for good mental health. This is contrary to van der Westhuizen and colleagues' findings, where adolescents viewed and recommended teachers and their schools as being important support structures (van der Westhuizen *et al.*, 2023).

This finding should not be viewed as a generalisation of the experiences of all the adolescents in the school because of the study method as well as the low number of adolescents interviewed in the context of the total number of learners in the school. Additionally, this could be influenced by the interview method not being structured to produce responses that would be contrary to this. This does, however, provide an opportunity to explore any barriers to the adolescents speaking to their teacher and provide solutions that could address them. Some of the issues the adolescents face such as bullying and academic stress occur within the school environment and having teachers as contact people for adolescents to speak about their problems earlier could improve the adolescents' experiences and mental well-being.

4.6.2 Adolescent coping mechanisms

The adolescents revealed that they coped with challenges in a variety of ways. While friends and family were their primary sources of support, they mentioned other ways they dealt with their challenges. Some adolescents preferred dealing with their problems on their own, due to fear of being judged or misunderstood, feeling embarrassed to speak, and a fear of not having their secret kept. This could also speak to how the adolescents feel they should be able to handle their struggles on their own. While resilience in adolescents is multifactorial and family stability is an important factor in facilitating this (Harrison, Loxton and Somhlaba, 2021), the adolescents' ability to be resilient may be adequate for them and their circumstances which informs their preference to handle their problem on their own. A male participant stated that they do not speak about their problems because of the belief that men do not talk to their friends and family about their problems. A similar finding from Johansson and colleagues (2007) and Lindsey and colleagues (2017) where adolescent males reported not talking about their feelings and related it to their masculinity (Johansson, Brunnberg and Eriksson, 2007; Lindsey, Brown and Cunningham, 2017). While this was mentioned by only one of the participants, it provides added insight into the beliefs of adolescent boys on mental health. Due to the lack of additional insights from other participants, any deductions made from this would be speculation.

Several recreational activities were cited by the adolescents as ways they keep themselves healthy and how they cope with mental health struggles. Many engaged in singing and listening to music, reading, drawing, baking, watching a movie, being on social media, playing sports, exercising and being around nature. This is consistent with some of the findings in Fourie and colleagues' (2011) assessment

on adolescents' participation in sports and recreational activities (Fourie, Slabbert and Saayman, 2011). Wegner and Majee (2022) articulate the importance of leisure time in adolescent development and positive behaviour (Wegner and Majee, 2022).

The adolescents expressed goals they wished to attain such as getting a degree, having a career and being a businesswoman, having their own families, owning a house and a car, travelling and being able to provide for their parents financially, which is an important feature for their lives. Some of the adolescents expressed feelings of hopelessness, lacking motivation and despondency as factors that impact mental health, and having goals and dreams provides them with hope and motivation throughout their lives.

4.7 Perceived and suggested facilitators for good mental health

The participants in this study offered ways in which the mental health of adolescents could be improved. They believed that preventing bullying and limiting forming groups according to their complexions could limit mental health struggles, which was similar to van der Westhuizen and colleagues' finding, where the adolescents proposed anti-bullying programmes for their schools (van der Westhuizen *et al.*, 2023). The adolescents espoused speaking to family and friends, and it was important that the person they confide in be empathic and understand their struggle. Family stability and having peaceful environments were viewed as essential facilitators for mental health for the adolescents, which is a similar finding reported in other studies (Harrison, Loxton and Somhlaba, 2021; van der Westhuizen *et al.*, 2023).

Many of the adolescents suggested fundraising for organisations that offered free professional counselling services for the youth when they needed them. This was also suggested by adolescents in van der Westhuizen dan colleague's study (van der Westhuizen *et al.*, 2023), who further suggested law and policy changes that would affect their community and their overall well-being (van der Westhuizen *et al.*, 2023). This aspect of mental health promotion was not mentioned by adolescents in this study. There is potentially an inability to relate changes in their environment to a direct correlation with their well-being. A few of the adolescents indicated that continued stay and adhering to the help provided would be dependent on an individual's commitment. This view suggests that they believe adherence to treatment programs is solely reliant on a person's desire. A critique of this would not be appropriate as understanding adherence to treatment has varying aspects and would likely be beyond the understanding of an adolescent.

The adolescents suggested mental health promotion programmes in schools and communities to increase the community's knowledge of mental health and mental illness. Additional suggestions were motivational talks for adolescents and increased advertising through social media, highlighting how to identify mental health symptoms and provide contact information for accessible mental health care

services. Similar suggestions were made by adolescents in van der Westhuizen and colleagues (2023). Further recommendations were community and school programs that integrated counsellor, health workers, parents, and the youth as stakeholders (van der Westhuizen *et al.*, 2023). Some of the recommendations in the study were likely informed by some participants being research facilitators and would have more information regarding adolescent mental health and mental health services (van der Westhuizen *et al.*, 2023).

4.8 Strengths and limitations

4.8.1 Strengths

The study used an exploratory qualitative research design to investigate the perceptions, attitudes and experiences of mental health and mental health services among adolescents. In addition to the in-depth interview guide, participants engaged in a collage activity where they described how they felt or what they were going through in their lives. Including this in the study methods proved to be beneficial to the data collection. Participants were able to express some of the issues they faced such as colourism and being self-conscious about their skin. Additionally, this method revealed the adolescents' aspirations and how having goals influenced their mental health. These findings may not have been revealed if this method had not been employed. The use of in-depth interviews helped reveal the perceptions and attitudes of mental health and mental health services among the adolescents in this study. The research methods relied on the adolescents' pre-existing knowledge, which highlighted their varying understandings of mental health. I was able to probe into the knowledge and experiences of the adolescents with provide rich data on their experiences and understanding of mental health (Choy, 2014).

4.8.2 Limitations

Some study limitations were experienced throughout the data collection of this study. Recruitment was halted by school holidays, which limited the number of participants that could have participated in the study. The participants consisted of ten girls and three boys. While the objective of the study was not to identify differences across sexes in the perceptions of mental health and mental health services, this disparity limited any potential analysis of that nature.

The study was limited to school-going adolescents and as such cannot be easily transferred to non-school-going adolescents. Due to the sensitive nature of the study, social desirability could have influenced the participants into providing responses they assumed were wanted by the researcher (Larson, 2019). An example of such a case was apparent when one participant researched the topic of mental health before the interviews. Because the researcher was a male, there needs to be consideration of how the female participants' responses could have been influenced by this. Although

the researcher was able to relate to the participants and build a rapport with them, due to my being older than them and my respective educational level, there may have been a power dynamic that influenced data collection throughout the study. The data collected as well as the researchers' experience suggests that female participants were not influenced by this, or it was at a minimum. The study was conducted in one Johannesburg high school and the results cannot be generalised to other populations. The research was only conducted in English which may have been an issue for the participants in not being able to express themselves appropriately in their home language.

Both social desirability bias and recall bias could have occurred when collecting data. To reduce the risk of social desirability bias, the participants were reassured of their confidentiality and anonymity while participating in the study, and the interview guide was structured to be clear and easily understood. While these measures were made to try and reduce any biases experienced, they cannot be fully eliminated and proper understanding of the questions by the participants was assumed. Participants who did not understand a question asked stated so or indicated that they did not have an answer.

Chapter 5 – Conclusion and Recommendations

5.1 Conclusion

This study aimed to explore the perceptions, attitudes and experiences of mental health and mental health services among adolescents from a Johannesburg high school. The findings of this study revealed some key aspects of adolescents' understanding of mental health and mental health services. The adolescents' knowledge of mental health was varied, and at times incomplete. Their knowledge ranged from understanding mental health as social well-being and having the ability to cope with life challenges, to intellectual capacity and creative ability. They believed good mental health was facilitated by family stability, healthy eating and exercise habits, and a peaceful environment.

Mental health was associated with negative emotions and feelings that are the resultant of challenges in their daily lives. The adolescents described their lived experience, with many of them mentioning bullying, peer pressure, violence, colourism, rape, and grief as some of the challenges that they have faced or perceived as posing a risk to their mental health. Other risk factors mentioned by the adolescents were family dysfunction, distrust among friends, and academic stress. The adolescents experienced several outcomes because of their experiences such as negative self-image, mood changes, depression, and suicidal ideation. The adolescents perceived mental health challenges as a part of the ebb and flow of life, and something they should be able to handle on their own.

The study findings reveal that mental illness was understood in a less varied manner as opposed to the different understanding of mental health. The adolescents' understanding of mental illness was limited to conspicuous psychiatric disorders, and cognitive and learning disabilities. The adolescents viewed people with mental illness as needing institutionalisation and permanent assistance. Stigmatising language was prevalent among the participants of the study, where they referred to people living with mental illness as being mentally disturbed, crazy, and not normal. The use of such language perpetuates the existing stigma and continues to be an added barrier to mental health.

The adolescents had minimal knowledge and experience with mental health care services. All but one were able to mention a service they could contact if they had a mental health challenge. Their knowledge of the types of mental health services available was also limited, and they were only able to name counselling/therapy as a professional health service.

Some of the adolescents in this study revealed stigmatising attitudes towards mental health care services, where the association was only for people living with severe mental and psychiatric disorders.

The adolescents viewed family and friends as primary support structures in their lives, and most of them suggested confiding in someone to alleviate mental health struggles. Family and friends were able to support some of the adolescents when they had a mental health challenge by providing advice,

motivation, coping mechanisms and referral to mental health care services where it was needed and available. This further highlights the significance of positive interpersonal relationships which assist in mitigating the mental health struggles of adolescents.

5.2 **Recommendations**

5.2.1 Future Research

Adolescents are faced with a plethora of challenges that affect their daily lives and in turn their mental health. As such it is important to investigate their understanding of mental health and their perceived causes of these mental health struggles. This study seeks to add to the limited data that exists in LMIC, and South Africa in particular. The findings of the study present an opportunity for further exploration of adolescent perspectives on mental health, that will inform how policy and programs are implemented. Research as to how adolescents identify mental health and illness will provide greater insight into adolescent mental health and inform policy development and implementation that is culturally and socially relevant. This study revealed the continued prevalence of stigma among adolescents and in their community, which is further perpetuated by the lack of a developed or popularised vocabulary on mental health and mental illness. Further exploration into what informs stigma for adolescents and how it manifests is essential to understanding the extent to which their lives after affected.

5.2.2 Parent and Teacher Participation

Parents and teachers have significant roles in adolescent development, which makes their involvement in mental health research more crucial. The varying experiences of the adolescents from this study suggest a complex interaction between their environment and interpersonal relationships. Some of the stressors experienced by the adolescents were in their school environment where they spend a significant proportion of their time. The adolescents highlighted communicating with family and friends when going through mental health challenges as being an important facilitator for good mental health, yet none recommended their teachers as confidants. Investigations centred around teacher-learner relationships could provide needed insight into the potential barriers and facilitators for adolescent mental health within the school environment.

5.2.3 Policy

Adolescent mental health remains a neglected area of health in South Africa, which is evidenced by the lack of any provincial CAMH policy (Mokitimi, Schneider and de Vries, 2022) and poor integration of mental health care into primary health care (PHC) (Mokgaola *et al.*, 2022). Participants in this study illustrated a Western understanding of mental illness whereas other studies identified a spiritual and cultural understanding of mental illness as well (Aluh *et al.*, 2018; Kometsi, Mkhize and Pillay, 2020).

Policy development and implementation should apply to the specific communities they are intended to serve. It then becomes essential to be aware of the knowledge, perceptions, and experiences of adolescents within a community. This will circumvent barriers such as the acceptability of intervention strategies which may not be appropriate for all communities.

5.2.4 School-based Programmes

The school environment is of great importance in the lives of adolescents. Beyond the educational benefits of attending school, they can socialise and engage in extracurricular activities where they are available. Furthermore, the school provides an opportunity for the implementation of health promotion and prevention of mental illness programmes. Collaborative efforts with teachers and parents should be made to establish adolescent mental health programmes that are relevant to their environment and immediate needs. Studies such as this provide the needed cultural and social context for adapting any proposed intervention programme that fits the needs of adolescents. The adolescents in this study were aware of the experiences that affected their mental health. It is then crucial to their development and well-being to be cognizant of this and how they communicate their struggles. Many of the risk factors associated with adolescent mental health disorders such as family dysfunction, academic stress and sexual violence were mentioned in this study. But additional findings such as colourism among young girls and the effects on their self-images, and masculinity being associated with mental strength, are areas of exploration as to the adolescents' experiences and views in a contemporary world. This will subsequently inform the nature and design of school-based mental health promotion programmes.

This study highlights the stigma and misinformation that is prevalent among adolescents. Their attitudes towards mental illness and mental health care services add an added barrier to accessing mental health care services. Their lack of knowledge about mental health care services coupled with negative perceptions around mental health care hinders their likelihood of seeking mental health care. Mental health promotion strategies for adolescents should seek to address their prevailing understanding of mental health and mental health care services in addition to providing information on available mental health care services in their community or telephonically.

Integration of mental health care services into PHC remains poor and inadequate due to barriers such as poor staff training and development, a lack of specialised child and mental health professionals, and a lack of specialised mental health services (Mokgaola *et al.*, 2022). The health outcomes of adolescents are worsened by the prevalent misinformation, stigma, and a perceived lack of a need for professional interventions as evidenced by this study. The inadequate recognition and referral for mental disorders in PHC settings indicates the need for alternative pathways that seek to improve adolescent mental health (Mokgaola *et al.*, 2022). The development and implementation of a Quality

Improvement Plan (QIP) in the school setting could be beneficial in raising awareness of mental health and bolstering referral to mental health care services. QIPs seek to assess risk and protective factors experienced by a community, develop and implement an intervention strategy, as well as monitor progress (National Department of Health, 2021). The training of teachers, parents and adolescents should be essential to the programmes as not only does it engage the direct stakeholders of the community but also equips them with the necessary skills for identifying and referring adolescents who are having mental health struggles.

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Appendices

Appendix A: Plagiarism Declaration

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Nkhluleko Joshua Ndlangamandla (Student number: 450258) am a student registered for the degree of Masters in Public Health in the academic year 2024.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature:  Date: 28 March 2024

Appendix B: Socio-Demographic Questionnaire

Date: ___/_____/_____ **Study ID**

DEMOGRAPHIC INFORMATION QUESTIONNAIRE

Please fill out the survey by circling and writing your answers.

1. Gender:
    a. Female
    b. Male
    c. Non-binary
    d. Genderqueer
2. Grade_____
3. Siblings Yes/ No
    a. If Yes, How many: _____
4. Who do you live with?
    a. Both biological parents
    b. Mother only
    c. Father only
    d. Grandparent
    e. Relative e.g. Aunt, uncle, cousin
    f. Brother/sister
    g. Other (not related) _____
    h. Other related _____
5. Age: _____
6. How do you get to school?
    a. Walk
    b. Catch a bus

c. Taxi

d. Parent drops you

e. Someone else drops you

f. Other _____

Appendix C: Patient Health Questionnaire (PHQ-9)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Appendix D: In-depth Interview Guide

In-depth interview guide

Collage aim: To create a collage that represents the participant's life at this exact point in time.

Today we are going to do an activity creating an artwork which is called a collage from pictures that you can choose from this pile here. Pick five or six pictures that really speak to you. You can also draw or write anything that you want to add to the artwork.

"Create an artwork or collage that shows me how your life is right now, all the aspects of your life that you can think about."

Here is a piece of cardboard, some glue, these coloured markers and pencils for you to use. We are going to create an artwork that represents your life at the moment. This collage can look like anything you want it to look because it is your art, whatever you decide to put on this cardboard is the right thing because there are no wrong ways to do this. You can write words or draw as well. Remember that your art will not be marked or judged so be free to take your time and see what you come up with and to have fun.

You can ask me any questions you may have while creating your collage and we can also talk about anything you want to talk about while you are creating your collage.

Well done! This is great, now if you could give this collage a name what would it be?

- Encourage the participant to give their collage a title and to write it on the collage.

Exploratory questions

- Tell me about your collage? (ask about the different parts, words or images)
    - Tell me about who is represented in the art (if this has not come out already); what is your relationship like (with anyone mentioned)
    - What does it say about your life right now?
    - What does it say about what you would like more of in your life?

- What do you know about "mental health" and what does it mean to you?
    - How is this the same or different from mental illness is?
- What are some of the mental health challenges that young people in this school or where you live may be facing?

- What do you think causes mental health challenges (or illnesses)? Think about your family, friends, school, community
- Have you ever experienced any mental health challenges?

  [If they disclose that they have]:

  - Can you give me a few examples of such challenges and how they have affected you?
  - Who do you talk to about what you go through, if anyone at all?
    - [If the participant has talked to anyone] How did the person respond when you talked to them? To what extent has it made a difference?
    - [If the participant has not talked to anyone] What makes it hard to talk to someone about what you're going through? What could make it easier, if anything?
- Have you ever used any mental health services and how was your experience if you have?

  [If they state that they haven't experienced any challenges]:

  - What are some of the things that you do to keep yourself mentally healthy?
  - Do you know of anyone that has experienced such a challenge and how they have dealt with it?

- What do you think makes the mental health of young people better/worse?
- What are some of the things that you think have contributed to your mental health? Think about your family, friends, school, community.
- What kind of support is available for people living with a mental illness, if any at all?
  - What mental health care services do you know about?

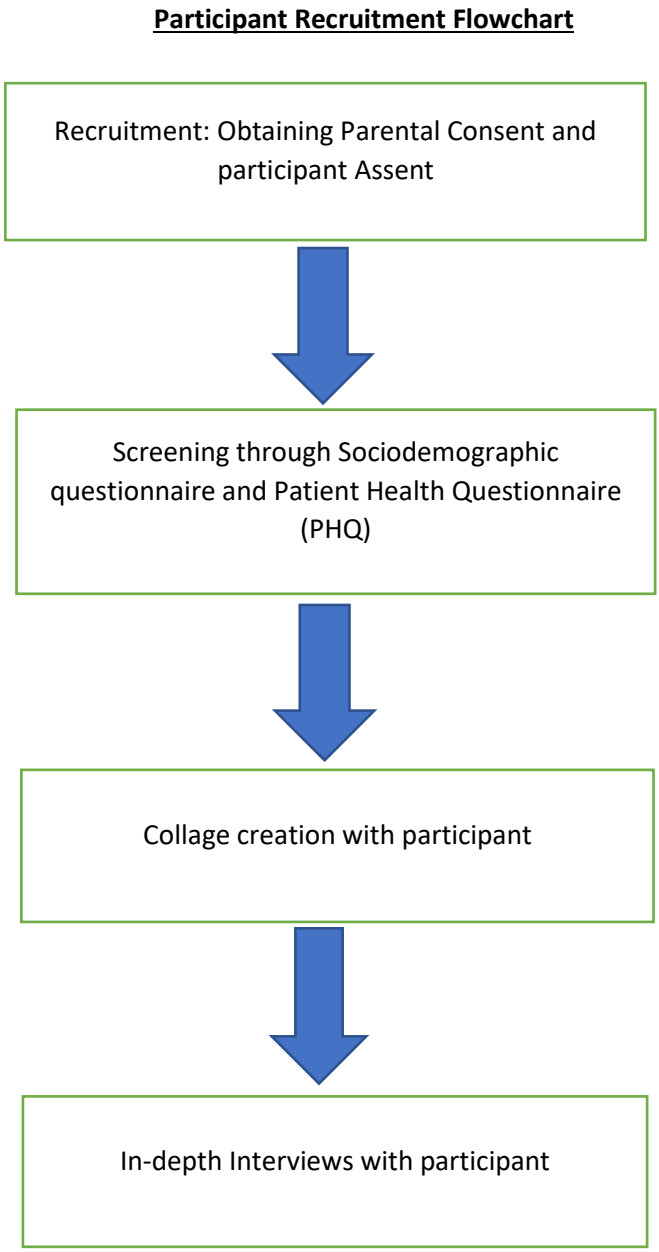
<u>Closing questions</u>

- If you could do anything in the world to improve the mental health of young people, what would you do?
- What do you think can be done better to improve the awareness of mental health for young people?
- Do you need some support right now? I am going to give you the name of someone you can call if you are going through a tough time.

I am going to give you the name of someone you can call if you are going through a tough time.

Thank you for your participation

Appendix E: Flow Chart



Appendix F: Human Research Ethics Committee (Medical) ethics certificate

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

R49 Mr NJ Ndlangamandla

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M220708

NAME: (Principal Investigator)	Mr NJ Ndlangamandla
DEPARTMENT:	School of Public Health Medical School
PROJECT TITLE:	*Perceptions, attitudes and experiences of mental health and mental health services amongst adolescents in a Johannesburg high school*
DATE CONSIDERED:	2022/07/29
DECISION:	Approved unconditionally
CONDITIONS:	
NOTE:	If contact information regarding student study participants is required, please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>
SUPERVISOR:	Professor N Christofides and Ms A Dreyer
APPROVED BY:	Dr CB Perrny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	2023/04/26

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated from the research protocol as approved, I/we undertake to submit details to the Committee. I agree to submit a yearly progress report. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in July and therefore reports and re-certification will be due in the month of July each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

27/04/2023
Date

Appendix G: Department of Basic Education, Gauteng ethics clearance certificate

GAUTENG PROVINCE
Department: Education
REPUBLIC OF SOUTH AFRICA

8/4/4/1/2

GDE RESEARCH APPROVAL LETTER

Date:	**06 February 2023**
Validity of Research Approval:	**08 February 2023– 30 September 2023** **2023/35**
Name of Researcher:	**Ndlangamandla NTJ**
Address of Researcher:	**6 Boundary Road**
	Houghton Village
	Parktown
Telephone Number:	**011 717 2475 / 063 009 5788**
Email address:	**Josh.ndlangamandla@gmail.com**
Research Topic:	**Perceptions attitudes and experiences of mental health and rental services among adolescents in a Johannesburg High School.**
Type of qualification	**Masters**
Number and type of schools:	**1 Secondary School**
District/s/HO	**Johannesburg East**

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

07/02/2023

The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below are met. Approval may be withdrawn should any of the conditions listed below be flouted:

Office of the Director: Education Research and Knowledge Management
7th Floor, 17 Simmonds Street, Johannesburg, 2001
Tel: (011) 355 0488
Email: Faith.Tshabalala@gauteng.gov.za
Website: www.education.gpg.gov.za

Appendix H: Study Information Sheet for Parent/Guardian



STUDY INFORMATION SHEET FOR PARENT/GUARDIAN

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

Good day

Introduction:

I Nkhluleko Ndlangamandla am doing research on adolescent mental health. The research is a process used in seeking new knowledge around the mental health of adolescents. The research is seeking to investigate what young people know about their mental health. The focus is on adolescents as these are the developmental years and adolescents are at risk of experiencing mental illness. The aim is to find out how much they know about their mental health and if they are aware of any services that are available in their communities should there be a need to access these services.

Invitation to Participate:

I am asking for your permission to allow your child to take part in this research study. This study is strictly voluntary and in no way hinders the child's learning as interviews will be conducted after schooling hours.

What is involved in the study?

The study involves me asking questions that are related to the mental health of your child. These questions will be asked in one-on-one interviews. Participants will be asked to fill out a brief socio demographic questionnaire as well as a questionnaire that will gauge how they have been feeling mentally, over a 2-week period. The questionnaires will be used to screen participants who will be participating in the in-depth interviews. The participant will also be asked to participate in an arts-based/visual task that will seek to ease communication between the participant and the researcher, prior to the beginning of the interviews. The interviews seek to explore the knowledge and attitudes of young people when it comes to their mental health. The interviews will take about 40 minutes to complete.

Risks of being involved in the study:
The study involves the risk of emotional or psychological distress that may be experienced during the interviews. In the event of any distress being experienced, the interviews will be stopped, and the participant will be allowed to debrief from the stressed experienced. Should there be a need for counselling services, the researcher will contact Prof Cora Smith on 011 481 5103 at no cost to the

participant. Prof Cora Smith is a registered counsellor and has agreed to aid with the study by availing herself should there a be a need to contact a counsellor. Taking part in the study may cause your child's peers to judge them unfairly because you have done so. This may result in them being treated differently after taking part in the study. Risk of being identified in the study will be limited by not having any participant's name used in the final report of the project or any publications that may come from the study. Only a study ID that will be assigned to them will be used for data collection purposes and not names

Benefits of being in the study: There is no direct benefit to the participant for participating in the study. The research is conducted to investigate the knowledge that adolescents have about their mental health and the services available to them.

Participation

Participation in the study is voluntary and refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled. With your consent, the interviews will be audio recorded for the purpose of data collection and analysis. Should the participant feel like they cannot continue in participating in the study they are free to withdraw from the study without providing a reason. Any data collected on such a person will in default be destroyed, unless the participant specifically consents to the data being used for the research study. The participation of your child is only permitted if both yourself and the child consent to their participation in the study. This can be done by signing the written consent forms which will be provided to you. The interviews will be held after hours on the school premises.

Reimbursements for "out of pocket" expenses

There is no payment for participating in the study. However, the participants will be given an appreciation gift valued at R30 each for participating in the study in the form of an Airtime voucher.

Confidentiality:

The participant's privacy will be treated with the utmost confidence and the data collected will be restricted to the principal investigator and the supervisors of the study. The data collected will be stored electronically and password protected to limit access to only the Principal Investigator and the Supervisors. As these in-depth interviews will be conducted individually, the participant's confidentiality will be maintained by restricting access to the data to the Principal Investigator and the Supervisors only..

The results of the study will be published and may lead to potential identification. All data collected during the study will be securely retained for two (2) years if a scientific publication arises from the study and six (6) years if there is no publication. Thereafter it will be destroyed accordingly. The write-up and publication of the report will not mention any names of the participants. Only a study ID will be used for data collection purposes. This will be to limit the risk of identification

Anonymity
Because this study will be in-depth interviews, anonymity cannot be guaranteed for the participants. Any information revealed throughout the interview will be kept confidential by the researcher.

Contact details of researcher/s: For any further information about the study or to report any bad effects that you may feel after the interviews have been completed, please feel free to contact us:

Principal Investigator:
Nkhluleko Ndlangamandla – 0630095788 – Nkhluleko.Ndlangamandla@students.wits.ac.za
Supervisors:
Prof Nicola Christofides – 0117172566 - Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer – 0117172438 - Abigail.Dreyer@wits.ac.za

Outputs

The study results will be published in an accredited journal and the results can be shared with the participant if they want to know the results of the study.

Contact details of HREC administrator and chair – for reporting of complaints / problems. The following text is recommended:

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number **011 717 2301**, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.

May 2023

Appendix I: Participant Information Sheet for participants 17 years or younger

PARTICIPANT INFORMATION SHEET FOR PARTICIPANTS 17 YEARS AND YOUNGER

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

Good day

Introduction:

I, Nkhluleko Ndlangamandla, am doing a study on the mental health of young people. I am hoping to learn what young people know about their mental health. I want to focus on the youth because this is a sensitive stage of growing up and young people are going through a lot of changes. I want to find out how much you know about mental health and where you can get help when you need to speak about your feelings.

Invitation to Participate:

I am asking for your approval for you to take part in this study. The choice to take part in the study is fully yours and will not affect your learning because the interviews will be after schooling hours.

What is involved in the study?

The study involves me asking you mental health related questions. These questions will be asked in one-on-one interviews. You will be asked to fill out a short form about yourself as well as a form that will tell me how you have been feeling mentally, over a 2-week period.

The form will be used to check participants who will be taking part in the in-depth interviews. You will also be asked to participate in an arts-based/visual task that will make it easier to speak to the researcher. The interviews will be asking about the knowledge and attitudes of young people when it comes to their mental health. The interviews will take about 40 minutes to complete

Risks of being involved in the study:

The interviews will be asking questions that are sensitive and may make you feel uncomfortable at times. If this does happen, the interview session will be stopped by the researcher, and you will be allowed to have a moment to deal with the uncomfortable feelings that you are feeling because of the interviews. If there is a need for counselling services, the researcher will contact Prof Cora Smith on 011 481 5103 at no cost to you. Prof Cora Smith is a registered counsellor and has agreed to help with the study by being available if there a be a need to contact a counsellor. Taking part in the study may cause your peers to judge you unfairly because you have done so. This may result in them treating you differently after you take part in the study. Risk of being identified will be limited by not using any

names in the write-up of the report or any of the publications that may come from this study. A study ID will be given to each participant and that will be used for data collection instead of names.

Benefits of being in the study:

You will not benefit from taking part in the study. The study is being done to find out what young people know and how they feel about their mental health status. This will have no direct benefit for those who choose to take part in the study.

Taking part in the study

It is your choice to take part in the study and you will not be treated any differently should you choose to not take part in the study. With your permission, the interviews will be audio=recorded so the information can be collected and stored for use in the study. If you feel like you can no longer continue with the interviews at any moment. You can stop the interview and ask that you be taken out of the study. You do not have to give a reason for no longer wanting to take part in the study. Any of the information that has been collected will be destroyed. The information will be kept only if you agree to it. Both you and your parent/guardian must first agree to you taking part in the study before you can do so. This will be done by signing the written consent forms that will be provided. The interviews will take place after school hours on the school grounds

Payment for "out of pocket" expenses

There is no payment for taking part in the study. But you will be given a gift valued at R30 each in the form of an Airtime voucher.

Privacy

The interviews will be done on a one-on-one basis. The participant's privacy will be maintained by limiting access to the data to the Principal Investigator and the Supervisors only

The interviews will be audio recorded to collect the data. The results collected will be stored electronically and will be password protected. Only the Principal Investigator and the Supervisors will have access to the information. The results of the study will be published. This may lead to you being identified. All data collected the study will be kept for two (2) years if the study is published. If the study is not published, it will be kept for six (6) years. After this time, all the information collected will be destroyed.

Anonymity
Because this study is will be in-depth interviews, anonymity cannot be guaranteed for the participants. Any information that comes out of the interview will be kept private by the researcher. This will only be shared with the supervisors.

Contact details of researcher/s: For any further information about the study or to report any bad effects that you may feel after the interviews have been completed, please feel free to contact us:

Principal Investigator:
Nkhluleko Ndlangamandla – 0630095788 – Nkhluleko.Ndlangamandla@students.wits.ac.za
Supervisors:
Prof Nicola Christofides – 0117172566 - Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer – 0117172438 - Abigail.Dreyer@wits.ac.za .

Outputs

The study results will be published in an approved journal. The results can be shared with you if they you to know the results of the study.

Contact details of HREC administrator and chair – for reporting of complaints / problems. The following text is recommended:

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). The work of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za . The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.

May 2023

Appendix J: Participant Information sheet for participants 18 years or older



STUDY INFORMATION SHEET FOR PARTICIPANTS 18 YEARS AND OLDER

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

Good day

Introduction:

I Nkhluleko Ndlangamandla am doing research on adolescent mental health. The research is a process used in seeking new knowledge around the mental health of adolescents. The research is seeking to investigate what young people know about their mental health. The focus is on adolescents as these are the developmental years and adolescents are at risk of experiencing mental illness. The aim is to find out how much they know about their mental health and if they are aware of any services that are available in their communities should there be a need to access these services.

Invitation to Participate:

I am asking for your permission to take part in this research study. This study is strictly voluntary and in no way hinders your learning as interviews will be conducted after schooling hours.

What is involved in the study?

The study involves me asking you mental health related questions.. These questions will be asked in one-on-one interviews. Participants will be asked to fill out a brief socio demographic questionnaire as well as a questionnaire that will gauge how they have been feeling mentally, over a 2-week period. The questionnaires will be used to screen participants who will be participating in the in-depth interviews. The participant will also be asked to participate in an arts-based/visual task that will seek to ease communication between the participant and the researcher, prior to the beginning of the interviews. The interviews seek to explore the knowledge and attitudes of young people when it comes to their mental health. The interviews will take about 40 minutes to complete.

Risks of being involved in the study:

The study involves the risk of emotional or psychological distress that may be experienced during the interviews. In the event of any distress being experienced, the interviews will be stopped, and the participant will be allowed to debrief from the stressed experienced. Should there be a need for counselling services, the researcher will contact Prof Cora Smith on 011 481 5103 at no cost to the participant. Prof Cora Smith is a registered counsellor and has agreed to aid with the study by availing herself should there a be a need to contact a counsellor. Taking part in the study may cause your peers to judge you unfairly because you have done so. This may result in them treating you differently after you take part in the study. Risk of being identified in the study will be limited by not having any

participant's name used in the final report of the project or any publications that may come from the study. A study ID that will be assigned to them will be used for data collection purposes and not names.

Benefits of being in the study: There is no direct benefit to the participant for participating in the study. The research is conducted to investigate the knowledge that adolescents have about their mental health and the services available to them.

Participation

Participation in the study is voluntary and refusal to participate will involve no penalty or loss of benefits to which the participant is otherwise entitled. With your consent, the interviews will be audio recorded for the purpose of data collection and analysis. Should the participant feel like they cannot continue in participating in the study they are free to withdraw from the study without providing a reason. Any data collected on such a person will in default be destroyed, unless the participant specifically consents to the data being used for the research study. The interviews will be held after hours on the school premises.

Reimbursements for "out of pocket" expenses

There is no payment for participating in the study. However, the participants will be given an appreciation gift valued at R30 each for participating in the study in the form of an Airtime voucher.

Confidentiality:

The participant's privacy will be treated with the utmost confidence and the data collected will be restricted to the principal investigator and the supervisors of the study. The data collected will be stored electronically and password protected to limit access to only the Principal Investigator and the Supervisors As these in-depth interviews will be conducted individually, the participant's confidentiality will be maintained by restricting access to the data to the Principal Investigator and the Supervisors only.

The results of the study will be published and may lead to potential identification. All data collected during the study will be securely retained for two (2) years if a scientific publication arises from the study and six (6) years if there is no publication. Thereafter it will be destroyed accordingly. The write-up and publication of the report will not mention any names of the participants. Only a study ID will be used for data collection purposes. This will be to limit the risk of identification

Anonymity
Because this study is will be in-depth interviews, anonymity cannot be guaranteed for the participants. Any information revealed throughout the interview will be kept confidential by the researcher.

Contact details of researcher/s: For any further information about the study or to report any bad effects that you may feel after the interviews have been completed, please feel free to contact us:

Principal Investigator:
Nkhluleko Ndlangamandla – 0630095788 – Nkhluleko.Ndlangamandla@students.wits.ac.za
Supervisors:
Prof Nicola Christofides – 0117172566 - Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer – 0117172438 - Abigail.Dreyer@wits.ac.za .

Outputs

The study results will be published in an accredited journal and the results can be shared with the participant if they want to know the results of the study.

Contact details of HREC administrator and chair – for reporting of complaints / problems. The following text is recommended:

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.

May 2023

Appendix K: Parent/Guardian consent form



PARENT/GUARDIAN CONSENT FORM

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

1. I have been given a Participant Information Sheet which explains the nature and processes involved in this study, which is attached hereto;
2. I was given time to read it, or had it read to me, in the language I best understand;
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;
5. I understand that there will be no immediate benefit to my child, should they agree to participate, nor will they receive any payment; conversely, participation will not cost them anything but their time;
6. I understand that, even if they initially consent to take part in the study, my child may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about them for the purposes of the study would immediately be destroyed, unless they give consent for it to be retained
7. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details:

Mr Nkhluleko Ndlangamandla, Principal Investigator, telephone no. 0630095788, or by e-mail at Nkhluleko.Ndlangamandla@students.wits.ac.za

Professor Nicola Christofides, Supervisor, on telephone no. 0117172566, or by e-mail at Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer, Supervisor, on telephone no. 0117172438 or by e-mail at Abigail.Dreyer@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of child/participant: _____

Name of Parent/Guardian: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Appendix L: Parent/Guardian consent form for audio-recording



PARENT/GUARDIAN CONSENT FORM FOR AUDIO-RECORDING

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

I hereby consent to audio recording of the interview being conducted with my child.

.

I understand that:

- The recording will be stored in a secure location (password-protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify my child will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications arise from this research
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Contact details:

Mr Nkhluleko Ndlangamandla, Principal Investigator, telephone no. 0630095788, or by e-mail at Nkhluleko.Ndlangamandla@students.wits.ac.za

Professor Nicola Christofides, Supervisor, on telephone no. 0117172566, or by e-mail at Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer, Supervisor, on telephone no. 0117172438 or by e-mail at Abigail.Dreyer@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of child/participant: _____

Name of Parent/Guardian: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Appendix M: Participant Assent form for participants 17 years and younger



PARTICIPANT ASSENT FORM FOR PARTICIPANTS 17 YEARS AND YOUNGER

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

1. I have been given a Participant Information Sheet for Minors, which explains what this study is about.
2. The study was explained to me, and I understand what will happen if I take part.
3. I was given time to ask any questions I wanted to and was happy with the answers I was given.
4. I understand that I will not benefit from the study, should I agree to take part. I also understand that I will not be paid to take part in the study; taking part will not cost me anything either.
5. I have been given a range of contact details, repeated below, should I require further information at a later stage, or have any cause for concern over anything which is done to me during the study; and
6. I understand that even if I agree to take part in the study, I can change my mind later and stop being a part of the study
7. My parent(s) or guardian(s) know that I have been invited to take part in the study. They agree that I may do so, but the decision to take part is also mine.

Contact details:

Mr Nkhluleko Ndlangamandla, Principal Investigator, telephone no. 0630095788, or by e-mail at Nkhluleko.Ndlangamandla@students.wits.ac.za

Professor Nicola Christofides, Supervisor, on telephone no. 0117172566, or by e-mail at Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer, Supervisor, on telephone no. 0117172438 or by e-mail at Abigail.Dreyer@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

Name of Parent or Guardian: _____

Date: _____

Place: _____

Signature or mark _____

Appendix N: Assent form for audio-recording by participants 17 years or younger

ASSENT FORM FOR AUDIO RECORDING BY PATRICIPANTS 17 YEARS AND YOUNGER

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

I hereby consent to audio recording of the interview.

.

I understand that:

- The recording will be stored on a password-protected computer, where access will be limited to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications come from this research
- Anyone who wants to get this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.
- My exact words may be used in the research report or any write-ups that may come from the research. This will be done in a way that will not lead to me being identified from this.

Contact details:

Mr Nkhluleko Ndlangamandla, Principal Investigator, telephone no. 0630095788, or by e-mail at Nkhluleko.Ndlangamandla@students.wits.ac.za

Professor Nicola Christofides, Supervisor, on telephone no. 0117172566, or by e-mail at Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer, Supervisor, on telephone no. 0117172438 or by e-mail at Abigail.Dreyer@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____
Date: _____
Place: _____
Signature or mark _____

Name of Parent or Guardian: _____
Date: _____
Place: _____
Signature or mark _____

Appendix O: Participant consent for participants 18 years and older

PARTICIPANT CONSENT FORM FOR PARTICIPANTS 18 YEARS AND OLDER

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

1. I have been given a Participant Information Sheet which explains what the study is about.
2. I was given time to read it, or had it read to me, in the language I best understand.
3. I was given time to ask any questions I wanted to and I was happy with the answers given to me
4. I believe I fully understand why the study is being done and what the results will be.
5. I understand that there will be no direct benefit to me if I agree to take part. I understand that I will not get paid to take part in the study. I also understand that it will cost me nothing but my time.
6. I understand that, even if I initially agree to take part in the study, I may withdraw at any time and do not need to give a reason. If that happened, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained
7. I have been given a range of contact details, listed below. If I need further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details:

Mr Nkhluleko Ndlangamandla, Principal Investigator, telephone no. 0630095788, or by e-mail at Nkhluleko.Ndlangamandla@students.wits.ac.za

Professor Nicola Christofides, Supervisor, on telephone no. 0117172566, or by e-mail at Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer, Supervisor, on telephone no. 0117172438 or by e-mail at Abigail.Dreyer@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Appendix P: Consent form for audio-recording of study participation by participants 18 years and older

CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION BY PARTICIPANTS 18 YEARS AND OLDER

Perceptions, attitudes and experiences of mental health and mental health services among adolescents in a Johannesburg high school.

I hereby consent to the audio recording of the interview.

.

I understand that:

- The recording will be stored in a secure password-protected computer where access will be limited to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years, if no publications arise from this research
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Contact details:

Mr Nkhluleko Ndlangamandla, Principal Investigator, telephone no. 0630095788, or by e-mail at Nkhluleko.Ndlangamandla@students.wits.ac.za

Professor Nicola Christofides, Supervisor, on telephone no. 0117172566, or by e-mail at Nicola.Christofides@wits.ac.za
Ms Abigail Dreyer, Supervisor, on telephone no. 0117172438 or by e-mail at Abigail.Dreyer@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant: _____

Date: _____

Place: _____

Signature or mark _____

Witnessed by:

Name of Witness: _____

Signature: _____

Date: _____

Appendix Q: Distress Protocol

Distress Protocol

1. Should a participant exhibit any signs of emotional or psychological distress the interview will be stopped immediately by the researcher.
2. The researcher will offer immediate support by assessing how the participant is feeling. This will be done by asking questions on how they feel and what they were thinking that led to the distress.
3. The Participant will be asked if they choose to continue with the interview or if they would like to stop participation. Should the participant indicate that they cannot continue with the interview, they will be excused from participating in the in-depth interview and allowed to leave. Should there be a need for counselling services, the researcher will contact Prof Cora Smith on 011 481 5103 at no cost to the participant. Prof Cora Smith is a registered counsellor and has agreed to aid with the study by availing herself should there a be a need to contact a counsellor
4. The participant will be checked up on by the researcher with a courtesy call should they consent to having one.