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Young people with depression and their satisfaction with the quality of care they receive from a primary care youth mental health service: a qualitative study

Terence V McCann and Dan I Lubman

Aim. To examine how satisfied young people with depression are with the quality of care they receive from clinicians of a primary care service for young people with mental health problems.

Background. There is a high prevalence of youth depression, but few studies have been undertaken to examine whether young people are satisfied with the care they receive in primary care youth mental health services.

Design. Qualitative interpretative phenomenological analysis.

Method. Individual, semi-structured, in-depth, audio-recorded interviews were carried out between March and September 2009. A purposive sample of 26 young people with depression, average age 18 years, were recruited through clinicians of a primary care service for young people with mental health problems, in Melbourne.

Results. Three overlapping themes highlight youth participants' satisfaction with care: First, clinicians being youth-friendly, highlights how, overall, clinicians are perceived as approachable and supportive, understanding and non-judgemental. Second, clinicians adopting a broad-based style of care illustrates that their use primarily of psychosocial therapies, and the judicious use of antidepressant medication, is received favourably by youth. Third, care facilitating recovery highlights that clinicians' youth-friendly and broad-based approach enables a therapeutic dialogue to be established with the young people, contributing to recovery from depression; recovery, in turn, enhances satisfaction with clinicians.

Conclusion. Youth-friendliness is an important expectation of mental health nurses and other clinicians within the youth service. This engagement style provides a useful framework for clinicians to adopt a broad-based approach to care. Ultimately, care should facilitate recovery from depression, and this strengthens satisfaction with mental health nurses and other clinicians.

Relevance to clinical practice. The findings make an important contribution to knowledge and research in mental health nursing. In particular, youth-friendliness is an important prerequisite for continuing engagement with services, and a broad-based approach to care should be adopted.

Key words: depression, early intervention, interpretative phenomenological analysis, qualitative research, quality of care, satisfaction, youth mental health service, youth-friendly

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Authors: *Terence V McCann*, MA, PhD, RN, Professor of Nursing Research, School of Nursing and Midwifery, Victoria University; *Dan I Lubman,* MB, ChB, PhD, Clinical Director and Professor of Addiction Studies and Services, Turning Point Alcohol and Drug Centre, Eastern Health and Monash University, Melbourne, Victoria, Australia

Correspondence: Terence McCann, Professor of Nursing Research, School of Nursing and Midwifery, Victoria University, PO Box 14428, Melbourne 8001, Victoria, Australia.
Telephone: +61 3 9919 2325.
E-mail: terence.mccann@vu.edu.au

Introduction

Adolescence and young adulthood, a critical period of emotional and social development, is also a time when the majority of mental health disorders first emerge (Costello *et al.* 2006b, Patel *et al.* 2007). In particular, depressive disorders, which often begin in adolescence or in early adult years (Kessler *et al.* 2005), have a prevalence rate of 5·7% in adolescents, with a higher rate in girls (5·9%) than boys (4·6%) (Costello *et al.* 2006a). Despite such high rates, young people with depression and other mental health problems often fail to recognise the severity of their situation and delay professional help-seeking (Wright *et al.* 2005, Reavley *et al.* 2010). Insufficient age-appropriate mental health services deter youth with significant mental health problems from obtaining suitable help (Cosgrave *et al.* 2008, Leavey *et al.* 2008).

In developed countries, most mental health care for young people is provided in outpatient and community settings, frequently within the framework of adult services (Patel *et al.* 2007). However, adult mental health services concentrate mainly on older adults and individuals with severe mental disorders and those at risk of harm, with limited attention given to young people. While increasing attention has been given to developing child and adolescent mental health services, these have began to change recently from a predominant focus on children to a greater emphasis on caring for young people but, overall, they still struggle to provide care for adolescents (Patel *et al.* 2007). Against a background of few youth focused services, several countries, such as Australia (Hodges *et al.* 2007) and Ireland (Illback *et al.* 2010), have developed youth platforms to cater for the needs of young people. In particular, the Australian *headspace* model of primary care service for young people, aged 12–25 years, was established and funded by the Commonwealth Government, in 2006. It provides a range of primary care services for young people, including mental health, general health, education and employment, and alcohol and drug services (Hodges *et al.* 2007, Muir *et al.* 2009).

Little research has been carried out into young people's satisfaction with primary care mental health services for youth. Of the few studies conducted in recent years, these have focused, overall, on two broad elements: organisation of services and satisfaction with the environment, and treatment outcomes (Biering 2010). A review of research literature summarised that the most frequently identified organisational and environmental concerns of young people are the need for good access to services and clinicians, comfort and service flexibility (Biering 2010). The review found a desired outcome of care commonly is that young people will recover; if improvement does not take place, then the service is perceived as unsatisfactory.

Understanding youth satisfaction with care is important in informing the development and delivery of appropriate primary care focused early intervention services for young people diagnosed with depression and other mental health problems. However, limited work has been conducted evaluating the experience of young people with depression within primary care mental health services and is particularly suited to qualitative investigation. In this qualitative study, we aim to examine how satisfied young with depression (with or without co-morbid disorders) are with the quality of care they receive from clinicians of a primary care service for young people with mental health problems.

Note

In this study, clinicians comprise mental health nurses, psychologists, social workers, occupational therapists and psychiatrists.

Methods

Design

Interpretative phenomenological analysis (IPA), based primarily on the Heideggerian perspective of phenomenology (Giorgi & Giorgi 2008), informed data collection and analysis. The guiding principles of the approach are phenomenology, hermeneutics and idiography (Smith *et al.* 2009). The method is phenomenological because it requires a careful analysis of people's lived experience and how they make sense of their personal and social world (Smith & Osborn 2008); in this instance, young people's satisfaction with the quality of care they receive from a youth mental health service. It is a hermeneutic or interpretative method informed by hermeneutics, the theory of interpretation (Smith & Osborn 2008). IPA is also idiographic as a result of the emphasis on beginning with the young person with depression as the unit of analysis and then shifting progressively to develop themes and subthemes (Smith *et al.* 2009). IPA can be used to develop theory, and to endorse, modify and/or challenge existing theory (Smith *et al.* 2009). The approach is especially useful in situations where the phenomenon is novel or under-researched, where problems are broad or unclear, and where the researcher seeks to comprehend how things occur and change (Smith & Osborn 2004), in this study the satisfaction of young people with depression with the care they receive from clinicians of a primary care youth mental health service.

Participants

Young people with a diagnosis of depression who were living in the community took part in the study.

Inclusion/exclusion criteria

Purposive sampling was used to guide data recruitment (Patton 2002, Parahoo 2006). Inclusion criteria were as follows: (i) primary diagnosis of depression and (ii) aged 16–25 years. Exclusion criteria were (i) a history of psychosis or currently expressing plans to commit suicide and (ii) inability to communicate in conversational English.

Recruitment

The young people were recruited through clinicians of a *headspace* primary care service for youth with mental health programme, situated in Melbourne. Clinicians gave them brief written and verbal information about the study. The telephone contact details of the young people who expressed an initial interest in taking part in the study were forwarded, with their permission, to the researchers. They were then followed up by the researchers who provided a more detailed explanation and answered questions about the study, prior to obtaining consent. Thirty-two young people were invited to take part in the study, and, of these, 26 agreed to participate (none withdrew from the study).

Data collection

Data were collected by university researchers who were not employees of the headspace service or related to the participants. Individual interviews were conducted in a private room at the youth mental health service. They were semi-structured, audio-recorded, each lasting 30–60 minutes. Examples of interview questions are provided in Table 1. Answers to questions were probed and explored further.

Ethical considerations

The study was approved by a university and a health service ethics committee. Particular emphasis was placed on voluntary participation and maintenance of confidentiality. All participants gave written informed consent. Written parental/guardian consent was also obtained for those under 18 years.

Table 1 Sample of interview questions relating to youth satisfaction with clinicians at the service

What do mental health professionals in this service do, if anything, to help you with depression?
What do mental health professionals in this service do, if anything, to make it difficult for you with depression?
What could mental health professionals in this service do, if anything, to help you with depression?

Data analysis

The interviews were transcribed verbatim and analysed in accordance with the IPA approach to data analysis (Smith & Osborn 2008). The transcribed data were read and re-read in order to obtain a broad understanding of the young people's satisfaction with clinicians at the service. They were examined closely and coded manually using *in vivo* codes (Holloway & Wheeler 2010). This form of coding was used because the codes are related directly to the words used by participants and helped avoid situations where researchers may impose preconceived frameworks and beliefs on the data (Hutchinson 1993, Holloway & Wheeler 2010). The initial codes were then grouped into conceptual themes, which reflected the young people's satisfaction with clinicians. Following this, themes were grouped into sets of themes. At the same time, data reduction was carried out with initial themes grounded inadequately in the data being omitted. Finally, a more focused analytical ordering of themes was carried out. This involved reordering and refining themes and abstracting them to a higher level (Smith *et al.* 2009).

Rigour

Sample size was determined by saturation of themes with 'thick' description of the data (Denzin 1989), an important aspect of the rigour of the qualitative approach to establishing sample size (Morse 1995, 2010). This was achieved when no new data emerged to support the themes. Each theme contained thick descriptions, deep, dense, representations (Eatough & Smith 2008, Sandelowski 2008) that highlighted the young people's satisfaction with the quality of care they received from clinicians. The quality of the data is more important in saturation of themes than the regularity with which it recurs. There is a greater likelihood of saturation taking place when the sample is clearly defined and restrictive, and the research questions are explicit (Catanzaro 1988, Morse 1995).

Dependability and confirmability were maintained in the study by developing an audit trail linking raw data and codes with themes. Credibility was strengthened by using a semi-structured interview guide to maintain a reliable approach to interviewing, and a search was carried out for negative cases to ensure that a wide range of participants views about the service was embodied in the data (Lincoln & Guba 1985). Credibility was also enhanced by participant verification,

which entailed summarising the young people's statements at the end of each main section of the interview, to ensure that their view was interpreted correctly (Guba & Lincoln 2005, Holloway & Wheeler 2010). Transferability of the findings was established by presenting sufficient raw data in this paper to enable readers to evaluate the findings and to ascertain their transferability to other contexts. Overall, using this trustworthy approach consistently in the study ensured that the themes developed in the context of the young people's satisfaction with mental health clinicians in this particular primary care service for youth could be transferred to other similar situations (Holloway & Wheeler 2010).

Results

Twenty-six youth, average age 18 years (ranging from 16 to 22 years) took part in the study. Sixteen (61·5%) were women, and most (n = 19, 73·1%) were single. Nearly, all were born in Australia, and for most, the primary language spoken at home was English. Their median duration of treatment at the primary care youth mental health service was 4·5 months. In most instances, their primary diagnosis was depression and anxiety, followed by depression and then depression, anxiety and/or substance use (mainly alcohol, cannabis and amphetamines).

Three overlapping themes in the data highlighted the young people's satisfaction with the care they received from clinicians at the service: clinicians being youth-friendly, clinicians adopting a broad-based approach to care and care facilitating recovery.

Clinicians being youth-friendly

Clinicians being youth-friendly highlights when young people feel engaged positively with mental health nurses and other clinicians, this enables them to feel valued, respected and supported to take control of their lives. There are three dimensions to youth-friendliness: developing open and friendly engagement, responding promptly to engagement problems and ensuring continuity of appointments. First, in developing open and friendly engagement with young people, clinicians are friendly, polite, down-to-earth and direct:

> Good people, nice, friendly, kind, polite people; genuine people that won't 'beat around the bush' …. They say how it is and how they see it. (Interviewee 11)

Young people perceive clinicians are understanding and communicate with them in a respectful and non-patronising way. They feel that interactions between clinicians and themselves are individualised and lack the formality of traditional client-to-clinician relationships. In so doing, it helps put the young people at ease and facilitates ongoing engagement:

> The specialists that I've had are quite understanding of … the issues that I experience …. not patronising and it's still respectful, like the way they treat us, and I guess it helps in that way …. it doesn't feel like a doctor/client sort of feeling. It feels more just like a person-to-person. So I find it easier to be able to talk to the person. (Interviewee 25)

Another aspect of developing open and friendly engagement with young people is clinicians being honest, non-judgemental and unbiased. As a consequence, young people are more likely to talk openly about their situation:

> … if I talk to the counsellor I know they're someone, like a third person that's not actually really part of my life but … I can tell them things and they won't pass judgement and they'll give me an honest opinion that's not biased. So, whenever I go and talk to my friends or my family their opinion is always biased to what they want me to do or what they think is best for me or what I want to hear. (Interviewee 26)

Second, implicit in dealing promptly with engagement problems is an acknowledgement that on some occasions, this process is not established or breaks down. In these situations, it is important that young people do not disengage from the service but a seamless transition occurs to enable timely access to an alternative clinician:

> I didn't really 'click' [engage] with the counsellor guy. But I just called back … the guy that I was seeing and explained, and he sorted it out … he found me someone else … (Interviewee 6)

Third, ensuring continuity of appointments. Continuity is achieved by staff using simple but effective telephone Short Message Service (SMS) to remind the young person about imminent appointments with clinicians. Young people regard these messages as a convenient, helpful and timely reminder about appointments:

> Oh the text messages, they give you a reminder to go to an appointment … so if you forget accidentally, they … text you … before your time on the day so you never forget. (Interviewee 13)

Clinicians adopting a broad-based approach to care

Young people perceive that clinicians adopt a broad-based approach to care, a style that is regarded favourably by these participants. The broad-based approach, promulgated within what young people refer to frequently as 'counselling' is wide ranging and founded on the use of psychosocial therapies and

inclusiveness of primary carers, and occasional use of antidepressant medications:

They'd [clinicians] rather suggest other ways of dealing with it [depression] than medication, which is so much better … I'd rather that system than just when you go to a normal GP, and then they go, 'oh, you are suffering from this; okay, have this and so here I will "shove" [put] you on these pills.' (Interviewee 12)

Other aspects of the broad-based approach are clinicians listening and encouraging young people to talk openly about their situation. By keeping quiet and encouraging young people to talk, it enables them to ventilate and explore their circumstances and for clinicians to gain a deeper understanding of the young people's situation:

They do so much already, like … [clinician's name] he barely talks in our meetings, I talk and he listens and when I finally give him a break and stop talking he tries to get a word in; so he's a really good listener. (Interviewee 14)

At times, this might also necessitate clinicians adopting an advisory approach, while on other occasions using an indirect, enabling style:

She gives pretty good advice … like, 'you have to get a good sleep pattern.' So I took her advice by doing that, and it's actually helped me a lot … [However] she mostly listens, and then she tells me, not what I should do, but she recommends like, 'Maybe you could do this or maybe you could do this, and how do you feel about it? Do you think it'll work for you?' (Interviewee 18)

On some occasions, adopting a broad-based approach incorporates recognising the contribution of primary carers in supporting young people and, with the latter's consent, inviting the former to participate in consultations. Carer inclusiveness increases their understanding of the young person's mental health problems and in these circumstances is welcomed and regarded as helpful by the latter:

she [clinician] actually offered a few times to meet my mum to talk to her and that helped a lot, because she [counsellor] was really experienced and she was a mother, and my mum could easily talk to her. I felt comfortable with her and my mum felt comfortable with her. So offering to get my mum in and talk to her personally was really helpful and I really appreciated it because after that my mum understood a little more. (Interviewee 26)

There are also circumstances when judicious prescribing of antidepressant medication is justified clinically and is incorporated within the broad-based approach to care. In these situations, the clinical effect of the medication is monitored frequently by clinical staff and this careful approach is valued by the young people:

… she [psychiatrist] gave me [antidepressant] tablets … She's very, very careful with what she prescribes and she's always checking up on me about this stuff and um, so I'm pretty happy with that. (Interviewee 21)

Care facilitating recovery

The youth-friendly and broad-based approach, including judicious use of antidepressant medication, enables a therapeutic dialogue to be established between the young person and the clinician. The ongoing dialogue enables an exploration of problems affecting the young person and gives them 'headspace', the opportunity to try to make sense of and reflect on their situation, and, hopefully, to see things differently:

… it's made me think differently. Like with my counsellor, she's taught me different ways of thinking and just exploring who I am. (Interviewee 2)

Well, before *headspace*, I didn't think counsellors … really existed or I didn't think I was ready to have one. But because of them they have helped so much. Like, I have been able to open up to things that I have never opened up and now, I mean it's kind of just, lightened the way. (Interviewee 22)

The dialogue also empowers them to come up with possible solutions to resolve or cope with their psychological and social situation:

They just talked to me about all the different issues I had and helped me come up with solutions. Like what I could do to get rid of my issues and problems, and how I could be able to go to school more … (Interviewee 15)

Arguably, a key indicator of youth satisfaction with clinicians at the service in helping to bring about improvements in their thoughts, feelings or behaviour is whether they would recommend these clinicians to friends with mental health problems. The data show, overall, that clinicians are held in high regard by the participants who, as a consequence, recommend the service to friends:

Headspace is pretty good. I recommended friends. Well, they've been really depressed or they've really, really needed help, so I've taken them here to see the Access Team … and then they've gotten counselling … (Interviewee 5)

Discussion

This exploratory study provides an insight into youth satisfaction with the quality of care they receive from

clinicians at a primary care youth mental health service. Three overlapping themes were identified in the data, signifying ways to enhance their satisfaction with clinicians. First, once young people access the service and receive care, overall, they perceive clinicians as being 'youth-friendly'. This term is conceived as services and, by inference, staff showing positive regard for, and engagement with, youth, being non-judgemental and valuing, respecting and empowering (Hickie & McGorry 2010) them to maintain or regain control of their lives (Crago *et al.* 2004, Muir *et al.* 2009). One feature of youth-friendliness in the present study is the open and friendly style of engagement that clinicians adopt. This finding is consistent with that reported in Australian (Medlow *et al.* 2010) and American (Lee *et al.* 2006) studies and in several key reports (Crago *et al.* 2004, Muir *et al.* 2009, Hickie & McGorry 2010), which emphasise engagement as a cornerstone of treatment. Adopting this engagement style also may enhance treatment perseverance (Lee *et al.* 2006, Medlow *et al.* 2010).

Another feature of youth-friendliness is recognition that on some occasions, youth-to-clinician engagement does not take place or breaks down. The implication of this is that young people may disengage prematurely from the service, prolonging the duration of untreated illness and contributing potentially to less favourable outcomes (Keshavan *et al.* 2003, Owens *et al.* 2010). The important finding from this study, although not reported elsewhere, is that clinicians acknowledge early when this situation occurs and take prompt and decisive action to offer young people access to an alternative clinician. A further feature of youth-friendliness is clinical staff taking steps to ensure continuity of appointments by using simple but effective telephone SMS to remind the young people about imminent appointments with clinicians. As most young people own and are savvy in using mobile telephones, including using SMS, they are a cost-effective, convenient and a timely means of communication for sending reminders about forthcoming appointments. The value of SMS with youth has also been highlighted in another study (Furber *et al.* 2011), which reported it to be a practical and convenient way of maintaining contact and coordinating appointments with a youth outreach service. Furthermore, the use of SMS by clinical staff could be conceived as a useful way to help bridge a perceived generation gap between young people (sometimes referred to as 'Generation Y') and older clinicians (sometimes referred to as 'baby boomers') and a lay-professional gap between young people as mental health services users and clinical staff.

Second, clinicians adopt a broad-based approach, where the main emphasis is placed on using psychosocial approaches to care, a method regarded favourably by youth participants. This entails using a range of interactive strategies such as listening, enabling reflection and encouraging young people to talk openly about their situation. It also involves using formal psychotherapies such as cognitive behaviour therapy. The broad-based approach is consistent with McGorry *et al.* (2006) 'clinical staging model', where young people with less severe depression are provided initially with non-pharmacological interventions (Hickie & McGorry 2010). Another aspect of the broad-based approach is the acknowledgement of the important contribution primary carers (McCann *et al.* 2011a), such as parents and friends, have in supporting young people with depression. In some situations, this extends to inclusion of carers in consultations with the young person and the clinician. Primary carer inclusiveness enhances their understanding of youth depression and can assist the carer and the young person to understand each other's situation. The need to involve families and carers, as appropriate, is recognised as an important attribute of effective youth mental health service provision (Hickie & McGorry 2010, McCann *et al.* 2011b).

It is also evident in the present study that when psychosocial therapies embedded within a broad-based approach are insufficient to alleviate or minimise depression, antidepressant medications may be prescribed. In these circumstances, judicious prescribing is justifiable clinically, incorporated within, rather than separate from, broad-based approaches to care. The clinical effect of the medication is also monitored frequently by clinical staff, and this careful approach is valued by young people. Cautious prescribing of antidepressants is consistent with the adoption of a clinical staging model in combination with a 'stepped care' approach (McGorry *et al.* 2006, Hickie & McGorry 2010).

Third, the findings show that young people perceive that the care they receive makes an important contribution to their recovery from depression. This is a key consideration as treatment outcomes have a profound influence on young people's satisfaction with mental health services and clinicians, and has been shown elsewhere in a north American study of youth experience and attitudes towards mental health services (Lee *et al.* 2006). Moreover, indicators of satisfaction of clinicians from the findings of the present study are that the young people are satisfied with the youth-friendly style of engagement, the broad-based approach adopted and their perception that the care they receive facilitates recovery. Together, these indicators are pivotal in influencing their decision to advocate the service to friends in a similar situation to themselves. This finding is similar to that of a national evaluation of *headspace* services (Muir *et al.* 2009), where 99% (n = 167) of youth participants said they would recommend the service to friends.

Limitation

There are two main limitations to this study. First, it is a qualitative study, and the results are context bound to the participants and the context in which the study took place: young people with depression using a particular youth mental health service. Even though generalisability is not an expectation in qualitative research (Sandelowski 1993), the results can be verified (Bloor 1997) and provide a useful reference point for young people with depression and mental health clinicians practising in other youth mental health settings. They also highlight the need for a greater focus on young people with a range of other common mental health problems in future research. Second, recruitment through key clinicians may have produced an atypical sample of engaged young people with a different level of satisfaction with clinicians than those who were less engaged with, or had disengaged from, the service. Subsequent research should aim to recruit young people with depression who have disengaged from, or are not engaged with, the service.

Conclusion and relevance to clinical practice

Youth satisfaction with clinicians at the primary care youth mental health service is critical to treatment perseverance and ongoing engagement with the service. Overall, the findings of the study indicate that the young participants were satisfied with the youth-friendly approach of clinicians, the broad-based style of care and the perception that the care they received contributed to their recovery from depression. The findings have implications for knowledge, the way the service's mental health nurses and other mental health clinicians and other youth mental health platforms care for young people and for future research. First, the study makes an important contribution to the limited body of mental health nursing knowledge and research about the factors that enhance young people's satisfaction with primary care mental health services for young people. Second, engagement with appropriate services is important as it increases service satisfaction and, arguably, reduces the likelihood of them withdrawing prematurely from services, increases the possibility of recovery and heightens the likelihood of future re-engagement with services, should the need arise. Two key factors that enhance engagement, and thus satisfaction, are clinicians adopting a youth-friendly approach to care and care being broad-based. In essence, nurses and other clinicians should strive to adopt these approaches with young people. Youth satisfaction is also determined by their perception that engagement with and treatment from mental health nurses and other clinicians makes a significant contribution to their recovery from depression. This highlights the need for nurses and other clinicians to combine youth-friendly and broad-based approaches with evidence-based treatments to enhance recovery. Finally, evaluative research is needed to determine the particular aspects of youth-friendliness that contribute to favourable clinical outcomes in young people with depression. Likewise, research is needed to assess if youth-friendliness, broad-based approach to care and care facilitating recovery are relevant themes to inform care in young people with other common mental health problems such as eating disorders, anxiety disorders and first-episode psychosis.

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Contributions

Study design: TMcC, DL; data collection and analysis: TMcC; manuscript preparation TMcC, DL.

Conflict of interest

None.

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