University of Southampton

Faculty of Environmental Life Sciences

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Mental Health Beyond the School Gate: Young People's Perspectives of Mental Health Support Online, and in Home, School and Community Contexts

By

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Thesis for the degree of Doctorate in Educational Psychology

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Abstract

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Children and young people's (CYP) mental health (MH) is of growing concern, particularly as evidence suggests prevalence rates are increasing. Although there is a drive by the government to improve and develop effective support systems, research suggests many CYP have not accessed effective help. Using technology to deliver mental health interventions offers a potential way to increase access to support. The aim of this systematic review was to evaluate the current evidence for the effectiveness of technology based interventions for CYP aged 16-25 with depression and anxiety. A systematic search of three databases identified 12 studies exploring a range of online technology based interventions. The findings identified positive outcomes for the use of iCBT in reducing anxiety and depression severity. It also outlined some promising evidence suggesting potential benefits of further exploring the use of online, solution-focused approaches. However, further work is needed to identify the key elements to effective online interventions and understand more about young people's experiences and opinions when using them.

The empirical paper sought to address this, through developing a greater understanding of what CYP identify as the most essential types of MH support, where they would like to access this support, and the key competencies they value in those delivering that support. An expert panel of CYP aged 16-25 who had previously experienced a MH difficulty participated in two rounds of a Delphi study. For each round, participants were asked to rate the importance of a series items. Items that were rated as either essential, or very desirable, by at least 75% of the panel were included in a final framework of recommendations. To gain feedback on the feasibility and utility of the framework, interviews with adult stakeholders were carried out. The current research found that trust and confidentiality were essential elements to service provision. Furthermore, it appears that CYP want practitioners to recognise their strengths and involve them in decision making. Implications of the research include a need for further awareness of mental health and larger scale, participatory research with CYP to expand upon the findings of the current study.

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Research Thesis: Declaration of Authorship

Print name:	Natalie May Jago

Title of thesis:	Mental Health Beyond the School Gate: Young People's Perspectives of Mental Health Support Online, and in Home, School and Community Contexts

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

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Definitions and Abbreviations

BDI-II	The Beck Depression Inventory
CAMHS	Child and Adolescent Mental Health Service
CES-D	The Centre for Epidemiologic Studies Depression Scale
CYP	Children and young people
d	Cohen's effect size
DASS-21	Depression, Anxiety and Stress Scale-21 items
DfE	Department for Education
DoH	Department of Health
EP	Educational Psychologists
g	Hedges' effect size
GAD	Generalised Anxiety Disorder
GAD-7	Generalised Anxiety Disorder 7-item scale
HADS-A	The Hospital Anxiety and Depression Scale- Anxiety
iCBT	Internet Cognitive Behavioural Therapy
LSAR-SR	The Liebowitz Social Anxiety Scale- Self Report
M	Mean
MH	Mental health
n	Total number of cases
NHS	National Health Service
NICE	National Institute for Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
p	Probability (significance of a test statistic)
PHQ-9	Patient Health Questionnaire
PRISMA	Preferred reporting items for systematic reviews and meta-analyses
RCT	Randomised controlled trial
SEND	Special Educational Needs and Disability
SD	Standard deviation

SPSQ-C	The Social Phobia Screening Questionnaire
TA	Thematic analysis

Chapter 1 Mental Health Beyond the School Gate: A Systematic Review of Technology Based Interventions to Support Anxiety and Depression in 16-25 year olds

1.1 Introduction

1.1.1 Defining Mental Health

Whilst it is widely acknowledged that mental health (MH) is integral to our overall health, there is a lack of consensus in terms of how it is defined, resulting in a vast array of definitions. This lack of consensus reflects the complexity of this concept. Indeed, MH can be considered a socially constructed concept, which evolves over time as the meaning we attach to it changes (Fee, 2011). Furthermore, how we define MH often depends on our own values and assumptions (Weare, 2000). Whilst it is beyond the scope of this review to explore the wide range of conceptualisations of MH, it is important to mention some of the key perspectives and to outline the definition used for the purpose of this review.

Traditionally, the construct of MH has been underpinned by a medicalised model, which has often focused on the illness and taken a within-person approach (Beresford, 2002). As a result, the term has often been synonymous with mental illness which has led to negative connotations associated with the concept (Weare & Markham, 2005). Within education, there has been a tendency to use terms such as 'emotional health' or 'wellbeing' because of the perceived stigma associated with MH (Danby & Hamilton, 2016). More recently, the concept of MH has evolved so that more positive terminology is being used, emphasising the factors that support and promote wellbeing, rather than pathologising difficulties (Weare & Markham, 2005). MH is now considered as an umbrella term that sees difficulties being positioned along a continuum, ranging from a state of emotional wellbeing to severe and enduring MH difficulties (Antonovsky, 1996; YoungMinds, 2016). This highlights its fluidity and the possibility that it can change over time depending on a range of environmental, family and health related factors (Apland, Lawrence, Mesie & Yarrow, 2017). It has been argued that this is an inclusive approach to MH, which acknowledges that everyone has it and our needs can change at different stages of our life, thus reducing any stigma (Weare, 2000).

For the purposes of this review, the definition developed by the World Health Organisation (WHO) has been adopted. This describes MH as "a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively

and fruitfully, and is able to make a contribution to his or her community" (WHO, 2014, p. 1). The WHO (2012) also highlights the social and socio-economic influences affecting wellbeing and considers environmental factors too. It is felt to be relevant to this review because it incorporates the interaction between social, environmental and individual influences, rather than merely emphasising the latter:

Mental health and wellbeing is influenced not only by individual attributes, but also by the social circumstances in which persons find themselves and the environment in which they live; these determinants interact with each other dynamically, and may threaten or protect an individual's mental health state. (WHO, 2012, p. 2)

Two of the largest challenges to MH are depression and anxiety which have been highlighted as the most prevalent MH difficulties experienced, with an estimated 676 million people affected worldwide (WHO, 2016). In the latest official statistics published by the National Health Service (NHS), the prevalence of MH difficulties has increased among CYP, with rates of anxiety, depression and bipolar disorder highest among 17 to 19 year olds (Sadler et al., 2018). Moreover, suicide is among the second leading cause of death among CYP worldwide (WHO, 2017) and within England, a quarter of 11 to 16 year olds and nearly half of 17 to 19 years olds with a MH difficulty have self-harmed or attempted suicide (Sadler et al., 2018). These figures highlight both the level of MH difficulties, nationally and worldwide, as well as their significant impact on CYP. In recent years, due to increasing demand and pressure on services, there has been a drive to reform MH provision to better meet the needs of service users and place more importance on early intervention (Department for Education (DfE) & Department of Health (DoH), 2017).

Within the health sector, Child and Adolescent Mental Health Services (CAMHS) are currently under extreme pressure to deliver specialist support with research highlighting a 26% increase in referrals over the past five years (Crenna-Jennings & Hutchinson, 2018). Within education, it appears school leaders also perceive a rise in MH difficulties among their students. In a survey carried out with 1,182 school leaders in England, 87% of secondary school leaders reported an increase in stress, anxiety and panic attacks among their pupils (The Key, 2017). However, it is important to note that the true extent of MH difficulties is difficult to ascertain due to lack of universally agreed MH definitions as well as differences in survey methodologies used (Greig, MacKay & Ginter, 2019). Nonetheless, the impact of MH issues, both nationally and worldwide, is clear.

Within the context of the UK, MH support has traditionally been delivered in clinical health based settings (Dunsmuir & Cobbald, 2017). However, as specialist MH services struggle to cope with limited resources and increased pressures, there is a growing responsibility being placed on schools. This is clearly stipulated in national policy with published guidance highlighting the key

role schools play in early detection and intervention in relation to mental health (DfE, 2018). To support this, the government has pledged to reform MH support to include additional support for schools and colleges, providing stronger links with health (DoH & DfE, 2017)

Although schools can be a helpful context in which to provide additional MH support for CYP, significant time constraints, workload and lack of skill set can create barriers which impact on the ability for school staff to deliver targeted interventions (O'Reilly et al., 2018). These demands placed on educational settings might have, in part, also led to a perceived rise in the use of therapeutic based approaches delivered by educational psychologists (EPs) including cognitive behavioural therapy (CBT) and personal construct psychology (Hoyne & Cunningham, 2019). In a recent survey of 2,780 educational settings, 61% of schools and colleges reported the use of educational psychology input to support pupils with MH within their settings (Marshall, Wishart, Dunatchik & Smith, 2017). However, research highlights that only a small proportion of CYP access specialist support in schools and clinical settings. In the official statistics published by the NHS, 25% of CYP with a diagnosed MH difficulty received support from a MH worker (Sadler et al., 2018). Furthermore, these statistics only represent those with a diagnosed MH difficulty and do not capture those who have not sought support.

Research highlights that CYP can be reluctant to seek help, and a fear of stigma is a key barrier to accessing support (Plaistow et al., 2014). In a YouGov survey, commissioned by The Prince's Trust (2017) with 2,215 16 to 25 year-olds, 78% CYP felt that stigma was attached to MH problems with 32% of participants stating that they would not talk to anyone even if they felt they were struggling with their MH. In addition, worries about maintaining confidentiality and a lack of trust in professionals can impact on whether CYP access and engage with support. In a systematic review exploring CYP's views on MH support, Apland et al. (2017) found that confidentiality was an essential precondition for accessing support and that violating this, represented a betrayal in trust reducing the likelihood of seeking support in the future. Research suggests that CYP value easily accessible and flexible support that promotes autonomy, so that CYP feel able to take control of their lives (Persson, Hagquist & Michelson, 2017; Apland et al., 2017).

The reluctance to seek help among CYP highlights the importance of youth friendly MH services, which are easily accessible and protect anonymity. Given the growth of the internet over the past decade, perhaps online technologies offer such an opportunity.

1.1.2 The Role of Online Technologies

For many CYP, the internet has become a key part of their daily lives. They have grown up in an era of digital technology, with readily available access to computers, mobile devices and the internet. Within the UK, statistics show that 98% of 16-24 year olds use the internet and on

average spend 34 hours browsing it weekly (Ofcom, 2018). The rise of the internet has provided opportunities to stay socially connected with others, particularly across long distances, helping to sustain relationships (Livingstone & Haddon, 2009). The increased level of anonymity online also allows CYP a space to express themselves, and foster a sense of belonging within online communities where they feel able to express and share thoughts and experiences. It has also become a valuable source of information and support, providing a space where CYP feel able to discuss complex and sensitive issues, 24 hours a day, 7 days a week (Wetterlin, Mar, Neilson, Werker & Krausz, 2014). This includes using the internet to find information about MH difficulties, seek help and share experiences via online forums and websites. In a study exploring CYP's internet use, researchers found that 21% of 12-17 year olds said they had searched online for support (Burns, Davenport & Durkin, 2010).

Given the high internet use among CYP, there has been a growing interest in the use of information and communications technology, also known as e-mental health (e-MH), to support and promote positive MH. E-MH is the umbrella term for a range of digital technologies used to deliver MH support. This includes computers, web-based platforms and mobile phones. A growing variety of options are available, from information websites and forums to interactive sessions with a MH practitioner (Rickwood, 2012). The use of e-MH interventions offers greater access and availability for CYP with the potential to offer 24-hour readily available and flexible support that defies geographical barriers (Ellis, Campbell, Sethi, & O'Dea, 2011; Hoek, Schuurmans, Koot, & Cuijpers, 2012). Furthermore, the increase of anonymity online may encourage CYP to seek help for MH difficulties, which may reduce concerns regarding associated stigma (Mitchell, McMillan, & Hagan, 2017).

Whilst access to online MH support may bring some clear benefits to CYP, information shared online is not always reliable and the emergence of 'fake news' or misinformation on the internet has particular implications for CYP and their health (Royal Society for Public Health, 2017) and at worst can lead to harmful and damaging outcomes. For instance, online platforms such as peer led forums and websites have led to the development of harm-advocating websites which promote ideas that are both psychologically and physically harmful. Oksanen et al. (2016) have highlighted that those experiencing MH difficulties might be at an increased risk of encountering communities that advocate harmful behaviour, such as pro-suicide or self-harm websites. According to the EU kids online study, which explored internet risk factors, they found that 7% of 11-16 year olds had visited self-harm websites and 5% had visited suicide websites (Livingstone, Hadden, Görzig & Ólafsson, 2011). This is particularly concerning, as websites that encourage, promote and describe methods of suicide can increase suicidal ideation and depression (Dunlop, More, & Romer, 2011; Biddle, Derges, Goldsmith, Donovan & Gunnell, 2018).

There are also several security considerations in relation to accessing support online, that pose risks to users' data. Shaw and Shaw (2006) highlight that online counsellors cannot completely guarantee confidentiality to clients over the internet and the use of emails or text based support can leave a digital record of sensitive information (Rummell & Joyce, 2010). CYP have also highlighted their concerns related to the privacy and confidentiality of their personal information, leading to reluctance to access support online (Chan, Farrer, Gulliver, Bennett & Griffiths, 2016).

The development of e-MH interventions also raises concerns about users' ability to form therapeutic relationships with practitioners in the absence of non-verbal cues. Evidence suggests that some CYP may prefer face-to-face support due to this. In a study exploring over 900 student's views on their internet use for MH information, it was found that 79% preferred face-to-face support because they felt it was more personal and easier to engage and communicate (Horgan & Sweeney, 2010). The importance of building strong therapeutic relationships is widely recognised. Lambert & Barley (2001) highlight that factors such as the client-therapist relationship, warmth and empathy are important in supporting therapeutic outcomes. Therefore, given the importance of the therapeutic relationship, this should be considered in the design and development of e-MH interventions.

The development of technology to support MH interventions with CYP is still in its infancy and, as discussed, presents challenges which developers need to consider. Nonetheless, online MH services appear to provide an innovative way that has the potential to promote help-seeking among CYP. The growth in this field provides an increasing challenge for CYP to navigate their way to high-quality and evidence based services that meet their needs (Rickwood et al., 2019). Given this, consideration should be given to such relational factors in the development of e-MH interventions.

There are a number of systematic reviews which have explored the effectiveness of e-MH interventions for CYP experiencing MH difficulties (Grist, Croker, Denne, & Stallard, 2018; Hollis et al., 2017; National Collaborating Centre for Mental Health (NCCMH), 2014; Pennant et al., 2015). Hollis et al. (2017) carried out a meta-synthesis evaluating the effectiveness of e-MH interventions, focusing on evidence from randomised control trials (RCTs). Overall, the researchers found that iCBT demonstrated effectiveness in reducing anxiety and depression symptomology. However, the researchers highlighted that iCBT was a dominant intervention in the review and research exploring alternative interventions was scarce. There were also a number of methodological limitations related to the papers reviewed. For instance, small sample sizes and variable engagement with interventions as well as short follow-up outcomes, made it difficult to measure long term impact. More recently, Grist et al. (2018) explored the effectiveness of MH interventions for CYP, aged 18 and under, experiencing anxiety and depression. Findings were

similar to those in the Hollis et al. (2017) review, demonstrating some support for the use of iCBT for CYP. However, similar methodological limitations of the studies were identified including poor reporting of completion rates.

The reviews discussed have focused predominantly on CYP under 18 or have excluded studies where the mean age was over 18 (Grist et al., 2018; Pennant et al., 2015; NCCMH 2014; Hollis et al., 2017). There appears to be a gap in research which have explored the effectiveness of e-MH interventions for those aged 16-25. The transition to adulthood has been identified as a critical time in a young person's life which leaves them at particular risk of experiencing MH difficulties (Lisznyai, Vida, Németh, & Benczúr, 2014; Morris & Atkinson, 2018). Furthermore, statistics suggest that 16% of young people aged 16-24 meet the criteria for a diagnosis of a MH difficulty including depression and anxiety and 75% of adults with a mental health difficulty experience symptoms before the age of 25 (Adult Psychiatric Morbidity Survey, 2014). Anxiety disorders can be described as persistent worries or fears which interfere with daily activities (National Institute of Mental Health, 2019). The WHO (2019) characterise depression as "persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks" (p.1).

Arnett (2000) describes this transitional phase as 'emerging adulthood'. Arnett (2000) proposes that this phase has distinct features that differ from adolescence and adulthood as individuals become more independent. These features comprise of identity exploration; heightened instability as individuals transition into adulthood; self-focus, where emerging adults decide what they want to do; the age of "in between" adolescence and adulthood; and possibilities for the future. Mondi (2017) suggests that these features can contribute to heighted risk of developing a mental health difficulty, particularly for those who are unable to focus on their own development and goals due to external obligations or where there are significant barriers to achieving goals such as a lack of social and financial support as well as lack of education. Wood (2017) highlights that during this life stage there is an increase in independence and agency as well as a decrease in social and institutional support offered by schools as well as child health and social services. For instance, Wood (2017) argues that service delivery models are either targeted towards child or adult populations and therefore ill-suited for those during the emerging adulthood stage of life. This can mean that CYP can fall between children and adult services. Research indicates that up to a third of CYP withdraw from the support during their transition to adult services (Singh & Tuomainen, 2015). MH provision during the transition to adulthood should therefore be of particular interest and highlights the importance of exploring the effectiveness of e-MH interventions for this age range.

1.1.3 Aims of the Current Review

The research discussed so far indicates that anxiety and depression are among the most prevalent MH difficulties in the 16-25 age group. In the context of the rapidly developing area of e-MH, which could have real potential to support CYP, being both quick to resource and easy to access, this review will explore the effect of technology interventions for anxiety and depression on CYP aged 16-25 years. Furthermore, whilst previous reviews (e.g. Grist et al., 2018; Hollis et al., 2017) have considered and explored the effectiveness of e-MH interventions, they have not explored this among 16-25 year olds. Therefore, it is unknown if e-MH interventions are effective for this age group. This review seeks to address this gap. For the purposes of this review, effectiveness will be assessed as symptom change in anxiety and depression scores. Usability and satisfaction data will be considered as possible moderators of effectiveness.

1.2 Methodology

1.2.1 Search strategy

A search strategy was developed based on the focus of the review (Appendix A). Search terms were generated by breaking down the review question into key concepts before producing a list of synonyms and spelling variations. This was further supported by reviewing key words in previous reviews and the use of a thesaurus to find related terms. Three electronic databases were used for the literature review. These included PsychINFO (via EBSCO), Medline (through EBSCO) and Web of Science (WoS). In total 2606 papers were identified (PsychINFO N= 592, WoS N= 1,261 and Medline N=753). The search was initially conducted between October and December 2018 and limited to the last 10 years (2008-2018) to explore the most recent research in this area. The search was updated in March 2019 to account for any new articles, the time period was therefore extended to 2019. The databases were searched within the domains of title and abstract headings. From reviewing previous reviews and searching relevant internet resources, two additional papers were identified. A visual representation of the systematic search strategy based on the PRISMA template is shown in Figure 1.

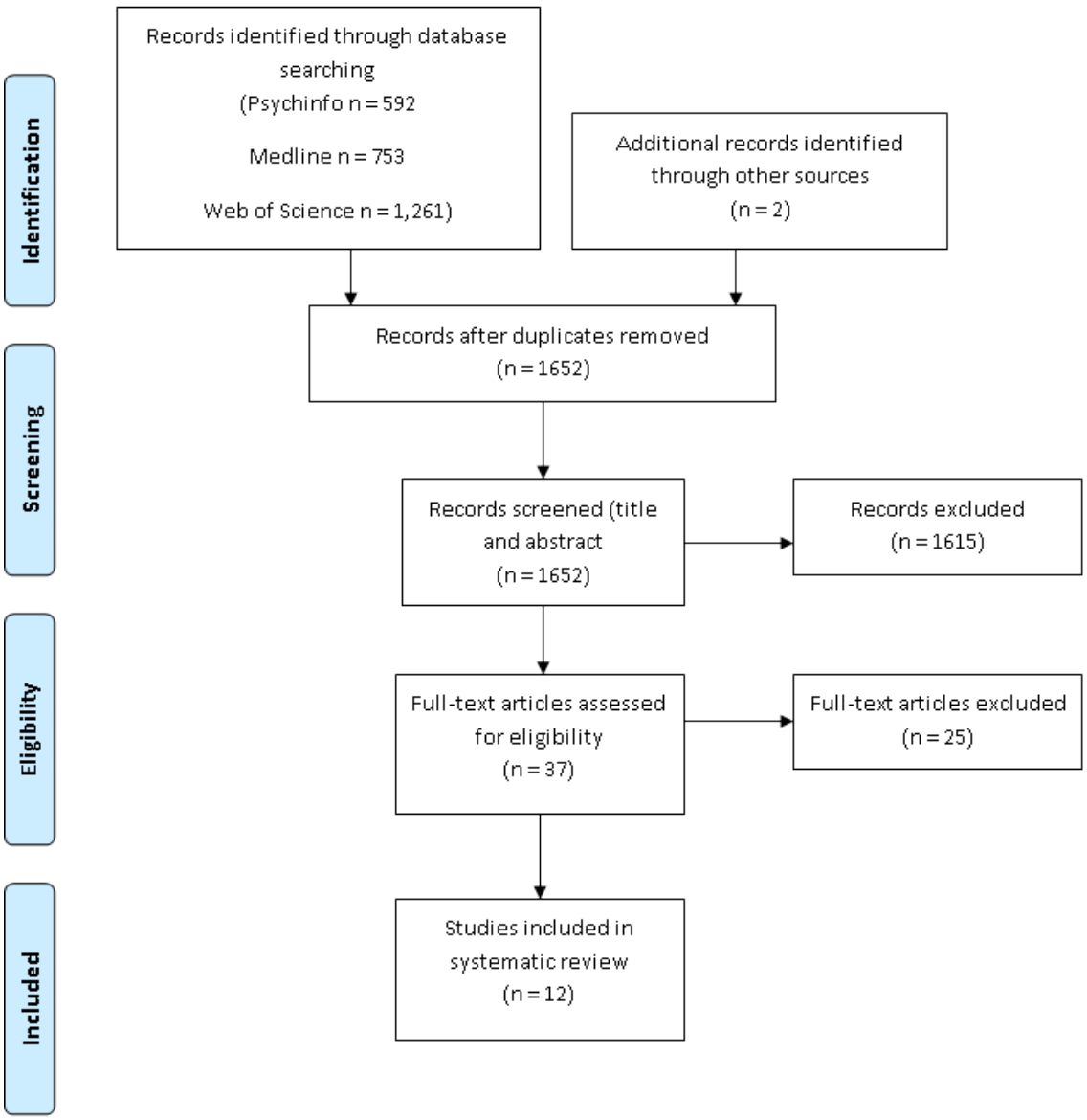


Figure 1. PRISMA Diagram

1.2.2 Inclusion and Exclusion Criteria

The results were filtered to include only peer-reviewed and English language papers. Of these, titles and abstracts were assessed against the pre-determined inclusion criteria (Appendix B). Studies that were not relevant or duplicates were excluded resulting in 37 studies for full text review. Full texts were accessed and an assessment of each paper was made against the inclusion criteria. Those that were not eligible were excluded. Following this process, a total of 12 studies were selected to be included in the review.

1.2.3 Data Extraction

The data extracted from the 12 studies included: descriptive information about the sample (age, gender, number of participants), country of origin, study design and aims, descriptive information about the intervention, outcome measures, target focus of the intervention and key findings. A data extraction table including the study characteristics can be found in Appendix C.

1.2.4 Descriptive Summary

The 12 studies reviewed were conducted in several countries: America (n=1), Australia (n=2), Canada (n=1), Ireland (n=1), Sweden (n=2), The Netherlands (n=3) and New Zealand (n=2). The majority of the studies were quantitative and only one employed a mixed method approach. Collectively, the 12 studies included in this review consisted of 1,790 participants. Participants mean age ranged from 16-25 in the studies. Female participants featured highly in the study sample accounting for 1,378 participants compared to 393 males, although one study did not include demographic data on gender (Tillfors et al., 2011). In the majority of the interventions, the primary outcome measure was depression symptomology (Clarke et al., 2009; Horgan, McCarthy, & Sweeney, 2013; Kramer, Conijn, Oijevaar, & Riper, 2014; Rickhi et al., 2015; Topooco et al., 2018; Van Der Zanden, Kramer, Gerrits, & Cuijpers, 2012). In four studies the primary outcome measure was both depression and anxiety (Anstiss & Davies, 2015; Dear et al., 2018; Ellis et al., 2011; Hoek et al.,2012) and in two studies the primary outcome measure was anxiety (Christensen et al., 2014; Tillfors et al., 2011). Half of the interventions evaluated iCBT interventions (Clarke et al., 2009; Dear et al., 2018; Ellis et al., 2011; Tillfors et al., 2011; Topooco et al., 2018; Van Der Zanden et al., 2012). Other interventions included: online support forums (Ellis et al., 2011; Horgan et al., 2013), solution focused brief therapy (Kramer et al., 2014), problem-solving therapy (Hoek et al., 2012), text message package (Anstiss & Davies, 2015), spiritual informed intervention (Rickhi et al., 2015) and a multi-modal approach (Christensen et al., 2014).

1.2.5 Quality Assessment

The Quality Assessment Tool for Quantitative Studies (Effective Public Practice Health Project, 1998) was used to assess the quality and possible bias within the final set of selected studies. The tool provides a useful structure to assess methodological quality for both quantitative and mixed method studies. It consists of six subscales which include selection bias, study design, confounding variables, blinding, data collection methods and withdrawals/drop-outs. It provides an overall global rating for each study ranging from weak to strong. For the purposes of the

current review, the tool was used qualitatively to describe and compare the strengths and weaknesses of the studies included and an overall quality assessment score has been provided. When quality assessing papers, difficulties can arise due to incomplete reporting of information of studies and this has been taken into account when assessing the quality of the research. A checklist comparing the components across each study has been provided (Appendix D).

1.2.5.1 Selection Bias

Selection bias can occur when the sample of participants are not representative of the target population. Overall, the representativeness of the samples were often limited by the recruitment methods adopted. The majority of the studies used non-probability, convenience sampling to recruit participants, using a number of recruitment strategies. These included: advertising research in educational settings (Ellis et al., 2011; Hoek et al., 2012; Horgan et al., 2013; Rickhi et al., 2015; Tillfors et al., 2011; Van Der Zanden et al., 2012), health settings (Hoek et al., 2012; Rickhi et al., 2015), via media platforms including newspapers, email and social media (Anstiss & Davies, 2015; Dear et al., 2018; Hoek et al., 2012; Kramer et al., 2014; Rickhi et al., 2015; Tillfors et al., 2011; Topooco et al., 2018; Van Der Zanden et al., 2012) or via specific organisations including a youth helpline (Anstiss & Davies, 2015) and a health maintenance organisation (Clarke et al., 2009). Only one study used probability sampling to recruit participants (Christensen et al., 2014). The majority of studies relied on self-selection. Therefore, participants may have been more open and willing to engage in MH support. Research demonstrates that there is a high level of stigma attached to MH difficulties and therefore, those in need of support might not actively seek it (Plaistow et al., 2014). Hence, it is possible that a number of CYP might have been reluctant to take part.

1.2.5.2 Study Design

10 out of the 12 studies included in this review were described as RCTs, employing a between-group design (Christensen et al., 2014; Clarke et al., 2009; Ellis et al., 2011; Hoek et al., 2012; Kramer et al., 2014; Rickhi et al., 2015; Tillfors et al., 2011; Van Der Zanden et al., 2012). Five studies used a wait-list control group (Hoek et al., 2012; Kramer et al., 2014; Rickhi et al., 2015; Tillfors et al., 2011; Van Der Zanden et al., 2012), two studies used an active control group (Christensen et al., 2014; Topooco et al., 2018), one employed a treatment as usual (TAU) control group (Clarke et al., 2009) and one employed a 'no treatment' control group (Ellis et al., 2011). One study was described as an RCT. However, it did not employ a control group but did use a comparator group to determine the difference between two interventions (Dear et al., 2018). Similarly, Ellis et al.(2011) described their study as a comparative randomised trial which included two intervention groups and a 'no treatment' control group. Randomisation procedures were

reported in seven of the studies, which included how allocation was carried out (Christensen et al., 2014; Clarke et al., 2009; Dear et al., 2018; Hoek et al., 2012; Rickhi et al., 2015; Topooco et al., 2018; Van Der Zanden et al., 2012). In the two remaining studies, Horgan et al. (2013) employed a mixed-method approach, which did not employ a control group and Anstiss & Davies (2015) used a cohort design and again did not use a control group.

1.2.5.3 Confounders

A confounder can be described as a variable that can have an effect on the dependent variable. Experimental and control groups may not be balanced with respect to important variables prior to the intervention which can impact on selection bias. As discussed, the majority of the studies used a randomisation process to assign participants to groups. Random assignment can prevent selection bias by distributing the characteristics of participants so that they are evenly distributed among the experimental and control groups. However, the majority of the studies did not explain in detail what the principal confounders may have been, with some studies acknowledging that participant demographics were similar at baseline. In such instances, it is more difficult to assess the robustness of the findings.

1.2.5.4 Blinding

Blinding is a way to protect against bias. This includes assessor blinding, in which the researcher is unaware which conditions participants are assigned to (this protects against detection bias) and participant blinding, in which the participants are not aware of the research question (which protects against reporting bias). Only one study reported a single blind procedure in which the assessor was blinded to the participants' allocation (Rickhi et al., 2015). Two studies reported that no blinding procedures were employed (Dear et al., 2018; Topooco et al., 2018) and the rest of the studies did not report any blinding procedures, making it difficult to ascertain if blinding was employed. Therefore, the quality of reporting is weak, making it difficult to determine the level of detection and reporting bias.

1.2.5.5 Data Collection Methods

All of the studies reported using valid and reliable outcome measures. Typically, researchers relied on published self-report measures for anxiety and depression, which varied across studies and were not triangulated with any other assessment methods. All studies used screening measures to assess anxiety and depression severity, with the majority using cut off scores as part of the inclusion criteria. Measures were often based on self-report questionnaires.

However, cut off scores varied across studies, depending on the measure used. Only three studies, incorporated a telephone interview to assess anxiety and depression severity (Rickhi et al., 2015; Topooco et al., 2018; Van Der Zanden et al., 2012). One limitation on the reliance of self-report measures is that they can be prone to demand characteristics and social desirability. As the majority of studies did not report participant blinding, it is possible that participants may have exaggerated intervention effects.

1.2.5.6 Withdrawals

The majority of the studies accounted for attrition rates, which varied across studies. Three studies experienced very high attrition rates during the intervention, where the post treatment rate was less than 60% (Anstiss & Davies, 2015; Horgan et al., 2013; Kramer et al., 2014). For five studies, the post treatment rate was 60-79% (Christensen et al., 2014; Clarke et al., 2009; Hoek et al., 2012; Topooco et al., 2018; Van Der Zanden et al., 2012) and for two studies the rate was 80% or greater (Dear et al., 2018; Rickhi et al., 2015). One study (Ellis et al., 2011) did not report attrition in the research paper, making it difficult to know if any attrition occurred and it was unclear in Tillfors et al., (2011) study how many participants withdrew from the study and those excluded by the researchers.

1.3 Findings

In the following section, the studies have been grouped by the type of intervention to compare effectiveness. For the purposes and clarity of this review, the researcher has only considered the primary outcome measures used in these studies.

1.3.1 iCBT Interventions

Description of Interventions. Six out of the 12 studies investigated the effectiveness of iCBT programmes for anxiety and depression. These programmes implemented a module, or sectional approach, replicating traditional CBT topics in a computerised format. Topics included patterns of thinking, challenging negative thoughts, relaxation and relapse prevention. Three of these studies evaluated iCBT programmes with CYP with depression (Clarke et al., 2009; Topooco et al., 2018; Van Der Zanden et al., 2012), two studies explored both anxiety and depression (Dear et al., 2018; Ellis et al., 2011) and one study was specifically designed for CYP with a social anxiety disorder (Tillfors et al., 2011). The majority of the interventions were completed individually by the participants and only one study employed a group approach (Van Der Zanden et al., 2012). They consisted of weekly sessions lasting between 3 weeks (Ellis et al., 2011) and 9 weeks (Tillfors et al., 2011). Most of the studies incorporated an element of support or guidance and only two

studies evaluated an intervention that was described as 'pure self-help', where no assistance or guidance was provided (Clarke et al., 2009; Dear et al., 2018). This included one study which compared clinician guided iCBT with self-help iCBT (Dear et al., 2018).

All of the studies utilised a between subjects design and five out of the six studies employed a control group. Two studies used a waitlist control group (Tillfors et al., 2011; Van Der Zanden et al., 2012). One employed an Tau control group (Clarke et al., 2009), one employed an active control group (Topooco et al., 2018) and one did not receive any treatment (Ellis et al., 2011). All studies employed standardised assessment tools to screen participants for anxiety and depression severity and also implemented pre-and-post measures. Measures for depression included the Patient Health Questionnaire (PHQ) including both the PHQ-8, an eight item scale (Clarke et al., 2009) and PHQ-9, a nine item scale (Dear et al., 2018); The Children's Depression Rating Scale (CES-D) (Van Der Zanden et al., 2012) and The Beck Depression Inventory (BDI-II) (Topooco et al., 2018). Measures of anxiety included the General Anxiety Disorder Scale (GAD) (Dear et al., 2018) and specific measures related to social anxiety disorder including The Social Phobia Screening Questionnaire for children and adolescents (SPSQ-C) and the Liebowitz Social Anxiety Scale Self Report (LSAS-SR) (Tillfors et al., 2011). The Depression, Anxiety and Stress Scale (DASS-21) was also used as a combined measure of depression and anxiety (Ellis et al., 2011).

Outcomes. The three studies which explored the effectiveness of iCBT on depression severity found a reduction in depressive symptoms post intervention and all found significant differences between the experimental and control groups. However, effect sizes varied from small (Clarke et al., 2009) to large (Topooco et al., 2018; Van Der Zanden et al., 2012). The study which showed the smallest effect size (d=0.20) was a pure self-help intervention, where no human interaction or assistance was provided in the intervention (Clarke et al., 2009). The study which showed the largest effect size involved an online CBT group course. The results found that the intervention was significantly more effective than the wait-list control group in decreasing depressive symptoms, with an effect size of d=0.94 (Van Der Zanden et al., 2012).

The two studies which explored the effects of iCBT for anxiety and depression both found reductions in anxiety. Only one of these studies included a control group and found a significant reduction in anxiety symptoms compared to the control group (p=.03) with an effect size of d=0.98 (Ellis et al., 2011). The second study did not employ a control group but compared clinician guided iCBT with self-help iCBT and found reductions for both anxiety and depression. However, no significant differences between the self-guided and clinician guided groups were found (Dear et al., 2018). The final study explored the efficacy of iCBT on social anxiety disorder (Tillfors et al., 2011) and found significant improvements. This demonstrating a large between group effect size at post-test (d=0.98).

Four of the six studies collected follow up data which included either a 6 month follow up (Topooco et al., 2018; Van Der Zanden et al., 2012) or a year follow up (Dear et al., 2018; Tillfors et al., 2011). Three out of the four studies found that post-intervention effects had been maintained (Tillfors et al., 2011; Topooco et al., 2018; Van Der Zanden et al., 2012).

Three out of the six studies reported satisfaction rates of the intervention. Participants reported high satisfaction rates in two studies (Dear et al., 2018; Tillfors et al., 2011). However, in one study only 39% indicated that they enjoyed the iCBT intervention (Ellis et al., 2011).

1.3.2 Peer Support

Description of Interventions. Two studies investigated the use of an online peer support website for CYP experiencing depression (Ellis et al., 2011; Horgan et al., 2013) and anxiety (Ellis et al., 2011). The Mood Garden intervention is an online MH resource offering peer-based support and information on various treatments and tools for self-management for anxiety and depression (Ellis et al., 2011). The Lose the Blues intervention provides a forum to allow participants to offer peer support to each other, including information on depression (Horgan et al., 2013). For both interventions, participants could use the website as much as they wanted for the duration of the study and there was no therapist guided support. The duration of the interventions varied. The Mood Garden intervention could only be accessed for a period of three weeks and the Lose the Blues intervention could be accessed over the course of two academic terms. Only Mood Garden employed a between-groups design including a 'no treatment' control group. Both studies included screening measures and pre- and post-outcome measures for anxiety and depression severity. These were self-report questionnaires and included the CES-D (Horgan et al., 2013) and the DASS-21 (Ellis et al., 2011).

Outcomes. The Mood Garden intervention (Ellis et al., 2011) was effective in reducing anxiety, compared with the control condition, with a significance value of p=.01 but no significant findings were found for depression. When calculating the effect size using Cohen's d, it appears that there was a large between group effect size (d=0.95). No significant findings were found for the Lose the Blues intervention (Horgan et al., 2013), although this might have been partly due to the high attrition rates experienced in the study. Out of 118 participants, only 16 completed the post-intervention measure.

Both studies collected data on participant satisfaction. As the Horgan et al. (2013) was a mixed method study, qualitative data was collected regarding the intervention. Participant evaluation of the Lose the Blues intervention suggests it was well received with almost two thirds of participants using the forum reporting that it helped them; they enjoyed using it, and would recommend it to others. However, a number of participants did not complete the post-test

questionnaire and reasons for this were not specified. Mood Garden had positive feedback with 62% of participants expressing that they enjoyed using it and would recommend it to others. However, only 39% expressed they would use it in the future.

1.3.3 Other Technology Based Interventions

The five remaining studies explored a range of different technology based interventions.

Spiritually Informed e-Mental Health Tool

Description of Intervention. Rickhi et al. (2015) investigated the use of a spiritually informed intervention called the LEAP project for CYP experiencing depression and was delivered over the course of eight weeks. The project aimed to evaluate the approach for managing depression in adolescents using principles such as gratitude, compassion, acceptance and forgiveness. The intervention was completed individually and participants were guided through the programme materials by an adult. A between-group design was used, which included the use of a wait-list control group. An initial screening was conducted by a nurse via the telephone and they administered the Children's Depression Rating Scale-Revised (CDRS-R) and the Hamilton Rating Scale for Depression (HAMD) depending on the age of the participants. These self-report questionnaires were also used as the primary outcome measures.

Outcomes. Post intervention, depression severity among the older age group was significantly reduced among participants (p=0.0001). This was maintained at 16 weeks and 24 weeks at follow up; suggesting longer term impact. It is difficult to identify the between-group effect due to a lack of information to calculate the effect size. No participant satisfaction data was collected.

Solution Focused Brief Chat

Description of Intervention. Kramer et al. (2014) investigated the effectiveness of a web-based solution focused brief chat treatment (SFBT) for depressive symptoms among adolescents and young adults. This involved SFBT techniques including setting goals, looking for strengths and keeping the focus on what is going well. The intervention consisted of individual real-time chat sessions with a trained health care professional in a chat room, lasting for an hour and limited to five sessions. A between-groups design was employed, which used a waitlist control group. The CES-D was used as a screening and primary outcome measure.

Outcomes. The results found that the experimental condition showed significantly greater improvement than the wait-list condition in depressive symptoms, demonstrating a small effect

size at 9 weeks (*d*=0.18) and a large effect size at 4.5 months (*d*=0.79). However, the researchers report that more than 70% of participants in the experimental group still experienced depressive complaints above the cut-off criteria for depression on the CES-D. It is important to note that only 42% of those who had access to the chat intervention made use of it, suggesting limited adherence. No participant satisfaction data was collected.

Problem Solving Therapy

Description of Intervention. Hoek et al. (2012) examined the effects of internet based guided self-help problem solving therapy for adolescents with depression and anxiety. The intervention was delivered over the course of five weeks and involved asking participants to describe what mattered to them, writing down their current worries and problems and categorising them into degrees of solvability. For each problem, a different strategy was proposed to either solve the problem or to learn to cope with the unimportant and unsolvable ones. A between-groups design was employed, which used a waitlist control group. No therapeutic support was provided but the authors offered feedback on completed exercises. The CES-D and the Hospital Anxiety and Depression Scale (HADS-A) were used as primary outcome measures.

Outcomes. A significant improvement was found for depressive symptoms for the complete sample. No support was found for the effects of the intervention in reducing depression and anxiety severity in comparison with the wait-list control group (*d*=0.04), making it difficult to conclude if the intervention was effective. Moderate satisfaction with the intervention was found with the mean overall satisfaction grade on a 1-10 scale was *M*=6.45, *SD*= 1.28.

Text Messaged Based Intervention

Description of Intervention. Anstiss and Davies (2015) investigated the efficacy of a text messaging intervention called 'reach out, rise up' for depression and anxiety. The text message package comprised of three weekly text messages which included a psycho-educational message, a weekly challenge relating to the message and an inspirational message. Half of the participants were randomly selected to receive a follow up call from a trained supporter each week to support them with the text package. No control group was used in the study. Screening measures included the GAD-7 and PHQ-9, which were also used as pre and post measures.

Outcomes. The researchers found that participants' scores on primary outcome measures were significantly lower at the end of the intervention for both anxiety (*p*=.005) and depression (*p*=.013).However, just over half the participants completed the intervention. Nevertheless, those that did complete the intervention rated the package highly with an average rating of 3.9 out of 5.

However, it is difficult to argue that the participants decrease in anxiety and depression severity was as a result of the intervention due to the absence of a control group.

Multi-Modal Intervention

Description of Intervention. Christensen et al. (2014) investigated the use of a combined psycho-education, iCBT, physical activity promotion and relaxation intervention, and the role of telephone and email reminders. This package was for CYP experiencing anxiety and ran for 10 weeks. The study consisted of five different conditions, three of which included the experimental intervention consisting of an active website with the multi-modal approach. Of these three groups, two included either telephone or email reminders. The remaining two conditions were control groups which consisted of a placebo website. One of the control groups included telephone reminders. No therapeutic input was provided. Screening measures included a telephone interview using the Mini-International Neuropsychiatric Interview (MINI). This is a structured clinical interview enabling the researchers to make diagnoses of psychiatric disorders (Sheehan et al., 1998). The primary outcome measure was the GAD-7.

Outcomes. The researchers found that anxiety symptoms as measured by the GAD-7 reduced at post-test and 6 month follow up but returned to baseline at 12 months for all groups. They found no significant differences between the control group and any of the intervention groups. The researchers highlighted that adherence to the intervention differed depending on the condition participants were in. Participants in the conditions where reminders were given completed the majority of the modules, whereas those who did not receive reminders completed just over a third of modules. Attrition was higher than the researchers expected, with 36% of participants not completing the study.

1.4 Discussion

Given the growth in the areas of technology and the rise in MH difficulties among CYP, the review sought to provide an up to date systematic review of the effects of technology-based interventions for CYP between the ages 16-25. Across the 12 studies, 13 different interventions were evaluated. Half of the studies evaluated iCBT interventions, which incorporated similar topics used in face-to-face CBT such as recognising and challenging negative thought patterns. Two of the studies evaluated online peer websites and the remainder of the studies evaluated a range of different technology based interventions. Overall, data characteristics across studies varied considerably, particularly sample size and the type and length of intervention, therefore making it difficult to draw any firm conclusions about the overall effectiveness of e-MH interventions for CYP aged 16-25. However, some tentative conclusions can be made. This review

will now summarise the main findings from each group of interventions, including the commonalities and differences among studies, before considering the relative strengths and limitations of this review, alongside some possible directions for future research.

1.4.1 iCBT Interventions

The majority of studies which evaluated iCBT interventions reported positive outcomes for depression and anxiety severity. Out of the four studies which employed a control group, only one study did not find any significant differences between the intervention and the control group for depression severity (Ellis et al., 2011).

The studies which demonstrated the greatest effect sizes were structured, involved an element of support from practitioners, and the length of the intervention ranged between 5-9 weeks, which is similar to face-to-face CBT (Tillfors et al., 2011; Topooco et al., 2018; Van Der Zanden et al., 2012). In terms of methodological rigour, the design of these studies was strong. All participants were randomly allocated to either the experimental or control group and the researchers were clear about their randomisation procedures. Random allocation makes it more likely that any differences in baseline characteristics between studies were evenly distributed among the experimental and control groups, thereby reducing bias. Attrition rates for these interventions were among the lowest of all studies, which might have been the result of therapist support and reminders. Furthermore, all three studies found the effects of the intervention had been maintained at 6 months (Topooco et al., 2018; Van Der Zanden et al., 2012) and 12 months (Tillfors et al., 2011) follow up time points, suggesting longer term impact. However, it is important to note that the studies relied on self-report outcome measures to evaluate effectiveness, and only one of these studies used a semi-structured diagnostic tool pre and post intervention (Topooco et al., 2018). Also, the sample sizes were generally small, which impacts on the generalisability of the findings.

Overall, the research evaluating iCBT interventions demonstrated some improvement on depression and anxiety severity among CYP aged 16-25. This is line with previous systematic reviews which have investigated the effectiveness of e-MH interventions. For example, Hollis et al. (2017) found support for the role of iCBT in improving symptoms of anxiety and depression, particularly those targeting older adolescents. The meta analyses found a small to moderate effect size for iCBT interventions when using Hedges' *g* (*g*=0.16-0.62). However, a number of methodological limitations across the studies made it difficult to draw firm conclusions. The findings also suggested that some human support was beneficial in adherence and effectiveness. However, the researchers identified vast differences in the level of human support between studies such as who was providing the support, the degree and the purpose of the support.

The findings of the Hollis et al. (2017) study are similar to that of Grist et al. (2018) which explored the efficacy of e-MH interventions for CYP under 18. They found that interventions which yielded the strongest effect size were iCBT interventions, demonstrating a medium effect size (*g*=0.66). The researchers concluded that there was a benefit using iCBT where access to traditional face-to-face methods were scarce. They also identified that contact therapies yielded higher effect sizes than purely self-administered interventions.

The current review adds to the existing body of evidence that iCBT may be beneficial at reducing anxiety and depression severity among CYP. It is important to note, however, that there were only a limited number of iCBT studies reviewed and the heterogeneity of the interventions makes it difficult to identify the magnitude of the effect. For instance, all of the interventions were single evaluations and varied in terms of length of intervention and the control group used. Furthermore, the aforementioned methodological weaknesses of the research examined mean that caution must be applied when interpreting these findings.

1.4.2 Peer Support

The review identified two studies examining the effectiveness of online peer support for CYP with anxiety and depression, with mixed results. Only Mood Garden (Ellis et al., 2011) found a significant effect, compared with the control condition, in reducing anxiety symptoms but this was not the case for depressive symptoms. However, the methodological rigour can be described as weak, thus limiting the robustness of the findings. The study consisted of a very small sample comprising of 13 participants in each condition, and only consisted of undergraduate university students, making it difficult to generalise the finding to the wider population. Furthermore, the intervention was conducted over a very short time frame of three weeks, which is a very limited period within which to assess change (and markedly less than the other interventions included in this review). There was also no discussion on assessor or researcher blinding.

The lack of high-quality research examining the effects of peer support makes it difficult to draw any firm conclusions about its effectiveness. This is line with previous reviews (Ali, Farrer, Gulliver & Griffiths, 2015; Rice et al., 2014) which have highlighted the paucity of research on online peer support and the need to further evaluate such interventions. Burns et al. (2010), argues that the lack of research in this area is even more salient, given CYP's extensive use of the internet to seek information and to connect with others. Furthermore, as discussed, such platforms can be associated with potential psychological and physical harm for CYP, given the rise of pro-suicide and self-harm websites. Therefore, it is vitally important that future, good-quality research explores this area further. Given the rapid growth in online use and opportunities for CYP to engage with peers in this way, it is important that researchers rise to the challenge of

keeping pace with such changes, if we are to ensure CYP are given clear advice about accessing interventions which are safe and have the best evidence base.

Both Ellis et al. (2011) and Horgan et al. (2013) gained data about participants' satisfaction with the interventions. Feedback suggested some positive features of the interventions. However, in the Horgan et al. (2013) study, there were very high attrition rates with over 80% of participants not completing the post self-report measure. The researchers note that this may have been related to factors such as a lack of up to date technology and a lack of moderation and support in the forum. Ali et al. (2015) highlights that moderation is a key part of online peer-to-peer support, particularly as it intends to keep users of the forum safe. Furthermore, research suggests online forums are viewed more positively when they are moderated (Webb, Burns & Colin, 2008).

Another reason for attrition might be linked to concerns regarding privacy and confidentiality. Research suggests that data security in online peer-to-peer interactions is very important for CYP (Farrer, Gulliver, Bennett & Griffiths, 2015) which may impact on the use of such interventions if data security is not explicitly guaranteed. Therefore, such concerns should be given careful consideration when developing online peer support websites and forums.

In the Ellis et al. (2011) study over half of the participants said they would not use the resource again or were unsure if they would use it in the future. This highlights the need to seek user opinions in the development of interventions, before they are designed and implemented.

The field of online peer support is still in its infancy, as demonstrated by the lack of research exploring this area. Given that a number of online interventions for CYP include a peer support component, there is a need to develop a greater understanding of these interventions, particularly gaining the perspective of CYP and identifying their value, safety and efficacy.

1.4.3 Other Technology Based Interventions

The review identified a range of other technology based interventions including a text based package, problem solving therapy, solution focused brief chat, multi-modal package and a spiritually-informed intervention. The two RCTs which showed a positive effect included the spiritually-informed intervention (Rickhi et al., 2015) and a solution focused brief chat intervention (Kramer et al., 2014). Both studies involved elements of solution focused practice including recognising successes and focusing on the positives. Both studies employed follow up measures, finding that the effects remained significant after the interventions, suggesting some longer-term impact.

In the Kramer et al. (2014) study, over a quarter of CYP receiving the intervention maintained clinically significant change at a 4.5 month follow-up, compared to waitlist controls. In

comparison with the other studies using other interventions, both studies demonstrated strong methodological rigour, particularly in terms of study design. However, attrition rates varied, Kramer et al (2014) experienced over 43% attrition rates post intervention, whereas Rickhi et al. (2015) reported only 13%. When comparing the interventions, differences can be found in terms of how they were structured. For instance, in the Kramer et al. (2014) study participants could access the intervention at a time and place convenient for them, whereas in the Rickhi et al. (2015) study and also in the iCBT interventions reviewed, the interventions consisted of weekly modular based sessions, which provided more structure and explored a range of different topics. It could be argued that more structured approaches are better suited for CYP than self-directed methods that rely on CYP to be pro-active and initiate contact with the service, particularly given that motivation may fluctuate among CYP with depression (O'Kearney, Kang, Christensen & Griffiths, 2009). Therefore, further exploration should be given to exploring the way different technology-based interventions are designed and structured so as to explore what is most preferable and helpful for users.

Although the interventions described evaluated different MH support interventions, it is noteworthy that the two studies which demonstrated significant findings both included components of positive psychology, particularly solution focused approaches which give weight to building solutions than problem-solving (Cane, 2016). Positive psychology approaches adopt a strength based model, seeking to foster and identify positive changes that can occur in an individual's life by developing goals and focusing on solutions. This sits within a systemic epistemology that considers the service user as a part of a complex interacting system and challenges the traditional 'within-child' approach (Cane, 2016). Over the past 20 years, there has been a rise in positive psychology, solution-focussed approaches, and research suggests they can be effective in supporting MH difficulties, among adult and child populations (Gingerich & Peterson, 2013; Lee, Greene, Mentzer, Pinnell & Niles, 2001). Within the field of educational psychology, solution focused approaches are widely used in school settings, and in recent years, there has been a drive within school communities to use person-centred approaches in their work that utilises the strengths and capabilities of individuals (Mansell & Beadle-Brown, 2004). Given the rise of such approaches and the drive to move towards a more systemic approach to MH, this would be a promising area to explore and evaluate further when delivered via online platforms.

1.4.4 Strengths, Limitations and Directions for Future Research

To the author's knowledge this is the first review which has solely explored the efficacy of e-MH interventions on anxiety and depression severity among CYP aged 16-25. The findings add to existing reviews which have identified positive outcomes for the use of iCBT in reducing anxiety

and depression severity (Hollis et al., 2017; Grist et al., 2018). The review has also identified a lack of robust support for the benefits of online peer websites but has outlined some promising evidence suggesting potential benefits of further exploring the use of online, solution-focused approaches. However, due to a lack of sufficient, good-quality research exploring these areas, it is difficult to make any firm conclusions. Careful use of the quality assessment tool enabled the researcher to understand the key strengths and limitations of each study enabling them to assess the risk of bias and reliability of the results and provide an indication of the quality of the studies and the weight of evidence. Furthermore, this review is timely, given the increasing rise in MH difficulties among young adults and the growth in the development of e-MH interventions claiming to offer effective support.

Although the review suggests promising findings for the use of iCBT and solution-focussed online interventions with young people, it is important to note some of the overall limitations of the review itself. Firstly, the studies included were predominately based on searches in three databases. Therefore it is possible that the search strategy failed to identify all eligible studies. Furthermore, a level of bias might have occurred due to strict inclusion criteria which included only English language papers and peer-reviewed papers. It is also important to note that the review did not include any studies in England and the UK. Therefore it is not clear how well the interventions would translate into this context. Additionally, judgements on methodological quality were made by one reviewer. Therefore this was not assessed for inter-rater reliability and therefore susceptible to subjectivity and bias.

Additionally methodological limitations include the reporting of effect sizes in papers. Effect sizes as a means of determining the efficacy of an intervention are well established (Hattie, 2008). However, there has been a recent call for caution in interpreting and comparing effect sizes (Simpson, 2017) and evidence that these can perhaps be more easily manipulated than first thought. Simpson (2017) has shown that the difference between the experimental and comparison groups, the effect size, is a product of the measures used and the variance in the sample of participants and therefore small changes can change the significance of an effect size without any changes to the actual intervention. He argues that to make effective judgements about a range of interventions, studies must use the same comparisons, measures and the range of participants. This caution is very applicable to the current review as these studies all used a range of measures and participants.

To date, research indicates that the use of iCBT interventions are effective in supporting anxiety and depression among CYP. However, there are some ethical considerations that need to be considered regarding their use. The iCBT interventions explored in the current and previous reviews vary in terms of design and delivery. Some replicate traditional face-to-face approaches, and include an element of therapeutic support with a similar amount of sessions, whereas others

appear to be short in length with no therapeutic contact. Given the centrality of the therapeutic relationships, it will be important to further explore and consider the role of the therapeutic relationship within the context of e-MH interventions and the potential benefits and limitations of receiving MH interventions with or without in-person or online contact with a human provider/facilitator. Future research could address this question through both quantitative studies comparing outcomes and qualitative studies exploring user engagement and experience. Future research could also explore more about other key factors which should be considered when designing or recommending technology-based interventions, such as the level of structure, the length of intervention and the type of content. When considering the findings of this review and of previous reviews, it appears that there is a benefit in using iCBT approaches to support anxiety and/or depression among CYP. However, it is important to note that the interventions evaluated appeared to vary in terms of its delivery such as the length of sessions and the amount of support provided to service users. Therefore, future research should explore these variations in more detail to see what is more effective in terms of supporting CYP.

1.4.5 Implications for Practice and Concluding Comments

The rise in MH difficulties among CYP has led to a growing political drive to increase support, particularly within school settings. As part of this, EPs can play a key role in supporting educational settings to meet the social and emotional needs of CYP. Furthermore, legislative changes to The Children and Families Act (DfE, 2014) has seen the extension of EPs working with post-16 populations in further educational settings. Therefore, EPs are well positioned to work collaboratively with a range of professionals and CYP to promote MH, through consultation, training, research as well as therapeutic interventions (Morris & Atkinson, 2018). Understanding the development and advances of MH support in the digital age will be important for EPs, including the evidence-base for specific interventions. EPs should also be aware of additional risks that online technologies pose in relation to MH support. For example, issues related to data security such as privacy and confidentiality. Furthermore, with a reported increase of misinformation, particularly on social media, it may be difficult for CYP to discern what online information is and is not beneficial for them. Research indicates that many CYP do not seek help due to a fear of stigma (Gulliver, Griffiths & Christensen, 2010) and therefore the internet may be their only source of support. It is therefore important that they are aware of the risks and know how to access credible and trustworthy information, support and advice. EPs have a duty of care and must work within the British Psychological Society and The Health and Care Professions Council standards of ethics and conduct. With this in mind, EPs should be mindful of ethical issues and potential risks when recommending interventions. Perhaps, when they have carefully

considered the evidence-base for good practice in this area, there is a role for EPs to provide information and training that can be shared with the school community.

Most importantly, EPs have a role in advocating for CYP and empowering them to make decisions about aspects of their life that affect them. Most of the interventions reviewed here did not report any involvement of service-users in terms of design and evaluation. The studies could be described as research on and for, rather than research with, young people themselves. Moreover, in the reviewed studies included here, there was a lack of reported information about the user experience and whether they would want to recommend or use the interventions again in the future which would be helpful to explore. Although a small number of studies included participant satisfaction data, it tended to be limited to quantitative scores, which did not provide sufficient information about the service user's experience. For interventions to be effective and have maximum impact, researchers and EPs need to start with the service user and be guided by them in terms of what they value and want in terms of MH support. Research highlights that CYP perceive services most helpful when they are given agency in decisions that affect them and their care (Apland et al., 2017). There is, therefore, much scope for EPs to provide a vehicle for CYP to voice their opinions, share their experiences and empower them to become co-researchers and co-participants in conceiving of, designing and evaluating the MH support available to them.

Chapter 2 Children and Young People's Perspectives of Mental Health Support in Home, School and Community Contexts: A Delphi Study

2.1 Introduction

2.1.1 Background and Context

Mental Health (MH) is a growing public health issue worldwide (Mental Health Foundation, 2019), with depression and anxiety being recognised as the most prevalent difficulties, affecting almost one in ten people (World Health Organization, 2016). Within the UK, there are significant concerns about children and young people's (CYPs) MH, and this has become a priority area for government and focus for educational policy. Research suggests that there are escalating numbers of CYP in the UK experiencing debilitating MH difficulties and it is reported that one in eight of CYP aged 5-19 years old experienced a MH disorder in 2017; a rise since 2004 (Sadler et al., 2018).

As a result, the demand for MH support across health, education and the voluntary sector is also intensifying (Care Quality Commission, 2018; Houses of Commons, 2018). Child protection charities such as the National Society for the Prevention of Cruelty to Children (NSPCC, 2018) have reported record high numbers of counselling sessions, between 2017-2018, for CYP who were experiencing suicidal thoughts and feelings. Moreover, a report by Frith (2017) found that over a quarter of CYP, referred to specialist MH services in England and Wales, had not received any support due to the high thresholds required for eligibility.

In response to such mounting need, the government has pledged to improve MH support for CYP and create a more joined up approach across health and education (DoH & DfE, 2017). CYP spend a high proportion of their time within educational settings and therefore, school staff can be viewed as a frontline source of support (Doyle, Treacy, & Sheridan, 2017). In England, the government has published guidance for educational settings as well as announcing plans to develop more training for school staff to be able to recognise, identify and support CYP who are experiencing MH difficulties (DfE, 2018).

2.1.2 Barriers to Support

Despite the growing need to improve MH support, the identification of CYP experiencing MH difficulties can be problematic. Firstly, research suggests there are a number of barriers that prevent CYP seeking support for their MH. In a systematic review exploring adolescent MH help-seeking, Gulliver, Griffiths, & Christensen (2010) identified the following barriers: perceived stigma and embarrassment, difficulties recognising the symptoms of a MH difficulty and a preference for managing problems independently. Within schools, research has highlighted that students can be reluctant to seek support from school staff due to an uncertainty about confidentiality; expressing concerns that their difficulties may be exposed more widely (Kendal, Keeley, & Callery, 2014).

A further barrier to effective practice is how poorly MH is defined and understood. MH can be described as a multi-faceted and complex concept for which there is no universally agreed definition (Greig, MacKay, & Ginter, 2019; Weare, 2000). Davidson (2008) proposes that the lack of agreed terminology among professionals is due to different theoretical perspectives and legal frameworks that shape these services. These perspectives impact on how MH difficulties are understood and described, as well as on how they are responded to. Within an educational context, research suggests that school practitioners may be reluctant to use terms such as 'mental health' due to a lack of understanding (Rothì, Leavey, & Best, 2008) and negative connotations (Danby & Hamilton, 2016).

It has also been highlighted that some professionals view MH problems through a medicalised lens; focusing on the illness and seeing it as an individual issue rather than recognising the wider context (Weare, 2000). In recent government publications (DfE, 2017) terminology such as 'Mental Health first aid' and 'mental ill health' have been used. Such terms, which focus on illness, suggest a within-child approach, where the child's difficulties are seen in isolation from any context that may create or perpetuate them. As a result, support may be merely targeted around the child needing 'treatment' as opposed to providing wider systematic support within family, school and community contexts or considering the impact these interactive factors have on MH (O'Hare, 2017). Davidson (2008) highlights the importance of multi-agency working and the need to collaboratively develop MH terminology that acknowledges multiple influences. Furthermore, a lack of common understanding of MH is a potential factor affecting whether the MH needs of CYP are recognised or supported appropriately (Danby & Hamilton, 2016).

Weare (2000) suggests viewing MH as a continuum on which everyone is placed. This approach highlights the fluidity of MH and the possibility that it can change over time. Using a

continuum can provide an inclusive approach to MH and research suggests that this can reduce stigmatisation of MH difficulties (Schomerus et al., 2016).

As there is not one universally agreed way to describe MH, for the purposes of the current study, MH will be conceptualised as being a continuum and affected by interacting factors both within and around the person (WHO, 2012). The term MH will be used in line with the WHO's definition, which recognises that good MH underpins everything we do:

> A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2014, p. 1).

2.1.3 Valuing the Voices of CYP

There has been a growing emphasis on support services, MH included, being more attuned to the needs of service users including CYP. In line with article 12 of the UN convention on the Rights of the Child (United Nations, 1989), CYP have the right to participate in decision-making processes that are relevant to them. In the UK, increased importance has been placed on capturing the views of CYP. This has been highlighted in government policies such as The Special Educational Needs and Disability (SEND) Code of Practice: 0 to 25 years (DfE, 2015). These policies have introduced new ways of working within educational settings, which aim to increase pupil voice and enable CYP to have a say about decisions that affect them.

Although there is a drive for CYP to be seen as equal stakeholders in decision making, research reveals that CYP are not always asked for their views by decision-makers in relation to mental health support (Aubery & Dahl, 2006; Apland et al., 2017). This has led to a discrepancy between what is provided or promoted and what CYP want (Kidger, Donovan, Biddle, Campbell & Gunnell, 2009). Incorporating CYPs' views and perspectives in the design of appropriate support approaches is an important way to give CYP a voice in issues that affect them, as well as ensuring provision is suitable (Plaistow et al., 2014).

Studies which have sought the views of CYP highlight that CYP are more likely to seek help from those they know and trust such as friends and family (Rickwood, Deane, Wilson & Ciarrochi, 2005). This suggests the need for interventions which target those immediate support networks who influence CYP, such as parents. Furthermore, CYP have highlighted the need for support services to be easily accessible including having counsellors within the school and community based services close to home, or within the home itself (Plaistow et al., 2014; Lavis & Hewson, 2011). In addition, online technologies appear to be serving as a way for CYP to reach out to others and access information and research indicates that CYP feel comfortable accessing online

information about MH (Oh, Jorm & Wight, 2009). This suggests that there is a need to consider interventions and approaches outside of the school context.

Understanding what CYP value in terms of MH support can provide some insight into whether current provision is desirable and appropriate. It appears, from the limited evidence base, that there is a need for investigating support beyond the school context and to consider the wider community and online technologies. In order to develop effective MH support systems for CYP, it is key that any approach is informed by the needs and wishes of CYP. This includes the type of support, who the support is delivered by and where support takes place. Engaging CYP directly in MH service redesign is, therefore, an important step in addressing concerns regarding the escalating MH needs of CYP.

2.1.4 Research Aims

The current study was designed to be exploratory in nature. The central aim was to ask CYP what they, personally, identified as the most essential types of MH support, where they would like to access MH support, and the key competencies they value in those delivering that support. It was hoped that the support and competencies that the CYP identified could then form the basis of a framework which would have clear implications for practice. The key areas being:

- The most valued personal qualities for practitioners supporting CYP's MH
- The most highly rated strategies and interventions that could be used to support the MH of CYP
- Preferred options regarding accessibility and availability of MH support for CYP

2.2 Methodology

2.2.1 Rationale

To achieve the aims of the current research, consultation with CYP was required in order to identify essential types of support. A Delphi methodology was considered as it is based on the premise that "group opinion is more valid than individual opinion" (Keeney, Hasson & McKenna, 2011, p. 3). The survey technique draws on the opinions of a group of 'experts' to establish consensus regarding a particular topic or issue via a series of questionnaires (Powell, 2003). The Delphi method has been increasingly used in research across a wide range of disciplines including MH research (Jorm, 2015). It is an iterative process that consists of a number of questionnaire rounds. After each round, feedback regarding the overall results is shared with participants, providing them with an opportunity to modify their responses in subsequent rounds. Typically,

questionnaires are sent out until consensus is reached. The literature suggests the number of questionnaire rounds can range between two and four depending on the time available and the research aims of the study (Keeney et al., 2011).

A key feature of the Delphi method is the formation of an 'expert' panel. According to Hsu & Sandford (2007), individuals can be considered eligible if they have experience concerning the target issue. Traditionally, Delphi studies in the area of health and education have used professionals as their 'expert' panel. However, service users are increasingly being recognised and included, due to their knowledge and experience with the issues being explored (Robinson et al., 2018; Jorm, 2015). A key methodological issue of the Delphi approach is carefully defining 'expertise' for the given study and selecting the participants accordingly. Participant selection does not require a statistical sample that is representative of any population but instead needs to be very purposive. The selection process is therefore a key component of the Delphi method and attention should be given to the criteria in selecting expertise (Jorm, 2015; Powell, 2003). For the purposes of the current research, panel members were required to have expertise in the area of MH. Accordingly, CYP aged 16-25, who had experienced a MH difficulty within the last three years, formed the 'expert' panel (details of the recruitment approach are detailed in 2.2.5.1). The three year time range was specified for their experiences to be recent enough to justify their familiarity and expertise with the topic. It was decided not to restrict participants to those with diagnosed MH difficulties as research suggests that there is a hidden population of CYP who experience difficulties but are reluctant to seek support, due to a fear of stigma associated with poor MH (Clement et al., 2015). Accordingly, the current research took an inclusive approach, providing an opportunity for those without a diagnosis, but with self-acknowledged experience of MH difficulties, to share their views on MH support particularly as this has been identified as a gap in the literature (Apland et al., 2017).

An advantage of using the Delphi approach with CYP who have experienced MH difficulties is that it enables participants to share their views anonymously, without the social pressures and constraints that might occur in more conventional face-to-face methods, such as focus groups. This anonymity enables honest views and reflections on the particular subject matter. Due to the sensitive nature of the topic of MH and suggestions that some CYP still perceive a stigma around this, the Delphi method was considered to be the most suited way of inviting open and honest perspectives on possible MH support.

A lack of universal guidelines and protocols associated with Delphi methodology is one of the main criticisms of the approach (Keeney et al., 2011). This in part has led to a wide variations and modifications of the technique, leading researchers to make pragmatic decisions about sample size, consensus level and number of rounds employed. This has resulted in much debate about what constitutes methodological rigour in Delphi studies (Hasson & Keeney, 2011). To

ensure credibility of the Delphi findings, and in line with recommendations of its use (Powell, 2003) the current study has been clear about the rationale for methodological decisions made.

Traditionally, the first round of data collection in a classic Delphi technique begins with an open-ended questionnaire which generates qualitative data, providing information on the topic area and guiding the development of questionnaire items. For the purposes of the current study, a modified Delphi technique was used which involves a pre-selected set of items based on the literature which forms the basis of the Delphi questionnaire, enabling participants to start from a 'common base' (Keeney et al., 2011). The Delphi was intended to provide consensus regarding valued practice and to identify key areas of disagreement which can then inform best practice. As the intended outcome was to create a framework of recommendations for practice, the perspectives of other key stakeholders were gained through qualitative interviews to identify the feasibility and utility of the recommendations developed from the view of CYP.

It should be highlighted that the quantitative data gathered in the Delphi was the central focus of the study; therefore, it was given priority over the qualitative data in the subsequent reporting and analysis.

Creating a Framework

Over the years, the Delphi method has been used to develop evidence-informed guidelines and competency frameworks. For instance, Cox et al. (2016) used the Delphi approach to produce a set of 'best practice' guidelines for secondary schools in response to the suicide of a student. Frameworks have also been developed as a tool to guide and evaluate practice enabling practitioners to reflect on their skill set (Atkinson, Dunsmuir, Lang & Wright, 2015; Green & Birch, 2019). From a scientist-practitioner perspective, as a Trainee Educational Psychologist, one key aim of this research was to develop and present a framework of recommendations, driven by the views and perspectives of CYP, which could be used as a tool to guide practice in relation to MH support. It was envisaged that this could help inform practice within home, school and community contexts.

Epistemological position

The current study is grounded in a social constructivist approach. Constructivism can be referred to as a process by which reality is created and constructed by a person's active experience of it (Khalifa, 2010). This is achieved through a process of proactive and purposive interactions with the world (Galbin, 2014) and has been described as an "ongoing iterative dance of discovery and interpretation" (Miller and Crabtree, 1999, pg.10). This is complementary to the Delphi approach which aims to explore a diverse range of 'constructed views' of panel members; a process which involves identifying and capturing the realities of panel members, with

opportunities for members to change their position based on feedback (Engles & Kennedy, 2007). In line with this stance, the Delphi methodology acknowledges and facilitates the interaction of panel members in this construction as opposed to the researcher having the "monopoly on knowledge construction" (Brown, 2008, pg. 20). Not only is construction of knowledge at the centre of the methodology, it is also core to the beliefs and values of the author as a researcher.

2.2.2 Research Design

For the purposes of the current study, a two round Delphi methodology was used. Due to the nature of the Delphi technique, a high level of participant commitment is required and it is not uncommon for participants to drop out during the process (Donohoe & Needham, 2008). One way to reduce the possibility of attrition is to limit the number of rounds, which can reduce participant fatigue (McMillan, King & Tully, 2016). With this in mind, along with the time constraints of the study, a modified Delphi approach was used. Items in the first survey were generated from a review of relevant literature which was then compiled to form the initial set of statements. It was considered that this approach would be more time efficient and would enable participants to start from a 'common base' (Keeney et al., 2011). At the start of each section, participants had the opportunity to identify approaches they felt were important to support MH. This was to ensure an inclusive approach was taken, which did not bias the responses or limit the available options, by only having pre-existing items to rank. Participants were then asked to rate the set of statements using a four point Likert scale, ranging from 'essential' to 'not essential'. Any new items identified by participants, were included in the second questionnaire (round 2). Participants were given a two-week deadline for completing questionnaires. Each stage of the Delphi process is summarised in Figure 2.

Literature search and questionnaire development

To inform the content of the initial survey, a literature search was conducted to identify what approaches were currently being used to support CYP, as well as identifying aspects of support that CYP had reported as important. The search was carried out across research and grey literature which included government publications and mental health charity websites. To locate the literature, publications were retrieved through the search engine Google, Google Scholar and the research database PsychINFO. Key words in the search included "mental health" AND child* OR "young people" OR "young adult*" OR adolescen* OR teenage* AND "voices" OR "views" OR "support" OR "strategies" OR "recommendations". Publications were screened for relevance and supportive factors identified were grouped into the following areas; personal qualities, strategies, how support is accessed and where support is accessed. Items in the initial survey were reviewed by the research team, any statements which were ambiguous or vague were taken out. The final

questionnaire included 55 statements. As discussed, It was decided that it would be important for participants to have an opportunity to provide additional statements that were not already included in the questionnaire, to not limit it to set of pre-defined statements and to instead act as a base that participants could add to. Therefore, in each section of the questionnaire participants had the option to add additional statements.

Figure 2. Summary of Delphi Process

2.2.3 Participants

2.2.3.1 Delphi Study Participants

Participants were recruited from one college in Greater London. In total, 23 students completed the first Delphi questionnaire (N=23). This consisted of 16 females and 7 males. Participants were aged between 16 and 20, from a range of ethnic backgrounds, and were undertaking either academic or vocational programmes. As part of the first round, participants were asked to complete an optional demographic questionnaire including questions related to their MH (Table 1).

Participants had experienced a range of MH difficulties, with anxiety and depression being the most frequently identified. 16 participants said they had received MH support. This included specialist support such as art therapy, counselling, group therapy and the use of anti-depressants, as well as support from friends. Some participants expressed their experiences of the support they received which included:

"A group therapy session once a week that really didn't help"

"…previously inadequate talking therapy"

"CAMHS, after being in foster care, therapy not helpful and my therapist [name] had to be transferred making everything pointless."

"I had counselling for a while but I stopped going because I feel like it didn't help me"

Participants identified the age at which they received support. This ranged between 8-17 years old, with the majority receiving support from age 14 and over and identifying that this was too late. 17 participants said they were still currently experiencing difficulties with their MH. Some attrition was experienced in the second Delphi round. In total, 18 participants completed the second questionnaire within the allocated time frame.

Table 1

Participants' Demographic Information

Characteristics		Round 1 Participants (n=23)	Round 2 Participants (n=18)
Gender	Male	7	13
	Female	16	5
Age	16	4	3
	17	8	6
	18	7	6
	19	3	2
	20	1	1
Ethnicity	White		
	Welsh/English/Scottish/Northern Irish/British	5	4
	Any other White background	3	2
	Mixed/Multiple ethnic groups		
	Any other Mixed/Multiple ethnic background	1	1
	Asian/Asian British		
	Indian	2	2
	Pakistani	1	
	Bangladeshi	1	1
	Chinese	1	1
	Any other Asian background	2	2
	Black/African/Caribbean/Black British		
	African	3	1
	Any other Black/African/Caribbean background	1	1
	Other ethnic group		
	Arab	1	1
	Do not state	2	2
Education	A level or equivalent	9	8
	GCSE or equivalent	13	9
	No qualification	1	1
MH difficulty	Anxiety	16	7
	Depression	12	4
	PTSD	4	2
	Psychosis	1	
	Eating disorder	1	
	Bipolar disorder	1	1
	Do not state	2	4

2.2.3.2 Qualitative Interviews

To gain an understanding of the utility and feasibility of the framework, feedback was sought from adults regarding what CYP had identified as important. Adult participants were recruited from within the same college setting as the CYP. Participants were purposively selected due to their experiences of either working with or supporting CYP experiencing MH difficulties. This was to ensure that participants had experience related to the topic area, so they were able to share their perspectives and comment on the results of Delphi study in relation to the utility and feasibility of the framework. In total, three participants took part. This included a teacher, a personal tutor and a parent who was also a member of staff within the college.

2.2.4 Ethical Considerations

Ethical approval was successfully sought from the University of Southampton's Psychology Ethics Committee (Appendix H). At the recruitment stage of the Delphi process, participants were provided with information about the nature of the study, in terms of the commitment and time required for completion of the two questionnaires. Participants were also made aware of the confidential nature of taking part and that all responses to the questionnaire would be anonymous to other participants. Due to the sensitive nature of the study, participants were told that if they disclosed information that indicated that they were at risk to themselves, then the researcher would have to break confidentiality. Adult participants taking part in the feedback interviews were asked to sign a consent form before the interview started. All participants were given clear information about their right to withdraw from the study at any time.

2.2.5 Recruitment Approach

2.2.5.1 Delphi Study

CYP participants were recruited via staff within their college. The inclusion manager at the college acted as the gatekeeper. She was briefed about the research and provided with information leaflets and posters to distribute within the setting (Appendix I). Before recruitment took place, the researcher gained the views and perspectives of a young person at the college about the recruitment approach. By taking into account the student's views, the researcher was helped to refine and finalise the recruitment materials and approach. As part of the recruitment process, direct contact between the researcher and students was arranged. The researcher attended tutorial lessons to introduce and explain the research, via a presentation (Appendix J). At the end of each presentation, students had the opportunity to ask questions and information leaflets were distributed within the class. The information leaflet included contact details of the

researcher, to enable students to opt-in to the study. Alternatively, participants were able to provide their details to their personal tutor if they wanted to be approached by the researcher to find out more or to take part.

2.2.5.2 Qualitative Interviews

The inclusion manager within the college also acted as the gatekeeper for recruitment of adult participants for the feedback interviews. She was given copies of the information sheet to share with potential participants (Appendix K). Contact details were provided on the information sheet or participants could agree to be approached by the researcher by passing their contact details to the gatekeeper. Those who agreed to take part were invited to take part in a focus group. Due to the difficulties related to the availability of participants, interviews were carried out instead of focus groups. With permission from the participants, interviews were recorded. The audio-recordings were transferred to a password-protected computer using an encrypted memory stick and stored anonymously. The interviews were carried out using a topic guide. Questions mainly focused on exploring with participants their views on the set of approaches that young people identified as important as shown in the framework (see Appendix O for topic guide).

2.2.6 Data Analysis

2.2.6.1 Delphi Study

Data from the first round was entered into SPSS and each item was created as a variable. Frequencies and descriptive statistics were run on the entire data set to identify patterns and whether consensus had been reached on any of the items. There is no definitive way of setting consensus. Keeney et al. (2011) highlight that this can range between 51% and 100%. For the purpose of the present study, consensus was set at 75% based on a review of the literature carried out by Green & Birch (2019), finding that the consensus level set often ranged between 70%-80%.

For each participant, a feedback report was developed with the percentages for each item; alongside the participants own rating (Appendix G). This was sent to each participant with a link to the second questionnaire. Items added by participants were analysed by both the researcher and a thesis supervisor for inclusion in the second round. Each item was considered in relation to the existing statement list. Additional items were added if they described either a personal quality, strategy/intervention or ways that support could be accessed or made available. To reduce possible researcher bias, all suggestions made by participants were included, unless they were already listed elsewhere. Some items identified by participants were considered as synonyms or examples of an already listed competency and careful consideration was given to these items. In

total 41 new items were added to the second questionnaire. It was acknowledged that the participants' interpretation of items might have been different from the researchers and what the research team interpreted as a synonym may, in fact, have been a way of describing an item that was more meaningful to the participants. If it was evident that the suggestion did not relate to the question asked or where misinterpretations were clearly made, this information was not incorporated into the second questionnaire.

18 participants completed the second questionnaire and as in the first Delphi round, all data collated was entered into an SPSS database and frequencies and descriptive statistics were run.

2.2.6.2 Qualitative Interviews

The semi-structured interviews were transcribed and analysed using thematic analysis. Thematic analysis is a commonly used approach within qualitative research for exploring patterns and identifying themes within a data set (Braun and Clarke, 2006). For the purposes of the current study, the researcher wanted to gain feedback regarding the feasibility and utility of the framework of recommendations. Therefore, it was deemed appropriate to use deductive thematic analysis. Braun and Clarke (2006) describe this as a theoretical 'top down' approach in which the analysis is explicitly driven by the researcher's topic of interest and features of the data. The researcher discussed and reflected on her thought processes with supervisors and kept a reflective log in order to remain aware of any research bias or factors influencing decisions regarding themes. The six stages of thematic analysis as outlined by Braun and Clarke (2006) were followed (Table 2). A coding manual (Appendix L) and thematic map (Appendix M) were developed as part of the analysis.

Table 2

Braun and Clarke's (2006) Thematic Analysis Stages

Phase	**Process taken by the researcher**
1. Familiarisation of the data:	• The interviews were transcribed verbatim by the researcher. This enabled her to become familiarised with the data. • The transcripts were then read multiple times, identifying and making notes of initial ideas.

2. Identifying initial codes:	• The researcher was concerned with addressing specific features of the data, i.e. identifying information about the feasibility of the framework. Initial codes were identified to reflect elements that captured the researcher's attention.
3. Searching for themes:	• Codes were collated and organised into potential themes, including main themes and sub-themes.
4. Reviewing themes:	• Themes were reviewed, modified and developed. Data associated with each theme was read to ensure suitability.
5. Defining themes:	• Themes were refined and clear definitions and names were given to each theme.
6. Analysis reporting:	• The findings section reports the final themes.

2.3 Findings

2.3.1 Delphi Results

The following sections illustrates the results obtained from the final Delphi poll. As discussed, consensus refers to the collective agreement among participants. For the purpose of the current study, a pre-determined level of consensus was set at 75%. An item was considered to be an essential aspect of MH support if 75% of participants rated an item as 'essential'. Equally, if 75% or more of participants rated the item as 'not essential' it was considered that consensus had been reached, suggesting the item was not an essential aspect or component to support MH. For each section, the consensus ratings have been discussed. The variance of the items has also been considered, as reporting this acknowledges items that were scored more variably in the final round (Ashmore, Flanagan, McInnis and Banks, 2016). In the current study, variance refers to the measurement of spread across participants' ratings. The mean and standard deviations for each item were computed to identify the variation in participant ratings (Appendix N). Responses with

larger variation, as measured by larger standard deviations, were interpreted as having a weaker consensus. Items displayed with an * next to them indicate items that were identified by the participants.

2.3.1.1 Personal Qualities

Figure 3 shows the spread of participant responses for items related to the personal qualities that would be most desirable in those providing MH support.

Consensus

Two of the 38 items reached the 75% consensus criteria level (see Figure 1) 'respecting confidentiality' (83%) and being 'trustworthy' (77%). Although only two items reached consensus, Figure 2 illustrates that many of the ratings were, nevertheless, skewed towards the upper end of the scales between 'highly desirable' and 'essential'.

Variance

The following items showed the largest standard deviations and therefore suggest the weakest agreement: 'has an enthusiastic personality' (*M*=2.78, *SD*=1.17), 'experienced' (*M*=2.94, *SD*=1.16) and 'a people person' (*M*=3.06, *SD*=1.16).

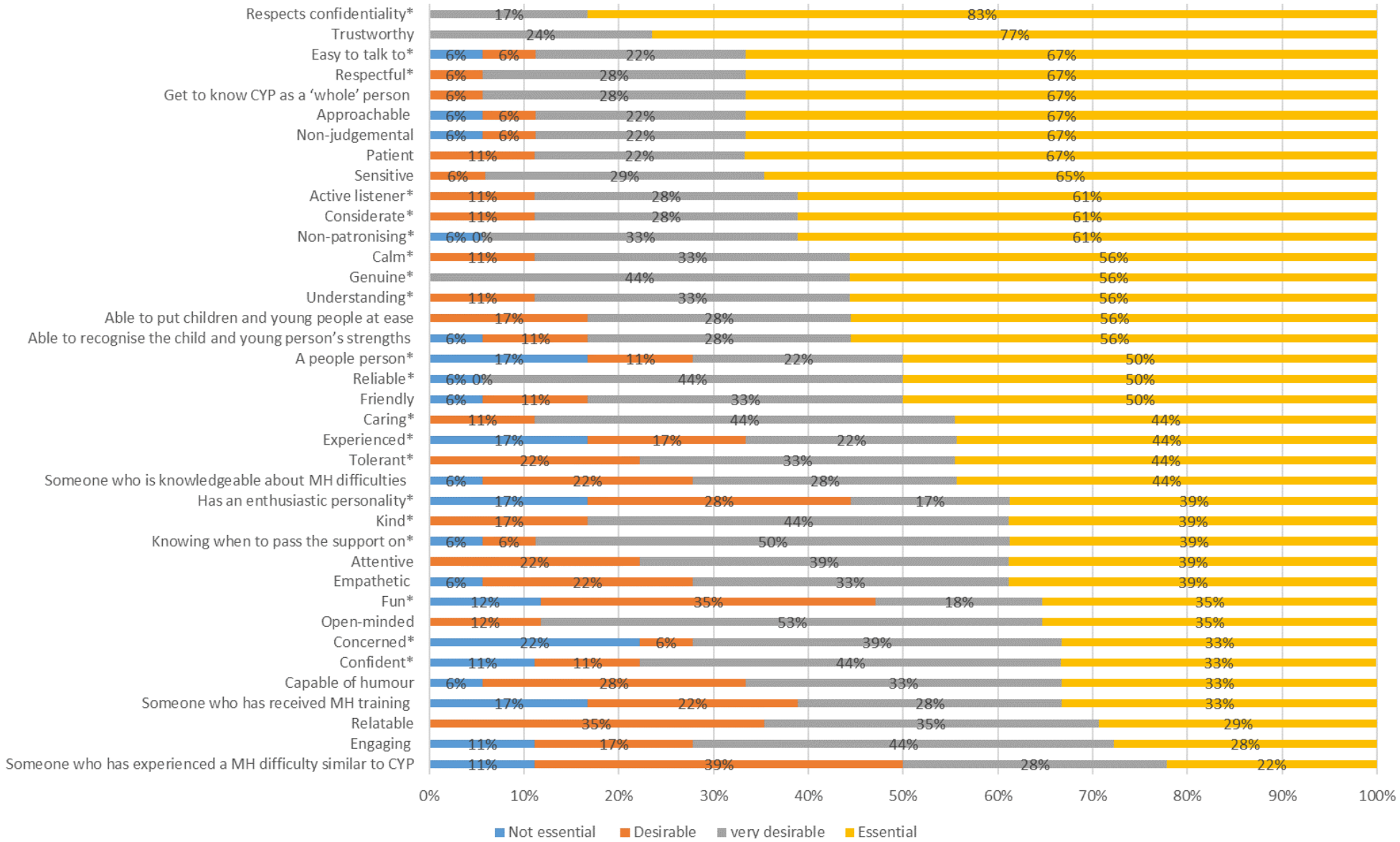


Figure 3. Personal Qualities

2.3.1.2 Strategies and Interventions

Figure 4 shows the spread of participant responses for items related to the type of strategies and interventions that were perceived as most desirable for supporting MH difficulties.

Consensus

Consensus was not achieved. The items which came closest to the 75% consensus level were 'supporting the child or young person in their understanding that they are not alone' (61%), 'support to manage stress' (61%) and 'access to 24/7 support' (61%).

Variance

The following items showed the largest standard deviations and therefore suggest the weakest agreement: 'access to peer interventions' (*M*=2.67, *SD*=1.19) 'access to technology-based apps and tools to support MH' (*M*= 2.83, *SD*=1.15) and 'access to social media' (*M*=2.56, *SD*= 1.15).

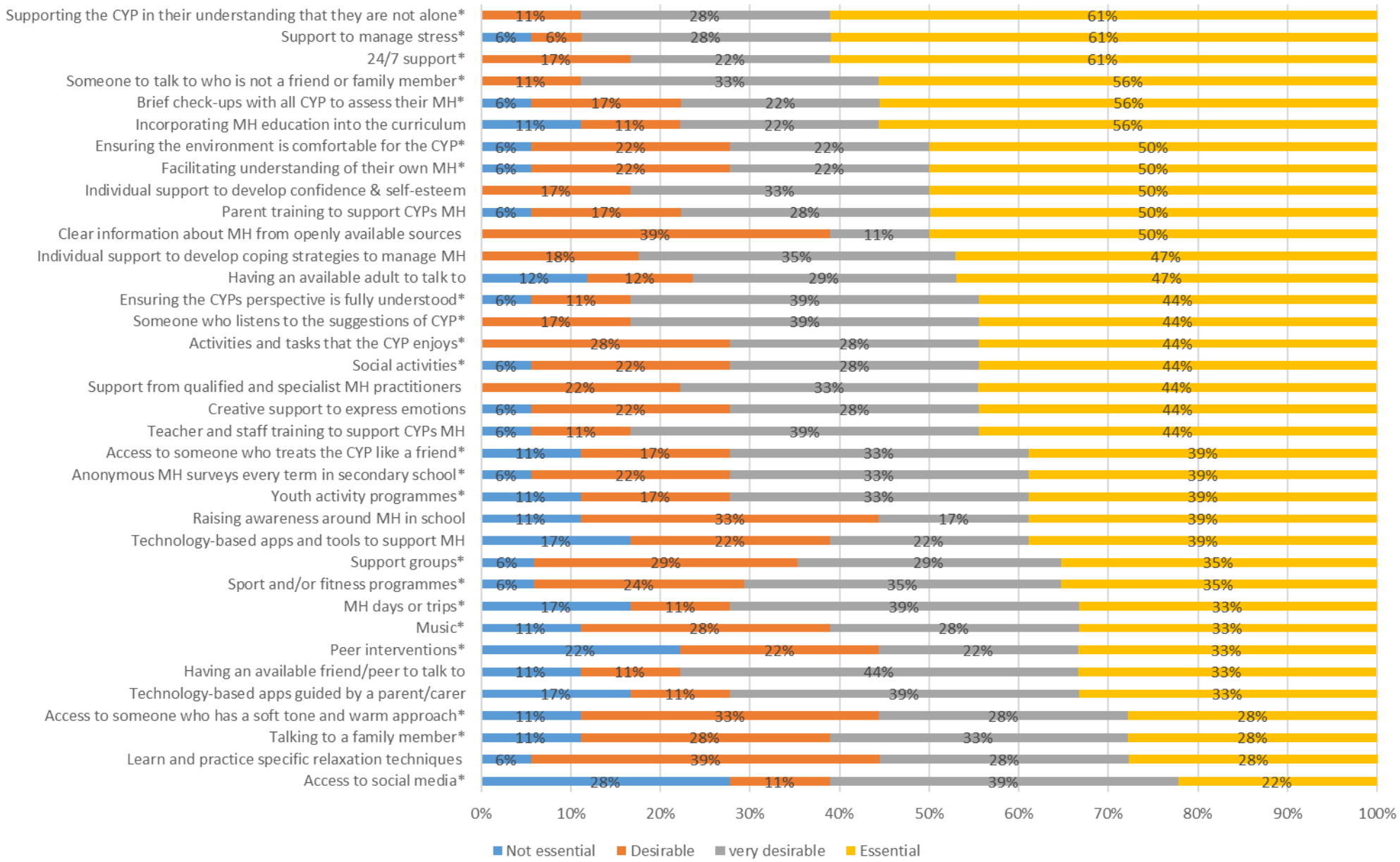


Figure 4. Strategies and Interventions

2.3.1.3 How support is Accessed

Figure 5 shows the spread of participant responses for items related to how they would most like to access any MH support.

Consensus

Consensus was not achieved for any of the items at 75%. The item that came closest was 'self-referral' (61%).

Variance

The following items showed the largest standard deviations and therefore suggest the weakest agreement: 'someone you don't know' (*M*=2.44 *SD*=1.39), 'a teacher' (*M*=2.56 *SD*= 1.20) and 'online' (*M*=2.94, *SD*= 1.16).

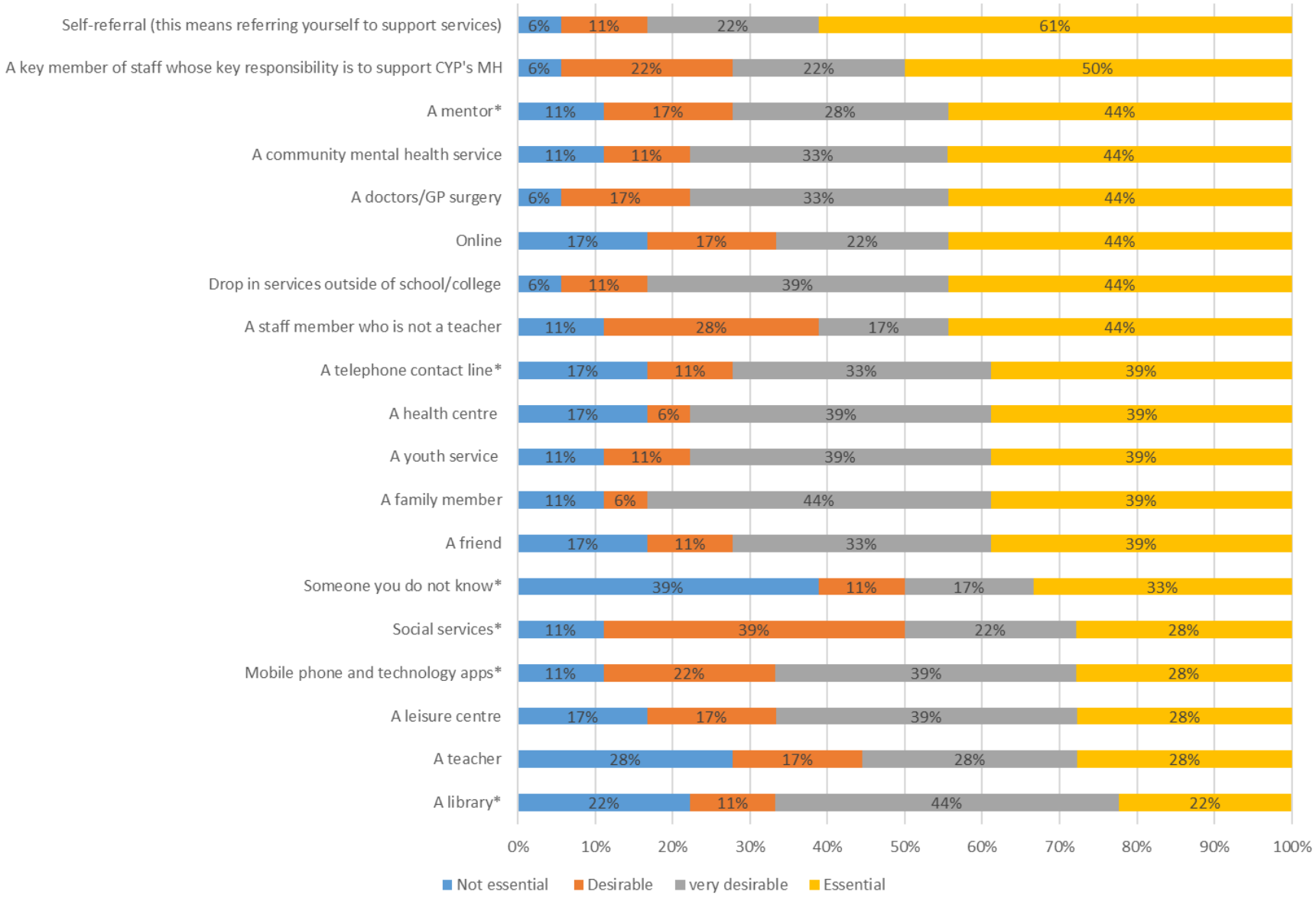


Figure 5. How Support is Accessed

2.3.1.4 Where Support is Available

Figure 6 shows the spread of participant responses for items related to where they would most like to receive MH support.

Consensus

Consensus was not achieved for any of the items at 75%. The items which came closest were 'at a doctors/GP surgery' (56%), 'online' (56%), 'drop in service outside school and college' (56%) and 'at school and college' (56%).

Variance

The following items showed largest standard deviations and therefore suggest the weakest agreement: 'At a spiritual place' (*M*=2.61 *SD*= 1.34), 'at a charity' (*M*=2.67, SD= (1.33) and 'at a health centre' (*M*=2.89, *SD*=1.23).

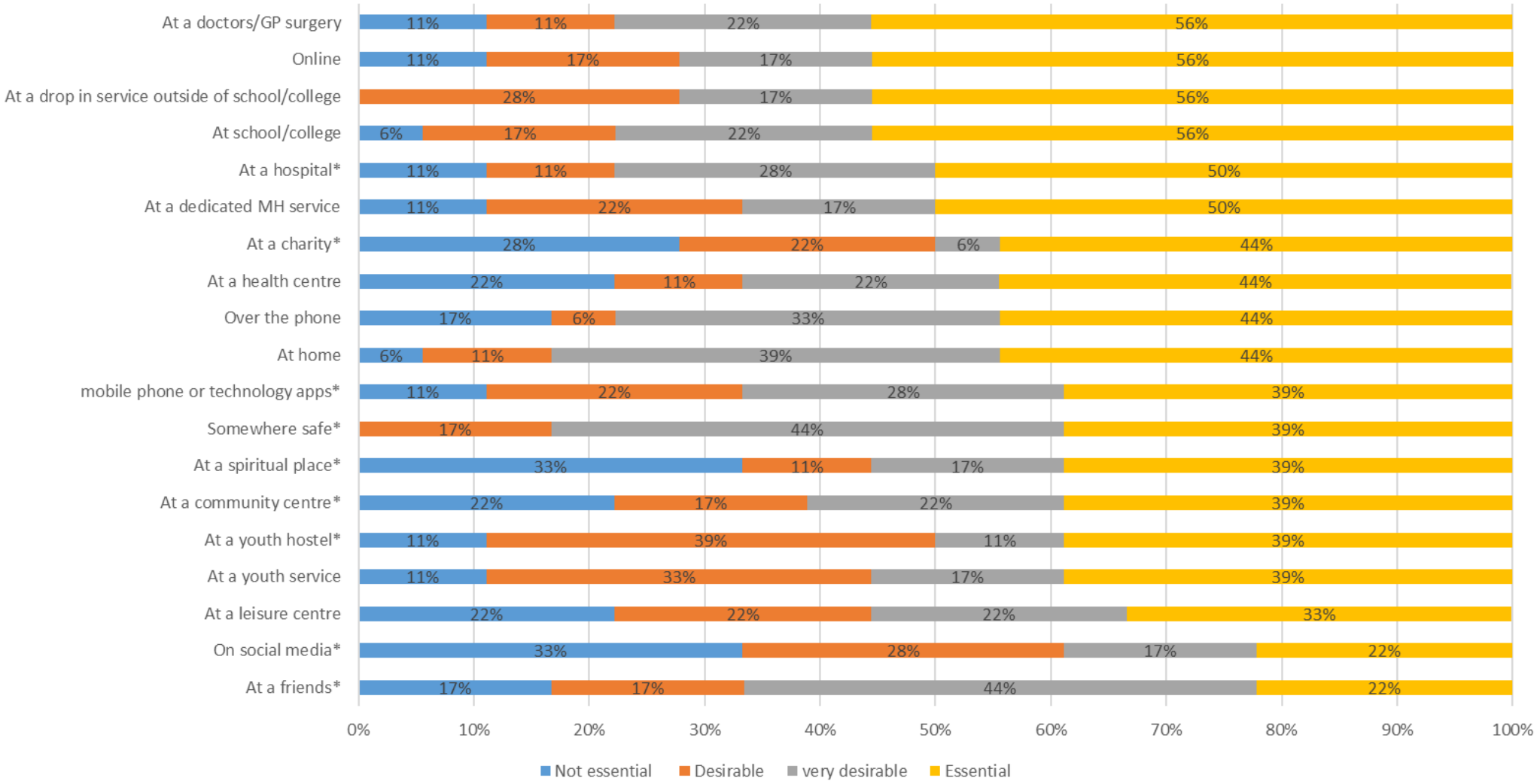


Figure 6. Where Support is Available

2.3.2 Summary of the Findings

Overall, across the two rounds there was a lack of consensus across all four areas when using a 75% consensus criteria. Due to the time constraints and commitments required of participants, the Delphi questionnaire was limited to two rounds. It is possible that further consensus might have been reached if a third round was conducted, particularly for items that were added in round two. Another reason for a lack of consensus might be attributable to participants' preferences for support. It may have been that each participant had diverse and subjective experiences of MH and therefore, the MH support they most valued differed depending on their needs. As well as this, participants' previous experiences of MH support may have also influenced the importance they placed on other aspects of support. For instance, some CYP might have placed higher value on online platforms due to higher levels of anonymity, whereas others might value face-to-face interactions due to positive previous experiences. Therefore, it is likely that CYP drew on their own experiences to guide their decisions. The high levels of variance on some items may reflect the fact that we need to take a highly personalised approach, and perhaps it is most important to acknowledge this and carry out some person-centred intervention planning and tailor services to the current needs and preferences of the CYP, rather than a one size fits all approach. It is also possible that a central tendency bias occurred, in which participants felt inclined to avoid the end points of a scale 'essential' and prefer to respond closer to the midpoint.

The two statements that did reach consensus described the essential qualities in professionals providing MH support and these were being 'trustworthy' and 'respecting confidentiality'. This is in line with research that has explored barriers to help-seeking, highlighting confidentiality and trust as barriers to seeking support (Gulliver et al., 2010).

Although there were only two items that reached the consensus level in terms of essentiality, many of the items included in the Delphi were rated towards the higher end of the scale, suggesting a high level of desirability. When studying the data across categories, if the 'highly desirable' and 'essential' ratings are considered and merged together, trends start to emerge. As the aim of the current study was to develop a workable framework of recommendations based on what CYP value in terms of MH support, it was considered appropriate to collapse 'essential' and 'highly desirable' categories together for a further exploration and review of the findings. Doing this provides an indication of the areas of support that CYP agree are wanted and needed to support MH. This is also in line with previous Delphi

studies which have collapsed categories based on the level of importance (Sawford, Dhand, Toriblo & Taylor, 2014; Phillips et al., 2014).

Collapsing the top two categories enabled the research team to highlight items that were rated as highly desirable for CYP. Statements that reached a 75% consensus level across these two categories were identified as valued approaches that would be worth considering and implementing into a framework of recommendations, according to the responses gained from this study. The following sections show the statements for each area that achieved 75% consensus or more. It must, however, be noted that this shows the level of agreement on the statement. However, it does not determine the level of importance of the statement within the context of all the statements. To identify the level of importance of these items, the mean was calculated to rank each item in order of importance. For this study, the mean was used to identify the average rating for each item.

2.3.2.1 Personal Qualities

Out of the 38 statements, 26 statements were identified as highly valued within this collapsed category. As can be seen in the Table 3 'respecting confidentiality' achieved the highest mean score, suggesting it is the most desirable item among participants.

Table 3

Personal Qualities

	M	SD	%	Range	Min	Max
Respects confidentiality*	3.83	0.38	100%	3	1	4
Trustworthy	3.76	0.44	100%	3	1	4
Able to get to know CYP as a whole person	3.61	0.61	95%	3	1	4
Respectful*	3.61	0.61	95%	3	1	4
Sensitive	3.59	0.62	94%	2	2	4
Genuine*	3.56	0.51	100%	1	3	4
Patient	3.56	0.71	89%	2	2	4
Non-patronising	3.5	0.79	94%	3	1	4
Active listener	3.5	0.71	89%	2	2	4
Approachable	3.5	0.86	89%	2	2	4

Considerate	3.5	0.71	89%	2	2	4
Easy to talk to	3.5	0.86	89%	2	2	4
Non-judgemental	3.5	0.86	89%	2	2	4
Calm*	3.44	0.71	89%	1	3	4
Understanding*	3.44	0.71	89%	3	1	4
Reliable	3.39	0.78	94%	1	3	4
Able to put CYP at ease	3.39	0.78	83%	3	1	4
Caring*	3.33	0.69	89%	2	2	4
Able to recognise the child and young person's strengths	3.33	0.91	83%	3	1	4
Friendly	3.28	0.90	83%	3	1	4
Open-minded	3.24	0.66	88%	3	1	4
Knowing when to pass the support on to someone with professional experience*	3.22	0.81	89%	3	1	4
Kind*	3.22	0.73	83%	2	2	4
Tolerant*	3.22	0.81	78%	3	1	4
Attentive	3.17	0.79	78%	3	1	4
Confident*	3.00	0.97	78%	2	2	4

*items that participants' identified as important in supporting MH

2.3.2.2 Strategies and Interventions

Out of the 36 statements, 15 statements were identified reached consensus when collapsing 'essential' and 'highly desirable' categories together. As can be seen in Table 4, it appears that 'Supporting the child or young person in their understanding that they are not alone' was rated as the most desirable item among participants.

Table 4

Strategies and Interventions

	M	SD	%	Range	Min	Max
Supporting the child or young person in their understanding that they are not alone*	3.50	0.71	89%	2	2	4
Access to someone to talk to who is not a friend or family member	3.44	0.71	89%	2	2	4
Support to manage stress*	3.44	0.86	89%	3	1	4
Access to 24/7 support*	3.44	0.78	83%	2	2	4
Individual support to help CYP to develop confidence and self-esteem	3.33	0.77	83%	2	2	4
Individual support to help CYP to develop coping strategies to be able to manage and improve their MH	3.29	0.77	82%	2	2	4
Access to someone who listens to the suggestions of CYP*	3.28	0.75	83%	2	2	4
Brief check-ups with all CYP to assess their MH*	3.28	0.96	78%	3	1	4
Teacher and staff training to support CYP MH	3.22	0.88	83%	3	1	4
Ensuring the CYP perspective is fully understood	3.22	0.88	83%	3	1	4
Parent training to support CYP's MH	3.22	0.94	78%	3	1	4
Incorporating MH education into the curriculum	3.22	1.06	78%	3	1	4
Support from qualified and specialist MH practitioners (e.g. through individual counselling, Cognitive Behaviour Therapy)	3.22	0.81	78%	2	2	4
Support through having an available adult to talk to	3.12	1.05	77%	3	1	4
Support through having an available friend/peer to talk to	3.00	0.97	78%	3	1	4

*items that participants' identified as important in supporting MH

2.3.2.3 How Support is Accessed

Out of the 19 statements, seven statements were identified as valued by CYP (Table 5) It appears that 'self-referral' was identified as the most desirable item with a mean score of 3.39.

Table 5

How support is Accessed

	M	SD	%	Range	Min	Max
Self-referral	3.39	0.92	83%	3	1	4
Drop in services outside of school/college	3.22	0.88	83%	3	1	4
A doctors/GP surgery	3.17	0.92	78%	3	1	4
A family member	3.11	0.96	83%	3	1	4
A community MH service	3.11	1.02	78%	3	1	4
A youth service	3.06	1.00	78%	3	1	4
A health centre	3.00	1.09	78%	3	1	4

2.3.2.4 Where Support is Available

Out of the 19 statements, six statements were identified as valued by CYP (Table 6). It appears that 'at school/college' was identified as the most desirable item among participants with a mean score of 3.28.

Table 6

Where Support is Available

	M	SD	%	Range	Min	Max
At school/college	3.28	0.96	78%	3	1	4
At home	3.22	0.88	83%	3	1	4
Somewhere safe*	3.22	0.73	83%	2	2	4
At a doctors/GP surgery	3.22	1.06	78%	3	1	4

At a hospital	3.17	1.04	78%	3	1	4
Over the phone	3.06	1.11	78%	3	1	4

*items that participants' identified as important in supporting MH

2.3.3 Framework of recommendations

Based on CYPs' views, as expressed through the Delphi questionnaire, a framework of recommendations was created to include; the valued personal qualities in practitioners supporting CYPs' MH; the most highly rated strategies and interventions that could be used to support the MH of CYP and the preferred options regarding accessibility and availability of that support. In the framework of recommendations (Figure 7), the * alongside items indicates that this item was identified by the CYP in the study and those with a 100% consensus rating have been highlighted.

Personal Qualities (Who)	What	How	Where
1. Respects confidentiality* 100% 2. Trustworthy 100% 3. Able to get to know CYP as 'whole' person and not just focusing on their needs 4. Respectful* 5. Sensitive 6. Genuine* 100% 7. Patient 8. Non-patronising 9. Non-judgemental 10. Approachable 11. Active listener 12. Considerate 13. Easy to talk to 14. Understanding* 15. Calm* 16. Reliable* 17. Able to put CYP at ease 18. Caring* 19. Able to recognise CYP's strengths 20. Friendly 21. Open-minded 22. Knowing when to pass the support on to someone with professional experience* 23. Kind* 24. Tolerant* 25. Attentive 26. Confident*	1. Supporting the CYP in their understanding that they are not alone* 2. Access to someone to talk to who is not a friend or family member 3. Support to manage stress* 4. Access to 24/7 support* 5. Individual support to help CYP to develop confidence and self-esteem 6. Individual support to help CYP to develop coping strategies to be able to manage and improve their mental health 7. Access to someone who listens to the suggestions of CYP* 8. Brief check-ups with all CYP to assess their mental health* 9. Teacher and staff training to support CYP's mental health 10. Ensuring the CYPs perspective is fully understood 11. Parent training to support CYP's mental health 12. Incorporating mental health education into the curriculum 13. Support from qualified and specialist mental health practitioners (E.g. through individual counselling, CBT) 14. Support through having an available adult to talk to 15. Support through having an available friend/peer to talk to.	1. Self-referral 2. Drop in services outside of school/college 3. A doctors/GP surgery 4. A family member 5. A community mental health service 6. A youth service 7. A health centre	1. At school/college 2. At home 3. Somewhere safe* 4. At a doctors/GP surgery 5. At a hospital* 6. Over the phone

*items that have been added by CYP in the research 100%- there was 100% consensus for this item

Figure 7. Framework of Recommendations

2.3.4 Qualitative Interviews

Interviews were carried out to elicit the views and perspectives of adult participants in relation to the framework of recommendations created as a result of the Delphi study. Two overarching themes were identified from the thematic analysis which included 'the role of the practitioner' and 'systemic factors'.

The Role of the Practitioner: All participants reflected on the personal qualities identified by the CYP in the Delphi study and highlighted the importance of building trust with their students, taking the time to get to know them, listening to them and being available for them.

> *"If they can't trust you, forget it. That would be really really important but you know that's for everyone not just CYP" (Participant 1)*

> *"we have built up that trust with our students, I mean the first few weeks of any school term or college term is you are getting to know your students and getting up a relationship with them" (Participant 2)*

> *"I think the general thing that comes across here has been stated they're looking for someone who they can talk to, I don't think they're finding it and they're basically more or less screaming out we want someone who we can talk to" (Participant 3)*

Nevertheless, the participants did reflect that they felt that there were constraints to their role which impacted on them being able to respond to the needs of CYP. Firstly, participants highlighted the need to safeguard their students which could impact on their ability to respect confidentiality (a quality identified as one of the most desirable in the Delphi study).

> *"I do have a right to report certain things because they need to know that I can't keep things secret because for me it is a legal requirement." (Participant 2)*

It was felt that being clear with students about the constraints of confidentiality and already having formed trusting relationships with them was important.

> *"If they trust us they trust us you know and they trust us to help them to find the help they need and they trust us to be able to support them in what it is they need…" (Participant 2)*

> *"…they normally still continue talking, the reason that they talk to me is at the end of the day they just want someone to listen to what their problem and hopefully get some advice from someone else." (Participant 3)*

It was also felt that time constraints and the demands of teaching could impact on staff ability to show the qualities identified by CYP and be available for them.

> *"I know a lot of teachers, they're on it 24/7, they've got classes to go to, x to y to z and then afterwards they've got to go to meetings so it's very much a very fast track business so sometimes the students themselves see that and know that they can't really console whatever their issues are" (Participant 3)*

One participant also reflected on their own emotions and how this can impact their ability to support students' MH.

> *"The nature of our job it's hard to be that all the time, we have deadlines we have so much that we have to do you know we are not always ourselves a 100% because we're stressed out because we've got a lot of our own issues going on ourselves it's hard to be all those things at all times." (Participant 2)*

Participants identified that the overlap of roles within the setting can impact on MH support for CYP. One participant expressed that difficulties can arise when there is overlap between providing pastoral support whilst also having to discipline students.

> *"Would you go to someone who's just punished you to say actually will you support me, no, you're going to go to someone who entirely different who is on your side…" (Participant 1)*

Furthermore, it was also identified that CYP may not seek support from teaching staff because they might feel the teacher will know too much information about them.

> *"Probably they would think actually if my teachers are here for academics and they're doing my MH, they're gonna know a lot about me and I don't want them knowing that much about me." (Participant 2)*

Systemic Factors: Participants echoed the CYP's views of the need for more MH awareness and training within educational and community settings. Participants felt that not enough had been done to incorporate MH into the curriculum. It was felt that this would not only support students but also support teaching staff in knowing how to respond.

> *"No, not enough anyway, not addressed enough they need to talk about anxiety and depression in a big way, it's far more important than learning trigonometry in my book anyway" (Participant 1)*

> *"I think having that training helps us to know a) how to talk to a student and b) how to deal with the issue but obviously for us because we do have first and foremost we are educators and we're here for their education" (Participant 2)*

From a parental perspective, MH training was seen as a need. One participant highlighted that some CYP may be reluctant to seek help from a parent due to a lack of knowledge around MH.

> *"I think they realise that their parents don't know what to do and I think some of our CYP probably if they did have a MH issue they probably wouldn't even want to speak to their parents." (Participant 2)*

Participants also talked about the stigma attached to MH and that perhaps this impacted on CYP seeking help but also families worrying about the impact of seeking professional help.

> *"It was clearly not just a phase so [daughter's name] needed to go and get specialist help but I know my family weren't very receptive to the idea of me basically going along with this because they were thinking it might impact on her in terms of work, relationships they were scared that she might get sectioned etc etc." (Participant 3)*

The environment was also considered an important aspect when considering support. Participants reflected on the availability and accessibility of support. They recognised the importance for CYP to have 24/7 support but felt that this would be difficult to put in place due to the resources available.

> *"…obviously a lot of our students are probably awake until god knows what time in the morning because they can't sleep and all this lot so that I would say would be an amazing thing to have in place but it's probably going to be one of the most difficult things to have in place." (Participant 2)*

They also acknowledged the need for support to be within accessible and convenient locations for CYP.

> *"they have gaps in their timetable so they're probably thinking oh yeah I could go and seek help from people when I've got the gaps which means I don't have to travel outside I don't have to book time off college" (Participant 2)*

Participants also talked about the lack of resources and funding within educational settings which they felt acted as a barrier for putting support in place. All participants highlighted the need to invest in MH but felt that in the current climate this was not possible.

> *"it's not there, that help isn't there, that funding isn't there, those resources aren't there and obviously I can sit here and say money money money money money until I'm blue in the face but if the money is not there the money is not there but we need to find the money from somewhere." (Participant 2)*

2.4 Discussion

2.4.1 Delphi Study

The involvement of CYP was central to this study and the main aim was to explore what they considered to be essential types of MH support for them, and the key competencies valued in those delivering that support. This was achieved through the use of a Delphi study to gain consensus among CYP. Items were considered to be valued if 75% or more participants rated items as either 'essential' or 'highly desirable'.

The competencies and areas identified were used to form a framework of recommendations for practice, from the CYPs' perspective which was shared with key adult stakeholders. Whilst it cannot be concluded from this study that the items identified in the framework are exhaustive, it does provide a starting point to attempt to understand and describe what CYP value in terms of MH support and contributes to the literature seeking to understand their perspectives. As it is beyond the scope of this thesis to discuss each item identified in the framework, the discussion will focus on the key areas which have emerged from the results and how these compare to existing literature.

Trust and Confidentiality

When reviewing the personal qualities identified as desirable by the CYP in the study, 'respecting confidentiality', being 'trustworthy' and 'genuine' showed the highest level of consensus with 100% of participants rating these items as 'essential' or 'highly desirable'. This reflects previous research which identifies that trust and confidentiality are important for CYP when seeking support (Plaistow et al., 2014; Rickwood et al., 2005). It has been highlighted that a violation of confidentiality can damage the relationship between the practitioner and young person, which can impact on the trust they place with services (Apland et al., 2017). This is in line with research which suggests CYP show greater help-seeking intentions towards trusted sources (Gulliver et al., 2010). A high level of consensus was also achieved for 'genuine' which was an item

added by the participants. Genuineness has been described as a relational quality of a therapeutic relationship which could be seen both as a personal characteristic of the person providing support and also an experiential quality of the relationship between the person supporting and the person being supported (Kolden, Klein, Wang & Austin, 2011). Although the concept of genuineness needs to be interpreted cautiously and is one which may overlap with other concepts such as empathy or congruence, wider literature does suggest that genuineness can enhance a therapeutic alliance and hence improve outcomes when supporting people with MH difficulties (Nienhuis et al., 2018).

Gulliver et al. (2010) highlights that CYPs' concern for confidentiality may relate to a fear of stigma, in which breaching confidentiality may result in others finding out. In the current study, one of the approaches added by the participants which achieved a high level of consensus was 'supporting the CYP in their understanding that they are not alone'. Perhaps this suggests to some extent, the benefits associated with normalising the experience of MH difficulties and supporting CYP to recognise that they are not isolated individuals. This links with the continuum approach that promotes the idea that MH lies on a continuum and that everyone's MH fluctuates at different stages of life (Weare, 2000).

Mental Health Awareness and Training

MH training achieved a high level of consensus among participants. This included 'teacher and staff training to support CYP's MH', 'parent training to support CYP's MH' and 'incorporating MH within the curriculum'. Research exploring the views of teaching staff suggests that teachers often feel unable to recognise MH problems, advocating for the need of specialist training (Rothi, Leavey and Best, 2008). This was expressed by the adult participants interviewed in this study, who acknowledged the need for further training and the importance of embedding MH within the curriculum. Such aspirations are also in line with the government's proposals to increase training in school settings (DfE, 2017). Nevertheless, it is worth noting that, in the current study, participants have highlighted the need for training to be extended to the wider community to include parent training.

Previous research highlights that CYP are more likely to seek help from trusted sources of support such as friends and family (Rickwood et al., 2005). Participants in the current study have identified that they would value access to someone to talk to who is not a friend or family member as well as support from friends. Therefore, perhaps good MH provision for CYP involves having different sources of support available when needed. Interestingly, consensus was reached for accessing support through a 'family member' and receiving support at 'home'. This is in line with research which highlights that CYP want flexibility and accessibility from services including access to support close to home or within the home (Lavis & Hewson, 2011; Plaistow et al., 2014).

Therefore, if parents feel more knowledgeable about MH then CYP may feel more able to confide in them and access support. Incorporating training within school, home and community contexts would lead to greater awareness and enable adults to feel more equipped and confident to talk about MH.

Conversely, two items that did not reach the 75% consensus level within the personal qualities section were 'experience' and 'someone who has received training'. Perhaps then, CYP value the qualities of the relationship between them and the adults supporting them, rather than their amount or level of training and past experience. For instance, being 'trustworthy', 'respectful' and 'genuine' ranked higher in importance than expertise. It has been highlighted that developing relationships between the facilitator and client is key to positive outcomes (Biering, 2010; Shirk, Karver and Brown, 2011). Research has found that CYP set high value upon practitioners' communication skills, such as empathy and a non-judgemental approach; and these skills are deemed more important than the practitioner's therapeutic approach (Hart, Saunders & Thomas, 2005). Perhaps then, there is value in equipping adults to reflect on their personal and interpersonal approach, as well as being more attuned to the needs of CYP, and that perhaps training in unconditional positive regard and attunement principles would be beneficial.

Relationships

CYP indicated, through the Delphi study, the need for more child-centred approaches within MH support. For example, consensus was reached for the following statements: 'recognising CYP's strengths', 'getting to know the child as a 'whole' person' as well 'access to someone who listens to the suggestions of CYP's and 'ensures the CYP's perspective is fully understood'. This suggests the need for a holistic understanding of the CYP. This is in line with research conducted by Lavis and Hewson (2011), which identified that CYP were more able to build a relationship with a practitioner who spent time getting to know them as a person, rather than focusing solely on their problems. Apland (2017) highlights that services are seen to be more helpful when CYP are given a sense of agency in terms of decision making in MH care.

The use of Technology

Overall there was a lack of consensus in relation to technology based approaches as well as accessing support 'online' and via 'social media'. As discussed in Chapter One, there has been an increase in the use of technology based interventions to support MH, particularly iCBT which demonstrates positive outcomes for supporting anxiety and depression. However, it appears from the current study that technology-based interventions are not valued as highly as face-to-face support. For instance, having an available adult to talk to, as well friends, received a greater level of consensus than online approaches. However, this is not to say it does not have value and for

some CYP, the level of anonymity that online approaches provide may be preferable for some CYP. What does appear to be an important component of support is the therapeutic relationship between the practitioner and service user. This was echoed in interviews with adult participants who expressed the importance of building trusting relationships with CYP and being available for them. Grist et al. (2018) highlights that increased opportunities for therapeutic interaction online provides scope to build a relationship, a component that has been found important for CYP (Horgan & Sweeney, 2010). Therefore perhaps, there is a need to consider this in the development of such interventions.

2.4.2 Qualitative Interviews

The second part of the study sought to reflect on the feasibility and utility of the framework with professionals and parents who had supported CYP experiencing a MH difficulty. Overall, participants acknowledged the benefits of producing the framework and the need to listen to the views of CYP in relation to MH.

Participants recognised the importance of fostering and demonstrating the personal qualities identified as desirable by CYP. However, they expressed that the constraints of their job could impact on their ability to consistently do this. For instance, participants recognised the importance of trust and the need to respect confidentiality but acknowledged the need adhere to safeguarding procedures. Participants identified that taking time to build trusting relationships and being clear about confidentiality procedures acted as a supportive factor and that often CYP would continue to disclose information if they felt they trusted them. Lavis and Hewson (2011) highlight that services need to be clear with CYP about their confidentiality policy and when they would need to pass information on.

It was also felt that the demands of teaching could impact on the ability to demonstrate some of the personal qualities identified by CYP. This was particularly the case when adults were placed in a dual-role which included both pastoral care and teaching. One view was that CYP might be reluctant to seek help from teachers. It was felt that CYP are aware of the time demands placed on teachers, which was seen as a barrier to seeking help. This sense of teachers being overburdened expressed by the CYP is supported by research which suggests that teaching professionals report higher levels of stress related to work compared to other occupations (Health Safety Executive, 2018). There was also a perception that CYP worried about teachers knowing too much information about them, if they were to seek support for their MH. Additionally, it was felt that CYP might be reluctant to seek support from adults who have to enforce the policies of the education setting.

Participants commented on the wider systemic factors in relation to the framework of recommendations. They acknowledged the need for further training for both educational settings and for parents. Research suggests that, in order to meet the MH needs of CYP in school and college, a whole-school, multi-modal model should be embedded within the system which involves all members of the school community and that includes teacher and parent education (Weare & Nind, 2011). Participants identified that for parents, a lack of knowledge about MH may act as a barrier for CYP seeking help from them. It was also felt that parents may also fear the outcomes of seeking professional help, including perceived stigma. Research indicates that the stigma of MH can affect parents and they may be reluctant to disclose their child's MH difficulties (Corrigan & Miller, 2004; Eaton, 2016). O'Reilly (2018) highlights that parents require support in recognising their child's MH needs as well as accessing information about specialist interventions. For instance, in the current study, one parent expressed a lack of knowledge of specialist MH services. This highlights the need for MH awareness and training for the wider community rather than isolated to professionals working in school settings. Participants also recognised the importance of the environment for receiving support. They acknowledged that CYP wanted a safe, accessible and convenient place to access support and believed that it was important to put this in place.

Participants perceived that one of the main barriers to putting support in place was a lack of resources and available funding to do this. As discussed at the beginning of this paper, the government has pledged to invest more in MH support for CYP including funding to provide training to schools and employing designated MH leads within educational settings, whose key responsibility is to promote wellbeing (DfE, 2017). Although additional funding is likely to be welcomed, it is difficult to ascertain if this will be effectively deployed, given the lack of consultation with CYP about their views on the various approaches advocated by government and adult professionals. When exploring the views of CYP relating to the government's proposals Barnardo's (2018) found that CYP raised concerns about teachers' being designated leads, suggesting that they might not have the right skills to help CYP open up about MH. CYP also felt that many school policies have a focus on discipline without considering the impact on MH. This perhaps links back to aforementioned issues where professionals have a dual role of pastoral care but also have to enforce whole-school behaviour polices. Understanding these tensions and differing perspectives has important implications for guiding the future direction of any MH support in school and in the community. Although this study sought the perceptions of young people, it was restricted to their views of the government proposals to improve mental health support. The current study goes beyond this, providing a more holistic understanding of what young people value in terms of the personal qualities of those supporting them, strategies and interventions, where support is accessed and where it is made available.

2.4.3 Synthesis

The present study provides an insight into CYPs' views in a college setting in Greater London on the approaches and the key competencies valued in those delivering that support. It echoes the findings of previous studies where trust and confidentiality have been found to be essential elements in effective service provision. CYP in this study expressed the need to be able to develop trusting relationships with adults before they would feel able to access support from them. In addition, these CYP want practitioners to take a holistic understanding, recognising their strengths and involving them in decision making. This reinforces the importance of the development of positive relationships between the practitioner and CYP, and the need for adults to be available and attuned to their needs.

The results also suggest that there is a need for further awareness raising of MH. The government has proposed plans to implement MH training within schools for teaching staff; however, the current research suggests that the scope of this should be wider. What has been revealed from the CYP participating in this study, and from frontline staff, is that there is a need for support outside of educational settings which involves parents, peers and other adults. Exploring community based approaches is thus an important direction for focus for both researchers and professionals. Even within schools, the interviews with teaching staff suggest barriers to them being trained to deliver MH support to CYP e.g. time constraints and the nature of their role. These barriers will need to be explored if the government plans are to be successful.

A key message from the current research is that CYP value the communicative and interpersonal skills of an adult more than the knowledge and experience they possess. This is in line with O'Connor (2010), who reports that higher quality teacher-child relationships occur when there is a positive emotional environment and where interactions are warm and supportive. Similarly, Poulson and Fouts (2001) suggest that attuned teaching can result in children feeling more comfortable and emotionally safe within the classroom. This knowledge may be helpful to ensure that practitioners are equipped with the actual qualities and skills that CYP most value.

2.4.4 Strengths and Limitations

To the best of the researcher's knowledge this is the first study to use a consensus building tool to explore CYPs' views and perspectives on MH support and to create a framework of recommendations for practice. The originality and practical utility of the research are key strengths, along with the value that was placed on the voices and participation of the CYP themselves.

The study included a diverse range of students both in terms of ethnicity and the MH difficulties experienced. Although the setting attracts a range of students from a wide

geographical area and from a range of socio economic backgrounds, the sample comprised of a small number of participants from one college setting in an urban area in Greater London. Furthermore, all participants were accessing education at the time, thus limiting overall generalisability to wider settings or populations, including those young people who are not accessing education. Moreover, participants' experiences of support within this single setting might have influenced how they rated items in the Delphi questionnaire. In order to further explore the applicability and generalisability of the framework it would be beneficial to gain the views and perceptions of other young people regarding the framework.

Another limitation was the fact that just two questionnaire rounds were used. It could be argued that greater consensus levels may have been reached after further rounds. Furthermore, the overall lack of consensus found suggests that some of the items in the questionnaire were seen as highly subjective, with CYP valuing different approaches and competencies according to their lived experiences. This suggests that decisions about best practice may need to be carefully considered regarding individual and contextual factors and any framework will need to have sufficient flexibility to allow this.

The Delphi questionnaire was developed from a review of the literature and although the scope for this review was broad and inclusive, it was not conducted systematically. There is, therefore, a possibility that some approaches and competencies were missed. However, it is a strength of the study that participants were given an opportunity to list any additional items that were not already there in the first round.

In terms of the feedback phase, interviews were carried out with only three adult participants who were self-selected, which has clear implications for the generalisability of these findings. Due to time constraints of the current study, the thematic analysis was not verified for consistency among any independent researchers and, therefore, the themes and quotes selected have the possibility of researcher bias and should be interpreted in this light.

Despite these limitations, it is proposed that the present study provides an initial step forward towards encouraging further research which places CYP centre-stage in decision-making about this sensitive yet much-needed aspect of their provision.

2.4.5 Reflexivity

Due to the nature of qualitative research, the values and assumptions of the researcher can influence and shape the research process (Willig, 2001). Reflexivity is therefore an important process as part of the research (Ritchie & Lewis, 2003). Reflecting on the process of conducting interviews the researcher was aware of the impact that her role as the interviewer may have had on the findings. Firstly, as an ex student from the college and with previous working relationship

with two of the participants, it is possible that this relationship impacted on the research process. Participants were very open and honest about their perspectives of the framework. The researcher wondered whether the dynamics of the relationships and having a previous connection enabled a greater level of honesty and reflection in the interview. Additionally, there was a tendency for participants to discuss the socio-political factors within the setting itself and perhaps they may have been less inclined to do so if the researcher was not familiar to the setting.

2.4.6 Implications and Future Research

The findings from this study have some valuable implications for policy and practice. Firstly, the study has highlighted the importance that CYP place on person-centred approaches in regard to MH support, particularly professionals being genuine and trustworthy, having a holistic understanding of them as a person, and recognising CYP's strengths. This emphasises the value of a systemic epistemology that considers the CYP as part of a complex interacting system, moving away from deficit, within-child interventions for MH and, instead, enhancing and empowering the support systems around CYP. The findings also suggest the importance of person-centred approaches when deciding how best to support CYP struggling with their MH. Although the use of person-centred approaches is a statutory requirement, as set out in the SEND Code of Practice (DfE, 2015), the extent to which such approaches are embedded within educational systems and ethos is unclear. This is an area that is relevant for educational psychologists (EPs) who often work in multi-agency contexts, at a systemic level. EPs are well placed to promote and facilitate a person-centred culture, supporting settings to be able to embrace and deliver person-centred approaches as well as reframing understanding from a 'within-child' model to a solution-focussed, strengths-based interactionist approach (Cane, 2016).

EPs also play a key role in supporting schools to promote and develop CYPs' MH and wellbeing. As evidence-based practitioners, psychological advice and support can be facilitated through the development of frameworks and models, which are informed and guided by theory and research. A recent example of this is the resilience ball, which is a collaborative planning tool that can be used with settings and parents to support and promote resilience (Lowther, 2018). EPs' knowledge and understanding of school systems, emotional wellbeing and child development, positions them well to offer consultation, advice and training as well as collecting and advocating for the voices of CYP themselves.

Secondly, the study acknowledges the role of the school, parents, health and community settings as all being helpful contexts for supporting CYP's MH. This suggests a multi-modal approach to MH that recognises that MH is a wider community issue. What the current study

captures is that there might be a reluctance for CYP to seek support from their parents, particularly if they feel parents do not have the skills to support them, or if parents have little access to information to know where to go for further help which was highlighted by the adult participants. Therefore, there could be a role in empowering parents and equipping them with the skills to better support their children through offering training and workshops, potentially hosted by schools.

Since CYP appear to value the personal qualities of the adults supporting them, more than their level of expertise relating to MH, perhaps a further and related implication is the need for EPs to teach the principles of attunement and unconditional positive regard to all key adults (including professionals, school staff and parents). Empowering key adults with the necessary skills to build positive attuned relationships with pupils could be achieved through consultation, supervision, discussion groups and training. EPs are well placed to provide an emotionally containing space and to facilitate discussions that enable key adults to reflect on their practice and to problem solve. Indeed, Virmani & Ontai (2010) showed that practitioners participating in a reflective supervision programme were more likely to develop a positively insightful understanding of the CYP with whom they worked.

The study has highlighted the importance of eliciting CYP's views, particularly in relation to service provision for MH. It is hoped that this will highlight the need to generate further research that takes account of CYP's perspectives, as larger scale research is needed to expand upon the findings of the current study. Of particular interest would be to explore the perspectives of CYP of different ages from a range of educational settings, as well as parental perspectives of CYP's MH.

2.4.7 Concluding comments

By positioning the CYP as the experts, this study has enabled further insight into what CYP value from MH support. As a trainee EP, I am proud of being part of a profession which can empower CYP, and ensure their voices are heard in decision making processes. Although it is not without its limitations, it is hoped that the study will provide valuable and practical insights into understanding what CYP want from MH provision. It is also hoped that this study is an innovative starting point, to encourage future interventions and approaches which involve seeking and being guided by the views and values of CYP themselves. In addition, it is hoped that this study has effectively illustrated how it is possible and helpful to listen and acknowledge the views of CYP and that positive change can be conceived with them rather than for them. This study has sought to listen to a variety of voices and it is, perhaps, this practitioner's reflection which offers a salient concluding remark…

"…from the list here, they're saying they just want someone to listen to them and I think they're not getting that and I don't know as we as adults are basically failing in our capacity to listen".

(Participant 3)

Appendix A Search Terms

1) Web of Science

TS=(teen* OR “CYP” OR “young person” OR adolescen* OR youth OR "young adult”)

AND

TS=(" mental health " OR "emotional wellbeing" OR "psychological wellbeing" OR anxi* OR depress*)

AND

TS=("mobile phone*" OR "mobile app*" OR "chat room*" OR "internet forum*" OR internet OR "text messag*" OR online OR "social network*" OR "virtual communit*" OR digital* OR "social media" OR web*)

AND

intervention OR program*

AND

TS=(evaluat* OR outcome OR result OR impact OR assess*)

Limiters applied: Peer Reviewed Journal Articles, English Language papers

2) PsychInfo via EBSCO

TI (teen* OR "CYP" OR "young person" OR adolescen* OR youth OR "young adult*") OR AB (teen* OR "CYP" OR "young person" OR adolescen* OR youth OR "young adult*")

AND

TI ("mental health " OR "emotional wellbeing" OR "psychological wellbeing" OR anxi* OR depress*) OR AB ("mental health " OR "emotional wellbeing" OR "psychological wellbeing" OR anxi* OR depress*)

AND

TI ("mobile phone" OR "mobile app*" OR "chat room*" OR "internet forum*" OR internet OR "text messag*" OR online OR "social network*" OR "virtual communit*" OR digital* OR "social media" OR web*) OR AB ("mobile phone" OR "mobile app*" OR "chat room*" OR "internet

forum*" OR internet OR "text messag*" OR online OR "social network*" OR "virtual communit*" OR digital* OR "social media" OR web*)

AND

TI (intervention OR program*) OR AB (intervention OR program*)

AND

TI (evaluat* OR outcome OR result OR impact OR assess*) OR AB (evaluat* OR outcome OR result OR impact OR assess*)

Limiters applied: Peer Reviewed Journal Articles, English Language papers

3) MEDLINE via EBSCO

TI (teen* OR "CYP" OR "young person" OR adolescen* OR youth OR "young adult*") OR AB (teen* OR "CYP" OR "young person" OR adolescen* OR youth OR "young adult*")

AND

TI ("mental health" OR "emotional wellbeing" OR "psychological wellbeing" OR anxi* OR depress*) OR AB ("mental health " OR "emotional wellbeing" OR "psychological wellbeing" OR anxi* OR depress*)

AND

TI ("mobile phone" OR "mobile app*" OR "chat room*" OR "internet forum*" OR internet OR "text messag*" OR online OR "social network*" OR "virtual communit*" OR digital* OR "social media" OR web*) OR AB ("mobile phone" OR "mobile app*" OR "chat room*" OR "internet forum*" OR internet OR "text messag*" OR online OR "social network*" OR "virtual communit*" OR digital* OR "social media" OR web*)

AND

TI (intervention OR program*) OR AB (intervention OR program*)

AND

TI (evaluat* OR outcome OR result OR impact OR assess*) OR AB (evaluat* OR outcome OR result OR impact OR assess*)

Limiters applied: Peer Reviewed Journal Articles, English Language paper

Appendix B Inclusion and Exclusion Criteria

Study Item	Inclusion criteria	Exclusion criteria
Participants	Adolescents and CYP aged 16-25 or where the mean age within the study was 16-25	Children under 16 years old
Study Design	Quantitative, Qualitative and mixed-method designs including pre- and post-intervention studies, and randomised controlled studies.	Case studies Studies that have not screened for anxiety and depression Protocols
Interventions	Technology-based interventions that utilise the internet, computer, mobile phone or other applications to reduce depression and anxiety symptoms among CYP	Clinic-based interventions School-based interventions Any intervention that did not measure anxiety or depression
Type of research	Peer reviewed journal articles	Reviews, conferences, unpublished dissertations
Languages	Published in English	Published in any language other than English

Appendix C Data Extraction Table

	Authors	Country	Design and aims	Sample characteristics	Intervention (Name, description, duration,)	Target focus	Primary outcome measures	Relevant key findings
1	Anstiss & Davies (2015)	New Zealand	**Design:** 10-aweek longitudinal cohort pilot. **Aims:** To establish whether a text message intervention was effective for anxiety and depression symptoms and whether human support via follow up phone calls would contribute to positive outcomes.	**Age range:** 12-24 **Mean age:** 19 **N:** 21 **Gender:** F- 14 M- 7	**Name:** Reach up, Reach out **Description:** module-based text package. Comprised of three weekly text messages including a psycho-educational message, weekly challenge related to the message and an inspirational message. **Procedure:** Half of the participants were randomly selected to receive a follow up phone call each week to support them with the text package. **Duration:** 10 weeks	Anxiety and depression	▪ GAD-7 Generalised anxiety disorder Questionnaire (self-report scale) ▪PHQ-9- Patient Health Questionnaire to measure the severity of depression (self-report scale)	▪ Scores for anxiety and depression were significantly lower after the intervention. Anxiety: (p=.005), depression (p=.013) ▪ 5/12 participants who received follow up call found it helpful to have someone guide them through the process.

2	Christensen et al. (2014)	Australia	**Design**: A randomized controlled trial with 5 arms Group 1: Combined intervention of psycho-education, internet delivered CBT for anxiety, physical activity promotion and relaxation- known as active website Group 2: Active website with telephone reminders. Group 3: Active website with email reminders	**Age range:** 18-30 **Mean age**: 25 **N:** 558 **Gender:** F- 450 M- 108	**Name:** iChill **Description:** Multi-modal intervention website including psychoeducation, CBT, physical activity promotion and relaxation training. **Procedure:** Participants randomly assigned to one of five groups: 1) Active website 2) Active website with telephone reminders 3) Active website with email reminders 4) Control website 5) Control website with telephone reminders **Duration:** 10 weeks	Anxiety	GAD-7 Generalised anxiety disorder (self-report scale)	▪Anxiety symptoms as measured by the GAD-7 reduced at post-test and 6 month follow up but returned to baseline at 12 months. ▪There were no significant differences between control group and any of the intervention groups.

			Group 4: Control group, including a placebo website Group 5: Control group (placebo website) with telephone reminders **Aims:** To establish whether a web-based multi-modal programme was effective in preventing anxiety symptoms in young adults and to determine the role of telephone and email reminders.					

3	Clarke et al. (2009)	USA	**Design:** Randomised Control Trial with two arms. Group 1: The experimental intervention; an internet self-help based programme providing self-guided, interactive cognitive behavioural therapy for young adults coping with depression. Group 2: Treatment as usual control group **Aims:** To establish whether a pure self-help iCBT	**Age range:** 18-24 **Mean age:** 22 **N:** 160 **Gender:** F- 128 M- 32	**Name:** No name **Description:** Pure self-help iCBT intervention via a website which is unattended. **Procedure:** Participants assigned to either intervention or treatment as usual control group **Duration:** 32 weeks	Depression	PHQ-8- Patient Health Questionnaire to measure the severity of depression (self-report measure)	▪Significant difference between groups (p=.05) although small effect size (d=0.20).

			intervention, with postal reminders would significantly improve depression symptoms					
4	Dear et al. (2018)	New Zealand	**Design:** Randomised Control Trial with 2 arms Group 1: iCBT intervention for anxiety and depression among young people guided by clinician Group 2: iCBT intervention for anxiety and	**Age range:** 18-24 **Mean age:** 21 **N:** 191 **Gender:** F-157 M-34	**Name:** Mood Mechanic Course **Description:** iCBT course consisting of 4 online lessons, homework assignments and case stories. **Procedure:** participants randomly allocated to either to a clinical guided group or self-guided group. **Duration:** 5 weeks	Anxiety and depression	PHQ-9 The Patient Health Questionnaire (self-report completed online) GAD-7 The Generalised Anxiety Disorder (self-report completed online)	▪Both treatment groups achieved significant reductions in anxiety symptoms after the interventions but no significant differences were found between the groups

			depression among young people in a self-guided format **Aims:** To compare the efficacy of an iCBT intervention with clinician support versus self-guided					
5	Ellis et al. (2011)	Australia	**Design:** Randomised Control Trial with three arms. Group 1: 13 participants completed MoodGym intervention (see intervention section for details). Group 2: 13 participants	**Age range:** 18-24 **Mean age:** 19 **N:** 39 participants **Gender:** F-30 M- 9	**Name:** Mood Gym and Mood Garden **Descriptions:** **MoodGym:** Self-help iCBT resource, consisting of five modules. Participants were asked to complete over three sessions. **Mood Garden:** An online forum offering peer-based support and information.	Anxiety and depression	DASS-21-Depression, anxiety and stress scale (self-report)	▪MoodGym and Mood Garden effective at reducing anxiety symptoms compared to control group. MoodGym (p=.03) and Mood Garden (p=.01) but not effective at significantly reducing depression severity.

			completed Mood Garden intervention (see intervention section for more details). Group 3: Control group. **Aims:** Aimed to assess the efficacy of a brief iCBT intervention compared to an online support group in reducing symptoms of depression and anxiety.		**Procedure:** Participants randomly allocated to either MoodGym or Mood Garden intervention or control group			
6	Hoek et al. (2012)	The Netherlands	**Design:** A Randomized Control Trial with two arms	**Age range:** 12-21 **Mean age:** 16 **N:** 45	**Name:** No name **Description:** Internet based problem-solving therapy (PST) intervention which is based	Anxiety and depression	CES-D-The Centre for Epidemiologic Studies Depression scale (self-report)	Depressive symptoms significantly declined across the two groups (p=0.009) but no

			Group 1: An internet-based guided self-help intervention Group 2: Waitlist control group **Aims:** To evaluate the effects of an internet based problem-solving therapy intervention for CYP with symptoms of depression or anxiety compared to a wait list control group.	**Gender:** F- 34 M- 11	on supporting users to use problem-solving strategies. **Procedure:** Participants randomly allocated PST intervention or waiting list control group. Those on the waiting list got access to a website which provided information on depression and anxiety. **Duration:** 5 weeks		HADS-A The Hospital Anxiety and Depression Scale (HADS-A) (self-report)	significant differences between groups were found.

7	Horgan, McCarthy & Sweeney (2013)	Ireland	**Design:** mixed method evaluation **Aims:** To evaluate the effect of online peer support on depressive symptoms.	**Age range:** 18-24 **Mean age:** 21 **N:** 118 **Gender:** F-42 M-76	**Name:** Lose the Blues **Description:** A forum to allow participants to offer peer support to each other, including information on depression. **Procedure:** Participants were invited to use the website and forum as often as they wanted. The website remained live for two academic terms. **Duration:** 3 months	Depression	▪CES-D- Centre for Epidemiological Studies Depression Scale (self-report) ▪ As part of the evaluation qualitative data were collected from forum posts over a three month period.	▪No significant findings, although some reduction in depression severity post intervention.
8	Kramer et al. (2014)	Netherlands	**Design:** Randomised control trial with two arms Group 1: Participants took part in a web-based Solution-Focused chat	**Age range:** 12-22 **Mean age:** 19.5 **N:** 263 **Gender:** F-207 M- 56	**Name:** PratenOnline Chat **Description:** brief web-based SFBT intervention for CYP with depressive symptoms. The chat consists of individual real-time chat sessions with a trained health care professional in a secured chat room.	Depression	CES-D- Centre for Epidemiological Studies Depression Scale (self-report)	The intervention group showed significantly greater improvement in depression symptoms compared to the control group. With a small effect size at 9 weeks (*d*=0.18) and a

			intervention called PratenOnline. Group 2: Waitlist control group **Aims:** To establish whether a solution focused brief therapy chat intervention (SFBT) was effective in reducing depressive symptoms compared to a wait list control group.		**Procedure:** participants randomised to either intervention or waitlist control group. **Duration:** Chat sessions were limited to five sessions each, with more if required.			large effect size at 4.5 months (*d*=0.79).

9	Rickhi et al. (2015)	Canada	**Design:** Randomised controlled trial with two arms Group 1: participants took part in an eight-week online programme called the LEAP project. Group 2: Waitlist control group **Aims:** To establish whether an online spiritual programme could reduce depressive symptoms in adolescents and young adults.	**Age range:** 13-18, 19-24 **Mean age:** 20 (for older group) **N:**62 **Gender:** F-44 M-18	**Name:** LEAP project **Description:** 8 week online programme guiding participants through spiritually informed principles including forgiveness, gratitude and compassion. **Procedure:** participants were randomly allocated to the intervention or waitlist control group. **Duration:** 8 weeks	Depression	Children's depression Rating Scale (aged 13-18) (administrated by a registered nurse) Hamilton Depression rating scale (aged 19-24) (administrated by a registered nurse)	Depressive symptoms reduced significantly for older age group (p=0.0001). At week 8, there was a significant difference in depression severity between intervention and control group (p=0.0244).

10	Tillfors et al. 2011	Sweden	**Design:** A randomised control trial with two arms Group 1: participants received internet-delivered CBT. Group 2: waitlist control group. **Aims:** To evaluate whether iCBT can have positive	**Age range:** 15-21 **Mean age:** 16 **N:** 19 **Gender:** Not specified	**Name:** iCBT (no specific name) **Description:** self-help manual which consisted of 9 modules including psychoeducation, cognitive restructuring, and exposure and relapse prevention. Homework assignments were also given. **Procedure:** Participants assigned to intervention group of waitlist control group. **Duration:** 9 weeks	Anxiety	SPSQ-C The Social Phobia Screening Questionnaire (self-report) LSAS-SR the Liebowitz Social Anxiety Scale (self-report)	Findings show that there were large between group effect size on social anxiety measures at post-test (*d*=1.38)

			effects on social anxiety disorder among high school students.					
11	Topooco et al. (2018)	Sweden	**Design:** Randomised controlled trial with two arms. Group 1: iCBT intervention Group 2: attention control condition which consisted of monitoring and non-specific counselling. **Aims:** To evaluate the efficacy of an iCBT intervention	**Age range:** 15-19 **N:** 70 **Gender:** F- 66 M- 4 **Mean age:** 17 (intervention) and 16 (control)	**Name:** iCBT (no specific name) **Description:** 8 skill based modules and 8 weekly chat sessions. Techniques included psychoeducation, behavioural activation, cognitive restructuring, anxiety management and relapse prevention. **Procedure:** Participants assigned to intervention group or control group. The control group consisted of monitoring and non-specific	Depression	BDI-II Beck Depression Inventory (self-report)	Findings showed the iCBT intervention resulted in significant reduction of depressive symptoms compared to the attention control condition with a large effect size (*d*=0.71) which were maintained over 6 months.

			which included therapist chat communication		counselling. **Duration:** 8 weeks			
12	Van Der Zanden, Kramer, Gerrits & Cuijpers (2012)	Netherlands	**Design:** Randomised Control trial with two arms Group 1: participants assigned to a web-based group course called Master Your Mind Group 2: Participants assigned to wait-list control group	**Age range:** 16-25 **N:** 244 **Gender:** F- 206 M- 38 **Mean age:** 20 (intervention) and 21 (control)	**Name:** Master Your Mind **Description:** Structured form of iCBT for depression. Focus is on cognitive restructuring of thinking patterns. **Procedure**: Participants were assigned either intervention or waitlist control. **Duration:** Six sessions	Depression	CES-D- Centre for Epidemiologic Studies-Depression scale (self-report)	Findings showed intervention proved significantly more effective than the control group in decreasing depressive symptoms. There was a large between-group effect size at 3 months (*d*=0.94) and maintained at 6-month follow-up.

			Aims: To examine effectiveness of a web based group course called Master your Mind in reducing depressive symptoms.					

Appendix D Quality Assessment Tool Checklist

Author	**Selection Bias** Is it likely selection bias occurred?	**Research Design** What research design was used?	**Confounders*** Were confounders identified and discussed?	**Blinding** Was the researcher and/or participants blinded to the conditions?	**Data Collection Measures** Were the primary outcome measures described as reliable and valid?	**Withdrawal and drop outs** What level of attrition occurred?	**Overall global rating**
Anstiss & Davies, 2015	Yes	Cohort pilot study	Not stated	Not reported	Yes	55%	Weak
Christensen et al., 2014	unlikely	RCT	To minimise imbalance between participant's stratification was conducted.	Not reported	Yes	36% at post-test and 53% at 12 month follow up	Moderate
Clarke et al., 2009	Yes	RCT	No significant differences across conditions after randomisation	Not reported	Yes	21% at week 1 and 36% by week 32	Moderate
Dear et al., 2018	Yes	RCT	Randomisation resulted in largely comparable groups	No	Yes	19% at post treatment and 69% at 12 month follow up	Weak
Ellis et al., 2011	Yes	RCT	Not stated	Not reported	Yes	Not discussed	Weak
Hoek et al., 2012	Yes	RCT	No statistically significant difference in demographics, symptoms or diagnostic status between groups at baseline	Not reported	Yes	38% at 3 month assessment and 40% at 4 months	Moderate

Horgan et al., 2013	Yes	Cohort study	Not stated	Not reported	Yes	only 86% did not complete post-test questionnaire	Weak
Kramer et al., 2014	Yes	RCT	No differences between groups at baseline	Not reported	Yes	43% at 9 weeks and 62% at 7.5 months	Moderate
Rickhi et al., 2015	Yes	RCT	Yes	Researcher blinding	Yes	13%	Strong
Tillfors et al., 2011	Yes	RCT	Randomisation procedure resulted no significant differences between groups	Not reported	Yes	It is not clear how many participants withdraw from the study	Weak
Topooco et al., 2018	Yes	RCT	Not reported	No	Yes	30%	Weak
Van Der Zanden et al., 2012	Yes	RCT	Randomisation procedure resulted no significant differences between groups	Not reported	Yes	21%	Moderate

*It is likely that randomization would have evenly distributed the effects of known and unknown confounders across conditions in RCT studies.

Appendix E Delphi questionnaire round 1

Delphi Questionnaire (Version 3, 15/10/2018)

Study title: Young people's perspectives of mental health support in home, school and community contexts: A Delphi Study

Researchers: Natalie Jago
ERGO Study ID number: 32190

What factors do you think are Important to effectively support the mental health of children and young people?

Below are areas relating to children and young people's mental health support. These refer to:

- The personal qualities needed to support children and young people
- The strategies and interventions that can be used to support the mental health of children and young people
- The availability of support and when it is delivered

Based on your experiences of mental health support (but not limited to these), Please first identify three items within each area you believe to be important to support the mental health of children and young people. You will then be provided with a list of items relating to each area; please rate how important you think each item is in terms of effectively supporting the mental health of children and young people.

The statements listed in each section (personal qualities, strategies, how support is accessed and where support takes places) are based on items found to be important in the current literature. Please email Natalie (nj1n15@soton.ac.uk) if you would like a copy of the reference.

Personal qualities

This section relates to the personal qualities that are needed to support children and young people's mental health. Personal qualities can be described as characteristics of an individual. Please list three personal qualities you think are important to support children and young people's mental health?

Based on your experiences (but not limited to these), please now rate, how important you think each of the following items are in supporting children and young people's mental health.

Personal qualities				
In order to effectively support the mental health of children and young people should be...	**Essential 1**	**Very desirable 2**	**Desirable 3**	**Not essential 4**
Sensitive (shows awareness and understanding of other people's feelings)				
Empathetic				
Friendly				
Capable of humour				
Attentive				
Relatable				
Engaging				
Trustworthy				
Non-judgmental				
Open-minded				
Approachable				
Patient				
Able to put children and young people at ease				
Able to get to know children and young people as a 'whole' person and not just focusing on their need				
Able to recognise the child and young person's strengths				
Someone who has experienced a personal mental health difficulty similar to the children or young person				
Someone who is knowledgeable about mental health difficulties				
Someone who has received mental health training				
Please add any other qualities that you believe are important and that are not already listed				

Strategies to support mental health

This section relates to the strategies and interventions that can be used to support children and young people's mental health. Please list three strategies or interventions you believe to be important to support children and young people's mental health.

Based on your experiences (but not limited to these), please now rate, how important you think each of the following items are in supporting children and young people's mental health.

Strategies and interventions				
In order to most effectively support the mental health of children and young people the range of strategies should include....	**Essential 1**	**Very desirable 2**	**Desirable 3**	**Not essential 4**
Access to clear information about mental health from openly available sources (e.g. the internet, fact sheets, books and research)				
Access to technology-based apps and tools to support mental health e.g. through mobile phone apps or websites				
Access to technology-based apps and tools to support mental health guided and supported by a parent/carer				
Awareness raising around mental health in school				
Parent training to support children and young people's mental health				
Teacher and staff training to support children and young people's mental health				
Access to creative support such as art, dance and drama to express emotions				
Access to opportunities to learn and practice specific relaxation techniques e.g. mindfulness or yoga				
Support through having an available friend/peer to talk to				
Support through having an available adult to talk to				
Individual support to help children and young people to develop confidence and self-esteem				
Individual support to help children and young people to develop coping strategies to be able to manage and improve their mental health.				
Group work with peers that supports children and young people to develop confidence and self-esteem				
Group work with peers that supports children and young people to develop coping strategies to be able to manage and improve their mental health.				
Support from qualified and specialist mental health practitioners e.g. through individual counselling, Cognitive Behaviour Therapy.				
Incorporating mental health education into the curriculum				
Please add any other strategies that you believe are important and that are not already listed				

How support is accessed

This section relates to how children and young people access support for their mental health. Please identify three ways children and young people should be able to access support

Based on your experiences (but not limited to these), please now rate, how important you think each of the following items are in supporting children and young people's mental health.

How support is accessed				
In order to most effectively support the mental health of children and young people, support should be accessed via...	**Essential 1**	**Very desirable 2**	**Desirable 3**	**Not essential 4**
A teacher				
A key member of staff whose key responsibility is to support children and young people's mental health				
A staff member who is not a teacher				
Self-referral (this means referring yourself to support services)				
drop in services outside of school/college				
A friend				
A family member				
Online				
A doctors/GP surgery				
A youth service				
A leisure centre				
A health centre				
A community mental health service				
Please add any ways that support could be accessed that you believe are important and that are not already listed				

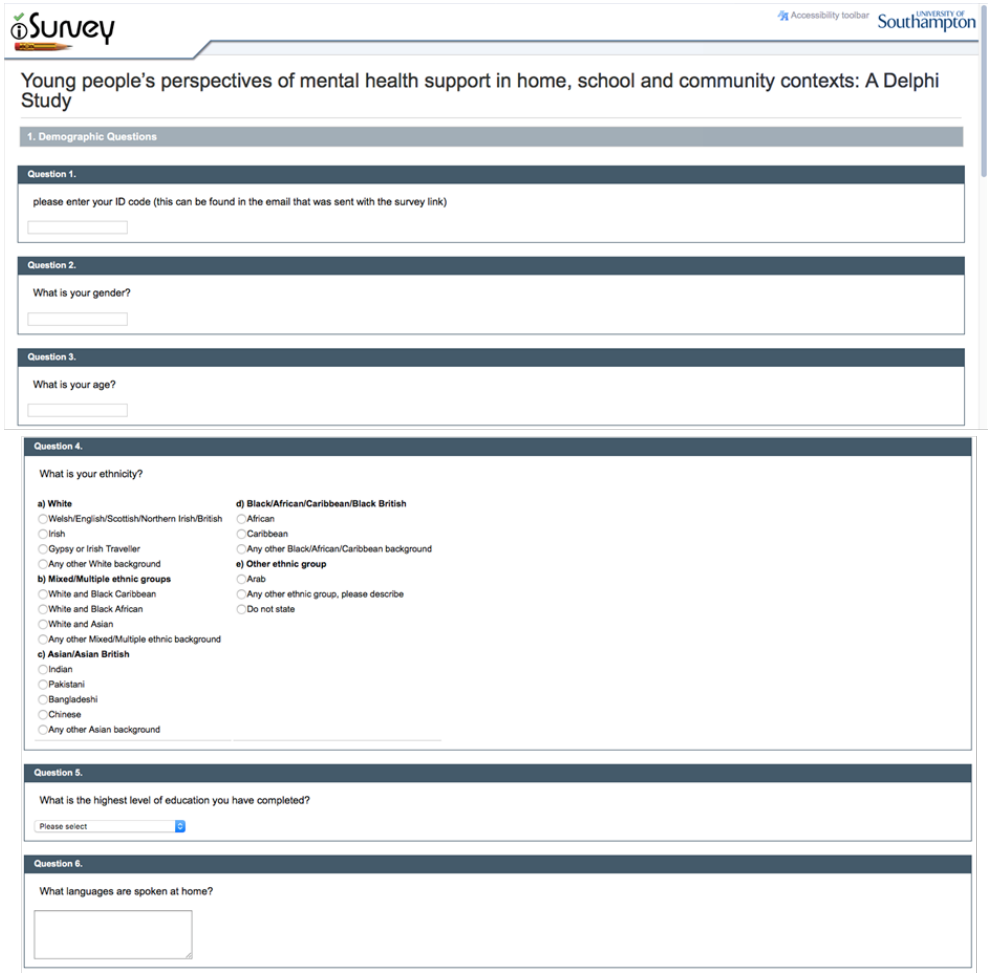
Where support takes place

This section relates to where support for children and young people's mental health is accessed. Please identify three places where you believe it is important for children and young people to access support.

Based on your experiences (but not limited to these), please now rate, how important you think each of the following items are in supporting children and young people's mental health.

Where support is takes place				
In order to most effectively support the mental health of children and young people, support should be available at...	**Essential 1**	**Very desirable 2**	**Desirable 3**	**Not essential 4**
A school/college				
home				
A drop in services outside of school/college				
Over the phone				
Online				
A doctors/GP surgery				
A youth service				
A leisure centre				
A health centre				
A dedicated mental health service				
Please specify any other places that you believe are important and that are not already listed				

Appendix F Demographic questionnaire



iSurvey

Accessibility toolbar University of Southampton

Young people's perspectives of mental health support in home, school and community contexts: A Delphi Study

1. Demographic Questions

Question 1.

please enter your ID code (this can be found in the email that was sent with the survey link)

Question 2.

What is your gender?

Question 3.

What is your age?

Question 4.

What is your ethnicity?

a) White
- Welsh/English/Scottish/Northern Irish/British
- Irish
- Gypsy or Irish Traveller
- Any other White background

b) Mixed/Multiple ethnic groups
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed/Multiple ethnic background

c) Asian/Asian British
- Indian
- Pakistani
- Bangladeshi
- Chinese
- Any other Asian background

d) Black/African/Caribbean/Black British
- African
- Caribbean
- Any other Black/African/Caribbean background

e) Other ethnic group
- Arab
- Any other ethnic group, please describe
- Do not state

Question 5.

What is the highest level of education you have completed?

Please select

Question 6.

What languages are spoken at home?

Question 7.

What mental health difficulties have you experienced?

Question 8.

What support, if any, have you received for your mental health difficulty?

Question 9.

Where did you recieve this support?

Question 10.

How old were you when your received support?

Appendix G Delphi Feedback Report Example

UNIVERSITY OF Southampton

Young people's perspectives of mental health support in home, school and community contexts: A Delphi study

First Questionnaire Feedback Report

Respondent ID Code: A101

Thank you for completing the first questionnaire of the Delphi poll. This feedback report includes your responses and the collated responses of other young people who completed the questionnaire. Each item will show your response and the responses of other young people. You will be able to see the number of people in brackets who rated the item as either 'not essential', 'desirable', 'very desirable' or 'essential' and the percentage (%) for this.

In the second questionnaire you will be given the opportunity to change your responses in light of this report. There are no right or wrong answers, what we are interested in is your opinions.

Section 1 – Personal qualities

In order to effectively support mental health, those supporting children and young people should be...	Your Response	Group response (including the percentage and number of responses for each item) Not essential	Desirable	Very desirable	Essential
1. Sensitive	Essential	0% (0)	17% (4)	9% (2)	74% (17)
2. Empathetic	Very desirable	0% (0)	13% (3)	35% (8)	52% (12)
3. Friendly	Very desirable	0% (0)	4% (1)	35% (8)	61% (14)
4. Capable of humour	Very desirable	4% (1)	17% (4)	48% (11)	30% (7)
5. Attentive	Very desirable	0% (0)	27% (6)	41% (9)	32% (7)
6. Relatable	Very desirable	9% (2)	22% (5)	35% (8)	35% (8)
7. Engaging	Very desirable	0% (0)	22% (5)	22% (5)	57% (13)
8. Trustworthy	Very desirable	0% (0)	0% (0)	17% (4)	83% (19)
9. Non-judgemental	Very desirable	0% (0)	0% (0)	17% (4)	83% (19)
10. Open-minded	Very desirable	0% (0)	4% (1)	26% (6)	70% (16)
11. Approachable	Very desirable	0% (0)	9% (2)	26% (6)	65% (15)
12. Patient	Very desirable	5% (1)	9% (2)	14% (3)	73% (16)
13. Able to put children and young people at ease	Very desirable	0% (0)	0% (0)	44% (10)	57% (13)
14. Able to get to know children and young people as a 'whole' person and not just focusing on their needs	Very desirable	5% (1)	9% (2)	32% (7)	55% (12)
15. Able to recognise the child and young person's strengths	Very desirable	4% (1)	13% (3)	26% (6)	57% (13)
16. Someone who has experienced a personal mental health difficulty similar to the child or young person	Very desirable	26% (6)	26% (6)	30% (7)	17% (4)
17. Someone who is knowledgeable about mental health difficulties	Very desirable	13% (3)	4% (1)	26% (6)	57% (13)
18. Someone who has received mental health training	Very desirable	17% (4)	13% (3)	26% (6)	44% (10)

Section 2- Strategies and interventions

In order to most effectively support the mental health of children and young people the range of strategies should include...	Your Response	Group response (including the percentage and number of responses for each item) Not essential	Desirable	Very desirable	Essential
1. Access to clear information about mental health from openly available sources (e.g. the internet, fact sheets, books and research)	Very desirable	14% (3)	5% (1)	36% (8)	46% (10)
2. Access to technology-based apps and tools to support mental health (e.g. through mobile phone apps or websites)	Very desirable	9% (2)	23% (5)	41% (9)	27% (6)
3. Access to technology-based apps and tools to support mental health which are guided and supported by a parent/carer	Very desirable	23% (5)	23% (5)	36% (8)	18% (4)
4. Raising awareness around mental health in school	Very desirable	5% (1)	14% (3)	32% (7)	50% (11)
5. Parent training to support children and young people's mental health	Very desirable	5% (1)	14% (3)	27% (6)	55% (12)
6. Teacher and staff training to support children and young people's mental health	Very desirable	5% (1)	5% (1)	32% (7)	59% (13)
7. Access to creative support such as art, dance and drama to express emotions	Very desirable	0% (0)	14% (3)	46% (10)	41% (9)
8. Access to opportunities to learn and practice specific relaxation techniques (e.g. mindfulness or yoga)	Very desirable	5% (1)	27% (6)	14% (3)	55% (12)
9. Support through having an available friend/peer to talk to	Very desirable	5% (1)	18% (4)	27% (6)	50% (11)

10. Support through having an available adult to talk to	Very desirable	5% (1)	23% (5)	27% (6)	46% (10)
11. Individual support to help children and young people to develop confidence and self-esteem	Very desirable	0% (0)	5% (1)	36% (8)	59% (13)
12. Individual support to help children and young people to develop coping strategies to be able to manage and improve their mental health	Very desirable	0% (0)	9% (2)	27% (6)	64% (14)
13. Support from qualified and specialist mental health practitioners (e.g. through individual counselling, Cognitive Behaviour Therapy)	Very desirable	5% (1)	18% (4)	23% (5)	55% (12)
14. Incorporating mental health education into the curriculum	Very desirable	14% (3)	9% (2)	32% (7)	46% (10)

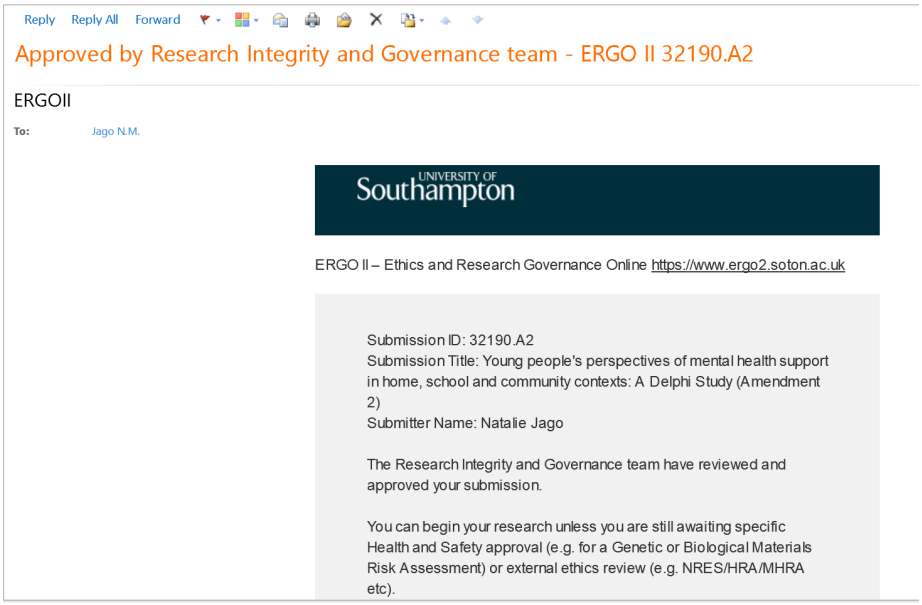
3. How support is accessed

In order to most effectively support the mental health of children and young people, support should be accessed through...		Group response (including the percentage and number of responses for each item)			
		Not essential	Desirable	Very desirable	Essential
	Your Response				
1. A teacher	Desirable	13% (3)	30% (7)	26% (6)	30% (7)
2. A key member of staff whose key responsibility is to support children and young people's mental health	Very desirable	0% (0)	17% (4)	35% (8)	48% (11)
3. A staff member who is not a teacher	Not essential	13% (3)	17% (4)	39% (9)	30% (7)
4. Self-referral (this means referring yourself to support services)	Very desirable	0% (0)	17% (4)	44% (10)	39% (9)
5. Drop in services outside of school/college	Not essential	9% (2)	13% (3)	26% (6)	52% (12)
6. A friend	Not essential	9% (2)	4% (1)	26% (6)	61% (14)
7. A family member	Desirable	13% (3)	35% (8)	22% (5)	30% (7)
8. Online	Desirable	13% (3)	30% (7)	26% (6)	30% (7)
9. A doctors/GP surgery	Desirable	9% (2)	26% (6)	13% (3)	52% (12)
10. A youth service	Not essential	26% (6)	4% (1)	22% (5)	48% (11)
11. A leisure centre	Not essential	30% (7)	13% (3)	30% (7)	26% (6)
12. A health centre	Not essential	22% (5)	4% (1)	26% (6)	48% (11)
13. A community mental health service	Not essential	17% (4)	4% (1)	13% (3)	65% (15)

4. Where support takes place

In order to most effectively support the mental health of children and young people, support should be available...		Group response (including the percentage and number of responses for each item)			
		Not essential	Desirable	Very desirable	Essential
	Your Response				
1. At school/college	Essential	9% (2)	13% (3)	13% (3)	65% (15)
2. At home	Essential	13% (3)	17% (4)	26% (6)	44% (10)
3. At a drop in service outside of school/college	Not essential	4% (1)	17% (4)	35% (8)	44% (10)
4. Over the phone	Not essential	17% (4)	35% (8)	17% (4)	30% (7)
5. Online	Essential	0% (0)	30% (7)	26% (6)	44% (10)
6. At a doctors/GP surgery	Very desirable	17% (4)	22% (5)	17% (4)	44% (10)
7. At a youth service	Not essential	17% (4)	17% (4)	22% (5)	44% (10)
8. At a leisure centre	Not essential	35% (8)	9% (2)	26% (6)	30% (7)
9. At a health centre	Not essential	17% (4)	17% (4)	17% (4)	48% (11)
10. At a dedicated mental health service	Not essential	13% (3)	9% (2)	9% (2)	70% (16)

Appendix H Ethical Approval



Reply Reply All Forward

Approved by Research Integrity and Governance team - ERGO II 32190.A2

ERGOII

To: Jago N.M.

University of Southampton

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 32190.A2
Submission Title: Young people's perspectives of mental health support in home, school and community contexts: A Delphi Study (Amendment 2)
Submitter Name: Natalie Jago

The Research Integrity and Governance team have reviewed and approved your submission.

You can begin your research unless you are still awaiting specific Health and Safety approval (e.g. for a Genetic or Biological Materials Risk Assessment) or external ethics review (e.g. NRES/HRA/MHRA etc).

Appendix I Information Leaflet and Poster

Are there any risks involved?
The Delphi questionnaire will focus on your views on mental health support rather than your direct experiences. However, it is possible that you might reflect on situations that you have found difficult. You can stop taking part whenever you want or take a break from the questionnaire.

If you are worried about your mental health, it is important that you are able to speak to someone or get support about this. The YoungMinds website www.youngminds.org.uk provides information and advice about mental health. If you require urgent support and are under 19 you can contact childline; a free, private and confidential service. You can contact them on 0800 1111 or visit their website www.childline.org.uk. Alternatively, if you are older than 19 you can contact Samaritans on 116 123 or visit their website www.samaritans.org.

Will my participation be confidential?
All your responses to the questionnaire will be anonymous to the other participants, which means no other participants will know you have taken part. You will be identified by a study identification number which will be associated with your email address. Your email address will be kept in a log that will be password-protected. Only the research team will have access to the information you provide. Please read the Data Protection Privacy Notice (Version 1, 29/08/2018) to find out more about how your data is processed. The only time I would be required to break confidentiality would be if you tell me something that makes me really worried that you might need some help to keep you safe.

What should I do if I want to take part?
If you would like to take part in the study, please contact me, Natalie Jago (see details below). If you would like me to get in touch with you, please provide your contact details to your personal tutor.

What happens if I change my mind?
You have the right to withdraw at any time of the study. If you decide you no longer want to take part in the research you can contact me letting me know you wish to withdraw from the research. Due to the nature of the Delphi study, it will not be possible to withdraw any data you have provided that has already been analysed.

What happens if something goes wrong?
If you have any concerns or complaints related to the current study, please contact the Research Integrity and Governance manager, rgoinfo@soton.ac.uk, 023 8059 5058.

Where can I get more information?
If you have any questions about the research, please contact:

Natalie Jago- nj1n15@soton.ac.uk

University of Southampton

What do you think about mental health support for children and young people?

ERGO number: 32190 19/09/2018, Version 5

What is the research about?
The research is being conducted to explore young people's perspectives of mental health support within the home, school and community contexts to identify a set of approaches that young people believe are important to support the mental health of children and young people. The research is being conducted to ensure that young people have a voice about support that is directly aimed at them and to better inform decision makers about approaches that are most and least valued by young people.

Why should I participate?
It is important for young people to share their views about any support that is offered to them. The research will be using an approach called the Delphi method, which is a way of combining the views of many different people to reach an agreement on a subject. These people are often referred to as 'experts' as they have experience on the subject; for this research the subject is mental health support.

The expertise we are looking for in this study is young people aged 16-25 who have experienced a mental health difficulty within the last three years. You do not need to have a diagnosis, but need to be able to identify that you have had a mental health difficulty.

What do you mean by having a mental health difficulty?
Just like physical health, we all have mental health and it's important to take care of it. The following definition can be helpful in understanding mental health:

"Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with." (Mind, 2013).

There are many different mental health difficulties. Everyone's experience is different and can change at different times.

What will happen to me if I take part?
Taking part will involve completing two online questionnaires, over a period of six weeks. If you agree to take part, you will be sent an email with a link to the questionnaire. To begin with you will be presented with a set of questions related to yourself known as demographic questions. This is to provide the research team with information about the characteristics of the people taking part in the research. Answering these questions is optional and you do not need to answer these questions if you prefer not to.

You will then be presented with the first Delphi questionnaire. The questionnaire will include questions related to the following areas:

- The personal qualities needed to support children and young people
- The strategies and interventions that can be used to support the mental health of children and young people
- The availability of support

Within each area, you will first be asked to identify approaches you believe are important to support children and young people's mental health. You will then be presented with a list of items related to each area and asked to rate how important you think these items are. In the second questionnaire, you will be able to see how other young people completing the questionnaire rated each item and you will have a chance to change your answers if you wish to do so. You will not be identifiable to others taking part in the research.

Are there any benefits in me taking part?
Your views will help to enable those working with children and young people to better understand what support approaches are most and least valued by young people. As a thank you for taking part, you will also receive a £10.00 Amazon gift voucher which you will receive after completing both questionnaires.

UNIVERSITY OF Southampton

What do YOU think about mental health support for children and young people?

Have you experienced a mental health difficulty and want to have your say about mental health support for children and young people?

WHY?

We are recruiting volunteers aged 16-25 who have experienced a mental health difficulty to gather their views on mental health support for children and young people.

WHAT IS INVOLVED IN TAKING PART?

Taking part will involve completing two online questionnaires, over a period of six weeks. Your participation in the study is voluntary and you can withdraw at any point. You will receive a £10.00 Amazon gift voucher as a thank you for taking part.

WHO DO I CONTACT?

If you are interested in taking part or would like to find out more, you can email Natalie Jago at nj1n15@soton.ac.uk or you can provide your contact details to your personal tutor and Natalie will be in touch.

ERGO Study ID number: 32190 Version 3 19/09/2018

Appendix J Presentation

What do you think about mental health support for children and young people?

Doctoral Thesis

Natalie Jago

Why should I participate?

- Important for young people to share their views about any support that is offered to them.
- The research will be using an approach called the Delphi method, which is a way of combining the views of many different people to reach an agreement on a subject.
- The expertise we are looking for in this study is young people aged 16-25 who have experienced a mental health difficulty within the last three years. You do not need to have a diagnosis, but need to be able to identify that you have had a mental health difficulty.

What is the research about?

- Exploring young people's perspectives of mental health support within the home, school and community contexts.
- To identify a set of approaches that young people believe are important to support the mental health of children and young people.
- Ensuring young people have a voice about support that is directly aimed at them.
- To better inform decision makers about approaches that are most and least valued by young people.

What will happen if I take part?

- Two online questionnaires
  - Questionnaire 1:

    1) email with a link to the questionnaire

    2) Presented with a set of questions related to yourself known as demographic questions

    3) Presented with the first Delphi questionnaire. The questionnaire will include questions related to the following areas:
    - The personal qualities needed to support children and young people
    - The strategies and interventions that can be used to support the mental health of children and young people
    - The availability of support

What is mental health?

Just like physical health, we all have mental health and it's important to take care of it. The following definition can be helpful in understanding mental health:

- "Good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health you might find the ways you're frequently thinking, feeling or reacting become difficult, or even impossible, to cope with." (Mind, 2013).

There are many different mental health difficulties. Everyone's experience is different and can change at different times.

What will happen if I take part?

- Questionnaire 2
  - In the second questionnaire, you will be able to see how other young people completing the questionnaire rated each item and you will have a chance to change your answers if you wish to do so.
  - You will not be identifiable to others taking part in the research.

Are there any benefits in me taking part?

- Your views will help to enable those working with children and young people to better understand what support approaches are most and least valued by young people.
- As a thank you for taking part, you will also receive a £10.00 Amazon gift voucher which you will receive after completing both questionnaires.

What should I do if I want to take part?

If you would like to take part in the study, please contact me using my email address which is **nj1n15@soton.ac.uk**

OR

If you would like me to get in touch with you, please provide your contact details to your personal tutor

Are there any risks involved?

- The questionnaire will focus on your views on mental health support
- It is possible that you might reflect on situations that you have found difficult. You can stop taking part whenever you want or take a break from the questionnaire.
- If you are worried about your mental health, it is important that you are able to speak to someone or get support about this.

What happens if you change your mind?

- You have the right to withdraw at any time of the study.
- Due to the nature of the Delphi study, it will not be possible to withdraw any data you have provided that has already been analysed.
- If you have any concerns or complaints related to the study, you can contact the Research Integrity and Governance manager at the University. The details are provided in the information leaflet.

Will my participation be confidential?

- All your responses to the questionnaire will be anonymous to the other participants.
- You will be identified by a study identification number which will be associated with your email address.
- Only the research team will have access to the information you provide.
- The only time I would be required to break confidentiality would be if you tell me something that makes me really worried that you might need some help to keep you safe.

Where can I get more information?

If you have any questions about the research, please contact:

Natalie Jago- nj1n15@soton.ac.uk

Questions?

Appendix K Qualitative Interview Information Sheet & Topic Guide

UNIVERSITY OF Southampton

Participant Information Sheet- Focus group (Version 4, 17/12/2018)

Study title: Young people's perspectives of mental health support in home, school and community contexts: A Delphi study

Researchers: Natalie Jago
ERGO Study ID number: 32190

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
The research is being carried out by Natalie Jago, a Trainee Educational Psychologist as part of her doctoral training at the University of Southampton. The research is being conducted to explore young people's perspectives of mental health support within the home, school and community contexts to identify a set of approaches that young people believe are important to support children and young people's mental health. There are two stages to the research. The first stage will use an approach called the Delphi method, which is a way of combining the views of multiple people to reach an agreement on a subject. For this research, it will be used to gather the views of young people to reach an agreement about mental health support. From this, a set of approaches will be identified. The second stage of the research will seek to gain feedback from parents and professionals about these approaches through the use of group discussions.

Why have I been asked to participate?
You have been identified as someone who has experience of either working with children professionally, or for your role as a parent of a child who has experienced mental health difficulties.

What will happen to me if I take part?
If you agree to take part in this study, you will be asked to participate in a small group discussion with other parents and professionals lasting no longer than 1.5 hours. During the discussion, you will be asked about your views on the approaches to support mental health that young people participating in the study have identified as important. With your permission, the discussion will be audio-recorded and transcribed. This is to ensure we have an accurate account of your views.

Are there any benefits in my taking part?
Participating in this research will provide an opportunity to reflect upon the approaches that are most and least valued by young people. By providing this information it may be possible that future interventions and approaches are better informed by the needs and wishes of key stakeholders. As a thank you for taking part, you will receive a £10.00 Amazon gift voucher at the end of the focus group.

Are there any risks involved?
Although there are no known risks to participating in this study, you might recall an experience you have found difficult while talking about mental health. You do not have to answer any questions you feel uncomfortable with.

What data will be collected?
During the discussion, you will be asked about your views on the approaches to support mental health that young people participating in the study have identified as important. With your permission, the discussion will be audio-recorded and transcribed. Your participation and the information we collect about you during the course of the research will be kept strictly confidential. The audio-recording will be stored on a password protected computer and will be deleted from the audio-recording device. All consent forms will be locked in a secure drawer. When the audio-recording is transcribed your name and other identifying characteristics will be anonymised. After transcription, the audio-recording will be deleted. In addition, all participants in the focus group will be asked to respect the confidentiality of everyone in the group. However, it is not possible for the researcher to guarantee that everyone will do so. The write up of the research may include quotes from the focus groups to help illustrate the points that were made. All quotes used will be anonymised.

Will my participation be confidential?
Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Do I have to take part?
No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part. If you would like to take part in the study, please contact researcher Natalie Jago- contact details are listed at the bottom of the page. Alternately, you can provide your contact details to [name of gatekeeper] and Natalie will contact you.

What happens if I change my mind?
If you agree to take part in the study, but then decide to withdraw you can contact the researcher (details provided below). During and after the focus groups, it will not be possible to withdraw your data. Due to the nature of a group discussion it may not be possible to identify all the information you have provided.

Where can I get more information?
If you have any questions about the research, please contact:

Natalie Jago: nj1n15@soton.ac.uk

What happens if there is a problem?
If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.
If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

What happens to the results of the research?
The findings from the research will help to enable those working with children and young people to better understand what support approaches are most and least valued by young people. By capturing this information, it may be possible that future interventions and approaches are better informed by the needs and wishes of key stakeholders. The research will be written up and examined as part of the researcher's doctoral qualification. It is also hoped that the findings of this study will be published in a relevant academic journal and disseminated more widely to interested parties, where appropriate. If you would like to receive a summary of the findings, please contact Natalie using the email address below.

Data Protection Privacy Notice
The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data collected in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you
Thank you for reading this information sheet and for considering taking part. Please do get in touch if you would like to take part or would like to find out more information about the study.

Topic Guide for Focus Group (version 1 29/04/2018)

Study title: Young people's perspectives of mental health support in home, school and community contexts: A Delphi Study

Researchers: Natalie Jago
ERGO Study ID number: 32190

1. **Introductions**
    - Introduce self and others
    - Purpose of the group discussion
    - Digital recording- check and reassure regarding confidentiality
    - Data kept securely in accordance with Data Protection Act
    - How the data will be used
    - Freedom to express views
    - Respect for others
    - Any questions/concerns?

2. **Background and context**

    Aim: To gather background information including the role participants have in supporting children and young people with mental health difficulties and to identify barriers and facilitators to support.

    - Participants role in supporting children and young people's mental health
    - What works well in supporting children and young people
    - Barriers/challenges they have experienced (if any)

3. **Approaches to supporting mental health support**

    Aim: To identify what approaches participants believe are important in supporting children and young people's mental heath

    - What personal qualities do they think are important in supporting CYP
    - What strategies are they aware of that they think are important
    - How support should be accessed
    - Where support is accessed

4. **Young people's views on mental health support**
    Aim: To explore with participants the set of approaches that young people have identified as important. (The main points from the Delphi questionnaire will be shared with participants)

    - What are your overall feelings towards the approaches?
    - Are there any approaches that surprise you or you had not thought about?
    - Do you think any of these approaches are currently used?
        - If not, how best do you think these approaches could be implemented/used?
    - What do you think are the positives of the approaches identified?
    - Do you think there are any challenges with any of the approaches?

5. **Closing discussion**
    - Thinking about all that we have talked about today, what do you think will be important for decision makers to know in relation to supporting the mental health of children and young people?

Appendix L Coding Manual

Theme	Sub-theme	Description	Examples
The role of the practitioner	The relationship	Participants identified the importance of building trusting relationships with CYP.	"*If they can't trust you, forget it. That would be really really important but you know that's for everyone not just CYP*" (participant 1) "*we have built up that trust with our students, I mean the first few weeks of any school term or college term is you are getting to know your students and getting up a relationship with them*" (participant 2) *"I think the general thing that comes across here has been stated they're looking for someone who they can talk to, I don't think they're finding it and they're basically more or less screaming*

			out we want someone who we can talk to" (participant 3)
	Role constraints	Participants identified barriers to CYP seeking support included restrictions to confidentiality, time constraints and demands placed on teaching. However, it was felt if CYP trusted adults this did not impact on confidentiality restrictions	"*I do have a right to report certain things because they need to know that I can't keep things secret because for me it is a legal requirement*." (Participant 2) "*If they trust us they trust us you know and they trust us to help them to find the help they need and they trust us to be able to support them in what it is they need…"* (Participant 2) *"…they normally still continue talking, the reason that they talk to me is at the end of the day they just want someone to listen to what their problem and hopefully get some advice from someone else*." (Participant 3)

			"I know a lot of teachers, they're on it 24/7, they've got classes to go to, x to y to z and then afterwards they've got to go to meetings so it's very much a very fast track business so sometimes the students themselves see that and know that they can't really console whatever their issues are" (participant 3) "*The nature of our job it's hard to be that all the time, we have deadlines we have so much that we have to do you know we are not always ourselves a 100% because we're stressed out because we've got a lot of our own issues going on ourselves it's hard to be all those things at all times*." (Participant 2)
	Role Distinctions	Participant's recognised that there is overlap between providing pastoral	"*Would you go to someone who's just punished you to say actually will you*

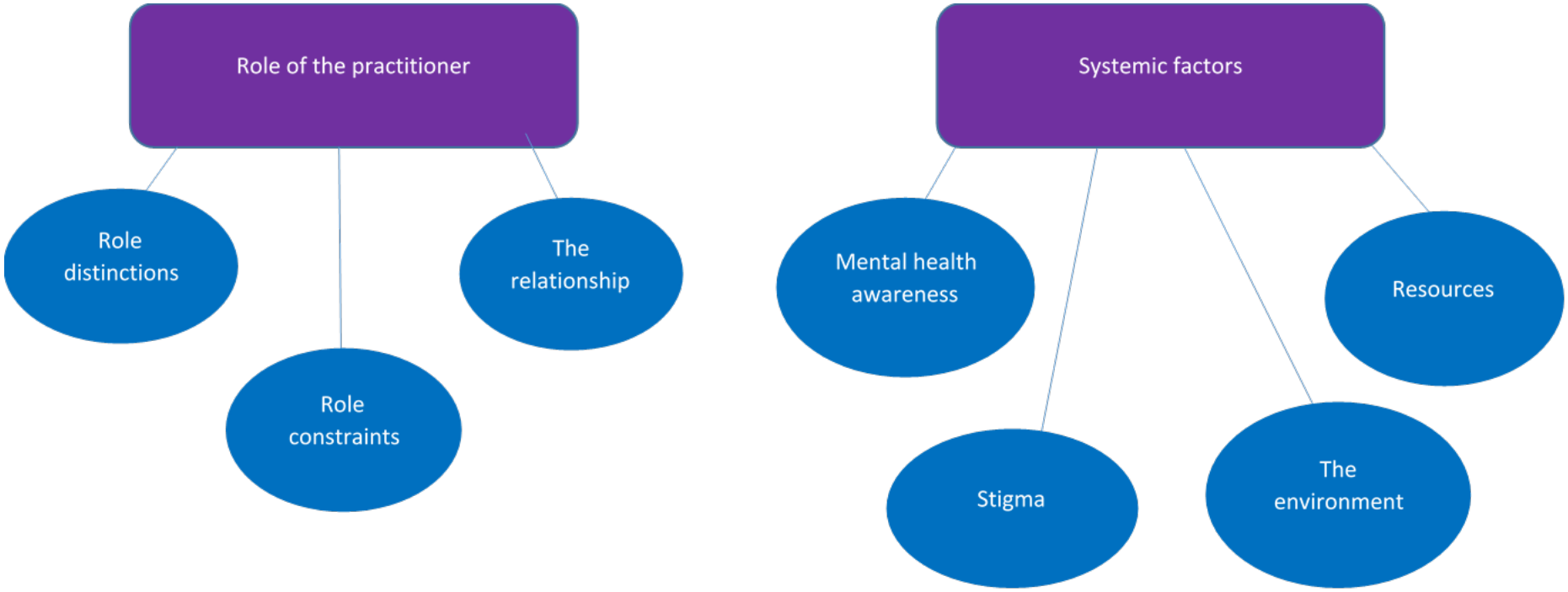
		support and ensuring behaviour policies in place which can impact on CYP seeking support from adults.	*support me, no, you're going to go to someone who entirely different who is on your side…"* (Participant 1) "*Probably they would think actually if my teachers are here for academics and they're doing my MH, they're gonna know a lot about me and I don't want them knowing that much about me*." (Participant 2)
Systemic factors	MH awareness	Participant's identified the need for more MH awareness within schools and the community in order to better recognise and support CYP.	"*No, not enough anyway, not addressed enough they need to talk about anxiety and depression in a big way, it's far more important than learning trigonometry in my book anyway*" (participant 1) "*I think having that training helps us to know a) how to talk to a students and b) how to deal with the issue but obviously for us because we do have first and*

			foremost we are educators and we're here for their education" (Participant 2) *"I think they realise that their parents don't know what to do and I think some of our CYP probably if they did have a MH issue they probably wouldn't even want to speak to their parents."* (Participant 2)
	Stigma	Participant's recognised that CYP may not want to seek help due to a fear of stigma.	"It was clearly not just a phase so [daughter's name] needed to go and get specialist help but I know my family weren't very receptive to the idea of me basically going along with this because they were thinking it might impact on her in terms of work, relationships they were scared that she might get sectioned etc etc." (participant 3)

	The environment	Participants recognised the need for CYP to seeking support in places that are accessible and convenient to them	"…obviously a lot of our students are probably awake until god knows what time in the morning because they can't sleep and all this lot so that I would say would be an amazing thing to have in place but it's probably going to be one of the most difficult things to have in place." (participant 2) *"they have gaps in their timetable so they're probably thinking oh yeah I could go and seek help from people when I've got the gaps which means I don't have to travel outside I don't have to book time off college"* (participant 2)
	Resources	Participants talked about a lack of resources and funding for MH within educational settings.	*"it's not there, that help isn't there, that funding isn't there, those resources aren't there and obviously I can sit here and say money money money money money until I'm blue in the face but if the*

			money is not there the money is not there but we need to find the money from somewhere." (participant 2)

Appendix M Thematic Map



Appendix N Descriptive Statistics

Personal Qualities

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Sensitive (shows awareness and understanding of other people's feelings)	17	2	2	4	3.59	.618	.382
Empathetic	18	3	1	4	3.06	.938	.879
Friendly	18	3	1	4	3.28	.895	.801
Capable of humour	18	3	1	4	2.94	.938	.879
Attentive	18	2	2	4	3.17	.786	.618
Relatable	17	2	2	4	2.94	.827	.684
Engaging	18	3	1	4	2.89	.963	.928
Trustworthy	17	1	3	4	3.76	.437	.191
Non-judgemental	18	3	1	4	3.50	.857	.735
Open-minded	17	2	2	4	3.24	.664	.441
Approachable	18	3	1	4	3.50	.857	.735
Patient	18	2	2	4	3.56	.705	.497
Able to put children and young people at ease	18	2	2	4	3.39	.778	.605
Able to get to know children and young people as a whole person and not just focusing on their needs	18	2	2	4	3.61	.608	.369
Able to recognise the CYPs' strengths	18	3	1	4	3.33	.907	.824
Someone who has experienced a personal mental health difficulty similar to the child or young person	18	3	1	4	2.61	.979	.958
Someone who is knowledgeable about mental health difficulties	18	3	1	4	3.11	.963	.928
Someone who has received mental health training	18	3	1	4	2.78	1.114	1.242
Active listener	18	2	2	4	3.50	.707	.500
Respects confidentiality	18	1	3	4	3.83	.383	.147
Understanding	18	2	2	4	3.44	.705	.497
Calm	18	2	2	4	3.44	.705	.497
Confident	18	3	1	4	3.00	.970	.941
Considerate	18	2	2	4	3.50	.707	.500
Has an enthusiastic personality	18	3	1	4	2.78	1.166	1.359
Experienced	18	3	1	4	2.94	1.162	1.350
Kind	18	2	2	4	3.22	.732	.536

Reliable	18	3	1	4	3.39	.778	.605
Genuine	18	1	3	4	3.56	.511	.261
Easy to talk to	18	3	1	4	3.50	.857	.735
Fun	17	3	1	4	2.76	1.091	1.191
Caring	18	2	2	4	3.33	.686	.471
Tolerant	18	2	2	4	3.22	.808	.654
Respectful	18	2	2	4	3.61	.608	.369
Knowing when to pass the support on to someone with professional experience	18	3	1	4	3.22	.808	.654
Concerned	18	3	1	4	2.83	1.150	1.324
A people person	18	3	1	4	3.06	1.162	1.350
Non-patronising	18	3	1	4	3.50	.786	.618
Valid N (listwise)	17						

Strategies and Interventions

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Access to clear information about mental health from openly available sources (e.g. the internet, fact sheets, books and research)	18	2	2	4	3.11	.963	.928
Access to technology-based apps and tools to support mental health (e.g. through mobile phone apps or websites)	18	3	1	4	2.83	1.150	1.324
Access to technology-based apps and tools to support mental health which are guided and supported by a parent/carer	18	3	1	4	2.89	1.079	1.163
Raising awareness around mental health in school	18	3	1	4	2.83	1.098	1.206
Parent training to support CYPs' mental health	18	3	1	4	3.22	.943	.889
Teacher and staff training to support CYPs' mental health	18	3	1	4	3.22	.878	.771
Access to creative support such as art, dance and drama to express emotions	18	3	1	4	3.11	.963	.928
Access to opportunities to learn and practice specific relaxation techniques (e.g. mindfulness or yoga)	18	3	1	4	2.78	.943	.889
Support through having an available friend/peer to talk to	18	3	1	4	3.00	.970	.941

Support through having an available adult to talk to	17	3	1	4	3.12	1.054	1.110
Individual support to help children and young people to develop confidence and self-esteem	18	2	2	4	3.33	.767	.588
Individual support to help children and young people to develop coping strategies to be able to manage and improve their mental health	17	2	2	4	3.29	.772	.596
Support from qualified and specialist mental health practitioners (e.g. through individual counselling, Cognitive Behaviour Therapy)	18	2	2	4	3.22	.808	.654
Incorporating mental health education into the curriculum	18	3	1	4	3.22	1.060	1.124
Access to sport and/or fitness programmes	17	3	1	4	3.00	.935	.875
Access to social activities	18	3	1	4	3.11	.963	.928
Support through talking to a family member	18	3	1	4	2.78	1.003	1.007
Access to peer interventions	18	3	1	4	2.67	1.188	1.412
Access to youth activity programmes	18	3	1	4	3.00	1.029	1.059
Access to music	18	3	1	4	2.83	1.043	1.088
Access to activities and tasks that the child or young person enjoys	18	2	2	4	3.17	.857	.735
Brief check-ups with all children and young people to assess their mental health	18	3	1	4	3.28	.958	.918
Access to support groups	17	3	1	4	2.94	.966	.934
Anonymous mental health surveys every term in secondary school	18	3	1	4	3.06	.938	.879
Facilitating the child or young person's understanding of their own mental health and the range of associated emotions (both positive and negative)	18	3	1	4	3.17	.985	.971
Access to 24/7 support	18	2	2	4	3.44	.784	.614
Access to someone who listens to the suggestions of children and young people	18	2	2	4	3.28	.752	.565
Access to someone to talk to who is not a friend or family member	18	2	2	4	3.44	.705	.497
Access to mental health days or trips	18	3	1	4	2.89	1.079	1.163

Ensuring the environment is comfortable for the child or young person when they are receiving any support	18	3	1	4	3.17	.985	.971
Ensuring the child or young person's perspective is fully understood	18	3	1	4	3.22	.878	.771
Access to someone who has a soft tone and warm approach	18	3	1	4	2.72	1.018	1.036
Access to someone who treats the child or young person like a friend rather than a client	18	3	1	4	3.00	1.029	1.059
Support to manage stress	18	3	1	4	3.44	.856	.732
Access to social media	18	3	1	4	2.56	1.149	1.320
Supporting the child or young person in their understanding that they are not alone	18	2	2	4	3.50	.707	.500
Valid N (listwise)	16						

How to access support

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
A teacher	18	3	1	4	2.56	1.199	1.438
A key member of staff whose key responsibility is to support CYPs' mental health	18	3	1	4	3.17	.985	.971
A staff member who is not a teacher	18	3	1	4	2.94	1.110	1.232
Self-referral (this means referring yourself to support services)	18	3	1	4	3.39	.916	.840
Drop in services outside of school/college	18	3	1	4	3.22	.878	.771
A friend	18	3	1	4	2.94	1.110	1.232
A family member	18	3	1	4	3.11	.963	.928
Online	18	3	1	4	2.94	1.162	1.350
A doctors/GP surgery	18	3	1	4	3.17	.924	.853
A youth service	18	3	1	4	3.06	.998	.997
A leisure centre	18	3	1	4	2.78	1.060	1.124
A health centre	18	3	1	4	3.00	1.085	1.176
A community mental health service	18	3	1	4	3.11	1.023	1.046
A telephone contact line	18	3	1	4	2.94	1.110	1.232
A library	18	3	1	4	2.67	1.085	1.176
A mentor	18	3	1	4	3.06	1.056	1.114
Mobile phone and technology apps	18	3	1	4	2.83	.985	.971

Social services	18	3	1	4	2.67	1.029	1.059
Someone you do not know	18	3	1	4	2.44	1.338	1.791
Valid N (listwise)	18						

Where support is available

	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
At school/college	18	3	1	4	3.28	.958	.918
At home	18	3	1	4	3.22	.878	.771
At a drop in service outside of school/college	18	2	2	4	3.28	.895	.801
Over the phone	18	3	1	4	3.06	1.110	1.232
Online	18	3	1	4	3.17	1.098	1.206
At a doctors/GP surgery	18	3	1	4	3.22	1.060	1.124
At a youth service	18	3	1	4	2.83	1.098	1.206
At a leisure centre	18	3	1	4	2.67	1.188	1.412
At a health centre	18	3	1	4	2.89	1.231	1.516
At a dedicated mental health service	18	3	1	4	3.06	1.110	1.232
At a youth hostel	18	3	1	4	2.78	1.114	1.242
At a community centre	18	3	1	4	2.78	1.215	1.477
At a friends	18	3	1	4	2.72	1.018	1.036
At a hospital	18	3	1	4	3.17	1.043	1.088
At a spiritual place	18	3	1	4	2.61	1.335	1.781
At a charity	18	3	1	4	2.67	1.328	1.765
Somewhere safe	18	2	2	4	3.22	.732	.536
On social media	18	3	1	4	2.28	1.179	1.389
mobile phone or technology apps	18	3	1	4	2.94	1.056	1.114
Valid N (listwise)	18						

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