University of Southampton

Faculty of Environmental and Life Sciences

School of Psychology

Supporting young people's mental health in schools: an exploration of the factors influencing help-seeking, and of the efficacy of an internet-based Cognitive Behavioural Therapy (iCBT) programme for reducing anxiety.

by

Fiona Lauren Marsh

Thesis for the degree of Doctorate of Educational Psychology

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Abstract

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Supporting young people's mental health in schools: an exploration of the factors influencing help-seeking, and of the efficacy of an internet-based Cognitive Behavioural Therapy (iCBT) programme for reducing anxiety.

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Literature review: The mental health of children and young people has become an increasing concern, both in the UK and globally (WHO, 2018). However, many young people around the world are not accessing the professional support they require (Rickwood & Thomas, 2012). Recently, there has been increased pressure on schools to provide effective mental health provision and support for their pupils; however, problems with service underutilisation continue to exist in this context. A systematic review of the international literature was conducted, with the aim of identifying key factors influencing young people's help-seeking for mental health concerns in schools. The findings highlight a number of barriers and facilitators at the pupil, provision, and environmental/societal level. Prominent barriers included stigma, poor mental health literacy, lack of confidence in providers, a preference for self-reliance, and logistical issues. In contrast, good pupil-staff relationships, Rogerian staff qualities, appropriate referral routes, and pupil autonomy could facilitate help-seeking. Symptom severity and confidentiality acted as a barrier or facilitator depending on the mental health problem, the pupils' context, or school's

implementation of confidentiality procedures. These studies highlight the global importance of schools for challenging stigma, raising awareness of mental health, and adopting whole-school approaches to effectively support and enhance their pupils' wellbeing.

Empirical paper: Anxiety has been identified as one of the most common youth mental health problems worldwide (Polanczyk et al., 2015). Despite this, many young people in the UK are not accessing the professional support they need (NHS, 2018). Internet-based Cognitive Behavioural Therapy (iCBT) has received growing interest for supporting anxious youth, with emerging evidence of its effectiveness for young people aged 7-18 (Grist et al., 2018). The following study aimed to explore the effectiveness of a school-based iCBT programme for reducing anxiety, as well as possible secondary benefits associated with the programme, such as enhanced self-efficacy and school attendance. In total, 54 pupils (aged 11- 14) from eight mainstream secondary schools were allocated to the waitlist control or intervention group, before completing questionnaires at pre-intervention (T1), post-intervention (T2) and follow-up (T3); their parents and 'Key Staff Members' (KSM) also completed corresponding anxiety and attendance questionnaires. Mixed model ANOVAs revealed no significant between-group differences on anxiety, self-efficacy or attendance. However, both groups showed significant decreases in overall, generalised, and panic anxiety (KSM- and parent- reported) between T1 and 2. Only KSM-reported differences in generalised anxiety were sustained at T3. Implications for educational psychology and avenues for future research are discussed.

Table of contents

Table of Tables

Table of Figures

Research Thesis: Declaration of Authorship

Print name:	Fiona Marsh
Title of thesis:	Supporting young people's mental health in schools: an exploration of the factors influencing help-seeking and of the efficacy of an internet-based Cognitive Behavioural Therapy (iCBT) programme for reducing anxiety.

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:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission.

Signature: Date:

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Finally, I want to thank my family, partner, and friends for all their love and support throughout these past three years. I could not have done it without their kindness, humour, and endless supply of coffee. This thesis is dedicated to them, although they are certainly not obliged to read it.

Definitions and Abbreviations

Term or abbreviation	Definition
CAMHS	Children and Adolescent Mental Health Service
DfE	Department for Education
DfH	Department for Health
LGBT	Lesbian, Gay, Bisexual, & Transgender
NHS	National Health Service
Ofsted	The 'Office for Standards in Education' is a non-ministerial department of the UK government, which is responsible for inspecting a range of educational provisions.
SBMHS	School-based Mental Health Service(s)
SES	Socio-economic Status
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

Chapter 1 What are the factors influencing children and young people's help-seeking for mental health concerns in schools?

1.1 Background and aims

The mental health of children and young people has become an increasing concern, both in the UK and globally (World Health Organisation [WHO], 2018; Department for Education [DfE], 2019). In a recent report, the UK's National Health Service (NHS, 2018) indicated that 12.8% of 5-19 year olds have at least one mental health disorder; this has increased by 1.6% since 2017. In particular, the number of emotional problems is reported to have risen for both genders, especially between adolescence and young adulthood (DfE, 2019; NHS, 2018). On a global scale, the prevalence of youth mental health disorders is considered to be around 13% (Polanczyk, Salum, Sugaya, Caye & Rohde, 2015), which has led several countries to take action to improve mental health for young people (e.g. The UK Department for Education's Green Paper on Transforming children and young people's mental health provision, 2017; WHO's Mental Health Action Plan, 2013-2020; USA's 21st Century Cures Act, 2016).

Currently, there is a lack of consensus about the definition of mental health, due to the different values and beliefs that operate across cultures, systems and practices. A popular definition amongst professionals and the public is as follows (Manwell et al., 2015):

> "Mental health is the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections and personal dignity." (p.3)

This definition highlights the multifaceted nature of mental health in how it influences our emotions, cognitive processes, and how we behave across different aspects of life. Indeed, research indicates that poor mental health in youth can have far-reaching effects such as lower wellbeing and academic attainment, greater negativity within their interpersonal relationships, and reduced school inclusion, engagement and overall quality of life (e.g. Deighton et al., 2017; de Lijster et al., 2018; Ford et al., 2017; Sharpe et al., 2016). However, despite the importance of improving their mental health, research indicates that many young people around the world are not accessing the professional support they require (see Rickwood & Thomas, 2012). For example, in the UK 24% of young people with a mental health difficulty reported having no contact with formal or informal support about their concerns (NHS, 2017). Given how rarely young people access available support, it is vital to understand the factors that support or inhibit their efforts to seek help.

1.1.1 Definition of help-seeking

In the context of mental health, help-seeking can be defined as: "an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern*"* (Rickwood & Thomas, 2012, p.180). Within the literature, there are two main forms of help-seeking: formal and informal. Formal help-seeking typically involves a young person seeking support from a professional with a qualification and recognised role in the area (e.g. health, social or educational professionals), whereas informal help-seeking involves gaining support from those within their social network (e.g. family and friends). Rickwood, Deane, Wilson and Ciarrochi (2005) suggest that help-seeking is primarily a social transaction involving four key stages: awareness, expression, availability, and

willingness (see Figure 1). In order to seek help the person must firstly be aware of their symptoms and recognise them as a problem requiring support; they then need to be able to express these problems in a way which another person will understand, and have a help source available to receive their message and offer support in return; lastly, the person needs to be willing and able to disclose this information to their help source.

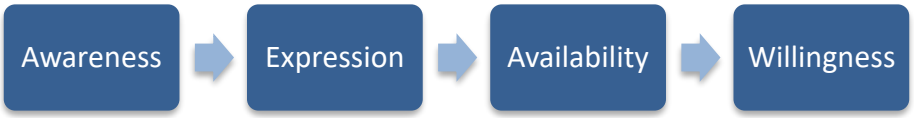


Figure 1. Rickwood et al.'s (2005) framework of help-seeking.

Cornally and McCarthy's (2011) framework of help-seeking offers a similar perspective (see Figure 2). They suggest help-seeking involves three defining attributes: problem-focused (the person is seeking help for a specific problem), intentional action (they are actively pursuing help), and interpersonal interaction (the person has to disclose their problem to a helper in exchange for support). The authors argue that certain conditions (antecedents) are required for help-seeking to occur, such as problem recognition or selecting a source of help, which can be influenced by a range of factors (e.g. demographics, values or fears). Their 'empirical referents' refer to the type and amount of help-seeking and type of source selected (e.g. formal or informal). There will also be a consequence to the help-seeking, in which the problem will either be resolved or remain unresolved; this may then reduce or increase further attitudes and intentions to seek help.

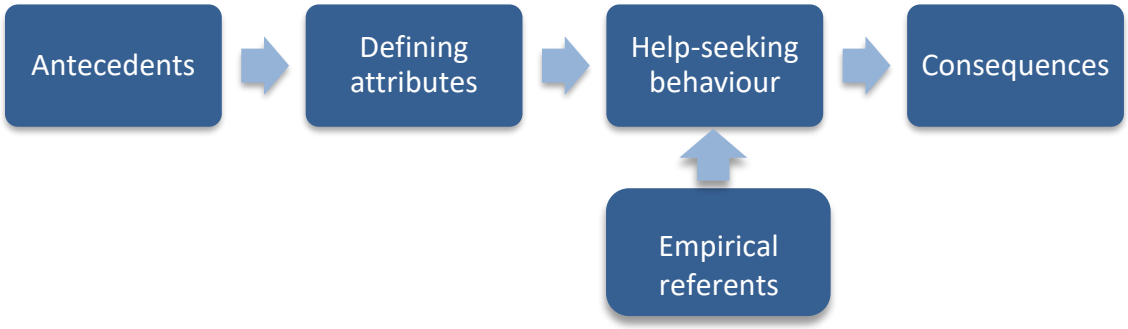


Figure 2. Cornally and McCarthy's (2011) framework of help-seeking.

Cornally and McCarthy (2011) draw on the work of Rickwood et al. (2005), which allows these two frameworks to complement, rather than conflict each other. An example of how the frameworks can be merged together is shown in Figure 3. Both frameworks highlight that each stage of the help-seeking process can be influenced by a range of different factors. Consequently, it is important to investigate factors that prevent or hinder the help-seeking process (barriers), as well as factors that can make each stage easier (facilitators).

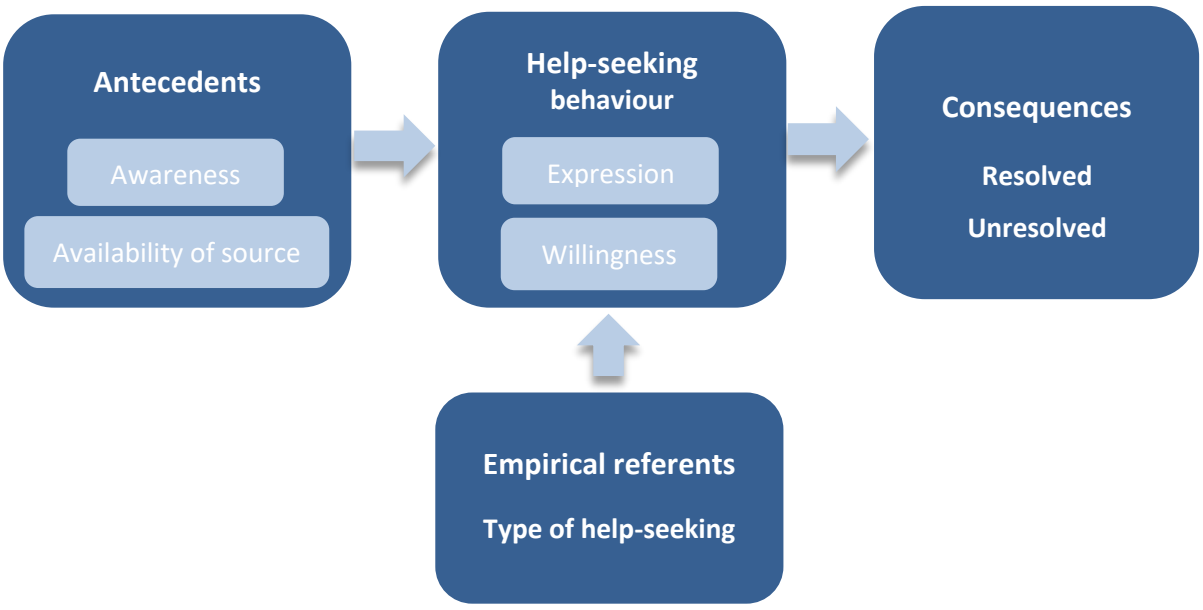


Figure 3. An example of how Cornally and McCarthy's (2011; in dark blue) and Rickwood et al.'s (2005; in light blue) frameworks can be merged.

1.1.2 Youth help-seeking for mental health

Over the past decade there has been a surge of interest in the area of youth help-seeking for mental health, especially the facilitators and barriers influencing this process. Several researchers have attempted to collate these findings using systematic reviews (e.g.

Gulliver, Griffiths & Christensen, 2010; Brown, Rice, Rickwood & Parker, 2016; Haavik, Joa, Hatloy, Stain & Langeveld, 2019; Pretorius, Chambers & Coyle, 2019).

Gulliver et al. (2010) carried out the first review to utilise both qualitative and quantitative data to explore the perceived barriers and facilitators to help-seeking for youth (aged 11-21). Drawing from 22 studies, they found that prominent barriers included: stigma, a lack of confidentiality, poor symptom recognition and accessibility (e.g. time and cost), a preference for self-reliance, and limited awareness of mental health services. The authors also found that concerns about provider characteristics and fear/stress about the act of help-seeking itself could hinder this process. 'Positive past experiences of help-seeking' was the only prominent facilitator identified, due to a lack of research in this area. Facilitators that featured less prominently included: social support, positive relationships, confidentiality, awareness of mental health, and good emotional competence, alongside perceiving a problem as serious, and positive help-seeking attitudes.

The threat of stigma and perceived lack of confidentiality feature as two of the most prominent barriers to youth help-seeking (Gulliver et al., 2010). These barriers are not isolated concerns, because they exist across age groups, cultures, socio-economic status (SES), gender and geographic location (Brown et al., 2016; Haavik et al., 2019; Planey, Smith, Moore & Walker, 2019). Even when young people are offered online, anonymous support, they continue to show fear about others finding out (Pretorius et al., 2019). Although these fears can act as a considerable barrier to seeking support, confidence in a help source's ability to maintain confidentiality also facilitated help-seeking. Additionally, there are other facilitators which may help to reduce stigma, such as the young person having good social support and positive relationships with their help source (e.g. Rickwood, Deane and Wilson, 2007; Talebi, 2014; Zhao et al., 2015).

Several of the 'service-level' barriers highlighted in Gulliver et al.'s (2010) study (e.g. accessibility and availability) have also been found in other reviews. For example, Anderson et al. (2017) carried out a review of 47 studies to explore the factors affecting young people's access to the UK's Child and Adolescent Mental Health Service (CAMHS). Similarly, the authors found that a lack of information about services, availability, cost, and concerns about the provider's attitudes, acted as barriers to access. A lack of awareness about services was also found to be a common barrier amongst several vulnerable youth, such as homeless, rural, and Lesbian, Gay, Bisexual and Transgender (LGBT) groups (Brown et al., 2016). Whereas providing easily accessible services, support for referrals, and information about these services was seen to facilitate help-seeking (Anderson et al., 2017; Brown et al., 2016).

Within these reviews, a number of 'youth-specific' barriers and facilitators have also been identified. For example, in Gulliver et al's (2010) review, the young people spoke about being unaware of the level of distress that was 'normal', and preferred to rely on themselves rather than seek external help. Poor mental health literacy and preference for self-reliance have also been identified as key barriers in other reviews (e.g. Rickwood et al., 2007; Planey et al., 2019; Pretorius et al., 2019). In contrast, key facilitators included being able to recognise mental health problems, show positive help-seeking attitudes and emotional competence (Gulliver et al., 2010; Brown et al., 2016). Brown et al. (2016) also identified that motivation to seek support, increased symptom severity and confidence in providers improved youth access to services.

It is not possible within the scope of this review to discuss all of the barriers and facilitators related to youth mental health help-seeking. However, the reviews outlined above highlight how help-seeking can be influenced at different levels (e.g. at the service and child level) and uncover several key barriers and facilitators, which appear to be

common across age, culture, SES and vulnerable groups of young people. These reviews also acknowledge limitations within the literature, such as a lack of focus on facilitators, poor sampling methods (e.g. use of convenience samples), reliance on self-report measures and an under-representation of youth from ethnic minority groups. Most of the reviews to date have only focused on help-seeking from mental health services or in general. However, given the growing importance of addressing mental health in schools, it is also important to identify specific barriers and facilitators to youth help-seeking that may exist in an educational context.

1.1.3 Youth help-seeking for mental health in the school context

In the last decade, there has been increased pressure on UK schools to provide effective mental health provision and support for their pupils, alongside their academic curriculum (e.g. 'Mental Health and Behaviour in Schools', DfE, 2018; Children and Families Act, DfE, 2014). For example, in a recent Green paper (DfE, 2017, p.3) the health and education secretaries stated, "we want to put schools and colleges at the heart of our efforts to intervene early..." and outlined how schools could be used to enable joined-up care. The new Ofsted framework (2019) now includes a 'personal development' section, which encourages schools to promote pupils' confidence, independence and mental health. However, perhaps the most vital information left out from these reports is the voice of young people with regards to how they feel about having integrated mental health care in their schools, and how they would want this to be provided.

As a result, several studies have investigated the help-seeking of young people, specifically from school-based adults or provisions (e.g. Doyle, Treacy and Sheridan, 2015, 2017; Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003; Wang, Barlis, Do, Chen & Alami, 2019). These studies include the voices of pupils from a range of social and

cultural backgrounds and explore youth help-seeking from different provisions (e.g. school-based services or adults) and for a range of mental health difficulties. The majority of studies indicate that mental health provision and support continues to be underutilised in the educational context (e.g. Pisani et al., 2012; Doyle et al., 2015, 2017; Fox & Butler, 2007; Conlon, Power, Cleary, Guerin, & Fitzpatrick, 2010). For example, only 6-15% of pupils who had self-harmed reported seeking help from a 'professional', including school-based adults (Pisani et al., 2012; Doyle et al., 2015, 2017; Fortune, Sinclair & Hawton, 2008). Many young people also report that they dislike or would be less likely to seek help from a school-based adult for mental health concerns (e.g. Doyle et al., 2015, 2017; Timlin-Scalera et al., 2003). Yet for some young people, the staff in school may be their first or only option for support. Given how underutilised these sources of support are, it is important to understand the barriers preventing young people from accessing them.

Several of the studies above have investigated the factors influencing young people's help-seeking in schools and revealed a range of barriers at the pupil, societal, and service level. Some of the key barriers have included: lack of confidentiality, stigma, a lack of support source, misconceptions about support, negative beliefs about staff, and poor mental health literacy (e.g. Timlin-Scalera et al., 2003; Arora & Algios, 2019; Arora & Persaud, 2019; Doyle et al., 2015; Ijadi-Maghsoodi et al., 2018). However, it is important to note that some of the young people in these studies did feel able to seek help from school-based adults and found this support helpful (e.g. Ijadi-Maghsoodi et al., 2018; Kendal, Keeley & Callery, 2011; Wang et al., 2019). These pupils discussed several factors which had enabled them to seek help, such as positive staff-student relationships, assured confidentiality, certain staff qualities (e.g. friendliness and trustworthiness), and appropriate detection of mental health issues.

Evidently there is growing interest and research in youth help-seeking for mental health in schools. However, there is a need for a comprehensive review, which can bring this research together, and systematically draw out the key barriers and facilitators to youth help-seeking, whilst also identifying any significant limitations or gaps within the literature. Previous reviews have primarily focused on youth help-seeking in healthcare or community contexts; however, this review will focus specifically on help-seeking in the school context. Such investigations are vital for helping schools to provide effective mental health provision and support, which not only removes key barriers, but also empowers their pupils to seek the support they need.

1.1.4 Aims of review

This review explored the barriers and facilitators to children and young people seeking help for mental health concerns in school, to inform best practice for mental health support and provision in this context. These aims are important, because the evidence suggests that school-based help sources continue to be underutilised, despite their availability and potential to improve mental health. Gaining young people's views should be a priority, because they can provide direct insight as to why they feel reluctant or unable to seek help from school-based sources.

To meet these aims, the following questions were explored:

1) What are the barriers to young people seeking help from school-based sources and provision?
2) What are the facilitators that enable young people to seek help from school-based sources and provision?

1.2 Method

1.2.1 Search strategy

The current review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009). Five databases were used including: PsychInfo, Medline, CINHAL (via EBSCO), Web of Science (WoS), and Education Resources Information Centre (ERIC). These databases were selected due to their inclusion of research related to education, mental health and psychology for young people. Initial search terms were developed based on the research question. A scoping search was then used to clarify and extend search terms, as well as identify relevant synonyms and culturally specific terms (e.g. 'pastoral' in the UK; Appendix A and B). In order to obtain more focused results, search strategies were utilised (e.g. Boolean operators and truncation). Key search terms included: 'child*', 'young people', 'mental health', 'school*', 'help-seek*' and 'factor*'. Searches conducted between May and September 2019 identified a total of 339 papers (ERIC = 38, CINHAL, Medline & PsychInfo = 129 and WoS = 172).

1.2.2 Identification of additional records

Difficulties locating and obtaining unpublished work and gray literature can lead many high-quality literature reviews to be affected by publication bias (Ferguson & Brannick, 2012). Consequently, efforts have been made to reduce such bias in this review. Several of the main authors in this field (e.g. Kendal, S. & Doyle, L., Glasheen, K.) were contacted via email, to enquire about unpublished work and current projects. Two out of the three authors responded; however, this research did not meet the inclusion criteria. To identify relevant gray literature, 'OpenGrey' and 'Worldcat' databases were searched,

which led to the inclusion of five papers. Further detail of these processes can be found in Appendix C.

1.2.3 Inclusion and Exclusion criteria

After removing duplicates, 260 papers were screened for their relevance to the research question, using the inclusion and exclusion criteria (See Table 1 below). The criteria focused on the help-seeking behaviours, intentions, or experiences of school-going young people (< 18 years) for mental health concerns, specifically in the school environment.

Table 1

Inclusion and Exclusion criteria.

Inclusion criteria	Exclusion criteria
Children and young people ≤ 18 years	Young people/adults over the age of 18.
Help-seeking for any mental health or emotional needs e.g. anxiety, depression, obsessive-compulsive disorder (OCD).	Help seeking in schools not directly for mental health (e.g. bullying, academic, social support)
Help-seeking from school-based adults or mental health provisions in schools (SBMHS).	Help seeking not directly related to school context e.g. clinic/medical/hospital based
Children and young people's help seeking behaviour/intention/experiences for mental health concerns.	Help seeking intentions/views/behaviours of families/parents/professionals outside of the school context.
Qualitative and quantitative study designs	Intervention/prevention studies
Journals/articles published during and after 2010.	Journals/articles published before 2010.
Journals/articles that have been peer reviewed.	Journals/articles that have not been peer reviewed.

To capture young people's views across a broad range of participant demographics, school environments, and countries, both qualitative and quantitative studies were included. Additionally, this review only included papers published after 2010, due to evidence of greater focus being paid to improving mental health in schools during and after this time, both in the UK and globally (e.g. 'No Health Without Mental Health', UK Department for Health [DfH], 2011; 'Mental Health in Schools Act' in the US, 2009-10).

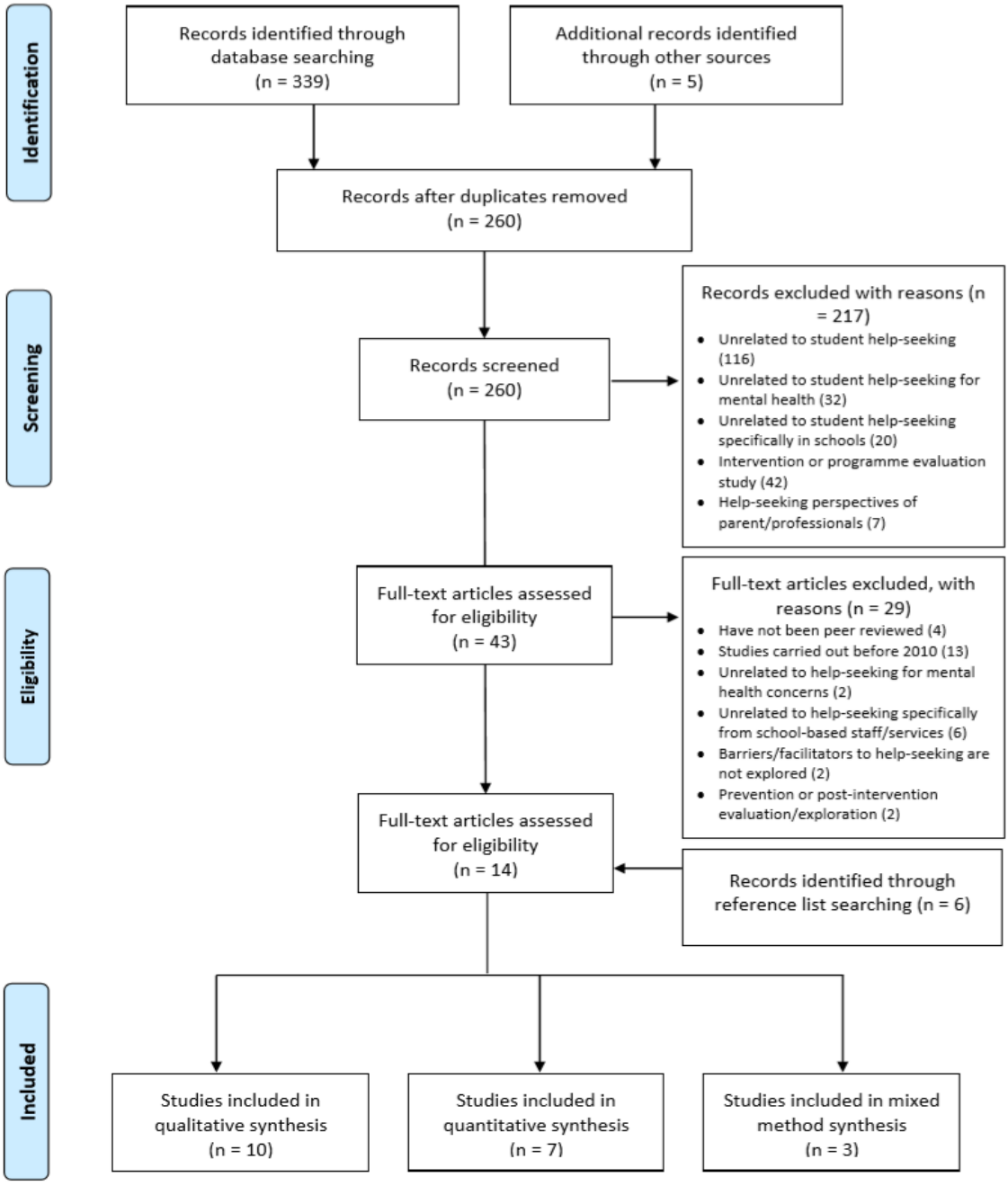


Figure 4. PRISMA flowchart demonstrating the systematic process.

It was also considered that societal and school values can change considerably over time (e.g. See 'Attitudes to Mental Illness 2014 Research Report'; Time to Change, 2015) and subsequently, recent articles will provide a more accurate indication of current barriers and facilitators to youth help-seeking.

Of the screened papers, 217 did not meet the inclusion criteria leaving a total of 43 papers. Reference list searching led to six additional papers being identified, which were included in the full-text articles screening for eligibility (n = 49). By using the exclusion and inclusion criteria, 20 articles were selected for this review (see Figure 4 above).

1.2.4 Data extraction

To assess the quality of the articles in this review, two measures were used (see Appendix E). The ten qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP, 2018) qualitative checklist. The CASP is designed to be used as an educational pedagogic tool, rather than a scoring system, which allows the researcher to make a 'yes', 'no', or 'can't tell' response to questions, along with additional comments. For the seven quantitative articles, the Appraisal Tool for Cross-Sectional Studies (AXIS; Downes, Brennan, Williams, & Deane, 2016) was used. This tool includes 20 questions, which enable the researcher to assess the key areas and issues often seen in cross-sectional studies, using 'yes', 'no', or 'I don't know' responses and space for short comments. Finally, for the three mixed method studies, both the AXIS and CASP were used to assess the quantitative and qualitative sections respectively. These tools were not used to determine the inclusion of papers in this review, because they are not considered to be a reliable indicator of validity, and there is a lack of consensus regarding what constitutes as 'quality' (Siddaway, Wood & Hedges, 2019). However, these tools were used to highlight some of the methodological strengths and weaknesses of the studies, which were taken into account when drawing conclusions from their findings.

1.3 Systematic review results

1.3.1 Study characteristics

A total of 20 articles were included in this review. For clarity, a numerical system is used to reference studies in the following sections (see 'Data extraction Table' in Appendix F for relevant identification numbers). These studies provide a unique opportunity to explore help-seeking across cultures, due to being implemented globally in the USA [1, 2, 3, 7, 11, 12, 15, 16, 17, 18], UK [13, 14], Australia [9, 10], Ireland [8], Turkey [20], South America [3], Israel [6], Malaysia [5] and Japan [19]. The way in which mental health provision is offered varies across countries. Within the USA and Malaysia, pupils can gain support from 'School-Based Mental Health Services' (SBMHS), which are run by community health organisations based in schools. In other countries, support is provided by professionals integrated within the school staffing (e.g. school counsellors or pastoral officers).

All of the studies are carried out in secondary educational provisions, with only one study [16] including primary-aged children (5-11 years). Ten of the studies are qualitative [2, 3, 4, 5, 7, 10, 11, 12, 13, 14], utilising either interviews, focus groups or short questionnaire responses to obtain their data. The remaining studies are quantitative (seven studies: [6, 9, 15, 16, 17, 19, 20]) or mixed method (three studies: [1, 8, 18]), and follow a cross-sectional design or draw on data from randomised controlled trials, using self-report questionnaires. Sample sizes varied considerably, with qualitative studies ranging from 6 – 277 participants, and quantitative from 55 – 18,104 participants.

The majority of studies included both male and female participants (n = 17), whilst one focused exclusively on male students [4] and two did not report this demographic [11; 19]. Six studies [1, 2, 4, 7, 12, 18] chose to explore the help-seeking of 'ethnic minority' pupils (e.g.

Asian, Latinx, African), whilst two studies [9, 10] looked specifically at pupils' help-seeking from online counselling services. Although the majority of studies (n = 14) looked at help-seeking for general mental health needs, six studies focused on a specific need, including: anxiety [16], suicide [3, 17], depression [15] and self-harm [8, 19].

1.3.2 Study quality

For the ten quantitative studies (including mixed method), the AXIS checklist indicated that nearly all of researchers [1, 6, 8, 9, 15, 16, 18, 19, 20] had clearly defined their aims, and used an appropriate study design and target population. The majority of researchers had a representative sample frame and showed clear methods to determine statistical significance (typically p-values). All of the researchers reported internally consistent results, and attempted to discuss the limitations of their study and draw reasonable conclusions. However, only one study provided a sample size justification [6] and only three studies [17, 19, 20] acknowledged the potential impact of 'non-responders' in their sample. Some of the studies [e.g. 8, 9, 19] also showed incomplete reporting, for example, of statistical measures and reliability of instruments.

Utilisation of the CASP for the 13 qualitative studies (including mixed method) revealed that all of the studies showed clear aims, appropriate methodology and research design. Ethical issues were considered by all of the researchers, and the majority of papers showed a thorough analysis with more than one researcher, and results sections that were inclusive of pupil quotes. However, it should be noted that only three studies included researcher reflexivity [5, 13, 14] and none discussed data saturation. Several of the studies also utilised convenience sampling [2, 3, 10, 18], which can lead to selection bias. Generally, there were good discussions of how the findings contributed to or extended the current literature.

Although further emphasis on how such findings may influence practice or policy, and transfer to other populations, would have been beneficial.

1.3.3 Synthesis of study results

Thematic synthesis of the reviewed articles revealed three overarching themes involved in young people's help-seeking in schools, including: pupil-, environmental/social-, and mental health provision- specific. Within each of these themes, key barriers and facilitators to young people's help-seeking have been identified, which will be reviewed separately in the following sections (see Table 2 for overarching themes and subthemes). Qualitative and quantitative data are synthesised together in this review, to provide a broader and comprehensive picture of the current research on help-seeking in schools.

Table 2

Overarching themes, with their associated barriers and facilitators.

	Overarching theme		
	Mental health provision	Environment/social	Pupil
Barriers	• Awareness of mental health services or provision • Misconceptions about services • Logistical (e.g. time, referral pathways) • Lack of confidence or negative beliefs about provider • Confidentiality	• Stigma / negative responses from others	• Gender • Symptom severity • Mental health literacy • Lack of problem recognition • Preference for self-reliance

Facilitators	• School staff qualities and relationships • Confidentiality and privacy • Access to a SBMHS • Access to online counselling • Appropriate detection and referral routes	• Community and family issues • Religion	• Symptom severity • Autonomy • Greater coping resources

1.3.4 Barriers to pupils' help-seeking for mental health concerns

1.3.4.1 Mental health provision- specific barriers

Across 12 studies (two mixed [1, 18]; two quantitative [9, 16]; eight qualitative [2, 3, 5, 7, 10, 11, 12, 13, 18]), young people raised several barriers to accessing their school's mental health provision, including: a lack of awareness and misconceptions about providers, logistical issues, negative beliefs about providers, and concerns over confidentiality.

Lack of awareness. In two mixed method [(1, 18)] and four qualitative studies [(2, 3, 11, 12)], pupils raised a lack of awareness about their school's mental health provision as a key barrier to help-seeking, including what the school offered, who the providers were, and how/where support could be accessed. This limited awareness was related to poor or inconsistent information sharing by schools, or misconceptions about the service itself across five of the above studies [(1, 2, 3, 11, 18)]. No positive findings for this barrier were identified. The majority of pupils who voiced these concerns had access to a SBMHS and/or identified as being from an ethnic minority background (e.g. Latinx, Asian, Indian), which could indicate that a lack of awareness is a particularly significant barrier for these youth groups. However, issues with representation can be found in several of these studies due to their utilisation of purposive or convenience sampling [(2, 3, 18)]. Although these types of sampling are less problematic for qualitative studies, which do not aim to generalise

findings (Eitkan, Musa & Alkassim, 2016), only one qualitative study [5] provided a reflexive account of possible bias their role or epistemology had on their research design or data analysis. Consequently, it is not possible to conclude that ethnic minority students have less awareness of mental health provision than their peers. Nevertheless, a lack of awareness can still be regarded as an important barrier to pupils accessing support, especially from SBMHS.

Misconceptions. In three studies (one mixed method [1], two qualitative [2, 3]) misconceptions about the purpose of SBMHS was raised by pupils, all with negative findings for service utilisation. In the mixed methods study [1] Chinese American students reported feeling less welcome or comfortable accessing their SBMHS, due to perceiving the service as being for a certain type of person with whom they did not identify (e.g. 'troublemakers' or those of a different race). These views were echoed in one of the qualitative studies [2] where interviews with 33 Asian American pupils (aged 14-20) revealed that students perceived the SBMHS as only being for those with very serious mental health problems (such as suicide) or academic concerns. The second qualitative study [3] indicated that a community's mistrust and negative views of mental health provision could also influence Guyanese pupils' perceptions and awareness of services. Overall, these studies indicate that the way in which SBMHS are promoted and perceived is particularly important for access, especially for Chinese, Asian American and South American communities.

Logistical issues. Pupils from a range of ethnic backgrounds (e.g. Caucasian, Asian and Latinx) discussed several key logistical issues, which all negatively affected their access to mental health support, such as a lack of time, understaffing, missing classwork, and difficulties booking appointments (four studies: two qualitative [5, 7], one quantitative [16], one mixed method [18]). Researchers in one qualitative study [7] also highlighted key issues

with referral pathways; they carried out a secondary analysis of interviews with 18 students (aged 12-18) from Latinx or African American backgrounds, with a history of truancy and mental health problems. 17 out of 18 pupils reported having contact with an adult relating to their needs but felt this primarily focused on attendance or discipline. Only nine pupils accessed a SBMHS, which was influenced by their willingness to engage, staff making timely referrals, and their staff-pupil relationships. Although this study is contextually specific there are key messages applicable to all services, such as having clear referral routes, avoiding focus on external behaviours, and building on key relationships. Providing adequate time and staffing to meet pupils' needs also appeared to be fundamental across these studies.

Lack of confidence / negative beliefs about support sources. Across eight studies (two mixed [8, 18], six qualitative [2, 3, 5, 7, 12, 13]) a lack of confidence or negative beliefs about mental health support sources (e.g. teacher, counsellor) or SBMHS acted as a barrier to utilisation. These studies identified negative findings for help-seeking from school counsellors and peers [3, 5, 7, 12, 13, 18], but mixed views with regards to their teachers [7, 8, 12, 18].

Students from primarily ethnic minority backgrounds (including Indian, Asian and Latinx) felt their school's service would be a 'waste of time' or voiced concerns about their school counsellors' competency, such as their professional status or ability to keep information confidential, or to listen to their pupils' problems [3, 5, 7, 18]. Several of these pupils also feared that they might not be welcomed or that their counsellor may not understand their background or the school context and only want to focus on academic issues [7, 12, 18]. Additionally, distrust over the use of peer mentoring systems was highlighted in two qualitative studies [12, 13]; pupils from Latino, White/Caucasian and

Asian backgrounds raised concerns regarding confidentiality, friends 'sugar-coating' the situation, inappropriate advice giving, or inconsistency of support.

Pupils also gave mixed views with regards to teachers being a source of help-seeking [7, 8, 12, 18]. In one Irish qualitative study [8], some of the young people expressed discomfort about the dual role of school counsellor / teacher in their school and wanted counselling to remain separate from their academic work. Pupils from Irish, Latinx and African American ethnicities also expressed concern that a poor teacher-student relationship could affect the teacher's level of empathy and support, as well as their own willingness to talk about their personal issues [7, 8]. Other barriers included concerns over confidentiality, being judged, or not believed by their teacher [7, 8, 18]. However, in one qualitative study [12] young people from predominately Latinx and Asian backgrounds identified their teacher as a primary source of help-seeking, before their friends or family.

Overall, these studies indicate that regardless of the young person's ethnicity or type of mental health support, their level of confidence, trust, and belief in their support source is crucial when they seek help.

Confidentiality. A significant barrier and facilitator to help-seeking was young people's concerns over confidentiality, with negative findings across nine studies (two quantitative [9, 16], one mixed method[18], six qualitative [2, 7, 10, 12, 13, 14]) and positive findings in six studies (see Facilitator section 1.3.4.1). Pupils expressed fear that their source of support may disclose their problems without consent and explained that a lack of clarity about what would be kept confidential, and when parents would need to be involved, reduced their help-seeking. These concerns were highlighted across age groups, cultures, and provision types. For example, in one qualitative study [10] exploring online provision 22 students (aged 13-18) continued to express fears about their account being hacked or

online transcripts being shown to others. Young people from a range of ethnic backgrounds (e.g. Caucasian, Latinx, Black) repeatedly brought up confidentiality concerns [e.g. 12, 14, 18] and expressed an additional fear about their communities spreading rumours about them [18]. Another quantitative study [16] revealed that children as young as six can worry about peers finding out about their needs; although it is unclear whether this is as significant for younger children, because the proportion of pupils represented in each age group was not specified.

In six of these studies pupils explicitly discussed how their confidentiality fears stemmed from perceived negative responses from their peers, school staff, family or communities (e.g. bullying or being treated unfairly). The impact of these negative responses on help-seeking are discussed further in the following section.

1.3.4.2 Environmental/social- specific barriers

Stigma & negative responses from others. Across all nine studies (one quantitative[16], two mixed method [8, 18], six qualitative [2, 3, 5, 11, 12, 14]) pupils discussed how aspects of their environment (both at home and school) and social factors could negatively impact on their help-seeking; in particular, pupils raised concerns about the negative responses or stigma from others if they sought help in school. Several pupils highlighted negative stereotypes that continue to persist in the school environment, such as being viewed as 'insane', 'crazy', or 'not being able to handle their own problems' [11, 12, 18]. Fears of being judged, mocked, or shamed by others led to reluctance and discomfort in finding support, which occurred repeatedly across cultures and age groups [e.g. 3, 5, 16, 18].

Pupils also expressed concern about the negative responses from others if they sought help, such as being teased/bullied by peers or isolated from their friendship groups [11, 16, 18]. This was particularly evident in one qualitative study [14] where students (aged 11-

16) explained how it would be easier and safer to have a 'tough image' in school, rather than seeking help from the pastoral staff and having to 'survive' emotional exposure. Pupils from ethnic minority backgrounds (including Latinx, Asian and South American) also raised additional worries about other people's responses, such as being ostracised or viewed as 'weak' or 'weird' by their communities, teachers treating them differently and lowering their grades, or parents being judgmental and using physical discipline [2, 3, 18].

These studies are carried out in specific contexts and have some methodological issues, such as the use of convenience sampling, lack of reflexivity, and limited information regarding 'non-responders', which means that subgroups of pupils may not be fully represented. Additionally, none of the researchers have attempted to define help-seeking or the processes involved, leading to variations in how it has been perceived and researched. Yet there appears to be a re-occurring message from pupils across cultures, that a fear or stigma or negative responses can act as a crucial barrier to help seeking from a range of school-based sources and provisions.

1.3.4.3 Pupil-specific barriers

Students raised several barriers which could be considered as more person-specific rather than a result of external influences; these barriers included: gender, symptom severity, mental health literacy, preference for self-reliance, and lack of problem recognition.

Gender. This review highlights mixed findings with regards to gender and help-seeking. In one quantitative study [20], which explored the help-seeking attitudes of 342 Turkish students (aged 14-18), female pupils held significantly more positive attitudes (e.g. openness and confidence towards mental health professionals) compared to their male peers. The male students showed greater positivity for seeking help from a female

counsellor for academic rather than personal-emotional concerns, which suggests they may feel less able to seek help for these types of problems in school. Yet, in other mixed method studies [e.g. 1, 4, 9], male pupils from a range of cultures (e.g. Australian, Latinx, African American, Asian) have indicated they would seek help from SBMHS or use online counselling for such problems. This indicates that a pupils' culture may also interact with gender to influence help-seeking.

It is difficult to draw conclusions from the above studies because they do not explore a common aspect of help-seeking, such as the type of provision or assistance required. These studies also investigate help-seeking attitudes or intentions, which do not always translate into actual behaviour. Indeed, in other quantitative studies gender was not found to be significantly associated with help-seeking behaviour for self-harm, suicide, or general SBMHS use [15, 17, 19]. Consequently, there is a lack of clarity around the factors that may influence or encourage help-seeking for males and females.

Symptom severity. Symptoms of poor mental health influenced help-seeking across five studies (one mixed method [18], four quantitative [9, 15, 16, 19]). Three of the studies identified negative findings [16, 18, 19], whilst two were positive [9, 15]. In the mixed method study[18] Asian and Latinx pupils suggested that the symptoms of poor mental health itself could prevent help-seeking (e.g. depression could lead to a lack of motivation or fear to seek help). This barrier was identified in two other quantitative studies using large sample sizes in Japan and the USA [16, 19]. For example, in one study [19] the researchers used self-report surveys to explore the help-seeking behaviours of 17,641 Japanese pupils (aged 12-18) who had self-harmed in the past year. They found that poor help-seeking was significantly associated with suicidal ideation, poor mental health, and physical illness within the past month.

However, these studies only used self-report measures, which can be subject to bias (e.g. social desirability) and do not provide an indication as to why or how symptom severity influences help-seeking. In other quantitative studies [9, 15], higher symptom severity has also been found to act as a facilitator to help-seeking. For example, students with higher levels of depression and stress, but not anxiety symptoms, were significantly more likely to use online counselling or access general SBMHS [9, 15].

Altogether, these studies indicate that the type of symptom may be important to help-seeking; anxiety, general poor health, and suicidal ideation could hinder help-seeking [16, 18, 19], whilst depression and stress severity may encourage the pupil to seek help [9, 15]. Although, these studies do not indicate the potential mechanisms involved in these processes.

Mental health literacy. In four studies (two mixed [11, 12], two qualitative [8, 18]), pupils from a range of backgrounds (e.g. Irish, Latinx, American) indicated that a lack of awareness about their own mental health could act as a barrier to help-seeking (with no positive findings). For example, students suggested they may not be able to recognise symptoms of poor mental health or distinguish this from normal stress [12, 18]. As a result, the young people suggested that they or their peers may stigmatise others and view people with mental health problems as 'crazy' or needing 'special education' [8, 11]. The need for greater mental health literacy for pupils, parents, schools, and communities was recommended by pupils across several studies [2, 3, 8, 12].

Lack of problem recognition. Another common barrier to help-seeking was a lack of problem recognition, with negative findings across all four studies (three mixed [1, 8, 18], one qualitative [5]). Pupils from mainly Asian or Latinx ethnicities spoke about 'not needing' the services or not feeling their problem was relevant or severe enough to access support;

these thoughts were linked to misconceptions about services, such as only being for young people with externalising behaviour problems [1]. A lack of problem recognition was also related to limited mental health awareness and stigma in two of the mixed method studies [8, 18]; pupils explained that mental health issues are often seen as a 'taboo' subject and not frequently spoken about in their communities, which can lead to stigma, and poor awareness and problem recognition. Consequently, raising mental health awareness and knowledge of services appears to be important for reducing stigma and improving both problem recognition and help-seeking.

Preference for self-reliance. Across three studies (one mixed [18], two qualitative [5, 12]) young people from predominantly Asian and Latinx ethnicities expressed a desire to handle mental health problems on their own, which negatively impacted their help-seeking from others. For example, in one qualitative study [5] 43.7% of 277 Chinese pupils (aged 13-18) felt they were responsible for and could solve their own problems, which has been linked to a sense of 'pride', 'toughness', or 'stubbornness' by other young people [12, 18]. However, pupils also spoke about wanting independence due to fears their parents would try to coerce them (e.g. to have therapy) or because they believed their problems would just get better on their own [12, 18]. This need for independence could be viewed as a form of avoidance or due to difficulties recognising mental health problems. Consequently, there seems to be a balance between providing students with enough independence and skills to tackle their own problems, but also being mindful of factors which may force pupils to feel that they have to appear 'tough' or self-reliant.

1.3.5 Facilitators to pupils' help-seeking for mental health concerns

1.3.5.1 Mental health provision- specific facilitators

Pupils highlighted several facilitators related to their mental health provision, including school staff qualities and relationships, confidentiality, access to a SBMHS or online counselling, and appropriate detection and referral routes.

School staff qualities and relationships. Across six studies (one mixed[1], five qualitative [3, 4, 7, 12, 13]) pupils from a range of backgrounds (e.g. British, Asian, African) spoke about the importance of relationships with school staff for encouraging help-seeking. Five of the studies identified positive findings or pupil recommendations [(1, 3, 4, 12, 13)], whilst one detailed the negative impact of poor relationships on help-seeking [(7)]. Several students felt their willingness to talk about problems or engage with services was (or would be) better if they had a positive relationship with staff members [(1, 4, 7, 12)]. Pupils also felt more comfortable seeking help from familiar staff with whom they had a personal connection, and who understood or shared their life experiences and/or background [(1, 7, 12)].

Young people suggested several staff qualities that could encourage their help-seeking, such as being genuine, caring, supportive, and trustworthy. In one qualitative study [(4)] male students commented that their counsellor's race did not matter as long as their difficulties felt validated and understood; these students also appreciated having accessible staff with whom they could chat to informally whenever they needed. This accessibility was highlighted in another qualitative study [(3)], where students recommended that staff show respect and use age-appropriate language with their pupils. The young people also wanted their staff to have relevant experience, actively listen to their concerns, and give helpful support on both a practical and emotional level [(3, 13)].

This review is not able to cover all of the qualities, skills and knowledge that young people would like their support staff to have. However, it is evident that a staff member's relationship with their pupil, and how they respond to requests for help, can be a very powerful facilitator or barrier to whether their pupil obtains appropriate support.

Confidentiality. Across six qualitative studies young people commented positively on the value of being able to access a confidential SBMHS or staff source [2, 4, 10, 11, 12, 14]; for example, they spoke about being able to seek help and open up about their difficulties, as well as keep issues private from others. The pupils' trust in their source's ability to maintain confidentiality also acted as a key barrier or facilitator to help-seeking [11, 12, 14]; several indicated they would only feel able to cope with the possibility of emotional exposure in school and seek help if they trusted the person offering support [12, 14].

Evidently, confidentiality is an important factor influencing pupils' willingness to use school-based mental health provisions, which was identified across cultures and age groups in this review. The pupils also made several recommendations as to how confidentiality could be maintained, such as by offering a private room, ensuring there are clear rules, and options to seek help anonymously [2, 8]. Confidentiality, and how it can be maintained in line with pupils' wishes and safeguarding legislation, should be a key consideration for all schools when providing mental health provision.

Access to a SBMHS. Across six studies (one mixed[1], five qualitative [2, 3, 4, 7, 12]) pupils from a range of ethnic minorities (e.g. Chinese, Asian American, African American, Latinx) raised positive [six: 1, 2, 3, 4, 7, 12] and negative views [four: 2, 3, 7, 12] about being able to access a SBMHS. In particular, pupils liked the convenience and ease of having a service based in school, rather than having to use outpatient providers [2, 4]. In one qualitative study [4] involving 22 African American and Latino males (aged 13-18), the students indicated

their SBMHS was a safe place in which they could feel heard and discuss sensitive problems; these male students also valued the opportunity to form trusting and familiar relationships with SBMHS clinicians/staff, which is a theme that is frequently voiced by pupils across cultures, ages and socio-economic backgrounds [1, 2, 7]. Students also valued being able to access support groups, informal support, and strategies to cope with their emotions from the SBMHS [1, 4, 7].

Confidentiality was an important factor influencing whether pupils saw their SBMHS has beneficial or unhelpful [2, 7, 4]. Pupils liked having a service they could access privately, without their parents, peers or communities knowing, as it allowed them to feel more confident in talking to a provider and opening up about sensitive issues [2, 4, 7]. Whilst students expressed mixed views about having a SBMHS where they did not trust their provider, felt they might be misunderstood or stigmatised, or identified logistical issues (e.g. timing) [2, 3, 12]. Consequently, it is evident that any SBMHS needs to be easily accessible, confidential, welcoming, and facilitating of positive relationships, to be effective.

Access to online counselling. Two Australian studies [9, 10]. explored students' views regarding online counselling in secondary school environments, with four positive and two negative findings. An initial qualitative study [10] using focus groups with 22 students (aged 13-18) found that pupils liked the accessibility of talking to their counsellor at home and school but highlighted possible issues with trust and privacy. A follow-up quantitative study revealed that the students also valued having confidentiality and anonymity, and felt able to use online counselling to discuss more sensitive or personal issues, such as sexuality, conflict at home, or worrying thoughts [9]. This type of counselling appeared to be most helpful for year 8 and 12 pupils, and those with higher psychological distress.

These two studies provide preliminary support for the use of online counselling in secondary schools, particularly for discussing more sensitive issues; however, they are carried out by the same researchers and only include Australian secondary-aged pupils, which limits how far it can be generalised to other youth populations. Consequently, it is not possible to draw conclusions about the potential of online counselling in schools from this review.

Appropriate detection and referral routes. Pupils in two studies (one mixed[1], one qualitative[7]) discussed how the detection of their mental health difficulties and referrals by school staff could facilitate [1, 7] or hinder [7] their help-seeking. For example, in the mixed method study[1], Chinese American students discussed how staff referrals enabled them to consider the benefits of accessing the service and overcome their discomfort in seeking help (especially for more stigmatising services). Other pupils (with a history of truancy and mental health problems) expressed a desire for their teachers to have a greater awareness of mental health problems, so that their issues would be 'believed', and appropriate referrals made [7]. Whilst some pupils recommended using peers/friends for detecting poor mental health, because their friends were often the best judges of their distress and could encourage them to seek help or build trust with providers [12, 13].

These studies highlight just how important appropriate detection and referral can be for gaining the right support for pupils, especially for those who are more vulnerable to slipping through the system. It is evident that the pupils would like their schools to develop better mental health awareness and clearer referral routes, which use reliable indicators of mental health and consult people who know them best (e.g. friends or teachers).

1.3.5.2 Environmental/social - specific facilitators

In terms of their environment, pupils across three studies (one quantitative[6], two qualitative [3, 4]) indicated that community and family issues, as well as their religion, could influence help-seeking with three positive [(3, 4, 6)] and one negative finding [(3)]. In one qualitative study [(4)], young male students explained how they had sought help from their SBMHS for certain social issues, which they considered to be prevalent in their culture, such as a lack of support from their parents, pressure from their peers (e.g. to do drugs or fight) and racism in the community. Students gave mixed views with regards to the role of religion in supporting help-seeking; some felt that using religious activities in school would be helpful, whereas others voiced caution that religion could be used to shame individuals [(3)]. One quantitative study indicated that certain religions may be associated with higher help-seeking [(6)]. However, because it is a regression study, it is not possible to infer causality or identify the particular aspect(s) of the religion that may influence help-seeking.

The above studies highlight the importance of providing access to school services for vulnerable students, who may have less support from their families or communities. However, there is not enough evidence from this review to examine the impact of these social and environmental factors on help-seeking in school.

1.3.5.3 Pupil- specific facilitators

Four studies highlighted positive findings (three quantitative [6, 9, 17], one qualitative[13]), in which young people spoke about several personal factors that had encouraged them to seek help, such as greater coping resources, symptom severity, and autonomy. One quantitative study[(17)] explored the help-seeking of 2737 American students (aged 14-17) across 12 schools who were participating in a suicide prevention programme;

they found that pupils who had sought help reported greater coping resources (especially for males), help-seeking acceptance, school engagement, autonomy, and perceptions that an adult would help, compared to those who had not sought help. The need for autonomy has also been highlighted in a qualitative UK study, where students expressed a desire for greater control over what and how their personal information would be exchanged, their counselling agenda, and online communication [13].

These studies indicate that having greater autonomy, school connections, and coping resources may facilitate youth help-seeking and engagement in support, although they do not indicate how schools could facilitate or enhance these factors for their pupils. Unfortunately, help-seeking facilitators have received less attention in the literature (especially for pupil and environmental factors), which means it is not yet possible to conclude how important these factors are for influencing access to school-based provision.

1.4 Discussion

This review critically appraised 20 studies with the aim of identifying key factors influencing young people's help-seeking for mental health concerns in schools globally. The findings highlight a number of factors at the pupil, provision and environmental/ societal level. Prominent barriers and facilitators (> 3 studies) to help-seeking are discussed below and placed in the context of current literature and theory. Implications from these findings and avenues for future research are also highlighted.

1.4.1 Theoretical framework of help-seeking

Given the paucity of research that attempts to define and understand help-seeking, it is important to use a clear conceptual framework when discussing findings. Pretorius, Chambers & Coyle (2019) carried out a systematic review to explore the factors affecting

young people's online help-seeking, and utilised Rickwood et al.'s (2005) model to discuss their findings. This review will build on Pretorius et al.'s (2019) approach, by using the combined model of Rickwood et al.'s (2005) and Cornally and McCarthy's (2011) frameworks to consider each stage of help-seeking in relation to the current findings. Table 3 indicates how the review findings can map onto these frameworks (empirical referents and consequences will be discussed in the text).

Table 3

Key findings mapped onto Rickwood et al.'s (2005) and Cornally and McCarthy's (2011) stages of help-seeking model (as seen in Pretorius et al.'s review, 2019).

	Antecedents		**Help-seeking behaviour**	
	Awareness	**Availability**	**Expression**	**Willingness**
Process	Becoming aware of symptoms and appraising them as needing support.	Finding a source of help that is available and accessible.	Expressing their symptoms verbally and that they need support.	Willingness to disclose issues to the help source.
Barriers	• Mental health literacy • Lack of problem recognition • Symptom severity	• Lack of confidence / negative beliefs about providers • Lack of awareness / misconceptions about services • Logistical	• Mental health literacy	• Stigma / negative responses from others. • Confidentiality/ privacy • Preference for self-reliance
Facilitators	• Appropriate detection and referral • Symptom severity	• School staff qualities • Staff-student relationships • Access to a SBMHS		• Confidentiality and privacy • Autonomy

Antecedents

Several factors influenced young people's awareness of their symptoms and need for support, as well as their ability to find an available help source. In particular, poor mental health literacy and problem recognition created significant barriers to help-seeking.

Mental health literacy refers to a person's understanding of how to develop and maintain positive mental health, as well as their knowledge of mental health problems and how they can be treated (Kutcher, Wei & Coniglio, 2016). The findings from this review concur with the preceding literature, which indicates that poor mental health literacy can affect a young person's ability to recognise problematic symptoms and therefore seek the help they need, whether from community, health, or educational sources (e.g. Gulliver et al., 2010; Pretorius et al., 2019; Haavik et al., 2019; Rickwood et al., 2007). Having higher symptom severity may also exacerbate or reduce this issue depending on the type of need and young person's context (e.g. Brown et al., 2016; Planey et al., 2019).

Encompassed within mental health literacy is the knowledge of where and when to seek help for a difficulty (Jorm et al., 1997). Pupils in this review raised a lack of awareness about providers as a key barrier to help-seeking, which appears to be a common issue for young people across age groups, geographic locations, socio-economic backgrounds, and cultures (e.g. Brown et al., 2016; Anderson et al., 2017; Planey et al., 2019). In this review, a lack of awareness was found to be salient for pupils with access to a SBMHS and/or from ethnic minority backgrounds; this was linked to poor information sharing and misconceptions about services (e.g. only being for academic problems or certain racial groups). Cross-cultural research indicates that people from developing countries tend to have poorer mental health literacy and may use religious or supernatural factors to explain mental ill-health (Furnham & Swami, 2018); these differences, alongside

poor information sharing in schools, may explain why some ethnic minority youth are not aware of, and underutilise traditional services (Planey et al., 2019; Cummings & Druss, 2011).

A lack of awareness about available support systems can evidently be detrimental to young people's help-seeking. However, help-seeking can be facilitated when school-based services and support are appropriately advertised, easily accessible, and provide a safe welcoming environment for pupils of all backgrounds. Appropriate referrals from staff or peers also appear to help this process, whilst logistical issues (e.g. ease, timing, understaffing) can be a hinderance. Other reviews, which explore access to community mental health services, also show similar findings (Anderson et al., 2017; Brown et al., 2016; Radez et al., 2019). For example, access and engagement improved where services were made easily accessible, provided relevant information, and offered youth-friendly and relaxed settings, and varied treatment opportunities. In contrast, a lack of availability and information hindered access, especially for young people who are vulnerable or from ethnic minority backgrounds. Consequently, the way in which school-based provisions are promoted and delivered can have vital implications for reducing misconceptions and facilitating access to support.

The young person's relationship and confidence in their help source also appeared to be an important factor influencing help-seeking. Pupils in this review suggested several qualities for their help source, such as Rogerian qualities of warmth, acceptance, trustworthiness and empathy (Rogers, 1995), as well as relevant experience and a shared understanding or background. The young people lacked confidence in their help source where there was distrust, confidentiality concerns, poor relationships, and fears they may be judged, not listened to, or welcomed. Current research already indicates that positive staff-pupil relationships are hugely significant for many aspects of student development,

especially academic, social and emotional (e.g. Cornelius-White, 2008; Roorda, Koomen, Split & Oort, 2011; Quin, 2016; Krane, Karlsson, Ness & Kim, 2016). These positive relationships will be essential for ensuring pupils feel supported and able to seek help.

Help-seeking behaviour

Several factors influenced the pupils' ability to express their symptoms verbally, and their willingness to do so. The young people in this review spoke about not being able to distinguish between normal stress and poor mental health, which is a common barrier in the literature on help-seeking (e.g. Gulliver et al., 2010; Rickwood et al., 2007); this indicates pupils may not have the appropriate mental health literacy to know and express when they feel distressed. Some pupils may also alter what is perceived to be 'normal' to accommodate their stress and avoid help-seeking (Gulliver et al., 2010). Consequently, good mental health literacy appears to be fundamental for enabling young people to develop the language and knowledge they need to firstly recognise, and then express their difficulties.

Stigma and fear of negative responses from others was also a fundamental barrier to pupils' help-seeking behaviour. For example, pupils voiced fears about being ostracised, judged, shamed, or labelled as 'insane' or 'crazy'. Young people from ethnic minority backgrounds also expressed additional concerns regarding their parents' and communities' responses to mental health problems. Stigma occurs where "stereotypes or negative views are attributed to a person or group of people, when their characteristics or behaviours are viewed as different from or inferior to societal norms" (Dudley, 2000, p.449). This review adds to evidence that stigma continues to exist in schools and community services globally, despite efforts to improve mental health awareness (e.g. Radez et al., 2019; Clement et al., 2015; Brown et al., 2016).

Stigma is also a well-documented barrier in the wider health literature, affecting people from a range of different populations and mental health difficulties (See Stangl et al., 2019). Recently, Stangl et al. (2019) proposed the 'Health Stigma and Discrimination Framework', which suggests that certain drivers and facilitators can lead to 'stigma markers' (stigma applied to specific people or groups) and subsequently manifestations of stigma (e.g. discrimination or internalised/perceived stigma), which can then cause poorer health and social outcomes for these populations. The researchers argue that effective stigma-reduction interventions need to be delivered at a range of socio-ecological levels. Therefore, it appears vital for schools to adopt multi-level interventions to tackle stigma (especially for ethnically diverse communities), which could involve promoting mental health awareness at the whole-school level, alongside individual support to enable pupils to voice their concerns and cope with their experiences.

Closely linked to stigma was the need for confidentiality and privacy when seeking help from school staff. Pupils in this review expressed fears about their source of help disclosing information or spreading rumours about them, regardless of their age, ethnicity or type of need. A lack of clarity about what would remain confidential and how this would be handled also reduced help-seeking, whereas the young people felt confident in seeking help when their privacy was assured. These findings are not new within the literature (e.g. Radez et al., 2019; Rickwood et al., 2005; Brown et al., 2016), but highlight that confidentiality processes need to be carefully considered within the school environment to promote rather than hinder help-seeking.

Lastly, the young people's willingness to seek support was influenced by their need for autonomy / preference for self-reliance. Several pupils expressed a desire to resolve their problems independently, which gave them a sense of 'pride' or 'toughness', whilst others wanted support but with greater control over the agenda and how their personal

information would be exchanged. Adolescence is a stage of life in which young people become increasingly independent, and research indicates that having less perceived autonomy over help-seeking can act as a barrier (Radez et al., 2019; Wilson & Deane, 2012). Given that rates of youth mental health difficulties are increasing, there is a clear need for schools to be offering a range of support; yet pupils need greater autonomy over when, where, and how they can access such support. Schools should actively involve their pupils in these types of decisions (e.g. through focus groups or pupil forums) to ensure the support they offer is accessible and helpful to those who need it. Schools should also regularly monitor, review, and adapt their provisions in order to meet the changing needs of their pupils.

Empirical referents and consequences

Empirical referents refer to the type (e.g. emotional, informative), source and amount of help-seeking. All of the studies in this review investigated help-seeking from a school-based source, such as SBMHS, counsellors, or teachers. Very few studies reported the type or amount of help-seeking, and only two drew out consequences (Bains, Franzen & White-Frese, 2014; DeFosset, Gase, Ijadi-Maghsoodi & Kuo, 2017). These studies indicated that some pupils viewed their help-seeking positively, because it allowed them to open up about problems, learn useful strategies and improve their grades and relationships, whilst others were left with unresolved issues and felt let down by the system. The lack of referent reporting may be in part due to the majority of studies focusing on perceptions, attitudes and intentions, rather than actual help-seeking behaviour. As such, there remains a lack of clarity about the optimal conditions for young people's help-seeking in schools.

1.4.2 Strengths and limitations

This review involved a rigorous systematic search, using five databases, culture-specific keywords, reference list searching, and efforts to recover gray literature and unpublished work. An understanding of young people's help-seeking in an educational context is receiving growing interest, and this review has drawn on studies globally to identify some of the key barriers and facilitators involved. Young people's views are also a focus of this review, because they have an active role to play in help-seeking and often their voices are missed within research and government initiatives.

The current review was inclusive of a range of study designs, mental health needs, and provision types; however, this led to heterogenous samples and varied measures, which made it difficult to compare outcomes and draw reliable conclusions across studies. It is also evident that further research is required to investigate the help-seeking of a wider range of youth groups and needs because the majority of studies were carried out in the USA (n= 10), focused primarily on secondary-aged pupils (n= 19), or only explored 'general' mental health needs (n= 14). There was also limited scope within this review to explore possible cross-cultural and personality differences as factors influencing the findings. Although some cultural similarities and differences were identified (e.g. fear of stigma), there was not enough research to explore these factors within specific ethnic groups and how they interact with other demographic differences (such as gender and personality). Furthermore, few researchers focused on investigating the facilitators to help-seeking, which are often vital for encouraging pupils to overcome barriers (e.g. social pressures) and seek help from support sources.

1.4.3 Implications for educational practice

Stigma continues to be a key barrier for young people accessing support, indicating there is a clear need for better mental health literacy in schools. In the UK, positive steps have been taken towards reforming the curriculum, which now requires schools to teach children and young people about mental health (DfE, 2020; Ofsted, 2019). However, it will be important for schools to ensure that messages and information about mental health are filtered throughout the curriculum and their policies, if stigma is to be tackled systemically. For example, the pupils in this review suggested mental health awareness could be improved by schools using formal teaching, open group discussions, liaison with local organisations/charities, parent drop-ins and non-academic activities (e.g. yoga and dance). Educational Psychologists (EPs) could also support schools to achieve this by running focus groups to gain key stakeholder views, and training and supporting staff to develop safe, open spaces, in which young people and their families feel able to learn about and discuss mental health.

This review also highlights the importance of confidentiality for facilitating help-seeking in schools. Although clear guidance on confidentiality exists in health and social care systems, this is less evident in education. Nevertheless, schools need to find a balance between a child's right to confidentiality and their duty to protect them from harm. The development of clear safeguarding and confidentiality procedures is vital for achieving this, which also need to be transparent and carefully explained to pupils and their families. EPs could support schools to develop such policies and offer supervision to staff working directly with vulnerable pupils (using pseudonyms to protect pupil confidentiality) to support effective risk management, appropriate referrals, and staff wellbeing. Pupils in this review also suggested schools could promote confidentiality by offering a private room or

options to seek help anonymously, alongside clear rules about the exchange of their personal information.

It is also clear from this review that there is not one 'right way' of providing mental health support or encouraging pupil help-seeking. The most consistent message from pupils was the need for any support to be welcoming, caring, non-judgmental, facilitative of problem-solving, and flexible in meeting their needs (i.e. person-centred). Consequently, schools need to be providing adequate time, resources, and space for staff to create welcoming and confidential environments for their pupils. Staff also need time to plan, deliver and monitor pupil-centred interventions, receive training and supervision, and liaise with external services. Alongside targeted support, schools also need to be working preventatively, at a whole-school level, to reduce stigma and champion mental health. This approach requires commitment from the senior leadership team and covers many different aspects, such as the curriculum, school ethos, student voice, and staff development (see Glazzard, 2019). EPs have an important role for ensuring mental health is a key priority within schools and promoting the protective factors of wellbeing, such as good staff-pupil relationships, high expectations, and pupils' sense of belonging and agency (Roffey, 2016). EPs also need to be more proactive in promoting their skills at a local and national level, otherwise their role will remain at the periphery of the mental health agenda (Grieg, MacKay & Ginter, 2019). Working in partnership with schools, families and external agencies will help to ensure both pupils and staff are mentally healthy and able to flourish.

1.4.4 Conclusions and Further research

This review investigated the factors affecting young people's help-seeking for mental health concerns in schools. Several barriers and facilitators were identified at the pupil, environmental/societal and mental health provision level. Key barriers included poor

mental health literacy (including awareness of problems and services), lack of confidence in providers, stigma and negative responses from others, a preference for self-reliance, and logistical issues. Having good pupil-staff relationships, Rogerian staff qualities, appropriate detection and referral routes, and greater pupil autonomy could facilitate help-seeking. Both symptom severity and confidentiality acted as barriers and facilitators, depending on the mental health problem, the pupils' context, and school's implementation of confidentiality procedures.

This review also highlighted the need for more high-quality research exploring help-seeking in schools. Further research would need to be based on a common conceptual understanding of help-seeking and use consistent measures and appropriate sampling techniques (controlling for bias where possible). In particular, a factor structure of common help-seeking measures would be helpful for identifying unique and shared mechanisms of help-seeking worldwide.

Given that the factors influencing help-seeking are unlikely to be the same across youth groups, future research would also need to explore this process within different mental health difficulties, provision-types, and pupil demographics (e.g. culture, age, SES). This will be particularly important for the younger age groups, whose views are currently missing from the literature. Further research exploring the nuances within cultures and personalities on help-seeking will also be vital. This may then help to draw out some of the distinct factors affecting help-seeking within specific youth populations, leading to more focused support and meaningful change within education systems.

Lastly, any further research will need to be inclusive of the facilitators to help-seeking, an area which has typically received less focus in the literature. This is because schools and educational professionals need to understand what works for young people's

help-seeking and why. Such knowledge will provide professionals, local authorities, and families the chance to remove barriers, but also to implement useful and effective support systems, which will ultimately improve their pupils' mental health and wellbeing.

Chapter 2 A pilot study exploring the effectiveness of a school-based iCBT programme for reducing anxiety in adolescents.

2.1 Background and aims

Anxiety has been identified as one of the most common mental health problems for young people worldwide. Pooled mental health data from studies with children and young people from 27 countries has calculated the worldwide prevalence to be as high as 6.5% (Polanczyk et al., 2015). In the UK, a national health survey revealed that 7.2% of young people (aged 2-19) have anxiety problems, which has increased by 1.9% since 2004 (NHS, 2018). In particular, the prevalence of emotional problems (including anxiety) appears to be higher for young people aged 11-19, especially those who identify as being female and/or LGBT (NHS, 2018; DfE, 2019). Despite this clear need, many young people in the UK are still not accessing the professional support they require (NHS, 2018). Several treatment barriers are reported to exist, such as long waiting times, social stigma, and limited awareness about services or anxiety symptoms (NHS, 2018; Anderson et al., 2017).

Anxiety can be defined as “an uncomfortable feeling of nervousness or worry about something that is happening or might happen in future” (Cambridge University Press, 2020). Although a certain amount of anxiety is normal (e.g. when taking a test), significant problems can occur when excessive worry/nervousness starts to interfere with daily life. Indeed, anxiety problems in youth have been associated with reduced cognitive ability (e.g. attention, problem-solving), school attendance, academic performance and attainment (Moran, 2016; Finning et al., 2019; Jones, West & Suveg, 2019). Increased anxiety can also negatively affect a young person’s wellbeing and self-efficacy (a belief in one’s ability to succeed; Bandura, 1997), as well as their ability to maintain social relationships and

regulate their emotions (Mathews et al., 2016; de Lijster et al., 2018). In terms of future outcomes, youth anxiety has been associated with greater risk of drug dependency, poorer mental health and continued academic under-achievement (Woodward & Fergusson, 2001). Given the potential impact of anxiety problems across many aspects of life, it is crucial that schools, communities, and health services are providing opportunities for young people to gain the support and resources they need.

2.1.1 Use of technology to support youth mental health

Recently, there has been growing interest in the use of technology to support young people's mental health, leading to the emergence of 'Digital' or 'e-Health' (e.g. Grist, Stallard, Croker & Denne, 2019; Hollis et al., 2017). This type of technology involves the delivery of interventions via computers, web-based platforms, mobiles, or tablets (Hollis et al., 2017). It is thought that such interventions could reduce the demand on mental health services, widen access, and provide greater anonymity, whilst remaining clinically effective and person-centred (Ebert et al., 2015; Grist et al., 2019). Due to rapid developments in technology, there are now thousands of commercially available mental health apps and online programmes (See Sucala et al., 2017). However, few of these apps offer clear psychological techniques, and their evidence base is limited. This raises concerns regarding their efficacy, privacy and safety, especially if young people are using them instead of appropriate mental health care.

Of these interventions, Internet-based Cognitive Behavioural Therapy (iCBT) has become increasingly popular, and there is growing evidence to suggest it can be effective for supporting young people's mental health (For reviews, see: Vigerland et al., 2016; Hill et al., 2018). CBT is based on the idea that our thoughts, feelings, and behaviours all interact together, which means that negative or unrealistic thoughts can lead a person to

feel distressed, and act in a way that reinforces these beliefs and vice versa (Ellis; 1958; Beck; 1967; Padesky & Mooney, 1990) (see Figure 5). iCBT aims to support people to develop more helpful ways of thinking, and therefore reduce distress, via the medium of internet- or web- based platforms. Several reviews indicate that iCBT programmes can be effective for reducing the anxiety symptoms of young people aged 7-18, with medium-large effect sizes reported (e.g. Grist et al., 2019; Hollis et al., 2017; Ebert et al., 2015). iCBT programmes also appear to be acceptable to young people and their families, which is vital for adherence and treatment efficacy (Hill et al., 2018).

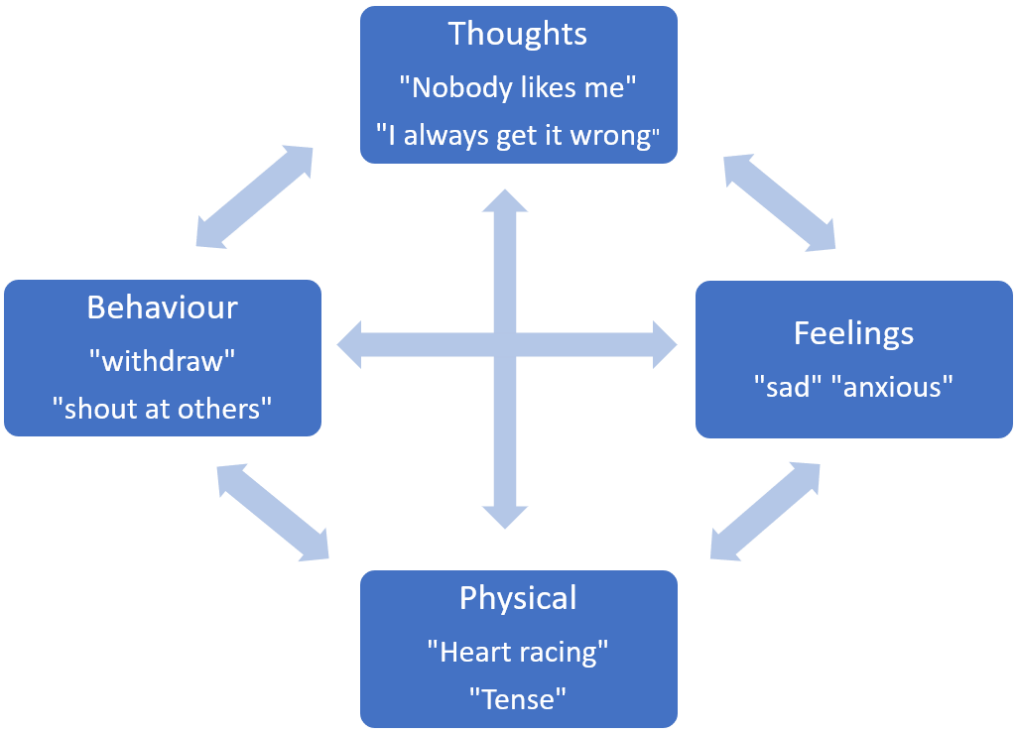


Figure 5. 'Hot Cross Bun' CBT model (Padesky & Mooney, 1990)

However, there is less consensus regarding the effectiveness of iCBT compared to face-to-face treatment, or whether the addition of therapist support and parental involvement is important (e.g. See Grist et al., 2019; Hollis et al., 2017). Several reviews also highlight the low-quality of this evidence-base due to a range of methodological issues, such as small sample sizes, lack of control comparison or follow up, and poorly reported study protocols (e.g. Vigerland et al., 2016; Rooksby, Elouafkaoui, Humphris,

Clarkson & Freeman, 2015; Grist et al., 2019). Given the considerable heterogeneity in these studies (e.g. due to study design and treatment variability), this has made it difficult to draw conclusions on the efficacy of iCBT for youth, especially in terms of format and delivery. Consequently, there is a need for further research, which can address these issues.

2.1.2 Use of iCBT to support youth mental health in schools

In the UK, schools have gradually been placed under more pressure to be a key source of support for their pupils' mental health (e.g. 'Mental Health and Behaviour in Schools', DfE, 2018; 'Transforming Children and Young People's Mental Health Provision', DfE, 2017). For example, in a recent Green paper (DfE, 2017), the government pledged £300 million to support the implementation of 'Mental Health Support Teams' (supervised by NHS staff) and training of 'Designated Mental Health Leads' in schools. Although these are positive steps towards improving mental health, this has also created additional tensions for schools and teaching staff, who are already struggling from budget cuts, professional burnout, and teacher retention (See Shackleton et al., 2019). This highlights the need for school staff to be provided with effective and easily implementable tools and approaches, which can enable them to feel confident and empowered in supporting their pupils' mental health.

Given this need, several researchers have begun to explore the use of iCBT in an educational context (e.g. Attwood, Meadows, Stallard & Richardson, 2012; Wong, Kady, Mewton, Sunderland & Andrews, 2014; Wright et al., 2017). These studies have investigated the efficacy of a range of prevention or targeted intervention programmes, designed for youth anxiety and/or depression (e.g. 'SPARX', 'MoodGYM' and 'Stressbusters'). For example, Wong et al. (2014) explored the efficacy of an iCBT teacher-led intervention ('This Way Up') for 976 pupils (aged 14-16) across 12 schools.

They found that students in the intervention group showed significant improvements in anxiety ($p < .05$) and depression ($p < .01$) compared to the waitlist control. Other iCBT studies have also shown significant reductions in anxiety post-intervention and at follow-up for young people aged 10-23 (e.g. Smith et al., 2015; Attwood et al., 2012; Sethi, Campbell & Ellis, 2010).

Despite these positive results, many of the studies evaluating the effectiveness of these iCBT programmes are weakened by the same methodological issues as the wider evidence base. For example, several of the studies have difficulties with attrition, small sample sizes, randomisation of groups, and lack of active controls. To the researcher's knowledge, only one study (Smith et al., 2015) has investigated the impact of iCBT on important secondary outcomes related to anxiety, such as pupil wellbeing or academic outcomes. Smith et al.'s (2015) study indicated that school-based iCBT can lead to fewer school absences and improved psychological outcomes (e.g. reduced anxiety), but may not significantly affect academic attainment. However, this study does not investigate the effects of iCBT on important aspects of wellbeing, such as self-efficacy; a factor which can act as an important moderator between anxiety and academic performance (Wood & Galla, 2012). Given the methodological weaknesses in this study (e.g. with attrition), it is evident that further, robust research is needed to assess the impact of iCBT programmes on both psychological and educational outcomes.

Recently, Wong, Calear and Christensen (2018) carried out a systematic review of existing reviews and meta-analyses to explore the efficacy of iCBT for youth anxiety and depression. Overall, they reported that iCBT prevention and intervention programmes can have significant, positive effects on anxiety and depression, with medium to large effect sizes. However, only four out of eleven Randomised Controlled Trials (RCTs) explored iCBT in a school setting, with few reporting user satisfaction, cost effectiveness and

longer-term efficacy. Wong et al. (2018) also identified several challenges for future iCBT research, including adherence, long-term effects, safety and privacy of users, and real-world implementation. This review highlights the need for further research to explore the efficacy, usability and feasibility of school-based iCBT programmes for young people.

2.2 Research aims and hypotheses

The following study aims to explore the effectiveness of a school-based iCBT programme 'Braive – Managing Anxiety for Youth' (B-MAY) for reducing the anxiety of young people, both in their school environment and wider day to day lives. This study also aims to investigate possible effects of the iCBT programme on two important secondary outcomes related to anxiety: pupil self-efficacy and school attendance. A qualitative study (separate from this thesis) is being carried out to explore the facilitators' and young people's experiences of this programme.

The current study is a pilot of the first version of B-MAY for use with young people in UK secondary schools. The following research questions will be explored:

1. Does B-MAY lead to a significant reduction in anxiety of the intervention group vs. waitlist control?
2. Does B-MAY lead to significant increases in self-efficacy and attendance of the intervention group vs. waitlist control?
3. Are the effects of B-MAY on anxiety maintained at a 2-month follow up?

Based on previous literature, it is hypothesised that this iCBT intervention will lead to a significant reduction in anxiety (primary outcome) and increases in attendance and self-efficacy (secondary outcomes) for pupils in the intervention group compared to the waitlist control. It is also hypothesised that the effects of iCBT on anxiety will be maintained or further improved at a 2-month follow up. In order to gain a broader picture

of the young person's anxiety across several environments, these effects will be explored from the perspective of the young people, their parents and key school staff members (a member of staff who knows the child best in school).

2.3 Methodology

2.3.1 Participants

An a-priori power analysis using G*power (Faul, Erdfelder, Lang & Buchner, 2007), with power set at 0.80, and alpha = .05, two-tailed was conducted to estimate the sample size required for a mixed model Analysis of Variance (ANOVA) with a within-between interaction. The analyses indicated a sample size of 46 would be required to obtain statistical power, assuming a medium effect size (f = 0.25) would be achieved (Cohen, 1988). To account for possible attrition (20%), the researcher aimed to obtain 56 young people (28 per group), as well as their parents and KSMs.

Mainstream secondary schools in the South West of England were approached by the Educational Psychology (EP) Service to take part in this study (n = 10). All secondary schools were alerted to the B-MAY project through the local Special Educational Needs (SEN) newsletter and their link EPs. An assistant psychologist fielded enquiries and kept a list of interested schools. The schools' SEN Coordinators (SENCo) then received B-MAY information flyers via email and follow-up calls from the assistant psychologist. A total of eight schools agreed to participate and were allocated the required number of B-MAY licenses.

Purposive sampling, using a criterion strategy, was used to identify and select participants (Palys, 2008). The school SENCos were asked to identify pupils in year 7, 8 or 9 (aged 11-14), who showed signs of generalised anxiety (longer than two weeks) and who

they thought may benefit from completing a school-based iCBT programme. They also allocated a KSM for each pupil; a staff member who was considered to know the pupil 'best' in school (apart from the facilitators). B-MAY was primarily aimed at pupils who were struggling with anxiety but fell below the CAMHS threshold for receiving targeted mental health support. Consequently, this study aimed not to include pupils receiving psychotherapy or direct support from CAMHS. Pupils with learning or developmental difficulties, or English as an Additional Language (EAL) were also not included, as it was felt that the programme may not yet be suitably adapted to meet their needs.

Of the young people approached (n = 70), 16 declined / felt unable to participate, due to not feeling anxious enough to require iCBT, discomfort in sharing personal information online, not returning paperwork in time, already receiving treatment from CAMHS, parental concerns (e.g. related to faith) or absence from school (e.g. due to bereavement). The final number of pupils included in this study was 54 (see Figure 6 below). The SENCos and facilitators were then asked to allocate these pupils to either the intervention or waitlist control group, matching as far as possible for gender, age and level of need. The school staff also considered group dynamics, facilitator capacity and timetabling during allocation.

In total, 54 pupils participated in this study. The intervention group contained 27 pupils (female = 14 and male = 13, *M* = 13 years and 2 months, *SD* = .97), as did the control group (female = 14 and male = 13, *M* = 12 years and 6 months, *SD* = .70). Additionally, 54 KSMs and parents completed research measures for their pupil/child. In terms of attrition, 7% of pupils between T1 and T2 (3.7% for each group) and 19% between T1 and T3 (11% intervention, 8% control) withdrew from the research study. Of those who remained, attrition rates for completing the research measures were: 7% for youth (3.7% for each group), 24% for parents (11% intervention, 13% control) and 30%

for KSMs (11% intervention, 19% control) between T1 and T2. At follow up (T3) attrition had increased to 39% for youth (25% intervention, 14% control), 45% for parents (29% intervention, 16% control) and 32% for KSMs (20% intervention, 12% control).

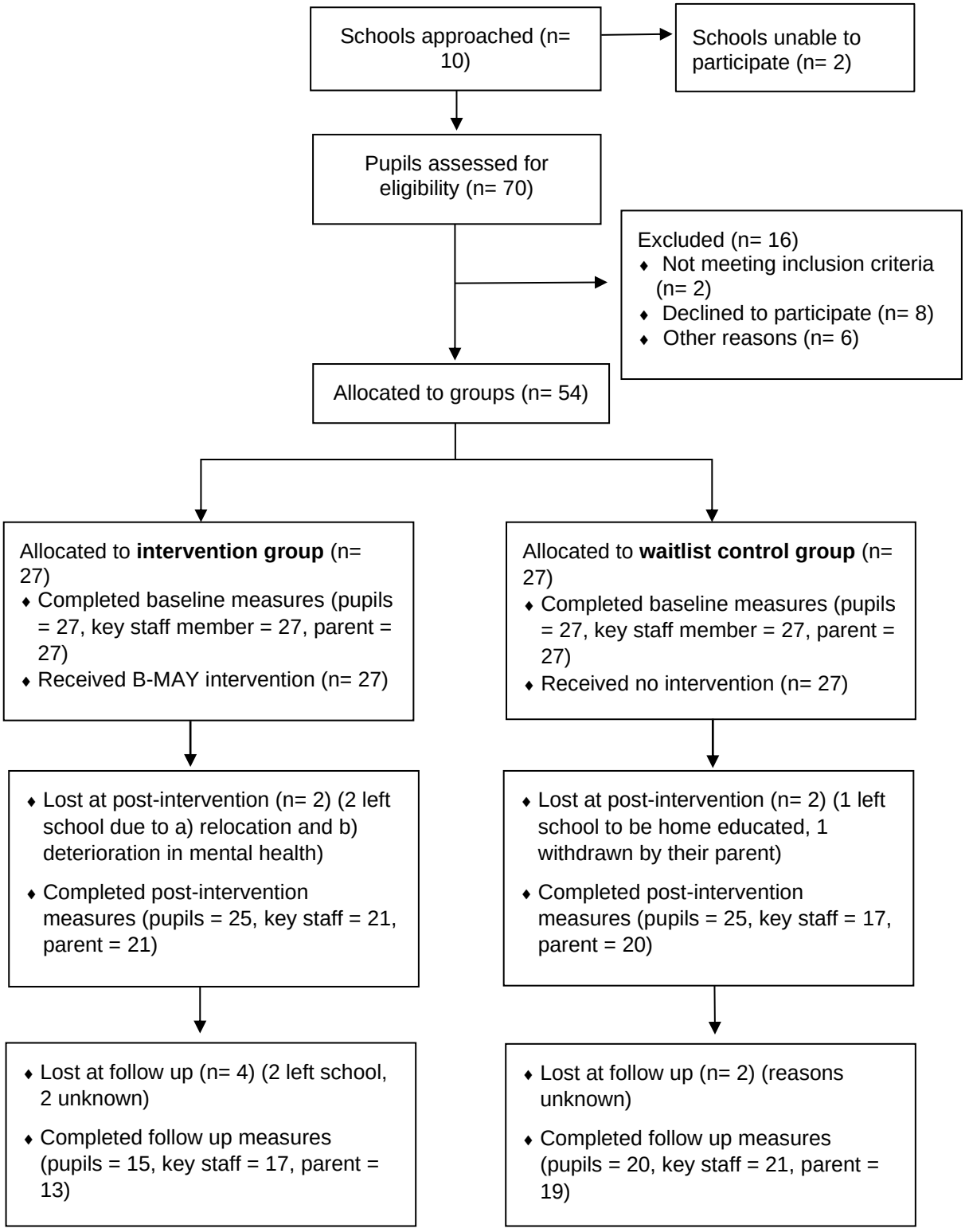


Figure 6. Flow chart to illustrate recruitment and retention.

2.3.2 Design

A mixed model (2 x 3) design, with between and within factors, was used to evaluate the effectiveness of B-MAY for young people identified by their school staff as having anxiety. The between-factor variable was the group (B-MAY intervention vs. waitlist control) and the within-factor variable was the three time points for measuring outcomes (pre-intervention [T1], post-intervention [T2], 2-month follow up [T3]). The analyses looked for differences in anxiety, attendance and self-efficacy (dependent variables) between the two groups at each time point. As is the case with most quantitative research a post-positivist modified objectivist epistemological stance was taken where, although reality is viewed to exist, it is also felt that it can never be perfectly apprehended due to differences in human cognition (e.g. biases, values, beliefs) and the uncontrollable nature of phenomena (Guba & Lincoln, 1994).

2.3.3 Braive – Managing Anxiety for Youth (B-MAY)

The current intervention was adapted from an iCBT programme for adults with generalised anxiety (‘Braive: General Anxiety’). The youth version is similar to the original programme in that it has online modules, which can be accessed by the person independently. However, it has been adapted by the Educational Psychology and Braive teams for use in schools, by adjusting the programme material to make it more age-appropriate and condensing the information down into 45-60 minute sessions. Although it was recommended for schools to deliver one session of the programme each week for 10 weeks, flexibility in duration was needed due to school holidays and pupil absences. As a result, the programme was typically delivered across two school terms (approximately 12-16 weeks).

B-MAY is based on theoretical and empirical research of anxiety and cognitive-behavioural therapy (e.g. Beck, A.T., 1967; Beck, J.S., 2011; Ellis, 1958; Vigerland et al., 2016). The programme consists of a range of CBT strategies including, psychoeducation about anxiety, relaxation techniques (e.g. progressive muscular relaxation, isometric relaxation and breathing exercises), cognitive strategies (e.g. cognitive restructuring, worry postponement), graded exposure, mindfulness and problem-solving skills. Additionally, the programme provides information on Growth Mindset, managing stress and panic attacks, as well as the importance of social support and relapse prevention. 'Superskill challenges' are used to encourage the application of learned skills beyond the sessions. Each online lesson is presented in an engaging, interactive manner, with a range of animated videos, exercises, tasks, and information sections to facilitate learning.

Although the programme is primarily online, it is also delivered in schools by a 'facilitator'; a member of staff who receives training and supervision from the Educational Psychology team. The facilitator also has access to a facilitator guide (created by the Educational Psychology team), which provides advice and information about each session, ways to build staff-pupil rapport, and how to solve common issues (e.g. with technology or pupil non-attendance). The facilitators can also access the Braive iCBT manual, which provides detailed information on each module for clinicians. The facilitators are given flexibility over the amount of involvement and delivery of the sessions. In the current study, the majority of staff chose to deliver B-MAY in small groups, with only a few activities being completed individually by pupils. There was no direct parental involvement requested or expected as part of this pilot programme. However, the resources could be accessed outside of school, so this may have been possible.

2.3.4 Measures

2.3.4.1 Demographic questionnaire

A short demographic questionnaire was created, which asked the pupils about their age, gender, year group, ethnicity, and whether they received free school meals and/or pupil premium (as a proxy measure of socio-economic status) (see Appendix G).

2.3.4.2 Youth Anxiety Measure (YAM-5, Muris et al., 2016)

The YAM-5 is a self- and parent- report anxiety measure for young people aged 8-18 years. A 'Key Staff Member' (KSM) version was also adapted from the parent measure, by changing the statements from 'my child' to 'the student' (see Appendix H). The YAM-5-I has 28-items which detect symptoms of common anxiety disorders, including separation anxiety, selective mutism, social anxiety, panic, and generalised anxiety. Young people, their parents and KSMs are asked to rate the items on a 4-point Likert scale (1= never, 2 = sometimes, 3 = often, 4 = always). Scores from each subscale can then be summed to provide an overall anxiety score. Research indicates that the YAM-5 has good internal consistency and test re-test reliability, as well as good content and construct validity (e.g. See: Çankaya & Cevik, 2018; Muris et al., 2016; Simon, Bos, Verboon, Smeekens, & Muris, 2017). In the current sample, the overall Cronbach's alpha value for the YAM-5 at each time point (T1-3) for the youth, parent and KSM data remained above 0.8, which is considered to show good internal reliability (Field, 2018).

2.3.4.3 Self-efficacy Questionnaire for Children (SEQ-C, Muris, 2001)

This questionnaire is composed of 24 items, which measures a young person's perceptions about their emotional self-efficacy (ability to regulate negative emotions), social self-efficacy (ability to get along with peers) and academic self-efficacy (ability to manage their own learning behaviour and succeed at school). A modified English version

of the SEQ-C was used (Landon, Enrenreich & Pincus, 2007), which aims to enhance the responder's understanding by using statements, rather than a question-answer format, and a 4-point endorsement scale (1 = not at all like me, 2 = somewhat like me, 3 = like me, 4 = very much like me) (see Appendix I). Overall, the English version has good internal consistency, construct and content validity (Landon et al., 2007; Valois & Zullig, 2013; Suldo & Shaffer, 2007). However, three items were removed prior to analysis, due to failing to load substantially on their hypothesised factor in the original paper (Muris, 2001).

2.3.4.4 Attendance

The number of days the young person attended school in the month prior to and month after the intervention was collected from the pupils' parent (taking into account school holidays). Due to differing term lengths between schools, the analysis was carried out on the number of days that the young person had missed, rather than attended.

2.3.4.5 Familiarity scales

A simple 5-point Likert scale was created to gain an indication of how well the facilitators and KSMs knew their allocated pupil(s) (1 = not at all, 2 = a little, 3 = some, 4 = quite well and 5 = very well). See Appendix J.

2.3.4.6 Programme data usage

During the intervention, the facilitators kept weekly records of each B-MAY session, including the lesson name, duration (minutes) and any additional input (e.g. discussions, challenges or games). At post-intervention, the pupils answered a simple questionnaire which asked how many weeks they had completed, frequency of use, and reasons for stopping (if applicable). At follow up, the young people indicated whether they

had used the programme or iCBT techniques since completion, and the approximate frequency of this use (See Appendix K for programme usage measures).

2.3.5 Procedure

Ethical approval for this study was granted by Southampton University's Ethics Committee and Research Integrity and Governance. Once approval had been gained, SENCos from participating schools were sent research information sheets and asked to identify pupils who showed signs of anxiety and who may benefit from accessing an iCBT programme. The SENCos then sent out consent forms, research information sheets, anxiety and attendance questionnaires to the young people's parents. Written assent was sought from the young person, once they had read through their information sheet with a caregiver. Consent for B-MAY to be coordinated and carried out in school was also gained from the school Head teachers, SENCos, facilitators and KSMs.

Once all consent had been gained, the SENCos allocated their pupils to either the B-MAY intervention or waitlist control group. Prior to B-MAY starting (T1), all pupils completed online demographic, self-efficacy and anxiety questionnaires. The pupils' KSM also completed online anxiety and familiarity scales. During this time, the facilitators attended a training day with the EP and research teams to learn more about the research project and how to deliver B-MAY in their schools. They also completed a familiarity scale relating to pupils in their intervention group.

On completion of the T1 data collection, the facilitators began the 10-week intervention for the intervention group, with weekly 45-60 minute sessions depending on their timetable and capacity (the control group continued as usual). During this time, the facilitators also kept track of the sessions completed (using the programme usage table) and received support from the assistant or link EP where required. After the intervention

had finished (T2), pupils in both groups completed anxiety and self-efficacy questionnaires, and the intervention group completed an additional programme usage questionnaire. The KSM and parent also completed the anxiety and attendance questionnaires. At the 2-month follow up (T3), both groups of pupils, their parents and KSMs completed the anxiety questionnaires again. The intervention group also filled in a short follow-up programme usage questionnaire. All participants then received a debrief form and the pupils obtained a £5 amazon voucher. At this point, the facilitators began to prepare and deliver the iCBT programme for the waitlist control group.

2.3.6 Data analysis

Initial exploration of the data was carried out to check the assumptions required for parametric testing. This was completed for all participant data, across three time points (T1, T2, T3) and for both groups (B-MAY and control). Inspection of histograms, p-plots and descriptive statistics tables indicated the data was normally distributed. The boxplots revealed several outliers in the data. To reduce potential bias, the winsorizing technique was used, which involves substituting the outlier with the next highest value that is not an outlier (Field, 2018). Boxplots and Levene's test indicated that the homogeneity of variance had been met across the data.

For the main analysis, a 2 x 2 (Group: B-MAY intervention vs. waitlist control, Time: T1 and T2) mixed model ANOVA was used to explore possible differences in overall anxiety (primary outcome), attendance and overall self-efficacy (secondary outcomes) between the intervention and control group. This was completed for pupil, KSM and parent data. Due to fewer participants completing the follow-up measures at T3 (youth = 35, parent = 32, KSM = 38), it was not possible to carry out 2x3 (Group: intervention vs. control, Time: T1, T2 & T3) ANOVAs. Instead, separate 2 x 2 (Group: intervention vs.

control, Time: T1 and T3) mixed model ANOVAs were used to indicate whether any differences in overall anxiety between groups would occur between T1 and T3. The EP and research teams also considered that B-MAY was specifically designed to target the pupils' generalised and panic anxiety, as well as having possible influences on their emotional and social self-efficacy. As a result, a post-hoc analysis of these sub-measures was carried out using 2x2 mixed model ANOVAs (as detailed above).

2.4 Results

This section will begin by exploring possible pre-intervention (T1) differences between the two groups (B-MAY vs Control), as well as data on familiarity (KSM and facilitator), programme adherence, usage and fidelity, and questionnaire reliability. The main findings for the primary (anxiety – overall and sub-measures) and secondary outcomes (self-efficacy – overall and sub-measures, and attendance) between T1 – T2 and T1 – T3 will then be presented.

2.4.1 Pre-intervention (T1) comparisons

Preliminary analysis of the data was used to investigate whether any group differences existed at T1, using independent sample T-tests. No significant differences occurred between the control and intervention group for KSM familiarity (p = .719), attendance (p = .998), overall self-efficacy (p = .760), emotional- (p = .928) or social- (p = .517) self-efficacy. Similarly, no significant differences occurred between groups on overall anxiety or sub-measures of anxiety (i.e. generalised and panic) across the KSM, youth, and parent data. A Chi-square test of independence also showed there was no significant group differences with regards to pupil premium, χ^2 (1, 53) = .167, p = .682, or gender, χ^2 (1, 54) <.001, p = 1.00. Although unusual, a p-value of 1.00 is possible where there are no differences between the groups, as seen in the current data (Dahiru, 2008).

Therefore, the intervention and control groups were considered to be equivalent at T1, in terms of attendance, KSM familiarity, self-efficacy, anxiety, number of pupils receiving pupil premium and gender (male or female).

However, preliminary analyses revealed the two groups did differ on age, $t(52) = -2.58$, $p = .013$, and school year, $t(52) = -2.91$, $p = .005$. Inspection of the data indicated that the B-MAY group ($M = 13.22$, $SD = .70$) had been allocated a higher number of pupils aged 13-14 (year 8 and 9), compared to the control group ($M = 12.63$, $SD = .97$), which had more pupils aged 11-12 (year 7 and 8). These differences in age/year were due to one of the schools selecting year 7 pupils who they felt would benefit most from B-MAY. Such differences will be considered when interpreting the results; however, as they are not the main variables under investigation, they have not been controlled for in the analysis. Indeed, several researchers argue against the adjustment of variables which are not considered to influence the main outcome (e.g. Pocock, Assmann, Enos & Kasten, 2002). There was also not enough variance in the data to explore possible group differences in ethnicity, intervention delivery format, facilitator familiarity, school cluster or B-MAY usage. Further participant and school characteristics can be found in Table 4 and 5 below.

Table 4

Participant characteristics for intervention and control group

Group	Participants	Gender	Ethnicity	Age *M* *SD*	Year *M* *SD*	Pupil premium
Intervention	27	14 f 13 m	22 WB 2 MB 1 GT 2 DnS	13:19 (.694)	8.58 (.504)	6 Y 20 N 1 Unknown
Control	27	14 f 13 m	23 WB 2 MB 1 GT 1 DnS	12:63 (.967)	8.07 (.781)	5 Y 22 N

Note. m = Male, f = female, *M* = mean, *SD* = standard deviation, WB = White British, MB = Multiple ethnic backgrounds, GT = Gypsy or Irish traveller, DnS = Do not state

Table 5

Characteristics of schools involved in the project.

School code	Type	Control or B-MAY?	No. of facilitators	Method of delivery
1	Academy (state funded)	Both	2	Group & individual
2	Academy (state funded)	Both	2	Group & individual
3	Academy (state funded)	Both	2	Group & individual
4	Academy	B-MAY	2	Group & individual
5	Academy	Control	1	N/A
6	Academy converter	B-MAY	1	Individual
7	Academy	Both	2	Group & individual
8	Academy converter	Both	2	Group & individual

2.4.2 Familiarity

The KSMs and facilitators rated their familiarity with their linked pupil(s) prior to B-MAY starting. Over half of the KSMs knew their pupils ‘quite well’ or ‘very well’ (56%), the rest rated their familiarity as ‘some’ (33%) or ‘a little’ (11%). The KSMs reported having a range of roles, including teachers, heads of house or year, form tutors, Teaching Assistants (TAs), SENCos, or pastoral officers. For the facilitators, there was greater variance in familiarity with their pupil(s); 32% knew them ‘quite well’ or very well’, 31% ‘some’, 14% ‘a little’ and 22% ‘not at all’. Facilitator roles included Emotional

Literacy Support Assistants (ELSAs) / Pastoral officer, TA, Teacher or 'Other' (e.g. inclusion or behaviour support officers).

2.4.3 Adherence, programme usage and fidelity

In terms of adherence, 81% of pupils in the intervention group completed eight or more sessions of B-MAY, whilst 15% finished less than six sessions. At follow-up, eight pupils (out of 15 who answered questionnaires) reported using B-MAY 'once or twice' in their own time since the intervention finished at T2. Ten of the pupils reported that they used some of the techniques they learnt during the intervention, including breathing exercises, positive coping strategies, creating alternative thoughts, and mindfulness/meditation. The majority of schools chose to deliver B-MAY with a mix of group and individual activities. The facilitators also identified 'extra' activities they used to compliment B-MAY; these included 'finding a positive of the week', recaps or individual catch-ups of previous sessions, relaxation or mindfulness exercises, discussions about the content, and starter/warm-up games.

2.4.4 Main analysis – pre- post intervention (T1 – T2)

For the main analysis, 2 x 2 mixed model ANOVAs (Group: B-MAY intervention vs. waitlist control, Time: T1 and T2) were used to investigate possible differences between the two groups for overall anxiety, sub-measures of anxiety (panic and generalised), overall self-efficacy, sub-measures of self-efficacy (social and emotional) and attendance. This was carried out for the youth, parent and KSM data. Table 6 shows the descriptive statistics for each outcome at T1 and T2 for the two groups.

Table 6

Means and standard deviations for youth, parent and KSM outcome measures at T1 and T2 for the control and intervention group.

	T1 (Pre-intervention)		T2 (Post-intervention)	
Measure	Control	B-MAY	Control	B-MAY
YAM-5 (youth)				
Overall anxiety	62.80 (15.99)	59.12 (16.90)	59.00 (14.86)	59.44 (18.14)
Panic anxiety	13.80 (5.53)	12.33 (4.79)	12.52 (4.03)	13.46 (5.57)
Generalised anxiety	17.20 (4.39)	16.08 (4.18)	15.92 (5.12)	15.36 (4.83)
YAM-5 (parent)				
Overall anxiety	63.95 (15.09)	57.10 (9.86)	61.33 (16.22)	56.95 (14.20)
Panic anxiety	12.52 (4.69)	11.82 (3.07)	11.86 (3.95)	11.88 (3.41)
Generalised anxiety	17.52 (3.98)	16.68 (3.13)	15.95 (4.22)	15.58 (4.49)
YAM-5 (KSM)				
Overall anxiety	55.90 (14.83)	56.76 (11.24)	49.60 (13.36)	50.05 (10.08)
Panic anxiety	11.68 (3.70)	11.94 (2.98)	9.89 (3.54)	10.61 (2.62)
Generalised anxiety	15.40 (4.01)	16.25 (3.39)	13.40 (3.98)	13.45 (2.67)
SEQ-C (youth)				
Overall SE	40.28 (9.52)	39.64 (8.27)	40.08 (8.14)	37.00 (9.35)
Social SE	15.84 (4.42)	14.76 (4.58)	15.60 (4.04)	14.52 (4.71)
Emotional SE	11.92 (4.35)	12.04 (4.25)	12.84 (4.19)	11.44 (3.92)
Attendance	1.41 (1.92)	1.88 (1.89)	0.91 (1.34)	1.28 (1.87)

Overall Anxiety (KSM, youth and parent report). The young people and their parents did not report any significant between- or within- group differences for overall anxiety. The KSMs reported a significant main effect of time, with the partial eta value indicating this was a large effect, $F(1, 39) = 14.50$, $p < .001$, $\eta^2 = .271$. However, there were no significant effects of group $F(1, 39) = .04$, $p = .853$, $\eta^2 = .001$, or interaction of

time by group, $F(1, 39) = .02$, $p = .904$, $\eta^2 < .001$. Thus, the KSMs reported a significant decrease in overall anxiety between T1 and T2 for both groups (see Table 5 and Figure 7).

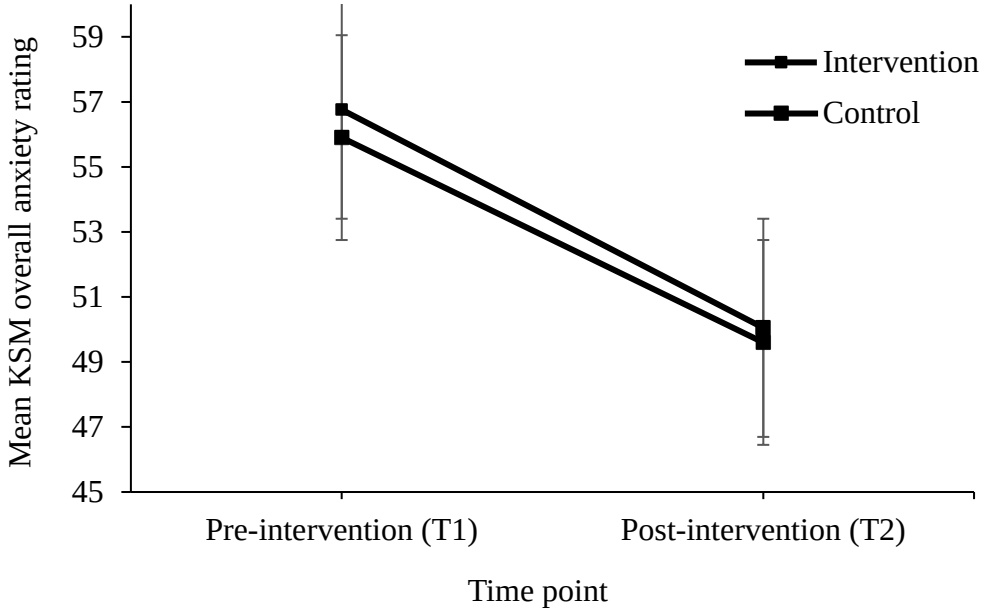


Figure 7. A graph to show the mean KSM overall anxiety rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

Anxiety sub-measures (KSM, youth and parent report). Sub-measures included generalised and panic anxiety. For the generalised anxiety sub-measure, the young people did not report any significant between- or within- group differences. The KSMs reported a significant main effect of time, with the partial eta value indicating this was a large effect, $F(1, 38) = 24.11$, $p < .001$, $\eta^2 = .388$, but not for the main effect of group, $F(1, 38) = .20$, $p = .659$, $\eta^2 = .005$, or interaction for time by group, $F(1, 38) = .67$, $p = .418$, $\eta^2 = .017$. Similar findings were seen in the parent data; a significant main effect of time was reported with a large effect, $F(1, 38) = 8.68$, $p = .005$, $\eta^2 = .186$, but not for group, $F(1, 38) = .26$, $p = .610$, $\eta^2 = .007$, or the interaction, $F(1, 38) = .26$, $p = .611$, $\eta^2 = .007$. These findings indicate that both the KSMs and parents reported a significant decrease in generalised anxiety between T1 and T2 for pupils in both groups (see Table 5 and Figures 8-9).

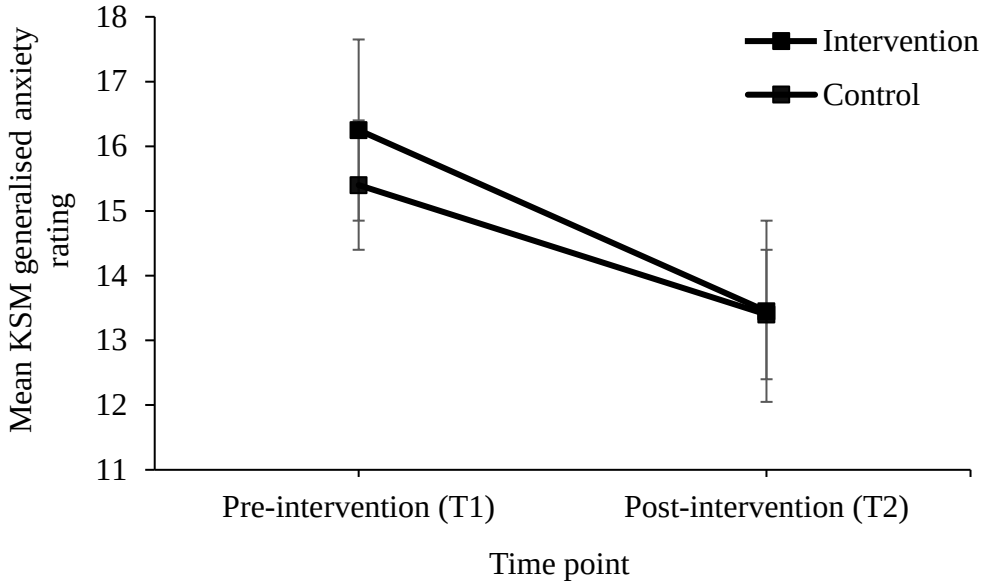


Figure 8. A graph to show the mean KSM generalised anxiety rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

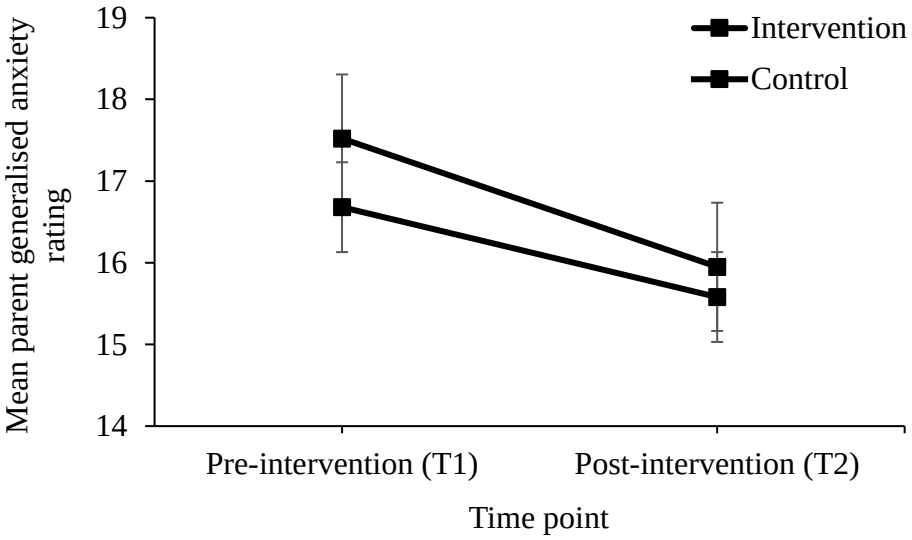


Figure 9. A graph to show the mean parent generalised anxiety rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

In terms of panic anxiety, the parents did not report any significant between- or within- group differences. The KSMs reported a significant main effect of time (with the partial eta value indicating this was a large effect), $F(1, 35) = 9.36$, $p = .004$, $\eta^2 = .211$, but not for the main effect of group, $F(1, 35) = .27$, $p = .606$, $\eta^2 = .008$, or interaction for time by group, $F(1, 35) = .20$, $p = .658$, $\eta^2 = .006$. This indicates that KSMs reported a significant decrease in panic anxiety between T1 and T2, regardless of group (see Table 5 and Figure 10).

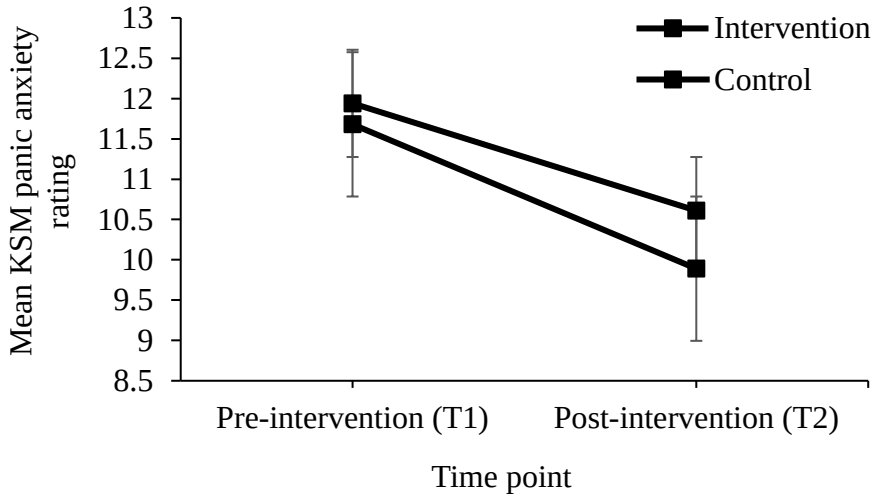


Figure 10. A graph to show the mean KSM panic anxiety rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

In contrast, the young people did not report any significant main effects of time, $F(1, 47) = .02$, $p = .881$, $\eta^2 = .001$, or group, $F(1, 47) = .04$, $p = .844$, $\eta^2 = .001$; however, there was a significant group by time interaction for youth-reported panic anxiety, with a medium effect size indicated by the partial eta value, $F(1, 47) = 5.46$, $p = .024$, $\eta^2 = .104$. Inspection of the descriptive statistics suggested that pupils in the intervention group reported a slight increase in panic anxiety between T1 and T2, whilst those in the control group reported a decrease in this sub-measure (see Table 5 and Figure 11). However, post-

hoc tests using the Bonferroni correction revealed that changes in panic anxiety failed to reach significance for the control (p = .082) or intervention (p = .133) group.

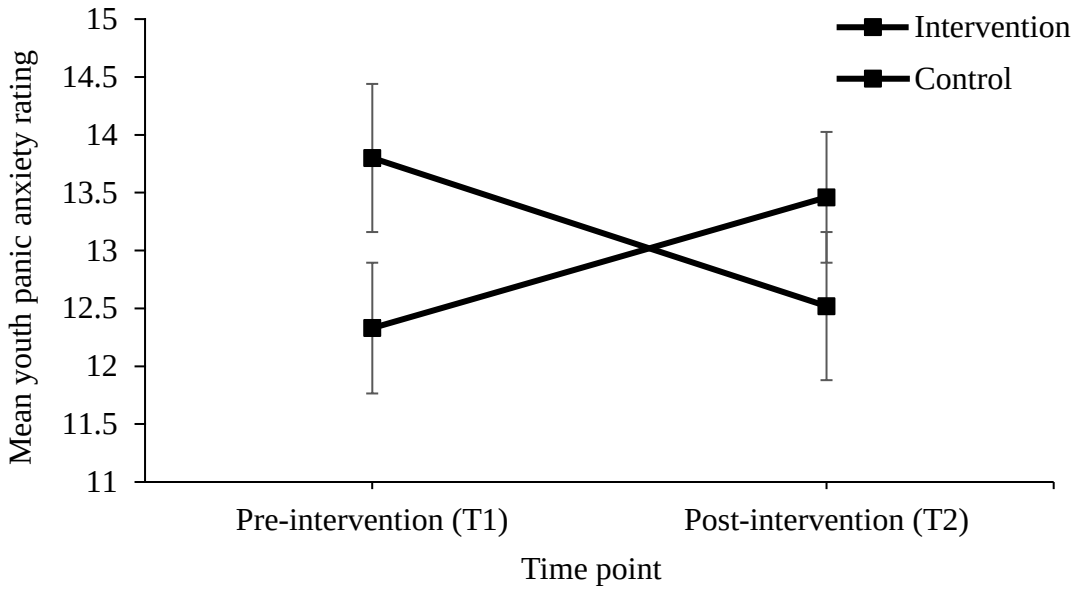


Figure 11. A graph to show the mean youth panic anxiety rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

Overall Self-efficacy (youth report). For youth-reported overall self-efficacy, there was no significant main effect of time, $F(1, 48) = 1.89$, $p = .176$, $\eta^2 = 0.38$, group, $F(1, 48) = .331$, $p = .568$, $\eta^2 = .014$, or interaction between group and time, $F(1, 48) = 1.39$, $p = .244$, $\eta^2 = .028$, between T1 and T2.

Self-efficacy sub-measures (youth report). Sub-measures included social and emotional self-efficacy. In terms of social self-efficacy, the young people did not report any significant main effects of time, F(1, 48) = .21, p = .647, η^2 = .004, group, F(1, 48) = .89, p = .350, η^2 = .018, or time by group interaction, F(1, 48) < .001, p = 1.00, η^2 = < .001. Although unusual, a p-value of 1.00 is possible where there are no differences between the groups (Dahiru, 2008). This is shown in the current data as the mean difference between the control and B-MAY group was the same at both T1 and T2 (MD = .24) (See Figure 12). Similarly, the main effect of time, $F(1, 48) = .16$, $p = .568$, η^2

= .014, and group, $F(1, 48) = .331$, $p = .568$, $\eta^2 = .007$, failed to reach significance for the emotional self-efficacy data. Although the value of the partial eta indicated a moderate effect size for the emotional self-efficacy time by group interaction, this was not significant, $F(1, 48) = 3.63$, $p = .063$, $\eta^2 = .070$ (See Table 5 and Figure 13).

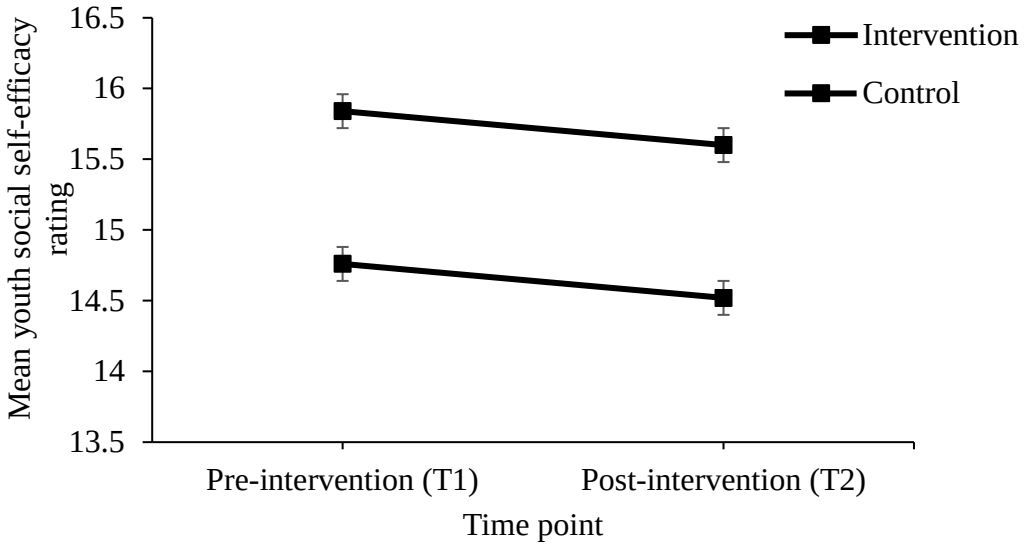


Figure 12. A graph to show the mean youth social self-efficacy rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

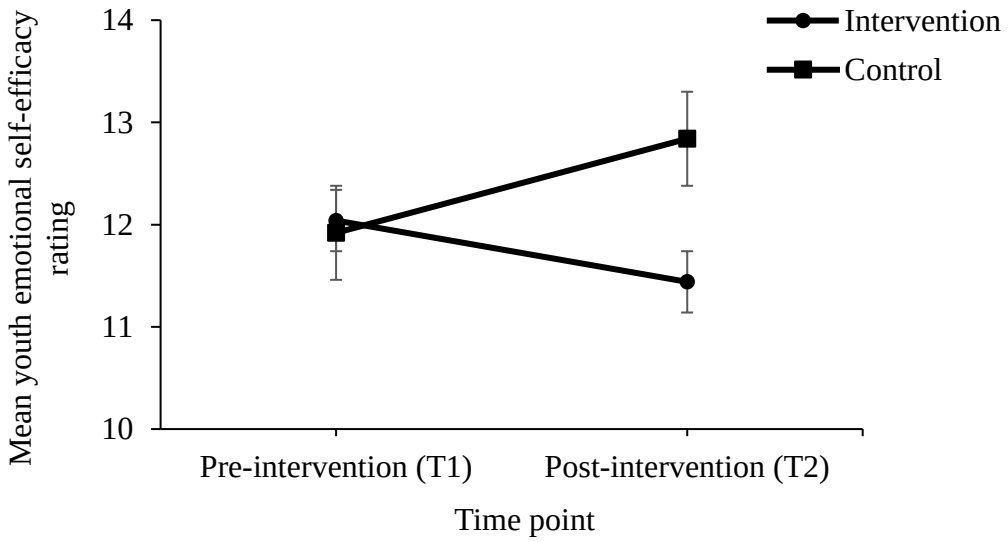


Figure 13. A graph to show the mean youth emotional self-efficacy rating between T1 and T2 for the intervention and control group. Error bars display +/- one standard error from the mean.

Attendance (parent report). There was no significant main effect of time, $F(1, 39) = 2.41$, $p = .128$, $\eta^2 = .058$, group, $F(1, 39) = .98$, $p = .329$, $\eta^2 = .024$, or interaction for group by time, $F(1, 39) = .02$, $p = .888$, $\eta^2 = .001$, for the pupils' attendance between T1 and T2.

2.4.5 Main analysis – pre-intervention – follow-up (T1 – T3)

Further 2 x 2 mixed model ANOVAs (Group: B-MAY intervention vs. waitlist control, Time: T1 and T3) were used to investigate possible differences between the two groups for overall anxiety and sub-measures of anxiety between T1 and T3. This was carried out for the youth, parent, and KSM data (see Table 7 for descriptive statistics).

Table 7

Means and standard deviations for youth, parent and KSM outcome measures at T1 and T3 for the control and intervention group.

	T1 (Pre-intervention)		T3 (Follow-up)	
Measure	Control	B-MAY	Control	B-MAY
YAM-5 (youth)				
Overall anxiety	62.25 (17.16)	55.00 (13.50)	56.80 (16.46)	54.36 (16.75)
Panic anxiety	14.10 (5.79)	12.00 (3.83)	12.90 (4.93)	12.62 (4.84)
Generalised anxiety	17.58 (4.59)	14.93 (4.23)	16.47 (5.28)	14.50 (5.16)
YAM-5 (parent)				
Overall anxiety	64.32 (14.72)	55.15 (11.45)	61.89 (14.30)	55.15 (19.01)
Panic anxiety	13.11 (4.61)	11.38 (3.52)	13.21 (4.12)	11.77 (4.49)

Generalised anxiety	17.58 (4.06)	16.00 (3.39)	16.58 (4.53)	14.62 (5.14)
YAM-5 (KSM)				
Overall anxiety	57.10 (16.12)	55.94 (11.86)	56.29 (14.27)	52.65 (12.57)
Panic anxiety	11.57 (4.26)	11.56 (3.31)	11.52 (3.63)	12.13 (3.86)
Generalised anxiety	15.71 (3.80)	16.06 (3.54)	14.90 (3.88)	13.24 (2.86)

The young people did not report any significant between- or within- group differences for overall anxiety or the sub-measures between T1 and T3. Similarly, their parents and KSMs did not report any differences for overall or panic anxiety. However, the KSMs reported a significant main effect of time for generalised anxiety (the partial eta value indicated this was a large effect), $F(1, 36) = 6.98$, $p = .012$, $\eta^2 = .162$, but not for the main effect of group, $F(1, 26) = .49$, $p = .497$, $\eta^2 = .014$, or time by group interaction, $F(1, 36) = 2.15$, $p = .152$, $\eta^2 = .056$. In terms of the parent data, the value of the partial eta indicated there was a moderate effect size for the main effect of time for generalised anxiety, $F(1, 30) = 3.17$, $p = .085$, $\eta^2 = .096$, but this did not reach significance. Overall, these findings showed that decreases in KSM-reported generalised anxiety continued to be sustained between T1 and T3 for both groups (see Table 6 and Figures 14-15).

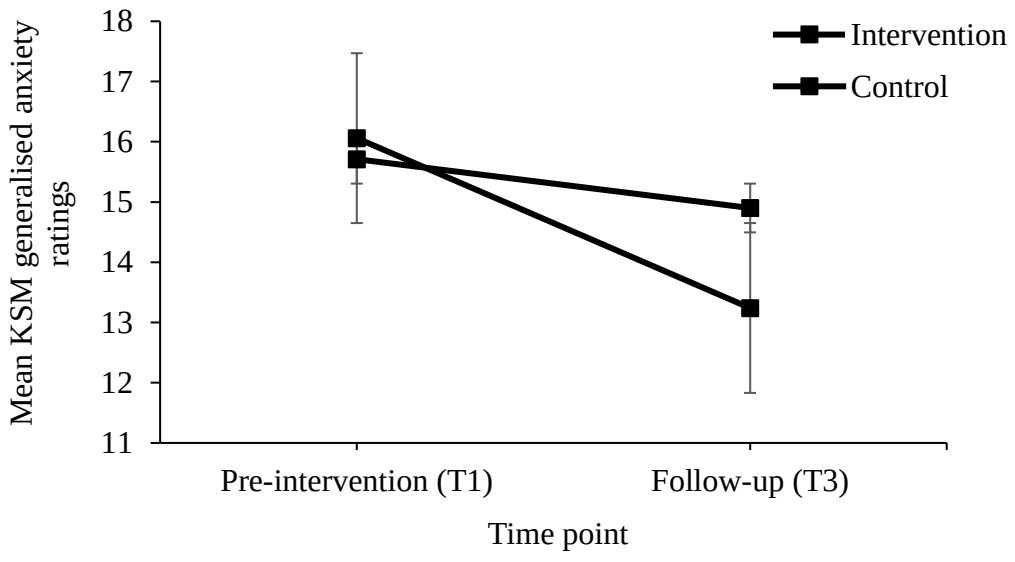


Figure 14. A graph to show the mean KSM generalised anxiety rating between T1 and T3 for the intervention and control group. Error bars display +/- one standard error from the mean.

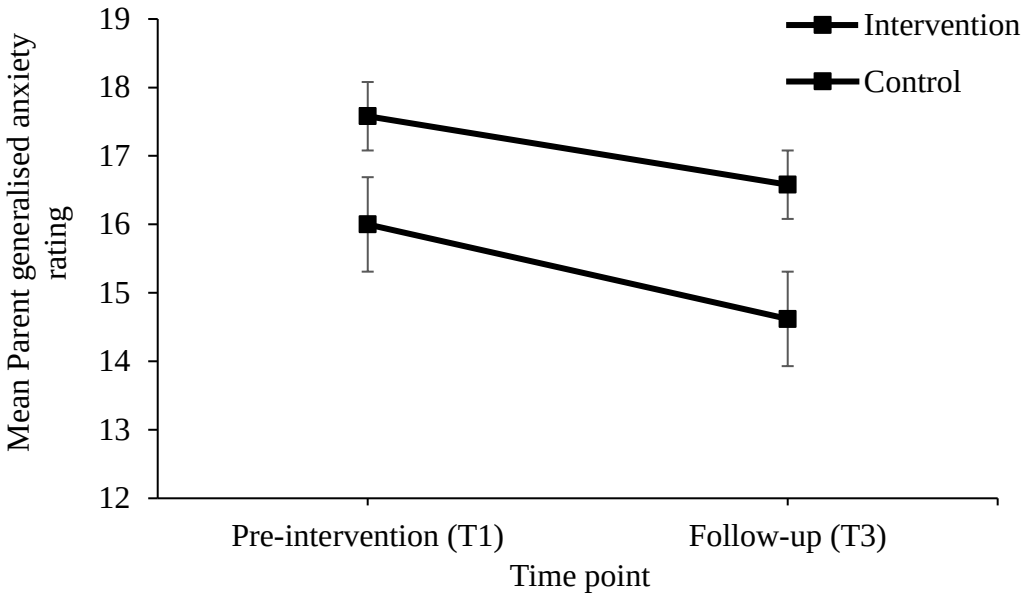


Figure 15. A graph to show the mean parent generalised anxiety rating between T1 and T3 for the intervention and control group. Error bars display +/- one standard error from the mean.

2.5 Discussion

This study aimed to explore whether a school-based iCBT programme (B-MAY) would be effective for reducing the anxiety of secondary aged pupils in the UK, and also whether there would be secondary benefits associated with the programme, such as enhancing the self-efficacy and attendance of these anxious pupils. Based on previous findings, it was hypothesised that B-MAY would lead to a significant reduction in anxiety (primary outcome) for pupils in the intervention group compared to the waitlist control at T2 and at a 2-month follow-up (T3). It was also hypothesised that the intervention pupils would show greater self-efficacy and attendance (secondary outcomes) at T2 compared to

the control group. Post-hoc investigations were carried out for the sub-measures of anxiety (generalised and panic) and self-efficacy (social and emotional). 81% of pupils completed eight or more of the 10 sessions of B-MAY between T1-2. However, adherence for completing the measures between T1-3 was lower; 35% for youth, 41% for parents and 30% for KSMs. The key findings and implications of this study are discussed in the following sections.

2.5.1 Effects of B-MAY on overall anxiety

The results of this study did not support the hypothesis regarding the effect of B-MAY on reducing pupils' overall anxiety. Only the KSMs reported a significant reduction in overall anxiety between T1 and T2; however, this was found for pupils in both groups and not sustained at T3. Neither the young people nor their parents reported any significant changes in anxiety over this period.

These findings are not consistent with previous studies, which indicate that iCBT can lead to significant improvements in youth anxiety (e.g. Smith et al., 2015; Attwood et al., 2012). Furthermore, initial findings from the nested qualitative study (separate from this thesis) suggested that the majority of pupils enjoyed using B-MAY and felt it was beneficial. Discrepancies between the current findings, previous literature, and pupils' opinions may have occurred for several reasons.

Firstly, there are many 'real-world' challenges to implementing iCBT research in an educational context, which may be applicable to the current study (Wong et al., 2018). For example, due to the research being a pilot study, the staff were given flexibility in how to deliver B-MAY to enable them to find the best approach for their pupils (e.g. for staffing and timetabling). As a result, the effectiveness of B-MAY may have been influenced by a number of factors, such as the skills/knowledge of the facilitators, group dynamics, or staff

familiarity with their pupils. Indeed, 36% of facilitators felt they knew their pupils only ‘a little’ or ‘not at all’, and research indicates that the pupil-staff relationship can play a significant factor in help-seeking for mental health concerns (as highlighted in Chapter 1). Although such design adaptations may have allowed for greater access and ease in delivering B-MAY, they also make it difficult to ascertain the effectiveness of this programme.

Additionally, the results may have been influenced by the sampling method used in the study. The school SENCos and facilitators were asked to identify, recruit, and assign young people to the Braive and Control groups. However, information from the nested qualitative study indicates the staff may not have strictly followed the sampling criteria. For example, a few of the pupils spoke about receiving therapy from CAMHS alongside B-MAY, which was one of the exclusion criteria. A few of the pupils also mentioned how they did not feel they needed the programme or that it was right for them (despite enjoying it), which indicates the sampling method may not have captured the most appropriate pupils for B-MAY. This is also highlighted in the pre-intervention group mean scores, which show relatively low overall anxiety scores (Control = 63, B-MAY = 59, out of 112). This indicates the staff may have benefitted from further EP guidance and clearer information about the sampling criteria and how to select/assign pupils.

Another possible consideration is that the anxiety measure (YAM-5) may not have captured certain changes for the pupils. The YAM-5 was primarily developed as a diagnostic screening tool for anxiety disorders, and on reflection, is more likely to measure ‘trait’ (i.e. a more stable personality characteristic), rather than ‘state’ anxiety (i.e. something that is transient depending on the context and/or person’s skills) (Çankaya & Cevik, 2019; Spielberger, 2010). Findings from the nested qualitative study suggested that whilst the pupils felt that B-MAY provided useful coping strategies, they also felt their

anxiety would always be a part of them. This indicates that whilst the pupils' trait anxiety may have remained stable, their quality of life, or knowledge and management of their anxiety may have improved, which was unfortunately not explored by the YAM-5 or other measures in this study.

These study findings may also differ from other school-based iCBT studies due to considerable variations in study design, intervention outcomes, and research measures. The current study is the first investigation of the B-MAY intervention in UK schools for anxious pupils, whilst other studies (e.g. Smith et al., 2014; Attwood et al., 2012) have focused on a range of prevention programmes, targeting various outcomes (e.g. depression and wellbeing). As a result, it is difficult to draw direct comparisons between this study's findings and the evidence-base. It is clear that further school-based research is required, which uses robust and replicable designs, and also contributes to identifying the core features of iCBT programmes that make them effective and engaging for young people.

2.5.2 Effects of B-MAY on anxiety sub-measures (post-hoc)

Post-hoc tests indicated that pupils in both groups showed significant reductions in generalised (KSM and parent report) and panic anxiety (KSM report) between T1 and T2. The pupils also reported an overall significant interaction effect for panic anxiety between T1 and T2; although the subgroup tests were not significant, pupils in the B-MAY group reported a slight increase, whilst the controls reported a slight decrease. Only reductions in KSM-reported generalised anxiety were sustained at T3. The suggestions stated in the previous section may also be applicable to the anxiety sub-measures; however, it is important to consider specific trends in the data.

The post-hoc tests indicated a difference in anxiety reporting between the youth and their key adults. It may be possible that the parents and KSMs reported significant

reductions in generalised and panic anxiety because this was an expected outcome of the B-MAY intervention (See 'Hawthorne effect', Noland, 1958). However, as the key adults consistently reported reductions for both the Control and B-MAY groups, this may be less likely. An alternative explanation is that the students could have learnt to mask or suppress their anxiety over time as a way of coping with the school environment (e.g. See Schafer, Naumann, Holmes, Tuschen-Caffier, & Samson, 2017), which would mean their anxiety may have appeared to reduce externally to their key adults, whilst internally they still felt the same. Additionally, young people and their key adults are likely to have different levels of knowledge and frameworks of anxiety, which will influence how they perceive and record anxiety in themselves and others.

In terms of the youth-reported overall interaction for panic anxiety, it may be possible that the intervention pupils' exposure to this terminology, as well as being given information on what panic attacks feel like, led to increased awareness and reporting of associated symptoms; whereas the control group were not exposed to such information, leading their anxiety to reduce in line with overall and generalised anxiety. Research has shown that some adults can have side effects from completing iCBT, such as insight of their problems leading to further anxiety or a deterioration of targeted symptoms (See Rozental, 2016). Often these symptoms tend to be temporary, and do not have enduring effects on the person's wellbeing. This also appears to be applicable in the current study; although the pupils initially reported a slight increase in panic anxiety, this was not sustained at follow up, and the nested qualitative findings indicate they found the information on panic helpful. However, these findings highlight the importance of monitoring young people's wellbeing when completing an iCBT programme, to ensure there are no enduring, negative effects.

2.5.3 Effects of B-MAY on self-efficacy (including sub-measures)

Contrary to the hypothesis, the intervention group did not show any significant differences in overall or social self-efficacy compared to the control group between T1 and T2. There was a medium interaction effect for the subgroup of emotional self-efficacy. Although this was not significant, it may be helpful to consider why the B-MAY pupils reported a slight decrease in emotional self-efficacy, whilst the controls reported a small increase.

Similar to the anxiety findings, small changes in emotional self-efficacy for the control group could reflect its natural fluctuations throughout the school year. Alternatively, it is possible that the control pupils may have received other pastoral support or interventions; some of which may have specifically targeted self-efficacy or managing emotions (e.g. Emotional Literacy programmes). However, it is not possible to confirm whether the control pupils received any specific emotional support, because this data was not collected.

In contrast, the B-MAY programme may have led the intervention pupils to become more aware of how they were managing their emotions and feel less self-efficacious if these techniques were contributing to, rather than helping their anxiety (Rozental, 2016). Although the B-MAY intervention provided strategies to cope with anxiety, it could be possible the pupils did not have enough time to acquire, practice, and become proficient in applying these techniques in their everyday life, in order to feel efficacious and report this at T2 (especially for pupils who did not manage to complete B-MAY). Previous research indicates that delays in CBT treatment effects can be common for adults and young people (e.g. Rachman, 1999; Skriner, 2019). This was not investigated in the current study, because the main focus at follow-up was the primary

outcome of anxiety to reduce possible attrition. However, future studies may benefit from using a follow-up measure of self-efficacy to explore any possible delayed effects.

2.5.4 Effects of B-MAY on attendance

The attendance data provided by the parents did not support the hypothesis regarding the effects of B-MAY for improving attendance between T1 and T2. However, this data indicates there was a ceiling effect, because the majority of pupils showed high attendance (as reported through 'days missed') at T1 (M = 1.98, SD = 2.19) and T2 (M = 1.09, SD = 1.61). This is perhaps not surprising, because by law children in the UK are expected to receive full-time education, unless there are exceptional circumstances (e.g. illness) or the parent has elected to home educate (See 'Education Act', Gov.uk, 1996). This effect may have also been due to the sampling criteria, because the study aimed to support young people who were falling just below the CAMHS threshold and still managing to attend school despite their anxiety. Additionally, the attendance measure may have lacked sensitivity to detect changes over time. Due to research governance complications of gaining attendance data directly from schools, this information was gained from the parents. However, several parents seemed unsure of the exact days their child attended school (e.g. putting question marks after their response) and this may have affected the data's accuracy. The questionnaire also did not ask the parents to specify why the child was not attending school, and this could have been due to illness/bereavement/extra-curricular activities rather than anxiety-related problems. Future measures could aim to record the number of lessons pupils attended and reasons for non-attendance, to give a more accurate picture of this outcome.

2.5.5 Adherence

Pupil adherence to B-MAY was good, with 81% of participants completing eight or more sessions and only 15% completing less than six. These rates are comparable to other school-based iCBT programmes (e.g. 62-86% adherence for Stressbusters; Smith et al., 2015; Wright et al., 2017) and favourable to iCBT projects not based in schools (e.g. 24.5% adherence for 'Brave self-help'; March, Spence, Donovan & Kenardy, 2018). Incompletion of B-MAY could have been due to pupil absences, the facilitators' pacing of sessions, and/or time constraints of the research project. Nevertheless, these findings contribute to evidence that school-based programmes can reduce issues related to adherence and drop-out, which are often found in general iCBT research (Wong et al., 2018). This may be due to the extra 'human support' pupils receive in school from the staff, such as frequent prompts and encouragement, which may increase retention rates (See Stjerneklar, Hougaard & Thastum, 2019).

Despite good adherence to B-MAY itself, participant completion rates for the research measures at T3 were much lower; 35% youth, 41% parents and 30% KSMs. Previous studies have also shown difficulties with participants completing research measures, especially at follow-up (e.g. Wright et al., 2017). In the current study, it may be possible that the young people did not feel motivated to complete a third survey, or perhaps did not feel it was a priority when transitioning to a new school year. These findings highlight the importance of developing and utilising quick, simple, and engaging research measures when working with young people.

2.5.6 Strengths, limitations and further research

This research study has several notable strengths. In particular, the project involved collaboration with the creators of the original Braive programme and an EP service. This

not only allowed for the adaptation of B-MAY for UK schools, but also enabled the research team to examine possible effects of B-MAY across several school environments. Schools in the UK are under increased pressure to provide effective mental health support for their pupils (DfE, 2019), and this pilot study attempted to bridge the gap between theory and practice by providing an 'evidence-informed' programme that school staff can be trained to deliver. This study also endeavoured to examine the effects of B-MAY from several perspectives (i.e. the pupils, their parents and KSMs) and on a range of outcomes, because anxiety can often have far-reaching effects on young people's lives, and present differently between home and school environments (See Swan & Kendall, 2016).

There are several limitations to this study, and areas in which further investigation would be beneficial. Firstly, due to the pragmatics of carrying out real-world research it was not possible to use randomisation or blinding in this study, which may have affected the findings. For example, 'contamination' effects may have occurred, in which the facilitators may have (consciously or subconsciously) used the techniques from B-MAY with control group pupils in the same school. Responses to questionnaires and B-MAY could have also been influenced by the pupils' or key adults' awareness of their grouping (e.g. the 'Hawthorne effect', Noland, 1958). Consequently, further research using robust and replicable designs (e.g. with randomisation, blinding and an active control group) is needed to determine the efficacy of B-MAY on anxiety, and the inclusion of key secondary outcomes that are important for its effectiveness (e.g. type of content, delivery or length).

Another limitation was the high attrition rates for the research measures, which meant there was not enough power to detect possible differences across all three time points and for certain sub-measures (e.g. type of delivery method, school cluster). To reduce the likelihood of making a Type II error, separate ANOVAs were carried out and effect sizes were explored, which are independent of sample size and therefore enable the

researcher to gain an indication of the magnitude of difference between groups (Sullivan & Feinn, 2012). Future researchers could reduce attrition rates in several ways, such as by using easy and short research measures, ensuring school staff are provided with adequate time to complete and/or obtain data, providing schools with further 1:1 or group support in completing measures, and avoiding busy months of the school year (such as the start or end of a term).

Additionally, there were several uncontrolled variables which may have influenced the study outcomes; for example, the school (e.g. differences in ethos, values, teaching styles), facilitator-pupil relationship, group dynamics or access to B-MAY via the app. Measuring such variables was beyond the scope of the current study. However, future research could particularly focus on the role of the facilitator, in terms of how they can establish rapport with their pupils, create positive group dynamics, and support their pupils to understand and generalise the B-MAY techniques. The potential benefits of involving parents/caregivers in iCBT programmes may also be a fruitful avenue of research (See Carnes, Matthewson & Boer, 2019; Kreuze, Pijnenborg, Jonge & Nauta, 2018). Future research should attempt to explore potential confounding factors, such as the type of school or group dynamics.

Lastly, this study only included a 2-month follow up for the primary outcome (anxiety) and did not have measures between data collection points for monitoring possible deterioration in the two groups. Several researchers (e.g. Rozental, 2016; Rozental, Boettcher, Andersson, Schmidt & Carlbring, 2015; Skriner, 2019) have already highlighted the importance of monitoring intervention effects over time, to understand the different short- and long- term responses that can occur, as well as to safeguard young people against any enduring, negative effects of iCBT. Currently this is not a key consideration in school-based iCBT research; however, longer-term exploration of iCBT effects appears to

be vital for identifying whether any positive changes can be sustained, and for ensuring the welfare of young people.

2.6 Conclusions and practical implications

This research study investigated the efficacy of an iCBT programme (B-MAY) for reducing the anxiety of secondary aged pupils in the UK. This study also explored whether there would be secondary benefits associated with the programme, such as enhanced self-efficacy and attendance of these anxious pupils. The findings revealed no significant between-group differences on anxiety, self-efficacy or attendance. However, pupils in both groups (intervention and control) showed reductions in overall, panic, and generalised anxiety between T1 and T2 (KSM- and parent- reported). Only KSM-reported differences in generalised anxiety were sustained at a 2-month follow up (T3). Adherence was good, with 81% of pupils completing eight or more of the ten iCBT sessions.

The limitations of this research restrict the ability to draw firm conclusions about the effectiveness of B-MAY, or the optimal conditions in which it could be delivered in schools. However, given the positive feedback from both the pupils and facilitators in the nested qualitative study (separate from this thesis), it appears that B-MAY may still have value in UK schools in ways that were not measured in the current study. There is evidently a need for evidence-based programmes that can support and help anxious pupils who fall below the threshold for CAMHS, and internet-based therapies could reduce barriers to access, such as feelings of stigma or long waiting times (NHS, 2018; Anderson et al., 2017). iCBT programmes (such as B-MAY) may also be particularly helpful for schools, because they provide an accessible resource that pastoral/support staff can be trained to deliver. This study has already shown that EPs can play an important role in providing initial training for iCBT programmes and ongoing supervision. Such support will

ensure that staff feel confident in delivering the materials, find solutions to any problems, and make appropriate referrals to relevant services (e.g. their SENCo or CAMHS).

Despite the potential value of B-MAY and of similar iCBT programmes in UK schools, this study also highlights the limited evidence-base for these programmes. Therefore, it is important that schools are not substituting iCBT programmes in the place of more evidence-based and/or professional mental health support. EPs should be cautious in advising the use of iCBT (such as B-MAY) without clear evidence and emphasise the use of these programmes to complement rather than replace other emotional support. Schools will also need to be aware of the need to set up suitable monitoring procedures, to ensure that no negative effects of iCBT occur for their pupils and they are receiving adequate support alongside the programme. EPs are well placed to help school staff set up appropriate monitoring and safeguarding systems, as well as to provide regular therapeutic support and advice.

It is also important to note that the quantitative (and qualitative data from the nested study) findings indicate that a minority of pupils did not appear to benefit from B-MAY. Previous studies have found that some young people prefer face to face contact for certain mental health issues and highlight several concerns about online programmes, such as their privacy, ability to ask questions and level of therapist support (Glasheen et al., 2015, 2016; Sweeney, Donovan, March & Forbes, 2019). Consequently, it is important that pupils are provided with a range of choice and agency when it comes to seeking and receiving support for their mental health. EPs could support schools to widen their range of provision, including the identification of evidence-based online therapies and resources, which may be preferred by some students (See Sweeney et al., 2019). Regardless of provision type, it will be vital for schools and EPs to continue keeping young people's needs and wishes at the forefront of any decisions regarding their mental health support.

Appendix A Literature review: Search terms

Back to Section 1.2.1 (Search strategy)

child* OR adolescen* OR teen* OR young people OR young person OR youth OR student* OR pupil*

AND

school* OR educational provision OR educational setting OR school-based* OR school-going OR class*-based OR teacher* OR school counsel* OR school-based adult OR school nurse OR pastoral*

AND

seek* OR look* OR search* OR obtain* OR find* OR request* OR ask* OR pursu* OR utili* OR view* OR perceive* OR experience* OR attitude* NEAR/5 help* OR support*

AND

Mental health OR psychological health OR emotional health OR wellbeing OR emotional difficult* OR emotional need* OR anxiety* OR depressi* OR self harm OR obsessive compulsive disorder OR OCD OR trauma OR stress

AND

barrier* OR obstacle* OR difficult* OR issue* OR challenge* OR problem* OR facilitator* OR enabl* OR motivate* OR factor* OR influenc* OR determin* OR prevent* OR mediat* OR moderat* OR predict*

Appendix B Literature review: Record of searches

Back to Section 1.2.1 (Search strategy)

Date accessed	Database used	Search Keywords used	Results	Relevant results (based on title or abstract)
10/05/19	Psychinfo	TI ("child*" OR "adolescen*" or "teen*" OR "young people" OR "young person" OR "youth*" OR "student*" OR "pupil*") OR AB ("child*" OR "adolescen*" or "teen*" OR "young people" OR "young person" OR "youth*" OR "student*" OR "pupil*") TI ("school*" OR "educational setting" OR "educational provision*" OR "school-based*" OR "school-going" OR "class*-based" OR "teacher*" OR "school counsel*" OR "school-based adult" OR "school nurse" OR "pastoral*") AND AB ("school*" OR "educational setting" OR "educational provision*" OR "school-based*" OR "school-going" OR "class*-based" OR "teacher*" OR "school counsel*" OR "school-based adult" OR "school nurse" OR "pastoral*") TI ("seek*" OR "look*" OR "search*" OR "obtain*" OR "find*" OR "request*" OR "ask*" OR "pursu*" OR "utili*" OR "view*" OR "perceive*" OR "experience*" OR "attitude*") N2 (help* OR support*) AND AB ("seek*" OR "look*" OR "search*" OR "obtain*" OR "find*" OR "request*" OR "ask*" OR "pursu*" OR "utili*" OR "view*" OR "perceive*" OR "experience*" OR "attitude*") N2 (help* OR support*) ("mental health" OR "psychological health" OR "emotional health" OR "wellbeing" OR "well being" OR "emotional difficult*" OR "emotional need*" OR "anxiet*" OR "depressi*" OR "self-harm" OR "self harm" OR "obsessive compulsive disorder" OR "OCD" OR "trauma" OR "stress") (“barrier*" OR "obstacle*" OR "difficult*" OR "issue*" OR "challenge*" OR "problem*"	82	18

		OR "facilitator*" OR "enable*" OR "motivat*" OR "factor*" OR "influenc*" OR "determin*" OR "prevent*" OR "mediat*" OR "moderat*" OR "predict*")		
17/05/19	Psychinfo, Medline & CINAHL	Same as above.	123	25
17/05/19	ERIC	TI ("child*" OR "adolescen*" OR "teen*" OR "young people" OR "young person" OR "youth" OR "student*" OR "pupil*") AND AB ("child*" OR "adolescen*" OR "teen*" OR "young people" OR "young person" OR "youth" OR "student*" OR "pupil*") TI ("school*" OR "educational provision" OR "educational setting" OR "school-based*" OR "school-going" OR "class*-based" OR "teacher*" OR "school counsel*" OR "school-based adult" OR "school nurse" OR "pastoral*") AND AB ("school*" OR "educational provision" OR "educational setting" OR "school-based*" OR "school-going" OR "class*-based" OR "teacher*" OR "school counsel*" OR "school-based adult" OR "school nurse" OR "pastoral*") TI ("seek*" OR "look*" OR "search*" OR "obtain*" OR "find*" OR "request*" OR "ask*" OR "pursu*" OR "utili*" OR "view*" OR "perceive*" OR "experience*" OR "attitude*") NEAR/5 ("help*" OR "support*") AND AB ("seek*" OR "look*" OR "search*" OR "obtain*" OR "find*" OR "request*" OR "ask*" OR "pursu*" OR "utili*" OR "view*" OR "perceive*" OR "experience*" OR "attitude*") NEAR/5 ("help*" OR "support*") AND "Mental health" OR "psychological health" OR "emotional health" OR "wellbeing" OR "emotional difficult*" OR "emotional need*" OR "anxiety*" OR "depressi*" OR "self harm" OR "obsessive compulsive disorder" OR "OCD" OR "trauma" OR "stress"	38	10

		AND “barrier*” OR “obstacle*” OR “difficult*” OR “issue*” OR “challenge*” OR “problem*” OR “facilitator*” OR “enabl*” OR “motivate*” OR “factor*” OR “influenc*” OR “determin*” OR “prevent*” OR “mediat*” OR “moderat*” OR “predict*”		
14/06/19	Web of Science	TI=(child* OR adolescen* or teen* OR young people OR young person OR youth* OR student* OR pupil*) AND TI=(school* OR "educational setting" OR "educational provision*" OR "school-based*" OR "school-going" OR "class*-based" OR teacher* OR "school counsel*" OR "school-based adult" OR "school nurse" OR pastoral*) AND TI=("seek*" NEAR/2 "help*") OR TI=("seek*" NEAR/2 "support*") AND TS=("mental health" OR "psychological health" OR "emotional health" OR "well being" OR "emotional difficult*" OR "emotional need*" OR anxiet* OR depressi* OR "self-harm" OR "obsessive compulsive disorder" OR OCD OR trauma OR stress) AND TS=(barrier* OR obstacle* OR difficult* OR issue* OR challenge* OR problem* OR facilitator* OR enable* OR motivat* OR factor* OR influenc* OR determin* OR prevent* OR mediat* OR moderat* OR predict*)	162	24
19/08/19 – 23/09/19	Reference list search	Searched systematically through each screened article’s reference list, using the exclusion/inclusion criteria.	N/A	6

07/09/19	Re-running of searches psychinfo, medline and CINHAL	Same search criteria as above.	129	23 (1 new relevant article)
07/09/19	Re-running of search on ERIC	Same search criteria as above.	38	9 (no new relevant articles)
07/09/19	Re-running of search on WoS	Same search criteria as above.	172	26 (1 new relevant articles)
07/09/19	Open Grey	(child* OR adolescen* or teen* OR young people OR young person OR youth* OR student* OR pupil*) AND (school* OR "educational setting" OR "educational provision*" OR "school-based*" OR "school-going" OR "class*-based" OR teacher* OR "school counsel*" OR "school-based adult" OR "school nurse" OR pastoral*) AND ("mental health" OR "psychological health" OR "emotional health" OR "well being" OR "emotional difficult*" OR "emotional need*" OR anxiet* OR depressi* OR "self-harm" OR "obsessive compulsive disorder" OR OCD OR trauma OR stress) AND (help* OR support*)	96	0
07/09/19	Worldcat	(child* OR adolescen* or teen* OR young people OR young person OR youth* OR student* OR pupil*) AND (school* OR "educational setting" OR "educational provision*" OR "school-based*" OR "school-going" OR "class*-based" OR teacher* OR "school counsel*" OR "school-based adult" OR "school nurse" OR pastoral*) AND ("mental health" OR "psychological health" OR "emotional health" OR "well being" OR "emotional difficult*" OR "emotional need*" OR anxiet* OR depressi* OR "self-harm" OR "obsessive compulsive disorder" OR OCD OR trauma OR stress) AND (“help seeking” OR “support seeking”)	69	14 after removing duplicates (5 new relevant articles)

Appendix C Literature review: Identification of additional records

Back to Section 1.2.2 (Identification of additional records)

Unpublished work searches:

19/08/19 – 23/09/19 - Reference list searches (see table above for details)

14/06/19 - Contacted researcher (Louise Doyle) with regards to missing information from an article and any further unpublished work. – email response on 16/06/19 confirmed missing information and highlighted another published paper, but this was already identified through the current literature review search.

11/10/19 – Emailed Kevin Glasheen and Sarah Kendal to request unpublished work relevant to review question.

25/10/19 – Email response from Sarah Kendal about new research project. The project aims to explore digital approaches to young people's mental health but does not focus on young people's help-seeking specifically. This project is currently in the process of being written, so will also not be included within this review's timeframe.

Gray and additional literature searches:

- Searched 'Open Grey' on 07/09/19 – no new articles
- Searched 'Worldcat' on 07/09/19 – 5 new articles – four dissertations & one published article* (Arora & Persaud, 2019*; Kramar, 2008; Best, 2014; Barlis & Wang, 2018; Williams, 2009)

(see Appendix B for search terms)

Appendix D Literature review: Inclusion and Exclusion criteria

Back to Section 1.2.3 (Inclusion and exclusion criteria)

Inclusion criteria	Exclusion criteria
Children and young people ≤ 18 years	Young people/adults over the age of 18.
Help-seeking for any mental health or emotional needs e.g. anxiety, depression, obsessive-compulsive disorder (OCD).	Help seeking in schools not directly for mental health (e.g. bullying, academic, social support)
Help-seeking from school-based adults or mental health provisions in schools (SBMHS).	Help seeking not directly related to school context e.g. clinic/medical/hospital based
Children and young people's help seeking behaviour/intention/experiences for mental health concerns.	Help seeking intentions/views/behaviours of families/parents/professionals outside of the school context.
Qualitative and quantitative study designs	Intervention/prevention studies
Journals/articles published during and after 2010.	Journals/articles published before 2010.
Journals/articles that have been peer reviewed.	Journals/articles that have not been peer reviewed.

Appendix E Literature review: Quality measures

Back to Section 1.2.4 (Data extraction)

E.1 Appraisal of Cross Sectional Studies (AXIS)

	Question	Yes	No	Don't know/ comment
Introduction				
1	Were the aims/objectives of the study clear?			
Method				
2	Was the study design appropriate for the stated aim(s)?			
3	Was the sample size justified?			
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)			
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?			
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			
7	Were measures undertaken to address and categorise non-responders?			
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?			

9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?			
10	Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)			
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			
Results				
12	Were the basic data adequately described?			
13	Does the response rate raise concerns about non-response bias?			
14	If appropriate, was information about non-responders described?			
15	Were the results internally consistent?			
16	Were the results presented for all the analyses described in the methods?			
Discussion				
17	Were the authors' discussions and conclusions justified by the results?			
18	Were the limitations of the study discussed?			
Other				
19	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?			
20	Was ethical approval or consent of participants attained?			

E.2 Critical Appraisal Skills Programme (CASP) checklist

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐ Can't Tell ☐ No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix F Literature review: Data Extraction Table

Back to Section 1.3.1 (Study characteristics)

Study code	Author(s), year	Key aims/objectives	Study setting	Sample characteristics	Methodology	Key findings
1	Anyon, Whitaker, Shields & Franks (2013)	To explore the role of school organisational and social factors in help-seeking from School Health Programmes (SHPs) by Chinese American (CA) high school students. Influences explored across three main areas of help-seeking: recognising need, deciding to seek help and selecting services.	High school San Francisco USA	1700 participants (44 in focus groups & 7 in interviews) Aged 14-18 50% male and 50% female Ethnicity: 42% Chinese American, 20% Latino, 9% White, 7% Black and 15% Asian other. 60% reported at least 1 'risky' behaviour, 40% accessed the SHP once.	Mixed method One self-report questionnaire: Youth Risk Behaviour Survey (YRBS) – Pearson chi-squared tests and regression analysis. Interviews and focus groups - Thematic analysis	**Key reasons for help-seeking from SHPs:** males - talking to someone about personal problem and take a break or hang out ($p<.05$), females – support/empowerment group (16%) **Recognition of need:** Significantly less CA youth were aware of SHP services and more CA girls reported 'not needing' it compared to peers. The SHP was perceived as being for 'troublemakers', or students they did not identify with. **Decision to seek help:** Significantly less CA youth reported feeling welcome or comfortable accessing their SHP. CA students did not identify with regular users (e.g. in terms of race, or 'having a problem'). Referral from school staff was a facilitator in accessing the SHP and overcoming discomfort in seeking help. **Service selection:** Significantly less CA youth reported visiting the SHP to relax, but higher

						proportion accessed the support groups. Relationships with SHP staff were important to CA youths' willingness to access their SHP.
2	Arora & Algios (2019)	To explore 1st and 2nd generation Asian American immigrant youth's perceptions of School-based Mental Health (SBMH) services and their recommendations for addressing MH needs in schools.	High school USA (State unknown)	33 participants Aged 14-20 58% female, 42% male Ethnicity: Chinese (76%), 'Asian other' (24%) e.g. Indian, Korean, Malaysian. First language: majority Mandarin (76%) Majority born outside the US (82%), with remainder born to immigrant parents.	Qualitative Focus groups Grounded theory approach	**Arora & Algios' key themes:** **Awareness of SBMH services:** students showed varying awareness of these services. For students who were aware, they had learnt this through a variety of sources e.g. teachers or school counsellors. **Misconceptions of MH services:** students felt that SBMH services were for academic or serious MH concerns only. **Positive views of SBMH services:** students felt the services were more practical (e.g. easier to access than outpatient services) and gave greater privacy (e.g. their peers, parents or local communities did not need to know about their MH issues). **Negative views of SBMH services:** students considered the SMBH providers may be unhelpful due to not knowing the pupil or their school/home context. Also concerns over logistics (e.g. timing), confidentiality (particularly disclosure to parents or teachers without their consent) and stigma.

						Recommendations for SBMH services: psychoeducation for parents and pupils, further engagement (e.g. liaising with local organisations and parent meetings at school), maintaining confidentiality (e.g. greater clarity around rules).
3	Arora & Persaud (2019)	To explore barriers to MH help-seeking for suicide among Guyanese youth, as well as recommendations for suicide prevention and intervention among youth.	1 secondary school Guyana South America	57 participants (17 adults, 40 students) Students aged: 12-17 Gender: 43% male, 57% female Ethnicity: East Indian (88%), 'Mixed' (8%) or African (4%) Religion: Hindu (75%), Christian (10%), Muslim (5%), Rastafarian (2.5%), None (5%)	Qualitative Interviews with young people Focus groups with adults (not reported here) Grounded theory approach	**Arora & Persaud's key themes:** **Barriers to help-seeking:** shame and stigma surrounding suicide (e.g. seen as weak or stupid), negative parental responses (e.g. punishing or dismissing), lack of awareness and negative beliefs about MH services (e.g. mistrust regarding their purpose). **Recommendations for prevention/intervention:** • Inclusion of spiritual or religious activities (e.g. yoga). • Involving parents through psychoeducation. • In schools: more opportunities to discuss concerns, which could be facilitated by teachers and include members of the community. The use of peer groups and non-academic activities to support and improve wellbeing. • School staff qualities: accessible, relatable, show interest, openness, maintain

						confidentiality, use age appropriate language and show respect. • Mixed views about having a SBMH provider e.g. helpful to have direct access but issues of confidentiality.
4	Bains, Franzen & White-Frese (2014)	To explore the reasons why African American (AA) and Latino adolescent males seek help from School-based health centres (SBHCs) and their perceptions of these services.	4 High schools and 3 Middle schools Connecticut USA	22 participants Aged 13-18 Gender: 100% male Ethnicity: 45% AA, 55% Latino, 34% South American All participants were receiving counselling from their SBHC.	Qualitative Semi-structured interviews Content analysis	**Bains et al.'s key themes:** **'Burdens and hurdles in life':** the students were referred to the SBHC for a variety of reasons e.g. risky behaviour, anger issues, family problems, depression and suicide. Students spoke about lack of parental support, home responsibilities, racism and peer pressure as key reasons for seeking support. **'The door is always open':** The SBHC provided easy and convenient access for these students, before their problems became too big to handle. The availability and informality of counsellors allowed them to stay in school and avoid conflict. **'Sanctuary within chaos':** The staff at the SBHCs helped the students to feel heard and understood. They had a number of qualities e.g. listening, encouraging, understanding, gave good advice, offered choices. The students also saw the SBHC as a place of

						safety when struggling with sexuality, emotions or problems. **'They get us':** Counsellors were seen as caring, trustworthy and non-judgemental, which allowed the students to feel more comfortable and open up. **'Achieve my best potential':** Availability and access to SBHC allowed the students to function better and improve their academic grades, behaviour and interpersonal relationships.
5	Chen & Kok (2017)	To investigate the barriers preventing Malaysian Chinese students from seeking help from school counselling services.	2 Chinese High schools Malaysia	277 participants Aged 13-20 43.7% male, 56.3% female Ethnicity: Chinese	Qualitative Questionnaire with open-ended question Thematic analysis	**Chen & Kok's key themes:** **Self & public stigma** – students expressed embarrassment, shame and fear about what others might think about their help-seeking. **Conceptualisation of problem** – some did not feel they had a problem, or it was severe enough to seek help for. They also felt they could solve the problem on their own. **Lack of courage** – students were afraid to seek support due to stigma attached. **Concerns about counsellor competence** – e.g. students did not feel counsellors were trained professionals or might disclose information to others.

						Lack of time – students perceived help-seeking to be a waste of time or valued academic achievement higher than their own wellbeing. **Support from family or friends** – these students felt they were able to seek help from family or friends if they had a problem.
6	Daeem et al. (2016)	To examine Israeli Arab adolescents' help-seeking in school, with the following research questions: Are students at high risk of developing a MH problem more likely to seek help than low risk pupils? Who do they seek help from? How does wellbeing at home, religion and neighbourhood	High schools Israel	2366 participants (1639 responses in first stage and 704 at follow up) Aged 14-15 43.6% male, 56.4% female Religion: 50.9% Muslim, 43.9% Druze and 5.3% Christian Ethnicity not reported.	Quantitative Strengths and difficulties questionnaire (SDQ) Sociodemographic questionnaire Help-seeking in school questionnaire Wellbeing at home questionnaire Pearson chi-squared and	**Daeem et al.'s key findings:** • Students in 'high risk' group had significantly higher means than low risk on all subscales of SDQ and lower pro-social behaviour. • Higher proportion of the high-risk group were female, living in Muslim localities (compared to Druze) and under welfare care compared to low risk. • Adolescents in high risk groups were more likely to feel the need to seek professional help and were twice as likely to have consulted a school source in past year compared to low risk group. • Among students who did not feel comfortable at home, consultation with a school source was high regardless of group. • For high risk group, only religion was significantly associated with help-seeking

		influence help-seeking?			logistic regression analysis.	in school: Muslim students twice as likely to seek help than Druze students. • For low risk group, wellbeing at home was significantly associated with help-seeking: students who did not feel comfortable were 3x more likely to seek help. • Both groups ranked their teacher as the best choice for support, followed by school counsellor and a friend.
7	DeFosset, Gase, Ijadi-Maghsoodi & Kuo (2017)	To explore how ethnic minority youth, with a history of school truancy, express their MH problems and perceptions of school-based MH services.	Middle and High schools Los Angeles USA	39 participants (only 18 included in this secondary analysis) Aged 12-18 72% female, 28% male Ethnicity: 16 Latino, 2 African American Youth with reported truancy at least once per month in past year and experienced at least one truancy intervention.	Qualitative Semi-structured interviews Thematic analysis	**DeFosset et al.'s key themes:** **Youth descriptions of MH problems:** Majority of youth reported both internalising and externalising symptoms and spoke about how these impacted on their school attendance (e.g. anxiety/depression led to youth missing school due to apathy or feeling overwhelmed). **Youth pathways through MH services:** • 17/18 reported contact with adult relating to MH needs. • Majority of contact occurred in school, initiated typically by school staff. Youth described encounters primarily focusing on discipline and attendance, with services offered in tandem with sanctions. • Only 9/13 youth offered services accepted them. This was due to youth and adult

						responses (e.g. unwillingness or adults not successfully linking them to services). **Main influences on service pathways:** • Quality of relationships – youth were less willing to talk about their problems and receive help without a positive relationship with an adult. • Perceived efficacy of help-seeking – many youths questioned the efficacy of services and preferred to rely on themselves.
8	Doyle, Treacy & Sheridan (2017)	To quantitively identify the extent and sources of adolescent help-seeking and to qualitatively explore help-seeking in the school setting.	11 secondary schools Ireland	856 participants (35 in the focus groups) Aged 15-17 51% male, 49% female Ethnicity: not reported Primary MH need: self-harm	Mixed method One self-report questionnaire: Lifestyle and coping questionnaire Also added questions regarding if the YP had ever had a MH concern and who they sought help from.	**Doyle et al.'s key quantitative findings:** • 68% of pupils did not feel they had serious enough MH problems to seek professional help. • 32% had a serious problem, but 78% did not seek any help. • 92% reported they had someone to talk to about their problems. Most commonly reported confidant was a friend (83%), then mother (65%). 84% would not go to their teacher. **Key qualitative themes:** **Barriers to help-seeking from school staff** – dual role of school staff (pupils had a desire to keep counselling separate from schoolwork)

					– reported descriptively. Focus groups - Thematic analysis	and confidentiality (unclear when a problem would require parental intervention). **Increasing education about MH & help-seeking** – stigma was seen as a root cause of confidentiality and low help-seeking. Pupils suggested better, targeted MH promotion to increase awareness (e.g. formally learning about MH during lessons).
9	Glasheen, Shochet & Campbell (2016)	To explore students' intentions to use online counselling in a school environment, concerns they may discuss online and factors which may influence this intention (e.g. gender or level of distress).	7 secondary schools South East Queensland Australia	215 participants Aged 13-18 47.9% male, 52.1% female Ethnicity: not reported.	Quantitative Online survey with 36 items (e.g. intentions to use online counselling, demographics, help-seeking behaviours). Descriptive statistics reported and Pearson chi-squared used.	**Glasheen et al.'s (2016) key findings:** • 80% females and 84% males indicated they 'might or would be likely' to use online counselling. 18% said they would not use it. • Significant difference of year on intentions to use online counselling: year 8 and 12 significantly more likely. • Students with moderate-severe levels of depression or stress were significantly more likely to use online counselling. No significant difference for anxiety levels. • Students would 'definitely prefer' to use online vs face to face counselling for sexuality concerns (30%), dealing with conflict at home (8.8%), worrying thoughts/feelings (7.9%), bullying (10.2%) and cyberbullying (10.2%).

						• Students preferred face to face counselling for career planning (29.8%), academic work (25.1%) and having someone listen to them (24.2%).
10	Glasheen, Campbell & Shochet (2015)	To ascertain the perceptions of students and school counsellors regarding online school counselling. To explore whether students would use online services and possible barriers to this use.	3 secondary schools South East Queensland Australia	22 participants (school counsellors not reported here) Aged 13-18 Mix of male and female (exact numbers not reported) Ethnicity: not reported.	Qualitative Focus groups Thematic analysis	**Glasheen et al.'s (2015) key themes:** **Individual preference –** students generally in favour of online counselling but felt it would depend on individual preference and experience of using online technology. There was also belief that communicating online would promote feelings of emotional safety, allowing the person to talk more freely (disinhibition effect). **Security and confidentiality** – students were conscious of negative aspects of online technology, particularly in terms of confidentiality (e.g. hacking). Some considered that parents may also be suspicious of their use of technology at home. **Consequences of 'disinhibition effect'** – students identified positive (e.g. anonymity can give the person a sense of safety and allow them to give more honest responses) and negative effects (e.g. using technology as a 'shield' for expressing bullying or abusive opinions).

						Trust – some students feared their trust may be broken and online transcripts shown or told to others. Although school counsellors were generally regarded as trustworthy. **Accessibility** – students preferred being able to contact counsellors at home but acknowledged that not everyone may have access to a private computer. **Ability to discuss sensitive issues** – the students suggested online counselling could allow young people to discuss a variety of sensitive issues e.g. bullying, sexuality and relationships.
11	Huggins et al. (2016)	To investigate the role of stigma as a contributing factor in students' decisions to utilise school mental health services.	3 High schools South Carolina USA	15 participants (6 students and 9 school staff) Aged 18 No other demographics reported.	Qualitative Semi-structured interviews Thematic analysis & adapted grounded theory	**Huggins et al.'s key themes:** **Knowledge of MH and School MH services –** students were uncertain of how to define MH problems and tended to lack understanding (e.g. saying a 'crazy person'). Students were most likely to reach out to a friend and then trusted adult but seemed unaware of the school services. **Perception of stigma associated with having MH problems** – 3/6 students suggested the most common stereotype for students accessing the school services would be 'crazy' or 'insane'. All students felt that peers may

						tease or pick on them for accessing such services. Some said they would feel embarrassed and awkward about talking to a school counsellor. **Concerns about privacy/confidentiality** – all students felt their school would maintain confidentiality and trusted the staff. They were comfortable with the location but suggested having sessions before or after school hours (possibly linked to being noticed and stigma). **Utilisation and effectiveness of services** – 5/6 students felt MH problems occur frequently and more students would benefit from the services. They suggested publishing of the services to make them more effective.
12	Ijadi-Maghsoodi et al. (2018)	To explore the views of students in under-resourced areas with School-Based Health Centres (SBHCs) to inform student care and engagement.	9 secondary schools USA (state unknown)	76 students Aged 11-18 (majority in grades 11-12: 67.2%) 34.2% male, 65.8% female Ethnicity: 77.6% Latino, 13.2% Asian,	Qualitative Focus groups Content analysis	**Ijadi-Maghsoodi et al.'s key themes:** **Student help-seeking –** teachers were identified as a primary source of help, followed by peers and MH counsellors. Students were least likely to obtain help from family members. **Barriers to help seeking:** • **Embarrassment** – in terms of help-seeking from a SBHC, especially for mental rather than physical problems.

				3.9% African American, 3.9% Multiracial.		• **Fear of being judged** e.g. being viewed as 'insane' or a 'wimp' • **Confidentiality** – many feared that parents, peers or police would learn of their problems. • **'Keeping things inside'** – some believed the problem would resolve itself or showed a preference for self-reliance (linked to pride and toughness). • **Lack of awareness** – students felt they and their peers did not know who providers were and how to access them. Also saw lack of awareness about their own MH as barrier to help-seeking. **Student recommendations for help-seeking:** • **The SBHC as a 'second home'** – making it a comfortable, welcoming and enjoyable place to be, and providing it with appropriate label. • **Increasing connections** – facilitating bonds between SBHC staff and students. • **Raising awareness** – disseminating MH information, drawing on peer experiences and role of teachers as MH advocates.
13	Kendal, Keeley &	To identify adolescents'	6 secondary schools	54 students	Qualitative	**Kendal et al.'s (2011) key findings:**

	Callery (2011)	preferences for emotional wellbeing (EWB) support in schools to inform the development of a pilot intervention.	UK	Aged 11-16 63% female, 37% male Ethnicity not reported.	Focus groups Thematic content analysis	**Domains of support –** students reported they would seek help in school for peer, academic or family issues. However, were reluctant to seek help for intensely personal issues. **Content –** students agreed they wanted effective support and wanted this to work on both a practical and emotional level. Students valued helpers who were friendly, trustworthy, with relevant practical skills and experience. **Delivery mechanisms** – expressed preference for adult rather than peer support, due to concerns over peers spreading rumours, not turning up or not knowing how to help. Having control over the exchange of their personal information, in a way which suits them, was important for privacy. **EWB outcomes –** social behaviour and subjective wellbeing identified as most relevant outcomes, rather than assessment based on behavioural outcomes (which were seen to be inaccurate).
14	Kendal, Keeley & Callery (2014)	To examine barriers and facilitators to help-seeking in a pastoral care project	3 secondary schools UK	50 participants (23 students, 27 staff) Aged 11-16	Qualitative Interviews	**Kendal et al.'s (2014) key themes:** **Students' fear of emotional exposure in school:** • Concerns about appearing vulnerable affected students' social behaviour and

		in UK secondary schools.		35% male, 65% female Ethnicity not reported.	Thematic analysis	emotional management e.g. presenting a self-image that would attract friendships. • The school context encouraged students to conform to peer group etiquette, which affected help-seeking e.g. seeking help may be viewed as sign of weakness, which would alienate possible friends. • Students had to 'weigh up risks' and benefits to help-seeking. i.e. resolving their issues vs. risk of emotional exposure and appearing weak for needing help, which affected help-seeking in school. • Students were wary of trusting staff with personal information, as they felt teachers might need to follow protocol or gossip with others. This acted as a barrier to help-seeking, unless the student was willing to cope with exposure or trusted the person offering help. **Impact of organisational context –** adult theme, relating to senior leadership/management providing adequate support for the project.
15	Lyon, Ludwig, Vander Stoep,	To investigate differences in service utilisation across three sectors	Secondary school	345 participants Aged 13-16	Quantitative Three self-report measures: service	**Lyon et al.'s key findings:** • For 'at risk' youth, 56% of youth and 52% of parents reported utilisation of MH services in at least one of the sectors.

	Gudmundsen & McCauley (2013)	(education, primary care and speciality MH) by ethnicity and SES for adolescents at risk of depression. Concordance rates between adolescent and parent reports of service use were also examined.	'Pacific North West Urban area' USA	62% female, 38% male Ethnicity: 62% Caucasian, 14% Asian American, 11% Latino, 10% African American Moderate SES level overall (greater representation from higher SES group)	utilisation ('Getting help'), depression (Mood and Feelings questionnaire) and demographic questionnaires. Logistic regression models, chi-squared and Cohen's Kappa statistic.	• Across ethnic and socioeconomic groups, the education sector was the most highly utilised. • Depression severity was a significant predictor of youth and parent reported school service utilisation. • SES and gender did not predict utilisation across any service. • Ethnicity only predicted parent-report utilisation of speciality MH services. • Moderate-low concordance rates between youth and parent report of all sectors. This may be especially be the case in education sectors, where adolescents are able self-refer and give their own consent.
16	Pella, Ginsburg, Casline, Pikulski & Drake (2018)	To examine anxious children's perceptions of barriers to treatment attendance in a school-based setting.	Primary and secondary school Connecticut USA	122 participants Aged 6-18 years 51.6% female, 49.4% male Ethnicity: white (49%), Asian (2.7%), African American (35.7%),	Quantitative Six self-report questionnaires: • Barriers to session attendance (child report) • SCARED (child & parent report)	**Pella et al.'s key findings:** • Most commonly endorsed barriers: ○ Missing classwork (45%) ○ Not wanting other children to know or ask questions (37%). ○ Teachers not letting them go (25%) ○ Sessions not being fun (22%) ○ Not understanding why they need to attend (17%) ○ Counsellor making them feel nervous (17%) ○ Being teased by others (14%)

				Hispanic (8%) and multiracial (4.5%). Primary need: Anxiety Children needed to be enrolled in the school-based treatment for anxiety. Excluded if needed more immediate treatment, receiving psychosocial treatment or victim of child abuse.	• Child behavioural checklist (parent) • Teacher report form • Brief symptom inventory (parent) • Demographics (parent) Descriptive statistics reported, T-tests, Pearson's and Spearman's rho correlations.	• 88% children endorsed at least one barrier, with a mean of 2.8 (no difference between the groups). • Non-white racial minority status (AA children more likely than Caucasian) and lower parental education (children with parents without college degree more likely) positively associated with children's perceived barriers. • Higher SCARED total scores (child report) and teacher-reported externalising behaviour positively associated with barriers. • On parent SCARED, only school avoidance was positively associated with barriers. On child report, somatic and separation subscales were significantly associated with greater number of barriers. • Higher scores on anxious rearing style significantly associated with higher number of barriers, but parental treatment and psychopathology not associated.
17	Pisani et al. (2012)	To examine key components of help-seeking among adolescents with recent suicidal	12 secondary schools New York and Dakota	2737 participants Aged 14-17	Quantitative Ten self-report questionnaires on:	**Pisani et al.'s key findings:** • 13.9% of students with SI in past 12 months.

ideation (SI), alongside associations between help-seeking behaviour and adolescents' attitudes about help-seeking, their perceived support for coping and school engagement.	USA	46.9% male, 50.9% female Ethnicity: Black/African American (3.5%), Hispanic/Latino (11.9%), White/Caucasian (79.5%). Primary need: suicidal ideation (13.9% of sample)	• Suicide ideation • Disclosure and help-seeking • Attitudes about help-seeking • Help-seeking acceptability in school • Adult help for suicidal youth • Attitudes to overcoming secrecy barriers • Social resources • Coping resources • School engagement • Depressive symptoms. Chi-squared tests, MANCOVAs, ANCOVA and generalised linear	• Females ($p < .001$) and Hispanic ($p = .03$) students more likely to report SI than males and white or black students respectively. • 22.8% had told an adult, which did not differ by age, sex or ethnicity. • 53% had disclosed to a peer, which was significantly more likely than to an adult ($p < .01$). Females ($p = .03$) and White ($p = .03$) students more like than males and Hispanic students respectively. • 29.4% reported trying to get help, which did not differ by age, sex or ethnicity. Only 15% of students had disclosed to an adult and tried to get help. • Help-seeking SI students reported greater help-seeking acceptance, perceptions that adults can help, intentions to overcome peer secrecy requests, school engagement and more coping resources, compared to SI peers who had not disclosed or sought help. • Help-seeking SI adolescents only differed from their peers on depressive symptoms: both suicidal groups reported higher rates than non-suicidal group.

					mixed model approach used.	
18	Wang, Barlis, Do, Chen & Alami (2019)	To explore relationships between mental health literacy (MHL), MH stigma and attitudes to help-seeking for Latinx and Asian American adolescents. Their perceptions of barriers to seeking MH services was also explored.	Middle and High schools California USA	55 participants Aged 11-19 18.2% male, 81.8% female 7 from middle school and 48 from high school Ethnicity: 49.1% Asian, 45.5% Latinx, 5.5% Asian & Latinx.	Mixed method approach Semi-structured interviews – thematic analysis Surveys – descriptive data reported.	**Wang et al.'s key findings:** **Quantitative:** • 83.9% correctly identified depression and bulimia vignettes • Participants endorsed formal and informal services at varying levels e.g. school counsellors were seen as most helpful (~90%), followed by a psychologist and GP. For informal, close friend (~80%), then support groups (80%), family members (77%) and teachers (39%). • No significant difference between ethnic groups in terms of identification of MH issues, stigma or perceived helpfulness. • Stigma negatively correlated with perceived helpfulness of formal providers ($p < .01$). **Qualitative:** **Three main types of barrier:** *Knowledge* – most common were: lack of knowledge about MH problems, providers/services and of the problem itself.

						Attitudinal – related to stigma, negative perceptions, perceived lack of support, and a preference for self-reliance/independence. *Practical* – confidentiality concerns, structural barriers (e.g. time and staff being too busy) and symptoms of MH disorder itself.
19	Watanabe et al. (2012)	To explore the prevalence of poor help-seeking behaviour and associated factors in Japanese students who self-harm.	Junior and senior high schools Japan	18,104 participants (17,671 of those reported on presence or absence of self-harm) Aged 12-18 No other demographics reported.	Quantitative Surveys – measuring self-harm, help-seeking, suicidal thoughts, psychotic experiences, MH & demographics Logistic regression analysis and Chi-square used.	**Watanabe et al.'s key findings:** • 3.3% of juniors and 4.2% of seniors reported self-harm in past year. Of these, 41% of juniors and 38% of seniors had not sought help. • Having no one to discuss psychological distress with was the strongest risk factor of poor help-seeking. Other variables with significant association with poor help seeking for both groups: current suicidal ideation, poor MH and feeling ill within last month. • Risk factors strongly associated with self-harm, but not help-seeking included: female gender, bullying and psychotic-type experiences. • Most common source of help for those who did and did not self-harm was friends (~75-80%). Second most common was family member, although those who self-harmed

						were significantly less likely to seek help from family, and more likely to seek help from a school nurse, compared to peers who do not self-harm.
20	Yilmaz-Gozu (2013)	To explore the help-seeking attitudes of Turkish High school students in terms of gender, preference of counsellor gender, problem type and interaction of these factors, as well as their influence on recognising need for help, stigma tolerance, interpersonal openness, confidence in MH professionals, psychological distress and help-seeking attitudes.	High school Turkey	342 participants 58% female, 42% male Aged 14-18 years Ethnicity not reported.	Quantitative Self-report measures: 'Attitude towards seeking professional help' scale, & 3 items on gender, preference of counsellor gender and type of problem. Descriptive statistics, ANOVAs and MANOVAs	**Yilmaz-Gozu's key findings:** • Significant difference in help-seeking attitudes between genders in terms of: interpersonal openness, psychological distress & confidence in MH professionals, but no difference in recognition of need for help. Females held more positive attitudes towards help-seeking. • Effects of problem type and counsellor gender had no significant effect on total attitude scores for either gender. • However, the interaction of these factors did affect help-seeking for males. Males showed higher psychological distress, but more confidence in MH professionals when seeking help from female counsellors for academic compared to personal-emotional problems. • The researchers suggest that male students may be more willing to discuss academic issues which appears more normal and does not affect their 'masculine identity'. Males may also assign more importance to academic problems and perceive counselling services are for this purpose.

Appendix G Demographic questionnaire

Back to Section 2.3.3.1 (Demographic questionnaire)

Age:…….

School year:……

What is your gender?

Male ☐ Female ☐ Other ☐

Which best describes your ethnicity? (please circle one)

White

1. English/Welsh/Scottish/Northern Irish/British
2. Irish
3. Any other White background, please describe.

Mixed / Multiple ethnic groups

4. White and Black Caribbean
5. White and Black African
6. White and Asian
7. Any other Mixed/Multiple ethnic background, please describe.

Asian / Asian British

8. Indian
9. Pakistani
10. Bangladeshi
11. Chinese
12. Any other Asian background, please describe.

Black / African / Caribbean / Black British

13. African
14. Caribbean
15. Any other Black / African / Caribbean background, please describe.

Other ethnic group

16. Any other ethnic group, please describe.

Appendix H Youth Anxiety Measures (YAM-5-1)

Back to Section 2.3.3.2 (YAM-5-1)

Youth Anxiety Measure (YAM-5- I)

On the following pages there are several statements for you to complete. Read every statement and fill in either: **never**, **sometimes**, **often** or **always** as it applies to you. Please try not to skip any of the questions and ask an adult if you are having difficulty reading or understanding the question. Remember there are no right or wrong answers!

Please complete the following:

Your identification number: ……..

1. I'm afraid to go anywhere without my parents.	☐ never	☐ sometimes	☐ often	☐ always
2. At school I don't speak to the teacher at all.	☐ never	☐ sometimes	☐ often	☐ always
3. I find it scary to meet new people.	☐ never	☐ sometimes	☐ often	☐ always
4. I panic for no reason.	☐ never	☐ sometimes	☐ often	☐ always
5. I worry about a lot of things.	☐ never	☐ sometimes	☐ often	☐ always
6. I get frightened if my parents leave the house without me.	☐ never	☐ sometimes	☐ often	☐ always
7. I find it scary to eat or drink if other people are looking at me.	☐ never	☐ sometimes	☐ often	☐ always
8. I suffer from anxiety or panic attacks.	☐ never	☐ sometimes	☐ often	☐ always
9. I think a lot about what can go wrong.	☐ never	☐ sometimes	☐ often	☐ always
10. I'm afraid that my parents will leave and never come back.	☐ never	☐ sometimes	☐ often	☐ always
11. If I meet a new person, I don't speak at all.	☐ never	☐ sometimes	☐ often	☐ always
12. I'm afraid that others will see that I blush.	☐ never	☐ sometimes	☐ often	☐ always

13. All of a sudden, I can become so scared that my heart starts to beat very quickly.	☐ never	☐ sometimes	☐ often	☐ always
14. I find it hard to stop worrying.	☐ never	☐ sometimes	☐ often	☐ always
15. I'm afraid that something bad will happen, so that I'll never see my parents again.	☐ never	☐ sometimes	☐ often	☐ always
16. I'm afraid I'll do something embarrassing.	☐ never	☐ sometimes	☐ often	☐ always
17. When I panic, I get afraid that I might die.	☐ never	☐ sometimes	☐ often	☐ always
18. I worry a lot about not doing well at school.	☐ never	☐ sometimes	☐ often	☐ always
19. I have very scary dreams where I lose my parents.	☐ never	☐ sometimes	☐ often	☐ always
20. At school I don't speak at all to the kids in my class.	☐ never	☐ sometimes	☐ often	☐ always
21. I have severe anxiety attacks during which I tremble all over my body.	☐ never	☐ sometimes	☐ often	☐ always
22. I worry a lot about all the bad things that happen in the world.	☐ never	☐ sometimes	☐ often	☐ always
23. I'm very afraid that other kids don't like me.	☐ never	☐ sometimes	☐ often	☐ always
24. I don't feel well when I have to go somewhere without my parents.	☐ never	☐ sometimes	☐ often	☐ always
25. I don't speak at all when there is a new visitor at our home or school.	☐ never	☐ sometimes	☐ often	☐ always
26. I'm afraid of having a new anxiety, or panic attack.	☐ never	☐ sometimes	☐ often	☐ always
27. I don't feel well because I worry so much.	☐ never	☐ sometimes	☐ often	☐ always
28. I am afraid that I might do or say something stupid in front of others.	☐ never	☐ sometimes	☐ often	☐ always

The end of YAM-5-I

Thank you very much for completing this questionnaire. Please let the member of school staff know that you have finished.

Youth Anxiety Measure (YAM-5- I) for parent

On the following pages there are several statements regarding anxiety in children. Please read every statement and fill in either: **never**, **sometimes**, **often** or **always** as applicable to your child. Although it can be difficult for parents to answer some of these questions, please try not to skip any of the questions.

Please complete the following:

Name of child: .....

Which school does your child attend? .....

What is your relation to the child?

☐ Father ☐ Mother ☐ Other, please state .....

.....

1. My child is afraid to go anywhere without his/her parents.	☐ never	☐ sometimes	☐ often	☐ always
2. At school my child doesn't speak to the teacher at all.	☐ never	☐ sometimes	☐ often	☐ always
3. My child finds it scary to meet new people.	☐ never	☐ sometimes	☐ often	☐ always
4. My child panics for no reason.	☐ never	☐ sometimes	☐ often	☐ always
5. My child worries about a lot of things.	☐ never	☐ sometimes	☐ often	☐ always
6. My child gets frightened if his/her parents leave the house without them.	☐ never	☐ sometimes	☐ often	☐ always
7. My child finds it scary to eat or drink if other people are looking at him/her.	☐ never	☐ sometimes	☐ often	☐ always
8. My child suffers from anxiety or panic attacks.	☐ never	☐ sometimes	☐ often	☐ always
9. My child thinks a lot about what can go wrong.	☐ never	☐ sometimes	☐ often	☐ always
10. My child is afraid that his/her parents will leave and never come back.	☐ never	☐ sometimes	☐ often	☐ always

11. If my child meets a new person, he/she doesn't speak at all.	☐ never	☐ sometimes	☐ often	☐ always
12. My child is afraid that others will see that he/she blushes.	☐ never	☐ sometimes	☐ often	☐ always
13. All of a sudden, my child becomes so scared that his/her heart starts to beat very quickly.	☐ never	☐ sometimes	☐ often	☐ always
14. My child finds it hard to stop worrying.	☐ never	☐ sometimes	☐ often	☐ always
15. My child is afraid that something bad will happen, so he/she will never see their parents again.	☐ never	☐ sometimes	☐ often	☐ always
16. My child is afraid he/she will do something embarrassing.	☐ never	☐ sometimes	☐ often	☐ always
17. When my child panics, he/she is afraid they might die.	☐ never	☐ sometimes	☐ often	☐ always
18. My child worries a lot about not doing well at school.	☐ never	☐ sometimes	☐ often	☐ always
19. My child has very scary dreams that he/she loses his/her parents.	☐ never	☐ sometimes	☐ often	☐ always
20. At school my child doesn't speak at all to the kids in his/her class.	☐ never	☐ sometimes	☐ often	☐ always
21. My child has severe anxiety attacks during which he/she trembles all over their body.	☐ never	☐ sometimes	☐ often	☐ always
22. My child worries a lot about all the bad things that happen in the world.	☐ never	☐ sometimes	☐ often	☐ always
23. My child is very afraid that other kids don't like him/her.	☐ never	☐ sometimes	☐ often	☐ always
24. My child doesn't feel well when he/she has to go somewhere without their parents.	☐ never	☐ sometimes	☐ often	☐ always
25. My child doesn't speak at all when there is a new visitor at our home.	☐ never	☐ sometimes	☐ often	☐ always
26. My child is afraid of having a new anxiety or panic attack.	☐ never	☐ sometimes	☐ often	☐ always
27. My child doesn't feel well because he/she worries so much.	☐ never	☐ sometimes	☐ often	☐ always

28. My child is afraid that he/she might do or say something stupid in front of others.	☐ never	☐ sometimes	☐ often	☐ always

The end of YAM-5-I.

Attendance and pupil premium eligibility questionnaire for parents

We would like to collect data about your child's attendance and pupil premium eligibility. This will help us to understand whether the Braive programme can improve young people's attendance at school and if it is effective for a particular pupil demographic (e.g. socio-economic background or age group).

How many days did your child attend school in March (please do not include any school holidays)?

……

Is your child currently receiving or eligible for pupil premium/free school meals?

……

Thank you very much for completing this questionnaire.

Please return this questionnaire to your child's school Special Educational Needs Coordinator (SENCo) using the envelope provided.

Youth Anxiety Measure (YAM-5- I) for Key staff member

On the following pages there are several statements regarding anxiety in young people. Please read every statement and fill in either: **never**, **sometimes**, **often** or **always** as applicable to your student. Although it can be difficult for school staff to answer some of these questions, please try not to skip any of the questions. If you are unsure, please fill in the response you feel would be most likely for your pupil.

Please complete the following:

Identification number of student: .....

What is your relation to the student?

☐ Teacher ☐ Teaching assistant ☐ Form tutor ☐ Other, please

state: ……..

1. The student is afraid to go anywhere without his/her parents.	☐ never	☐ sometimes	☐ often	☐ always
2. At school the student doesn't speak to the school staff at all.	☐ never	☐ sometimes	☐ often	☐ always
3. The student finds it scary to meet new people.	☐ never	☐ sometimes	☐ often	☐ always
4. The student panics for no reason.	☐ never	☐ sometimes	☐ often	☐ always
5. The student worries about a lot of things.	☐ never	☐ sometimes	☐ often	☐ always
6. The student gets frightened if his/her parents leave without them.	☐ never	☐ sometimes	☐ often	☐ always
7. The student finds it scary to eat or drink if other people are looking at him/her.	☐ never	☐ sometimes	☐ often	☐ always
8. The student suffers from anxiety or panic attacks.	☐ never	☐ sometimes	☐ often	☐ always
9. The student thinks a lot about what can go wrong.	☐ never	☐ sometimes	☐ often	☐ always
10. The student is afraid that his/her parents will leave and never come back.	☐ never	☐ sometimes	☐ often	☐ always

11. If The student meets a new person, he/she doesn't speak at all.	☐ never	☐ sometimes	☐ often	☐ always
12. The student is afraid that others will see that he/she blushes.	☐ never	☐ sometimes	☐ often	☐ always
13. All of a sudden, the student becomes so scared that his/her heart starts to beat very quickly.	☐ never	☐ sometimes	☐ often	☐ always
14. The student finds it hard to stop worrying.	☐ never	☐ sometimes	☐ often	☐ always
15. The student is afraid that something bad will happen, so he/she will never see their parents again.	☐ never	☐ sometimes	☐ often	☐ always
16. The student is afraid he/she will do something embarrassing.	☐ never	☐ sometimes	☐ often	☐ always
17. When the student panics, he/she is afraid they might die.	☐ never	☐ sometimes	☐ often	☐ always
18. The student worries a lot about not doing well at school.	☐ never	☐ sometimes	☐ often	☐ always
19. The student has very scary dreams that he/she loses his/her parents.	☐ never	☐ sometimes	☐ often	☐ always
20. At school the student doesn't speak at all to the kids in his/her class.	☐ never	☐ sometimes	☐ often	☐ always
21. The student has severe anxiety attacks during which he/she trembles all over their body.	☐ never	☐ sometimes	☐ often	☐ always
22. The student worries a lot about all the bad things that happen in the world.	☐ never	☐ sometimes	☐ often	☐ always
23. The student is very afraid that other kids don't like him/her.	☐ never	☐ sometimes	☐ often	☐ always
24. The student doesn't feel well when he/she has to go somewhere without their parents.	☐ never	☐ sometimes	☐ often	☐ always
25. The student doesn't speak at all when there is a new visitor at the school.	☐ never	☐ sometimes	☐ often	☐ always
26. The student is afraid of having a new anxiety or panic attack.	☐ never	☐ sometimes	☐ often	☐ always
27. The student doesn't feel well because he/she worries so much.	☐ never	☐ sometimes	☐ often	☐ always

28. The student is afraid that he/she might do or say something stupid in front of others. ☐ never ☐ sometimes ☐ often ☐ always

The end of YAM-5-I.

Thank you very much for completing this questionnaire.

Appendix I Self-efficacy Questionnaire for Children (SEQ-C)

Back to Section 2.3.3.3 (SEQ-C)

On the following pages there are several statements for you to complete. Read every statement and fill in either: **Not at all like me, some-what like me, like me or very much like me** as it applies to you. Please try not to skip any of the questions and ask an adult if you are having difficulty reading or understanding the question. Remember there are no right or wrong answers!

Please provide your identification number: …….

Please check the box that applies to you on the sheet for each statement.	**Not at all like me**	**Some-what like me**	**Like me**	**Very much like me**
I am good at expressing my opinions when classmates disagree with me.				
I am good at cheering myself up when bad things happen.				
I can study when there are other fun things to do.				
I am good at calming myself down when I am very scared.				
I am good at making friends with other young people.				
I am good at studying for tests.				
I am comfortable talking with new people.				
I am good at keeping myself from becoming nervous.				
I am good at finishing my homework every day.				

I am good at cooperating with my classmates.				
I am good at controlling my feelings.				
I am good at paying attention during all my classes.				
I can tell other young people that they are doing something that I don't like.				
I can cheer myself up when I feel down.				
I can pass all subjects at school.				
I am good at telling a joke to a group of young people.				
I am good at getting unpleasant thoughts out of my mind.				
I can please my parents with my schoolwork.				
I am good at keeping friends.				
I am good at keeping myself from worrying about the future.				
I am good at passing tests.				
I am good at asking teachers for help with schoolwork.				
I can tell a friend when I am sick.				
I am good at avoiding fights with other young people.				

The end of SEQ-C

Thank you very much for completing this questionnaire. Please let the member of school staff know when you have finished.

Appendix J Familiarity scales for Key staff Members and Facilitators

Back to Section 2.3.3.5 (Familiarity scales)

Facilitator familiarity scale

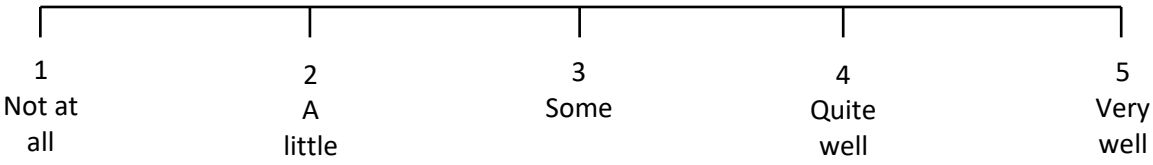
Please indicate your role within the school:

☐ Teacher ☐ Teaching assistant ☐ ELSA/Pastoral support ☐ Other, please state:

……

Please enter your pupil's identification number: ……..

Please rate on the following scale how well you know the young person:

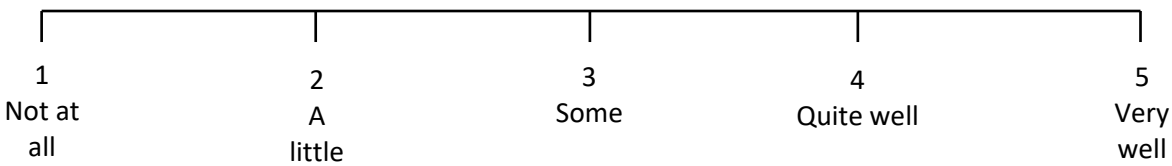


KSM familiarity scale

Please enter your pupil's identification

number: ……

Please rate on the following scale how well you know the young person:



Appendix K Programme usage measures

Back to Section 2.3.3.6 (Programme usage measures)

Braive facilitator usage record for (pupil ID number): _____

Date of session	Lesson number (1-10)	Student Attended Session (Y/N)	Duration of session (approx./minutes)	Extra input (anything in addition to the iCBT programme e.g. activities, games)	Superskill Challenge Superpower	Sessions completed outside of school (lesson number, approx. duration & any extra support)

Programme usage post-intervention (youth report)

These questions relate to how often you were able to carry out the iCBT Braive programme over the past 10 weeks. Please choose the most relevant response for you.

1.	How many weeks did you carry out the iCBT Braive programme?											
	Never started	1	2	3	4	5	6	7	8	9	10	10+

2.	How many times a week on average did you access the iCBT Braive programme?				
	Never Started	1-2 Days	3-4 Days	5-6 Days	Most Days

Please only complete questions 4-7 if you stopped using the iCBT Braive programme at any point throughout the 10 weeks.

3.	Which lessons of the iCBT Braive programme did you complete? Please tick all the lessons you completed.
	1 – Recognise and become aware 2 – Understanding stress 3 – Observe and handle worry 4 – Fine tuning your thoughts 5 – Helping and unhelpful ways of coping 6 – Panic and how to deal with it 7 – Making changes 8 – Focus and attention 9 – Healthy relationships 10 – Habits for life All of the lessons!

4.	Did you stop doing the iCBT Braive programme because you no longer had symptoms of anxiety?	Yes	No

5.	Did you stop doing the iCBT Braive programme because of other reasons? (please describe)……..	Yes	No

	…… …… …… …… ……		

6.	Despite stopping the iCBT programme, did you continue using any of the techniques (even if only occasionally?)	Yes	No

7.	**Only answer if you answered 'Yes' to question 6** Which of the iCBT programme techniques did you continue to use? (please circle as many as apply)				
	Breathing	Progressive muscular relaxation	Isometric relaxation	Mindfulness	Notice and return meditation
	Worry postponement	Positive coping strategies	Creating alternative thoughts	Mapping symptoms/ Observation model	Psychoeducation (your knowledge of anxiety)
	Other, please specify:				

Adapted from Kirby, S., Donovan-Hall, M., & Yardley, L. (2014)

Programme usage at follow-up (youth report)

These questions relate to how often you have accessed Braive or used the iCBT techniques since finishing the programme last term. Please choose the most relevant response for you.

Please give your identification number:

1.	Have you accessed the Braive iCBT programme at any point since finishing last term?	Yes	No

2.	**Only answer if you answered 'Yes' to question 1.** Approximately how much did you access the Braive iCBT programme during this time?			
	Once or twice	Sometimes	Often	Regularly (most days)

3.	Have you used any of the Braive iCBT techniques from the programme since finishing last term?	Yes	No

4.	**Only answer if you answered 'Yes' to question 3.** Which of the Braive iCBT programme techniques did you continue to use? (please circle as many as apply)				
	Breathing	Progressive muscular relaxation	Isometric relaxation	Mindfulness	Notice and return meditation
	Worry postponement	Positive coping strategies	Creating alternate thoughts	Mapping symptoms/ Observation model	Psychoeducation (your knowledge of anxiety!)
	Other, please specify:				

Adapted from Kirby, S., Donovan-Hall, M., & Yardley, L. (2014)

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