REBECCA FORSYTH BSc (Hons) MSc PG Cert

TARGETED MENTAL HEALTH INTERVENTIONS IN SCHOOLS

Section A:

Young peoples' views and experiences of targeted mental health and wellbeing interventions being provided in schools: A systematic review and qualitative thematic synthesis

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Section B:

A Delphi survey investigating the implementation of a new workforce of school-based mental health practitioners

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COVID-19 Statement

Unfortunately, due to the closure of schools and time pressures experienced in study recruitment arising from the COVID-19 pandemic, it was not possible to include children and young people as participants in Section B, as had originally been planned. This is acknowledged as a limitation of the research.

Summary of the Major Research Project

Section A: Presents a systematic search exploring young peoples' views and experiences of targeted mental health and wellbeing interventions being provided in schools. Following quality appraisal, a thematic synthesis of 11 included papers identified three overarching themes (impact of school context, intervention factors, and young people factors) that shape the acceptability of school-based provision. Schools should adapt their practices to address practical concerns, promote young peoples' sense of choice and agency, and guarantee confidentiality. The voices of young people should be privileged in research and practice moving forwards to ensure that school-based provision is acceptable and responsive to their needs.

Section B: Presents a three-round Delphi survey exploring professionals' perspectives on the implementation of a new workforce of school-based mental health practitioners. This process facilitated consensus-building between professional groups. Participants agreed that mental health interventions are more accessible when provided in schools. Results highlighted challenges associated with translating mental health interventions to the school context. A tension between prioritising quality of service and equality of access was identified. Findings demonstrate the need to facilitate dialogue between local collaborators in supporting implementation. To promote workforce sustainability, resources invested in school-based practitioners should be matched by measured, strategic thinking.

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Section A: Literature Review

Young peoples' views and experiences of targeted mental health and wellbeing interventions being provided in schools: A systematic review and qualitative thematic synthesis

Word Count: 7,962 (+272)

Abstract

In the context of developing an evidence-base for school-based mental health and wellbeing interventions, there is a need to include the voices of young people in guiding intervention implementation. This review explored young peoples' views and experiences of targeted mental health and wellbeing interventions provided in schools with a view to identifying barriers and facilitators of engagement. Following a systematic search and quality appraisal, a thematic synthesis was conducted on 11 papers. This synthesis identified three overarching themes (impact of school context, intervention factors, and young people factors) that shaped the acceptability of school-based provision. To facilitate engagement, schools should adapt their practices to address practical concerns, promote young people's sense of choice and agency, and guarantee confidentiality. The complex task of addressing stigma associated with help-seeking is also an important future endeavour. By including the perspectives of young people in research and practice, school-based provision can be promoted that is acceptable and responsive to their needs.

Keywords: acceptability; mental health; qualitative methods; school-based; targeted

Introduction

Status of mental health in children and young people

Children and young people (CYP) today live in stressful times (Morgan et al., 2017). Despite improved material conditions in recent decades, psychosocial conditions have become 'more complicated and demanding' (Bell et al., 2019). It has been proposed that CYP experience contemporary society as particularly challenging to their wellbeing (Eckersley, 2011). As they transition to secondary school, CYP must navigate the onset of puberty and associated cognitive and emotional changes alongside increasing social and academic pressures (Goldstein et al., 2015). This has been further complicated by uncertainty and isolation arising from the COVID-19 global pandemic (Imran et al., 2020).

In this context, the mental health and wellbeing of CYP has received increased attention (Collishaw, 2015). Concerns around an apparent deterioration in the subjective wellbeing of CYP have been described (Currie et al., 2012). In the United Kingdom (UK), it has been reported that an estimated one-in-eight CYP meet current diagnostic criteria for a mental health difficulty (Vizard et al., 2018).

A perceived 'crisis' in the behaviour and emotional wellbeing of CYP today has been debated (Coppock, 2010). According to Timimi (2009) it is unclear whether there has been a real increase in mental health difficulties, or whether our perception of and the meaning that we ascribe to CYP's emotions and behaviour may have changed over time. Also relevant are expanding classification and diagnostic systems that have been described as "enveloping more and more [CYP]" (Coppock, 2010). Nevertheless, reported poor mental health and wellbeing in childhood and adolescence has been associated with a range of adverse social and economic outcomes throughout the lifespan (Gondek et al., 2018). Indeed, the strongest predictor of a

measure of life satisfaction in adulthood has been identified as subjective emotional health aged 16 (Layard et al., 2014).

Access to specialist provision

Only one-third of CYP access any professional help for difficulties related to their mental health and wellbeing (Sadler et al., 2018). Limited knowledge of mental health, perceived stigma and compromised confidentiality have been associated with poor service use in CYP (Radez et al., 2020). To address this 'crisis', calls for greater investment by the state have been made (Coppock, 2010). In response, increased access to evidence-based interventions has been pledged by the UK Government (Department of Health & Social Care, 2015). An emphasis on developing services that are adaptive to the needs of CYP, rather than CYP being expected to fit within existing service structures, such as specialist Child and Adolescent Mental Health Services (CAMHS), has emerged.

The role of schools

Subsequent policy has promoted schools as appropriate settings for CYP to receive mental health and wellbeing support (Department for Education, 2016). Due to near total population cover, schools have a 'captive audience' to provide interventions and have been described as "the best placed institutions within which to centralise our holistic efforts" (Rothi & Leavey, 2006). Despite this potential, it is important to recognise that schools operate within a broader context and are not positioned to remedy key social determinants of poor mental health and wellbeing, such as poverty (Ford et al., 2021). It is also acknowledged that educational and social pressures within schools can in themselves contribute to the onset of mental health difficulties, complicating schools' role as a setting of intervention (Cosma et al., 2020).

Approaches to mental health and wellbeing used in schools include 'preventative' and 'targeted' interventions. School-based interventions can be delivered by internal staff (teaching/pastoral staff) or by external practitioners attending schools (Fazel et al., 2014). The foci of preventative interventions vary, but usually involve classroom-based psychoeducation, behavioural techniques or skills building to promote resilience (Dray et al., 2017). Targeted interventions are offered in individual or group formats to CYP identified as experiencing difficulties related to their mental health/wellbeing. Targeted interventions use a range of approaches but are often informed by cognitive behavioural (CBT) or supportive listening counselling principles (Gee et al., 2020).

Evidence for school-based provision

Current systematic review findings suggest 'neutral to small effects' of universal interventions aimed at promoting wellbeing (Mackenzie & Williams, 2018). Meta-analytic evidence for targeted interventions has indicated a 'small effect' on measures of depression and a 'medium effect' for anxiety measures post-intervention, with little evidence of effects being maintained in the longer-term (Gee et al., 2020). Targeted interventions have been associated with greater stigma than universal interventions, however service user satisfaction is also rated more highly in targeted than universal interventions (Rapee et al., 2006).

Investment in targeted intervention

Demonstrating the popularity of school-based provision amongst policymakers, 'Mental Health Support Teams' (MHSTs) have recently been introduced to schools in the UK (Department of Health & Social Care and Department for Education, 2017). Employed by the National Health Service (NHS), these teams of practitioners are located in schools to deliver targeted low-intensity CBT (Health Education England, 2020). Representing significant

investment, this workforce is intended to be rolled-out to a quarter of the population by 2023 with 8,000 additional practitioners supporting schools in the long-term (Department of Health and Social Care & Department for Education, 2017).

The role of 'implementation science'

'Implementation science' (IS) studies the translation of evidence-based interventions to real-world settings (Eccles & Mittman, 2006). IS recognises the impact of personal, social and organisational factors on implementation (Bauer & Kirchner, 2020). A framework of implementation outcomes for study, outlined in Table 1, has been proposed by Proctor et al. (2011).

Table 1

Implementation outcomes (Proctor et al., 2011)

Implementation outcome	Definition
Acceptability	How far an intervention is perceived to be agreeable or satisfactory to stakeholders
Adoption	The intention, initial decision, or action to try or employ an intervention; also described as 'uptake'
Appropriateness	The perceived fit, relevance, or compatibility of an intervention in a given setting
Cost	The cost impact of an implementation effort
Feasibility	The extent to which an intervention can be successfully carried out within a specific setting
Fidelity	The degree to which an intervention can be implemented as prescribed in the original protocol
Penetration	The integration of a practice into a specific setting and its subsystems
Sustainability	The extent to which a newly implemented treatment is maintained within a service over time

Proctor et al. (2011) proposed that implementation outcomes are "interrelated in dynamic and complex ways". For example, how far an intervention is acceptable to stakeholders will affect the way it is adopted, and in turn penetration and sustainability over time.

A focus on acceptability

A review of school-based mental health interventions by Paulus et al. (2016) found that effective implementation of interventions promotes positive outcomes. Subsequent reviews established a link between intervention acceptability and attendance in CYP (Gee et al., 2020), leading to improved outcomes (Rojas-Andrade & Bahamondes, 2019). In the context of a limited evidence-base for school-based interventions, promoting intervention acceptability is therefore an important endeavour.

High acceptability has been demonstrated where school-based interventions are designed to match the needs and preferences of CYP, focusing on what is important to them, and ensuring that delivery is accessible and interactive (Gee et al., 2020). The importance of incorporating the voices of CYP in guiding the design and delivery of services has also been recognised in UK Government policy (Department of Health & Social Care, 2015). However, interventions are often transported to schools from clinical settings with limited involvement of their target population (Rapee et al., 2006). A need to improve our understanding of CYPs' experiences of intervention and elicit their recommendations for the future has been described (Day et al., 2006). This is especially pertinent given that the school context presents distinct challenges to intervention implementation. For example, the dominant ethos of a school community, the availability of an appropriate venue within the school building, and timetabling pressures have been identified as factors that affect implementation (Gronholm et al., 2018; Owens et al., 2014).

The value of qualitative research

The 'hierarchy of evidence' used in evidence-based practice (Evans, 2003) privileges quantitative methodologies from the positivist tradition, which has come to influence how we understand 'legitimate' knowledge (Coppock, 2010). In this context, evidence derived from qualitative methodologies has been viewed as subordinate to 'hard' scientific research (Coppock, 2010). However, qualitative methodologies have increasingly been promoted in exploring the implementation of complex interventions and guiding intervention planning (Williams, Boylan & Nunan, 2019). Qualitative methodologies are able to provide a "thick description" of experiences in context, beyond the breadth of understanding achieved using quantitative methodologies (Palinkas, 2014).

Existing reviews

Qualitative findings from a review of CYPs' views of mental health services in the UK found that CYP value their needs being responded to flexibly and using language that is familiar to them. CYP value convenient venues and timing of sessions and identified key qualities of warmth, authenticity, and expertise in the practitioners they worked with. Barriers to intervention include fear of being stigmatised and a lack of continuity between services (Plaistow et al., 2014).

A subsequent review assessed qualitative evidence into stigma related to accessing targeted mental health interventions in schools (Gronholm et al., 2018). CYP described both anticipated and experienced stigma with concerns around confidentiality being compromised limiting intervention uptake. CYP responded favourably when interventions were set up as a space for talking, listening and problem-solving and thereby normalised. Fostering a sense of choice and control and building trust also promoted engagement. Engagement has been

described as a process involving affective, cognitive and behavioural components (King et al., 2014). Engagement is thought to be greater when an individual is emotionally involved in the process of intervention with a practitioner, believes in the need for such intervention and that it has the potential to be effective, and acts accordingly through attendance and applying strategies beyond sessions.

Rationale and aims

To date, qualitative research on CYPs' experiences of targeted interventions in UK schools has not been reviewed. Although related, the review by Gronholm et al. (2018) was limited in its focus on stigma and used international research. Exploring the acceptability of schools as a context for intervention is important to help us understand where and how to best allocate resource. This is especially important given the current investment in this area. For example, finding out how CYP experience different modes of targeted delivery (such as internally versus externally delivered interventions) could be used to refine practices and promote engagement.

Qualitative findings from studies conducted within the UK specifically have not been synthesised. This is important as research conducted internationally is situated from different educational, social and policy contexts. In the UK, mental health provision has traditionally been delivered in NHS settings, with school-based services being less developed than in some other Western countries, such as the United States of America (USA), where related research is often conducted (Gee et al., 2020).

This review will foreground the voices of CYP to explore their views and experiences of targeted mental health and wellbeing interventions being provided in schools. It will summarise relevant literature and offer a balanced critique of published papers. Findings will then be

synthesised with a focus on understanding barriers and facilitators to engagement. Recommendations on the implementation of targeted school-based interventions will be offered to improve acceptability and outcomes for CYP.

Method

Search strategy

Electronic database searching was conducted in December 2020 and repeated in May 2021. 'ASSIA', 'British Education Index', 'Child Development and Adolescent Studies', 'CINAHL Complete', 'ERIC', 'MEDLINE' and 'PsycInfo' databases were searched to obtain relevant papers across health, social sciences, and education literature.

Inclusion criteria

Inclusion and exclusion criteria are described in Table 2. Eligible papers used a qualitative or mixed-methods design including a qualitative component. Papers conducted outside the UK were excluded. Due to focusing on how CYP view and experience interventions being provided in the school context, rather than how they experience an intervention itself, a decision was made to include papers using a range of targeted interventions related to mental health and wellbeing in schools. In addition, only papers conducted in 'mainstream' primary or secondary schools were eligible, due to differences in how support is provided to CYP with social, emotional and behavioural difficulties within specialist provision (Michael & Frederickson, 2013). Papers that explored views on preventative/universal interventions were excluded. No time limits were applied.

Table 2

Review inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Used qualitative or mixed design including qualitative method, e.g., interviews, focus groups, or questionnaires • Conducted in the United Kingdom • Explored views of children and young people on targeted mental health/wellbeing interventions in school setting in principle (rather than their view of a particular intervention) • Conducted within mainstream primary or secondary schools • Published in English language	• Was not primary research (i.e. theoretical or review articles) • Did not use any form of qualitative design • Conducted outside the United Kingdom • Conducted within specialist provision e.g. Pupil Referral Unit • Explored views on preventative or universal school-based mental health interventions • Exclusively explored views of professionals or parents on school-based mental health intervention • Explored views of children and young people on views of specific interventions rather than the principle of providing interventions in school settings

Literature search

Preliminary searching using Google Scholar and screening of Medical Subject Headings (MeSH) terminology used in relevant papers identified informed database selection and search terms employed. Search terms used are described below in Table 3.

Table 3

Review search terms

Search terms	Boolean operation	Location
School* OR 'school-based'	AND	Abstract
Adolesce* OR child* OR 'young pe*'	AND	Abstract
'Focus group' OR interview* OR qualitative	AND	Abstract
Anxiety OR emotion* OR 'mental health' OR 'mental illness' OR wellbeing OR 'well-being'	AND	Full text
Counselling OR 'guided self-help' OR 'guided self help OR intervention* OR support OR therapy	AND	Full text

The five searches were run separately to maximise results obtained then combined using the 'AND' function to limit results to articles using some combination of terms from all five searches. This final search was then limited to results in the English language.

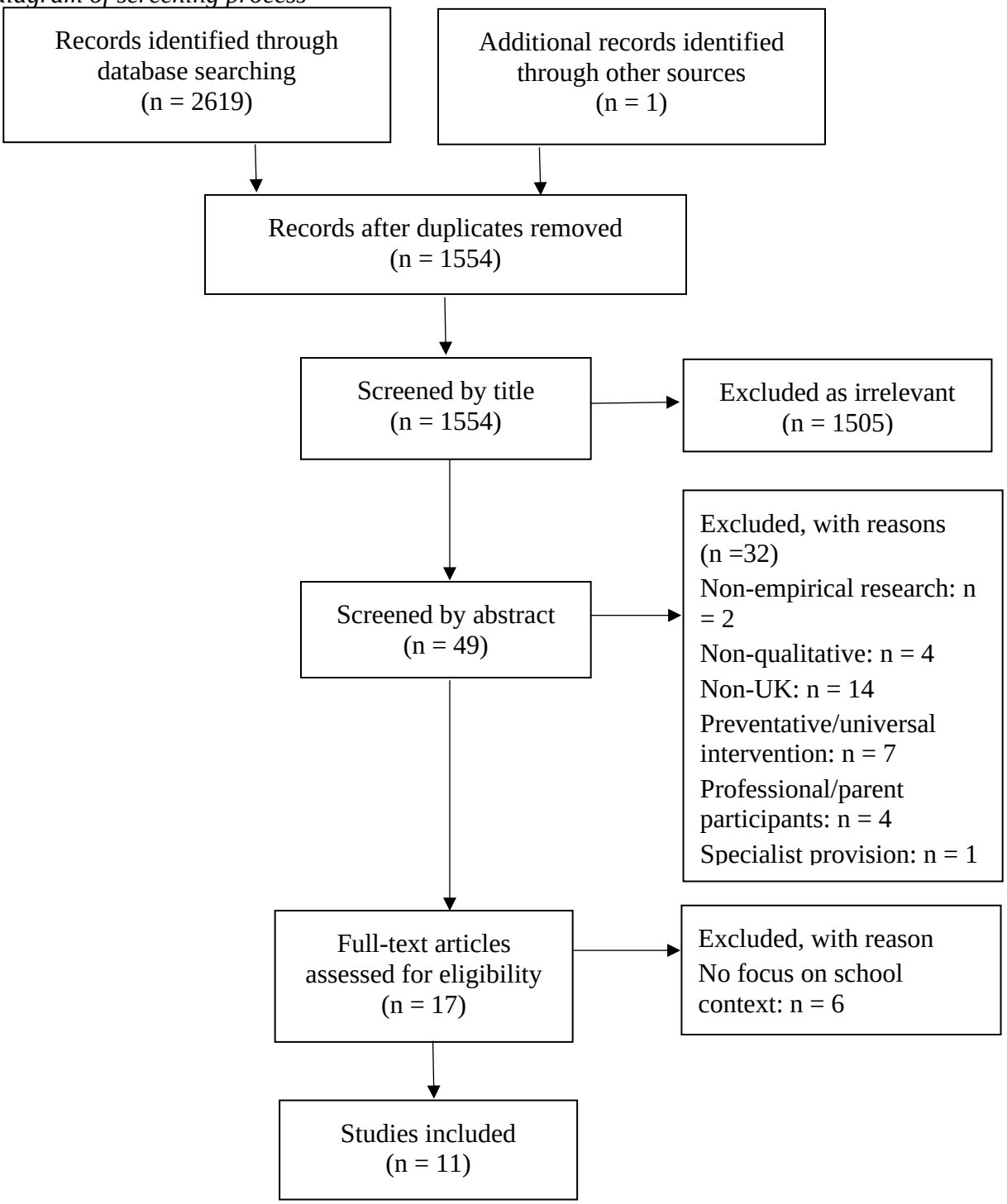
Database searches were run separately. The results were imported and combined into 'Rayyan QCRI', a web-based systematic review tool, and duplicates were removed. Results were then screened first by title to identify papers that appeared relevant. Relevant papers were then screened by abstract and lastly remaining papers were screened by full text.

Following screening, reference lists of included articles were hand-searched. All articles citing included articles were identified using Google Scholar and screened. No new relevant articles were identified. Finally, publication lists of first authors for included articles were hand-searched. This yielded one additional relevant article for inclusion. The journal 'Child and Adolescent Mental Health' was also hand-searched, yielding no additional results. To address the possibility of publication bias and ensure inclusion of as many eligible papers as possible, grey

literature was searched for using the 'OpenGrey' database, with no additional result identified. A PRISMA Flow Diagram (Moher et al., 2009) outlines the screening process (Figure 1).

Figure 1

Flow diagram of screening process



Results

Summary of papers

In total, 11 papers retrieved from the literature search met criteria for inclusion in the review. The papers were published between 2006 and 2020, perhaps reflecting increased interest in the mental health and wellbeing of CYP in the past 20 years (Collishaw, 2015). Seven papers were conducted in England, two were conducted in Wales and two did not specify where in the UK they took place. All papers used qualitative methodology except for Cale et al. (2020) whose research adopted a mixed-methods approach comprised of quantitative and qualitative evaluation. All included papers were conducted in secondary schools with participants aged between 11 and 18. Four papers recruited CYP alone (Evans et al., 2015; Fox & Butler, 2007; Prior, 2012; Spencer et al., 2020), whilst seven papers also recruited professionals/parents as participants to explore their aims.

The included papers varied in their stated aims. Seven papers aimed to explore views and experiences of intervention (Cale et al., 2020; Chase et al., 2006; Evans et al., 2015; Fox & Butler, 2007; Kendal et al., 2011; McGeechan et al., 2019; Segrott et al., 2013). Kendal et al. (2014) aimed to explore the perspectives of CYP who had and had not sought help. McKeague et al. (2018) aimed to investigate the acceptability and feasibility of their workshop programme. Prior (2012) aimed to "elucidate the key features and stages of the help-seeking process as defined by young people accessing school counselling". Finally, Spencer et al. (2020) aimed to "explore young people's lived experience...[to] inform the future development of school-based mental health support".

The included papers used a range of targeted interventions, including workshops for exam stress (Cale et al., 2020; McKeague et al., 2018), school-based counselling (Fox & Butler,

2007; Prior, 2012), guided self-help (Kendal et al., 2011; Kendal et al., 2014), a confidential drop-in service (Chase et al., 2006), a targeted social and emotional learning intervention (Evans et al., 2015); a mindfulness course (McGeechan et al., 2019), and an emotional support service (Segrott et al., 2013). One paper (Spencer et al., 2020) did not specify an intervention but described exploring views on "mental health support in schools".

Six papers described interventions delivered to individual CYP (Chase et al., 2006; Fox & Butler, 2007; Kendal et al., 2011; Kendal et al., 2014; Prior, 2012; Segrott et al., 2013), whilst four papers used group-based formats. Seven papers described interventions delivered by external professionals (Cale et al., 2020; Chase et al., 2006; Evans et al., 2015; Fox & Butler, 2007; McKeague et al., 2018; Prior, 2012; Segrott et al., 2013), whilst three papers described interventions delivered by internal school staff. Key characteristics of included papers are described below in Table 4.

Table 4

Characteristics of included papers

Authors; Year	Study Title	Location	Aims	Intervention	Data Collection	Sample	Data Analysis	Key Findings
Cale et al., 2020	'Get(ting) to the Start Line – the evaluation of an innovative intervention to address adolescents' school related stress and anxiety'	East Midlands	'To determine participant perceptions and experiences of the programme, establish the perceived effectiveness of the programme in achieving positive pupil outcomes.'	Programme to address adolescents' school-related stress and anxiety delivered by an external athlete mentor. Six 90-minute workshops including psychoeducation, 'Managing Me' (positive self-talk; role of exercise; relaxation and visualisation) and 'Team YOU' (final planning; support networks).	Mixed methods using quantitative and qualitative techniques. Qualitative component: focus groups with young people and interviews/ online surveys with staff.	Recruited from six secondary schools 9-12 Year 11 pupils per school One 'school champion' and 'athlete mentor' from each school.	Thematic analysis	The programme was "positively received by most pupils and resulted in positive outcomes such as reported reductions in examination-related stress and anxiety for some, and fewer pupil well-being referrals."
Chase et al., 2006	'Evaluating school-based health services to inform future practice Lessons from "Teen Talk" at Kidbrooke School in Greenwich'	South East London	'To elicit the experiences and perceptions of service users and gather insights and perspectives from service providers involved in the project.'	Confidential drop-in service, 'Teen Talk', staffed by health practitioner and youth worker designed to support young people in addressing their health needs.	Case study approach using questionnaires and interviews	180 Year 7-Year 11 students completed questionnaire. 12 students took part in an interview Health/education professionals and parents interviewed	Not described	"Teen Talk' [was] greatly valued by pupils and staff, provided a unique service, good value for money. However, the evaluation identified important lessons in setting up and managing the project which can help refine the service."
Evans et al., 2015	'The unintended consequences of targeting: young people's lived experiences of social and emotional learning interventions'	Wales	'To explore young people's lived experiences of participating in a targeted social and emotional learning intervention.'	'Student Assistance Programme' designed to provide a 'developmentally appropriate and supportive context where children and young people may develop social and emotional competencies' Conducted by two external trained facilitators with 8–12 students per course	Case study approach using observation and focus groups	41 Year 8/9 students	'Drew upon a thematic approach, encompassing analytical techniques associated with grounded theory"	"Students' identification for participation in the intervention and their reaction to the group composition may lead to harmful effects."

Authors; Year	Study Title	Location	Aims	Intervention	Data Collection	Sample	Data Analysis	Key Findings
Fox & Butler, 2007	'If you don't want to tell anyone else you can tell her': young people's views on school counselling'	Not specified – England	'To assess the views of young people about school counselling.'	One-to-one school counselling	Qualitative design using survey and focus groups	415 Year 7-11 students 9 focus groups with 3-10 young people in each	Content analysis of open-ended survey responses, the transcripts of the focus groups were read many times to identify themes which were common across the groups	Young people valued having a school counsellor; service knowledge was limited; confidentiality was important; concern that others would find out and reluctance to speak to a stranger were barriers to access
Kendal et al., 2011	'The feasibility and acceptability of an approach to emotional wellbeing support for high school students'	'Urban areas of northern England'	'To evaluate the Change Project's feasibility and acceptability from perspectives of staff and students in those schools.'	Guided self-help; goal-focused interventions using behavioural and cognitive techniques; delivered by pastoral and teaching support staff	Qualitative design using semi-structured interviews	23 students (aged 11–16 years) and 27 school staff	Involved familiarisation with the data, coding, checking, summarising and charting (Ritchie et al., 2007).	Confidentiality, emotional support, effectiveness and delivery modes were important to students. Organisational values influenced feasibility.
Kendal et al., 2014	'Student help seeking from pastoral care in UK high schools: a qualitative study'	'Urban UK high schools'	'To explore perspectives on the Project by consulting students who had, and students who had not sought help, plus members of school staff.'	Structured, low-intensity support for students who self-referred with anxiety, low mood and related difficulties, using the supported self-help model, delivered by teaching assistants and pastoral staff already based in the schools	Qualitative design using interviews	23 students (15 from KS3, 8 from KS4) and 27 staff	Data were organised using the 'framework method' and a thematic analysis was developed by the method of constant comparison and responsiveness to emerging insights.	Peer group perceptions may discourage young people from seeking emotional support within a school setting; help seeking could be encouraged by involving staff whom students perceive as trustworthy.
McGeechan et al., 2019	'Qualitative exploration of a targeted school-based mindfulness course in England'	Not specified – England	'To qualitatively explore young people's experience of learning mindfulness techniques in school, and to gain feedback on the mindfulness course from teaching staff who delivered the course to young people.'	10-week mindfulness course delivered by either a teacher or teaching assistant Each session focussed on a distinct mindfulness skill, structured with a brief presentation to the students, with visual aids and practical demonstrations	Qualitative design using semi-structured interviews and focus group	16 young people aged 12-15 interviewed 3 staff attended focus group	Inductive thematic analysis	While young people felt that they had to take part, once they started the programme, they enjoyed it. However, the targeted approach of the intervention could lead to young people being stigmatised by their peers.

Authors; Year	Study Title	Location	Aims	Intervention	Data Collection	Sample	Data Analysis	Key Findings
McKeague et al., 2018	'Exploring the feasibility and acceptability of a school-based self-referral intervention for emotional difficulties in older adolescents: qualitative perspectives from students and school staff'	Inner London	'To investigate the feasibility and acceptability of the DISCOVER workshop programme.'	DISCOVER 'How to Handle Stress' workshop programme, a self-referral school-based group intervention designed for stressed sixth form students, aimed to provide early intervention for adolescents with emotional difficulties, applying cognitive-behavioural strategies within a broad stress-coping paradigm, delivered by external clinical psychologists	Qualitative design using semi-structured interviews	15 workshop attenders, 9 non-attenders, average age of 17 10 members of staff	Thematic analysis	The delivery and evaluation of this intervention is perceived as feasible and acceptable. Students, including those from BME backgrounds, described the setting as suitable and reported that the workshop helped them.
Prior, 2012	'Young people's process of engagement in school counselling'	Not stated – United Kingdom	To elucidate the key features and stages of the help-seeking process as defined by young people accessing school counselling	School counselling	Qualitative design using interviews	Eight young people aged 13-17 years	Thematic narrative analysis	Highlights the complex process of engaging with school counselling; the careful management of stigmatisation concerns; the significant balanced position of the counsellor; and the key role of facilitators in enabling young people to access counselling.
Segrott et al., 2013	'Creating safe places: an exploratory evaluation of a school-based emotional support service'	Wales	'To explore the views of young people who had used the service in terms of acceptability and perceived outcomes.'	'Bounceback' provided one-to-one sessions delivered by charity staff to Year 10-11 pupils experiencing stressful situations. Distinctive from counselling, in terms of informality, the degree of control which pupils could exercise over the focus of sessions and practical help and advice (e.g. on employment), as well as emotional support	Qualitative design using interviews	5 members of Bounceback staff; 7 service users (Year 10-11)	Developed 'a coding framework'	Pupils reported high levels of acceptability and described relationships of trust with Bounceback staff. Although pupils had choice about most aspects of Bounceback, teachers controlled access to it, partly in order to manage demand.

Authors; Year	Study Title	Location	Aims	Intervention	Data Collection	Sample	Data Analysis	Key Findings
Spencer et al., 2020	A qualitative exploration of 14 to 17-year old adolescents' views of early and preventative mental health support in schools	North East of England	'To explore young people's lived experience of emotional and psychological challenges, which can negatively impact upon their mental health in order to better inform the future development of school-based mental health support.'	Intervention not specified	Qualitative design using semi-structured interviews	12 young people aged 14–17	Thematic analysis	Young people want more regular and in-depth mental health education, tailored levels of support in school and improved training for teachers.

Approach to quality appraisal

The applicability of quality appraisal in qualitative research is debated (Majid & Vanstone, 2018). Evaluating qualitative findings by extrapolating standards developed for quantitative research is inappropriate due to differing epistemological underpinnings of each approach (Williams, Boylan & Nunan, 2019). Instead, the utility of assessing concepts such as transparency, transferability (distinct from 'generalisability' described in quantitative research) and reflexivity has been outlined (Williams, Boylan & Nunan, 2019).

A range of frameworks have been designed to facilitate quality appraisal of qualitative findings using these concepts. Studies identified through the search were subject to quality appraisal using the Critical Appraisal Skills Programme (CASP) qualitative checklist (CASP, 2018) and refined by Long et al. (2020) as used in published qualitative reviews (Dornan et al. 2021; Shankleman et al., 2021). Selection of this tool was informed by a review of existing qualitative quality appraisal tools (Majid & Vanstone, 2018). Long et al. (2020) introduced a new category to the CASP qualitative checklist considering whether a study describes its theoretical underpinnings in appraising quality. Long et al. (2020) further proposed organising subsequent synthesis of qualitative findings according to their quality rating, whereby studies of 'higher' quality according to checklist criteria are given greater emphasis in the findings. The refined CASP qualitative checklist (Long et al., 2020) is shown in Appendix A.

Quality appraisal

Overall, methodological quality of included papers varied according to the checklist criteria. Long et al. (2020) described decisions on "essential quality criteria" for inclusion in qualitative thematic synthesis as "necessarily subjective". They did not recommend weighting CASP criteria or provide a 'benchmark' for categorising quality (Long et al., 2020). In the

context of limited research in this area, most papers at least partially addressed a majority of CASP criteria, with notable limitations in describing theoretical underpinnings and reflexivity (Table 5). Despite these limitations, all 11 papers presented direct quotations in their results and were considered to be of sufficient quality to be included in the review. A colour-coded summary of the quality appraisal is shown in Table 5 and in full in Appendix B.

Table 5

Summary of quality appraisal according to CASP criteria

	CASP criteria										
Paper	Clear aims?	Qualitative methodology appropriate?	Research design appropriate?	Theoretical underpinnings clear?	Recruitment strategy appropriate?	Data collection appropriate?	Relationships considered?	Ethical issues considered?	Data analysis rigorous?	Clear findings?	Valuable contribution?
Cale et al., 2020	Yes	Yes	Yes	Somewhat	Somewhat	Somewhat	Somewhat	Somewhat	Somewhat	Somewhat	Yes
Chase et al., 2006	Yes	Yes	Yes	No	Yes	Somewhat	No	No	No	Somewhat	Yes
Evans et al., 2015	Yes	Yes	Yes	No	Somewhat	Somewhat	No	Somewhat	Somewhat	Yes	Yes
Fox & Butler, 2007	Yes	Yes	Yes	No	Somewhat	Somewhat	No	No	Somewhat	Yes	Yes
Kendal et al., 2011	Yes	Yes	Somewhat	No	Yes	Yes	No	Yes	Somewhat	Somewhat	Yes
Kendal et al., 2014	Yes	Yes	Somewhat	Somewhat	Somewhat	Yes	Yes	Somewhat	Yes	Yes	Yes
McGeechan et al., 2019	Yes	Yes	Somewhat	No	Yes	Somewhat	No	Yes	Somewhat	Yes	Yes
McKeague et al., 2018	Yes	Yes	Yes	Somewhat	Yes	Somewhat	Yes	Somewhat	Yes	Yes	Yes
Prior, 2012	Yes	Yes	Yes	No	Yes	Somewhat	Yes	Yes	Yes	Yes	Yes
Segrott et al., 2013	Yes	Yes	Somewhat	No	Yes	Yes	No	Yes	Somewhat	Yes	Yes
Spencer et al., 2020	Yes	Yes	Somewhat	Somewhat	Yes	Yes	No	Yes	Somewhat	Yes	Yes

Note. Adapted from Long et al. (2020)

Aims and method

Included studies clearly set out their research aims with the use of qualitative methodologies being appropriate to address these aims. Each paper explicitly described exploring or eliciting the views and experiences of CYP but varied slightly in their focus. For example, McKeague et al. (2018) focused on assessing feasibility and acceptability of their workshop, whilst Kendal et al. (2014) focused on understanding barriers and facilitators to accessing help in schools. These different emphases were important to recognise during the process of thematic synthesis.

Research design

Data were collected either using focus groups or interviews across all papers. Several studies did not explicitly justify the research design used, for example, by explaining why interviews were used over another form of qualitative design.

Theoretical underpinnings

All papers were limited in describing their theoretical underpinnings. Seven papers made no reference to their epistemological assumptions or guiding theoretical framework used. McKeague et al. (2018) described that data analysis was "not conducted from any particular theoretical standpoint" whilst Spencer et al. (2020) made reference to adopting a "theoretically flexible approach". Cale et al. (2020) outlined their approach as "guided by constructivist grounded theory" despite using thematic analysis. Kendal et al. (2014) described an "analytic aim of interpreting the meaning and significance of data". This was an area of limitation across papers and as a result it was not possible to assess how far the paradigm guiding the research was congruent with the qualitative methodology employed.

Sampling and data collection

Each paper used purposive sampling; however, the process of recruitment was described in varying detail. Some papers omitted a description of participant selection altogether. Several papers explained that CYP volunteered to take part but did not always address how they were approached and how the research was explained to them. Reasons behind CYP choosing to not take part were not explained. Consequently, it is unclear how far response bias may have affected findings as CYP with particularly negative or positive experiences may have been more likely to take part.

Three papers described sampling a 'cross-section' of participants in terms of gender (Segrott et al., 2013), socioeconomic background (Spencer et al., 2020), and ethnicity (McKeague et al., 2018). Description of demographic characteristics varied. Each paper outlined the age range of their participants. Ethnicity of participants was described by five papers (Chase et al., 2006; Evans et al., 2015; McKeague et al., 2018; Prior, 2012, Spencer et al., 2020). Ten papers stated the gender of participants whilst Cale et al. (2020) did not. Some description of socio-economic status was provided by three papers in terms of free school meals status (Chase et al., 2006) and level of deprivation (Kendal et al., 2011; Spencer et al., 2020). Ranged reporting of demographic characteristics limits the extent to which the 'transferability' of qualitative findings beyond study settings may be considered (Korstjens & Moser, 2018).

Data collection processes were also described in varying detail, from a brief explanation that "interviews with young people explored whether [the intervention] had helped them…" (Segrott et al., 2013), to a fuller account of how an interview schedule was developed and implemented, how participation was explained and set up and how data were recorded and handled (Spencer et al., 2020). An interview schedule/topic guided was explicitly provided in

three papers (Kendal et al., 2011; Kendal et al., 2014; Spencer et al. 2020). In the absence of an interview/schedule/topic guide in other papers, it is not possible to ascertain precisely what CYP were asked and how this relates to stated findings.

Reflexivity and ethical considerations

Papers were notably limited in addressing author reflexivity. Six papers made no reference to the relationship between the researcher and participants. Two papers stated that the researcher was not involved in delivering the intervention being explored (McKeague et al., 2018; Segrott et al., 2013). Two papers addressed the role of the researcher as a school counsellor and efforts made to mitigate this [e.g. use of a reflexive diary (Kendal et al., 2014; Prior, 2012.)] One paper acknowledged the role of the researcher in co-creating knowledge (Cale et al., 2020). Overall, it was unclear how researchers' own backgrounds and assumptions may have impacted the process of data collection and analysis and therefore the integrity of findings.

Ethical issues were at least partially addressed by nine papers and omitted by Chase et al. (2006) and Fox and Butler (2007). Nine papers stated that ethical approval was obtained from a relevant research ethics committee. Informed consent processes were referenced by five papers and described more fully in four papers.

Issues around confidentiality were explicitly acknowledged in four papers (Fox & Butler, 2007; Kendal et al., 2011; Kendal et al., 2014; Prior, 2012) and absent in seven. Two papers described offering debriefing following participation (Kendal et al., 2014; Prior, 2012).

Data analysis and findings

All papers used thematic analysis. A majority of papers described the analytic strategy adopted with sufficient clarity and detail to enable understanding of how themes were developed. One paper made no reference to data analysis employed (Chase et al., 2006). A range of inductive, deductive and narrative approaches were described. Several papers outlined measures taken for quality assurance, including multiple researchers being involved in data analysis and an explanation of how agreement was reached. All papers provided sufficient quotations from the data to support themes described, although this varied. The application of thematic analysis can vary due to the 'theoretical freedom' of the method, from essentialist to constructionist paradigms (Braun & Clarke, 2006). Since a majority of the papers omitted a description of their epistemological positioning, our understanding of how the data were analysed and the conclusions drawn is limited. Each paper provided a clear statement of findings in relation to the aims of the research. Papers largely acknowledged contrasting perspectives between different CYP and integrated these in their findings.

Value of research

The final criteria of quality appraisal when using the CASP checklist is to assess the value of contribution made by the research (Long et al., 2020). This includes determining whether findings further existing knowledge or understanding; if recommendations for future research or practice are offered; and whether the transferability of findings has been addressed. Each paper addressed at least one of these areas, most frequently highlighting the novelty of their findings or offering ideas for future research to build on findings. The limited extent to which findings were transferable to other populations was explicitly addressed in six papers, with

references made to the exploratory nature of the research (Chase et al., 2006; Evans et al., 2015; Fox & Butler, 2007; Kendal et al. 2011; Kendal et al., 2014; Segrott et al., 2013).

Approach to synthesis of findings

Following quality appraisal, qualitative findings of the 11 studies identified through the search were thematically synthesised following steps outlined by Thomas and Harden (2008) as used in published thematic synthesis reviews (Bridges et al., 2010; Franco et al., 2015).
First, data from the 11 studies were extracted and imported into NVIvo Qualitative Data Analysis Software. This included all reported findings/results sections of each study, and all direct interview quotations presented, as described by Thomas and Harden (2008).

Papers identified as having fewer methodological limitations and greater relevance to the aims of the review were prioritised during the process of thematic synthesis, using a combination of direct quotations and authors' interpretation of qualitative findings presented (e.g., Prior, 2012; McKeague et al., 2018). Conversely, for papers that did not address issues of bias or sufficiently explain how data were analysed (e.g., Chase et al., 2006; Fox & Butler, 2007), only direct quotations were used in the thematic synthesis.

Initially the data were coded using an inductive approach according to their meaning and content. An example extract of coded data is presented in Appendix C. Only data pertinent to the aims of this review were analysed. Where studies included adult participants, such as staff or parents, only data from CYP participants were analysed. Line-by-line coding was used to generate overarching themes and subthemes in line with the review question. Themes developed were reviewed by the research supervisors. To ensure the reliability of the coding procedure used, a fellow trainee clinical psychologist familiar with thematic analysis methodology was

asked to match a randomly organised sample of sub-themes into themes. This resulted in inter-rater agreement of 100%.

Synthesis of findings

Three overarching themes were developed: impact of school context, intervention factors, and young people factors. Each theme describes barriers and facilitators to targeted mental health and wellbeing interventions being provided in schools as experienced by CYP. A full description of themes developed with example quotations is presented in Appendix D. Synthesised findings are described below, with subthemes highlighted in bold.

Theme 1: Impact of school context

The theme 'impact of school context' described how factors inherent to the school context informed how young people felt about interventions being provided in this setting.

The impact of **school as a venue** for intervention was described in five papers. Some CYP felt that school was a **familiar and comfortable** setting for intervention ("It was quite good doing it in school, 'cause we're all comfortable with our surroundings" – McKeague et al., 2018). Conversely, other CYP voiced concerns that the public nature of the school setting might **compromise confidentiality** ("[expressed] concern that privacy and confidentiality might not be fully assured in the school setting" – McKeague et al., 2018). To mitigate this, a need for the location of intervention within schools to be both **discreet** ("People don't actually see you going into the room…Yes, they do, it's on the Year 9 corridor!" – Fox & Butler, 2007) and easily **visible/accessible** was apparent ("It needs to be easy to find and pupils need to be told where it is" – Fox & Butler, 2007).

A need to **balance competing demands** within the school day was described by four papers. Attending interventions necessitated missing lessons and other timetabled commitments. This was perceived **negatively** as disruptive by some CYP ("They took us out of lessons, that you kind of needed to be in, working towards the exam" – Cale et al., 2020) and **positively** as a welcome break from the school day by others ("I loved it!...It just really helped me like, having a break from school, for what was a positive thing" – Cale et al., 2020). In the context of an already busy school day, some CYP felt that the **required time commitment was too great** to engage with intervention ("Students did not feel able to give up the amount of time that was required" – McKeague et al., 2018).

The **profile of interventions within school community** was discussed in five papers. **Poor awareness** of support available within schools was described. To remedy this and improve uptake, calls to **promote interventions** to CYP were made ("Participants felt it was important that the availability of support should be better advertised" - Spencer et al., 2020).

Theme 2: Intervention factors

The theme 'intervention factors' described the impact of how interventions are introduced and delivered within schools.

Referral processes were discussed in seven papers. CYP spoke favourably about the value of **self-referral in promoting engagement** ("Students spoke in favour of the self-referral route...most acted independently prompted by awareness of personal need combined with publicity in school" – Kendal et al., 2011). **Promoting choice and a sense of agency** fostered openness to help-seeking and provided CYP with a sense that support was available to them ("If someone notices something, then a teacher can approach them. Not force them into, because that would cause stress, but just let them know, "you've got support here, if you want it, it's yours" –

Spencer et al., 2020). **Support from a trusted adult** was further described in supporting CYP to engage where they felt unsure about what an intervention might involve ("Backing from Mrs Smith [that helped me go]. I didn't actually know what to expect really" – Prior, 2012).

Where CYP were identified for intervention rather than self-referring, both **unhelpful consequences** and a **positive impact** of this were described. Some CYP felt that being targeted meant that they were thought of as struggling ("We thought we were being picked on because we were like, stupid" – Cale et al., 2020) whilst others felt dismissed by their school ("Jayden: They want us out. Neil: They want us out of lessons anyway" – Evans et al., 2015). For some CYP, a consequence of being targeted was that they felt engagement was compulsory ("Many of the young people interviewed felt like they had no choice but to take part" – McGeechan et al., 2019). However for others, being identified for intervention enabled CYP to feel 'seen' and that intervention presented an opportunity for their needs to be met ("Faye said she felt lucky and special to have been chosen" – Evans et al., 2015).

Perspectives on whether interventions should be facilitated by **internal school staff or external professionals** were discussed in seven papers. Teaching staff occupying a **dual role** in facilitating intervention was experienced as problematic. CYP felt uneasy at the prospect of being supported by teachers ("if they were your counsellor as well, you would feel a bit uncomfortable" – Fox & Butler, 2007) and described a wariness about disclosing personal information to staff. Instead, a **preference to share information with non-teaching staff** was described ("I enjoy it because it's not a teacher, so you can tell him more...like, you can have an actual conversation with him" – Cale et al., 2020). A perception that professionals are external to the school **supported CYPs' trust in confidentiality (**"the counsellor's separateness was a key

factor in her decision to engage" - Prior 2012). Relatedly, external professionals were described as having **expertise** "…where other school staff are not always equipped" (Prior, 2012).

Ideas on the **timing of intervention** were described in three papers. Some CYP felt that interventions should be offered early in secondary school to prevent difficulties from escalating ("It was important that support should be offered to young people at an early stage" – Spencer et al., 2020). It was also important that interventions were planned around timetable constraints. **Close proximity to exams** was identified as being particularly unhelpful ("Young people expressed concerns over their timings and particularly their proximity to examinations" – Cale et al., 2020).

Theme 3: Young people factors

The theme 'young people factors' described how attitudes and perceptions held amongst CYP impacted engagement with school-based intervention.

The **role of stigma** was present in seven papers. **Self-stigma** was described as one 'risk' that prevented CYP from accessing intervention ("there was a clutch of risks that had to be considered, including feeling inadequate for needing help" – Kendal et al., 2014). Anticipatory fear that help-seeking would come at some cost by **risking exposure and judgement from others** was also described ("Stigmatisation concerns loom large as [CYP] consider what other people might think if they discovered the young person was in counselling" – Prior, 2012).

How far CYP **perceived a need** to engage with intervention was also important in four papers. Some CYP reported that if they were experiencing difficulties, they would not recognise school as a potential source of support, but rather would turn to friends and family, or **manage independently** ("[CYP] reported feeling able to cope with stress by themselves" – McKeague et

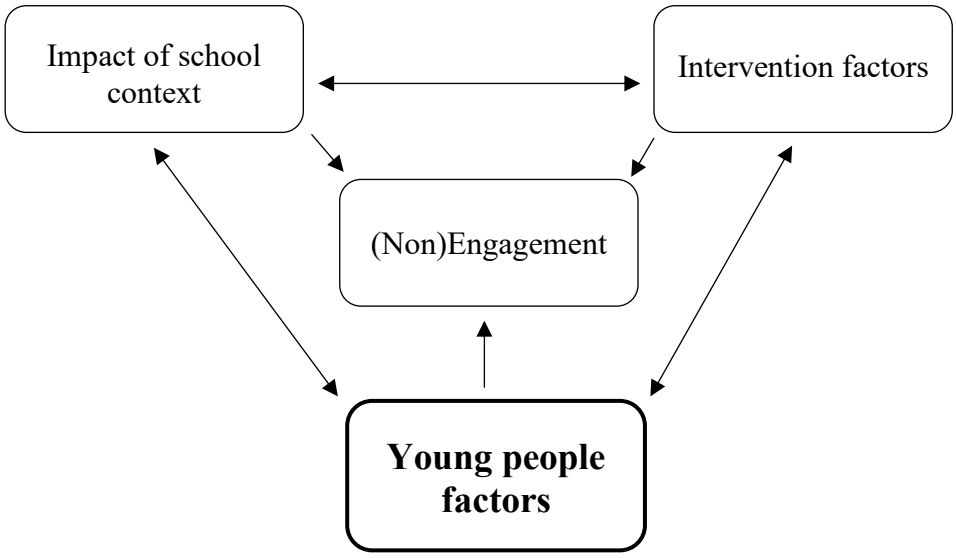
al., 2018). Conversely, openness and **interest in receiving school-based support** was also identified. Some CYP described experiences of long-waiting lists for support and a perception that if more of their peers were aware of support available, it would be taken up ("If my mates knew about that project they might go to it" – Kendal et al., 2014).

Finally, the impact of **peers' responses** to CYP accessing school-based support was highlighted. Varied experiences of **indifference** ("young people felt that others simply would not care whether they were doing it or not" – McGeechan et al., 2019), to **jealousy** ("They were like jealous but they had no clue what it was about" – McGeechan et al., 2019), and **curiosity** were reported ("It's during lesson time and they want to know why you're going out" – Fox & Butler, 2007).

Themes identified through the thematic synthesis can be understood as inter-related processes that impact each other. A figure illustrating this interaction is presented below.

Figure 2

Interaction of themes



The following examples are used to illustrate how these processes interact. If the venue of the intervention is public and exposing, a CYP's fear of exposure and judgement may be

greater. If a CYP experiences self-stigma related to help-seeking in this situation and is part of a peer group in which mental health difficulties are stigmatised, their likelihood of self-referring for intervention may be compromised. Furthermore, if the intervention is provided by a teacher in the school, fear of exposure and judgement may be greater, making it increasingly unlikely that the CYP will engage.

Conversely, if the venue of intervention is considered to be sufficiently discreet, CYPs' fear of exposure and judgement may be minimised, promoting engagement. This engagement will be further supported if the intervention is provided by an outsider to the organisation promoting a sense of confidentiality, and if the peer group are experienced by the CYP as being envious of the opportunity.

In considering the relationship between these processes, 'young people factors' could be hypothesised as most important in underlying engagement. For example, if a CYP does not perceive a need for intervention or experiences significant self-stigma that prevents them from disclosing their difficulties, working at the level of making adaptations to the school context and how interventions are delivered may not be sufficient to promote engagement.

Discussion

Review findings

This review explored qualitative research on CYPs' views and experiences of targeted mental health and wellbeing interventions being provided in schools. This was achieved by performing a systematic literature search, quality appraisal and thematic synthesis. The 11 included papers gave rise to three overarching and interacting themes: impact of school context, intervention factors, and young people factors. Key findings are discussed with reference to

existing literature. Next, implications for practice and research are proposed. Finally, strengths and limitations of the review are considered.

Impact of school context

Locating provision within the school context was received positively by some CYP, while others expressed concern, highlighting practical issues. This was in line with findings of related reviews describing the impact of logistical difficulties on school-based implementation, such as timetabling constraints and lack of appropriate private, clinical space (Gee et al., 2021; Paulus et al., 2016). Differing perspectives on the acceptability of school-based provision were in line with existing findings that CYP can be apprehensive about engagement (Gronholm et al., 2018) but for some, school-based support is experienced as less stigmatising than 'conventional' clinic-based services (Gee et al., 2021). The need to promote awareness of support available within schools also echoed existing findings that CYP want more information about mental health, services available, and what to expect from them (Plaistow et al., 2014).

Intervention factors

Positive perceptions of self-referral linked to findings highlighting the importance of facilitating access to support on CYPs' own terms (Plaistow et al., 2014). Indeed, allowing CYP to self-select may mitigate the negative impact of being selected for intervention, which was sometimes experienced as undermining or dismissive in findings of this review. This tension has been described to continue throughout the process intervention, where CYP describe valuing their self-reliance being fostered, but find that this can be at odds with the lived experience of accessing services (Plaistow et al., 2014).

A role for teaching and school staff identified in supporting CYP to engage with intervention was consistent with the 'gateway provider model' described by Stiffman et al. (2004). This model focuses on the role of a 'gateway provider' in identifying need. It states that the more knowledge of mental health and available resources a 'provider' has, the more likely they are to signpost for intervention. However, a lack of confidence and identity conflict amongst school staff in supporting mental health need has been described (Graham et al., 2011). Consequently, school staff should be supported to become familiar with what is available in schools and recognise CYP who may benefit from intervention, as far as they perceive this to be their role (Reinke et al., 2011; Rothì et al., 2008).

Promoting a sense of choice for CYP through discussion was important in this review. Adolescence has been characterized as a life-stage marked by the development of autonomy (DiClemente et al., 1996). However, as CYP strive for independence, maintaining some dependence on others for help during this life-stage has been associated with "significant positive implications for later independent functioning in adulthood" (Szwedo et al., 2017). It is important that professionals are sensitive to this tension in approaching CYP. This supports the findings of Gronholm et al. (2018) where value of informal discussion without immediate pressure to engage was described by CYP. To further develop trust, Gronholm et al. (2018) highlighted the need to be explicit about how privacy and choice would be protected during intervention. A qualitative study exploring young men's experiences of accessing CAMHS described the role of an adult, such as parents and teachers, in recognising, normalising, and initiating help-seeking. Professionals adopting a 'developmentally sensitive approach' and treating young men as equals – "they don't talk down to you" - was also important to engagement (Hassett & Isbister, 2017). These interactions could be viewed as fostering self-

determination, where greater perceived autonomy (feeling our actions are self-determined), relatedness (feeling supported in relationships) and competence (feeling able to manage situations) promote motivation and engagement (Deci & Ryan, 1985).

A preference to engage with external facilitators was in line with findings that interventions delivered by internal school staff may not be as effective as those delivered by external professionals (Gee et al., 2020). However, it is acknowledged that internally delivered interventions may be more sustainable and cost-effective over time than those depending on external facilitation (Gee et al., 2020). Additional challenges associated with mental health professionals delivering interventions in schools include integration within the school community and establishing clear communication channels (Gee et al., 2021).

Child and young people factors

Findings on the impact of stigma on help-seeking and engagement resonated with those described by Gronholm et al. (2018) and Radez et al. (2020). Self-stigma (seeing help-seeking as a sign of weakness and a poor reflection of personal character) and anticipated embarrassment about being 'found out' were identified as important barriers to engagement in these reviews. Clement et al. (2015) further identified that CYP may be disproportionally deterred from help-seeking as a consequence of stigma compared to their adult counterparts, further highlighting the importance of addressing this within school communities.

Low perceived need for intervention described by some CYP could be understood by drawing on findings suggesting that CYP prefer to rely on themselves rather than seek professional help (Radez et al., 2020). Furthermore, CYP may not perceive that their difficulties warrant support, or may prefer to rely on informal support networks, including family and friends (Radez et al., 2020; Reardon, et al., 2019). This finding corresponds with the 'cycle of

avoidance' developed by Biddle et al. (2007). This cycle proposes that CYP often view their psychological difficulties as 'normal' and not requiring intervention. This view normalises experiences of distress even in the context of escalating difficulties. Consequently, the threshold for help-seeking continually shifts. This threshold is 'crossed' as a result of experiencing crisis or the intervention of another.

The impact of peers in this review was consistent with findings of Gronholm et al. (2018) who described a range of hostile peer reactions, from perceived judgement to overt instances of bullying, impacting engagement. Our understanding of the impact of peers could be developed using the 'network episode model', which outlines how an individual's social and cultural context impact their help-seeking behaviour, rather than behaviour occurring in isolation (Pescosolido, 1991). This model proposes that individuals come to understand their difficulties through the responses of others. Social networks have the power to support or inhibit an individual's engagement with support depending on their assumptions and beliefs. This is especially important in the Western context of increasing importance of peers during adolescence (Ciranka & Wouter van den Bos, 2019).

Clinical implications

Practical recommendations

Ensuring the location of intervention is discreet yet accessible and minimising disruption to the school day and calendar was identified as important to CYP. Gee et al. (2021) also recommended ensuring that sessions are contained within one class period and allowing for breaks in the delivery of interventions around exam periods.

Combining the option for self-referral with support from trusted adults could support engagement. Delivering interventions through non-teaching staff or external professionals as possible is also recommended to promote acceptability. Where school-based staff are involved in signposting or delivering interventions, high-quality training and ongoing support is indicated (Gee et al., 2021). Schools should also promote awareness of available interventions across the school community.

Furthermore, adapting implementation practices based on feedback from CYP would help to overcome barriers to engagement described and ensure that services meet their needs (Plaistow et al., 2014). Involving CYP in local implementation planning would also promote their sense of being valued stakeholders.

Promoting engagement

Bordin (1979) conceptualised therapeutic alliance as consisting of three parts: goal agreement, task agreement and bond. Bordin (1979) proposed that therapeutic alliance is strong when: i) a shared understanding of goals for intervention has been established, ii) a plan for how these goals will be met has been agreed, and iii) a 'bond' is formed from trust and confidence in the approach taken. Schools could harness this model in fostering therapeutic alliance with CYP. Goal agreement could be promoted by providing intervention to CYP who explicitly perceive need for this and agree that support of this nature could be meaningfully help to them. Targeting CYP for intervention such that they feel obliged to participate is not conducive to genuine engagement. Indeed, the potential for iatrogenic labeling resulting from targeted school-based intervention has been cautioned (Bierman, 2003; Coppock, 2010). CYPs' wishes to manage their difficulties independently or rely on support from informal networks should be respected. Schools could promote task agreement by ensuring that the proposed delivery and format of

interventions is acceptable to CYP, including their willingness to miss lessons and the venue of intervention. Finally, schools could promote a 'bond' by aligning themselves alongside CYP, listening to and validating their concerns, and developing their confidence in the privacy of interventions as described earlier.

Targeting stigma

A need to address stigma experienced as a barrier to intervention was evident in findings. However, a systematic review of school-based interventions targeting stigma around mental health difficulties found no strong evidence that such interventions are effective for CYP (Mellor, 2014). Consequently, further work is required to establish how to address the complex phenomenon of stigma at individual, organisational and community levels (Mannarini & Rossi, 2019).

Research implications

The richness of findings synthesised in this review demonstrates the value of foregrounding the voices of CYP in research. Studies exploring CYP's experiences of receiving school-based provision are relatively scarce indicating need for further research to explore acceptability (Gee et al., 2021). It is also important that future research investigating the effectiveness of targeted school-based interventions should incorporate service user perspectives in their evaluation. This would allow for exploration of how interventions are experienced in context. Augmenting randomised controlled trials with a qualitative evaluation would also reveal insight into which aspects of intervention are most acceptable to CYP and where adaptations are needed to improve outcomes (O'Cathain et al., 2013). Indeed, although the 'hierarchy of evidence' (Evans, 2003) privileges quantitative data from experimental conditions, if factors

impacting engagement are not understood, the effectiveness of interventions in real world conditions will remain limited.

Given the importance of context highlighted by this review's findings, future research should focus on exploring the implementation of novel school-based interventions and identifying factors that facilitate and impede school-based delivery. Research could also focus on how to adapt interventions across different school settings. Whilst protecting the principles underlying manualised intervention, developers should consider and outline ways that the materials and format used could be adapted to promote acceptability (Malti et al., 2016).

In this review, it was not possible to determine how far themes identified might apply to CYP of different protected characteristics. Studies varied in their reporting of participant demographic characteristics and did not differentiate between participants in reporting their findings. It is important that future research works to establish how different CYP perceive school-based intervention and how they may be differentially impacted by stigma. For example, CYP who identify as lesbian, gay, bisexual or transgender are understood to often experience stigma in the school context (Carlile, 2020). It is currently unclear how this impacts the acceptability of school as a context for intervention in this group.

Findings from papers included in this review did not specifically address how CYP view individual versus group formats of targeted interventions. Establishing how these formats impact stigma and uptake would be helpful to guide future implementation. Lastly, the views and experiences of primary school-aged children were not explored, warranting further investigation.

Strengths and limitations

It is important to acknowledge the potential impact of editorial constraints of publishing journals on what was reported in each paper included in this review. This may bias the process of appraising research quality. For example, the journal 'Child and Adolescent Mental Health' (which published several papers included in this review) stipulates a word count of 5,500 words. This is in contrast with the 'Journal of Public Health', which published one paper included in this review, and has a word count between 2,000-3,000 words. These constraints may limit how much detail authors are able to report, impacting quality ratings. However, after reviewing guidance for each publishing journal used in this review, a relationship between quality and editorial constraints was not observed.

Qualitative quality appraisal checklists have been critiqued for adopting a "broad brush approach to qualitative research as a whole" with little differentiation between methodologies (Williams et al., 2021). Augmenting use of the CASP checklist (Long et al., 2020) with a tool developed for assessing quality in thematic analysis (e.g., Braun & Clarke, 2020) may have allowed for more specific quality appraisal.

Additionally, although efforts were made to prioritise methodologically robust papers, it is important to acknowledge that the thematic synthesis conducted involved re-interpreting authors' interpretation of their findings. This may have introduced the potential for bias in the review process in addition to possible bias pre-existing in the primary research (Thomas & Harden, 2008). To mitigate this, use of direct quotations was prioritised. Papers also varied in their direct applicability to the aims of this review, resulting in some papers contributing more data to the thematic synthesis than others.

Despite these limitations, to the author's knowledge this review represents the first qualitative synthesis of research into CYPs' experiences of targeted interventions in being provided in schools. This process facilitated the identification of overlapping themes between individual papers included, providing new understandings of the data and improving the transferability of qualitative findings discussed.

Conclusion

Increased concern around the mental health and wellbeing of CYP has resulted in schools being promoted as settings in which to provide support (Department for Education, 2016). In the context of a limited evidence-base, a need to improve our understanding of how CYP perceive school-based provision has been described (Day et al., 2006). This review explored views and experiences of targeted mental health and wellbeing interventions being provided in schools amongst CYP in the UK. A thematic synthesis of 11 papers identified how factors inherent to the school context, the manner in which interventions are introduced and delivered, and attitudes and perceptions held by CYP shape the acceptability of school-based provision. To facilitate engagement, schools should adapt their practices to address practical concerns, promote choice and agency, and guarantee confidentiality. The complex task of addressing stigma associated with help-seeking is also an important future endeavour. The voices of CYP should be privileged in research and practice moving forwards, to promote school-based provision that is acceptable and responsive to their needs.

References

Bauer, M. S., & Kirchner, J. (2020). Implementation science: What is it and why should I care? *Psychiatry Research, 283*. https://doi.org/10.1016/j.psychres.2019.04.025

Bell, J., Reid, M., Dyson, J., Schlosser, A., & Alexander, T. (2019). There's just huge anxiety: Ontological security, moral panic, and the decline in young people's mental health and well-being in the UK. *Qualitative Research in Medicine and Healthcare*, *3*(2), 87-97. https://doi.org/10.4081/qrmh.2019.8200

Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: A dynamic interpretive model of illness behaviour. *Sociology of Health & Illness*, *29*(7), 983-1002. https://doi.org/10.1111/j.1467-9566.2007.01030.x

Bierman, K. L. (2003). Commentary: New models for school-based mental health services. *School Psychology Review*, *32*(4), 525-529. https://doi.org/10.1080/02796015.2003.12086217

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252–260. https://doi.org/10.1037/h0085885

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 1-25. https://doi.org/10.1080/14780887.2020.1769238

Bridges, J., Flatley, M., & Meyer, J. (2010). Older people's and relatives' experiences in acute care settings: Systematic review and synthesis of qualitative studies. *International Journal of Nursing Studies*, *47*(1), 89-107. https://doi.org/10.1016/j.ijnurstu.2009.09.009

Cale, L., Harris, J., & Hooper, O. (2020). Get(ting) to the start line–the evaluation of an innovative intervention to address adolescents' school-related stress and anxiety. *European Physical Education Review*, *26*(3). 642-663. https://doi.org/10.1177/1356336X20902487

Carlile, A. (2020). The experiences of transgender and non-binary children and young people and their parents in healthcare settings in England, UK: Interviews with members of a family support group. *International Journal of Transgender Health, 21*(1), 16-32. https://doi.org/10.1080/15532739.2019.1693472

Chase, E., Goodrich, R., Simon, A., Holtermann, S., & Aggleton, P. (2006). Evaluating school-based health services to inform future practice: Lessons from "Teen Talk" at Kidbrooke School in Greenwich. *Health Education, 106*(1), 42-59. https://doi.org/10.1108/09654280610637193

Ciranka, S., & van den Bos, W. (2019). Social influence in adolescent decision-making: A formal framework. *Frontiers in Psychology, 10*, 1915. https://doi.org/10.3389/fpsyg.2019.01915

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11-27. https://doi.org/10.1017/S0033291714000129

Collishaw, S. (2015). Annual research review: Secular trends in child and adolescent mental health. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *56*(3), 370– 393. https://doi.org/10.1111/jcpp.12372

Coppock, V. (2010). Cause for hope or despair? Limits to theory and policy in relation to contemporary developments in promoting mental health and well-being in schools in the UK and implications for children's rights. *Advances in School Mental Health Promotion, 3*(1), 52-62. https://doi.org/10.1080/1754730X.2010.9715674

Cosma, A., Stevens, G., Martin, G., Duinhof, E. L., Walsh, S. D., Garcia-Moya, I., & De Looze, M. (2020). Cross-national time trends in adolescent mental well-being from 2002 to 2018 and the explanatory role of schoolwork pressure. *Journal of Adolescent Health, 66*(6), 50-58. https://doi.org/10.1016/j.jadohealth.2020.02.010

Critical Appraisal Skills Programme (2018). *CASP Qualitative Checklist.* Retrieved from https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Currie, C., Zanotti, C., Morgan, A., Currie, D., de Looze, M., Roberts, C., Samdal, O., Smith, O., & Barnekow, V. (2012). *Social determinants of health and well-being among young people. Health behaviour in school-aged children (HBSC) study: International report from the 2009/2010 survey*. World Health Organisation. https://www.euro.who.int/__data/assets/pdf_file/0003/163857/Social-determinants-of-health-and-well-being-among-young-people.pdf

Day, C., Carey, M., & Surgenor, T. (2006). Children's key concerns: Piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry, 11*(1), 139-155. https://doi.org/10.1177/1359104506056322

Deci, E. L., & Ryan, R. M. (1985). The general causality orientations scale: Self-determination in personality. *Journal of Research in Personality, 19*(2), 109-134. https://doi.org/10.1016/0092-6566(85)90023-6

Department for Education. (2016). *Supporting mental health in schools and colleges: Summary report*. https://www.gov.uk/government/publications/supporting-mental-health-in-schools-and-colleges

Department of Health & Social Care. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Department of Health and Social Care & Department for Education. (2017). *Transforming children and young people's mental health provision: A green paper*. https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

DiClemente, R. J., Hansen, W. B., & Ponton, L. E. (1996). Adolescents at risk. In R. J. DiClemente, W. B. Hansen, & L. E. Ponton (Eds.), *Handbook of adolescent health risk behavior* (pp. 1-4). Springer.

Dornan, M., Semple, C., Moorhead, A., & McCaughan, E. (2021). A qualitative systematic review of the social eating and drinking experiences of patients following treatment for head and neck cancer. *Supportive Care in Cancer*, 1-11. https://doi.org/10.1007/s00520-021-06062-7

Dray, J., Bowman, J., Campbell, E., Freund, M., Hodder, R., Wolfenden, L., & Wiggers, J. (2017). Effectiveness of a pragmatic school-based universal intervention targeting student resilience protective factors in reducing mental health problems in adolescents. *Journal of Adolescence*, *57*, 74-89. https://doi.org/10.1016/j.adolescence.2017.03.009

Eccles, M.P. & Mittman, B.S. (2006). Welcome to implementation science. *Implementation Science, 1*(1). https://doi.org/10.1186/1748-5908-1-1

Eckersley, R. (2011). A new narrative of young people's health and well-being. *Journal of Youth Studies*, *14*(5), 627-638. https://doi.org/10.1080/13676261.2011.565043

Evans, D. (2003). Hierarchy of evidence: A framework for ranking evidence evaluating healthcare interventions. *Journal of Clinical Nursing*, *12*(1), 77-84. https://doi.org/10.1046/j.1365-2702.2003.00662.x

Evans, R., Scourfield, J., & Murphy, S. (2015). The unintended consequences of targeting: Young people's lived experiences of social and emotional learning interventions. *British Educational Research Journal*, *41*(3), 381-397. https://doi.org/10.1002/berj.3155

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*, *1*(5), 377-387. https://doi.org/10.1016/S2215-0366(14)70312-8

Ford, T., Degli Esposti, M., Crane, C., Taylor, L., Montero-Marín, J., & Blakemore, S. J. (2021). The role of schools in early adolescents' mental health: Findings from the MYRIAD study. *Journal of the American Academy of Child & Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2021.02.016

Fox, C. L., & Butler, I. (2007). 'If you don't want to tell anyone else you can tell her': Young people's views on school counselling. *British Journal of Guidance & Counselling*, *35*(1), 97-114. https://doi.org/10.1080/03069880601106831

Franco, M. R., Tong, A., Howard, K., Sherrington, C., Ferreira, P. H., Pinto, R. Z., & Ferreira, M. L. (2015). Older people's perspectives on participation in physical activity: A systematic review and thematic synthesis of qualitative literature. *British Journal of Sports Medicine, 49*(19), 1268-1276. https://doi.org/10.1136/bjsports-2014-094015

Gee, B., Reynolds, S., Carroll, B., Orchard, F., Clarke, T., Martin, D., & Pass, L. (2020). Practitioner review: Effectiveness of indicated school-based interventions for adolescent depression and anxiety–a meta-analytic review. *Journal of Child Psychology and Psychiatry, 61*(7), 739-756. https://doi.org/10.1111/jcpp.13209

Gee, B., Wilson, J., Clarke, T., Farthing, S., Carroll, B., Jackson, C., & Notley, C. (2021). Delivering mental health support within schools and colleges–a thematic synthesis of

barriers and facilitators to implementation of indicated psychological interventions for adolescents. *Child and Adolescent Mental Health*, *26*(1), 34-46. https://doi.org/10.1111/camh.12381

Goldstein, S. E., Boxer, P., & Rudolph, E. (2015). Middle school transition stress: Links with academic performance, motivation, and school experiences. *Contemporary School Psychology*, *19*(1), 21-29. https://doi.org/10.1007/s40688-014-0044-4

Gondek, D., Ning, K., Ploubidis, G. B., Nasim, B., & Goodman, A. (2018). The impact of health on economic and social outcomes in the United Kingdom: A scoping literature review. *PLoS One*, *13*(12). https://doi.org/10.1371/journal.pone.0209659

Graham, A., Phelps, R., Maddison, C., & Fitzgerald, R. (2011). Supporting children's mental health in schools: Teacher views. *Teachers and Teaching*, *17*(4), 479-496. https://doi.org/10.1080/13540602.2011.580525

Gronholm, P. C., Nye, E., & Michelson, D. (2018). Stigma related to targeted school-based mental health interventions: A systematic review of qualitative evidence. *Journal of Affective Disorders*, *240*, 17-26. https://doi.org/10.1016/j.jad.2018.07.023

Hassett, A., & Isbister, C. (2017). Young men's experiences of accessing and receiving help from child and adolescent mental health services following self-harm. *Sage Open*, *7*(4), https://doi.org/10.1177/2158244017745112

Health Education England. (2020). *Module aims and content of education mental health practitioner for children and young people curriculum (EMHP).* https://www.hee.nhs.uk/sites/default/files/documents/EMHP%20training%20curriculum.pdf

Imran, N., Zeshan, M., & Pervaiz, Z. (2020). Mental health considerations for children & adolescents in COVID-19 pandemic. *Pakistan Journal of Medical Sciences*, *36(*4), 67-72. https://doi.org/10.12669/pjms.36.COVID19-S4.2759

Kendal, S., Callery, P., & Keeley, P. (2011). The feasibility and acceptability of an approach to emotional wellbeing support for high school students. *Child and Adolescent Mental Health*, *16*(4), 193-200. https://doi.org/10.1111/j.1475-3588.2011.00602.x

Kendal, S., Keeley, P., & Callery, P. (2014). Student help seeking from pastoral care in UK high schools: A qualitative study. *Child and Adolescent Mental Health*, *19*(3), 178-184. https://doi.org/10.1111/camh.12029

King, G., Currie, M., & Petersen, P. (2014). Child and parent engagement in the mental health intervention process: A motivational framework. *Child and Adolescent Mental Health*, *19*(1), 2-8. https://doi.org/10.1111/camh.12015

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120-124. https://doi.org/10.1080/13814788.2017.1375092

Layard, R., Clark, A. E., Cornaglia, F., Powdthavee, N., & Vernoit, J. (2014). What predicts a successful life? A life-course model of well-being. *The Economic Journal*, *124*(580), 720-738. https://doi.org/10.1111/ecoj.12170

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences, 1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Mackenzie, K., & Williams, C. (2018). Universal, school-based interventions to promote mental and emotional well-being: What is being done in the UK and does it work? A systematic review. *BMJ Open*, *8*(9). https://doi.org/10.1136/bmjopen-2018-022560

Majid, U., & Vanstone, M. (2018). Appraising qualitative research for evidence syntheses: A compendium of quality appraisal tools. *Qualitative Health Research*, *28*(13), 2115-2131. https://doi.org/10.1177/1049732318785358

Malti, T., Noam, G. G., Beelmann, A., & Sommer, S. (2016). Toward dynamic adaptation of psychological interventions for child and adolescent development and mental health. *Journal of Clinical Child & Adolescent Psychology*, *45*(6), 827-836. https://doi.org/10.1080/15374416.2016.1239539

Mannarini, S., & Rossi, A. (2019). Assessing mental illness stigma: A complex issue. *Frontiers in Psychology, 9*, 2722. https://doi.org/10.3389/fpsyg.2018.02722

McGeechan, G. J., Richardson, C., Wilson, L., Allan, K., & Newbury-Birch, D. (2019). Qualitative exploration of a targeted school-based mindfulness course in England. *Child and Adolescent Mental Health, 24*(2), 154-160. https://doi.org/10.1111/camh.12288

McKeague, L., Morant, N., Blackshaw, E., & Brown, J. S. (2018). Exploring the feasibility and acceptability of a school-based self-referral intervention for emotional difficulties in older adolescents: Qualitative perspectives from students and school staff. *Child and Adolescent Mental Health, 23*(3), 198-205. https://doi.org/10.1111/camh.12234

Mellor, C. (2014). School-based interventions targeting stigma of mental illness: Systematic review. *The Psychiatric Bulletin*, *38*(4), 164-171. https://doi.org/10.1192/pb.bp.112.041723

Michael, S., & Frederickson, N. (2013). Improving pupil referral unit outcomes: Pupil perspectives. *Emotional and Behavioural Difficulties*, *18*(4), 407-422. https://doi.org/10.1080/13632752.2013.801112

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7), 332-336. https://doi.org/10.1136/bmj.b2535

Morgan, C., Webb, R. T., Carr, M. J., Kontopantelis, E., Green, J., Chew-Graham, C. A., & Ashcroft, D. M. (2017). Incidence, clinical management, and mortality risk following self harm among children and adolescents: Cohort study in primary care. *British Medical Journal, 359*(4351). https://doi.org/10.1136/bmj.j4351

O'Cathain, A., Thomas, K. J., Drabble, S. J., Rudolph, A., & Hewison, J. (2013). What can qualitative research do for randomised controlled trials? A systematic mapping review. *BMJ Open*, *3*(6). http://dx.doi.org/10.1136/bmjopen-2013-002889

Owens, J. S., Lyon, A. R., Brandt, N. E., Warner, C. M., Nadeem, E., Spiel, C., & Wagner, M. (2014). Implementation science in school mental health: Key constructs in a developing research agenda. *School Mental Health, 6*(2), 99-111. https://doi.org/10.1007/s12310-013-9115-3

Palinkas, L. A. (2014). Qualitative and mixed methods in mental health services and implementation research. *Journal of Clinical Child & Adolescent Psychology, 43*(6), 851-861. https://doi.org/10.1080/15374416.2014.910791

Paulus, F. W., Ohmann, S., & Popow, C. (2016). Practitioner review: School-based interventions in child mental health. *Journal of Child Psychology and Psychiatry, 57*(12), 1337-1359. https://doi.org/10.1111/jcpp.12584

Pescosolido, B (1991). Illness careers and network ties: A conceptual model of utilization and compliance. In G. Albrecht, & J. Levy (Eds.), *Advances in medical sociology* (pp. 161–184). JAI Press.

Plaistow, J., Masson, K., Koch, D., Wilson, J., Stark, R. M., Jones, P. B., & Lennox, B. R. (2014). Young people's views of UK mental health services. *Early Intervention in Psychiatry*, *8*(1), 12-23. https://doi.org/10.1111/eip.12060

Prior, S. (2012). Young people's process of engagement in school counselling. *Counselling and Psychotherapy Research, 12*(3), 233-240. https://doi.org/10.1080/14733145.2012.660974

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(2), 65-76. https://doi.org/10.1007/s10488-010-0319-7

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2020). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, 30, 183–211. https://doi.org/10.1007/s00787-019-01469-4

Rapee, R. M., Wignall, A., Sheffield, J., Kowalenko, N., Davis, A., McLoone, J., & Spence, S. H. (2006). Adolescents' reactions to universal and indicated prevention programs for depression: Perceived stigma and consumer satisfaction. *Prevention Science, 7*(2), 167-177. https://doi.org/10.1007/s11121-006-0035-4

Reardon, T., Harvey, K., & Creswell, C. (2019). Seeking and accessing professional support for child anxiety in a community sample. *European Child & Adolescent Psychiatry*, 29, 649–664. https://doi.org/10.1007/s00787-019-01388-4

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly*, *26*(1), 1–13. https://doi.org/10.1037/a0022714

Rojas-Andrade, R., & Bahamondes, L. L. (2019). Is implementation fidelity important? A systematic review on school-based mental health programs. *Contemporary School Psychology, 23*(4), 339-350. https://doi.org/10.1007/s40688-018-0175-0

Rothì, D. M., & Leavey, G. (2006). Mental health help-seeking and young people: A review. *Pastoral Care in Education*, *24*(3), 4-13. https://doi.org/10.1111/j.1468-0122.2006.00373.x

Rothì, D. M., Leavey, G., & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education*, *24*(5), 1217-1231. https://doi.org/10.1016/j.tate.2007.09.011

Sadler, K., Vizard, T., Ford, T., Goodman, A., Goodman, R., & McManus, S. (2018). *Mental Health of Children and Young People in England, 2017: Trends and characteristics*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

Segrott, J., Rothwell, H., & Thomas, M. (2013). Creating safe places: An exploratory evaluation of a school-based emotional support service. *Pastoral Care in Education, 31*(3), 211-228. https://doi.org/10.1080/02643944.2013.788062

Shankleman, M., Hammond, L., & Jones, F. W. (2021). Adolescent social media use and well-being: A systematic review and thematic meta-synthesis. *Adolescent Research Review,* 1-22. https://doi.org/10.1007/s40894-021-00154-5

Spencer, L., McGovern, R., & Kaner, E. (2020). A qualitative exploration of 14 to 17-year old adolescents' views of early and preventative mental health support in schools. *Journal of Public Health,* 1–7. https://doi.org/10.1093/pubmed/fdaa214

Stiffman, A. R., Pescosolido, B., & Cabassa, L. J. (2004). Building a model to understand youth service access: The gateway provider model. *Mental Health Services Research, 6*(4), 189-198. https://doi.org/10.1023/B:MHSR.0000044745.09952.33

Szwedo, D. E., Hessel, E. T., Loeb, E. L., Hafen, C. A., & Allen, J. P. (2017). Adolescent support seeking as a path to adult functional independence. *Developmental Psychology, 53*(5), 949–961. https://doi.org/10.1037/dev0000277

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1). https://doi.org/10.1186/1471-2288-8-45

Timimi, S. (2009). The commercialization of children's mental health in the era of globalization. *International Journal of Mental Health*, *38*(3), 5-27. https://doi.org/10.2753/IMH0020-7411380301

Vizard, T., Pearce, N., Davis, J., Sadler, K., Ford, T., Goodman, A., & McManus, S. (2018). *Mental health of children and young people in England, 2017: Emotional disorders*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

Williams, V., Boylan, A. M., & Nunan, D. (2019). Qualitative research as evidence: Expanding the paradigm for evidence-based healthcare. *BMJ Evidence-based Medicine*, *24*(5), 168-169. http://doi.org/10.1136/bmjebm-2018-111131

Williams, V., Boylan, A. M., Newhouse, N., & Nunan, D. (2021). Appraising qualitative health research—towards a differentiated approach. *BMJ Evidence-Based Medicine*. https://doi.org/10.1136/bmjebm-2021-111772

Section B: Empirical Paper

A Delphi survey investigating the implementation of a new workforce of school-based mental health practitioners

Word Count: 7,949 (+300)

Abstract

Background: New school-based practitioners have been introduced to provide targeted mental health interventions in schools. This research aimed to explore the implementation of this new workforce and identify factors that facilitate and impede their work to support the initiative's continued roll-out. Method: A three-round Delphi method was used. Thematic analysis of first-round questionnaire data informed the development of a second-round questionnaire that was completed by school-based practitioners (N = 17), their supervisors (N = 10), and school staff (N = 13). A third-round questionnaire was used to finalise consensus within and between groups. Results: Overall, consensus was high. Results highlighted the importance of developing relationships and shared understandings of the initiative in schools, and the need to overcome practical issues to create conditions that facilitate successful working. Participants agreed that a greater range of low-intensity interventions should be offered. A tension between prioritising quality of service and equality of access was also identified. Conclusions: Findings demonstrate the need to facilitate dialogue between local collaborators to recognise and resolve issues together in supporting implementation. To promote sustainability of this workforce, it is crucial that resources invested in recruiting and training practitioners are matched by measured, strategic thinking.

Keywords: implementation, mental health, multi-agency, school-based, targeted

Introduction

Mental health in children and young people

The profile of children and young peoples' (CYP) mental health has increased in recent years (Collishaw, 2015). A marked increase in reporting of mental health difficulties amongst CYP has been observed in developed countries over the last two decades (Pitchforth et al., 2019). In the United Kingdom (UK), an estimated one-in-eight CYP meet current diagnostic criteria for a mental health difficulty (Vizard et al., 2018).

A range of issues have been proposed to account for increased mental health difficulties in CYP, including social media usage, school pressures, the impact of living under austerity, and the medicalisation of emotional distress (Bell et al., 2019). However, evidence supporting such hypotheses is limited and it remains unclear whether a real increase has been observed, or if this could be better explained by elevated presentation and increased use of diagnosis for CYP (Gunnell et al., 2018). Concern around the mental health of CYP has also been characterised as a 'moral panic', bolstered by mainstream media commentary, where public anxiety in response to perceived societal threat has resulted in narratives of this generation being 'in crisis' (Bell et al., 2019).

Irrespective of whether rates have been inflated, mental health difficulties are recognised to negatively impact individual development throughout the life course if left untreated (Rocks et al., 2020). Poor mental health in childhood has been associated with a range of adverse outcomes including educational underachievement, relationship difficulties, and poorer physical and mental health into adulthood (Clayborne et al., 2019).

Access to specialist support

In the UK, approximately a quarter of CYP who report mental health difficulties access specialist Child and Adolescent Mental Health Services (CAMHS) within the National Health Service (NHS) (Department of Health & Social Care, 2015). Barriers to access include limited knowledge of mental health, sources of support available and how to access them. Structural obstacles include long waiting lists and lack of time to attend appointments (Radez et al., 2020).

The UK Government's 'Future in Mind' report pledged to increase access to evidence-based support (Department of Health & Social Care, 2015). A central recommendation focused on the role of early intervention, in which the timing of support is considered crucial in promptly address emerging concerns before they escalate and lead to adverse outcomes (McGorry & Mei, 2018). The subsequent 'Five Year Forward View for Mental Health' highlighted the need to address inequalities in access to healthcare provision (Mental Health Taskforce, 2016). Early intervention for childhood mental health difficulties has been described as "the most effective social investment any government could make from both economic and ethical perspectives" (Fonagy & Pugh, 2017). However, the current policy agenda has been critiqued for adopting "a biological framing of psychological distress" that locates mental health difficulties within individuals and overlooks the role of socio-economic context and structural inequalities that shape psychological distress (Callaghan et al., 2017; Glazzard & Stones, 2021).

The role of schools

In the UK, mental health support has traditionally been delivered within NHS settings (Gee et al., 2020). However, schools have been promoted as appropriate settings to provide intervention in recent years (Department for Education, 2016). Schools play a formative role in

child development beyond formal education, including cognitive development, building peer relationships, and learning emotional regulation skills (Fazel et al., 2014).

Approaches to mental health in schools can include preventative (usually delivered across a school or class [e.g., resilience building curriculum 'Friends for Life' (Higgins & O'Sullivan, 2015)] and targeted interventions (for CYP identified as in need of help). Interventions can be delivered internally by school staff, or by external professionals attending schools (Fazel et al., 2014). Locating services within schools is proposed to increase accessibility of support for groups who have not traditionally accessed specialist CAMHS (Wolpert et al., 2013), including ethnic minority CYP (Cummings et al., 2010). School-based intervention is also proposed to be more convenient than attending community clinics (Wolpert et al., 2013). However, targeted support in schools can be experienced as stigmatising by CYP (Gronholm et al., 2018). There have also been calls to limit demands placed on schools and ensure that staff are not taken away from their core responsibilities whilst facilitating interventions (Glazzard & Stones, 2021; O'Reilly et al., 2018).

Over the last two decades, various initiatives have been piloted, including 'Targeted Mental Health in Schools' (TaMHS) in the UK. TaMHS used external practitioners to provide evidence-based interventions to CYP in small group and individual formats (Wolpert et al., 2013). Schools benefitted from embedded specialist support but identified the need for a 'common language' to bridge the gap between the different working practices of health and education, and the initiative did not secure permanent funding (Wolpert et al., 2013).

Introducing Children's Wellbeing/Education Mental Health Practitioners

Most recently, funding for new school-based practitioners was announced (Department of Health & Social Care & Department for Education, 2017; Department of Health & Social Care,

2018). Part of the national Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) initiative, Children's Wellbeing Practitioners (CWPs), and Education Mental Health Practitioners (EMHPs) deliver targeted low intensity guided self-help (GSH) interventions to CYP and parents (Health Education England, 2020).

CWPs were first to receive funding from Health Education England (HEE) and are trained to work in Tier 2 CAMHS (community-based teams providing early help and targeted interventions) and school settings. EMHPs, part of Mental Health Support Teams (MHSTs), have separate funding from HEE and work exclusively in schools. EMHPs work alongside senior practitioners in MHSTs, with a designated internal mental health lead also being introduced in each school.

Representing significant investment, this workforce is intended to be rolled-out to a quarter of the population by 2023, with 8,000 additional practitioners supporting schools in the long-term (Department of Health and Social Care & Department of Education, 2017). CWPs and MHSTs were introduced as an adjunct to specialist CAMHS with an aim to develop integrated services best serving need. CWPs/EMHPs can refer to specialist CAMHS where needed (Health Education England, 2020).

CWPs/EMHPs use cognitive behavioural therapy (CBT) based interventions with secondary school-aged young people experiencing mild to moderate anxiety and depression. They also provide parent-led interventions for primary school-aged children experiencing mild to moderate anxiety or behavioural difficulties (NHS England, 2016). Developing novel coping strategies through such interventions has been found to improve poor self-efficacy implicated in the maintenance of mental health difficulties (Garnefski et al., 2002; Heyne et al., 2011; Parto & Besharat, 2011). More specifically, behavioural mechanisms in GSH interventions

include promoting exposure over avoidance for anxiety, and activation over withdrawal for depression (Peris et al., 2015). Cognitive mechanisms include reducing 'thinking errors' implicated in the maintenance of common mental health difficulties through cognitive restructuring techniques (Shirk et al., 2013).

Evidence for targeted school-based intervention

A recent meta-analytic review demonstrated that externally delivered school-based interventions can be effective in helping CYP experiencing anxiety or depression post-intervention; however, there was a lack of evidence on whether changes are maintained longer term (Gee et al., 2020). Interventions delivered by internal school staff did not demonstrate effectiveness (Gee et al., 2020).

A further review across primary and secondary schools found ''moderate positive effects for treatments administered in school settings" and concluded that good outcomes occur when practices are implemented effectively (Paulus et al., 2016). However, evidence-based interventions are often not adopted and sustained successfully, in part because the context in which they are implemented is not sufficiently considered (Proctor et al., 2009).

A focus on implementation

'Implementation science' (IS) has developed to understand how to translate the benefits of evidence-based interventions to real world settings (Bhattacharyya et al., 2009). Studying implementation requires an understanding of the social context in which an intervention is implemented, and examination of the 'technical resources' and conditions that support successful execution (Rojas-Andrade & Bahamondes, 2019). Key outcomes examined through IS research include 'acceptability' (defined as a perception among stakeholders that an intervention is

agreeable or satisfactory), ‘feasibility’ (the extent to which an intervention can be successfully carried out within a specific setting), ‘fidelity’ (the degree to which an intervention can be implemented as prescribed in the original protocol), ‘penetration’ (the integration of a practice into a specific setting and its subsystems), and ‘sustainability’ over time (Proctor et al., 2011).

Early research investigating the feasibility of providing low intensity interventions (LIIs) in schools indicated good acceptability to CYP (Pass et al., 2018). This is significant, as acceptability has been identified as the most important factor in determining whether school-based interventions achieve clinically significant outcomes (Rojas-Andrade & Bahamondes, 2019).

Gee et al. (2021) reviewed factors that influence successful implementation of targeted mental health interventions in schools. Intervention characteristics, organisational capacity, technical assistance, and community-level factors were found to impact implementation. The review highlighted the importance of addressing logistical challenges inherent to the school context in creating conditions that enable interventions to be delivered with fidelity. A need to align the priorities of healthcare and education systems was also emphasised (Gee et al., 2021).

Rationale and aims

The introduction of CWP/EMHPs in schools is being evaluated locally in implementer sites and by training organisations. In line with CYP-IAPT principles, this evaluation predominantly focuses on measuring intervention effectiveness using goal-based and clinical outcomes. A broader exploration of the implementation of this new workforce, incorporating the perspectives of a range of stakeholders involved, has not been undertaken.

Supporting stakeholders to agree on what to prioritise is important to promote successful implementation (Stephan et al., 2007). It is important that practical issues are addressed to support integration with schools and promote sustainability. Previous interventions, such as TaMHS, were limited in their under-exploration of how differing priorities between healthcare and education systems impacted the dynamic process of implementation (Lyon & Bruns, 2019).

Building on the work of Gee et al. (2021), this project aims to explore different professionals' experiences of CWP/EMHP implementation in schools and identify areas of agreement and disagreement between stakeholder groups. Specifically, it will ask: What is helpful about this way of working? What is challenging about this way of working? Based on this, what improvements could be made? Developing an understanding of CWPs/EMHPs in context and identifying factors that facilitate and impede their work in schools is key in supporting the continued roll-out of this initiative, especially given the significant investment and opportunity to increase access to support that it represents.

This research relates to the NHS value of *commitment to quality of care* by investigating how CWP/EMHP implementation could be optimised. By incorporating the perspectives of stakeholders across healthcare and education, it also relates to *working together for patients.*

Method

Design

This study used Delphi methodology to elicit the opinions of three groups of stakeholders with direct experience of CWP/EMHP implementation in schools. The Delphi method was developed to incorporate the perspectives of multiple expert groups, based on the assumption that group judgements are more valid than those of individuals (Dalkey & Helmer, 1963). It uses

sequential ‘rounds’ of data collection and feedback to develop consensus on a given topic (Linstone & Turoff, 1975). The method elicits and structures views and opinions without the need for face-to-face focus groups (West, 2011). The Delphi method is commonly used in areas where little evidence currently exists (Minas & Jorm, 2010). It has previously been used in healthcare research to inform policy, guidelines and service planning (Jorm, 2015), including CAMHS provision and service design (Howarth et al. 2019; Sayal et al. 2012).

As with previous Delphi method research (e.g. Langlands et al., 2008), the current study employed three rounds of online questionnaires. Qualitative and quantitative data were collected across the consensus-building process. In round 1 (R1), qualitative data were collected and developed into statements. At round 2 (R2), participants were asked to rate their level of agreement and disagreement with each statement. In round 3 (R3), participants were shown how their responses compared to others at R2 and were invited to re-rate their agreement or disagreement on a sub-set of remaining statements. This final round aimed to reach consensus between participants and clarify areas of divergence between groups (Hasson et al., 2000).

Participants were also asked to choose the three statements they considered to be most important at the end of R2 and R3, as it was anticipated that there could be high levels of agreement on some statements across groups. This addition was made in the light of Mullen’s (2003) recognition that the Delphi method can be applied flexibly and can be guided by the aims of the research.

Service user consultation

During study development, the researcher consulted a group of ‘Young Champions’ (experts by experience) at a national charity. The group was presented with the research proposal and accompanying study materials. The group offered suggestions on how to improve readability

of the participant information sheet. They praised the anonymous nature of Delphi methodology in facilitating honest sharing of opinions and experiences, and commented on the timely nature of the proposed study.

Recruitment

This study defined 'experts' as those with direct experience of CWP/EMHP implementation in schools in one of three roles: 1) as a CWP/EMHP; 2) as an NHS staff member supervising CWPs/EMHPs; or, 3) as a school staff member hosting and liaising with a CWP/EMHP (school link worker (SLW)).

A purposive sampling strategy was used to recruit participants in two NHS sites in south east England. Both sites were 2018/19 MHST 'Trailblazer' areas. The first site was comprised of two teams and served 36 schools in the area that had opted-in to the initiative (21 primary schools, 11 secondary schools, three specialist provision schools and one college). Both teams had six CWPs/EMHPs. CWPs/EMHPs delivered individual and group interventions. This included CBT-based GSH for anxiety; behavioural activation for low mood in secondary schools; and parent-led interventions for anxiety and challenging behaviour in primary schools, in addition to psychoeducation-based workshops supporting emotional well-being.

The second research site recruited from two teams. The first team served all mainstream schools in the locality (20 secondary schools and 53 primary schools) and was staffed by 14 CWPs/EMHPs. The second team, established later, served 16 selected secondary schools and 16 selected primary schools so far, and was staffed by 16 CWPs/EMHPs. CWPs/EMHPs delivered the same interventions as the other site, with the addition of a three-session sleep intervention and exam stress groups.

Prior to recruitment, the researcher contacted five CWP/EMHP training centres across England to explore variations in courses and interventions delivered. Training centres described following a national curriculum matching models used by the two research sites, with some minor variations in group-based interventions and workshops. It is therefore likely that both sites used were typical of practice across England.

To be eligible, participants needed to have been in their role for at least one full school term to guarantee sufficient experience to answer the research questions. Their experience could be based in primary or secondary schools.

Prospective CWP/EMHP and supervisor participants were emailed the participant information sheet by an identified study coordinator in both sites. The researcher also attended remote team meetings to promote participation. Study coordinators in both sites contacted eligible school staff with the study information sheet inviting them to take part. All prospective participants were invited to contact the researcher with any questions.

Ethics

The study received ethical approval from the London Central Research Ethics Committee, Health Research Authority, and local NHS Research and Development departments (Appendices E-G). The British Psychological Society (BPS) Code of Ethics and Conduct (2009) was followed throughout the research process.

Participant information sheets outlined the purpose of the research, procedures, benefits and risks of taking part, and confidentiality (Appendices H-J). It was emphasised that participation was entirely voluntary; prospective participants were not obliged to take part as part of their job role. A ‘forced response’ option was utilised when designing the questionnaire using

Qualtrics software to ensure that participants provided their informed consent before proceeding. Individual participant numbers were allocated to maintain anonymity. Study data were stored on password-protected databases. Participant names and email addresses (required for questionnaire distribution) were stored in a separate password-protected database. Participants were informed that their anonymous responses could be shared with other participants, included in the study write-up, and future publications.

Participants

A total of 44 participants contributed to the study (10 supervisors, 13 SLWs and 21 CWPs/EMHPs). Twenty participants completed the R1 questionnaire (four supervisors, four SLWs and 12 CWPs/EMHPs). Table 1, below, summarises participant demographics for R1.

Table 1

Round 1 participant demographics

	CWPs/EMHPs (n=12)	Supervisors (n=4)	School link workers (n=4)
Age			
18-24	4	0	0
25-34	7	1	0
35-44	0	2	1
45-54	1	1	1
55-64	0	0	1
Missing data	0	0	1
Gender			
Female	12	3	3
Male	0	1	1
Ethnicity			
White British	6	4	4
White Other	2	0	0
Black African	2	0	0
White/Asian	1	0	0
White/African	1	0	0
NHS Trust			
Trust 1	12	3	0
Trust 2	8	1	4
Professional background			
Clinical psychologist		4	
Job title			
Safeguarding Lead			2
Special Educational Needs Coordinator			2
Time in role			
Mean	16 months	19.5 months	22.5 months
Range	9-24 months	9-36 months	9-36 months

40 participants completed the R2 questionnaire (10 supervisors, 13 SLWs and 17 CWPs/EMHPs). 16 of these participants had completed the R1 questionnaire. 34 participants completed the R3 questionnaire, resulting in a response rate of 85%. This ranged between participant groups from 70% of supervisors, to 84% of SLWs, and 94% of CWPs/EMHPs. Table 2, below, summarises participant demographics for R2 and R3.

Table 2

Round 2 and 3 participant demographics

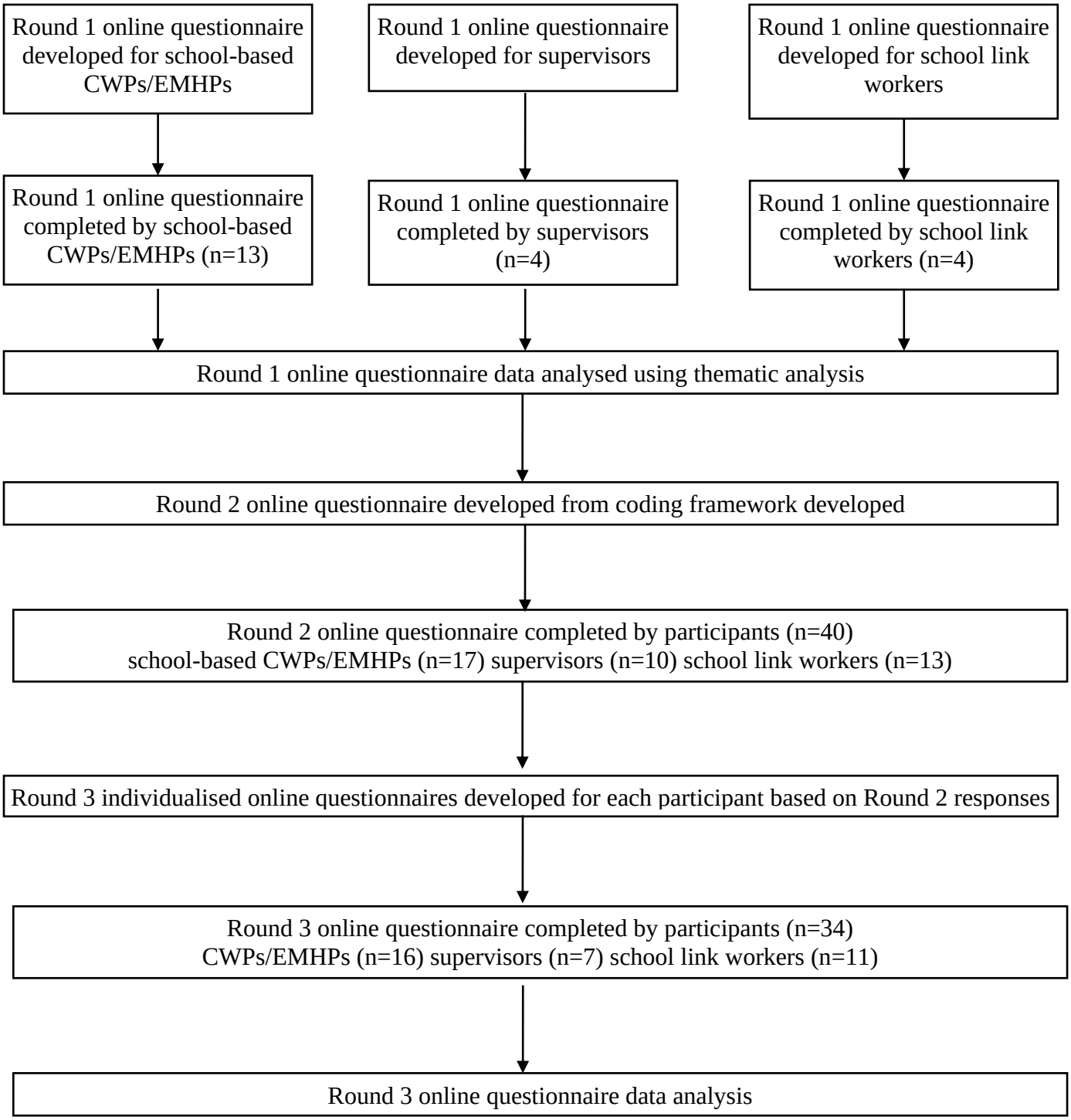
	CWPs/EMHPs (n=17)	Supervisors (n=10)	School link workers (n=13)
Age			
18-24	4	0	0
25-34	11	2	2
35-44	1	3	4
45-54	1	2	5
55-64	0	2	1
Missing data	0	1	1
Gender			
Female	15	9	9
Male	2	1	4
Ethnicity			
White British	12	10	11
White Other	2	0	0
Asian Indian	2	0	1
Black African	1	0	0
White/Asian	0	0	1
NHS Trust			
Trust 2	9	5	10
Trust 1	8	5	3
Professional background			
Clinical psychologist		5	
Cognitive behavioural therapist		2	
Specialist mental health practitioner		2	
Educational psychologist		1	
Job title			
Assistant/Deputy Headteacher			4
Head of Year			3
Safeguarding Lead			2
Special Educational Needs Coordinator			2
Head of Student Support			1
Pastoral Lead			1

Data collection and analysis

The data collection process took seven months between September 2020 and March 2021. The process was the same for each participant group. Questionnaires were distributed using Qualtrics software. Each questionnaire was first piloted by four CWPs known to the researcher and also reviewed by the primary and secondary research supervisors. Those completing pilot questionnaires were asked to provide feedback on the readability of instructions and appropriateness of the questions asked. Subsequent changes at R1 included asking participants to specify the interventions they used and broadening the scope of questions, including prompts. At R2 and R3, changes were made to clarify terminology and acronyms. Figure 1, below, depicts the Delphi procedure flowchart.

Figure 1

Delphi flow chart



Round 1

R1 questionnaire development was guided by the study of relevant literature to ensure that questions addressed a range of implementation outcomes (e.g., Gee et al., 2021; Proctor et al., 2011) and that their phrasing was consistent with existing Delphi research (e.g., Fenton et al., 2021; South et al., 2016). The researcher's clinical experience working as a school-based CWP, supported by consultation with the research supervisors, also informed questionnaire development.

R1 questionnaires (Appendices K-M) were tailoired to each participant group. Questionnaires collected demographic and contextual information before participants proceeded to complete open-ended questions regarding perceived fit and acceptability of the workforce, challenges experienced and how these were overcome, and suggestions for future development.

R1 data were analysed using thematic analysis (Braun & Clarke, 2006). Following updated guidance, the thematic analysis adopted a reflexive approach, recognising the researcher's active role in the process (Braun & Clarke, 2019, 2020). This invites researchers to consciously attune to their reactions during the research process and recognise the role that they play in constructing knowledge (Dodgson, 2019). The importance of considering the position of the researcher as an 'insider' or an 'outsider', and how far they have shared experiences with participants has also been highlighted (Berger, 2015).

A critical realist epistemological position was taken throughout this research, based on the assumption that the world as we know and understand it is constructed from our perspectives and experiences (Sayer, 2004, p.6). This study adopted a view that different participants would have experienced benefits and challenges to the work of CWPs/EMHPs, but that perceptions

would vary between participants and did not represent some universal 'truth'. It was hoped that the iterative Delphi process would support participants to engage with each other's perspectives.

NVivo software was used to facilitate coding and the development of themes. The aim of analysis was primarily to inform the development of a Round 2 (R2) questionnaire. Data were analysed inductively to ensure emerging themes were data driven (Braun & Clarke, 2019). An example extract of coded R1 questionnaire data is presented in Appendix N. IS outcomes, including acceptability, fidelity and sustainability (Proctor et al., 2011) were then considered in organising coded data into seven resulting themes and 34 sub-themes. The thematic framework was reviewed and refined over a period of weeks with input from the research supervisors. To ensure the reliability of the coding procedure used, a fellow trainee clinical psychologist familiar with thematic analysis methodology was asked to match a randomly organised sample of sub-themes into themes. This resulted in inter-rater agreement of 100%.

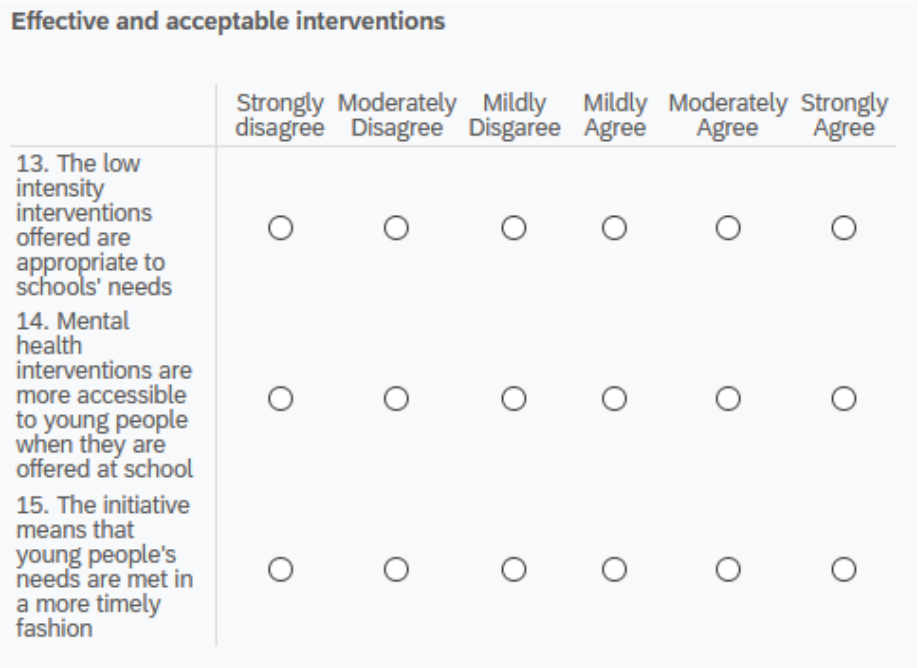
Round 2

R2 questionnaire statements were then developed from each sub-theme, using participants' words from R1 where possible whilst ensuring that each statement was relevant to all stakeholders. In total, 40 positively framed statements were generated. Statements were refined with feedback from the research supervisor. All participant groups were sent the same questionnaire at R2. R2 participants did not need to have participated at R1. Statements were presented by theme. Participants were asked to rate how far they agreed or disagreed with each statement on a six-point Likert scale from 'strongly agree' to 'strongly disagree' (Figure 2). Participants were invited to write comments in free-text boxes at the end of each theme to elaborate their point of view. At the end of the questionnaire, participants were asked to choose

the three statements they considered to be most important. The questionnaire took approximately 20 minutes to complete and was online for three weeks (Appendix O).

Figure 2

Example R2 questionnaire statement



Round 3

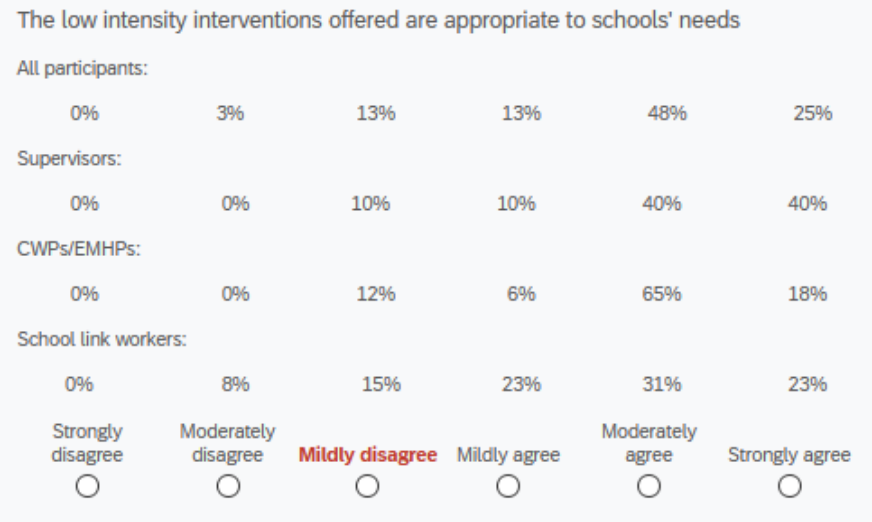
The Round 3 (R3) questionnaire used the same statements as R2 but did not include statements that had reached ≥75% consensus across participants at R2, consistent with existing Delphi research (Fenton et al., 2021). R3 questionnaires were individualised for each R2 participant. For each remaining statement, participants were shown how others had responded at R2 (for all participants and by role), with their own response highlighted in red (Figure 3). Participants were also shown the three statements they had considered to be most important at R2 compared to others overall and by group. Qualitative comments from R2 responses were also anonymously presented at the beginning of each theme's remaining statements. Qualitative

comments allowed participants to understand how others had approached each statement to help build consensus.

For each statement, participants were asked to consider R2 responses and qualitative comments presented, and decide if they wished to change their response. Participants were also invited to change any of their choices of the three most important statements if they wished. Questionnaires took approximately 20 minutes to complete and were online for three weeks (Appendix P).

Figure 3

Example R3 questionnaire statement

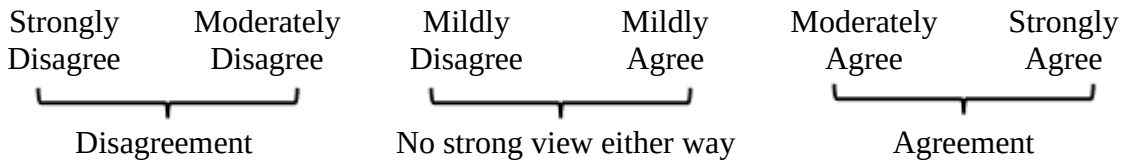


At present, a consistent method for reporting findings in Delphi method research has not been established (Hasson, Keeney & McKenna, 2000). The current study used descriptive statistics to calculate rates of 'consensus' and 'divergence' in R2 and R3 data, in line with previous research (Holey et al., 2007). An agreed standard of how to measure consensus in Delphi method studies has also not been established (Von der Gracht, 2012). At the end of R2 and R3, the six-point Likert scale was collapsed into three categories to establish rates of agreement and disagreement for each statement (Figure 4), consistent with previous Delphi

method research (South et al., 2016). Strong and moderate views are presented as results in line with the research aims. Percentages of 'agreement' (participants selecting strongly/moderately agree) and 'disagreement' (participants selecting strongly/moderately disagree) were calculated for each statement by participant group (establishing within-group consensus) and overall (establishing overall consensus).

Figure 4

Collapsed categories of Likert scale ratings



Consistent with previous Delphi method research (Fenton et al., 2021) consensus categories were operationalised as presented in Table 3:

Table 3

Consensus categories

Consensus category	Rate of 'agreement' or 'disagreement'
Strong consensus	≥75%
Moderate consensus	62.5-74.9%
Weak consensus	50-62.4%
Lack of consensus	<50%

Divergence between groups was treated as two or more consensus categories difference between groups (i.e., strong-weak consensus; strong-lack of consensus; moderate-lack of consensus).

Participant choices of the three most important statements were analysed descriptively by calculating the frequency with which each statement was chosen, overall and by group.

Quality assurance and reflexivity

Combining quantitative and qualitative data collection in the research design, as recommended for implementation research, promoted a deeper understanding of the topic than would be allowed by a single method (Palinkas, 2014). Taking breaks from R1 analysis provided 'distance' from the data which facilitated refinement of the thematic framework over time (Watts, 2014). Quantitative analysis employed was both consensus and divergence-orientated to obtain a deeper understanding of the data (Von der Gracht, 2012). The researcher kept a research diary throughout the process to promote reflexivity (Appendix Q). This was especially important given the researcher's previous role as a school-based CWP. For example, when analysing R1 data, the researcher used the diary to reflect on experiences and challenges described by supervisors and SLWs. This facilitated a balanced coding process representing the perspectives of all three participant groups. Regular supervision from both an internal primary supervisor and external secondary supervisor offered multiple perspectives on the research process and data collected and facilitated ongoing reflection**.** The researcher also considered how they might experience issues described by participants in different roles. The researcher was mindful to attend to the range of experiences and ideas described when analysing the data, looking out for similarities and differences between participants and reflecting on whether findings corresponded to their expectations.

Results

Round 1

Themes were developed from R1 in line with the research aims. In total, seven themes and 34 sub-themes were developed.

The first theme related to **establishing working practices with schools** to foster a shared understanding of the initiative. This theme emphasised the importance of formally setting up processes with schools, including referral/waiting list protocol and communication channels, and promoting the role throughout the school community. Next, **adapting to the needs and culture of schools** was described, highlighting differences in culture between education and healthcare settings. Issues around CWPs/EMHPs being 'external' to schools and needing time to embed were identified. The third theme related to the extent to which interventions were **effective and acceptable.** How far interventions meet needs and increase access to support as intended were described. Next, a theme around **practical issues** included challenges related to time (practitioners having enough time in each school to do the work, CYP missing lessons, and SLWs keeping to agreed liaison time) and resources (adequate room space and administrative burden). A fifth theme described CWPs/EMHPs' **relationship to CAMHS,** including their fit and integration and the impact of their work on specialist CAMHS. Then, ideas around the **future development of the role** were identified, including expanding interventions and developing indirect ways of working. A final theme related to **long-term strategy** around improving access across schools, promoting communication, and working together.

Themes and sub-themes are presented in Table 4, below, with example R1 questionnaire quotations and corresponding R2 questionnaire statements developed (40 statements in total).

Table 4

R1 themes and sub-themes

Theme 1: Establishing working practices with schools *Descriptor: Jointly setting up processes; fostering a shared understanding of the initiative*		
Sub-theme	Example quotes	R2/3 questionnaire statement(s)
Explaining remit of role and interventions to schools	"Hostility towards us from other services already embedded in schools can get worse because of lack of communication about who we are as a service" – CWP/EMHP	1. An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools
	"As the programme becomes more mainstream in schools and more schools come on board, I think there needs to be a blanket understanding of the role in the area and what support can be offered" – CWP/EMHP	5. Schools' understanding of the CWP/EMHP role should be supported by communication from supervisors
Promotion throughout school community	"Ensuring the service is promoted adequately in school/with staff/parents/students" – Supervisor	3. Schools' understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources
	"Lots and lots of promotion - leaflets, videos, flyers, posters, dissemination amongst school staff. Raising awareness of who we are and what we do" – CWP/EMHP	6. The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters
Formalising introductions	"CWP/EMHPs should also be physically introduced to all staff and their roles explained" – Supervisor	2. Practitioners' introduction to schools should be formalised through a meeting jointly attended by supervisors
Clarifying referral criteria and processes	"In larger secondary schools making sure that your service is known to all teachers to help identify young people rather than just being the link worker's job" – CWP/EMHP	7. All school teaching staff should be able to make referrals

	"Communication from other members of staff to identify students who would benefit from the GSH sessions" – School link worker	
Establishing waiting list protocol	"We operate a completely open referral system and so our waiting lists did become unmanageable (6 months waiting lists)" – CWP/EMHP	8. Waiting list numbers should be limited to manage demand
Establishing procedures for link-worker EMHP communication	"At the moment, EMHPs do all contact with schools and it would be nice to have some strategy in place for meetings and some support for those meetings" – CWP/EMHP	4. Practitioners should act as the primary contact with schools 9. Supervisors should act as the primary contact with schools

Theme 2: Adapting to needs and culture of schools

Descriptor: Practicing within education context

Sub-theme	Example quotes	R2/3 questionnaire statement(s)
Acknowledging different cultures of health and education	"All schools are different, and we've had to work hard to understand the individual needs of each school" – Supervisor "The challenges when school culture meets mental health (the 'us' and 'them') + putting together two huge sectors that work differently (NHS and education)" – CWP/EMHP	12. Practitioners should adapt their practice within their skill-set to suit the needs and requests of each school
Needing time in schools to embed	"I would have liked to have only been in about three schools so that you got to know them better and felt a part of them a little more" – CWP/EMHP	11. Practitioners should be based in fewer schools with greater time commitment in each
EMHPs as 'external' to schools	"It would help if EMHPs were expected to attend school in the same way that teachers have to, in order to become more integrated and have better relationships with students & staff" – School link worker	10. Practitioners should be treated as a member of staff in the schools they are based in

	"I can feel isolated from school staff" – CWP/EMHP	
Theme 3: Effective and acceptable interventions *Descriptor: Attributes of the initiative that indicate effectiveness and acceptability*		
Sub-theme	Example quotes	R2/3 questionnaire statement(s)
Interventions meet needs	"The manualised evidence-based approach seems to fit pretty well in the highly achievement-oriented schools as well as the more nurturing schools" – Supervisor "CWPs / EMHPs are different because they really are trained in evidence-based practice" – Supervisor "The interventions have been appropriate and seem to have had a positive impact for these individuals" – School link worker	13. The low intensity interventions offered are appropriate to schools' needs
Interventions offer increased access to support	"I get to see young people in their environment, providing better access to therapy" – CWP/EMHP "Easy to come out of lesson and have a session, compared to being taken out half day of school to be driven to CAMHS by mum/dad etc." – School link worker	14. Mental health interventions are more accessible to young people when they are offered at school
Interventions provide timely access to support	"We can be a good 'in-between' step if other provisions have a long waiting list" – CWP/EMHP	15. The initiative means that young people's needs are met in a more timely fashion
Theme 4: Practical issues *Descriptor: Issues impacting implementation 'on the ground'*		

Sub-theme	Example quotes	R2/3 questionnaire statement(s)
Protected room space /storage	"Limited access to boards - we could be far more creative and engaging with the right tools, space and equipment" – CWP/EMHP "We were not provided with resources and so we had to go and buy them ourselves e.g. paper" – CWP/EMHP	19. Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g., printing) to host a practitioner
Timetabling/scheduling difficulties	"Problematic for scheduling sessions, as there is very little choice of subjects they have to miss" – School link worker	18. The mental health needs of young people should be prioritised where timetabling difficulties occur
Administrative burden	"Ensuring administrative tasks are kept to a minimum so the work can be completed" – Supervisor	20. The demands of administrative tasks should be minimised to prioritise time for sessions
Low visibility within schools	"We have been working with schools to raise awareness of our work and the difference to other talking therapies available" – Supervisor	17. At present, practitioners have low visibility within schools which can be a problem
Difficulty keeping time for liaison	"Finding the time to find and organise the referrals and meetings" – School link worker "School link workers not sticking to agreed meetings with practitioners" – Supervisor	16. Demand on school staff means it can be hard to keep protected time for liaison with practitioners
Not enough time in each school	"For EMHPs to be around in school more so that young people have a place to talk" – School link worker "They need to spend more time in the school - such as a whole day, rather than three hours to see three pupils" – School link worker	21. Practitioners should be based in schools for the full school day
Theme 5: Relationship to CAMHS *Descriptor: Fit with CAMHS; impact on CAMHS*		

Sub-theme	Example quotes	R2/3 questionnaire statement(s)
Integration with wider CAMHS	"It takes a long time to integrate with wider CAMHS" – CWP/EMHP	26. Integration with wider CAMHS should be promoted through practitioner presence at team base 27. Practitioners should be treated as CAMHS staff by colleagues in wider CAMHS
Association with CAMHS	"The name CAMHS can be stigmatising" – CWP/EMHP "It helps that we have a link with CAMHS" – CWP/EMHP	25. Practitioners should act as a 'link' between schools and CAMHS
Identifying unmet need for CAMHS	"I would say as CAMHS waiting lists are long, our teams are often seen as the first point of call and often I feel that the mental health needs are slightly above our remit as a team, for example, past trauma, that ideally would have CAMHS PTSD work for, however it's either try our team or wait for a year etc... so we often take them on in the hope that they will get something from it" – CWP/EMHP	23. Through their work in schools, practitioners are identifying unmet need requiring input from CAMHS 24. Difficulty accessing CAMHS increases the complexity of referrals made to practitioners
Reducing CAMHS burden	"A lot of services are over-subscribed and we are able to assist with reducing this caseload" – Supervisor	22. Over time, the initiative should reduce the number of referrals made to CAMHS

Theme 6: Future development of the role

Descriptor: Ideas suggested on how the CWP/EMHP role could be developed in the future

Sub-theme	Example quotes	R2/3 questionnaire statement(s)
Working with greater complexity of presenting problems	"I would prefer if the pupils with most need were seen, rather than the ones with low mood or mild depression" – School link worker	31. Practitioners should be trained to work with more complex presentations such as self-harm,

	"I personally would like to see a move towards upskilling EMHPs to better manage the complexities that some with the moderate side of needs in school" – Supervisor "To provide additional training for CWPs/EMHPs to allow them to develop their scope outside of anxiety/low mood i.e. trauma informed approaches" – Supervisor	drug and alcohol use, and trauma-informed approaches
Working with a greater range of low intensity intervention models	"We have realised there are some needs not being met, such as anger, sleep, rumination etc." – CWP/EMHP "We need more clarification about what we can work with, such as specific phobias etc." – CWP/EMHP	29. Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep
Providing training, consultation and signposting to schools	"We are signposted elsewhere if this service is not the right intervention or support for a child" – School link worker "Providing training and resources for members of the Inclusion team" – School link worker	30. Practitioners should receive training in providing training and consultation to school staff
Developing a 'whole-school approach'	"I think we should have also had more support developing the whole-school approach with schools. That is one of the reasons I took this post, however I feel it is the most neglected part of our role" – CWP/EMHP	28. Practitioners should be given protected time to work on promoting a whole-school approach

Theme 7: Long-term strategy

Descriptor: Ways to support implementation in the longer term; goals for the longer term

Sub-theme	Example quotes	R2/3 questionnaire statement(s)

Need for strategic planning	"A really great project/programme and the rationale and aims are great, however I think it needs a lot more preparing, planning and strategy than our team did" – CWP/EMHP	38. There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools
Achieving access across schools	"In the future it would be great if each school had an EMHP" – School link worker "Having more capacity to reach the whole community" - Supervisor	32. Practitioners should be based in more schools to increase access across local authorities
Sharing good practice and problems	"Discussions of problems remain private which is a shame but I'm not sure how to overcome this - with all the vested interests?" – Supervisor	37. The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues
Connection and communication with wider MHST	"Problem solving as a team is key and being able to have discussions and reflections on how things are going" – Supervisor "As a team, I feel we could have more regular meetings as often messages get passed through in supervision about a plan going forwards, but then this is not reiterated to the whole team and we often are all on different pages which leads to confusion" – CWP/EMHP	34. Supervisors should support connection between school-based practitioners through regular team meetings
Addressing funding uncertainty	"CWPs need permanent funding in order for providers to be able to undertake workforce planning" – Supervisor	39. Uncertainty around longer term funding means it is difficult for services to plan for the future
Expanding evidence base	"We need to find out what the limits of effectiveness are for our LIIs. We also need to develop a wider array of LIIs" – Supervisor	35. Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus

Retaining scope of role	"The role is well conceived - though perhaps too ambitiously hoped to be all things to all people" – Supervisor	33. Practitioners should practice with a high level of fidelity to the manualised interventions they are trained to deliver
	"We are becoming a bit like a CAMHS in school, rather than doing early intervention/prevention workshops and assemblies to promote a whole-school approach, working with not only CYP/parents but the whole schools and teachers etc." – CWP/EMHP	36. The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties
Buy-in from schools	"It would be great to see this become something that schools have embedded within their settings on a longer term basis- i.e. buy in the service and have practitioners in for more than just a day" – CWP/EMHP	40. In future, schools should have the option to buy-in practitioner resource full-time

Round 2

Only statements achieving 'strong' consensus between participants at R2 are presented as R2 results, in line with existing Delphi research (e.g. Putnam et al., 1995). Statements achieving 'strong' consensus are presented by theme in Tables 5-11. Within and between-group consensus is reported, and differences in level of consensus between groups are highlighted in bold where observed. Statements presenting with divergence between participant groups are outlined. Example questionnaire quotations are presented for each theme to elaborate on participant perspectives. Of the 40 statements making up the R2 questionnaire, 22 achieved 'strong consensus' between participant groups.

Theme 1: Establishing working practices with schools

Of the nine statements under this theme, six achieved 'strong' consensus. Participants agreed on the need to formalise introductions to schools, promote understanding of the role, and raise awareness of the initiative across schools. Participants also agreed that practitioners should act as the primary contact with schools, with supervisor support.

"Sometimes it can be difficult to know how best to manage schools' expectations and demands and it would be helpful to have a supervisor working more closely with schools to support with this." – EMHP

Table 5

Consensus for statements relating to establishing working practices in schools

Strong consensus		Agree (%)	Disagree (%)
1. An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools	CWPs/EMHPs	100	0
	Supervisors	100	0
	School link workers	100	0
	Overall	100	0
2. Practitioners' introduction to schools should be formalised through a meeting jointly attended by supervisors	CWPs/EMHPs	88	0
	Supervisors	80	0
	School link workers	100	0
	Overall	90	0
3. Schools' understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources	CWPs/EMHPs	82	0
	Supervisors	80	0
	School link workers	85	0
	Overall	82.5	0
4. Practitioners should act as the primary contact with schools	CWPs/EMHPs	94	0
	Supervisors	90	0
	School link workers	92	0
	Overall	92.5	0
5. Schools' understanding of the CWP/EMHP role should be supported by communication from supervisors	CWPs/EMHPs	94	0
	Supervisors	90	0
	School link workers	92	0
	Overall	92.5	0
6. The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters	CWPs/EMHPs	100	0
	Supervisors	80	0
	School link workers	92	8
	Overall	92.5	2.5

Theme 2: Adapting to the needs and culture of schools

Of the three statements under this theme, two achieved ‘strong’ consensus. One statement achieving strong consensus (11) presented with divergence between groups. Participants agreed that practitioners should adapt their practice within their skill-set to suit each school. Overall, participants agreed that practitioners should be based in fewer schools with greater time commitment in each, but supervisor agreement was lower than CWPs/EMHPs and SLWs.

“Fidelity with (limited) flexibility is key.” – Supervisor

Table 6

Consensus for statements relating to adapting to the needs and culture of schools

Strong consensus		Agree (%)	Disagree (%)
11. Practitioners should be based in fewer schools with greater time commitment in each	CWPs/EMHPs	**71**	6
	Supervisors	**50**	10
	School link workers	100	0
	Overall	75	5
12. Practitioners should adapt their practice within their skill-set to suit the needs and requests of each school	CWPs/EMHPs	88	0
	Supervisors	90	0
	School link workers	85	8
	Overall	87.5	2.5

Theme 3: Effective and acceptable interventions

Of the three statements under this theme, two achieved ‘strong’ consensus. Participants agreed that mental health interventions are more accessible when offered in schools and that the initiative enables need to be met more promptly.

“I get to see young people in their environment, providing better access to therapy.” – CWP

Table 7

Consensus for statements relating to effective and acceptable interventions

Strong consensus		Agree (%)	Disagree (%)
14. Mental health interventions are more accessible to young people when they are offered at school	CWPs/EMHPs	100	0
	Supervisors	80	0
	School link workers	85	0
	Overall	90	0
15. The initiative means that young people's needs are met in a more timely fashion	CWPs/EMHPs	94	6
	Supervisors	90	0
	School link workers	77	0
	Overall	87.5	2.5

Theme 4: Practical issues

Of the six statements under this theme, four achieved ‘strong’ consensus. One statement achieving strong consensus (16) presented with divergence between groups. Participants agreed on prioritising time for clinical work over administrative tasks and clinical need over timetable clashes. They also agreed that schools should guarantee provision of required facilities to host a

practitioner. Overall, participants agreed that demand on school staff compromises liaison time, but SLW agreement was lower than CWPs/EMHPs and supervisors.

"We could be far more creative and engaging with the right tools, space and equipment." – EMHP

"Generally, schools want more from us but struggle to match resource to sustain balanced partnership work." – Supervisor

Table 8

Consensus for statements relating to practical issues

Strong consensus		Agree (%)	Disagree (%)
16. Demand on school staff means it can be hard to keep protected time for liaison with practitioners	CWPs/EMHPs	94	0
	Supervisors	90	0
	School link workers	**62**	15
	Overall	82.5	5
18. The mental health needs of young people should be prioritised where timetabling difficulties occur	CWPs/EMHPs	88	0
	Supervisors	80	0
	School link workers	100	0
	Overall	90	0
19. Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g., printing) to host a practitioner	CWPs/EMHPs	94	0
	Supervisors	100	0
	School link workers	85	8
	Overall	92.5	2.5
20. The demands of administrative tasks should be minimised to prioritise time for sessions	CWPs/EMHPs	82	0
	Supervisors	90	0
	School link workers	92	8
	Overall	87.5	2.5

Theme 5: Relationship to CAMHS

Of the six statements under this theme, three achieved 'strong' consensus. Participants agreed that practitioners identify unmet need for CAMHS through their work. Overall, participants agreed that high thresholds in CAMHS increase the complexity of referrals and that the initiative should reduce CAMHS referrals over time, but supervisor agreement was lower than CWPs/EMHPs and SLWs.

"Sometimes schools try to bypass the CAMHS waiting times by referring into MHSTs."

– Supervisor

Table 9

Consensus for statements relating to relationship to CAMHS

Strong consensus		Agree (%)	Disagree (%)
22. Over time, the initiative should reduce the number of referrals made to CAMHS	CWPs/EMHPs	76	0
	Supervisors	**60**	20
	School link workers	85	8
	Overall	75	7.5
23. Through their work in schools, practitioners are identifying unmet need requiring input from CAMHS	CWPs/EMHPs	94	0
	Supervisors	90	0
	School link workers	85	0
	Overall	90	0
24. Difficulty accessing CAMHS increases the complexity of referrals made to practitioners	CWPs/EMHPs	88	0
	Supervisors	**60**	0
	School link workers	77	0
	Overall	77.5	0

Theme 6: Future development of the role

Of the four statements under this theme, three achieved 'strong' consensus. One statement achieving strong consensus (30) presented with divergence between groups. Participants agreed that low-intensity interventions should be expanded, and practitioners should promote a whole-school approach. Overall, participants agreed that practitioners should be trained to provide training and consultation to schools, but supervisor agreement was lower than CWPs/EMHPs and SLWs.

"We are seeing a lot of need around sleep hygiene, resilience, emotion-regulation, managing stress etc." – EMHP

"There needs to be a focus on exam stress and perfectionism." – School link worker

Table 10

Consensus for statements relating to future development of the role

Strong consensus		Agree (%)	Disagree (%)
28. Practitioners should be given protected time to work on promoting a whole-school approach	CWPs/EMHPs	88	0
	Supervisors	80	10
	School link workers	85	0
	Overall	85	2.5
29. Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep	CWPs/EMHPs	100	0
	Supervisors	80	0
	School link workers	92	0
	Overall	92.5	0
30. Practitioners should receive training in providing training and consultation to school staff	CWPs/EMHPs	94	0
	Supervisors	**60**	0
	School link workers	85	0
	Overall	82.5	0

Theme 7: Long-term strategy

Of the nine statements under this theme, two achieved ‘strong’ consensus. Both statements achieving strong consensus (34 and 35) presented with divergence between groups. Overall, participants agreed that supervisors should support connection between school-based practitioners, and that contributing to the evidence-base of interventions offered should be a key focus, but SLW agreement was lower than CWPs/EMHPs and supervisor.

“Problem solving as a team is key and being able to have discussions and reflections on how things are going.” – Supervisor

Table 11

Consensus for statements relating to long-term strategy

Strong consensus		Agree (%)	Disagree (%)
34. Supervisors should support connection between school-based practitioners through regular team meetings	CWPs/EMHPs	82	0
	Supervisors	100	0
	School link workers	**62**	0
	Overall	80	0
35. Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus	CWPs/EMHPs	76	6
	Supervisors	100	10
	School link workers	**62**	0
	Overall	77.5	5

Round 3

A total of 18 statements that did not achieve strong consensus at R2 comprised the R3 questionnaire. The R3 questionnaire was sent only to participants who had completed the R2 questionnaire. A response rate of 85% was observed between R2 and R3. 25 participants made at least one change to their ratings from R2 to R3. This ranged from changing one rating to changing 11 ratings, with a mean of 3.28 changes per participant. At least one participant changed their rating on each statement. This ranged from one participant changing their response (statement 40) to eight participants changing their responses (statement 13), with a mean of 4.22 participants changing their response for each statement. Due to the change in participant ratings observed between R2 and R3, it was decided not to include the data of R2 participants who did not complete R3 in the final analysis, as they may have gone on to change their R3 ratings in line with other participants. Additionally, the high retention rate meant that in doing so, only the data of six participants was lost at R3.

As with R2, results from R3 are presented by theme in Tables 12-18. Statements are organised according to level of consensus obtained across the sample, beginning with 'strong consensus'. Differences in level of consensus between participant groups are highlighted in bold where observed. Example questionnaire quotations are again presented for each theme to elaborate on participant perspectives. Of the 18 statements comprising the R3 questionnaire, six achieved 'strong consensus'.

Theme 1: Establishing working practices with schools

Of three remaining statements, one achieved 'strong' consensus, one achieved 'weak' consensus, and one lacked consensus. One statement (7) presented with divergence between groups.

Participants disagreed that supervisors should act as the primary contact with schools. Participants showed some agreement that waiting list numbers should be capped, but this did not reach strong consensus. CWPs/EMHPs showed some agreement that all school teaching staff should be able to make referrals, but this was not observed in supervisors and SLWs.

"Definitely no to all school staff making direct referrals. They can recommend referrals to the link worker who is developing an understanding around referral thresholds." – Supervisor

Table 12

Consensus for statements relating to establishing working practices in schools

Strong consensus		Agree (%)	Disagree (%)
9. Supervisors should act as the primary contact with schools	CWPs/EMHPs	13	75
	Supervisors	14	**71**
	School link workers	9	82
	Overall	12	76
Weak consensus		Agree (%)	Disagree (%)
8. Waiting list numbers should be limited to manage demand	CWPs/EMHPs	56	19
	Supervisors	57	14
	School link workers	55	9
	Overall	56	15
Lack of consensus		Agree (%)	Disagree (%)
7. All school teaching staff should be able to make referrals	CWPs/EMHPs	**63**	6
	Supervisors	43	43
	School link workers	27	27
	Overall	47	21

Theme 2: Adapting to the needs and culture of schools

One remaining statement achieved 'strong' consensus but presented with divergence between groups. Lower agreement that practitioners should be treated as school staff was observed with supervisors.

"It is important that EMHPs are seen as part of the school system, otherwise they will always be seen as the outsider coming in which makes rapport challenging." – EMHP

Table 13

Consensus for statements relating to adapting to the needs and culture of schools

Strong consensus		Agree (%)	Disagree (%)
10. Practitioners should be treated as a member of staff in the schools they are based in	CWPs/EMHPs	81	0
	Supervisors	**57**	0
	School link workers	82	0
	Overall	76	0

Theme 3: Effective and acceptable interventions

One remaining statement achieved ‘moderate’ consensus and presented with divergence between groups. Lower agreement that LIIs are appropriate to schools’ needs was observed with SLWs.

“I would prefer if the pupils with most need were seen, rather than the ones with mild depression.” – School link worker

"I feel there is a gap between the service we offer and the service CAMHS offer." – CWP

Table 14

Consensus for statements relating to effective and acceptable interventions

Moderate consensus		Agree (%)	Disagree (%)
13. The low intensity interventions offered are appropriate to schools' needs	CWPs/EMHPs	**75**	6
	Supervisors	71	0
	School link workers	**55**	9
	Overall	68	6

Theme 4: Practical issues

Of two remaining statements, one achieved ‘moderate’ consensus and one lacked consensus. One statement (17) presented with divergence between groups. CWPs/EMHPs agreed about low visibility within schools, however this was not observed with supervisors and SLWs. Supervisors and SLWs showed some agreement that practitioners should be in schools for the full day, but this was not observed with CWPs/EMHPs.

"Visibility can vary between schools. Some are proactive in promoting the service and gaining referrals, but some are less so due to demands." – EMHP

Table 15

Consensus for statements relating to practical issues

Moderate consensus		Agree (%)	Disagree (%)
17. At present, practitioners have low visibility within schools which can be a problem	CWPs/EMHPs	**88**	0
	Supervisors	**57**	0
	School link workers	**36**	9
	Overall	65	3
Lack of consensus		Agree (%)	Disagree (%)
21. Practitioners should be based in schools for the full school day	CWPs/EMHPs	31	6
	Supervisors	**57**	14
	School link workers	**55**	0
	Overall	44	6

Theme 5: Relationship to CAMHS

Of three remaining statements, two achieved 'strong' consensus and one achieved 'moderate' consensus. Two statements (25 and 26) presented with divergence between groups. Supervisors demonstrated lower agreement around integration with CAMHS, treating practitioner as CAMHS staff, and practitioners providing a link with CAMHS.

"Intuitively it sounds a good idea for EMHPs to be the link between school and wider CAMHS. While they can offer brief advice, I would not want this to be their role as they will get caught up in discussions that will take them away from their practice." – Supervisor

Table 16

Consensus for statements relating to relationship to CAMHS

Strong consensus		Agree (%)	Disagree (%)
26. Integration with wider CAMHS should be promoted through practitioner presence at team base	CWPs/EMHPs	88	6
	Supervisors	**57**	0
	School link workers	100	0
	Overall	85	3
27. Practitioners should be treated as CAMHS staff by colleagues in wider CAMHS	CWPs/EMHPs	81	0
	Supervisors	**71**	0
	School link workers	100	0
	Overall	85	0
Moderate consensus		Agree (%)	Disagree (%)
25. Practitioners should act as a 'link' between schools and CAMHS	CWPs/EMHPs	**75**	0
	Supervisors	**29**	14
	School link workers	**91**	0
	Overall	71	3

Theme 6: Future development of the role

One remaining statement achieved ‘moderate’ consensus and presented with divergence between groups. Lower agreement that practitioners should be trained to work with more complex presentations was observed with supervisors with 29% disagreeing.

“Even if we don't end up taking on young people who have more complex presentations it is likely that we will see a number of these cases and it would help to be more informed so as to manage the situation appropriately.” – EMHP

Table 17

Consensus for statements relating to future development of the role

Moderate consensus		Agree (%)	Disagree (%)
31. Practitioners should be trained to work with more complex presentations such as self-harm, drug and alcohol use, and trauma-informed approaches	CWPs/EMHPs	**81**	0
	Supervisors	**14**	29
	School link workers	**91**	9
	Overall	71	6

Theme 7: Long-term strategy

Of seven remaining statements, two achieved ‘strong’ consensus, four achieved ‘moderate’ consensus and one lacked consensus. Four statements (32, 37, 38 and 40) presented with divergence between groups. Participants agreed that the initiative would benefit from a problem-solving forum and greater strategic planning, but lower agreement was observed in SLWs. SLWs agreed that practitioners should be based across more schools, but lower agreement was observed in CWPs/EMHPs and supervisors. Supervisors agreed that practitioners should practice with high fidelity to manualised interventions, but lower agreement was observed in CWPs/EMHPs and SLWs. Participants showed some agreement that funding uncertainty inhibited service planning, but this did not reach strong consensus. Supervisors agreed that schools should be able to buy-in practitioner resource, but lower agreement was observed with SLWs. Agreement was not observed regarding protecting the early intervention scope of the initiative.

“CWPs need permanent funding in order for providers to be able to undertake workforce planning.” – Supervisor

“The challenge is working out service priorities, as if you do more of one thing, you need to do less of something else.” – Supervisor

Table 18

Consensus for statements relating to long-term strategy

Strong consensus		Agree (%)	Disagree (%)
37. The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues	CWPs/EMHPs	100	0
	Supervisors	86	0
	School link workers	**55**	18
	Overall	82	3
38. There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools	CWPs/EMHPs	100	0
	Supervisors	**71**	0
	School link workers	**55**	9
	Overall	79	0
Moderate consensus		Agree (%)	Disagree (%)
32. Practitioners should be based in more schools to increase access across local authorities	CWPs/EMHPs	69	13
	Supervisors	**57**	0
	School link workers	**82**	9
	Overall	71	6
33. Practitioners should practice with a high level of fidelity to the manualised interventions they are trained to deliver	CWPs/EMHPs	63	6
	Supervisors	**100**	0
	School link workers	64	18
	Overall	71	6
39. Uncertainty around longer term funding means it is difficult for services to plan for the future	CWPs/EMHPs	69	6
	Supervisors	71	14
	School link workers	73	27
	Overall	71	6
40. In future, schools should have the option to buy-in practitioner resource full-time	CWPs/EMHPs	69	6
	Supervisors	**86**	0
	School link workers	**45**	27
	Overall	65	9
Lack of consensus		Agree (%)	Disagree (%)
36. The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties	CWPs/EMHPs	38	31
	Supervisors	29	0
	School link workers	45	27
	Overall	38	26

Lastly, the three statements most frequently chosen as most important by participants at R3 are presented in Table 19. 6 participants (18%) changed their choices from R2 to R3, ranging from changing one of three choices (n=3) to changing all three choices (n=1).

Table 19

Most important statements at R3

Statement	CWPs/EMHPs *n* (%)	School link workers *n* (%)	Supervisors *n* (%)	Overall *n* (%)
Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep (Statement 29)	11 (69)	4 (36)	1 (14)	16 (47)
Practitioners should be trained to work with more complex presentations such as self-harm, drug and alcohol use, and trauma-informed approaches (Statement 31)	5 (31)	5 (45)	2 (29)	12 (35)
Mental health interventions are more accessible to young people when they are offered at school (Statement 14)	4 (25)	3 (27)	1 (14)	8 (24)

Overall, the sample considered expanding the menu of interventions offered, and that mental health interventions are more accessible when they are provided in schools to be most important. The top three statements chosen by CWPs/EMHPs and SLWs corresponded with each other. A range of statements emerged as most important to supervisors, with their choices being distributed across themes. The frequency with which each statement was chosen by participants at R2 and R3 is presented in Appendix R.

Discussion

This Delphi method study developed an understanding of professionals' experiences of CWP/EMHP implementation in schools and their ideas on how to improve the implementation of this workforce. Findings are discussed with reference to IS outcomes (Proctor et al., 2011)

What is helpful about this way of working?

A finding that mental health support is more accessible when provided in schools indicated the 'appropriateness' of interventions delivered by CWPs/EMHPs (Proctor et al., 2011). Developing and maintaining positive relationships with schools has been recognised as an important facilitator of implementation (Gee et al., 2021). This was reinforced by the importance of taking time to establish working practices with schools identified in this study.

Guaranteed access to required resources was also important. Lacking access to appropriate clinical space and materials can prevent mental health practitioners from carrying out their work effectively and has been linked to practitioner burn-out (Weist et al., 2012). This demonstrates the importance of attending to these factors early on and creating the conditions required to support 'adoption' of interventions (Proctor et al., 2011).

What is challenging about this way of working?

Reconciling where CWPs/EMHPs fit between CAMHS and schools emerged as challenging. CWPs/EMHPs' low visibility was consistent with prior research identifying difficulty experienced by external practitioners in obtaining status and legitimacy within school settings (Massey et al., 2005). From the CWP/EMHP perspective, being treated as school staff could promote 'penetration' (Proctor et al., 2011) and afford the status required to obtain necessary support (Burn et al., 2020). However, supervisors appeared to prioritise protecting role boundaries (MacNaughton et al., 2013).

CWPs/EMHPs' relationship to CAMHS was also contested. Better integration may provide CWPs/EMHPs with a sense of identity and legitimacy to their work (Karam et al., 2018) and offer schools a link to specialist CAMHS (Pass et al., 2018). However, supervisors could be

motivated to prevent CWPs/EMHPs from being drawn into challenges experienced within CAMHS (Sims et al., 2015). These findings could represent a need amongst CWPs/EMHPs to develop a sense of belonging to a 'community of practice' (defined as a group of people who "share a concern or a passion for something they do and learn how to do it better as they interact regularly") as they navigate working across health and education contexts (Wenger-Trayner & Wenger-Trayner, 2015). Difficulty maintaining protected time for liaison between CWPs/EMHPs and schools was also identified, perhaps indicating miscommunication, or differences in preferred communication styles (e.g., action-oriented versus reflective discussion) between agencies (Rothi & Leavey, 2006).

How could this way of working be improved?

Discrepancy arose over whether to expand the scope of the CWP/EMHP role. Developing further manualised LIIs could enable CWPs/EMHPs to practice within their level of training and competence, whilst matching the needs and preferences of service users to ensure intervention acceptability (Gee et al., 2021). Supervisors' disagreement that practitioners should be trained to work with more complex presentations may demonstrate caution and a desire to prioritise safe practice, acknowledging where clinical responsibility is held. CWPs/EMHPs on the other hand may be motivated to develop their skillset and strive to meet the expressed needs of schools (Shepherd & Rosairo, 2008). These differences could be understood through the work of Menzies-Lyth (1960) who described a tendency of superiors to project their anxiety around task performance 'downwards' into more junior staff, such that their capabilities are underestimated. Conversely, junior staff project their capabilities 'upwards', alongside an expectation that superiors will assume responsibility if required, such that anxiety around being able to manage a task is relieved.

Time to work on whole-school approaches, intended to de-stigmatise mental health, was also endorsed. Whole-school approaches represent a shift from the discourse of evidence-based practice towards a public health paradigm, and as such, require additional competencies and dedicated time to be developed and implemented (Glazzard, 2019).

Further discrepancy was identified over how to best allocate resources. A tension between prioritising quality of service and equality of access was identified. Additional recruitment is required to facilitate practitioners embedding and developing relationships through presence in schools, as well as increasing the number of schools accessing the service.

Implications

Findings highlight outstanding issues to be resolved in supporting the implementation of CWPs/EMHPs in schools. As was put forward by a supervisor participant, the challenge is one of reaching compromise on service priorities, as "if you do more of one thing, you need to do less of something else".

Menzies-Lyth (1979) further outlined the need for institutions to clearly define their 'primary task'. Staff require a sense of satisfaction from their work to feel supported in their role. Lack of agreed purpose can result in confusion and conflict, compromising effective performance. If the work is too ambitious or inadequately resourced, staff can become over-worked and disappointed in the results. However, if the primary task is more realistic in relation to available resources, but the needs of service users are not meaningfully addressed, this can be painful and even intolerable for staff. The 'primary task' can be implicitly redefined when societal pressures against a more realistic task are too great. Ensuring the 'primary task' is precise, realistic, and in line with the values of an institution protects role boundaries (Menzies-Lyth, 1979). This phenomenon could be described in the work of CWPs/EMHPs, who were

introduced to offer LIIs with CYP experiencing mild/moderate mental health difficulties. Concern held within schools for CYP presenting with more complex difficulties may have informed the suggestion that CWPs/EMHPs should be trained to work with this different group of CYP, where input from more senior clinicians and specialist CAMHS is indicated.

In addition, the presence of different discourses between professional cultures are understood to present challenge to effective collaboration (Hall, 2005). This is compounded when stress in the workplace causes workers to 'retreat' into their professional silos, which feel safe and clearly boundaried (Hall, 2005). Further, 'disciplinary centrism' describes the assumption that one's own profession offers the first or last word on matters of practice (Arrendondo et al., 2004). Facilitating dialogue between inter-professional groups has been proposed to support the capacity for staff to suspend their assumptions and engage with genuine joint-working (McCallin, 2005). A primary implication of this study is the need for local collaborators to have protected opportunities to engage with the perspectives of others and reach compromise on what to prioritise moving forwards. Such opportunities may even support collaborators to clarify their underlying motivations and the values they are operating from (Sadler, 2005).

Results also indicate that expanding the range of LIIs offered is desirable. Models could be adapted from those used in adult IAPT services, such as psychoeducational workshops for sleep difficulties (Bonin et al., 2014). However, it is important that any interventions offered are translated to CYP populations and evaluated rigorously before being introduced.

There appears to be a gap in provision between the LIIs offered by CWPs/EMHPs and schools' concerns around mental health need. To help address this, a senior clinician post could be introduced to support pastoral teams in schools, offering consultation, signposting and

facilitating contact with specialist CAMHS as required. Such a post could also support the development of whole-school approaches and strategy for how to evaluate impact. This is important in the context of a limited evidence-base for using these approaches, despite a number of initiatives being widely implemented (Goldberg et al., 2019).

In addition to further training and recruitment, improved access to CWP/EMHP services across schools could be promoted through developing a 'menu' of interventions, with schools choosing what to opt-in to. Schools could prioritise individual GSH, workshops, or whole-school approaches and consultation.

Finally, the need to support CWPs/EMHPs through high-quality clinical supervision, supporting communication with schools, and creating opportunities for connection between practitioners working autonomously across the community is indicated.

Strengths and limitations

This study contributes to early research into CWPs/EMHPs and, to the author's knowledge, is the first to focus its investigation on the implementation of this new workforce. This study benefited from a high response rate between R2 and R3, minimising the risk of attrition bias and improving the validity of findings (Hsu & Sandford, 2007).

Due to participant anonymity, the Delphi method promoted honest sharing of opinions and reduced the potential impact of power differentials between participant groups (Iqbal & Pipon-Young, 2009). Indeed, the Delphi method values expertise gained from different perspectives, including the importance of CWPs/EMHPs and SLWs' direct experience 'on the ground' in schools and supervisors' experiences of overseeing roll-out across a locality. This is

key, as incorporating diversity of experience has been found to improve decision making quality (Jorm, 2015).

The introduction of CWPs and MHSTs constitutes a national initiative. This study was situated within a local context, exploring CWP/EMHP services in two specified research sites. Consequently, the study findings cannot be considered generalisable to the national picture, especially given the emphasis on understanding social context within IS research (Rojas-Andrade & Bahamondes, 2019). Furthermore, areas of consensus identified amongst participants in Delphi method research should not be assumed to indicate 'correctness' (Soong et al., 2016). Rather, findings reveal what is important to participants in this study within their context.

Unfortunately, it was not possible to include CYP in receipt of CWP/EMHP services in schools as a participant group as had been originally planned. This meant that the extent to which CYP agreed or disagreed with professional stakeholders, and their priorities and ideas for the future could not be established, as has been proposed for implementation research (Gee et al., 2021). Furthermore, this study did not differentiate between primary and secondary schools. Implementation outcomes may vary between these settings, for example, due to the different GSH models used, and it is important to be mindful of this when considering the study findings.

Lastly, final data analysis did not include the responses of 15% of participants who had not completed the R3 questionnaire. This included 30% (n=3) of supervisor participants. It is unknown whether these participants would have changed their responses, potentially impacting rates of consensus identified.

Future research

Focus groups could be used to better understand reasons behind findings of non-consensus and to seek to resolve outstanding areas of disagreement. This would facilitate dialogue between stakeholders, and enable participants to elaborate on their positions. For example, supervisors could explain why they did not agree that practitioners should be trained to work with more complex presentations. Such differences in opinion may reflect different types of knowledge at play between stakeholder groups. For example, the perspectives of CWPs/EMHPs may represent their 'experiential knowledge' gained through working in schools during this initiative (Nimkulrat et al., 2020). Supervisors' thinking, by contrast, may be informed by different strategic priorities.

It has been recognised that mental health interventions are often introduced to school settings with limited involvement of CYP in receipt of support (Gronholm et al., 2018). Future studies should be conducted exploring the introduction of CWPs/EMHPs from a service user perspective. Qualitative methodologies could be used to establish how far seeing CWPs/EMHPs in school and the interventions they offer are acceptable to CYP. Factors that promote or undermine the effectiveness of LIIs in schools according to CYP could also be explored to refine implementation (McKeague et al., 2018).

In addition to further implementation research, it is imperative that studies evaluating CWP/EMHP interventions using routine outcome measure data are published. A "poor track report" of collecting outcome data in CAMHS has been described (Ludlow et al., 2020). Demonstrating effectiveness of LIIs under real-world conditions in line with CYP-IAPT principles could support the case for longer-term funding and promote sustainability for this workforce (Burn et al., 2020). To promote sustainability, it is also important to monitor

workforce progression over the coming years. MHSTs could learn from the experiences of adult IAPT services, where difficulties in retaining low-intensity practitioners have been observed. To address this, adult IAPT has introduced specialities and diversified training opportunities to support retention (e.g., Wroe et al., 2015).

Conclusion

This study aimed to explore different professionals' experiences of CWP/EMHP services in schools and identify factors that facilitate and impede their implementation. The Delphi method facilitated consensus-building between participant groups and identified important areas for future development. Participants recognised the importance of developing relationships and shared understandings of the initiative within schools, and the need to overcome practical issues to create conditions that facilitate successful working. Results also highlighted challenges associated with translating mental health interventions to the education context, and different priorities in partnership working emerged. Participants agreed that CWPs/EMHPs should be trained to deliver a greater range of interventions; however, it is important that this is achieved in a measured way. Findings also demonstrate the need to facilitate dialogue between local collaborators to recognise and resolve issues together in supporting implementation. The study was limited by not incorporating service user perspectives; further research is therefore warranted, to explore acceptability among CYP. To promote sustainability of this workforce, it is crucial that resources invested in recruiting and training practitioners are matched by measured, strategic thinking.

References

Arredondo, P., Shealy, C., Neale, M., & Winfrey, L. L. (2004). Consultation and interprofessional collaboration: Modeling for the future. *Journal of Clinical Psychology*, *60*(7), 787-800. https://doi.org/10.1002/jclp.20015

Bell, J., Reid, M., Dyson, J., Schlosser, A., & Alexander, T. (2019). There's just huge anxiety: Ontological security, moral panic, and the decline in young people's mental health and well-being in the UK. *Qualitative Research in Medicine and Healthcare*, *3*(2), 87-97. https://doi.org/10.4081/qrmh.2019.8200

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Bhattacharyya, O., Reeves, S., & Zwarenstein, M. (2009). What is implementation research? Rationale, concepts, and practices. *Research on Social Work Practice*, *19*(5), 491-502. https://doi.org/10.1177/1049731509335528

Bonin, E. M., Beecham, J., Swift, N., Raikundalia, S., & Brown, J. S. (2014). Psycho-educational CBT-Insomnia workshops in the community. A cost-effectiveness analysis alongside a randomised controlled trial. *Behaviour Research and Therapy, 55*, 40-47. https://doi.org/10.1016/j.brat.2014.01.005

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 1-25. https://doi.org/10.1080/14780887.2020.1769238

British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society*. British Psychological Society.

Burn, A. M., Vainre, M., Humphrey, A., & Howarth, E. (2020). Evaluating the CYP-IAPT transformation of child and adolescent mental health services in Cambridgeshire, UK: A qualitative implementation study. *Implementation Science Communications*, *1*(1), 1-13. https://doi.org/10.1186/s43058-020-00078-6

Callaghan, J. E., Fellin, L. C., & Warner-Gale, F. (2017). A critical analysis of child and adolescent mental health services policy in England. *Clinical Child Psychology and Psychiatry, 22*(1), 109-127. https://doi.org/10.1177/1359104516640318

Clayborne, Z. M., Varin, M., & Colman, I. (2019). Systematic review and meta-analysis: Adolescent depression and long-term psychosocial outcomes. *Journal of the American Academy of Child & Adolescent Psychiatry*, *58*(1), 72-79. https://doi.org/10.1016/j.jaac.2018.07.896

Collishaw, S. (2015). Annual research review: Secular trends in child and adolescent mental health. *Journal of Child Psychology and Psychiatry*, *56*, 370-393. https://doi.org/10.1111/jcpp.12372

Cummings, J. R., Ponce, N. A., & Mays, V. M. (2010). Comparing racial/ethnic differences in mental health service use among high-need subpopulations across clinical and school-based settings. *Journal of Adolescent Health*, *46*(6), 603-606. https://doi.org/10.1016/j.jadohealth.2009.11.221

Dalkey, N., & Helmer, O. (1963). An experimental application of the Delphi method to the use of experts. *Management Science*, *9*(3), 458-467. https://doi.org/10.1287/mnsc.9.3.458

Department for Education. (2016). *Supporting Mental Health in Schools and Colleges: Summary report*. https://www.gov.uk/government/publications/supporting-mental-health-in-schools-and-colleges

Department of Health & Social Care & Department for Education. (2017). *Transforming children and young people's mental health provision: A green paper*. https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Department of Health & Social Care. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Department of Health & Social Care. (2018). *Government response to the consultation on transforming children and young people's mental health provision: A green paper and next steps*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/728892/government-response-to-consultation-on-transforming-children-and-young-peoples-mental-health.pdf

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*, *1*(5), 377-387. https://doi.org/10.1016/S2215-0366(14)70312-8

Fenton, S. K., Joscelyne, T., & Higgins, S. (2021). Part 1: Exploring views from fathers and perinatal practitioners on the inclusion of fathers by perinatal services. *British Journal of Midwifery*, *29*(4), 208-215. https://doi.org/10.12968/bjom.2021.29.4.208

Fonagy, P. & Pugh, K. (2017). CAMHS goes mainstream. *Child and Adolescent Mental Health*, *22*, 1-3. https://doi.org/10.1111/camh.12209

Garnefski, N., Legerstee, J., Kraaij, V., van Den Kommer, T., & Teerds, J. A. N. (2002). Cognitive coping strategies and symptoms of depression and anxiety: A comparison between adolescents and adults. *Journal of Adolescence*, *25*, 603-611. http://doi.org/10.1006/jado.2002.0507

Gee, B., Reynolds, S., Carroll, B., Orchard, F., Clarke, T., Martin, D., & Pass, L. (2020). Practitioner review: Effectiveness of indicated school-based interventions for adolescent depression and anxiety–a meta-analytic review. *Journal of Child Psychology and Psychiatry*, *61*(7), 739-756. https://doi.org/10.1111/jcpp.13209

Gee, B., Wilson, J., Clarke, T., Farthing, S., Carroll, B., Jackson, C., & Notley, C. (2021). Delivering mental health support within schools and colleges–a thematic synthesis of barriers and facilitators to implementation of indicated psychological interventions for adolescents. *Child and Adolescent Mental Health*, *26*(1), 34-46. https://doi.org/10.1111/camh.12381

Glazzard, J. (2019). A whole-school approach to supporting children and young people's mental health. *Journal of Public Mental Health*,18(4), 256-265. https://doi.org/10.1108/JPMH-10-2018-0074

Glazzard, J., & Stones, S. (2021). Supporting young people's mental health: Reconceptualizing the role of schools or a step too far? *Frontiers in Education, 5.* https://doi.org/10.3389/feduc.2020.607939

Goldberg, J. M., Sklad, M., Elfrink, T. R., Schreurs, K. M., Bohlmeijer, E. T., & Clarke, A. M. (2019). Effectiveness of interventions adopting a whole school approach to enhancing social and emotional development: A meta-analysis. *European Journal of Psychology of Education*, *34*(4), 755–782. https://doi.org/10.1007/s10212-018-0406-9

Gronholm, P. C., Nye, E., & Michelson, D. (2018). Stigma related to targeted school-based mental health interventions: A systematic review of qualitative evidence. *Journal of Affective Disorders*, *240*, 17-26. https://doi.org/10.1016/j.jad.2018.07.023

Gunnell, D., Kidger, J., & Elvidge, H. (2018). Adolescent mental health in crisis. *British Medical Journal, 361*(2608). https://doi.org/10.1136/bmj.k2608

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care*, *19*, 188-196. https://doi.org/10.1080/13561820500081745

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*, *32*(4), 1008-1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Health Education England. (2020). *Module aims and content of education mental health practitioner for children and young people curriculum (EMHP).* https://www.hee.nhs.uk/sites/default/files/documents/EMHP%20training%20curriculum.pdf

Heyne, D., Sauter, F. M., Van Widenfelt, B. M., Vermeiren, R., & Westenberg, P. M. (2011). School refusal and anxiety in adolescence: Non-randomized trial of a developmentally sensitive cognitive behavioral therapy. *Journal of Anxiety Disorders*, *25*, 870-878. http://doi.org/10.1016/j.janxdis.2011.04.006

Higgins, E., & O'Sullivan, S. (2015). "What Works": Systematic review of the "FRIENDS for Life" programme as a universal school-based intervention programme for the prevention of child and youth anxiety. *Educational Psychology in Practice, 31*(4), 424-438. https://doi.org/10.1080/02667363.2015.1086977

Holey, E. A., Feeley, J. L., Dixon, J., & Whittaker, V. J. (2007). An exploration of the use of simple statistics to measure consensus and stability in Delphi studies. *BMC Medical Research Methodology*, *7*(1), 1-10. https://doi.org/10.1186/1471-2288-7-52

Howarth, E., Vainre, M., Humphrey, A., Lombardo, C., Hanafiah, A. N., Anderson, J. K., & Jones, P. B. (2019). Delphi study to identify key features of community-based child and adolescent mental health services in the East of England. *BMJ Open*, *9*(6). http://doi.org/10.1136/bmjopen-2018-022936

Hsu, C. C., & Sandford, B. A. (2007). Minimizing non-response in the Delphi process: How to respond to non-response. *Practical Assessment, Research, and Evaluation*, *12*(1), https://doi.org/10.7275/by88-4025

Iqbal, S., & Pipon-Young, L. (2009). The Delphi method. *The Psychologist*, 22, 598– 600.

Jorm, A. F. (2015). Using the Delphi expert consensus method in mental health research. *Australian & New Zealand Journal of Psychiatry*, *49*(10), 887-897. https://doi.org/10.1177/0004867415600891

Karam, M., Brault, I., Van Durme, T., & Macq, J. (2018). Comparing interprofessional and interorganizational collaboration in healthcare: A systematic review of the qualitative research. *International Journal of Nursing Studies*, *79*, 70-83. https://doi.org/10.1016/j.ijnurstu.2017.11.002

Langlands, R. L., Jorm, A. F., Kelly, C. M., & Kitchener, B. A. (2008). First aid for depression: A Delphi consensus study with consumers, carers and clinicians. *Journal of Affective Disorders*, *105*(1-3), 157-165. https://doi.org/10.1016/j.jad.2007.05.004

Linstone, H., & Turoff, M. (1975). The Delphi method: Techniques and applications. *Journal of Marketing Research, 18*(3). https://doi.org/10.2307/3150755

Ludlow, C., Hurn, R., & Lansdell, S. (2020). A current review of the children and young people's improving access to psychological therapies (CYP IAPT) program: Perspectives on developing an accessible workforce. *Adolescent Health, Medicine and Therapeutics*, *11*, 21. https://doi.org/10.2147/AHMT.S196492

Lyon, A. R., & Bruns, E. J. (2019). From evidence to impact: Joining our best school mental health practices with our best implementation strategies. *School Mental Health*, *11*(1), 106-114. https://doi.org/10.1007/s12310-018-09306-w

MacNaughton, K., Chreim, S., & Bourgeault, I. L. (2013). Role construction and boundaries in interprofessional primary health care teams: A qualitative study. *BMC Health Services Research*, *13*(1), 1-13. https://doi.org/10.1186/1472-6963-13-486

Massey, O. T., Armstrong, K., Boroughs, M., Henson, K., & McCash, L. (2005). Mental health services in schools: A qualitative analysis of challenges to implementation, operation, and sustainability. *Psychology in the Schools*, *42*(4), 361-372. https://doi.org/10.1002/pits.20063

McCallin, A. (2005). Interprofessional practice: Learning how to collaborate. *Contemporary Nurse*, *20*(1), 28-37. https://doi.org/10.5172/conu.20.1.28

McGorry, P. D., & Mei, C. (2018). Early intervention in youth mental health: Progress and future directions. *Evidence-based Mental Health*, *21*(4), 182-184. https://doi.org/10.1136/ebmental-2018-300060

McKeague, L., Morant, N., Blackshaw, E., & Brown, J. S. (2018). Exploring the feasibility and acceptability of a school-based self-referral intervention for emotional difficulties in older adolescents: Qualitative perspectives from students and school staff. *Child and Adolescent Mental Health*, *23*(3), 198-205. https://doi.org/10.1111/camh.12234

Mental Health Taskforce. (2016). *The five year forward view for mental health: A report from the independent mental health taskforce to the NHS in England*. NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

Menzies Lyth, I. (1979). *Containing anxiety in institutions.* Free Association Books.

Menzies-Lyth, I. (1960). Social systems as a defence against anxiety: An empirical study of the nursing service of a general hospital. In. E. Trist & H. Murray (Eds.), *The social engagement of social science vol. 1: The socio-psychological perspective* (pp. 439-462). Free Association Books.

Minas, H., & Jorm, A. F. (2010). Where there is no evidence:Use of expert consensus methods to fill the evidence gap in low-income countries and cultural minorities. *International Journal of Mental Health Systems*, *4*(1), 1-6. https://doi.org/10.1186/1752-4458-4-33

Mullen, P. M. (2003). Delphi: Myths and reality. *Journal of Health Organization and Management, 17*(1), 37-52. https://doi.org/10.1108/14777260310469319

NHS England. (2016). *Children and young people's mental health local transformation plans – a summary of key themes*. https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/08/cyp-mh-ltp.pdf

Nimkulrat, N., Groth, C., Tomico, O., & Valle-Noronha, J. (2020). Knowing together–experiential knowledge and collaboration. *CoDesign*, *16*(4), 267-273. https://doi.org/10.1080/15710882.2020.1823995

O'Reilly, M., Svirydzenka, N., Adams, S., & Dogra, N. (2018). Review of mental health promotion interventions in schools. *Social Psychiatry and Psychiatric Epidemiology*, *53*(7), 647-662. https://doi.org/10.1007/s00127-018-1530-1

Palinkas, L. A. (2014). Qualitative and mixed methods in mental health services and implementation research. *Journal of Clinical Child & Adolescent Psychology*, *43*(6), 851-861. https://doi.org/10.1080/15374416.2014.910791

Parto, M., & Besharat, M. A. (2011). The direct and indirect effects of self-efficacy and problem solving on mental health in adolescents: Assessing the role of coping strategies as mediating mechanism. *Procedia-Social and Behavioral Sciences*, *30*, 639-643. http://doi.org/10.1016/j.sbspro.2011.10.124

Pass, L., Sancho, M., Brett, S., Jones, M., & Reynolds, S. (2018). Brief Behavioural Activation (Brief BA) in secondary schools: A feasibility study examining acceptability and practical considerations. *Educational and Child Psychology*, *35*(2).

Paulus, F. W., Ohmann, S., & Popow, C. (2016). Practitioner Review: School-based interventions in child mental health. *Journal of Child Psychology and Psychiatry*, *57*(12), 1337-1359. https://doi.org/10.1111/jcpp.12584

Peris, T. S., Compton, S. N., Kendall, P. C., Birmaher, B., Sherrill, J., March, J., ... & Keeton, C. P. (2015). Trajectories of change in youth anxiety during cognitive—behavior therapy. *Journal of Consulting and Clinical Psychology*, *83*, 239. http://doi.org/10.1037/a0038402

Pitchforth, J., Fahy, K., Ford, T., Wolpert, M., Viner, R. M., & Hargreaves, D. S. (2019). Mental health and well-being trends among children and young people in the UK, 1995–2014: Analysis of repeated cross-sectional national health surveys. *Psychological Medicine*, *49*(8), 1275-1285. https://doi.org/10.1017/S0033291718001757

Proctor, E. K., Landsverk, J., Aarons, G., Chambers, D., Glisson, C. & Mittman, B. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological, and training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, *36*, 24-34. https://doi.org/10.1007/s10488-008-0197-4

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(2), 65-76. https://doi.org/10.1007/s10488-010-0319-7

Putnam, J. W., Spiegel, A. N., & Bruininks, R. H. (1995). Future directions in education and inclusion of students with disabilities: A Delphi investigation. *Exceptional Children*, *61*(6), 553-576. https://doi.org/10.1177/001440299506100605

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J., Evdoka-Burton, G., & Waite, P. (2020). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systematic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, 30, 183–211. https://doi.org/10.1007/s00787-019-01469-4

Rocks, S., Fazel, M., & Tsiachristas, A. (2020). Impact of transforming mental health services for young people in England on patient access, resource use and health: a quasi-experimental study. *BMJ Open*, *10*(1). https://doi.org/10.1136/bmjopen-2019-034067

Rojas-Andrade, R., & Bahamondes, L. L. (2019). Is implementation fidelity important? A systematic review on school-based mental health programs. *Contemporary School Psychology*, *23*(4), 339-350. https://doi.org/10.1007/s40688-018-0175-0

Rothì, D. M., & Leavey, G. (2006). Mental health help-seeking and young people: A review. *Pastoral Care in Education*, *24*(3), 4-13. https://doi.org/10.1111/j.1468-0122.2006.00373.x

Sadler, J. Z. (2005). Social context and stakeholders' values in building diagnostic systems. *Psychopathology*, *38*(4), 197-200. https://doi.org/10.1159/000086091

Sayal, K., Amarasinghe, M., Robotham, S., Coope, C., Ashworth, M., Day, C., & Simonoff, E. (2012). Quality standards for child and adolescent mental health in primary care. *BMC Family Practice*, *13*(1), 1-8. https://doi.org/10.1186/1471-2296-13-51

Sayer, A. (2004). Why critical realism? In S. Ackroyd & S. Fleetwood (Eds.), *Critical realist applications in organisation and management studies* (pp. 6-20). Routledge.

Shepherd, M., & Rosairo, M. (2008). Low-intensity workers: Lessons learned from supervising primary care mental health workers and dilemmas associated with such roles. *Mental Health in Family Medicine*, *5*(4), 237-245.

Shirk, S. R., Crisostomo, P. S., Jungbluth, N., & Gudmundsen, G. R. (2013). Cognitive mechanisms of change in CBT for adolescent depression: Associations among client involvement, cognitive distortions, and treatment outcome. *International Journal of Cognitive Therapy*, *6*, 311-324. http://doi.org/10.1521/ijct.2013.6.4.311

Sims, S., Hewitt, G., & Harris, R. (2015). Evidence of collaboration, pooling of resources, learning and role blurring in interprofessional healthcare teams: A realist synthesis. *Journal of Interprofessional Care*, *29*(1), 20-25. https://doi.org/10.3109/13561820.2014.939745

Soong, J. T., Poots, A. J., & Bell, D. (2016). Finding consensus on frailty assessment in acute care through Delphi method. *BMJ open*, *6*(10). https://doi.org/10.1136/bmjopen-2016-012904

South, R., Jones, F. W., Creith, E., & Simonds, L. M. (2016). Understanding the concept of resilience in relation to looked after children: A Delphi survey of perceptions from education, social care and foster care. *Clinical Child Psychology and Psychiatry*, *21*(2), 178-192. https://doi.org/10.1177/1359104515577485

Stephan, S. H., Weist, M., Kataoka, S., Adelsheim, S., & Mills, C. (2007). Transformation of children's mental health services: The role of school mental health. *Psychiatric Services*, *58*(10), 1330-1338. 10.1176/ps.2007.58.10.1330

Vizard, T., Pearce, N., Davis, J., Sadler, K., Ford, T., Goodman, A., & McManus, S. (2018). *Mental health of children and young people in England, 2017: Emotional disorders*. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

Von der Gracht, H. (2012). Consensus measurement in Delphi studies: Review and implications for future quality assurance. *Technological Forecasting and Social Change, 79*(8), 1525-1536. https://doi.org/10.1016/j.techfore.2012.04.013

Watts, S. (2014). User skills for qualitative analysis: Perspective, interpretation and the delivery of impact. *Qualitative Research in Psychology*, *11*(1), 1-14. https://doi.org/10.1080/14780887.2013.776156

Weist, M. D., Mellin, E. A., Chambers, K. L., Lever, N. A., Haber, D., & Blaber, C. (2012). Challenges to collaboration in school mental health and strategies for overcoming them. *Journal of School Health, 82*(2), 97-105. https://doi.org/10.1111/j.1746-1561.2011.00672.x

Wenger-Trayner, E., & Wenger-Trayner, B. (2015). *Communities of practice: A brief introduction*. http://wenger-trayner.com/wpcontent/uploads/2015/04/07-Brief-introduction-to-communities-of-practice.pdf

West, A. (2011). Using the Delphi technique: Experience from the world of counselling and psychotherapy. *Counselling and Psychotherapy Research*, *11*(3), 237-242. https://doi.org/10.1080/14733145.2010.492429

Wolpert, M., Humphrey, N., Belsky, J., & Deighton, J. (2013). Embedding mental health support in schools: Learning from the targeted mental health in schools (TaMHS) national evaluation. *Emotional and Behavioural Difficulties, 18*, 270-283. https://doi.org/10.1080/13632752.2013.819253

Wroe, A., Rennie, E., Gibbons, S., Hassy, A., & Chapman, E. (2015). IAPT and long term medical conditions: What can we offer? *Behavioural and Cognitive Psychotherapy 43*(4), 412-425. https://doi.org/10.1017/S1352465813001227

Section C: Appendices of Supporting Material

Appendix A
Refined Critical Appraisal Skills Programme qualitative checklist (Long et al., 2020)

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Appendix B

Quality appraisal of included papers

CASP Criteria	Cale et al., 2020	Chase et al., 2006	Evans et al., 2015	Fox & Butler, 2007	Kendal et al., 2011	Kendal et al 2014	McGeechan et al., 2019	McKeague et al., 2018	Prior, 2012	Segrott et al., 2013	Spencer et al., 2020
Clear statement of aims?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Qualitative methodology appropriate?	Yes – exploring perceptions and experiences of the programme	Yes – to elicit in depth understanding of 'Teen Talk'	Yes – exploring lived experiences	Yes – exploring views of young people	Yes – exploring process	Yes – exploring views	Yes – exploring experiences	Yes – investigating feasibility	Yes – exploring descriptions of accessing school counselling	Yes – exploring views of young people	Yes - exploring young people's lived experience
Research design appropriate for aims?	Yes – rationale for qualitative component of evaluation outlined	Yes – rationale for range of methods used outlined	Yes – to ensure participant validation of observational data	Yes – focus group complimented survey	Partially – rationale for using interviews specifically not explicitly described	Partially – rationale for using interviews specifically not explicitly described	Partially – rationale for using interviews specifically not explicitly described	Yes – rationale for qualitative component of randomised controlled trial	Yes – rationale for interviews as component of 'wider evaluation'	Partially – rationale for using interviews specifically not explicitly described	Partially – rationale for using interviews specifically not explicitly described
Theoretical underpinnings described?	Partially- "guided by an approach akin to constructivist grounded theory"	Not described	Not described	Not described	Not described	Partially – "informed by principles of flexibility in response to social context and an analytic aim of interpreting the meaning and significance of data"	Not described	Partially – data analysis "was not conducted from a particular theoretical standpoint"	Not described	Not described	Partially – reference to 'theoretically flexible' approach
Recruitment strategy appropriate?	Partially - purposive sampling; selection of focus group participants not described	Yes - purposive sampling; young people volunteered to take part	Partially - purposive sampling; selection of participants not described	Partially - purposive sampling; selection of focus group participants not described	Yes – purposive sampling; young people invited to take part	Partially - purposive sampling; selection of participants not described	Yes – purposive sampling, participants volunteered to take part	Yes – purposive sampling, reasons for sampling were explained	Yes – purposive sampling; participants invited to take part	Yes – purposive sampling, participants opted-in	Yes – purposive sampling, facilitated by schools and youth workers
Data collection appropriate?	Partially – semi-structured focus groups; audio recorded; focus of discussion was described but an interview	Partially – setting and procedure described; recording and interview schedule not provided	Partially – interview schedule not described or provided	Partially – data collection described; topic guide described but not provided; focus	Yes – data collection described, and topic guide outlined	Yes, process described, topic guide presented	Partially – interviews described; interview schedule described but not presented	Partially – interviews described; audio recorded; topics described but interview schedule not provided	Partially – interview process described; topic guide used but not provided	Partially, interviews described, topic guide not presented	Yes – interview process described; interview schedule provided; audio recorded

CASP Criteria	Cale et al., 2020	Chase et al., 2006	Evans et al., 2015	Fox & Butler, 2007	Kendal et al., 2011	Kendal et al 2014	McGeechan et al., 2019	McKeague et al., 2018	Prior, 2012	Segrott et al., 2013	Spencer et al., 2020
	schedule was not provided			groups audio recorded							
Relationship between researcher and participants considered?	Partially – role of researcher in co-creating data acknowledged	Not addressed	Not addressed	Not addressed	Not addressed	Yes – use of reflexive diary outlined	Not addressed	Yes - interviewer had no involvement in delivery of intervention	Yes - 'reflexive statement' used including impact of role of researcher as a school counsellor	Yes - conducted by university-based researchers who had no involvement in i ntervention	Not addressed
Ethical issues considered?	Partially – ethical approval was granted; written consent was provided; consent process not described	Not addressed	Partially – ethical approval was granted; young people/parents provided consen t but process not described	Not addressed	Yes - ethical approval granted and consent processes described	Partially – ethical approval granted, safeguarding protocol used, efforts made to protect confidentiality; consent processes not described	Yes – ethical approval granted , consent proces ses described	Partially - ethical approval obtained, consent provided but procedures not elaborated on	Yes - Consent obtained and processes described; debriefing offered; ethical approval obtained	Partially – ethical approval obtained, consent provided but procedures not elaborated on	Yes - ethical approval obtained; consent process described
Data analysis sufficiently rigorous?	Partially – stages of thematic analysis described; role of researcher not examined; quota tions provided to illustrate results	Not described, but quotations provided to illustrate findings	Partially – thematic analysis described; role of researcher not examined; quotations provided to illustrate results	Partially - Content analysis described; conducted by multiple researchers, analysis of focus group data not described; quota tions provided to illustrate results	Partially – thematic analysis mentioned; validation processes described; quotations provided to illustrate results	Yes – framework method and thematic analysis were described; double coding and potential influence of researchers described; quotations provided to illustrate results	Partially - applied thematic analysis using inductive approach outlined; quotations provided to illustrate results	Yes – process of thematic analysis was described, quota tions provided to illustrate results	Yes – two stage process of narrative thematic analysis described; mixed inductive and deductive approach; quotations provided to illustrate results	Partially – Development of coding framework described minimally, data were double coded, quotation s provided to illustrate results	Partially - Inductive thematic analysis described; themes discussed between researchers; role of researcher not examined
Clear statement of findings?	Partially – findings discussed in relation to aims; credibility not discussed	Partially – qualitative findings described; credibility not discussed	Yes – findings described; contradictory experiences discussed; limita tions including generalisability acknowledged	Yes - findings discussed; limitations including generalisability acknowledged	Partially - findin gs discussed but credibility not discussed	Yes – findings described in relation to question, findings discussed tentatively; credibility addressed	Yes – findings discussed in relation to aims; limitations addressed	Yes – findings discussed in relation to aims; limitations and triangulatio n addressed	Yes– findings presented as stages; co-researcher involved in preliminary analysis; credibility addressed	Yes – findings discussed in relation to aims; generalisa bility discussed	Yes – findings related to aims, limitations of sample addressed

CASP Criteria	Cale et al., 2020	Chase et al., 2006	Evans et al., 2015	Fox & Butler, 2007	Kendal et al., 2011	Kendal et al 2014	McGeechan et al., 2019	McKeague et al., 2018	Prior, 2012	Segrott et al., 2013	Spencer et al., 2020
Valuable contribution?	Yes – contribution of findings discussed; future recommendations made	Partially – contribution of findings discussed, limited reference to transferability; no recommendations for future research	Yes – contribution of findings discussed, recommendations for future research made	Yes - contribution of findings discussed; implications discussed	Yes – contribution of findings discussed in context of exploratory stage of intervention development	Yes – contribution outlined, suggestions for research and practice offered	Yes - contribution of findings discussed in relation to prior literature, practical implications and future research ideas discussed	Yes – findings discussed in relation to existing literature, research and clinical implications offered	Yes – findings discussed in relation to theory and literature; practice implications offered	Yes – findings discussed in relation to existing literature, research and clinical implications offered	Yes – contribution of findings highlighted; future recommendations made

Appendix C
Extract of coded data

Prior, 2012	Coding
"Well, my guidance teacher, she spoke to me and she explained everything clearly to me and she said that once I'd tried it for the first time, if I didn't want to go back, I didn't have to. It was up to me."	Giving young people choice
A shared theme across the stories of these conversations is the facilitator's promotion of the young person's agency, control and self-determination: the counselling is presented as a service which they may choose to access, in order to assess if it meets their needs, as they define them, and which they are free to stop at any time.	Promoting agency in young people
In some accounts, the facilitator emphasises the counsellor's expertise in areas where other school staff are not always equipped.	Emphasising the expertise of an external facilitator
"Mrs Jones suggested it, because she felt that it wouldn't help me, or do me any good, to continue talking to her, it would be better if I spoke to someone who would know more and be probably able to help me more than she could."	Trusted adult promotes engagement
Yet the unfamiliarity and separateness of the counsellor also provided reassurance that the concerns they need to discuss will be kept separate from the rest of their lives and information will not flow out in ways which have unwanted consequences.	External facilitation promotes confidentiality
For Alison, the counsellor's separateness was a key factor in her decision to engage: "I had like an anger management thing in here, but if you told them anything like confidential, like anything that happens at home, they have to go and tell the Head to see if you need social work or anything. Especially, cos, like, they're teachers in the school as well, like, maths teachers and that. So I stopped going to that. And then that's how I knew I wanted somebody that I could talk to that wouldn't go back and tell anybody about it."	Perception that teachers are obliged to break confidentiality Internal facilitation prohibits engagement
Stigmatisation concerns loom large. These are eloquently conveyed in Maria's recollection of her pre-engagement fears: "I was like that, I'm gonna get to hear, like, there's something wrong with me or something like that. People would think, like, I'm psycho or that."	Stigma associated with help-seeking Fear of judgement

Appendix D
Themes developed in qualitative synthesis

Theme	Subtheme	Codes	Quote	Corresponding theme from included papers
Impact of school context	School as venue	School perceived as familiar and comfortable	“It was quite good doing it in school, ‘cause we’re all comfortable with our surroundings [...] whereas if we done it in a place we’ve never been to before, we’d be a bit, like, on edge” McKeague et al., 2018	‘Impact of the organisational context’ Kendal et al., 2014
		Public setting limits confidentiality	"Two students suggested that a different location might be beneficial, with one expressing the concern that privacy and confidentiality might not be fully assured in the school setting" McKeague et al., 2018	‘Lack of confidentiality’ Kendal et al., 2014 ‘Confidentiality’ Fox & Butler, 2007
		Need for a discreet venue	“People don’t actually see you going into the room...Yes, they do, it’s on the Year 9 corridor!" Fox & Butler, 2007	
		Need for an easily accessible venue	"It needs to be easy to find and pupils need to be told where it is" Fox & Butler, 2007	
	Balancing demands of school day	Positive and negative aspects of missing lessons/activities	“They took us out of lessons, that you kind of needed to be in, working towards the exam” Cale et al., 2020 “I loved it! It just really helped me like, having a break from school, for what was a positive thing” Cale et al., 2020	‘Barriers to attending a school-based intervention’ McKeague et al., 2018
		Time commitment too great	"Students did not feel able to give up the amount of time that was required" McKeague et al., 2018	
	Profile within school community	Poor awareness warrants promotion	"Participants also felt it was important that the availability of support should be better	‘Awareness of the school counselling service’ Fox & Butler, 2007

Theme	Subtheme	Codes	Quote	Corresponding theme from included papers
			advertised, therefore normalising help-seeking" Spencer et al., 2020	
Intervention factors	Referral processes	Self-referral promotes engagement	"Students spoke in favour of the self-referral route....most acted independently prompted by awareness of personal need combined with publicity in school" Kendall et al., 2011	
		Promoting choice and agency	"My guidance teacher spoke to me and she explained everything clearly to me and said that once I'd tried it for the first time, if I didn't want to go back, I didn't have to. It was up to me" Prior, 2012	
		Support from trusted adult to engage	"Backing from Mrs Smith [that helped me go]. I didn't actually know what to expect really" Prior, 2012	
		Positive impact of being targeted	"Faye said she felt lucky and special to have been chosen" Evans et al., 2015	
		Unhelpful consequences of being targeted	"We thought we were being picked on because we were like, stupid" Cale et al., 2020	'Negative labelling: inspiring resistance and rejection' Evans et al., 2015
	Internal or external facilitation	Dual teacher-facilitator role as problematic	"There was consensus between the students that they should be wary of trusting staff, particularly teachers, with personal information" Kendal et al., 2014	
		Expertise of external facilitator	"Counsellor's expertise in areas where other school staff are not always equipped" Prior, 2012	
		Preference to disclose to non-teaching staff	"You kind of felt that even though they were older than you, you were kind of in the same	

Theme	Subtheme	Codes	Quote	Corresponding theme from included papers
			boat, you were on the same level" Segrott et al., 2013	'Delivery by pastoral and support staff' - Kendal et al., 2011
		Non-teacher facilitation supports trust in confidentiality	"The unfamiliarity and separateness of the counsellor also provided reassurance that the concerns they needed to discuss will be kept separate from the rest of their lives and information will not flow out in ways which would have unwanted consequences" Prior, 2012	
	Timing of intervention	Need for earlier intervention	"Participants felt that it was important that support should be offered to young people at an early stage, before the development of potentially serious mental health issues" Spencer et al., 2020	
		Proximity to exams as unhelpful	"Young people expressed concerns over their timings and particularly their proximity to examinations" Cale et al., 2020	
Young people factors	Role of stigma	Self-stigma	"On the other, there was a clutch of risks that had to be considered, including feeling inadequate for needing help' Kendal et al., 2014	
		Fear that help-seeking risks exposure and judgement	"Stigmatisation concerns loom large as they consider what other people might think if they discovered the young person was in counselling" Prior, 2012	'Students' fear of emotional exposure in school; weighing up the risks' Kendal et al., 2014 'The risk of others finding out' Fox & Butler, 2007
	Perceived need	Interest in receiving support	"I know some people who have been ... and she is fully booked and they haven't been able to go and see her for like 23 weeks" Fox & Butler, 2007	

Theme	Subtheme	Codes	Quote	Corresponding theme from included papers
		Rather manage independently	“[CYP] reported feeling able to cope with stress by themselves” – McKeague et al., 2018	
	Response of peers	Indifference	" Young people felt that others simply would not care whether they were doing it or not" McGeechan et al., 2019	‘Discussing participation with those not part of the group’ McGeechan et al., 2019
		Jealousy	“One young person in particular discussed that his friends had been quite jealous when they heard he got out of class to take part” McGeechan et al., 2019	
		Curiosity	""It’s during lesson time and they want to know why you’re going out" Fox & Butler, 2007	

Appendix E
Research Ethics Committee letter of favourable ethical opinion

This has been removed from the electronic copy

Appendix F
Health Research Authority letter of approval

This has been removed from the electronic copy

Appendix G
R&D approvals for recruiting staff for research

This has been removed from the electronic copy

Appendix H
Round 1 participant information sheet

Information about the research

Project Title: A Delphi survey investigating the implementation of a new workforce of school-based mental health practitioners

Hello, my name is Becky Forsyth and I am a trainee clinical psychologist at Salomons Institute for Applied Psychology.

I would like to invite you to take part in my doctoral research study into Children's Wellbeing Practitioner/Education Mental Health Practitioner services based in schools.

Before you make your decision, it is important that you understand why I am conducting this research and what taking part would involve.

What is the purpose of the study?

Children's Wellbeing Practitioners (CWPs) and Education Mental Health Practitioners (EMHPs) have started working with young people in schools over the last three years.

This workforce was introduced by the Government to provide a service to young people experiencing anxiety or low mood, without attending CAMHS.

This is a new initiative and at present we don't know a lot about how it is being experienced by the different groups of people involved.

I am using a type of research called a Delphi survey, which involves three different stages, to find out what people think of this new service and to seek ideas on how it could be improved in the future.

Why have I been invited to take part?

I am finding out what different people involved in this new way of working think. I am expecting that everyone involved will have different but equally important points of view. I am talking to CWP/EMHPs, their supervisors, and school link workers.

I am hoping to put all these peoples' thoughts and ideas together to get an overall view of what everyone thinks and to generate ideas on how to improve the continued roll out of this new workforce.

Do I have to take part?

No. Taking part is entirely voluntary; it is completely up to you if you would like to take part. You are not obliged to take part as part of your job.

If you do decide to take part, you are free to change your mind at any point during the research without having to give a reason.

What will happen if I take part?

This research involves three stages.

You can decide if you want to take part in all three stages or Stages 2 and 3 only.

<u>Stage 1:</u>

If you would like to take part in Stage 1 and you are a CWP/EMHP or school link worker, you will be asked to complete an online questionnaire about what you think is good and bad about CWP/EMHPs working in schools and how you think this service could be improved in future. If you prefer, you could also complete this questionnaire with me by telephone. If you complete this questionnaire over the phone, it will be audio recorded over speakerphone, to allow me to transcribe this information.

If you would like to take part in Stage 1 and you are a CWP/EMHP supervisor, you can choose if you would like to complete this questionnaire online or with me by telephone. This would be audio recorded over speakerphone, to allow me to transcribe this information. Once transcribed, all interview data will be destroyed.

Stage 2:

Stage 2 involves filling in an online questionnaire that will be sent to you by email. This questionnaire will comprise a list of statements put together from ideas that people had at Stage 1. You will be asked to rate how much you agree with each statement.

Stage 3:

A few weeks after Stage 2, I will send a final questionnaire to complete by email. This will look very similar to the questionnaire you answered in Stage 2 but will show how your scores compare with those of other people. You will be asked to rate how much you agree with each statement again. The reason you will be asked to do this for a second time is that there is a chance you might change your mind when you see what other people have answered.

As a thank you for taking part, you will be entered to a prize draw for a chance to win a £20 Amazon voucher for each of the three rounds you participate in.

How long will it take?

The Stage 1 questionnaires/phone interview would take around 20 minutes to complete.

The Stage 2 and 3 questionnaires should take around 15-20 minutes to complete.

There will be a few weeks' gap between each stage.

What are the possible benefits of taking part?

The information you share will help us to understand more about how this initiative is being experienced in schools and will inform recommendations made to improve these services.

What are the possible risks of taking part?

Taking part will use up some of your free time as you will need to answer the questionnaires outside your normal working hours.

During the three rounds of the study, there may be some repetition in the sort of questions asked which could feel a little tiresome. This reason we do things that way is to see if we can get different groups of stakeholders to agree about what is important about having CWPs and EMHPs in schools.

It might feel difficult to give feedback about the initiative that isn't entirely positive. However, this feedback will not be linked to you personally, and is important information for us to know about in improving services in the future.

How will I use information about you?

I will need to use information from you for this research project.

This information will include your age, gender, ethnicity, professional title, and your level of involvement with the initiative.

I will keep all information about you safe and secure.

I will write my report in a way that no-one can work out that you took part in the study.

Will participation be confidential?

Yes. We will follow ethical and legal practice and all information will be handled in confidence.

I would only share information with other professionals if I have reason to be worried about someone's safety. All information and notes from the study will be made anonymous and kept in a secure place.

Information from the study will be stored securely at Salomons Institute for Applied Psychology for five years after the project is complete and will then be destroyed.

What if there is a problem?

If you have any concerns or complaints about anything to do with the study during participation, please do not hesitate to contact me by email (bf103@canterbury.ac.uk) or phone (01227 927070) and I will do my best to answer any questions you have.

If I am not able to answer your questions in a satisfactory way, and you would like to talk to someone further about anything that you were not happy with, you can contact Dr Fergal Jones, the Research Director at Salomon's Institute for Applied Psychology (Tel: 01227 927110 or Email: fergal.jones@canterbury.ac.uk).

If you would like to contact the Data Protection Officer for the Sponsor, please email Deborah Chadwick on deborah.chadwick@canterbury.ac.uk or call 01227 927074.

What will happen if I begin taking part but then decide that I don't want to carry on with the study?

You can stop being part of the study at any time, without giving a reason, but we will keep information collected from you that we already have for analysis.

If you choose to stop taking part in the study and would like information collected from you until this point to be deleted and not used for analysis, this will be respected.

Who is organising and funding the research?

This research project forms part of the assessment for my Doctorate in Clinical Psychology training programme. The study is funded and organised by Salomons Institute for Applied Psychology which is part of Canterbury Christ Church University.

Who has reviewed the study?

All research conducted in the NHS is looked at by an independent group of people (Research Ethics Committee) to protect participants' interests. This group of people look at the plans of a research study before it begins and agree for the study to go ahead if it meets high standards for keeping participants safe from any potential harm. This study has been reviewed to make sure that I am working in a safe way by the London Central REC and has been granted Health Research Authority Approval (Reference: 20/LO/0450)

What will happen to the results of the research study?

When the research is finished it will be written up in a report which will be available to everyone who has taken part. The results of the research may be published in a scientific journal, online and in print. You will not be identified in any report or publication.

The results of the study will also form part of my doctoral thesis to become a qualified clinical psychologist.

Taking part

You might like to talk to someone about this information and whether you would like to participate. If you have questions to ask, then please do contact me by emailing bf103@canterbury.ac.uk or leaving a voicemail at 01227 927070 and I will get back to you as soon as I can.

If following this you decide to take part, you can access the relevant Round 1 questionnaire using the following links. I hope to complete recruitment for Round 1 over the next few weeks.

If you are a school-based CWP or EMHP:
https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_1YNtHg7pim82X1r

If you are a school link worker: https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_5A2AvgPvIVYKybj

If you are a supervisor: https://cccusocialsciences.az1.qualtrics.com/jfe/form/SV_9RdWuyLGQ1SehEN

Thank you for your interest in this research study

Appendix I
Round 2 participant information sheet

Information about the research

Project Title: A Delphi survey investigating the implementation of a new workforce of school-based mental health practitioners

Hello, my name is Becky Forsyth, I am a trainee clinical psychologist at Salomons Institute for Applied Psychology.

I would like to invite you to take part in my doctoral research study into Children's Wellbeing Practitioner/Education Mental Health Practitioner services based in schools.

Before you make your decision, it is important that you understand why I am conducting this research and what taking part would involve.

What is the purpose of the study?

Children's Wellbeing Practitioners (CWPs) and Education Mental Health Practitioners (EMHPs) have started working with young people in schools over the last three years.

This workforce was introduced by the Government to provide a service to young people experiencing anxiety or low mood, without attending CAMHS.

This is a new initiative and at present we don't know a lot about how it is being experienced by the different groups of people involved.

I am using a type of research called a Delphi survey to find out what people think of this new service and to seek ideas on how it could be improved in the future.

Why have I been invited to take part?

I am finding out what different people involved in this new way of working think. I am expecting that everyone involved will have different but equally important points of view. I am talking to CWP/EMHPs, their supervisors, and school link workers.

I am hoping to put all these peoples' thoughts and ideas together to get an overall view of what everyone thinks and to generate ideas on how to improve the continued roll out of this new workforce.

Do I have to take part?

No. Taking part is entirely voluntary; it is completely up to you if you would like to take part. You are not obliged to take part as part of your job.

If you do decide to take part, you are free to change your mind at any point during the research without having to give a reason.

What will happen if I take part?

This research is comprised of three stages.

I have completed Stage 1 of the research. This involved asking CWP/EMHPs, their supervisors and school link workers about what they think is good and bad about CWP/EMHPs working in schools and how this service could be improved in future.

I am now recruiting participants to complete Stage 2. You are invited and eligible to take part in Stage 2 whether you took part in Stage 1 or not.

<u>Stage 2:</u>

Stage 2 involves completing this online questionnaire. This questionnaire is comprised of a list of statements put together from ideas that people had at Stage 1. You will be asked to rate how much you agree with each statement and select the three statements you consider to be most important.

Stage 3:

A few weeks after Stage 2, I will send you another questionnaire to complete by email. This will look very similar to the questionnaire you answered in Stage 2 but will show how your scores compare with those of other people. You will be asked to re-rate how much you agree with each statement and which you think are most important. The reason you will be asked to do this for a second time is that there is a chance you might change your mind when you see what other people have answered.

To be eligible to complete the Stage 3 questionnaire, you must have responded to the Stage 2 questionnaire.

As a thank you for taking part, you will be entered to a prize draw for a chance to win a £20 Amazon voucher for each of the three rounds you participate in.

How long will it take?

The Stage 2 and 3 questionnaires should take around 15-20 minutes to complete.

There will be a few weeks' gap between stages.

What are the possible benefits of taking part?

The information you share will help us to understand more about how this initiative is being experienced in schools and will inform recommendations made to improve these services.

What are the possible risks of taking part?

Taking part will use up some of your free time as you will need to answer the questionnaires outside your normal working hours.

During the different rounds of the study, there may be some repetition in the sort of questions asked which could feel a little tiresome. This reason we do things that way is to see if we can get different groups of stakeholders to agree about what is important about having CWPs and EMHPs in schools.

It might feel difficult to give feedback about the initiative that isn't entirely positive. However, this feedback will not be linked to you personally, and is important information for us to know about in improving services in the future.

How will I use information about you?

I will need to use information from you for this research project.

This information will include your age, gender, ethnicity, professional title, and your level of involvement with the initiative.

I will keep all information about you safe and secure.

I will write my report in a way that no-one can work out that you took part in the study.

Will participation be confidential?

Yes. We will follow ethical and legal practice and all information will be handled in confidence.

I would only share information with other professionals if I have reason to be worried about someone's safety. All information and notes from the study will be made anonymous and kept in a secure place.

Information from the study will be stored securely at Salomons Institute for Applied Psychology for five years after the project is complete and will then be destroyed.

What if there is a problem?

If you have any concerns or complaints about anything to do with the study during participation, please do not hesitate to contact me by email (bf103@canterbury.ac.uk) or phone (01227 927070) and I will do my best to answer any questions you have.

If I am not able to answer your questions in a satisfactory way, and you would like to talk to someone further about anything that you were not happy with, you can contact Dr Fergal Jones, the Research Director at Salomon's Institute for Applied Psychology (Tel: 01227 927110 or Email: fergal.jones@canterbury.ac.uk).

If you would like to contact the Data Protection Officer for the Sponsor, please email Deborah Chadwick on deborah.chadwick@canterbury.ac.uk or call 01227 927074.

What will happen if I begin taking part but then decide that I don't want to carry on with the study?

You can stop being part of the study at any time, without giving a reason, but we will keep information collected from you that we already have for analysis.

If you choose to stop taking part in the study and would like information collected from you until this point to be deleted and not used for analysis, this will be respected.

Who is organising and funding the research?

This research project forms part of the assessment for my Doctorate in Clinical Psychology training programme. The study is funded and organised by Salomons Institute for Applied Psychology which is part of Canterbury Christ Church University.

Who has reviewed the study?

All research conducted in the NHS is looked at by an independent group of people (Research Ethics Committee) to protect participants' interests. This group of people look at the plans of a research study before it begins and agree for the study to go ahead if it meets high standards for keeping participants safe from any potential harm. This study has been reviewed to make sure that I am working in a safe way by the London Central REC and has been granted Health Research Authority Approval (Reference: 20/LO/0450).

What will happen to the results of the research study?

When the research is finished it will be written up in a report which will be available to everyone who has taken part. The results of the research may be published in a scientific journal, online and in print. You will not be identified in any report or publication.

The results of the study will also form part of my doctoral thesis to become a qualified clinical psychologist.

Taking part

You might like to talk to someone about this information and whether you would like to participate. If you have questions to ask, then please do contact me by emailing bf103@canterbury.ac.uk or leaving a voicemail at 01227 927070 and I will get back to you as soon as I can.

Thank you for your interest in this research study

Appendix J
Round 3 participant information sheet

Information about the research

Project Title: A Delphi survey investigating the implementation of a new workforce of school-based mental health practitioners

Hello, my name is Becky Forsyth, I am a trainee clinical psychologist at Salomons Institute for Applied Psychology.

I would like to invite you to take part in my doctoral research study into Children's Wellbeing Practitioner/Education Mental Health Practitioner services based in schools.

Before you make your decision, it is important that you understand why I am conducting this research and what taking part would involve.

What is the purpose of the study?

Children's Wellbeing Practitioners (CWPs) and Education Mental Health Practitioners (EMHPs) have started working with young people in schools over the last three years.

This workforce was introduced by the Government to provide a service to young people experiencing anxiety or low mood, without attending CAMHS.

This is a new initiative and at present we don't know a lot about how it is being experienced by the different groups of people involved.

I am using a type of research called a Delphi survey to find out what people think of this new service and to seek ideas on how it could be improved in the future.

Why have I been invited to take part?

I am finding out what different people involved in this new way of working think. I am expecting that everyone involved will have different but equally important points of view. I am talking to CWP/EMHPs, their supervisors, and school link workers.

I am hoping to put all these peoples' thoughts and ideas together to get an overall view of what everyone thinks and to generate ideas on how to improve the continued roll out of this new workforce.

Do I have to take part?

No. Taking part is entirely voluntary; it is completely up to you if you would like to take part. You are not obliged to take part as part of your job.

If you do decide to take part, you are free to change your mind at any point during the research without having to give a reason.

What will happen if I take part?

This research is comprised of three stages.

I have completed Stages 1 and 2 and am now inviting participants to complete the third and final stage.

Stage 1 involved asking CWP/EMHPs, their supervisors and school link workers about what they think is good and bad about CWP/EMHPs working in schools and how this service could be improved in future.

Stage 2 involved asking CWP/EMHPs, their supervisors and school link workers to complete an online questionnaire comprised of a list of statements put together from ideas that people had at Stage 1.

Participants rated how far they agreed with each statement and selected the three statements they considered to be most important.

Stage 3 involves completing a final online questionnaire. This questionnaire looks very similar to the one you completed at Stage 2, but shows how your ratings compare with those of other people.

This questionnaire asks you to re-rate how much you agree with each statement and pick three statements that you think are the most important. The reason you are being asked to do this for a second time is that there is a chance you might change your mind when you see what other people have answered.

As a thank you for taking part, you will be entered to a prize draw for a chance to win a £20 Amazon voucher for each of the three rounds you participate in.

How long will it take?

The Stage 3 questionnaire should take around 15-20 minutes to complete.

What are the possible benefits of taking part?

The information you share will help us to understand more about how this initiative is being experienced in schools and will inform recommendations made to improve these services.

What are the possible risks of taking part?

Taking part will use up some of your free time as you will need to answer the questionnaires outside your normal working hours.

During the different rounds of the study, there may be some repetition in the sort of questions asked which could feel a little tiresome. This reason we do things that way is to see if we can get different groups of stakeholders to agree about what is important about having CWPs and EMHPs in schools.

It might feel difficult to give feedback about the initiative that isn't entirely positive. However, this feedback will not be linked to you personally, and is important information for us to know about in improving services in the future.

How will I use information about you?

I will need to use information from you for this research project.

This information will include your age, gender, ethnicity, professional title, and your level of involvement with the initiative.

I will keep all information about you safe and secure.

I will write my report in a way that no-one can work out that you took part in the study.

Will participation be confidential?

Yes. We will follow ethical and legal practice and all information will be handled in confidence.

I would only share information with other professionals if I have reason to be worried about someone's safety. All information and notes from the study will be made anonymous and kept in a secure place.

Information from the study will be stored securely at Salomons Institute for Applied Psychology for five years after the project is complete and will then be destroyed.

What if there is a problem?

If you have any concerns or complaints about anything to do with the study during participation, please do not hesitate to contact me by email (bf103@canterbury.ac.uk) or phone (01227 927070) and I will do my best to answer any questions you have.

If I am not able to answer your questions in a satisfactory way, and you would like to talk to someone further about anything that you were not happy with, you can contact Dr Fergal Jones, the Research Director at Salomon's Institute for Applied Psychology (Tel: 01227 927110 or Email: fergal.jones@canterbury.ac.uk).

If you would like to contact the Data Protection Officer for the Sponsor, please email Deborah Chadwick on deborah.chadwick@canterbury.ac.uk or call 01227 927074.

What will happen if I begin taking part but then decide that I don't want to carry on with the study?

You can stop being part of the study at any time, without giving a reason, but we will keep information collected from you that we already have for analysis.

If you choose to stop taking part in the study and would like information collected from you until this point to be deleted and not used for analysis, this will be respected.

Who is organising and funding the research?

This research project forms part of the assessment for my Doctorate in Clinical Psychology training programme. The study is funded and organised by Salomons Institute for Applied Psychology which is part of Canterbury Christ Church University.

Who has reviewed the study?

All research conducted in the NHS is looked at by an independent group of people (Research Ethics Committee) to protect participants' interests. This group of people look at the plans of a research study before it begins and agree for the study to go ahead if it meets high standards for keeping participants safe from any potential harm. This study has been reviewed to make sure that I am working in a safe way by the London Central REC and has been granted Health Research Authority Approval (Reference: 20/LO/0450).

What will happen to the results of the research study?

When the research is finished it will be written up in a report which will be available to everyone who has taken part. The results of the research may be published in a scientific journal, online and in print. You will not be identified in any report or publication.

The results of the study will also form part of my doctoral thesis to become a qualified clinical psychologist.

Taking part

You might like to talk to someone about this information and whether you would like to participate. If you have questions to ask, then please do contact me by emailing bf103@canterbury.ac.uk or leaving a voicemail at 01227 927070 and I will get back to you as soon as I can.

Thank you for your interest in this research study

Appendix K
Round 1 CWP/EMHP questionnaire

I have read and understood the information sheet (Dated: 19/06/2020, Version: 3); I have been able to ask questions about the research, and have had any questions answered

I agree
I do not agree

I understand that I do not have to take part in this study and that I can stop being part of the study at any time, without having to give a reason

I agree
I do not agree

I understand that the study involves completing three questionnaires

I agree
I do not agree

I understand that I can complete the first questionnaire via telephone interview if this is more convenient for me

I agree
I do not agree

I understand that my responses may be looked at by the project supervisors and I give permission for this

I agree
I do not agree

I understand that my responses will be kept strictly confidential

I agree
I do not agree

I agree that anonymous quotes from my responses may be used in published reports of the study findings. I understand that my name or any other identifiable information will not appear anywhere in the final report

I agree
I do not agree

I understand that I will be entered to a prize draw to receive a £20 Amazon voucher as a thank you gift for completing this questionnaire

I agree
I do not agree

I agree to take part in the study

I agree
I do not agree

I would like to receive a copy of the main findings of this study (via email):

Yes
No

Name of participant:

Email address:

Demographic information
Please provide your:

Age	
Gender	
Ethnicity	

Are you a trainee or qualified school-based CWP or EMHP?

- Trainee CWP
- Qualified CWP
- Trainee EMHP
- Qualified EMHP

Where did you train as a CWP/EMHP (University and host Trust)?

How long have you been practicing as CWP/EMHP, including your training year?

What made you decide to take up this training?

Please briefly outline the interventions you use in your role as a school-based CWP/EMHP

What do you like about being based in schools?

In your opinion, how do CWP/EMHP interventions fit with existing provision in the schools you have worked in?

In your opinion, how far do the interventions you have been trained in meet the needs of the young people you have worked with?

What have been the main challenges you have experienced as a school-based CWP/EMHP?

How were these challenges overcome?

Please describe any practical issues you have encountered, both good and bad:

Please describe any issues to do with communication you have encountered, both good and bad:

How have you been supported in your role (including by your training organisation and in post)?

Do you have any thoughts about how successful this support has been, or what could be improved about the support you receive?

In your opinion, how could the introduction of CWP/EMHPs in schools be improved?

Do you have any final thoughts or feedback you would like to share about your work as a CWP/EMHP in schools that it would be useful for me to know?

Thank you very much for taking the time to complete this questionnaire.

You have now been entered into the prize draw for this round of the research study.

Please contact Becky Forsyth (bf103@canterbury.ac.uk) if you have any questions.

Appendix L
Round 1 school link worker questionnaire

I have read and understood the information sheet (Dated: 19/06/2020, Version: 3); I have been able to ask questions about the research, and have had any questions answered

I agree
I do not agree

I understand that I do not have to take part in this study and that I can stop being part of the study at any time, without having to give a reason

I agree
I do not agree

I understand that the study involves completing three questionnaires

I agree
I do not agree

I understand that I can complete the first questionnaire via telephone interview if this is more convenient for me

I agree
I do not agree

I understand that my responses may be looked at by the project supervisors and I give permission for this

I agree
I do not agree

I understand that my responses will be kept strictly confidential

I agree
I do not agree

I agree that anonymous quotes from my responses may be used in published reports of the study findings. I understand that my name or any other identifiable information will not appear anywhere in the final report

I agree
I do not agree

I understand that I will be entered to a prize draw to receive a £20 Amazon voucher as a thank you gift for completing this questionnaire

I agree
I do not agree

I agree to take part in the study

I agree
I do not agree

I would like to receive a copy of the main findings of this study (via email):

Yes
No

Name of participant:

Email address:

Demographic information
Please provide your:

Age	
Gender	
Ethnicity	
Job Title	

How long have you had a CWP/EMHP in your school?

How did you end up becoming a school 'link worker' for this initiative?

How early in the introduction of CWP/EMHPs to your school were you involved?

Did you have an existing interest in initiatives like this?

What have been the benefits of having a CWP/EMHP in your school?

What have been the main challenges of having a CWP/EMHP in your school?

Please describe any specific practical issues you have encountered:

Please describe any specific communication issues you have encountered:

How have these challenges been addressed?

In your opinion, how far do CWP/EMHP interventions meet the needs of young people in your school?

In your opinion, how far do CWP/EMHP interventions fit with existing provision in your school?

In your opinion, how could the role of CWP/EMHP develop to best meet the needs of schools?

In your opinion, how could the introduction of CWP/EMHPs in schools be improved?

Do you have any final thoughts or feedback you would like to share about how the CWP/EMHP role has been implemented in your school?

Thank you very much for taking the time to complete this questionnaire.

You have now been entered into the prize draw for this round of the research study.

Please contact Becky Forsyth (bf103@canterbury.ac.uk) if you have any questions.

Appendix M
Round 1 supervisor questionnaire

I have read and understood the information sheet (Dated: 19/06/2020, Version: 3); I have been able to ask questions about the research, and have had any questions answered

I agree
I do not agree

I understand that I do not have to take part in this study and that I can stop being part of the study at any time, without having to give a reason

I agree
I do not agree

I understand that the study involves completing three questionnaires

I agree
I do not agree

I understand that I can complete the first questionnaire via telephone interview if this is more convenient for me

I agree
I do not agree

I understand that my responses may be looked at by the project supervisors and I give permission for this

I agree
I do not agree

I understand that my responses will be kept strictly confidential

I agree
I do not agree

I agree that anonymous quotes from my responses may be used in published reports of the study findings. I understand that my name or any other identifiable information will not appear anywhere in the final report

I agree
I do not agree

I understand that I will be entered to a prize draw to receive a £20 Amazon voucher as a thank you gift for completing this questionnaire

I agree
I do not agree

I agree to take part in the study

I agree
I do not agree

I would like to receive a copy of the main findings of this study (via email):

Yes
No

Name of participant:

Email address:

Demographic information
Please provide your:

Age	
Gender	
Ethnicity	
Job Title	

How long have you been involved in supervising CWP/EMHPs?

How did you come to the role of CWP/EMHP supervisor?

How early in the introduction of CWP/EMHPs to your Trust were you involved?

Did you have an existing interest in initiatives like this?

What has worked well in introducing CWP/EMHPs to schools in your area?

What have been the main challenges in introducing CWP/EMHPs to schools in your area?

Were these challenges expected or unexpected?

Please describe any specific practical issues you have encountered:

Please describe any specific communication issues you have encountered:

How have the challenges you have experienced been addressed?

How far are interventions offered by CWP/EMHPs appropriate to the needs of young people in schools? What could improve this?

How far do CWP/EMHP interventions fit with the ethos of schools in your area?

How far have CWP/EMHPs been able to embed to the schools they work in? What could improve this?

How has feedback from participating schools been so far?

How could the school-based CWP/EMHP role develop in future?

What factors do you think are most important to optimising the implementation of school-based CWP/EMHPs?

How could the continued roll-out of school-based CWP/EMHPs be best supported?

Do you have any final thoughts or feedback you would like to share about CWP/EMHPs in schools that it would be useful for us to know?

Thank you very much for taking the time to complete this questionnaire.

You have now been entered into the prize draw for this round of the research study.

Please contact Becky Forsyth (bf103@canterbury.ac.uk) if you have any questions.

Appendix N
Extract of coded data

Questionnaire data (school link worker)	Coding
They need to spend more time in the school - such as a whole day, rather than 3 hours to see 3 pupils. This is problematic for scheduling sessions, as there is very little choice of subjects they have to miss.	Not enough time in each school Timetabling/scheduling difficulties
If they spent longer within the school, they might be able to plan assemblies - reaching out to more students & generally have time to get to know some staff & how the school runs. They could also run small groups.	Needing time to embed in schools
They could help pupils in crisis & following up with them. Giving advice to staff on the best way to handle some of the mental health issues that arise.	Working with greater complexity of presenting problems
An easier referral system with a simpler form to fill in. A dedicated day a week in a particular school - to make planning easier.	Administrative burden
It would help if EMHPs were expected to attend school in the same way that teachers have to, in order to become more integrated and have better relationships with students & staff. To provide training and resources for members of the Inclusion team.	EMHPs as ‘external’ to schools Providing training, consultation and sign-posting to schools

Appendix O
Round 2 questionnaire

Welcome to the second stage of my research into Children's Wellbeing Practitioner/Education Mental Health Practitioner services in schools.
The next step of the Delphi survey involves completing a questionnaire comprised of a list of statements put together from participant responses at Stage 1.
You will be asked to rate how far you agree or disagree with each statement and select the three statements you consider to be most important.
Before proceeding, please take a moment to look over the participant information sheet attached below.
If you have any questions before you take part, please contact me by emailing bf103@canterbury.ac.uk

Thank you very much

I have read and understood the information sheet (Dated: 21/01/2021, Version: 4); I have been able to ask questions about the research, and have had any questions answered

I agree

I do not agree

I understand that I do not have to take part in this study and that I can stop being part of the study at any time, without having to give a reason

I agree

I do not agree

I understand that participating involves completing two questionnaires

I agree

I do not agree

I understand that my responses may be looked at by the project supervisors and I give permission for this

I agree

I do not agree

I understand that my responses will be kept strictly confidential

I agree

I do not agree

I agree that anonymous quotes from my responses may be used in published reports of the study findings. I understand that my name or any other identifiable information will not appear anywhere in the final report

I agree

I do not agree

I understand that I will be entered to a prize draw to receive a £20 Amazon voucher as a thank you gift for completing this questionnaire

I agree

I do not agree

I agree to take part in the study

I agree

I do not agree

I would like to receive a copy of the main findings of this study (via email):

Yes

No

Name of participant:

Email address:

Demographic information
Please provide your:

Age	
Gender	
Ethnicity	
Job Title	

Please rate how far you agree or disagree with each statement listed below

NB. 'Practitioners' is used to refer to school-based CWP/EMHPs

Establishing working practices with schools

	Strongly Disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
1. An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools	○	○	○	○	○	○
2. Practitioners' introduction to schools should be formalised through a meeting jointly attended by supervisors	○	○	○	○	○	○
3. Schools' understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources	○	○	○	○	○	○
4. Practitioners should act as the primary contact with schools	○	○	○	○	○	○
5. Schools' understanding of the CWP/EMHP role should be supported by communication from supervisors	○	○	○	○	○	○
6. The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters	○	○	○	○	○	○
7. All school teaching staff should be able to make referrals	○	○	○	○	○	○
8. Waiting list numbers should be limited to manage demand	○	○	○	○	○	○
9. Supervisors should act as the primary contact with schools	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Adapting to the needs and culture of schools

	Strongly disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
10. Practitioners should be treated as a member of staff in the schools they are based in	○	○	○	○	○	○
11. Practitioners should be based in fewer schools with greater time commitment in each	○	○	○	○	○	○
12. Practitioners should adapt their practice within their skill-set to suit the needs and requests of each school	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Effective and acceptable interventions

	Strongly disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
13. The low intensity interventions offered are appropriate to schools' needs	○	○	○	○	○	○
14. Mental health interventions are more accessible to young people when they are offered at school	○	○	○	○	○	○
15. The initiative means that young people's needs are met in a more timely fashion	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Practical issues

	Strongly disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
16. Demand on school staff means it can be hard to keep protected time for liaison with practitioners	○	○	○	○	○	○
17. At present, practitioners have low visibility within schools which can be a problem	○	○	○	○	○	○
18. The mental health needs of young people should be prioritised where timetabling difficulties occur	○	○	○	○	○	○
19. Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g. printing) to host a practitioner	○	○	○	○	○	○
20. The demands of administrative tasks should be minimised to prioritise time for sessions	○	○	○	○	○	○
21. Practitioners should be based in schools for the full school day	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Relationship to CAMHS

	Strongly disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
22. Over time, the initiative should reduce the number of referrals made to CAMHS	○	○	○	○	○	○
23. Through their work in schools, practitioners are identifying unmet need requiring input from CAMHS	○	○	○	○	○	○
24. Difficulty accessing CAMHS increases the complexity of referrals made to practitioners	○	○	○	○	○	○
25. Practitioners should act as a 'link' between schools and CAMHS	○	○	○	○	○	○
26. Integration with wider CAMHS should be promoted through practitioner presence at team base	○	○	○	○	○	○
27. Practitioners should be treated as CAMHS staff by colleagues in wider CAMHS	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Future development of the role

	Strongly disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
28. Practitioners should be given protected time to work on promoting a whole-school approach	○	○	○	○	○	○
29. Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep	○	○	○	○	○	○
30. Practitioners should receive training in providing training and consultation to school staff	○	○	○	○	○	○
31. Practitioners should be trained to work with more complex presentations such as self-harm, drug and alcohol use, and trauma-informed approaches	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Long-term strategy

	Strongly disagree	Moderately Disagree	Mildly Disgaree	Mildly Agree	Moderately Agree	Strongly Agree
32. Practitioners should be based in more schools to increase access across local authorities	○	○	○	○	○	○
33. Practitioners should practice with a high level of fidelity to the manualised interventions they are trained to deliver	○	○	○	○	○	○
34. Supervisors should support connection between school-based practitioners through regular team meetings	○	○	○	○	○	○
35. Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus	○	○	○	○	○	○
36. The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties	○	○	○	○	○	○
37. The initiative would benefit from a forum for Trusts to share best practice and problem-solve	○	○	○	○	○	○
38. There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools	○	○	○	○	○	○
39. Uncertainty around longer term funding means it is difficult for services to plan for the future	○	○	○	○	○	○
40. In future, schools should have the option to buy-in practitioner resource full-time	○	○	○	○	○	○

If you have any comments you would like to share about this section of statements, please write these below:

Please write below the numbers of the three statements (from all 40 statements above) that you consider to be most important

NB. These do not need to be ranked

1.

2.

3.

If you have any comments you would like to share about your responses, please write these below:

Thank you very much for taking the time to complete this questionnaire.

You have now been entered into the prize draw for this round of the research study.

Please contact Becky Forsyth (b.forsyth103@canterbury.ac.uk) if you have any questions.

Appendix P
Example Round 3 questionnaire

Welcome to the third and final stage of my research into Children's Wellbeing Practitioner/Education Mental Health Practitioner services in schools.

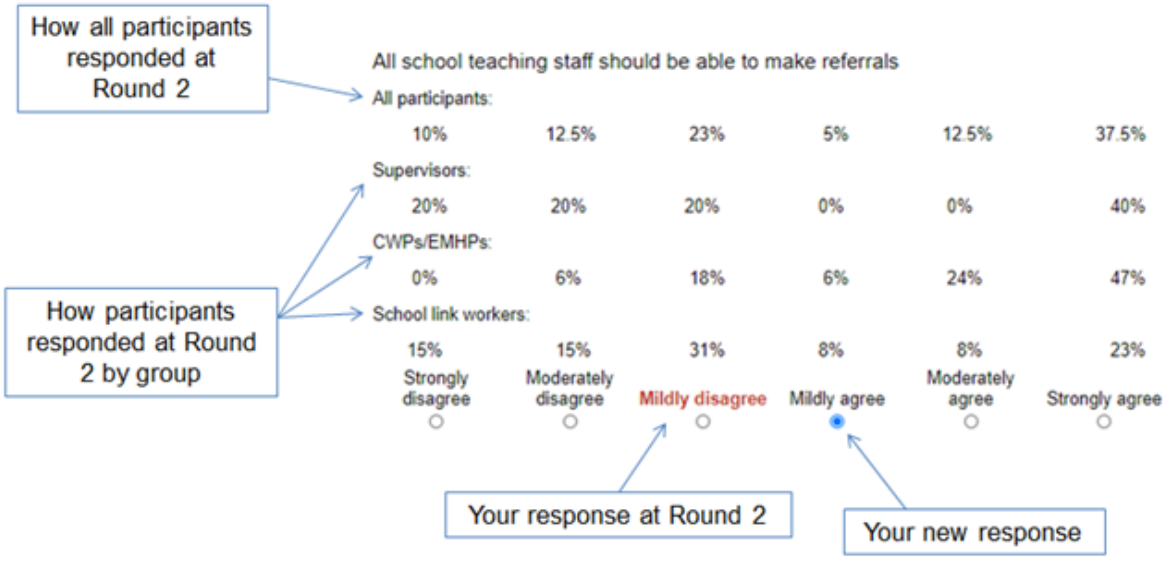
In this final questionnaire you will see the same statements shown in the previous round. This round uses fewer statements because ones reaching high levels of agreement last time have not been included again.

For each statement, you will be shown how all participants responded last time, overall and by group. Your previous response will be highlighted in **bold red.**
Participant comments from last time are also presented at the beginning of each section.

This is your opportunity to either change or validate your response to each statement.

If you would like to change your response, please select this from the Likert scale.
If you would like to keep the same response, please leave the boxes blank and move on to the next statement.

An example is shown below



You will also be shown which statements other participants chose as the most important in Round 2. You will be asked to re-rate the three statements you consider to be most important. Again, if you wish to choose the same statements as before, please leave the boxes blank.

Before proceeding, please take a moment to look over the participant information sheet attached below.

If you have any questions before you take part, please contact me by emailing bf103@canterbury.ac.uk.

Thank you very much
I have read and understood the information sheet (Dated: 19/02/2021, Version: 5); I have been able to ask questions about the research, and have had any questions answered
I agree
I do not agree

I understand that I do not have to take part in this study and that I can stop being part of the study at any time, without having to give a reason
I agree
I do not agree

I understand that participating involves completing one final questionnaire
I agree
I do not agree

I understand that my responses may be looked at by the project supervisors and I give permission for this
I agree
I do not agree

I understand that my responses will be kept strictly confidential
I agree
I do not agree

I agree that anonymous quotes from my responses may be used in published reports of the study findings. I understand that my name or any other identifiable information will not appear anywhere in the final report
I agree
I do not agree

I understand that I will be entered to a prize draw to receive a £20 Amazon voucher as a thank you gift for completing this questionnaire
I agree
I do not agree

I agree to take part in the study
I agree
I do not agree

Name:

Job title:

In the previous round, you were asked to rate how far you agree or disagree with the following statements.
Please look at the responses given by other participants in the previous round (presented as percentages overall and by group for each statement) and decide whether you would like to change your response or keep it the same.
Your previous responses are highlighted in **bold red** for each statement.
If you would like to change your response, please select this from the Likert scale.
If you would like to keep the same response, please leave the boxes blank and move on to the next statement.

Terminology:
'Practitioner' is used to refer to school-based CWPs/EMHPs;
'School link worker' is used to refer to members of school staff involved in hosting/liaising with a school-based CWP/EMHP;

'Supervisor' is used to refer to members of CAMHS staff supervising school-based CWPs/EMHPs

---

Establishing working practices

Participant comments from the previous round:

"I think the model works well when it is a joint point of contact between supervisors and practitioners"

"In some instances I feel it is best that practitioners are [point of contact] (e.g. there are a lot of schools and impractical for supervisors to be primary contact for all schools, gives practitioner autonomy and can build rapport), however at times I feel that the practitioner's remit and role is above them and instead it would be nice for supervisors to be more aware of schools, the relationships we have with schools, what we are doing in schools"

"The EMHP team works well by practitioners organising contact with their own schools and asking supervisors for support when schools are difficult to contact"

"Referrals need to be managed and prioritised by someone within the school. i.e. referrals should be made by any teacher to the school lead who then refers to EMHP"

"It is much better that the practitioner is [primary contact] communicating directly as they know the students"

"It's important that a limited number of staff make referrals - not all staff. There should be systems within a school where cases are triaged using the systems within the school to assess need / priority, rather than 'anyone' being able to refer"

"All staff should know how to refer and have an understanding of the service/type of case which may be appropriate for early intervention support GSH"

"I would not have time to be the primary contact in schools. It is important for CWPs and EMHPs to develop relationships with the link worker so that they routinely make contact with them after sessions"

"Definitely no to all school staff making direct referrals. They can recommend referrals to the link worker who is developing an understanding around referral thresholds. Initially, schools tend to refer the cases causing them the most concern - often these are not appropriate for cases for GSH"

All school teaching staff should be able to make referrals

All participants:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
10%	12.5%	23%	5%	12.5%	37.5%

Supervisors:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
20%	20%	20%	0%	0%	40%

CWPs/EMHPs:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
0%	6%	18%	6%	24%	47%

School link workers:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
15%	15%	31%	8%	8%	23%

Strongly disagree ○ Moderately disagree ○ Mildly disagree ○ Mildly agree ○ Moderately agree ○ **Strongly agree** ○

Waiting list numbers should be limited to manage demand

All participants:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
5%	8%	3%	33%	38%	15%

Supervisors:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
0%	10%	0%	30%	40%	20%

CWPs/EMHPs:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
12%	6%	0%	29%	47%	6%

School link workers:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
0%	8%	8%	38%	23%	23%

Strongly disagree ○ Moderately disagree ○ Mildly disagree ○ **Mildly agree** ○ Moderately agree ○ Strongly agree ○

Supervisors should act as the primary contact with schools

All participants:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
23%	30%	20%	15%	8%	5%

Supervisors:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
30%	30%	10%	20%	10%	0%

CWPs/EMHPs:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
29%	35%	18%	12%	0%	6%

School link workers:

Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
8%	31%	31%	15%	8%	8%

Strongly disagree ○ Moderately disagree ○ Mildly disagree ○ **Mildly agree** ○ Moderately agree ○ Strongly agree ○

If you have any comments you would like to share about this section of statements, please write these below:

Adapting to the needs and culture of schools

Participant comments from the previous round:

"Practitioners need to feel they are part of the school setting and have the opportunity to make relationships with staff, however for many families having a slight separation from school may help them form relationships with the practitioners"

"EMHPs are effectively peripatetic workers, they come into school to do their interventions and then return to base"

"It becomes difficult when confidentiality and risk comes up, as school and NHS have different processes. I also think that we don't always want to be seen as 'teachers' or 'staff' and for children who don't like school/teachers this is important. However it is important that EMHPs are seen as part of the school system for them to feel part of the school, otherwise they will always be seen as the outsider coming in which makes rapport and whole school approaches challenging"

Practitioners should be treated as a member of staff in the schools they are based in

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	0%	5%	13%	15%	38%	30%
Supervisors:	0%	20%	10%	20%	40%	10%
CWPs/EMHPs:	0%	0%	18%	18%	41%	24%
School link workers:	0%	0%	8%	8%	31%	54%

If you have any comments you would like to share about this section of statements, please write these below:

Effective and acceptable interventions

Participant comments from the previous round:

"There are times when low intensity interventions are not suitable to some young people, but the benefit

of having an EMHP means that we can directly signpost these young people into the appropriate service and ensure any referrals being sent to CAHMS are suitable"

"There needs to be a focus on exam stress, exam anxiety and perfectionism (if these are not already covered)"

"The interventions are appropriate to a sub-population - yes, but that isn't the same as according with the school's priorities which are likely to focus on a different sub-population with more severe and complex problems"

"The low intensity interventions meet some of the school needs, but [our] clients experience considerable social deprivation and I don't think these interventions always meet their needs. I still think there isn't sufficient provision in CAMHS above the MHSTs, eg a 2 year wait for assessment of ADHD and or ASD"

"By capturing early anxieties and behaviours will hopefully impact on CAMHS referrals in the future"

"The task with schools isn't really one of explaining low intensity interventions for mild-to moderate MH problems to schools – rather, it is one of persuading them that precious resource (theirs and ours) should be spent on CYP with mild problems rather than the CYP with severe and complex problems that preoccupy the school staff"

"We also need counsellors in schools who offer different work to GSH. GSH is very structured, and a lot of young people need counselling to talk about bullying, friendship issues, things going on at home, bereavement, trauma etc."

The low intensity interventions offered are appropriate to schools' needs

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	0%	3%	13%	13%	48%	25%
Supervisors:	0%	0%	10%	10%	40%	40%
CWPs/EMHPs:	0%	0%	12%	6%	65%	18%
School link workers:	0%	8%	15%	23%	31%	23%

If you have any comments you would like to share about this section of statements, please write these below:

Practical issues

Participant comments from the previous round:

"Some schools may not need a full day whereas other schools need more. It is difficult with a smaller team to manage this time. Admin is also a necessary part of the EMHP job and is difficult to minimise whilst maintaining high levels of communication"

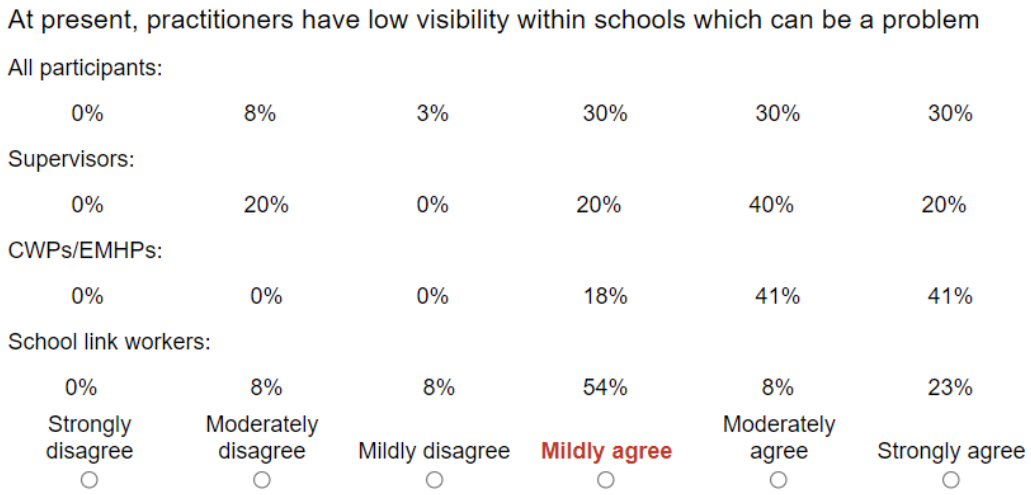
"Either a full day or half a day, however the schools would need to be relatively close"

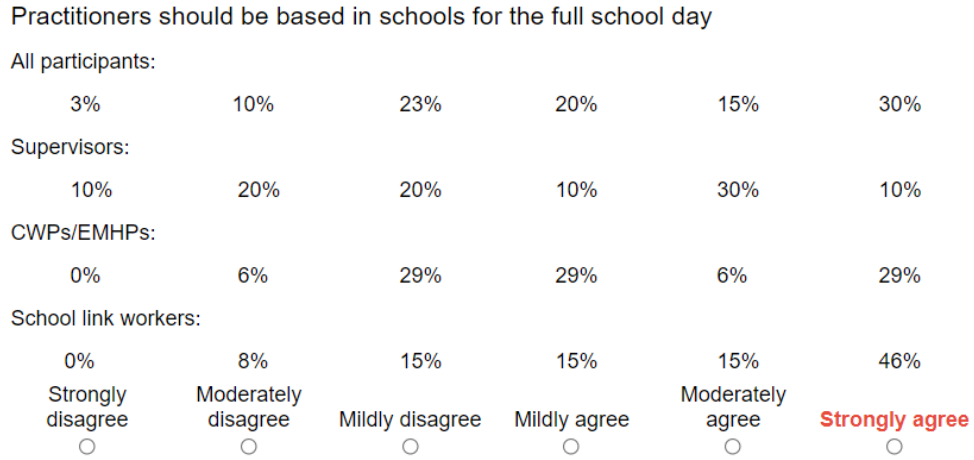
"It is important to consider the needs of the practitioner as well and if space is available to complete other tasks. Important for practitioners to also have therapeutic break in the day"

"The model of half a day at school and half a day at base works well as practitioners need to have a space to debrief with colleagues"

"Visibility can vary between schools. Some are proactive in promoting the service and gaining referrals, whereas, some are less so due to the demands on the Mental Health Leads"

"Practitioners definitely have low profile since Covid measures have been in place - schools have been working incredibly hard to literally keep the wheels on the bus"





If you have any comments you would like to share about this section of statements, please write these below:

Relationship to CAMHS

Participant comments from the previous round:

"I do not think EMHPs should be treated as part of CAMHS - as CAMHS has stigma attached to it that may potentially limit the amount of young people that would come forward for less intense early intervention"

"Being seen as CAMHS staff supports the step up and step down process, risk management, supervision and a team around the child approach"

"Intuitively it sounds a good idea for EMHPs to be the link between school and wider CAMHS, while they can offer brief advice I would not want this to be their role as they will get caught up in discussions that will take them away from their CYP practise"

"Tricky balance, for MHSTs not to get sucked too far into CAMHS, and end up emulating CAMHS systems/including long wait lists. They need to stay their course and focus on work in schools. I strongly feel therefore teams need to have a balance of clinical professionals as well as educational psychologists - as there needs to be an emphasis on a new way of working, not doing the same as CAMHS and getting stuck. MHSTs need to think systemically too, as well as having GSH as a robust base; they need to be able to also prioritise building capacity in schools"

Practitioners should act as a 'link' between schools and CAMHS

All participants:					
3%	3%	13%	18%	30%	35%
Supervisors:					
10%	10%	30%	40%	10%	0%
CWPs/EMHPs:					
0%	0%	12%	6%	41%	41%
School link workers:					
0%	0%	0%	15%	31%	54%
Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	**Moderately agree**	Strongly agree
○	○	○	○	○	○

Integration with wider CAMHS should be promoted through practitioner presence at team base

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	3%	5%	3%	20%	30%	40%
Supervisors:	0%	10%	0%	40%	50%	0%
CWPs/EMHPs:	0%	6%	6%	12%	18%	59%
School link workers:	8%	0%	0%	15%	31%	46%

Practitioners should be treated as CAMHS staff by colleagues in wider CAMHS

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	0%	3%	13%	13%	28%	45%
Supervisors:	0%	10%	20%	20%	20%	30%
CWPs/EMHPs:	0%	0%	18%	12%	12%	59%
School link workers:	0%	0%	0%	8%	54%	38%

If you have any comments you would like to share about this section of statements, please write these below:

Future development of the role

Participant comments from the previous round:

"I think practitioners should at least be given basic training in other mental health conditions outside of anxiety/depression/challenging behaviour. I recently had a case that included eating disorder linked behaviour and was unclear on what questions I specifically needed to ask in order to refer into CAMHS"

"I think there are so many different early interventions that the EMHP could offer and that would significantly reduce the current strain felt in CAMHS...Our team have recently produced materials around ASC/ADHD which I feel is also increasingly important, especially in primary schools"

"It is always important to have extra training around self-harm and emotional regulation, etc. However, as a CWP I would signpost young people and parents to more appropriate services, e.g. drug and alcohol and trauma services as I know they exist in our borough and we have links to these services and I feel I am not the right person to support with this. After all we are early intervention - mild-moderate"

"More training would be positive particularly around self harm as this is often a presenting concern. For some other approaches it would need to be considered if the young person would want to discuss that in school (pros and cons) and if this would keep it an early intervention service"

"I definitely agree that more training is required for practitioners to work with more complex presentations- self-harm doesn't always mean that the young person is high risk"

"Mostly no, a mild level of self harm, not drug and alcohol or trauma - CBT trainees could be better placed to work on these areas"

"Maintain early intervention approach. Wider training basis, would mean more approaches could be offered on a menu, because not all schools will want the same thing. Challenge is working out service priorities, as if you do more of one thing, you need to do less of something else"

"I feel there is a gap between the service we offer and the service CAMHS offer. If there were further training and CPD, or even CYP-IAPT CBT therapists built into the team, this means we could offer interventions to a greater population and this could include trauma informed approaches, more complex cases, etc. I don't think this is suitable for an EMHP to offer without the training"

"Expanding the scope of the EMHP role needs to be done in a measured way that co-evolves with the wider system"

"Having a clinical psychologist or higher band who can work across several schools, or expand CAMHS so that practitioners are available"

Practitioners should be trained to work with more complex presentations such as self-harm, drug and alcohol use, and trauma-informed approaches

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	3%	8%	10%	23%	23%	35%
Supervisors:	10%	30%	20%	30%	10%	0%
CWPs/EMHPs:	0%	0%	6%	24%	18%	53%
School link workers:	0%	0%	8%	15%	38%	38%

If you have any comments you would like to share about this section of statements, please write these below:

Long-term strategy

Participant comments from the previous round:

"Spreading the resource too thinly (in an effort to achieve equity / access hard to reach schools) and trying to be all things to all people / mission creep are 2 of the biggest existential threats to MHSTs"

"Sharing best practice = talking shop for bragging about 'creative' initiatives that are shiny but not sustainable - or likely even effective. Could be really good with the right framework / terms of reference"

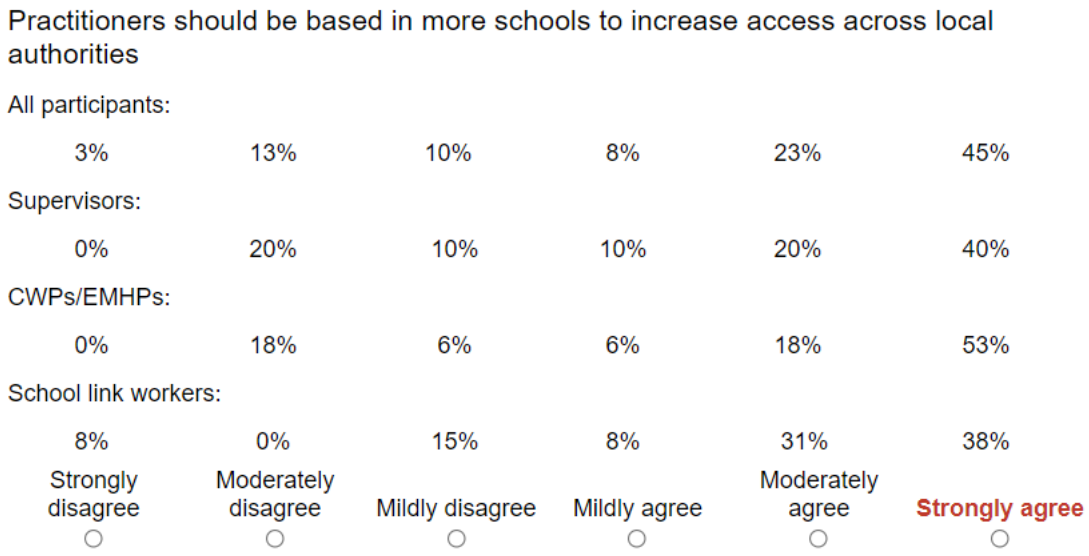
"The initial vision was very sound - but always vulnerable to mission creep"

"Funding needs to be secure so that the service can plan for the future and schools can commit to the service"

"There is still a big workforce issue around career pathways for EMHPs. These practitioners are usually highly capable people who want to pursue a career in CAMHS but there is little scope for progressing"

"I do not feel that schools should be able to buy in practitioner time - as this enables an unequal access for schools that are privately funded, have more money and therefore some of the poorest children in society will be unfairly impacted"

"The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties' - this is wholly dependant on whether there is an intention to train new staff/upskill existing staff. It is not fair to focus on more complex presentations with staff trained to work with mild/moderate cases"



Practitioners should practice with a high level of fidelity to the manualised interventions they are trained to deliver

All participants:

0%	8%	5%	23%	45%	20%

Supervisors:

0%	0%	0%	0%	50%	50%

CWPs/EMHPs:

0%	12%	12%	24%	41%	12%

School link workers:

0%	8%	0%	38%	46%	8%
Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	**Moderately agree**	Strongly agree

The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties

All participants:

8%	15%	15%	20%	23%	20%

Supervisors:

0%	0%	10%	30%	20%	40%

CWPs/EMHPs:

6%	24%	18%	24%	12%	18%

School link workers:

15%	15%	15%	8%	38%	8%
Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	**Strongly agree**

The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues

All participants:					
0%	3%	3%	23%	30%	43%
Supervisors:					
0%	0%	0%	20%	40%	40%
CWPs/EMHPs:					
0%	0%	6%	18%	18%	59%
School link workers:					
0%	8%	0%	31%	38%	23%
Strongly disagree ○	Moderately disagree ○	Mildly disagree ○	Mildly agree ○	Moderately agree ○	**Strongly agree** ○

There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools

All participants:					
0%	3%	8%	20%	28%	43%
Supervisors:					
0%	0%	10%	30%	20%	40%
CWPs/EMHPs:					
0%	0%	6%	12%	24%	59%
School link workers:					
0%	8%	8%	23%	38%	23%
Strongly disagree ○	Moderately disagree ○	Mildly disagree ○	Mildly agree ○	Moderately agree ○	**Strongly agree** ○

Uncertainty around longer term funding means it is difficult for services to plan for the future

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	3%	8%	8%	23%	15%	45%
Supervisors:	0%	30%	10%	10%	0%	50%
CWPs/EMHPs:	6%	0%	12%	18%	18%	47%
School link workers:	0%	0%	0%	38%	23%	38%

In future, schools should have the option to buy-in practitioner resource full-time

	Strongly disagree	Moderately disagree	Mildly disagree	Mildly agree	Moderately agree	Strongly agree
All participants:	5%	10%	10%	15%	33%	28%
Supervisors:	10%	10%	10%	10%	40%	20%
CWPs/EMHPs:	6%	6%	12%	12%	41%	24%
School link workers:	0%	15%	8%	23%	15%	38%

If you have any comments you would like to share about this section of statements, please write these below:

In Round 2, you were asked to select the three statements you thought were the most important.

A table attached here (Statement Rankings.docx) shows how all participants voted.

You chose statement **7, 24 and 40**

If you would like to change your top three statements now, please write them below (these do not need to be ranked).
If you would like to keep the same statements, please leave the box blank.

If you have any comments you would like to share about your choice of top three statements, please write these below:

Lastly, if you have any comments you would like to share about this final questionnaire, please write these below:

Thank you very much for taking the time to complete this questionnaire.

You have now been entered into the prize draw for this round of the research study.

This is the final round of the study. You will be contacted with a report of the study findings when they are available if you have requested this.

Please contact Becky Forsyth (bf103@canterbury.ac.uk) if you have any questions.

Appendix Q
Abridged extract from research diary

September 2020

I can finally begin recruitment! The ethics process ended up being very long and complicated. I feel like I almost lost touch with what the Delphi process actually involves in the midst of all the REC, HRA and R&D paperwork. At points, I regretted not applying for university ethics and recruiting via Twitter, but then I could not be sure who my participants were and how CWPs and EMHPs work in different areas.

November 2020

Thematic analysis of my Round 1 data has taken longer than anticipated. Due to delays with ethical approval, I notice I am feeling a sense of urgency about my work. My supervisor advised that I take some time away from the data before returning to it and revising my themes. I had a higher number of responses from CWPs and EMHPs and they tended to write longer responses to each question than supervisors or school link workers did. It was helpful to take a break and come back to it with 'fresh eyes.'

January 2021

I have been attending team meetings via Zoom to facilitate recruitment for Round 2. I am developing a sense that the infrastructure around MHSTs seems to have developed a lot since I worked as a CWP, where we felt quite niche within CAMHS. I remember clinicians sometimes asking who we were when we were at the team base, despite being several months into our posts.

March 2021

Despite the teams having expanded a lot since my work as a CWP, I am developing a sense from the data that lots of the issues coming up are familiar with my own experiences, for example, a desire from schools for support for young people they are most concerned about. The longevity of such issues indicates the importance of addressing them for the role to be most effective.

April 2021

I am feeling a little overwhelmed by how much data the Delphi method has generated as I start writing up. Although I recognise that the Delphi method is about developing consensus, it would be interesting to look at where and how far different participants change their ratings between rounds. For example, it looks like CWPs/EMHPs are more likely to change their responses than supervisors or school link workers, perhaps indicating their open-mindedness to perspectives of others.

From looking at the data, I am struck by the tendency of supervisors towards more 'mild' to 'moderate' positions. I wonder if supervisors, who are less involved 'on the ground' in schools, may see reasons 'for' and 'against' each statement. This reflects my experience across clinical psychology training, where I now feel better able to appreciate complexities around a given issue and find it harder to adopt a 'strong' view either way. If I were responding to my own Delphi questionnaires, I think I would probably respond "it depends" to most statements!

It was helpful to discuss this with my secondary supervisor. We spoke about what assumptions may underlie a participant's response. For example, CWPs/EMHPs may be motivated to receive further training and develop their competence as an individual but may be able to see the difficulties associated with delivering a greater range of interventions as a workforce overall.

Appendix R
Most important statements at R2 and R3

Choices of three most important statements at R2

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
29. Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep	10	3	1	14
31. Practitioners should be trained to work with more complex presentations such as self-harm, drug and alcohol use, and trauma-informed approaches	5	4	2	11
14. Mental health interventions are more accessible to young people when they are offered at school	4	3	2	9
30. Practitioners should receive training in providing training and consultation to school staff	1	3	2	6
11. Practitioners should be based in fewer schools with greater time commitment in each	3	1	1	5
16. Demand on school staff means it can be hard to keep protected time for liaison with practitioners	1	1	3	5
39. Uncertainty around longer term funding means it is difficult for services to plan for the future	1	2	2	5
1. An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools	3	1	0	4
12. Practitioners should adapt their practice within their skill-set to suit the needs and requests of each school	2	2	0	4
22. Over time, the initiative should reduce the number of referrals made to CAMHS	0	2	2	4

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
24. Difficulty accessing CAMHS increases the complexity of referrals made to practitioners	0	2	2	4
38. There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to school	3	0	1	4
6. The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters	2	1	0	3
19. Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g. printing) to host a practitioner	2	1	0	3
27. Practitioners should be treated as CAMHS staff by colleagues in wider CAMHS	2	1	0	3
28. Practitioners should be given protected time to work on promoting a whole-school approach	2	1	0	3
32. Practitioners should be based in more schools to increase access across local authorities	2	1	0	3
33. Practitioners should practice with a high level of fidelity to the manualised interventions they are trained to deliver	0	0	3	3
40. In future, schools should have the option to buy-in practitioner resource full-time	0	3	0	3
7. All school teaching staff should be able to make referrals	0	1	1	2
13. The low intensity interventions offered are appropriate to schools' needs	0	0	2	2
15. The initiative means that young people's needs are met in a more timely fashion	0	1	1	2
17. At present, practitioners have low visibility within schools which can be a problem	0	1	1	2

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
23. Through their work in schools, practitioners are identifying unmet need requiring input from CAMHS	2	0	0	2
25. Practitioners should act as a ‘link’ between schools and CAMHS	1	0	1	2
34. Supervisors should support connection between school-based practitioners through regular team meetings	2	0	0	2
36. The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties	1	0	1	2
2. Practitioners’ introduction to schools should be formalised through a meeting jointly attended by supervisors	0	1	0	1
4. Practitioners should act as the primary contact with schools	0	0	1	1
5. Schools’ understanding of the CWP/EMHP role should be supported by communication from supervisors	1	0	0	1
10. Practitioners should be treated as a member of staff in the schools they are based in	0	1	0	1
18. The mental health needs of young people should be prioritised where timetabling difficulties occur	0	1	0	1
21. Practitioners should be based in schools for the full school day	0	1	0	1
35. Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus	0	0	1	1
37. The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues	1	0	0	1
3. Schools’ understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources	0	0	0	0
8. Waiting list numbers should be limited to manage demand	0	0	0	0

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
9. Supervisors should act as the primary contact with schools	0	0	0	0
20. The demands of administrative tasks should be minimised to prioritise time for sessions	0	0	0	0
26. Integration with wider CAMHS should be promoted through practitioner presence at team base	0	0	0	0

Choices of three most important statements at R3

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
29. Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep	11	4	1	16
31. Practitioners should be trained to work with more complex presentations such as self-harm, drug and alcohol use, and trauma-informed approaches	5	5	2	12
14. Mental health interventions are more accessible to young people when they are offered at school	4	3	1	8
30. Practitioners should receive training in providing training and consultation to school staff	3	2	1	6
39. Uncertainty around longer term funding means it is difficult for services to plan for the future	2	2	1	5
1. An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools	3	1	0	4
11. Practitioners should be based in fewer schools with greater time commitment in each	3	1	0	4
16. Demand on school staff means it can be hard to keep protected time for liaison with practitioners	1	1	2	4
32. Practitioners should be based in more schools to increase access across local authorities	2	2	0	4
38. There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools	3	0	1	4
19. Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g. printing) to host a practitioner	2	1	0	3
6. The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters	2	0	0	2

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
12. Practitioners should adapt their practice within their skill-set to suit the needs and requests of each school	0	2	0	2
13. The low intensity interventions offered are appropriate to schools' needs	0	0	2	2
15. The initiative means that young people's needs are met in a more timely fashion	0	1	1	2
22. Over time, the initiative should reduce the number of referrals made to CAMHS	0	2	0	2
24. Difficulty accessing CAMHS increases the complexity of referrals made to practitioners	0	1	1	2
25. Practitioners should act as a 'link' between schools and CAMHS	1	0	1	2
27. Practitioners should be treated as CAMHS staff by colleagues in wider CAMHS	1	1	0	2
28. Practitioners should be given protected time to work on promoting a whole-school approach	2	0	0	2
33. Practitioners should practice with a high level of fidelity to the manualised interventions they are trained to deliver	0	0	2	2
34. Supervisors should support connection between school-based practitioners through regular team meetings	2	0	0	2
2. Practitioners' introduction to schools should be formalised through a meeting jointly attended by supervisors	0	1	0	1
4. Practitioners should act as the primary contact with schools	0	0	1	1
7. All school teaching staff should be able to make referrals	0	0	1	1
10. Practitioners should be treated as a member of staff in the schools they are based in	0	1	0	1

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
17. At present, practitioners have low visibility within schools which can be a problem	0	0	1	1
18. The mental health needs of young people should be prioritised where timetabling difficulties occur	0	1	0	1
23. Through their work in schools, practitioners are identifying unmet need requiring input from CAMHS	1	0	0	1
35. Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus	0	0	1	1
37. The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues	1	0	0	1
40. In future, schools should have the option to buy-in practitioner resource full-time	0	1	0	1
3. Schools' understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources	0	0	0	0
5. Schools' understanding of the CWP/EMHP role should be supported by communication from supervisors	0	0	0	0
8. Waiting list numbers should be limited to manage demand	0	0	0	0
9. Supervisors should act as the primary contact with schools	0	0	0	0
20. The demands of administrative tasks should be minimised to prioritise time for sessions	0	0	0	0
21. Practitioners should be based in schools for the full school day	0	0	0	0
26. Integration with wider CAMHS should be promoted through practitioner presence at team base	0	0	0	0

Statement	CWPs/EMHPs	School link workers	Supervisors	Overall
36. The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties	0	0	0	0

Appendix S
End of study notification form and letter sent to HRA, REC, and R&D departments

End of study notification form has been removed from the electronic copy

Dear colleagues

I am writing to briefly summarise my major research project conducted as part of my clinical psychology doctoral training.

This research was sponsored by Canterbury Christ Church University. The research received favourable ethical opinion from the London Central Research Ethics Committee and was approved by the Health Research Authority. A summary of the research and the results are detailed below.

Title

A Delphi survey investigating the implementation of a new workforce of school-based mental health practitioners

Background

In the context of increased concern around the mental health of children and young people, schools have been promoted as a setting to provide early intervention. Representing significant investment by the UK Government, new school-based practitioners have been introduced to provide targeted low intensity guided self-help. However, evidence-based interventions are often not adopted and sustained successfully when introduced to new contexts. It was therefore important to explore the implementation of this new workforce and identify factors that facilitate and impede their work in schools to support the initiative's continued roll-out.

Aims

This research achieved its aim to explore different professionals' experiences of CWP/EMHP implementation in schools and identify areas of agreement and disagreement between stakeholder groups.

Method

A three-round Delphi survey was employed. Thematic analysis of first-round questionnaire data informed the development of a second-round questionnaire that was completed by 10 supervisors, 13 school staff and 17 CWPs/EMHPs. A third-round questionnaire was used to finalise consensus within and between groups.

Results

Overall, consensus between professional stakeholder groups was high. Participants agreed that mental health interventions are more accessible when they are provided in schools. Participants recognised the importance of developing relationships and shared understandings of the initiative within schools, and the need to overcome practical issues to create conditions that facilitate successful working.

Results also highlighted challenges associated with translating mental health interventions to the education context and different priorities in partnership working emerged. Reconciling where school-based practitioners fit between CAMHS and schools emerged as challenging. Participants agreed that a greater range of interventions should be offered, however it is important that school-based practitioners continue to practice within their level of training and competence. A tension between prioritising quality of service and equality of access was also identified.

Findings also demonstrated the need to facilitate dialogue between local collaborators to recognise and resolve issues together in supporting implementation. To promote sustainability of this workforce, it is crucial that resources invested in recruiting and training practitioners are matched by measured, strategic thinking.

Ideas for future practice that showed strong agreement or lacked agreement between participant groups are shown below.

Dissemination

A summary of the research findings has been disseminated to participants. This research will be submitted to a peer-reviewed journal for publication (journal to be confirmed)

If you have any questions or would like to discuss the research, please contact me using the details provided below.

Yours sincerely

Becky Forsyth
Trainee Clinical Psychologist

Salomons Institute for Applied Psychology
1 Meadow Road
Tunbridge Wells
TN1 2YG
Email: bf103@canterbury.ac.uk

Ideas that achieved strong consensus between professional groups

- An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools
- Practitioners' introduction to schools should be formalised through a meeting jointly attended by supervisors
- Schools' understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources
- Practitioners should act as the primary contact with schools
- Schools' understanding of the CWP/EMHP role should be supported by communication from supervisors
- The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters
- Supervisors should act as the primary contact with schools (participants strongly disagreed)
- Practitioners should be treated as a member of staff in the schools they are based in
- Practitioners should be based in fewer schools with greater time commitment in each
- The mental health needs of young people should be prioritised where timetabling difficulties occur
- Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g., printing) to host a practitioner
- The demands of administrative tasks should be minimised to prioritise time for sessions
- Integration with wider CAMHS should be promoted through practitioner presence at team base
- Practitioners should be given protected time to work on promoting a whole-school approach
- Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep
- Practitioners should receive training in providing training and consultation to school staff
- Supervisors should support connection between school-based practitioners through regular team meetings
- Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus
- The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues
- There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools

Ideas that lacked consensus between professional groups

- All school teaching staff should be able to make referrals
- Practitioners should be based in schools for the full school day
- The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties

Appendix T
End of study report for participants

Dear participant

Thank you for taking part in my research on the introduction of CWPs and EMHPs in schools. It would not have been possible to carry out this research without the valuable contributions of all participants, especially given the challenges presented to our work during the COVID-19 pandemic. I am pleased to say that the research is now complete, and I am writing to provide a summary of the main findings.

The research aimed to explore different professionals' experiences of CWP/EMHP implementation in schools and identify areas of agreement and disagreement between professional groups. 44 participants took part across three rounds of the Delphi survey.

Overall, consensus between professional groups was high. Participants agreed that mental health interventions are more accessible when they are provided in schools. Participants recognised the importance of developing relationships and shared understandings of the initiative within schools, and the need to overcome practical issues to create conditions that facilitate successful working.

Results also highlighted challenges associated with translating mental health interventions to the education context. Reconciling where school-based practitioners fit between CAMHS and schools requires further work. Participants agreed that a greater range of interventions should be offered, however it is also important that school-based practitioners continue to practice within their level of training and competence. A tension between prioritising quality of service and equality of access was identified.

Our findings also demonstrated the need to facilitate dialogue between schools and the NHS to recognise and resolve issues together in supporting implementation. To promote sustainability of this workforce, it is crucial that resources invested in recruiting and training practitioners are matched by measured, strategic thinking.

Ideas for future practice that showed strong agreement or lacked agreement between participant groups are shown below.

Ideas that achieved strong consensus

- An understanding of the role of CWP/EMHPs and the manualised interventions they are trained to deliver should be promoted within schools
- Practitioners' introduction to schools should be formalised through a meeting jointly attended by supervisors
- Schools' understanding of the CWP/EMHP role should be supported through written materials and sharing of manualised resources
- Practitioners should act as the primary contact with schools
- Schools' understanding of the CWP/EMHP role should be supported by communication from supervisors
- The initiative should be promoted to staff and young people in schools through assemblies, workshops and posters
- Supervisors should act as the primary contact with schools (participants strongly disagreed)
- Practitioners should be treated as a member of staff in the schools they are based in
- Practitioners should be based in fewer schools with greater time commitment in each
- The mental health needs of young people should be prioritised where timetabling difficulties occur
- Schools should be required to guarantee access to appropriate clinical space, storage, and facilities (e.g., printing) to host a practitioner
- The demands of administrative tasks should be minimised to prioritise time for sessions
- Integration with wider CAMHS should be promoted through practitioner presence at team base
- Practitioners should be given protected time to work on promoting a whole-school approach
- Current low intensity interventions offered should be expanded, for example, working with emotional regulation, perfectionism and sleep
- Practitioners should receive training in providing training and consultation to school staff

- Supervisors should support connection between school-based practitioners through regular team meetings
- Contributing to the development of an evidence-base for low intensity interventions in schools, such as through collecting routine outcome measures, should be a key focus
- The initiative would benefit from a forum for Trusts to share best practice and problem-solve issues
- There is greater need for strategic planning, for example, in anticipating demand and how to timetable training sessions to schools

Ideas that lacked consensus

- All school teaching staff should be able to make referrals
- Practitioners should be based in schools for the full school day
- The purpose of the initiative should not be expanded beyond providing early intervention for mild/moderate mental health difficulties

I plan to submit my research to be published in a peer reviewed journal in due course. I will also share my findings with the London and South East CYP IAPT Learning Collaborative.

Thank you again for taking part. I hope that our findings can help to inform the continued roll-out of the MHST initiative. If you have any questions or comments about the research, please do not hesitate to contact me.

With best wishes
Becky Forsyth
Trainee Clinical Psychologist

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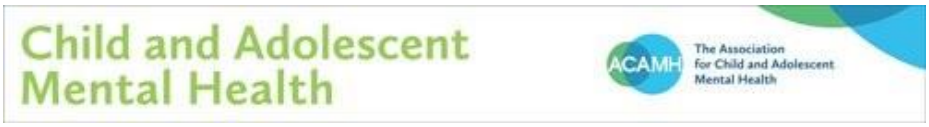
Appendix U
'Child and Adolescent Mental Health' author guidelines



1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Innovations in Practice; Narrative Matters; Debate Articles.

CAMH considers the fact that services are looking at treating young adults up until the age of 25, with the evidence that brains continue to develop until the age of 25, as well as the fact that a lot of issues that affect young adults and students are also relevant and topical to older adolescents. CAMH offers a discretionary approach and will take into consideration papers that extend into young adulthood, if they are pertinent developmentally to the younger population and contribute further to a developmental perspective across adolescence and early adult years.

Authors are asked to remember that CAMH is an international journal and therefore clarification should be provided for any references that are made in submitted papers to the practice within the authors' own country. This is to ensure that the meaning is clearly understandable for our diverse readership. Authors should make their papers as broadly applicable as possible for a global audience.

Original Articles: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

Review Articles: These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

Innovations in Practice: These papers report on any new and innovative development that could have a major impact on evidence-based practice, intervention and service models.

Narrative Matters: These papers describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences.

Debate Articles: These papers express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: **http://mc.manuscriptcentral.com/camh_journal** and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from the Editorial Office at ACAMH (email: **publications@acamh.org**)

4. Authors' professional and ethical responsibilities

Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Preprints
CAMH will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article. Please find the Wiley preprint policy **here**.

Recommended guidelines and standards
The Journal requires authors to conform to CONSORT 2010 (see **CONSORT Statement**) in

relation to the reporting of randomised controlled clinical trials; also recommended is the **Extensions of the CONSORT Statement** with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix.

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the **PRISMA Statement**. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis, as well as a completed PRISMA Checklist. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g. The International Prospective Register of Systematic Reviews, or PROSPERO).

The **Equator Network** is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work **http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields** and on quasi-experimental **http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research** and mixed method designs **http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond**

Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Key Practitioner Message: Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

Keywords: Please provide 4-6 keywords use **MeSH Browser** for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style,

avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at **http://authorservices.wiley.com/bauthor/english_language.asp**. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that he or she had full access to all the data in the study and takes responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

10. For referencing, *CAMH* follows a slightly adapted version of APA Style **http:www.apastyle.org/**. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.
See **http://authorservices.wiley.com/bauthor/illustration.asp** for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Original Articles
Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice. Adult data is not usually accepted for publication unless it bears directly on developmental issues in childhood and adolescence.

Your Original Article should be no more than 5,500 words including tables, figures and references.

Review Articles
Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the **PRISMA statement**. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

Manuscript Processing
Peer Review Process: All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE **http://publicationethics.org/resources/guidelines** and ICMJE **http://icmje.org/** best practice.

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