“I Feel Like We Experience It Differently To Them…”

A Participatory Approach To School Mental Health Services

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Abstract

The mental health and wellbeing of children and young people, both in the UK and globally, is a growing concern, with evidence of increased anxiety and depression. Schools in Wales are central to Welsh government strategies for responding to these issues, with the introduction of counselling and the adoption of a whole-school approach framework. While a wealth of research has examined prevalence, risk factors and barriers to access, there is less insight into how young people themselves perceive school-based mental health support, and how services might be designed from their perspective.

The study adopts a children's rights framework to explore how pupils understand and experience school-based mental health support services. Using a mixed methods design, it combined survey data with semi-structured, paired interviews and a pupil focus group.

Findings highlighted both structural and cultural barriers to support, such as a lack of clarity about how to access services, stigma and long waiting lists. There were clear gender differences, with girls more likely to identify barriers and boys more often describing personal challenges in relation to help-seeking. Pupils also identified facilitators to accessing services, such as positive relationships with staff and a variety of support services, and suggested improvements, including greater autonomy in accessing services and person-centred provision.

This study contributes to the existing literature by foregrounding the perspectives of young people. It demonstrates that even where provision is available, pupils often experience services as difficult to access or not responsive to their needs. Implications include the importance of meaningful pupil participation, ensuring that young people's views are heard by those in a position to act upon them, strengthening mental health literacy, and ensuring that services are co-produced with pupils. In doing so, schools can move toward more accessible support models that align with children's rights.

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Final recognition goes to the young person who inspired this research. I hope this can help shape a positive change for young people.

Contents

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Abbreviations and Glossary

ARTICLE	A specific section or clause within the UNCRC that outlines a particular right or a governmental obligation concerning children
BACP	British Association for Counselling and Psychotherapy
BERA	British Educational Research Association
CRC	Committee on the Rights of the Child
CRIA	Children’s Rights Impact Assessment
D of E	Department of Education
DoH	Department of Health
ESTYN	Official inspectorate for education and training in Wales
GENERAL COMMENT	Official interpretation of the treaty's articles and principles issued by the UN Committee on the Rights of the Child. They are used to guide implementation and address emerging issues.
GENERAL PRINCIPLE	Four fundamental principles that underpin all other articles in the Convention, guiding their interpretation and implementation
ITE	Initial Teacher Education
NHS	National Health Service
UNCRC	United Nations Convention on the Rights of the Child
WSA	Whole School Approach
WSA Framework	Welsh Government's Whole School Approach (WSA) to Emotional and Mental Wellbeing

Table 1.1 UNCRC Articles Relevant to the Study and Their Application

UNCRC Article	Article focus	Relevance to the study	Application within the thesis
Article 2	Non-discrimination	Ensures that children's rights to mental health support and participation apply to all pupils, including those with protected characteristics under the Equality Act.	Frames the rights-based approach; it informs methodological reflections on inclusion and representation.
Article 3	Best interests of the child	Establishes the obligation for decision-making in schools and services to prioritise children's wellbeing and outcomes.	Informs analysis of school practices, referral processes, and service design.
Article 6	Right to life, survival and development	Recognises mental health and emotional wellbeing as fundamental to children's development.	Underpins discussion of early intervention, whole-school approaches, and preventative support.
Article 12	Right to be heard	Central to the focus on pupil voice and participation in shaping school-based mental health support.	Core to the research design and methods; informs data collection, analysis, and interpretation of pupil perspectives.
Article 17	Right to information	Highlights children's entitlement to accessible, appropriate information about mental health and available support.	Informs analysis of pupils' knowledge of services, help-seeking behaviour, and mental health literacy.
Article 24	Right to the highest attainable standard of health	Establishes mental health as a children's rights issue and supports access to appropriate services.	Frames the discussion of school-based counselling, referral pathways, and service accessibility.
Article 29	Aims of education	Emphasises the role of education in supporting children's holistic development, including emotional wellbeing.	Supports the integration of mental health and wellbeing within whole-school approaches.

Chapter 1 Introduction

The mental health and wellbeing of children and young people are a growing concern in the United Kingdom and worldwide. Over the past two decades, evidence has shown rising rates of emotional distress, anxiety, and depression among children and adolescents (Gunnell et al., 2018; Moore et al., 2022). The COVID-19 pandemic further exacerbated these challenges by disrupting education and support systems and increasing social isolation (Cowie & Myers, 2021). This emphasises the need to find effective ways to support young people's wellbeing.

Children's rights provide a fundamental framework for considering these challenges. Children and young people are entitled to the same fundamental human rights as adults, along with additional rights that acknowledge their unique needs. The Convention on the Rights of the Child sets out the essential rights children need to reach their full potential, ensuring their dignity, wellbeing, and development. By recognising children's rights as separate from adult human rights, children are acknowledged as individuals with equal status in society. The United Nations Convention on the Rights of the Child (UNCRC) (1989), ratified by the UK in 1991, affirms children's rights to health (Article 24), to education directed to their fullest development (Article 29), and to be heard in all matters affecting them (Article 12). Wales has taken number of steps to incorporate the UNCRC into domestic law and policy, including *The Rights of Children and Young Persons (Wales) Measure* (2011), the *Children's Rights Scheme* (Welsh Government, 2021c), and the adoption of the *'Right Way'* (Children's Commissioner for Wales, 2017) framework, which highlights embedding rights, equality, participation, and accountability within government and public services.

One of the key bodies for addressing the issues of increasingly poor mental health and securing children's rights is education. Schools are increasingly seen by the Welsh Government as key delivery partners for realising children's rights and supporting wellbeing. The introduction of the *Framework on Embedding a Whole-School Approach to Emotional and Mental WellBeing* (Welsh Government, 2021a), (hereafter referred to as the WSA Framework), made it a statutory requirement for educational settings to adopt a whole-school approach (WSA). Based upon the values of belonging, efficacy and voice, the WSA Framework aims to develop positive school climates in which wellbeing is prioritised. Alongside the statutory duty to provide school counselling from Year 6 onwards, it reflects a strong policy commitment to addressing children's mental health needs in schools.

However, important questions remain about how young people themselves experience these policies. While a growing body of research has examined the prevalence and causes of poor mental health in young people (Kelly et al., 2018; Harrison et al., 2022), less attention has been given to how children perceive and engage with the mental health support available to them in schools, and specifically, what student-designed services might look like. A logical way to explore these perceptions is through participatory opportunities; however, criticisms of participation in schools suggest that 'pupil voice' initiatives, defined in the broadest sense by Whitty & Wisby (2007) as any opportunities pupils have to share their views and preferences, are often tokenistic (Lundy, 2007; Tisdall, 2015; Jayman & Quickfall, 2024). This raises concerns that children's legal right to be heard is not always realised in meaningful ways. In parallel, while whole-school approaches have been promoted as effective in supporting wellbeing (Moore et al., 2018; Hewitt et al., 2022), their impact on pupil mental health remains unknown.

This thesis addresses the gap in understanding pupil perceptions of mental health services by exploring how young people at a school in Wales perceive and experience mental health and wellbeing support, and how these experiences intersect with children's rights to be heard. The study employs a mixed-methods approach to gather both breadth and depth of data, including a survey of pupils to ensure wide participation and inclusivity, semi-structured interviews to explore individual experiences in greater detail, and a focus group to facilitate collective reflection and the development of ideas among peers.

The terms 'mental health' and 'wellbeing' are used in this thesis and are defined as follows:

Mental health: Defined by the World Health Organisation as "*a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community*" (WHO, 2022. Para.1). The WHO goes on to define mental health conditions as "*mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm*" (WHO, 2022 Para. 3).

Many children experiencing mental health conditions either do not meet the threshold for clinical support or go clinically unidentified and, as such, do not access specialist services (Davies, 2014; Patton et al., 2016). This thesis will focus on the area of mental health conditions in relation to young people who are not in clinical services, where they may be noticed in schools in the form of emotional and behavioural difficulties. These are typically measured using the Strengths and Difficulties Questionnaire (SDQ). Emotional difficulties such as anxiety and depression are associated with distress, impairment and an impact on long-term outcomes (Anthony et al., 2024).

Wellbeing: good wellbeing encompasses happiness, life satisfaction, sense of purpose, and self-acceptance. It is typically measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) (Bell et al., 2019).

1.1 Research aims and questions

This study aims to explore young people's experiences of accessing school-based mental health support through a children's rights lens, with a particular focus on how pupils themselves experience participation and decision-making. The study adopts a child-centred orientation that recognises young people as experts in their own lives and as active contributors to the development of services that affect them.

The research seeks to foreground children's voices in order to better understand both the barriers to, and the facilitators of, access to mental health support in school settings.

The central research questions guiding the study are:

1. What do young people think are the barriers and facilitators to accessing mental health support in schools?

2. How would young people make mental health support services in schools more accessible to pupils?
3. What would a pupil-designed mental health support service in schools look like?

The following chapter situates these questions within existing literature on children's rights, school-based mental health provision, and Whole School Approaches to wellbeing.

The thesis is structured as follows:

Chapter 2 reviews the existing literature on children's mental health, analysing trends and prevalence, with a particular focus on the Welsh context. It then discusses children's rights, critiques of the UNCRC, and emphasises the rights to participation, health, and information, before again considering the Welsh context. **Chapter 3** examines the role of schools in supporting children's mental health, exploring whole-school approaches and wellbeing services, and pupils' experiences of these.

Chapter 4 outlines the methodological approach, which includes adopting critical realism as a theoretical framework, a mixed-methods design, and ethical considerations for conducting research with children and young people.

Chapters 5 and 6 present the findings from the survey and qualitative stages of the research, identifying broad patterns and exploring more in-depth perspectives.

Chapter 7 discusses the implications of these findings, linking them to existing theory and policy, and considering how schools can more effectively embed participatory approaches to mental health and wellbeing.

Finally, **Chapter 8** concludes by summarising the study's key contributions, reflecting on its limitations, and identifying directions for future research and policy development.

Chapter 2 – Literature review

2.1 Introduction

The chapter begins by examining existing research into young people's mental health. It then reviews policy and literature on the realisation of children's rights. Next, it explores literature and policy on the role of schools in supporting pupils' mental health, as well as pupils' experiences of mental health support. Finally, it considers research on the opportunities available for young people to participate in school decision-making and service design. The issues discussed will help me situate my findings within the broader literature and reflect on the contribution this thesis aims to make to the field. The following subsection outlines the approach taken to the selection and analysis of literature included in this review.

2.1.1 Literature review methodology

This literature review was designed to provide a broad, interdisciplinary understanding of school-based mental health support through a children's rights lens. A narrative review approach was adopted, as this method is appropriate for synthesising literature across multiple disciplines and sources, including academic research, policy documentation, and grey literature (Baumeister & Leary, 1997).

Literature was identified through searches of academic databases, including APA PsycINFO (via Ovid), ASSIA, Scopus, Google Scholar, and Cardiff University Library Search. Search terms were combined using Boolean operators and included variations of the following: children's rights, adolescent mental health, school-based support, pupil voice, participation, whole-school *approach*, and *wellbeing*. Policy and grey literature were identified through targeted searches of relevant organisational and governmental websites, including the Welsh Government, Department for Education, NHS, UNICEF UK, and YoungMinds. This dual approach was necessary due to the policy-driven nature of school-based mental health provision in Wales and the significance of children's rights within legislative and strategic frameworks.

The review included sources published primarily between 2008 and 2025, reflecting the introduction and development of school-based counselling in Wales, the incorporation of the United Nations Convention on the Rights of the Child into Welsh law, and the development of the WSA Framework with its approach to mental health and wellbeing. Earlier foundational texts on children's rights, participation, and adolescent mental health were included as needed to establish the key theoretical and conceptual frameworks underpinning the analysis. Sources were included if they focused on children or adolescents, school-based mental health support, children's rights or participation. Clinical studies focused exclusively on diagnosis or treatment within specialist health settings, as well as literature focused solely on adult populations, were excluded.

In total, 196 sources were included in the review. These comprised journal articles, policy documents, and grey literature, with approximately half drawn from peer-reviewed publications. Of the policy sources, fifteen were Welsh Government documents and associated guidance, reflecting the central role of devolved policy in shaping school-based mental health provision and children's rights in Wales. The inclusion of policy documents was essential to understanding how children's rights and mental health support are conceptualised, implemented, and operationalised within the Welsh education system.

Following identification, sources were read iteratively and analysed using a thematic approach (Braun & Clarke, 2006). Themes such as social media use, academic pressure, and the COVID-19 pandemic emerged inductively through repeated references in the literature on adolescent mental health. These themes were not treated as discrete explanations but as interconnected factors shaping young people's experiences. More recent policy documents and empirical studies were prioritised where they directly related to current statutory requirements or practice in Welsh schools.

2.2. The state of young people's mental health

This section will consider the current state of children's mental health in the UK, exploring some of the factors that are contributing to the decline in mental health, such as social media, academic pressure and the COVID-19 pandemic. It will go on to look at the context of young people's mental health in Wales.

2.2.1. Mental health trends and prevalence

Prior to the COVID-19 pandemic, child mental health in the UK, including Wales, was already described as having reached a point of crisis (Gunnell et al., 2018), with a significant increase in emotional difficulties noted among young people in Wales between 2013 and 2019 (Anthony et al., 2024). UK and Welsh policy, such as the statutory school counselling duty (School Standards and Organisation (Wales) Act 2013), indicates that addressing this was a priority; however, there have been few improvements in either prevalence or outcomes. (Collishaw and Sellers, 2020). As identified in the Introduction chapter, many children with mental health conditions do not receive a clinical diagnosis or receive support from specialist services (Davies, 2014; Patton et al., 2016), and when children do seek help, it is often in non-clinical settings, predominantly in schools (Anderson et al., 2018). Pitchforth et al. (2019) highlight that, while there is a clear need for policy initiatives, these are undermined by inadequate funding and a lack of measures to promote mental health and wellbeing in schools and wider society.

Research into the causes of declining mental health in adolescents suggests several potential causes, some of which include the increase in social media use, pressures related to school and academic success, and the result of the COVID-19 pandemic (Hermann et al., 2022). These explanations are not mutually exclusive. However, there are some who suggest that it is not solely declining mental health contributing to the rise in cases, but the impact of a normalisation of mental health issues leading to increased awareness (Bell et al., 2019) and a parallel argument of over-diagnosis of mental health conditions in recent years (Davies & Salisbury, 2025). There is evidence to suggest that some of the increase in prevalence can be attributed to improved mental health literacy, more open presentation and greater symptom recognition, improved willingness to share concerns, and more professional help-seeking as a result (Cheng et al., 2018; Gunnell et al., 2018; Pitchforth et al., 2019).

Social media use

A study examining the relationship between adolescent mental health and social media found a correlation between wellbeing and time spent on social networking sites (Hartas, 2019). Increased social media use is associated with poor sleep, poor body image, low self-esteem, and the increased possibility of online harassment. Each of these side effects is linked to increased depressive symptoms (Kelly et al., 2018). Girls are more likely to be adversely affected by social media use than boys (Hartas, 2019), being more vulnerable to pressure related to appearance and body image (Yurdagül et al., 2021) and online harassment (Craig et al., 2020), which can lead to poor self-esteem. Evidence also suggests that girls are at greater risk of experiencing declines in their wellbeing and mental health as adolescence progresses into adulthood (Yoon et al., 2023). However, the nature of the relationship between mental health and social media use remains unclear, with limited evidence about whether poor wellbeing leads to excessive social media use in a bid for connection and validation, if excessive use causes depressive symptoms by reducing meaningful face-to-face interactions, or if no relationship exists. Recent research by Anthony et al. (2023) found that online communication within existing friendship groups can enhance wellbeing, whereas online interaction with virtual friends is more likely to harm it.

Academic pressure

There is a small but growing body of research indicating that academic pressure and associated stress negatively impact the mental health of school pupils (Tharaldsen et al., 2022; Pascoe et al., 2019). In a systematic review of studies examining the relationship between education, academic achievement, and the decline in adolescent mental health, Steare et al. (2023) found a positive correlation in 92% of studies. Studies examining self-injurious behaviour found that incidents typically occurred at their lowest rates during school holidays, suggesting a possible link between school and such behaviour. However, this decrease may be due to various school-related factors rather than academic pressure specifically. Similar to social media use, it is not clear if preexisting mental health issues influenced a pupil's tolerance to academic pressure, or if the pressure was the cause of deteriorating mental health.

COVID-19

A third leading source of stress and anxiety for young people in recent years is the COVID-19 pandemic. Studies show that COVID-19 had a significant impact on young people's mental health globally, increasing adolescent rates of depression and anxiety (Harrison et al., 2022). The closure of schools and a reduction in access to in-person support systems, such as peer groups, along with the daily media briefings and intense coverage, were contributing factors to increased levels of stress and anxiety experienced by young people (Cowie & Myers, 2021). Wright et al. (2020) suggest that the increase in COVID-19-related depression and behaviour problems in childhood and adolescence may have longer-term implications, as these symptoms are associated with increased risk for depression later in life. They go on to suggest that services should anticipate an increase in referrals due to the pandemic's effects. Research in Wales indicated a marked increase in the prevalence of emotional difficulties among 10 -11-year-olds, rising from approximately one in six in 2019 (pre-pandemic) to more than one in four in 2021 (Moore et al., 2022).

Young people's mental health in Wales

Whatever the cause or causes of the increased prevalence of mental health conditions among young people, this upward trend in Wales is consistent with that seen across the UK, the United States, and other high-income European nations (Anthony et al., 2024). The biennial Student Health and Wellbeing survey (Page et al., 2021) showed that in academic year 2019/2020, 39% of young people in secondary schools in Wales reported mental health symptoms, with 19% reporting 'very high' mental health symptoms as reported on the Strengths and Difficulties Questionnaire. The data for this study were collected between September and December 2019, before the onset of COVID-19-related school closures (Page et al., 2021). The subsequent study in 2021/2022 showed an increase to 46% of young people reporting mental health symptoms, with 24% reporting 'very high' symptoms (Page et al., 2023). Furthermore, Welsh Government statistics (Stats Wales, 2024) show that in 2023/24, 13,935 children and young people in Wales attended counselling sessions. This number has increased steadily since 2013/14, when 10,536 young people attended counselling, despite the population of 0 -15-year-olds decreasing by approximately 1.1% over the same period (Welsh Government, 2024). In 2023/24, Year 9 pupils demonstrated the highest level of engagement with school-based counselling. Anxiety has been the most commonly presented issue on referral since 2019/20, followed by family issues. These two issues are reported significantly more often than anger, stress, and self-worth, which together make up the five most common presentations at referral (Welsh Government, 2024). It should be noted that the time period covered by these statistics includes the 2021 statutory requirement for schools to provide counselling, and therefore, an increase in uptake would be expected.

Mahedy et al. (2025) highlight the strong negative association between mental health difficulties and wellbeing among 11–16-year-olds in Wales, and point out that responding to the mental health and wellbeing of children and young people in Wales is a national priority. However, as a clinical intervention, the specialist Child and Adolescent Mental Health Service (CAMHS) in Wales is under pressure due to a significant increase in demand over recent years (Simkiss et al., 2023) and investment in these services is crucial to meet the growing need (Moore et al., 2022). A joint review by the Healthcare Inspectorate, Care Inspectorate and Estyn (Healthcare Inspectorate Wales, 2024) found that over half of young people aged 11-16 did not know where to go for support, and many believed that help was not always available when needed. The review also identified concerns relating to information sharing across services, where continuity of care is disrupted, placing additional pressure on young people to repeat traumatic experiences with new professionals. The review called for a joined-up system that would ensure young people receive the support they need, when they need it.

In summary, this section has shown that young people’s mental health in the UK, and in Wales specifically, has been deteriorating over the last decade. Despite recognition of the problem's growing scale, many young people continue to face barriers to accessing appropriate support, with CAMHS services in Wales overstretched. Consequently, many young people turn to their schools as their first point of contact for support. The next section will consider the implications of this in relation to children's rights.

2.3 Children's Rights

Table 1.1 (pg. iv) provides an overview of the UNCRC articles that underpin this study and indicates how they inform the policy, methodological, and analytical components of the thesis.

Wales has incorporated the UNCRC into law and guidance through the *Rights of Children and Young Persons (Wales) Measure* (2011); therefore, this chapter adopts a children's rights perspective to examine school-based mental health support. The following section outlines the background of the UNCRC, emphasising children's rights as a concept, the challenges to enacting them, and the intersection of the rights to participation (Article 12), health (Article 24), and information (Article 17), along with the relevant General Comments, to explore young people's rights in shaping the development of services intended to support them. The section will conclude with an analysis of how the rights agenda has been integrated into mental health policy in Wales, and what this means for improving outcomes for children and young people.

In 1978, the Commission on Human Rights presented a draft Convention on the Rights of the Child for consideration by United Nations Member States. This draft underwent a decade of debate about which rights children should be entitled to, culminating in the 1989 United Nations Convention on the Rights of the Child (UNCRC). The Convention acknowledges children as active participants in society, recognising their roles across social, economic, political, civil, and cultural spheres (UNICEF, 1990). The United Nations Committee on the Rights of the Child (CRC) examines compliance with the Convention. Comprising 54 articles, the UNCRC is the world's most widely ratified human rights treaty. Articles 1 - 42 relate to the treatment of children and young people, and articles 43 – 54 focus on the role of duty bearers to uphold those rights (Welsh Government, 2021c, pg. 5). The introduction of the UNCRC positioned children as active citizens with their own views, opinions and ideas about the world, and recognised them as holders of rights. This marked a significant shift from viewing children through the lens of developmental theory as future citizens who needed to be cared for and protected by adults (Varadan, 2019).

General principles

The CRC identified four articles as general principles which are intended to support the interpretation and implementation of all other rights. The articles are:

1. Non-discrimination (Article 2). All the rights guaranteed by the UNCRC must be available to all children without discrimination of any kind.
2. Best Interests of the Child (Article 3). The best interests of the child must be a primary consideration in all actions concerning children.

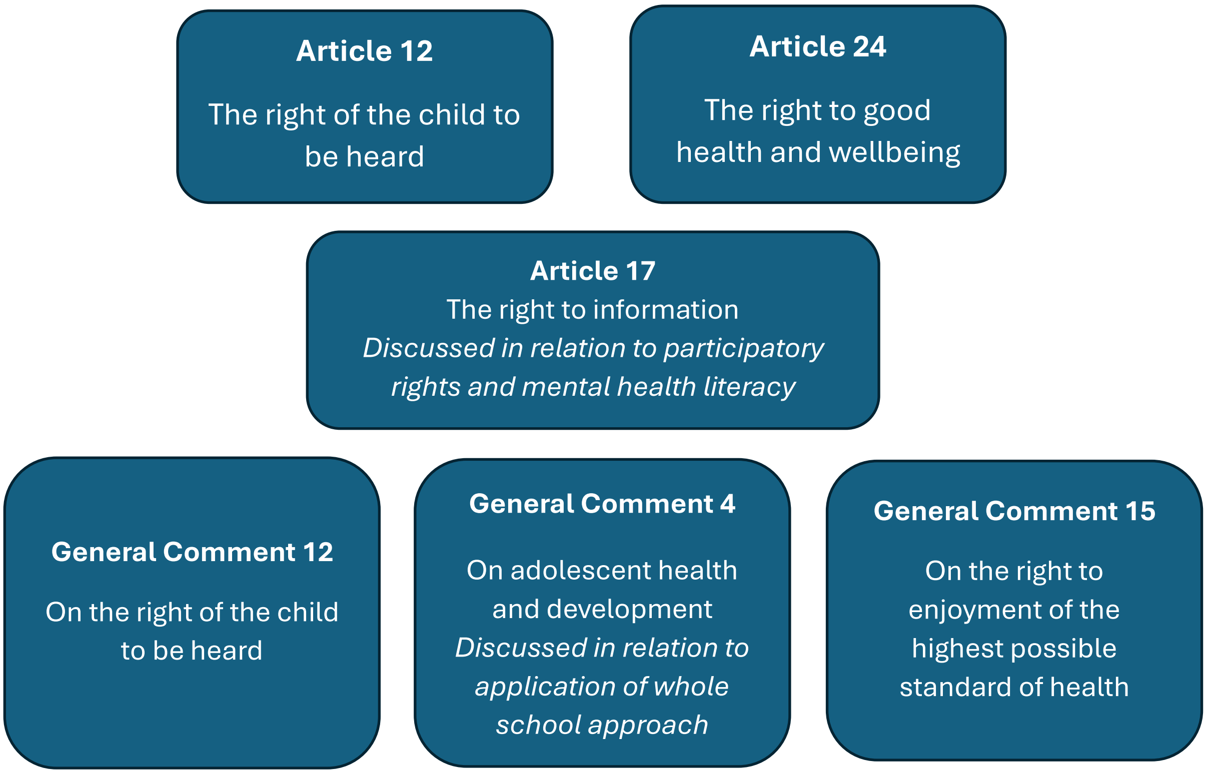
3. The Right to Life, Survival and Development (Article 6). Every child has the right to life, survival and development.
4. The Views of the Child (Article 12). Every child has the right to be involved in making decisions, planning and reviewing any action that might affect them.

While the general principles are widely accepted, Hanson and Lundy (2017) have challenged the phrasing, arguing that they are neither general nor principles and suggesting a lack of clarity and consistency in their development and application. They suggest using the term ‘cross-cutting standards' and propose replacing Article 6 (right to life) with Article 5 (evolving capacity), arguing that this better reflects the balance between child autonomy and the need for protection.

The diagram (**Fig. 1.1**) below highlights the key articles of the UNCRC relevant to this study. Two primary articles (12 and 24) are considered. Article 12 outlines the child’s right to participation, specifying that children who are capable of forming their own views have the right to express them and have them taken seriously. This article is included because of the study's participatory nature. The second primary article is Article 24 – the right to the best possible health and wellbeing supported by access to services. This article is discussed in relation to children’s rights, supporting their mental health. The CRC reviewed both articles, and they were subsequently supported by General Comments 12, 4, and 15, respectively. Article 17 (the right to information) is also discussed to better understand the information children need and are entitled to in order to support their mental health. These are outlined in the diagram below.

Fig. 1.1 Key articles of UNCRC relevant to the study:

Figure 1.1 is used to situate the study within a children's rights framework, illustrating how specific UNCRC articles inform both the methodological approach and the interpretation of pupils' experiences of school-based mental health support.



As illustrated in **Figure 1.1**, this study is primarily informed by Articles 12 and 24, and supported by Article 17 and relevant General Comments. These articles collectively frame the rights-based approach adopted throughout the thesis and are revisited in Chapter 4 (Methodology) and Chapter 6 (Findings) to analyse pupils' experiences of participation and access to mental health support.

Critiques of the convention

It is acknowledged that the UNCRC was reached by a process of negotiation and has been conceptualised as the minimum standards for children accepted by governments (Freeman, 2000). This has made it the subject of a number of academic criticisms. Quennerstedt et al. (2018) argue that the Convention's language is vague, which was necessary to ensure all states could ratify it, permitting nations to agree on the concept of children's rights rather than their specific details (Tobin, 2013). The use of vague language complicates efforts to measure the Convention's implementation, although

Lundy et al. (2013) contend that, while establishing a definitive measure of the impact of children's rights on their lives is challenging, incorporating the UNCRC into law is essential to its implementation. It has also been argued that the Convention is rooted in Western cultural values, overlooking cultures and nations with different cultural concepts of childhood (Gadda, 2008). It can be seen to position children as dependents, prioritising their protection over child autonomy (Arce, 2012; Tobin, 2013). Furthermore, it has been claimed that, as a Convention, it is challenging to implement and that its enforcement mechanisms are not strong enough (Lundy, 2012). Tobin (2013) suggests that the document is adult-centric in its interpretation of children's interests and notes the absence of child involvement in its drafting. This literature review will focus on the latter two criticisms.

Enactment and enforcement mechanisms.

In ratifying the Convention, a "State accepts an obligation to respect, protect and fulfil the rights as outlined – including adopting or changing laws and policies that are needed to implement the provisions of the agreement" (UNICEF, 1990). Once a Nation has ratified it, it is obliged by international law to meet its requirements (Lansdown et al., 1996). The CRC monitors the implementation of the UNCRC at the state level, and under Article 44, Nations are expected to report to the CRC every five years to demonstrate compliance. The CRC also identifies any breaches of the Convention at the state level and may make recommendations for implementation and improvement. However, a UK Parliament briefing paper (Lang, 2016) acknowledged that the Committee lacks the power to penalise Nations that breach the Convention or to enforce the CRC recommendations. Furthermore, Lundy (2012) points out that the information provided to the CRC is self-reported by Nations and, as such, is likely to lack critical detail. The Committee supports the submission of evidence by NGOs and children to provide a more comprehensive assessment of States' application of children's rights (Child Rights Connect, 2014). Heymann et al. (2014) suggest that a complementary quantitative measure of law and policy indicators is necessary to address this.

Wales has adopted a model of indirect incorporation, as outlined in the Rights of Children and Young Persons Measure (2011), which places a duty of Due Regard on ministers in their decision-making and embeds rights thinking at the policy level (Gray, 2022). Indirect incorporation, while raising its profile and facilitating broader implementation efforts, may fall short of providing constitutional protection for children's rights (Hoffman & Stern, 2020). In comparison, Scotland has adopted a model of direct incorporation, whereby the treaty's text is incorporated into domestic law and directly enforceable in national courts (McCall-Smith, 2021).

Despite its fragile enforcement mechanisms, the UNCRC's ability to influence law and policy and embed children's rights into practice remains worthwhile. Additionally, initiatives such as UNICEF's Rights Respecting Schools increase awareness of the UNCRC and normalise children's rights in educational settings (Covell et al., 2010). In this way, even without strong enforcement mechanisms, the UNCRC continues to exert significant influence.

Adult gatekeeping

One of the most significant criticisms of the UNCRC is that, although children were the subject of the agreement, they were not involved in its development (Alderson, 2017; Tobin, 2013; Gadda, 2008; Freeman, 2000). As a result, it is based on adult definitions of childhood (Arce, 2012). Furthermore, some argue that the Convention rests on two contrasting views of childhood: children as inherently vulnerable and in need of protection, versus children as experts in their own lives and as holders of participatory rights (Warrington & Larkins, 2019). Warrington & Larkins (2019) suggest that this dichotomy can be exploited to deny children their participation rights by prioritising their protection. As discussed, the Convention holds that Article 12, a child's right to participate, is one of its general principles, guiding the interpretation of all other articles. However, Article 12 has also faced criticism. Archard (2004) contends that, although the right exists in principle, in practice it only provides children with an opportunity to influence adults who will ultimately make decisions on their behalf.

2.3.1 Right to Participation (Article 12)

Purpose of the article and general comment

Article 12 of the UNCRC is the relevant commitment to the expression and respect of children's views. It says:

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Lundy et al. (2015) suggest that the application of Article 12 should be determined by first identifying whether the issue affects children and, if so, whether they are capable of forming and expressing a view on it. However, a 2009 UN Committee found that children were often deprived of the right to be heard, even when the above conditions were met. In its General Comment on the right of the child to be heard, the CRC identified concerns about the quality of many practices used to allow children to be heard (UN, 2009, p. 5). To support best practice in listening to children, Lundy (2007) presents a model that demonstrates that Article 12 should be viewed not as a stand-alone right of children, but rather as a right to be understood alongside other significant rights. These are: Article 2, ‘the right to non-discrimination’, Article 3, ‘the right to best interests’, Article 5, ‘the right to guidance from adults’, Article 13, ‘the right to information’ and Article 19, ‘the right to safety’. The fulfilment of these Articles underpins the fulfilment of the UNCRC. Using the combination of these rights, Lundy (2007) goes on to identify four factors which should be considered in terms of their implication in applying children’s rights -

- **Space** – giving children the opportunity to express a view. Key points to consider within this factor include ensuring the space is inclusive and that children have the opportunity to make anonymous contributions, allowing for freedom of speech.
- **Voice** – giving children a platform to express a view. Children’s views should be sought freely, allowing time for them to understand the issues, and using methods and means that are suitable and preferred by the child.
- **Audience** – ensuring children’s views are listened to, and they are empowered to share their views using methods other than verbal communication if necessary. The responsibility within this factor lies with adults to act on or share children's views with those in a position to act on them.

- **Influence –** Lundy picks up on the prevalence of tokenism in child participation initiatives, where views are requested by adults but not taken seriously, proposing that this can be countered by ensuring that children are informed of how their views have influenced decisions (2007).

Fig. 1.2 Lundy model of conceptualising Article 12.

Figure 1.2 is used to frame how Article 12 is understood within this study, providing a structure through which pupils' opportunities for voice, audience and influence are examined across the research process.

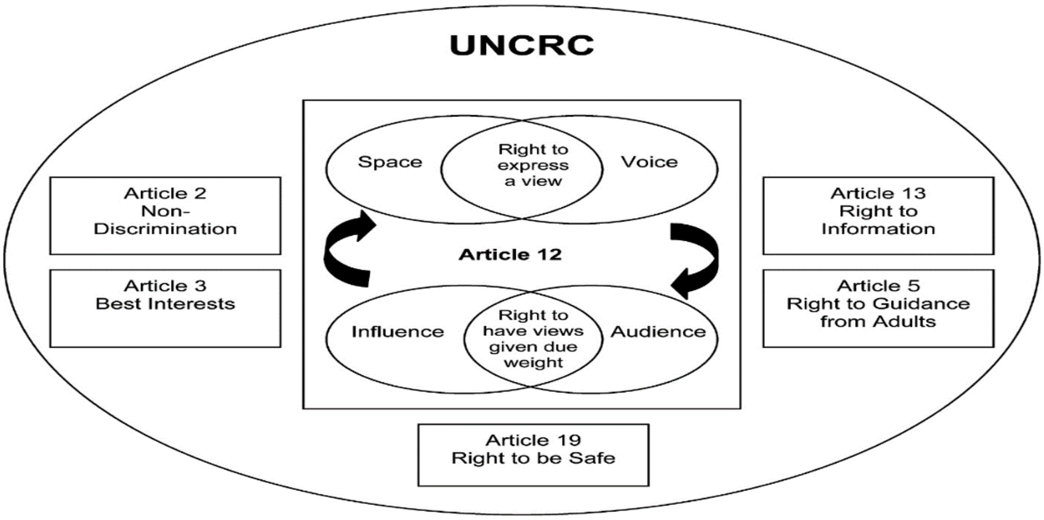


Figure 1.2 demonstrates the interdependent elements of space, voice, audience, and influence, which are used in this study to guide both the research design and the interpretation of pupil experiences. This framework is applied in Chapter 4 (Methods) and informs the analysis of participation in Chapter 6 (Findings).

In 2009, the United Nations Committee issued General Comment 12 to provide further guidance on the interpretation of Article 12. The comment described the concept of participation as "*the starting point for an intense exchange between children and adults on the development of policies, programmes and measures in all relevant contexts of children's lives*." (pg. 7). It advocates for the involvement of children in the development of policy and services within health care and expects that their views are sought on:

> *What services are needed, how and where they are best provided, discriminatory barriers to accessing services, quality and attitudes of health professionals, and how to promote children's capacities to take increasing levels of responsibility for their own health and development. This information can be obtained through, inter alia, feedback systems for children using services or involved in research and consultative processes and can be transmitted to local or national children's councils or parliaments to develop standards and indicators of health services that respect the rights of the child* (pgs. 23-24).

The General Comment also specifies that within education, mechanisms such as student councils should be utilised to include children in decision-making processes, allowing their voices to be heard in the development and implementation of school policies (pg. 25).

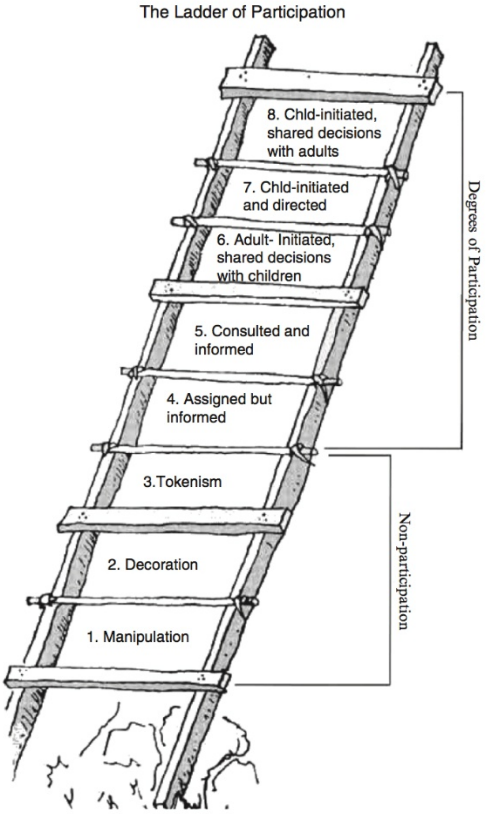
Several challenges are associated with implementing Article 12, primarily related to the application of the right by adults. Meaningful participation can be time-consuming, and adults may lack motivation, capacity, or time to fully engage with listening to young people. Additionally, in some circumstances, children may be perceived by adults as not yet capable or competent citizens (Bragg, 2007; Lundy, 2007).

A further significant barrier to the application of Article 12 is a lack of understanding of its meaning. It is frequently referred to as 'the right to be listened to', 'the right to express views', or the 'right to be heard', but none of these fully capture the complexity of Article 12 (Lundy, 2007). This lack of understanding directly contradicts the Convention, which states in Article 42 that the principles and provisions of the Convention should be known to both adults and children. Nations that are signed up to the Convention are obliged to enact it, and inclusion in the decision-making process is not a kindness offered to children by adults but a child's right (Lundy, 2007).

According to his ladder of Children's Participation (Hart, 1992), adapted from the original Ladder of Citizen Participation (Arnstein, 1969), tokenism is regarded as a form of non-participation in decision-making (see Figure 1.3 below). Non-participation includes consulting with children after a decision has been made, asking for input only on less important issues, children lacking enough time or support to engage meaningfully with a topic, or children being patronised by adults (Perry-Hazan, 2016; Tisdall, 2017). Research indicates that tokenistic participatory opportunities are not uncommon (Lundy, 2018; Jayman & Quickfall, 2024; Littlefair & Jopling, 2025), but a well-known criticism of tokenism is that children recognise when it happens, which can lead to disillusionment with involvement in participatory projects (Lewars, 2009).

Fig. 1.3 Hart's Ladder of Children's Participation (1992).

Hart's Ladder of Children's Participation is frequently used to illustrate varying degrees of participation, ranging from non-participation to child-initiated decision-making.



As shown in **Figure 1.3**, the lower rungs of the ladder represent tokenistic or non-participatory practices, which are critiqued in this study in relation to school-based pupil voice mechanisms. The ladder provides a point of comparison for the participatory approaches discussed in Chapters 2 (Literature review) and 6 (Findings), particularly when examining the authenticity of pupils' influence on mental health support provision.

Power imbalances between children and adults

Several scholars have explored the concept of power and its influence on participatory practices. Invernizzi and Milne (2005) propose that participation may be offered to children based on an adult's assessment of the child's ability and competence, as well as their interpretation of the child's best interests, making participatory opportunities conditional on adult perceptions of the child. In some circumstances, this is formalised in law, for example, the Gillick competencies (Wheeler, 2006), in which children must demonstrate sufficient understanding and maturity before their views are considered valid. While these frameworks aim to protect children, they also reveal an inherent tension between safeguarding and Article 12; adult responsibilities to act in the child's best interests can sometimes be used to limit opportunities for meaningful participation (Archard & Skivenes, 2009; Lansdown, 2005).

Robinson (2011) suggests that within schools, a hierarchical relationship exists, with inherent power imbalances between staff and pupils that limit young people's voices from being heard in a meaningful and age-appropriate manner. Lundy (2007) identified three areas that cause adults concern about the full realisation of Article 12: a) a child's capacity for meaningful input into decisions; b) anxiety that giving children power will threaten adult authority; c) the sense that to meaningfully listen to children is not an easy process and will take time and effort away from education. However, Lundy (2018) cautions against aiming for only perfect participation, as this can deny children opportunities to be heard. While the tokenistic inclusion of individual children cannot be justified, Lundy proposes that there may be benefits to allowing groups of children to participate in conversations with decision-makers, even if their influence is limited. She suggests that children may learn from the experience and be encouraged to voice their opinions in other situations, and that adults will benefit from exposure to children's perspectives, potentially improving subsequent participatory opportunities.   Mannion (2010) describes this as a 'warts and all' participatory approach, accepting that it may not work, but challenging the notion that it is not possible.

School mechanisms for enacting Article 12.

Rubenstein et al. (2022) describe pupil voice groups as a method that allows pupils to express their views on decisions affecting the school system, providing structured opportunities for pupils to voice their opinions and contribute to school life. They serve as a mechanism for schools implementing Article 12 of the UNCRC, and schools in Wales are mandated to implement such systems. However, their effectiveness is the subject of some debate. Hall (2016) suggests that the concept of student voice has become a “catch-all,” comprising two competing narratives: “student voice as democratic and transformational; and student voice as ‘policy’ and strategic initiative” (p. 180). Thornberg (2010) argues that schools are based on institutional structures where teachers are seen as powerful, and pupils are seen as subordinates or incompetent. He identifies a hidden curriculum based on a pupil-control discourse, in which the teacher is viewed as the primary source of knowledge and authority, and pupils’ ability to make independent choices is limited. Such a pupil-control discourse may manifest in the use of tokenistic participation opportunities in schools, in which pupils are offered opportunities to share their opinions on school developments, but adults decide which developments to discuss and which pupils to involve (Robinson, 2011). As discussed, the implications of tokenism may lead pupils to be sceptical and disillusioned about pupil voice initiatives (Lewars, 2009), and to miss out on the potential benefits of meaningful participation (Lundy, 2018). Additionally, Alderson (2000) suggests that tokenistic school councils had as much, or more, negative impact as having no council at all. In addition to the risk of tokenism, several other criticisms of student voice initiatives have been raised. The range of influence is often limited, focusing on issues such as the school environment or facilities rather than school policy, or pupil voice being used to legitimise predetermined decisions (Whitty & Wisby, 2007). Finally, they can become centred on articulate or confident pupils, excluding the voices of less engaged or less vocal pupils (Flutter, 2007). However, as previously discussed, there are benefits to participation, even when not carried out perfectly. These include pupils reporting improved confidence in sharing opinions and feeling that their voice is effective, as well as greater confidence in raising concerns with teachers (Conner et al., 2024). Pupil voice groups can make school a more enjoyable place (Whitty & Wisby, 2007), and Mannion (2007) points out that pupil participation can lead to improved relationships between adults and children. Anderson & Graham (2016) also suggest a link between participation and pupil wellbeing. Secondary school pupils involved in their research defined wellbeing as having ‘rights’, ‘freedom of speech’, and ‘having a say’ at school. However, they noted the importance of being able to contribute to decision-making on all aspects of school life and having those views respected and acted upon. Furthermore, when asked to imagine their perfect school, the pupils centred their design on ideas around participatory practices and having a say. Similar findings were also reported in more recent research by Barrance & Hampton (2023), who found that the opportunity to contribute to school decisions had a significant impact on subjective wellbeing.

While pupil voice mechanisms, such as school councils, are helpful methods for promoting children's right to be heard under Article 12 and have seen some legal and policy support in Wales, research suggests they are often not truly effective in practice (Whitty & Wisby, 2007). To meet the requirements of Article 12, shifts are needed in the school's ethos, structures, and attitudes among adults (Whitty & Wisby, 2007).

2.3.2. Right to good health (Article 24)

Purpose of the Article and General Comment

In its original, complete form, Article 24 specifically addresses a child’s physical health but does not mention their mental health. This omission was recognised in a 2013 General Comment (General Comment 15), which acknowledged the issue of mental health. The General Comment made specific reference to the increasing rates of mental ill-health among adolescents and urged approaches centred on early intervention rather than a reliance on a medicalised response (para 38). It highlights that there is evidence showing interventions aimed at promoting good mental health and preventing mental illness are effective in children. States are encouraged to incorporate these interventions into mainstream policies and programmes, such as health, education, and protection, and to involve families and communities (p. 10). Paragraph 19 of the General Comment draws the connection between the articles related to health and participation, emphasising that children should have their views considered on “all aspects of health provisions, including, for example, what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals”. It advocates for the provision of State-level, regular participatory consultations with children to understand their experiences and to give them a voice in shaping interventions and programmes (p. 7), demonstrating that duty bearers must seek out the views of children and young people regarding health services at all levels, from the quality and availability of services to barriers in accessing them and considering their perspectives when designing services.

In a speech at The Wales Observatory on Human Rights of Children and Young People (2017), Mr Justice MacDonald argued that from a rights perspective, children's mental health should not sit under a single article but should be inferred and drawn from a number of rights. MacDonald listed the ways in which the law places a duty on adults to promote and protect the welfare of children and young people, drawing on the Children's Act 1989 and relevant Articles of the UNCRC listing, amongst others, the right to survival and development (Article 6); the right to health (Article 24), emphasising that mental health cannot become a forgotten factor of this, and the right to access to information aimed at promotion of health (Article 17).

He goes on to say:

> "*In the circumstances, beyond the moral and philosophical justification for such a right, founded upon the seminal importance to the individual child and to society of good mental health, I would contend that it is eminently arguable that there is a legal foundation for what can be termed a right to mental health in the legal instruments that I have discussed*".

In saying this, MacDonald proposes that, under the UNCRC, children have a fundamental right to support in maintaining good mental health.

2.3.3. Right to information (Article 17)

Purpose of the article

Article 17 states that "*State Parties… shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral wellbeing and physical and mental health*." Stalford et al. (2017) suggest that the availability and accessibility of information are critical to upholding a children's rights approach. The Article outlines the child's right to access a wide range of information, with a particular emphasis on content that supports their social, emotional, and mental wellbeing (Lundy et al., 2012). It acknowledges the role of media and information in helping children understand the world around them and to make informed choices (Livingstone & Third, 2017), which includes not only having access to information but also being able to comprehend it and utilise it in ways that foster their development (Stalford et al., 2017).

Ensuring people have the knowledge, confidence, and opportunities to prioritise their own mental health and wellbeing is a vision statement in Wales's Mental Health and Wellbeing Strategy (2025). Several actions are recommended to deliver this vision, including strengthening knowledge and understanding of what works to protect and promote mental health and wellbeing, improving mental health literacy, and implementing a life-course approach that encompasses enhancing understanding of parent-infant relationships, infant mental health, and adolescence. The need for effective communication and clear, accessible information on mental health services and support was identified as a key theme during the pre-consultation engagement in Wales. In response to feedback, the Welsh Government has published a Mental Health and Wellbeing Strategy Delivery Plan (Welsh Government, 2025), which develops a standardised approach to provide information about mental health services and how to access them, ensuring it is accessible, appropriate, and in formats that are child- and young-person-friendly.

2.3.4. Children's Rights – the Welsh context

Rights of Children and Young Persons (Wales) Measure 2011

Wales enshrined the UNCRC in its domestic law through the *Rights of Children and Young Persons (Wales) Measure* (2011), committing to uphold the 42 Rights of Children. The Measure imposes a duty on Ministers to pay due regard to the Convention in all new or amended legislation (the Due Regard Duty) and a duty on Ministers to promote awareness of the Convention, ensuring that children's rights are supported by a policy and legal framework (Tyrie & Beauchamp, 2018). At the time of its introduction in Wales, it was the first general legislative measure implementing the UNCRC in the UK (Hoffman, 2019). The Measure introduced Children's Rights Impact Assessments (CRIA) as a mechanism to ensure compliance and enable policymakers to evaluate how proposed laws, policies, or budgetary decisions affect children and their rights. It required Ministers to publish a ‘children’s scheme’ (the ‘Scheme’), setting out arrangements for ensuring compliance with the duty of Due Regard. Additionally, following any recommendation made by the Committee on the Rights of the Child, Ministers are required to consider whether the Scheme should be revised to reflect the new recommendation. There is an obligation on Ministers to involve children and young people, the Children’s Commissioner for Wales, and any other relevant persons in the preparation of the Scheme, providing opportunities for children and young people to be heard and influence policy development in Wales. However, nearly a decade later, a 2020 Senedd report on children’s rights in Wales (Welsh Parliament (Children, Young People and Education Committee), 2020) criticised the Welsh Government’s approach to maintaining children’s rights. The report highlighted a lack of references to children’s rights in strategic documents and an absence of a systematic approach to informing children about their rights. It reflected on the 2011 Measure and found that it had had no discernible impact at the policy level on mental health services or early mental health interventions in schools.

The Right Way – Children’s rights approach in Wales 2017

Published in 2017 by the Children’s Commissioner for Wales, *The Right Way* (Children’s Commissioner for Wales, 2017) was not a response to the 2020 Senedd critique; rather, it set out a framework for working with children, based on the UNCRC, to encourage public services to commit to upholding it. The approach was later reflected in the Welsh Government’s *Children’s Rights Scheme* (2021c), which was structured around its five principles of:

Embedding – putting children’s rights at the centre of planning and service delivery.
Equality – ensuring every child has equal opportunity to make the most of their lives.
Empowerment – enhancing children’s ability to take advantage of their rights.
Participation - listening to children and giving their views due weight. The document suggests that authorities “Involve children directly in the design, monitoring and evaluation of service delivery” as a means of meeting this principle.
Accountability - Children should be provided with the information and procedures to support them in challenging decision-makers where necessary.

The document emphasises that the UNCRC should not be viewed as an “abstract” idea, and stresses the need for real, practical improvements if children's rights are to have a genuine impact.

Children’s Rights Scheme 2021.

The Children’s Rights Scheme (2021c) replaced the earlier 2014 version and was based on the five principles of the 'The Right Way' approach. It outlined arrangements for paying due regard to the UNCRC and aimed to support policy-making that would improve the lives of children and young people, promote their active participation in policy development, and help them exercise their rights. The Scheme emphasised the importance of the Right Way participation principle and relies on several mechanisms: an engagement model providing children and young people with meaningful opportunities to share their views and ensuring their views are considered; national participation standards – ‘Having a Voice, Having a Choice’, which set out seven standards to include young people in planning, delivering, and evaluating services, and guide adults through the process of effective participation; Young Wales – funded by the Welsh Government, and underpinned by the UNCRC and National Participation Standards, aims to ensure that young people can discuss issues and be heard by decision-makers and Ministers; and provision of accessible information—where children are affected, information should be available using language that is age-appropriate and relevant to their needs.

There has not been a formal review of the scheme, and Croke (2023) suggests that, while it has been successful in promoting structural changes, such as CRIAs, it has only been partially successful in shaping policy; therefore, a review is required.

Statutory Whole School Approach to Emotional and Mental wellbeing 2021

The incorporation of children’s rights into policy has been further operationalised through the introduction of the statutory WSA Framework, which provides a practical mechanism for the realisation of the principles of the UNCRC, particularly Articles 3, 12, 17, and 24, in schools. By embedding responsibility for wellbeing across school culture, leadership, curriculum, and support services, the WSA Framework positions supporting pupil mental health as a shared responsibility that requires a holistic approach.

Despite the policy prominence of the WSA Framework, there remains limited empirical evidence assessing its effectiveness or impact on pupils' mental health outcomes. This absence of evidence is not necessarily indicative of ineffectiveness, but reflects its position as a relatively recent statutory requirement. In addition, flexibility in implementation across schools, differences in capacity and resources, and the absence of agreed-upon outcome measures complicate consistent assessment of impact. Much of the existing evidence, therefore, focuses on process, implementation, or policy intent rather than on pupils' lived experiences or outcomes. This gap in the evidence base reinforces the need for research that foregrounds young people's perspectives on how whole-school approaches are experienced in practice, rather than relying solely on policy-level assumptions about effectiveness.

Wales' mental health and wellbeing strategy

The Wales Mental Health and Wellbeing Strategy was published in April 2025 (Welsh Government, 2025). It specifically referenced the concluding observations of the CRC (United Nations Committee, 2023) on the UK's combined sixth and seventh periodic report. The observations raised criticisms about the length of waiting lists for children requiring mental health support, but did not explicitly reference the shortcomings in Wales. The Strategy identified children's mental health as one of six priority areas. The comment stated (paragraph 43) that nations should:

> ...*develop or strengthen strategies, with sufficient resources, to ensure the availability of community-based therapeutic mental health services and programmes for children of all ages and to promote comprehensive mental health services, screening for mental health issues and early intervention services in schools; and (d) Urgently address the long waiting times for accessing mental health services and the stigma associated with such services*.

A CRIA into The Mental Health and Wellbeing Strategy set out four vision statements to support the strategy.

Vision Statement 1: There is action to ensure the building blocks are in place to support good mental health and wellbeing, which involves considering the wider social, environmental, and economic determinants and their potential positive impact on mental health and wellbeing.

Vision Statement 2: Everyone will have the knowledge, confidence, and opportunities to protect and improve their mental health and wellbeing, providing individuals with information and opportunities to participate in activities that promote and protect their wellbeing. It requires people to understand what their rights are and how to claim them.

Vision Statement 3: There is a connected system in which all people receive the appropriate level of support wherever they reach out for help. In practice, this means schools and workplaces should have a comprehensive understanding of mental and emotional health, along with the steps they can take to support it.

Vision Statement 4: There are seamless mental health services – person-centred, needs-led and guided to the proper support first time, without delay. In practice, this means that support services should be easily accessible, recovery-focused, and connected. An individual's views should be taken into account and help shape the support they receive.

Additionally, there are cross-cutting principles that support the vision statements, which include, among others, an all-age approach, a person-centred approach, the use of co-production in designing and developing policies and services, a rights-based approach, ensuring equity of access, taking a preventative approach, and being free of stigma and shame.

This section has shown how Wales has worked to incorporate children's rights into legislation, frameworks, and policy. The next chapter will explore the role of schools in pupils' mental health.

Chapter 3: The role of schools

This section will focus on the role that schools and school staff play in supporting pupils' mental health. It will examine the expectations placed on teachers and the training they receive to meet those expectations, before considering the support that staff in pastoral roles can provide. It will then consider the support mechanisms available to pupils in schools, including whole-school approaches, pastoral or support workers, and school-based counsellors. In this thesis, the statutory Whole School Approach to emotional and mental wellbeing introduced in Wales is referred to as the WSA Framework to distinguish it from other theoretical or conceptual frameworks discussed throughout the study.

As part of the Welsh Government's response to rising mental health concerns, the Wellbeing of Future Generations Act (Welsh Government, 2015) requires public bodies to promote positive wellbeing. As such, it has increasingly become a key aspect of education and social policy in Wales (Greenway et al., 2025), with schools considered by the Welsh Government to play a central role in advancing children's rights and wellbeing. It is widely accepted that schools are well-positioned to support pupils' emotional health (Lendrum et al., 2013; O'Reilly et al., 2018; Garside et al., 2021), as most children attend for at least 30 hours per week. While the UK education system uses performance measures, such as examination results and pupil attendance, to rate and rank schools, there is an academic incentive for schools to promote their pupils' emotional and physical health. However, research has also found that pupil wellbeing is positively associated with educational outcomes. Deci & Ryan (2012) suggest that pupils with higher levels of wellbeing are more motivated in academic tasks, and the Department for Education (2018) finds that pupils' relationships with staff and peers are significant predictors of academic performance. A Public Health England study (Brooks, 2014) identified links between good health and wellbeing among pupils and improved academic outcomes, as well as a correlation between social and emotional competencies and better academic achievement. Furthermore, eudaimonia and a sense of competence and success had a greater impact on academic attainment than hedonia and life satisfaction (Clarke et al., 2025).

3.1 The Role of Teachers in Supporting Pupil Mental Health.

In Wales, teachers are classified as tier 1 Child and Adolescent Mental Health Services (CAMHS) practitioners. Tier 1 practitioners are those working in universal services but are not mental health specialists (Bostock et al., 2011). They are expected to offer general advice, identify issues early, and refer to specialist services when necessary (DoH, 2004). Tier 1 also includes GPs, school nurses, social workers, and youth justice workers, among others (Bostock et al., 2011). Within this classification, teachers play a vital role in supporting the mental health of adolescent pupils in the UK (Lowry et al., 2022); however, unlike health professionals, teacher training does not require child mental health education (DfE, 2024), which creates several challenges regarding their perceived ability to do so.

Teachers report a lack of training and a sense of feeling unprepared to address sensitive issues (Shelemy et al., 2019a). The Estyn report, *Happy and Healthy* (2019), found that only a minority of school staff felt they had received sufficient initial training to support pupils' mental health. In a study by Maelan et al. (2018), teachers acknowledged their professional responsibility to support pupils with their mental health as a component of their ability to learn, and many teachers acknowledge that pastoral care is an integral part of their role, with some embracing the opportunity to support their pupils in a more holistic way (Rice O'Toole & Soan, 2021). However, many are concerned about providing inappropriate guidance to pupils in need, crossing professional boundaries and becoming 'too close' to a pupil, as well as the logistical barriers that make this level of support too challenging to provide meaningfully (Shelemy et al., 2019b). Teachers have highlighted the need for support and training to enable them to confidently support pupils with their mental health (Rice O'Toole & Soan, 2021) and Mathews et al. (2020) suggest that initial teacher training programmes covering pupil mental health have the potential to improve teacher accuracy in recognising pupils with more severe mental health issues. Research suggests that the training teachers want would focus on practical skills and application. Through focus groups with secondary school teachers across England and Wales, Shelemy et al. (2019a) identified a lack of confidence in the practical management of mental health issues. Teachers requested evidence-based, accredited training delivered by experts, with real-world applications that would enable them to identify and support pupils' mental health needs and draw on in a potential crisis. The teachers involved expressed anxiety about exacerbating a situation by saying or doing the wrong thing. The WSA Framework (2021) specifies that understanding and awareness of pupils' emotional and mental wellbeing are core to new programmes in initial teacher education (ITE). To facilitate this, the updated *Criteria for the Accreditation of Initial Teacher Education Programmes in Wales* (Welsh Government, 2023a) specifies that ITE should: provide opportunities to consider how wellbeing underpins effective learning; develop the skills needed to identify learners at risk of poor wellbeing; and reflect on the approaches schools and other agencies use to support the wellbeing of pupils.

Teachers are already under stress from managing targets, workloads, pupil behaviour, exams, and inspections (Naghieh et al., 2015), and many report that concerns about student mental health have a detrimental effect on their own wellbeing (O'Reilly et al., 2018b). However, the link between pupil and teacher wellbeing may be even more cyclical. Research by Kidger et al. (2021) suggests that when teachers experience poor mental health, this is likely to negatively impact the mental health of pupils. In providing pastoral care, teachers are called upon to support pupil emotional wellbeing but report that they are increasingly expected to manage diagnosed mental health disorders for which they feel unequipped (O'Reilly et al., 2018b). Through the introduction of a whole school approach, the addition of designated pastoral staff, and engagement with services specifically aimed at supporting pupil mental health, teachers can support the development of student mental health literacy more holistically via the classroom, in the knowledge that there are professionals within the school team better placed to carry out screening and targeted support for pupils who need it (Beames et al., 2020).

3.1.1 Whole school approaches

The UNCRC general comment 4 (2003) (pg. 12), which focuses on adolescent health and development, states:

> *States parties should provide a safe and supportive environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make.*

Furthermore, the UNCRC General Comment 15 (2013) on a child's right to the highest attainable standard of health, reiterates the importance of the environment in relation to health-seeking behaviour (p. 9), and that within this environment, consideration should be given to the availability of services, the degree of health knowledge, and the values held. Taken together, these elements can be understood as providing a rights-based foundation for whole-school approaches to mental health.

Higgins & Booker (2023) define a whole-school approach as one that engages all members of a school community in a process of organisational and systemic change. This change is achieved by moving beyond the emphasis on teaching and learning to focus on all areas of school life that affect wellbeing. Proctor et al. (2021) describe whole-school approaches as having three interdependent elements: the backing and support of the approach at leadership and management level; the inclusion of the whole school community, including the voices of pupils and the wellbeing of the staff team; and the acknowledgement of the importance of universal, targeted and specialist work.

Universal interventions are designed to target general population groups (O’Connor et al., 2018) and have the potential to be a valuable tool for supporting young people’s mental health due to their wide reach. A key goal of these interventions is to enhance mental health literacy (Kutcher, 2016; Ma, 2023). Jorm et al. (1997) define mental health literacy as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention.” (p 182). They identify six domains: recognising distress or psychological disorders; understanding risk factors and causes; awareness of self-help strategies; awareness and perceptions of professional help-seeking; attitudes towards recognising and seeking help; and knowing how to find supportive information (2000). Kutcher et al. (2015) later refined these into four domains: understanding how to achieve and maintain good mental health; recognising mental ill-health and treatment options; reducing stigma; and encouraging help-seeking behaviour. Developing mental health literacy is central to universal interventions. However, research suggests that the impact of widely implemented interventions tends to be modest (MacKenzie & Williams, 2018; O’Connor et al., 2018). O’Reilly et al. (2018) emphasise that the success of such programmes is often underpinned by the quality of the WSA employed. Durlak et al. (2011) suggest that, for these interventions to be effective, their delivery should focus on developing personal or social skills, include an active form of learning, and target specific skills rather than holistic positive development. One challenge of universal interventions is that, by nature, they are delivered to whole-school groups, some of whom may be experiencing mental health issues while others have no difficulties; thus, not all participants may actually need the intervention (Foulkes & Stapley, 2022). Garmy et al. (2015) warn of the risk of highlighting negative thoughts within a whole class, which could lower the mood of students who were previously happy. Recent research suggests that there is an increased risk of the prevalence inflation hypothesis (Foulkes & Andrews, 2023), whereby raising awareness can inadvertently lead to more mental health problems, not only through better recognition but also via overinterpretation.

Where universal interventions are insufficient, a WSA allows for the provision of targeted support for those who require it. Research supports this two-tier approach. Gronholm et al. (2018) conducted a systematic review that found interventions targeting individuals at risk for, or presenting with, mental health difficulties are associated with more robust and longer-lasting positive effects. However, school-based targeted interventions were also associated with an increased perception of risks related to stigmatisation, including confidentiality, information sharing, and proximity to peers.

Research suggests that a number of benefits can be gained from fully integrating a WSA into school systems, with consideration of both staff and pupil well-being. When there is a greater sense of connectedness within the school and stronger relationships between staff and pupils, pupils report fewer mental health concerns (Moore et al., 2018). In settings where pupils believe that health and wellbeing are priorities, this is viewed as promoting overall wellbeing (Beynon, 2019). There are also advantages to early intervention and support for pupils' mental health (Brown et al., 2023), as well as the inclusion of everyone within the school system to create a culture that supports wellbeing (Brown et al., 2025). Whole school approaches that facilitate open conversations about mental health, clarifying what poor mental health looks and feels like, and outlining available support, can develop mental health literacy and challenge stigma. A comprehensive whole-school approach has the potential to serve as a preventative measure, helping to reduce the likelihood of children developing mental health difficulties to the point where they need targeted support (Hewitt et al., 2022). Integrating counselling services into this approach could be an effective way to normalise mental health concerns, with the potential to prevent issues from worsening and thereby reduce demand for external specialist services (Hewitt et al., 2022).

Research has also identified several shortcomings in whole-school approaches (Green et al., 2005). O'Reilly et al. (2018a) suggested that their application could be weakened by a lack of support (related to staff inclination and/or funding), as well as by a lack of clarity about approaches and inconsistent understanding of mental health/illness and the language used. Support and supervision from trained staff, along with the engagement of pupils in the development of programmes, could help strengthen these approaches. Whole-school approaches can create environments that are open and destigmatising about mental health, but this depends as much on the school ethos as on curriculum content. Effective whole-school approaches rely on the engagement and involvement of all parties (Balasooriya Lekamge, 2025); therefore, it is vital to include pupil experiences and perspectives in their development and implementation. The extent to which pupils feel listened to can have a direct impact on relationships between staff and pupils, and in turn, on pupil mental health (Jessiman et al., 2022). Interventions that proactively engage pupils in the development of the socio-cultural aspects of school life are significant for pupil wellbeing.

The direct influence of the UNCRC is evident in whole-school approaches in several ways. The WSA Framework requires schools to adopt a rights-based approach, grounded in three core values: belonging, efficacy, and voice. Each value applies to the whole school community, including staff, pupils, and families. It is underpinned by Article 6 (the right to survive and develop), Article 12 (the right to be heard and have one's views considered), Article 24 (the right to health and access to health services), and Article 29 (education as a means of supporting children to develop fully). This framework bridges children's rights with their school experience.

The introduction of the WSA Framework (Welsh Government, 2021a) made it a statutory requirement for all educational settings in Wales to develop a whole-school approach to underpin pupil mental health and emotional wellbeing. The WSA aims to support pupil wellbeing by fostering strong relationships among all members of the school community, creating a supportive environment that values the wellbeing of everyone. The WSA framework recommends that schools introduce setting-specific systems and integrate the WSA into the curriculum to support a flexible approach to implementation (Brown et al., 2023) and distinguishes between universal and targeted interventions. Universal interventions aim to support young people in understanding their own wellbeing, building resilience and coping strategies for everyday challenges, and recognising when support is needed. These skills can be achieved through a combination of evidence-based structured programmes and a school ethos that fosters trusting relationships between staff and pupils. In contrast, targeted support should be proportionate, ranging from low-level early interventions, such as empathetic responses from trusted adults, peer mentoring, or alternative break-time provision, through to talking therapies and specialist support for those who need it. Targeted support should be evidence-based and presented and delivered in a non-stigmatising way, and delivered based on evidence of need, rather than a formal diagnosis (Welsh Government, 2021a).

Alongside the introduction of school counselling to be made available to all pupils from Year 6 and throughout their school career (Education Wales, 2020) the use of a WSA may make early intervention mental health support accessible to a much wider range of young people than has previously been possible but does require the engagement of all school staff, pupils and families (Brown et al., 2023). Research indicates that not only are early interventions aimed at supporting the mental health and wellbeing of children and adolescents effective (McGorry & Mei, 2018), but they may also help prevent the escalation of mental health issues in adulthood (Brown et al., 2023).

3.1.2 Relationships with staff

The Wales WSA also advocates for good relationships between staff and pupils, emphasising the importance of a supportive school climate. As previously mentioned, it is well established that pupils with good relationships with their teachers tend to have better wellbeing (Aldridge & McChesney, 2018). However, research also indicates that the *quality* of relationships between school staff and pupils affects pupils' willingness to seek support for their mental health (Halladay et al., 2020). Krane et al. (2016) describe these relationships in two dimensions: *Affective relationships* encompass characteristics such as emotional support, closeness, and caring; *Evaluative relationships* include factors such as respect, trust, and judgment. A systematic review by Aguirre Velasco et al. (2020) found that trusted, strong relationships with potential gatekeepers, such as school staff, were commonly cited as a facilitator of adolescents' access to mental health support. Trusting relationships can help reduce barriers such as fear, shyness and perceived stigma (Gulliver, Griffiths, & Christensen, 2010; Yap, Reavley, & Jorm, 2013) and where teachers can identify pupils with mental health support and engage with them, access to support may be improved (Kidger et al., 2010; Halladay et al., 2020). In contrast, poor relationships between teachers and pupils may negatively impact pupil mental health by reducing self-esteem (Krane et al., 2016). Furthermore, teachers with poor mental health are likely to find it more challenging to develop good relationships with pupils (Harding et al., 2019), may struggle to maintain a supportive environment, and find it harder to manage classrooms (Jennings & Greenberg, 2009).

3.1.3. Pastoral staff

In a report produced for UNICEF on the global picture of children's mental health, Keeley (2021) suggests that pastoral care systems in schools are ideally placed to challenge stigma surrounding mental illness. Pastoral support can be provided by any member of school staff, with some teachers expressing how much they enjoy the role and working with a child beyond the traditional teacher-pupil relationship (Rice O'Toole & Soan, 2022). In light of growing recognition of the importance of pastoral care, there is an expanding range of support roles within schools aimed at promoting pupil wellbeing, such as teaching assistants and 'pastoral' or 'wellbeing officers' (Littlecott et al., 2018). There is no single, consistent description of pastoral care as a dedicated role, and expectations may differ across settings. However, the key areas of responsibility generally include supporting pupils with emotional and mental health needs or challenging behaviour (Rice O'Toole & Soan, 2021). Pastoral care has been shown to work by providing a supportive environment that nurtures socio-emotional skills, particularly for vulnerable pupils (Cowie, 2022). Littlecott et al. (2018) suggest that such support staff are well placed to have the space and time to respond quickly to pupils' wellbeing concerns, and that faster service provision can support more rapid resolutions. However, finding time for pastoral care within structured schedules can be challenging for teachers. Their research also highlights that positive relationships built by support staff with pupils can encourage help-seeking behaviour, as pupils tend to approach adults they trust for support. They go on to suggest that pupils generally prefer having options among teaching and support staff from whom they feel comfortable seeking help. Additionally, having a dedicated team responsible for wellbeing indicates to pupils that the school prioritises mental health, which also reassures wider stakeholder groups (Littlecott et al., 2018; Jessiman et al., 2022).

Research suggests that tensions between teaching and pastoral staff are linked to role expectations, training, and perceived status. Unlike other support staff, such as teaching assistants, there is no formal training requirement for the role of pastoral or wellbeing officer, which some suggest leads to a lack of status (Long, 2022). This lack of training and status may contribute to difficulties sometimes experienced in relationships between teaching and support staff, including a lack of trust between parties and inconsistencies in approaches to pupil support (Rice, O'Toole & Soan, 2022). Rice, O'Toole & Soan (2022) highlight that pupils seeking additional support from a member of the pastoral care team may have some of the greatest needs, yet are often supported by someone with little or no relevant training; in the same study, teachers perceived overfamiliarity between some support staff and pupils, as well as resentment that support staff were not subject to the same levels of accountability as teaching staff.

3.2 School-based counselling

School-based counselling is distinct from pastoral support and is one of the most prevalent forms of psychological therapy for young people in the UK (Department for Education, 2016). This may be because schools are in a position to offer pupils access to counselling that cannot be matched by any other service. When schools provide mental health support, it becomes available and accessible to pupils, some of whom would not seek it through other means (McPhail et al., 2024). Overcoming barriers to time, location, and cost can increase usage and reduce inequalities in counselling services (Cooper, 2021). However, access to school-based services is not necessarily straightforward for many young people. Pupils are often reliant on staff to refer them to the service. In Wales in the 2022-23 academic year, 57% of referrals came from school staff, compared with 24% from pupil self-referrals.

Despite the majority of referrals being made through school staff, Prior (2012) suggests that self-referral is increasingly seen as an important access route for pupils. He outlines six stages that young people go through in the emotional process of deciding to engage in counselling. The first four stages happen before meeting with a counsellor, while stages five and six follow reflection on the initial counselling experience.

1. Recognition to self of a concern.
2. Interaction with a supportive adult who can inform and enable access to counselling.
3. Consideration of engaging with counselling. This includes re-evaluating the decision to seek support after a conversation with a supportive adult and deliberating on the possible advantages and disadvantages of engagement.
4. Decision to meet with a counsellor.
5. Assessing the reliability and trustworthiness of the counsellor and developing confidence in the confidentiality of the service.
6. Decision to open up fully to the counsellor.

Prior (2012) goes on to suggest that developing supportive systems, such as normalising help-seeking and giving young people the autonomy to seek help, would be beneficial in supporting them through the engagement process.

3.2.1. Pupil views and experiences of counselling

Reflections from pupils who have engaged with a school-based counselling service are largely positive (Fox & Butler, 2007), and counselling services are rated as helpful by the majority of users (Cooper, 2006). Pupils report that the chance to discuss their problems (Cooper, 2004), learning coping strategies and receiving advice (Bondi et al., 2006), and feeling accepted (Cooper, 2009) are the most helpful elements.

Pupils' criticisms of counselling commonly focus on concerns about confidentiality (Radez, 2021; McPhail et al., 2024) and on the counselling approach not being as directive as pupils wanted (Cooper et al., 2025). Evidence suggests that young people generally offer improvements to services rather than criticisms (Cooper, 2009; Raynham et al., 2023). In terms of delivery, pupils wanted the counsellor to have more availability, with options for more sessions, better promotion of the service, and assurances of privacy and confidentiality. The data did not include feedback from young people who had not accessed counselling.

3.2.2. The Welsh approach to school counselling

The *National Strategy for School-Based Counselling Services* (Welsh Assembly Government, 2009) was introduced in 2008 to make high-quality counselling accessible to all secondary school pupils in Wales. In 2023/24, 13,935 young people accessed counselling. Sixty-six per cent of the service users were girls, and 84% were in school years 7-11. 61% of referrals to the counselling service came from school staff, and the most common reasons for referral were anxiety and family issues.

The evaluation of the strategy's implementation was carried out in two stages. The *Stage One report* was published in July 2011 (Welsh Government, 2011a), with the final report following in November of the same year (Welsh Government, 2011b). Both reports stated that nearly all children who accessed a support service experienced positive outcomes (Welsh Government, 2011a; 2011b) and highlighted the ease with which young people could access the service as a strength of school-based services (2011a). Feedback from those who had used counselling was very positive, with almost 90% saying they would use it again if needed, and nearly 75% saying they would recommend it to a friend. However, these figures were obtained from a Post-Counselling Evaluation Questionnaire, which had a response rate of less than 10% of pupils who attended counselling sessions (2011b). A 2019 Estyn evaluation (Benjamin, 2019) highlighted that not all schools could provide suitable counselling accommodations, which could compromise confidentiality and accessibility. Concerns were also raised that, in some cases, school staff controlled who could access the service. Following the Welsh Government's 2021 WSA framework and the additional funding allocated to expand school counselling services (Welsh Government, 2023b), a review was commissioned to assess whether the current service was fit for purpose, explore extending provision to younger children, and make recommendations for improvements (Hewitt et al., 2022). The review emphasised the importance of flexible delivery, provision of suitable space, and support for access to ensure effective implementation of the counselling service. Self-referral for secondary school pupils was recognised as a key means of improving confidentiality and autonomy. However, some staff expressed discomfort with this method, as they would be unaware of pupils accessing counselling and therefore unable to provide additional support (Hewitt et al., 2024).

Further findings from the Welsh Government-funded review (Hewitt et al., 2022) indicated that key stakeholders (young people, parents/carers, school staff, and LA counselling service leads) perceived counselling services as insufficient, with long waiting times risking the worsening of symptoms in young people. There was variation in how counselling services assessed referral eligibility and prioritised cases, with some services prioritising referrals by date received and others by the level of need indicated in the referral information. The review suggested that adopting a child-centred approach to counselling delivery models could expand reach, as young people would be more likely to engage with services aligned to their preferences and needs. Several recommendations were made, including:

- **Recommendation 3**: A set of core features should characterise a future high-quality school and community-based counselling service in Wales. These include a range of referral routes, a combination of appointment and drop-in sessions, various therapeutic approaches, a designated and suitable space, and multiple delivery formats.
- **Recommendation 5**: Primary and secondary school-aged children and young people should be provided with more information about counselling services. This information should consider the aims of counselling, the identity of the counsellor, how confidentiality will be maintained, the cost of provision, and what children and young people may experience when they attend.
- Recommendation 9: Key system stakeholders need to engage in multi-agency working to ensure that mental health services, including counselling, best meet the needs of primary and secondary school-aged children and young people. Key

stakeholders who should be involved are children and young people; parents and carers; counsellors and counselling services; educational professionals; third-sector organisations; and Local Authority health and social care services.

3.3. Other mental health support in schools in Wales.

From 2018 to 2021, the Welsh Government funded the CAMHS In-Reach to Schools Pilot Programme (Welsh Government, 2021e), which aimed to improve access to specialist support and enhance schools' ability to manage mental health concerns locally in Wales. The programme placed CAMHS staff as a link between schools and the CAMHS service. Their role was to provide training to school staff to support their ability to meet pupils' mental health needs and to be available to support when specialist interventions were required. In some Local Authorities, they were also expected to act as a liaison between schools and specialist services. Findings from the pilot review by Holtom et al. (2021) indicated that the programme was generally effective. After receiving training, school staff felt more confident in supporting pupils who reached out for help, and decisions about referrals to specialist services were made more efficiently. Improved communication between schools and specialist services through the liaison role increased the continuity of support for pupils and had a small impact on staff wellbeing. Following the completion of the pilot, local authorities now run School In Reach programmes to improve early intervention and access to support for both staff and young people in education settings.

A joint review carried out by the Health Inspectorate, Care Inspectorate, and Estyn (Healthcare Inspectorate Wales, 2024) in Wales highlighted that improved access to preventive initiatives and support, an increasing number of school-based counsellors, and the introduction of the WSA Framework were among the positive developments identified within education services. However, the surge in demand for mental health support services, intensified by the pandemic, puts an increasing burden on resources, and school leaders have highlighted a pressing need for additional staffing and specialist provisions.

3.4. Adolescents’ experience of help-seeking.

Research shows that girls are more likely than boys to seek help for their mental health, and become increasingly likely to do so as they get older, whereas for boys, who are less likely to seek help at all, the likelihood of them seeking help decreases with age (Mariu et al., 2012). In general, greater symptom severity is associated with a greater intention to seek help (Ashworth & Saini, 2024). However, for young people who internalise their symptoms, the opposite is true, and they become less likely to seek support (Allouche et al., 2021). Recent statistics for Wales show that between 2015/2016 and 2021/2022, girls consistently made up approximately two-thirds of school counselling users. However, it is worth noting that during this time period, data were not tracked for any gender identification beyond the binary categories of ‘girl’ or ‘boy’.

3.4.1. Facilitators to help-seeking.

One definition offered for help-seeking for mental health concerns is “an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns” (Rickwood & Thomas, 2012, p.180). Ajzen's theory of planned behaviour (1991) can be applied to understand young people’s motivation to seek help for their mental health and access external support. Ajzen identifies three conditions that support this: the person’s “attitude towards the behaviour” and whether it is seen as beneficial or not; the “subjective norm attached to the behaviour” – the social pressure to carry out the behaviour; and the “perceived behavioural control” – a person’s perception of how easy or difficult it will be to carry out the behaviour, which is dependent on the availability of opportunities, and resources including the skills to carry out the behaviour and the cooperation of others. When applied to adolescents seeking support in school, this involves a belief that support will be helpful, the social acceptability of seeking help, and awareness of and knowledge about available support services. As previously discussed, mental health literacy encompasses domains related to knowledge, stigma, and help-seeking (Wei et al., 2015). Ratnayake and Hyde (2019) suggest that individuals with higher levels of mental health literacy exhibit greater help-seeking behaviour.

3.4.2. Barriers to help-seeking.

While much of the research surrounding school-based counselling is very positive, it does not necessarily represent the experiences of young people who do not access it (Gronholm et al., 2018). It is important to understand the reasons behind this, as one of the most significant obstacles to the early intervention and prevention of escalation of mental health concerns is poor rates of help-seeking (Rickwood & Thomas, 2012). Radez et al. (2021) suggest barriers can be grouped into four categories: (1) young people's individual factors, (2) social factors, (3) relationship factors, and (4) systemic and structural factors.

Individual factors include mental health literacy, perceptions of help-seeking, and self-reliance or autonomy. Poor mental health literacy may result in young people not having adequate abilities to recognise signs and symptoms of declining mental health, in self and others, and a lack of awareness of available support (Aguirre Velasco et al., 2020). Gronholm et al. (2018) also found that some pupils feel anxiety about the support service itself – how to initiate contact, what to expect from it, and apprehension about having to share personal information. They were worried they would be judged for needing support and, as a result, downplayed their need for help. Maturation and the accompanying desire for autonomy, as well as the perception that problems should be managed independently, may also contribute to adolescents' avoidance of help-seeking behaviour (Haavik et al., 2019).

Social factors refer predominantly to stigma. Stigma is one of the most commonly reported barriers to help-seeking (Rickwood et al., 2005; Gronholm et al., 2018; Aguirre Velasco et al., 2020). Gronholm et al. (2018) suggest that anticipated and experienced stigma, both internalised and from others, prevent adolescents from seeking help. Pupils report concerns about peer responses to mental health support service use, expressing anxieties about being labelled negatively by peers, rejection from the peer group, and bullying. They also raise concerns about judgment by adults, with some pupils reporting that they felt teachers treated them differently because of their use of support services (Gronholm et al., 2018). Family-held beliefs also fall under the bracket of social factors. Familial poor communication and distrust of health professionals, or previous bad experiences with mental health support, can lead to a belief that treatment will be ineffective. (Aguirre Velasco et al., 2020).

Relationship factors reflect the quality of the relationship between the young person and the source of support and may be influenced by factors such as trust and confidentiality. This relates to informal help-seeking, where young people are concerned about friends sharing personal information, and to formal help-seeking, characterised by a lack of trust in counsellors' ability to maintain confidentiality (Gronholm et al., 2018; Rickwood et al., 2005, 2007). These views are typically related to previous experiences (personal or peer), misconceptions about the service, or a belief that the therapist lacks skill, competence, or qualifications (Wang et al., 2020).

Systemic and structural factors include the availability and accessibility of support. Delays in receiving help due to limited availability and long waiting times have been identified as a significant issue for adolescents (Haavik et al., 2019). Additionally, pupils say they find it difficult to attend support sessions without their peers knowing. Sessions taking place during lesson time, and the location of the counselling room being conspicuous, lead to a lack of privacy, which creates a barrier for many young people, despite all efforts to increase openness and reduce stigma. (Pretorious et al., 2019; Radez, 2021).

3.4.3. Demographic context

There are several demographic factors of interest regarding help-seeking and access to mental health support. Pupils from lower socio-economic backgrounds tend to report poorer wellbeing (Reiss, 2013; Page et al., 2023), and there is some evidence that socioeconomic status negatively influences young people’s sensitivity to and uptake of help-seeking opportunities (McPhail et al., 2024). Guan et al. (2024) suggest that children from ethnic minority groups in the UK face broadly similar mental health risks as White British children. A 2021 review found mixed experiences with Welsh-medium counselling, highlighting a shortage of trained Welsh-speaking counsellors and concerns that Welsh-medium services may not always be delivered in a timely manner (Welsh Government, 2021f), despite the Welsh Government *Counselling Operating Toolkit* (2020), which mandates that Local Authorities ensure pupils who prefer to take part in counselling in Welsh have equal access to the same level of service as in

English. However, the following section will focus on gender, as the most consistently measured characteristic in UK youth mental health datasets and reviews, and because disparities in help-seeking behaviour among boys are well documented.

3.4.4. Gender differences

As with counselling, research finds there are differences by gender in the likelihood of adolescents seeking any mental health support. Girls are more likely to have an awareness of support services but recognise more barriers to accessing them (Haavik et al., 2019), and boys typically have lower levels of mental health literacy (Rice et al., 2021). Sagar-Ouriaghli et al. (2020) suggest that the use of mental health services is seen as threatening to some male pupils, and an affiliation with hegemonic masculinity ideals may create resistance in help-seeking behaviour in boys (Clark et al., 2020). Stentiford et al. (2024) indicate that gendered discourse still influences the acceptability of help-seeking behaviour, with it being perceived as a feminine trait, and that there is increased social acceptance of girls discussing their emotions and taking advantage of opportunities to engage with helpful resources. While service use by males is growing (Johnson et al., 2018), the young male demographic not only has the lowest rate of help-seeking and engagement with mental health support (Slade et al., 2009), but they also withdraw from support earlier than their female counterparts (Seidler et al., 2020). Research suggests that there is a need to tailor mental health support services to engage adolescent males, with a lack of scholarship dedicated to advancing gender-sensitive, male-friendly interventions for adolescent males (Boerma et al., 2023). There have been demands for youth-specific, gender-sensitive interventions (Rice et al., 2021), as much of the literature on ‘male-friendly counselling’ focuses on the adult male population (Beel et al., 2018; Swift et al., 2018).

In an effort to understand approaches to improving help-seeking among males, Sagar-Ouriaghli et al. (2020) conducted focus groups with male university students in the UK. The research highlighted the need to protect male vulnerability, the benefits of a help-seeking narrative tailored to boys and men, the necessity of tailoring intervention formats, and approaches to engage male students. Haavik et al. (2019) suggest that services should be perceived as accessible, avoid causing the service user to lose autonomy, and reduce concerns about being treated differently as a result of using the service.

3.5. Pupil voice

There is very little evidence of young people being involved in the design of mental health services aimed at engaging them. Faithfull et al. (2018) suggest that the reasons for researchers' hesitancy to involve young people in mental health research are complex but, like broader participatory opportunities, relate to a poor understanding of participation, concerns about power dynamics, and fears of losing control over the process. Typically, when young people have been consulted, it is to reflect on their experience of a service, to understand whether it achieved its aims, or to identify barriers to accessing services. This section will explore the application of pupil voice in more depth, drawing on Article 12 of the UNCRC and the WSA Framework in Wales. It will highlight some of the theories underpinning pupil voice and the challenges involved in meaningfully listening to pupils.

As previously discussed, Article 12 of the UNCRC states all children have "the right to express their views, feelings and wishes, and to have their views considered and taken seriously". The National Participation Standards in Wales (2018) set out seven stages of the participatory process to fully meet the requirements of Article 12, stating that all children:

1. Have the right to information that is easy for them to understand and allows them to make an informed decision.
2. Have the right to choose to be involved and to work on things that are important to them.
3. Are all different and have the right to be treated fairly.
4. Have the right to have a say. Their opinions are important and should be respected.
5. Have positive experiences and the right to work with others to make a difference.
6. Have the right to know what differences have been made as a result of their input, and how their ideas have been listened to.

7. Decision makers should put children’s rights at the centre of everything they do.

These standards can also be conceptualised through the Lundy model of Space, Voice, Audience and Influence, which was discussed in Fig. 1 .2 of Chapter 2. The stages of providing ‘audience’ and ‘influence’ reflect the ‘due consideration’ of children's views and require onward actions and support from adults. As a result, where pupil voice opportunities are tokenistic, these are the domains that are most likely to be missed. Lundy highlights that children have no guarantee their views will be heard by those in a position to act on them, suggesting a need for a ‘right of audience’ and for formal channels to be established so children’s views can reach decision-makers. Furthermore, young people should be informed how decisions were made and how their views were considered in reaching such decisions. Sinclair (2004) argues that schools need to undergo a shift in culture to one where pupils’ views are an integral part of decision-making, while Lundy (2007) asserts that all adults in the education sector should be aware of the weight of Article 12, which is legally binding and should be applied in all educational decision-making.

Research shows that pupil consultation and inclusion in school processes are beneficial to both the school and the individual pupil. Keddie (2014) positions pupils as a resource for school improvement, Hargreaves & Shirley (2009) describe them as ‘partners of change’ (p.82), and Woods & Macfarlane (2017, p.85) reflect that in ‘great schools’ pupils have their voice heard at every level, both through formal processes and through everyday opportunities in the classroom. However, Jones & Bubb (2020) find that even in schools that value democracy and pupil voice, its implementation is challenging. Furthermore, many pupils regard the mechanisms to promote pupil voice as unsatisfactory (Jessiman et al., 2022). Research shows that not all pupils recognise that they can participate in such opportunities, and many feel ignored and powerless (Keisu & Ahlström, 2020). It is essential to ensure that the voices heard from pupils are diverse and representative of the whole school community, not just those who present as articulate and responsible (Bragg, 2007; Flutter, 2007). Where this is the case, while visible, pupil voice lacks any authentic influence (Whitty & Wisby, 2007; Cremin et al., 2011; Czerniawski, 2012). Where disengaged groups of pupils are not represented or heard, there is a missed opportunity to understand and learn from their insights and to address their disengagement (Flutter, 2007).

Keisu & Ahlstrom (2020) suggest three sub-discourses related to the impact of power on participation in schools: **Normative barriers to participation -** a sense of loyalty within the teaching team, resulting in a perceived lack of loyalty to pupils. This makes collaborative working between teachers and pupils challenging. **Structural barriers to participation** – the power imbalances between pupils and teaching staff and the need for structures in place to overcome these; and **openings in the barriers to participation work** – these openings are typically via the teachers who believe in the ethos of pupil voice, which carries an inherent risk of the school relying on those teachers to provide participatory initiatives and not integrating participation opportunities into school philosophy. The presence of these discourses in schools may contribute to the absence of meaningful pupil voice.

In line with the requirements set out in Article 12, the WSA Framework (2021) makes 'having your voice heard' one of its three core values, demonstrating an expectation that pupils are empowered and feel safe to speak up, and that their views will be given due consideration. It also calls for pupils to be seen as 'valued contributors' to the development and implementation of a school's WSA, stating that "learner feedback is actively encouraged and given due consideration" (p. 12). Coproduction is highlighted as a vital element in implementing and evaluating the WSA Framework, and the document makes clear that while school councils are one mechanism through which pupils can participate in this process, those pupils who are not part of such groups should also have opportunities to contribute. Furthermore, Estyn's Healthy and Happy report (Estyn, 2019) highlights the importance of school leaders and staff genuinely listening to learners, rather than merely having systems in place for pupil representation.

3.5.1. Examples of pupil voice enactment

When pupils are authentically included in decision-making in school, Foulkes & Stapley (2022) point out that the value of this lies in the fact that, by their nature, young people are experts in their own experiences and are able to offer an alternative, and more meaningful, perspective to those with decision-making power, such as policymakers.

Where researchers understand how young people experience interventions, they are better equipped to modify them, making them more engaging and potentially more effective (Foulkes & Stapley, 2022). Co-production can be an effective mechanism for addressing the power imbalance between those who design or deliver interventions and those who use them; however, it can be particularly challenging within the hierarchical structure of a school environment. A study by Kohfeldt et al. (2011) found that challenges faced by young co-researchers in schools included negative responses from staff, limited resources, and a sense that adults controlled which issues should or should not be raised. Evidence suggests that the opportunities for young people to share their ideas and effect change at the service design stage remain limited (Bromark et al., 2023).

3.6. Summary

This literature review has considered existing research on pupils' access to mental health support in secondary schools, situating it within the broader literature on children's rights, Welsh policy, and pupil voice. It highlights the importance of rights-based, participatory approaches to school-based mental health support. The WSA Framework provides the policy context in which these principles are expected to be enacted in practice, while the UNCRC offers the normative foundation for understanding children's entitlement to participation, information, and appropriate support. This study is therefore framed at the intersection of children's rights and the WSA Framework, using young people's perspectives to examine how these principles are experienced in practice. This review has highlighted multiple challenges in delivering mental health support and in incorporating a rights-based approach meaningfully. The study aims to contribute to this literature by seeking young people's views on what supports or hinders their access to school-based support services and by examining whether a rights-based approach can be employed more meaningfully in research. Most of the literature on this topic focuses on the facilitators and barriers to existing, adult-designed support services. When considering improved access, much of the research fails to differentiate by gender, and there is a notable lack of adolescent male perspectives that could help address this issue. This thesis seeks to address this gap by exploring issues from the perspective of young people.

The following chapters aim to answer the research questions:

3.6.1. Research questions:

1. What do young people think the barriers and facilitators are to accessing mental health support in schools?
2. How would young people make mental health support services in schools more accessible to pupils?
3. What would a pupil-designed service in schools look like?

The next chapter aims to explain the rationale behind the methodology used to answer these questions.

Chapter 4 Methodology

4.1 Introduction

This chapter discusses the methodological approaches and methods chosen for this thesis. It is broken down into three sections. The first section focuses on the research design, explaining the rationale for using a children's rights approach and a mixed-methods design. This will be done by using relevant literature to justify the decisions and the appropriateness of the methods for exploring the research questions. The second section focuses on the research process, covering collaboration with the advisory group to develop the research instruments and conducting fieldwork. Modifications to planned research will also be addressed. The third section explains the analysis and evaluation of the data.

This study sought to explore pupils' views and experiences of school-based mental health support through a children's rights lens, with particular attention to how accessible, responsive, and participatory these systems are from young people's perspectives. The methodological approach was therefore designed not only to gather evidence about pupils' experiences, but also to embed a children's rights perspective throughout the research process. A key methodological aim was to examine how children's rights, particularly the right to be heard, can be ethically and meaningfully put into practice in the context of school-based mental health research.

4.2. Philosophical approach

It is important to recognise that all researchers have unique experiences, perspectives, and values that shape their worldview and research approach. Situating research within a philosophical position clarifies how the researcher conceptualises key issues, such as the values they hold and how they interact with the research they are conducting. Adopting a mixed-methods approach to research can make defining this position more challenging, as the opposing positivist and subjectivist paradigms underpin quantitative and qualitative research, respectively (Bryman, 2016). Shannon-Baker (2016) identifies that critical realism is compatible with both research methods and argues that, when used together, quantitative and qualitative research can address each other's limitations.

A critical realist stance adopts a constructivist epistemology, asserting that the world is constructed and understood through individual perceptions, while situating this within a realist ontology that posits a real world existing independently of our perceptions and constructions (Bhaskar, 1975). This allows for an understanding of the social world that recognises both the organised social structure and the agency of those inhabiting it (Mukumbang, 2023).

Critical realism has three distinct layers (Bhaskar, 1975) – the empirical (events as we experience them), the actual (events as they occur, whether observed or not), and the real (causal mechanisms within structures that cause empirical-level events to occur).

This study examines these assumptions by investigating pupil engagement with school support services. Critical realism helps us understand the underlying causal relationships in social events and is useful for making recommendations for change in addressing social issues (Fletcher, 2017). It places an emphasis on the importance of perspectives in research, particularly the need to attend to variations in situated meanings and avoid suppressing difference when interpreting empirical data (Modell, 2009), making it an appropriate stance for research questions that seek to understand the perspectives of an underrepresented group.

This study adopts a critical realist perspective across three domains. At the real level, it presumes enduring mechanisms, such as rights-based governance, access to trusted adults, and mental health literacy, with causal effects. Within school contexts (culture, systems, and resources), these mechanisms may be triggered, generating actual events and practices such as the delivery of universal and targeted support, engagement with services, and changes in help-seeking behaviour. The empirical domain consists of pupils' accounts of accessing and experiencing support.

Shannon-Baker (2016) asserts that critical realists value perspectives, voices and viewpoints, yet acknowledges that these perspectives are only a partial depiction of reality (Maxwell & Mittapalli, 2010). This makes this stance advantageous for evaluative studies by helping to understand how and why an intervention works. Furthermore, this range of perspectives underpins the decision to gain a deeper understanding of the school context and the wider policy landscape, as explored in the literature review.

This thesis argues that pupils' views and experiences can offer a new perspective, making a valuable contribution to the design of school-based mental health support services.

4.3. Design of research

4.3.1. Children's rights approach

The introduction of the Convention on the Rights of the Child has influenced some of the approaches to conducting research with children. There has been a growing movement away from treating child participants as passive and towards recognising them as active subjects, with participatory approaches becoming more commonplace (Bessell, 2017).

As discussed in the previous chapter, while those using a participatory approach may refer to Article 12, commonly cited as 'children's voice' or 'listening to children', the loose application of the article alone does not ensure the authentic participation of young people. The articles of the UNCRC are interdependent, and using a children's rights approach to research requires the fulfilment of a greater number of Convention Articles. It is important to build capacity (Lundy & McEvoy, 2012) in children to form these views by interpreting Article 12 alongside Article 5, summarised as the right to be supported and guided by adults, Article 13, which relates to a child's right to freedom of expression and Article 17, which provides the right to access to impartial and wide-ranging information. Lundy's model of participation (2007), shown in Chapter 2 (Fig. 1.2), provides a helpful framework for this research, particularly for its methodology.

In this study, a children's rights approach positions young people as co-researchers (Lundy & McEvoy, 2011). Their role will be to frame the research from a young person's perspective, support the development of research instruments, assist with data interpretation, and suggest solutions to address the findings.

Lundy & McEvoy (2012b) suggest three principles for carrying out rights-based research:

i) Using children's rights standards to inform research design.

ii) Building the capacity of rights-holders to claim their rights.
iii) Building the capacity of duty-bearers to fulfil their obligations (p.79–82).

While Lundy & McEvoy (2012b) suggest that it is unusual for research to meet all three of these principles, this research aims to do so.

As discussed above, endorsing children as rights holders has changed the way they are involved in research. There has been a shift from research *on* children to research *with* children, and research methodologies have evolved to meet this change, supporting the move to active, rather than passive, participants (Alderson & Morrow, 2011; Bradbury Jones & Taylor, 2013). There are, however, a number of criticisms and potential weaknesses associated with working with children as co-researchers (Kellett, 2010), which Bradbury-Jones & Taylor (2013) summarise as six challenges. A counter-challenge and solution is offered to each of these challenges:

Challenge 1. Children lack research competence – Children are often assumed to lack the knowledge and the capability to participate fully as co-researchers. As discussed earlier, as specified by the UNCRC, it should be assumed that a child has the capacity to form and express their own views. This should not be seen as a barrier to engagement, but rather as a demonstration of the need to choose appropriate methods that support children's maximum engagement (Kellett, 2010; Bradbury-Jones & Taylor, 2013).

Challenge 2. A comprehensive training programme is required – there are significant time and resource implications to this; however, if the value of the research will be magnified by young people's involvement, then they must be properly prepared and supported to be fully involved (Bradbury-Jones & Taylor, 2013)

Challenge 3. Insider/outsider perspectives are difficult to balance – there is a risk of viewing young people as a homogeneous group (Hunleth, 2011). This view is not specific to adults; research by Kellett (2011) found that young researchers are often surprised to learn that their peers do not always share the same views and opinions as they do. The benefits of bringing the insider perspective of young people to the research process far outweigh the risks. Young people are able to bridge the generational gap (Kellett et al., 2004), which is particularly useful when framing the language used in research instruments. A further benefit of an insider perspective, identified by Lundy et al. (2011), is that young researchers can apply their own perspectives to the findings, thereby avoiding the risk that adult explanations may skew children's answers.

Challenge 4. Remuneration is complex – Schafer & Yarwood (2008) found that many young people viewed the training they received and interest in the research topic as compensation for participating in the research. However, not appropriately remunerating young people runs the risk of compounding the power inequality.

Challenge 5. Power differentials need to be overcome – the automatic power imbalance between child and adult researchers must be acknowledged. Pascal & Bertram (2009) discuss how adults should avoid directing the discussion, how to accurately record what is said, and how to interpret what others are saying. Power in peer-to-peer relationships (Kellett, 2011) must also be considered. This can include the risk of more persuasive young people taking over the research or valuing findings that align with their own thinking more highly. These risks are balanced by the significant benefit of the opportunity to raise the voices of children (Bradbury-Jones & Taylor, 2013) with the intention of making a positive impact.

Challenge 6. Children need to be protected – this challenge focuses on the issues of consent, confidentiality, and safeguarding. Ensuring that consent is both informed and age-appropriate is difficult, as is determining whether consent should be obtained from the young person or their parents. Some suggest that confidentiality is more hazardous when young people conduct research, and this can be further affected by the power dynamics within a group (Kellett, 2011). A particular risk in this research is the potential impact on the wellbeing of the young people, as it addresses a sensitive topic. Coad and Evans (2008) stress the importance of allowing time for debriefing and addressing any difficult issues that arise during the research. While the ethical burden rests with the adult researcher, the potential increase in research strength that comes from involving young people counterbalances this.

The rest of the chapter will outline how the research design was intended to address each challenge.

4.3.1.1. Reflecting on challenges in adopting a children's rights approach

While the previous section outlined some of the theoretical challenges associated with adopting a children's rights approach, it is also important to reflect on how these challenges were encountered and responded to in practice within this study.

One challenge identified in the literature is the risk of treating children and young people as a homogeneous group (Hunleth, 2011). This was a consideration throughout the research process. Although participants were drawn from the same school and academic year, their experiences of mental health, help-seeking, and participation were shaped by a range of intersecting factors, including gender, socio-economic background, cultural expectations, and differing levels of confidence and agency. Previous research has highlighted that young people's perspectives are socially situated and relational, and that presenting youth voice as uniform can obscure difference and reinforce dominant narratives (Holland & Renold, 2016).

A number of steps were taken to address this. Using multiple methods allowed pupils to engage in different ways: the survey offered a low-threshold, anonymous opportunity to share views, while interviews and the focus group supported more detailed, conversational accounts. This recognised that pupils differ in how comfortable they feel expressing their views, and that no single method is equally accessible to all. Attention was also paid to diversity within the sample, particularly in relation to gender and self-described identity, and care was taken during analysis not to privilege more confident or frequently expressed views. Where pupils' perspectives differed, these differences were treated as analytically meaningful rather than as inconsistencies to be resolved.

Reflecting on protected characteristics under the Equality Act also highlighted the complexity of representation in rights-based research. While demographic data were collected, the study was not designed to examine specific protected characteristics in isolation. This meant there was a risk that some pupils' experiences might be less visible within aggregated findings. This limitation was addressed reflexively by remaining attentive to how structural inequalities and social positioning could shape pupils' access to support and willingness to participate, and by avoiding claims that pupils' experiences were universally representative.

These challenges were particularly evident in school-based research, where young people are often grouped by age, year group, or institutional category, and opportunities to disaggregate experiences by protected characteristics are limited. Although rights-based approaches emphasise inclusion and participation, there is a risk that the structural features of school settings can unintentionally smooth over differences, particularly where aspects of identity are not visible or where pupils may not feel able to disclose them. This highlights the need for ongoing reflexivity when interpreting pupils' accounts, and for caution in assuming that participation alone ensures that all voices are equally heard.

Adopting a children's rights approach also required careful navigation of insider and outsider roles. While positioning young people as contributors to the research supported relevance and authenticity, it also required ongoing reflexivity to ensure that adult assumptions did not shape or constrain pupils' contributions (Holland et al., 2010). Through these approaches, the study sought to uphold children's right to participate while remaining transparent about the challenges and limitations of representing diverse young people's voices in research settings.

4.3.2. Mixed Methods design.

Quantitative and qualitative methods offer complementary approaches to research. Quantitative methods are concerned with the measurement and analysis of numerical data, enabling the identification of patterns and the making of claims that can be generalised to wider populations (Cresswell & Cresswell, 2017). However, quantitative approaches may not fully capture the meaning of participant experiences. In contrast, qualitative methods foreground participant perspectives (Denzin & Lincoln, 2008), often using smaller samples that may not be generalisable, and may be biased by the researcher's opinions and experiences (Hammarberg et al., 2016).

Quantitative data, grounded in a positivist paradigm that assumes an objective reality can be measured, is effective for highlighting broad patterns and relationships. It is limited in its ability to capture complexity and nuance (Silverman, 2011), but a key strength is that participants' responses are treated as equally valuable, allowing all voices to contribute equally. In contrast, the interpretivist position of qualitative data emphasises the meanings that individuals attach to their experiences. The data provide more contextual insights but inherently privilege some perspectives over others (Denzin & Lincoln, 2007). Critical realism merges these different paradigms and supports the idea that social structures and individual agency can coexist. (Mukumbang, 2023).

Mixed methods research is based on the principle that the research questions should inform the choice of methods (Silverman, 2011). Data drawn from both quantitative and qualitative methods provide a more comprehensive understanding of the issue for the researcher (Creswell & Creswell, 2017). The research questions in this thesis could not be comprehensively answered using a single approach; therefore, a mixed-methods approach was selected to gather a broader set of perspectives and more detailed findings, which reflect the study's critical realist underpinnings. The quantitative strand of the research employs a survey method, allowing for a larger sample of pupils, while the qualitative strand utilises semi-structured interviews and a focus group with pupils to deepen the understanding of the quantitative findings (Yauch & Steudal, 2003). Each research type has its advantages and disadvantages, and a mixed-methods approach can help counterbalance these weaknesses. Although it was originally planned to use a sequential design, with qualitative research to explore the quantitative findings, the opportunity arose to gather significantly more quantitative data when the Welsh Government requested the inclusion of questions on school-based counselling in the WISERD Education Multi-Cohort study. This led to the adoption of a multiphase design (Creswell & Plano Clark, 2017), which enabled triangulation of the quantitative data. The quantitative and qualitative elements of the research were combined using what Bryman (2016) describes as context. The quantitative survey data provided a broad picture of young people's views and experiences, which were given context through more focused qualitative interviews, where young people could provide more detailed answers about their views and experiences.

4.3.3. Use of mixed methods within a children's rights approach

A mixed methods approach is appropriate for a children's rights framework. The use of a survey allows the widest possible group of children to participate in an accessible and comfortable format, especially for those who are less confident speaking in groups.

When administered appropriately, they can support children’s right to privacy by providing a safe space to express their views (Lundy & McEvoy, 2008). In contrast, the flexibility of qualitative research supports a deeper exploration of the issues and the freedom to study children’s views (Vujcic et al., 2018). A combination of interviews and a focus group was used to gain different insights. Interviews were chosen because they provide a private, supportive space in which participants can speak openly about sensitive issues, such as mental health. They provide young people with the opportunity to express their thoughts more deeply and connect directly with the researcher (O’Reilly & Dogra, 2016). The focus group allowed participants to discuss their experiences collectively, highlighting both shared and opposing perspectives that could not be observed in interviews (Kitzinger, 1995).

4.4. Research methods

The survey was co-designed with pupils at the advisory school and piloted in School X. Language refinements were made, and the survey was administered in its entirety in School A. Following the completion of quantitative data collection in School A, semi-structured interviews and a focus group were conducted. Finally, four survey questions were administered to an additional 11 secondary schools as part of the WMCS data collection. Further details on each method are provided in the Research Process section later in the chapter.

Table 4.1 Participating schools, context, data collection methods, and participants (by gender).

School	Context	Data collection methods	Participants involved	By gender
Advisory school	Inner city. Multi-cultural	Development of research instruments	**12**	5 Male 7 Female
School X	Mid-size town Predominantly white British	Pilot survey		
School A	Rural. Predominantly white British	Survey	**74**	39 Male 28 Female 7 did not answer/prefer not to say
School A	Rural. Predominantly white British	Semi-structured interviews	**12**	4 Male 8 Female
School A	Rural. Predominantly white British	Focus group	**9**	3 Male 6 Female
WMCS (11 secondary schools)		Survey	**1614**	744 Male 783 Female 87 prefer not to say/self-describe

Table 4.1 summarises the methods used within the study and is included to support transparency around data collection and participation across different stages of the research.

4.4.1 Contextualising the sample school

School A is a mixed secondary school in rural mid Wales, serving a catchment area made up of small towns and villages. The pupil population is predominantly White British, with limited ethnic diversity. The school has a designated wellbeing lead and an established emphasis on pupil voice, which may have shaped pupils' awareness of, and willingness to engage with, mental health support.

In contrast, the WMCS survey includes pupils from a wide range of secondary schools across Wales, encompassing urban, suburban, and rural settings and a more socio-demographically diverse population. This national dataset captures variation in school context, size, and pupil background that is not reflected within the single-school qualitative sample.

Bringing together these two datasets strengthens the study by situating the in-depth findings from School A within a broader national context. At the same time, it is important to acknowledge that the experiences of pupils at School A cannot be assumed to be representative of all Welsh pupils. The qualitative findings should therefore be understood as context-specific, with the WMCS data used to identify areas of convergence and broader patterns rather than to make claims of generalisability.

4.4.2. Survey

The aim of the survey was to establish pupil perceptions of mental health services in schools, what support services they currently use, what made accessing them difficult and what might make engagement easier.

Gillham (2008) presents several advantages and disadvantages of using surveys as a research tool. For the researcher, time and financial costs are low; surveys enable the collection of data from a large number of people in a short space of time, and the simplicity of analysing answers to closed questions is advantageous. There are also benefits for respondents, including the opportunity to complete the survey at a time that suits them, the chance to consider responses to questions, and a greater guarantee of anonymity.

Bryman (2016) also reports the absence of interviewer effects as a further advantage of self-administered questionnaires. This is a significant benefit, particularly where social desirability bias (Sudman & Bradburn, 1982) may affect responses, as research of a sensitive nature can lead participants to over-report socially desirable responses and/or under-report less desirable ones.

However, surveys have several disadvantages as a data collection method. They can suffer from low response rates and lack depth, as they are unable to ask more than general questions (Patten, 2016). A particular disadvantage of surveys delivered electronically is the lack of flexibility. Once the survey is shared, the data is restricted to whatever is input by the participants. If questions are poorly worded or instructions are unclear, this cannot be amended or clarified, and it could result in poor or unusable data. While it is possible to mitigate this somewhat through piloting the survey, it is difficult to eliminate this risk entirely (Braun & Clarke, 2013). These issues were addressed by designing the research instruments in collaboration with a peer advisory group, which supported the design and guided the language, phrasing, and format of the survey. The involvement of the advisory group is described in greater detail in the Research Process section of the chapter.

Nonprobability sampling was used to select year 9 pupils as the survey audience. As identified through the literature review, they are the age group most likely to seek support with their mental health.

Recruiting schools presented a significant barrier. Initially, it was hoped to invite schools with a similar demographic to the school where the advisory group was formed, but located in a different county within Wales, to participate in the research. This was intended to maximise the benefit of engaging an advisory group to support research instrument development while minimising the possibility of advisory group members recognising interview participants through the data collected. Initial contact was made with seven schools, and discussions took place with senior managers (ALNCo, Deputy Heads and Head of Wellbeing) in four of those schools. In all cases, the discussions were positive, and school staff recognised the value of the research. However, personnel changes, the subject, and the direct involvement of children presented barriers, and several of the schools withdrew before data collection commenced. One of the schools began administering the survey but did not complete it and withdrew before qualitative data collection could be arranged. Following the withdrawal of the final school, it was necessary to contact all English-speaking or bilingual secondary schools in Wales. This generated interest from a further four schools, one of which expressed a proactive approach to pupil voice and agreed to participate in the research.

This resulted in the sample becoming self-selected. The participating school (School A) is a mixed secondary school in rural mid Wales with a predominantly White British intake. The catchment area is made up of a number of small towns and villages. Pastoral provision at the school includes a designated wellbeing lead. It is acknowledged that a school that prioritises pupil voice is likely to already have strategies in place to ensure that pupils can influence systems; therefore, the inclusion of a national survey sample through the multi-cohort study is advantageous.

4.4.3. Semi-structured interview

The aim of the semi-structured interviews was to explore survey responses in more detail and clarify pupils' knowledge, and understanding of, processes such as access to support services. Participants were given the opportunity to elaborate on their experiences of barriers and what they felt supported access to services, and were free to describe what they considered a pupil-friendly service to look like. Participants were asked about the key issues they felt decision-makers should know about from young people.

Semi-structured interviews were used to complement the quantitative data gathered through the surveys. One disadvantage of surveys, as discussed above, is the lack of opportunity for participants to elaborate on their answers or for the researcher to clarify the meaning behind them (Patten, 2016). Using a semi-structured interview approach, participants can answer questions generally uninterrupted, providing more detailed and contextual information. Interviewers can then ask supplementary questions for clarification as needed. Semi-structured interviews can be prepared for, inasmuch as a set of questions can be developed that reflect the research questions and the literature review. However, their use is flexible, and new questions can be formulated to respond to the answers given (Longhurst, 2003). This allows participants to discuss the significant issues as they perceive them and may lead to previously unconsidered aspects or questions.

They can be successfully carried out with a smaller number of participants and are more suitable for discussing sensitive issues than alternative methods, such as focus groups, where managing anonymity, confidentiality, and the risk of harm is more challenging (Sim & Waterfield, 2019). Braun & Clarke (2013) highlight the concept of interviewing across difference, suggesting that interview participants may feel more at ease discussing sensitive information with someone who is predominantly like them (in terms of gender, race, or culture). In a small-scale research project, it was not possible to provide interviewers to ‘match’ all participants; therefore, to address this difficulty, paired friendship interviews were offered. Paired interviews involve one interviewer interviewing two people together, allowing them to interact during the interview (Wilson et al., 2016). The pairs were formed by participants choosing an existing friend with whom they were comfortable talking. When more than one person is being interviewed simultaneously, there is an increased risk of confidentiality being breached (Sim & Waterfield, 2019). This risk was mitigated by asking participants about their opinions and suggestions rather than requiring them to reflect on personal experiences. Being part of a pair could provide the support for someone who would not have been comfortable in a one-on-one interview style to take part and share their experiences. (Wilson et al., 2016). However, there are counter-risks associated with this method: one participant can dominate the conversation, reducing the other participant's opportunity to be heard; disagreements or conflicts may arise; or one participant might alter their response to support or agree with their peer. (Wilson et al., 2016). This risk was managed by facilitating a conversation at the start of each interview about the purpose of the interview, the participants' roles, and reaching an agreement on privacy, confidentiality, and respect. I also reminded participants of their option to stop the interview at any point without consequence and was mindful of their body language, checking in on their comfort levels throughout.

Paired interviews and focus groups pose the same ethical challenges in research. Guaranteeing privacy and confidentiality is more challenging when using these methods. Although the research does not focus on the use of a mental health support service, and participants do not have to have used one to participate, it is possible that when a child is leading the conversation, they may reflect on their personal experiences. It is important that participants are not asked by the researcher to share any personal information, and that they are also able to manage situations in which they are asked to do so by their peers. There are several advantages to their use; the focus is on the interviewee’s perspective, and looser-style questions allow the participant to focus on what they believe is important, helping the researcher to better understand participant perspectives. The flexibility of a partly structured approach allows the researcher to deviate from the interview guide and explore points of interest in greater detail (Bryman, 2016).

However, there are several disadvantages to interviews as a method. They are time-consuming to organise, to carry out, and to transcribe, and the lack of anonymity could be daunting to some potential participants (Braun & Clarke, 2013). These disadvantages are addressed by having a small sample size to reduce time implications and by making pupil participation voluntary. The consent processes are outlined in the 'ethics' section.

Flewitt (in Clark et al., 2014) describes interviews as "*a relationship between two or more people, and however brief that relationship may be, its nature and quality will deeply influence what can be found out through the interview process*" (p. 136). It is important to establish rapport with an interviewee so that they feel at ease with the process and are confident in speaking openly. Interviews began with an introduction to who I am, why I am conducting the research, and the role that interview participants play in the data collection. Asking participants questions about themselves can encourage greater engagement during interviews with teenagers (Bassett et al., 2008). Therefore, conversational-style questions were used at the beginning of the interview to build rapport between the interviewer and participants, and the interview pace was set by the interviewee.

4.4.4. Focus group.

The focus group was designed to explore the themes identified through the survey and interview processes and to determine whether there was consensus around issues such as gender and autonomy. The session concluded with an activity which was focused on solutions to ensure that pupil voices were explicitly captured.

The themes identified through the questionnaires and semi-structured interviews were explored in greater depth in a focus group with pupils. Focus groups bring together a group of individuals to explore a specific issue or set of issues, with the aim of holding discussions that reveal individual and group opinions about the topic (Cyr, 2015). They are suitable for participatory research as they support the development of a mutual understanding of a shared problem and, consequently, its resolution (Wilkinson, 1998). In this context, the focus group provided participants with an opportunity to elaborate on themes identified in earlier data collection and to collectively reflect on them, highlighting areas of agreement and conflict. This provided an appropriate way to bring together and explore the findings from the survey and interviews.

As with any data collection method, focus groups have strengths and limitations. Many of their strengths lie in the group dynamic. This may contribute to them being seen as less intimidating than an interview (Guest et al., 2017). Focus groups can create a sense of ‘safety in numbers’ when participants discuss potentially sensitive subjects (Guest et al., 2017). Furthermore, they can be useful in highlighting valuable insights for service providers, as group discussions may reveal previously unconsidered perspectives on service provision (Barbour, 2018). Participants can build upon each other's points and develop perspectives, leading to richer discussions (Barbour, 2018). A further strength of focus groups is that, because the number of participants is greater than the number of researchers, the balance of power may lie with the participants rather than the researcher. This may be particularly important when working with school pupils, where power typically lies with the adult running the session.

However, convening a group can introduce weaknesses into focus group methodology. Dominant members of the group may make it more difficult for quieter members to contribute, and the loudest voice may not accurately represent the group's views and opinions (Stewart & Shamdasani, 2014). Additionally, the group aspect of a focus group discussion may lead to competing voices and experiences. This can produce data that is difficult to assign to individuals and complicated to order sequentially, making analysis complex (Barbour, 2018). A further risk associated with focus groups is the phenomenon of “groupthink” (Janis, 1972), whereby individuals within the group tend to conform to a majority outlook. This may be seen when individuals censor their own perceptions or behaviour in an attempt to match that of the majority (Carey & Smith, 1994).

Sim and Waterfield (2019) propose three potential ethical issues associated with focus groups – consent, confidentiality/anonymity, and risk of harm – and outline four strategies to mitigate them. These strategies were implemented as follows: informed consent was obtained by providing information before the focus group. A further discussion at the start of the session outlined the structure and likely content, and participants were reminded that they could leave at any time without explanation or repercussions. A briefing before the focus group commenced allowed the group to agree on confidentiality and anonymity for discussions, and included a conversation about sharing personal experiences. During the focus group, participants were monitored and supported to ensure everyone had the opportunity to contribute, and those who chose not to were not made to feel uncomfortable. As the researcher, I was attentive to any signs of distress or breaches of confidentiality. A debrief at the end of the session summarised the content and reminded participants about confidentiality and anonymity. I also informed participants that I would be available for a short time after the session if they had anything they wanted to share that they did not feel comfortable discussing with the group.

4.5. Ethical considerations in research

The research is approved by the Ethics Committee of Cardiff University's School of Social Sciences (see Appendix 5).

As specified in the British Educational Research Association (BERA) guidelines (2018), researchers have a number of responsibilities towards their participants. These include seeking voluntary, informed consent; transparency; communicating the right to withdraw; considering the use of incentives; considering the potential harm arising from participation in research; and ensuring privacy, data storage, and disclosure. Due to their significance, the processes for obtaining consent, managing harm arising from participation and disclosures, and protecting privacy and confidentiality will be discussed in more detail below.

4.5.1. Ethics in a children's rights approach

Conducting research within a children's rights framework necessitates an enhanced level of ethical adherence. Lundy & McEvoy (2012) assert that for research to be considered rights-based, it must be carried out in a manner that respects and protects the rights of the children involved. Drawing on Articles 12, 13, 36 and 3(3) of the UNCRC, Beazley et al. (2009) highlight the responsibilities of researchers to ensure that children’s involvement in research is safe, respectful, and meaningfully participatory. They summarise this as children being involved as participants in research, using methods that enable them to express their opinions, views, and experiences, and being protected from harm through appropriate safeguards and robust, ethical research practices (p. 370).

It is important to consider these additional elements to support an authentically children’s rights approach. The participants in this research were in school year 9, and therefore, a minimum of 14 years of age and legally defined as children. BERA (2018) highlights UNCRC Article 13, which states that “children have the right to freedom of expression,” provided that the best interests of the child are the foremost consideration. These considerations are addressed in the following paragraphs.

4.5.2. Obtaining voluntary consent

Ethical research expects, as a standard, that prospective participants are allowed to make an informed choice about whether or not to participate in research (BERA, 2018). When participants agree to take part, they should do so with a comprehensive understanding of their role in the process and of any potential consequences. To ensure this, Alderson & Morrow (2004) suggest that information leaflets are an appropriate method for sharing information with children. They argue this method ensures that the information provided to all prospective participants is consistent and can be revisited. It also allows participants the opportunity to discuss the research with others, supporting them to make informed decisions. For this study, information sheets were developed using age-appropriate language and emailed to all eligible pupils in advance of data collection via the school. Hard copies were provided to anyone who expressed interest in participating in the research. Sample information sheets and consent forms are shown in Appendix 6.

Alderson and Morrow (2004) go on to suggest that informed consent includes allowing children the opportunity to ask questions, and to take time over making their decision; they describe this as the “invisible act of evaluating information”, which should be followed by a “visible act of signifying the decision” (pg. 96) and giving their consent. They also say that it should be made clear to children that they can speak to others about their decision to participate and may withdraw at any time, without needing to provide an explanation. BERA (2018) reiterates that researchers should be mindful that participants may withdraw their consent at any time. In line with this, I ensured that pupils had the opportunity to ask questions before giving their consent. At the start of each data collection activity, I revisited the key information, invited questions, and reminded pupils that participation was voluntary and that they could withdraw at any time without needing to provide an explanation.

Heath et al. (2007) and Gallagher et al. (2010) discuss the potential negative implications for children participating in research, particularly in a school environment. They state that there is a risk that children may feel obligated to comply with their teachers' or researchers' wishes and give their consent to participate to appear cooperative. To mitigate this, I emphasised that there would be no negative consequences if they chose not to take part, and I ensured participants had the opportunity to consent or withdraw independently of school staff by reiterating consent discussions and providing a private opt-out option at the start of each session. I also reminded pupils again at the start of interviews and focus groups that they could decline to answer individual questions or stop the session altogether. This approach was designed to eliminate any pressure to participate and ensure that consent was genuinely voluntary.

Consent was sought at a number of levels throughout research instrument development with the advisory group, and at each stage of the data collection:

Advisory Group - Participation in the advisory group required written consent from both participants and their parents or guardians. To ensure that consent was informed, all pupils involved were provided with an information sheet and a pupil consent form. This was provided in hard copy and given to pupils prior to their engagement. It was reissued at the first meeting with them, and I reviewed it at the start of each subsequent meeting to ensure they all understood and agreed. Each meeting with the advisory group began with a recap of their right to withdraw at any time and a reminder of the support systems available if they found any of the content upsetting. Parents were provided with a hard copy of an information sheet which outlined the purpose of the research and the role their child would take, including contact details should they have any additional questions. They were asked to sign a consent form indicating their approval, which was returned to me before the first advisory group meeting.

Survey - For participation in the survey, parents were asked to provide opt-out consent before their child completed the survey; no parents opted their child out of the study. Pupils were asked to opt in by ticking a box at the start of the survey. As the research site was a bilingual school, an information sheet was emailed to all parents in both Welsh and English, and an English-language version was shared with pupils two weeks before the survey commenced. Parents were asked to return the consent form only if they did not wish their child to participate in the study. Pupils were reminded of the information sheet on the first page of the survey, and they were unable to access the survey until they had ticked a box indicating their agreement to participate (Mahon, 2013).

Interview - Interview participants required written parental and individual consent. Parental documents were provided in both English and Welsh; pupil documents were in English. To ensure informed consent, I shared written information at a Year group assembly led by the Assistant Head Teacher. This was followed by an email and an information sheet from me, which were sent to all Year 9 pupils via the school email system two weeks prior to the interviews, giving participants time to reflect on their decision to participate. At the beginning of each interview, participants were reminded that they could end the interview at any time without any repercussions or explanation. Parents received an information sheet outlining the purpose of the research and the role their child would play, one week prior to the scheduled interviews, with an invitation to contact me if they wished to discuss anything further. They were asked to return a hard copy of the consent form to confirm their consent for their child to take part.

Focus group - participation required written consent from both parents and individuals. An information sheet was shared with all Year 9 pupils via the school two weeks prior to the planned focus group date, allowing participants time to ask questions and make an informed decision about participation. Parents were also provided with an information sheet detailing the aims and purpose of the research, as well as their child's role in the study. This information sheet included my contact details and an invitation to contact me with any questions or queries. They were asked to return a hard copy of the consent form to confirm their consent for their child to participate. Parental documents were provided in both English and Welsh; participant documents were in English.

4.5.3. Managing harm and disclosures

Participant distress - Although the research focuses solely on the process of accessing mental health support in schools, the participant self-selection process increases the likelihood that those who volunteer to participate in an interview will have a particular interest in this area, which could lead to participant distress during the interview.

During an interview, the interviewer should remain attuned to the child's emotional and physical safety, ensuring that the participant maintains autonomy over how much they want to share and retains the right to end the interview (Basset et al., 2008). Recognising any distress, checking that the participant was happy to continue with the interview, and, if necessary, moving the conversation to a new topic were used to support the participant in continuing with the interview as far as possible (Braun & Clarke, 2013). Furthermore, pupils currently using the school's mental health support service were excluded from participating in the qualitative data collection.

As identified in the BERA 2018 guidelines, researchers should not undertake work for which they are not competent (p. 8). I was confident in my ability to undertake this work due to my extensive professional experience of working with vulnerable young people, using a trauma-informed approach, discussing sensitive topics, and a high level of safeguarding training and experience.

4.5.4. Privacy and confidentiality

Ethical research requires assurances of participants' privacy and confidentiality. Alderson & Morrow (2011) define privacy as 'avoiding undue intrusion into their personal affairs' and confidentiality as 'concealing their identity and sometimes other details when reporting them'. This is of even greater importance when conducting research with children, as highlighted in Article 16 of the UNCRC, which refers to a child's right to privacy. Thomas and O'Kane (1998) emphasise the power difference between adults and children and the impact this can have on children expressing their views to adults.

An additional consideration of confidentiality concerns the safe storage of data. Cardiff University's guidance and procedures (https://www.cardiff.ac.uk/documents/2927412-

records-management-policy) were followed. Hard copies of non-anonymised data were stored in a locked filing cabinet, and non-anonymised electronic data and audio files were saved on a password-protected device. In accordance with university retention policies, data will be stored for five years after the project concludes. Pseudonyms were assigned to the interview participants to ensure they could not be identified in the reported findings.

4.6. Research process

This study was carried out across four interrelated phases, with each stage informing the next and contributing to an iterative research process.

The first phase involved forming a Peer Advisory Group, which played an important role in shaping the research design. Through a series of capacity-building activities and structured discussions, pupils contributed to developing the survey questions and advised on language, format, and accessibility. This helped ensure that the research tools reflected young people's priorities and ways of expressing their views.

The second phase focused on survey data collection. The survey was initially piloted in School X and then administered in full in School A. A selection of survey questions was also incorporated into the WISERD Education Multi-Cohort Study (WMCS), enabling the collection of a broader national dataset. Analysis of the survey data provided an overview of pupils' awareness of, and engagement with, school-based mental health support, and highlighted key areas of concern, including gaps in information and perceived barriers to access.

The third phase consisted of semi-structured interviews with pupils at School A. The interview guide was informed by patterns identified in the survey data, allowing for more detailed exploration of pupils' experiences of referral processes, perceptions of agency, and opportunities for participation. This phase helped to clarify and contextualise the survey findings and supported a more nuanced interpretation of pupils' responses.

The final phase involved a focus group, which brought together themes emerging from both the survey and interview data. This provided a space for collective reflection, where pupils were able to discuss areas of agreement and difference and suggest ways to address barriers to access. This stage was particularly important in foregrounding pupil-generated recommendations.

Bringing together data from pupils at School A and from the wider Welsh sample within the WMCS strengthened the study by situating in-depth, school-based findings within a broader national context. While this triangulation enhanced the robustness of the analysis, it also introduced limitations, as the national survey data lacked the contextual depth of the qualitative data collected within the school. This was addressed by using the WMCS data to provide context and points of comparison, rather than to generalise from the experiences of pupils at School A.

4.6.1. Involvement of Peer Advisory Group

The research process began with the recruitment of an advisory group of young people to support the development of research instruments. The group was expected to include up to eight Year 9 pupils, with both boys and girls. The group assigned by the school differed somewhat in that it provided a greater number of pupils than expected to accommodate the school's timetabling. The resultant group comprised 12 pupils (7 girls, 5 boys) from Year 10. It was originally planned to return to the advisory group following the first stage of data collection, analyse the survey data, and use this as a basis for developing the interview questions. Unfortunately, the delay in recruiting a second school to carry out data collection meant that by the time the survey data was completed, the pupil cohort I had worked with had moved on to further education.

Development of research instruments

The session plan and capacity-building activities are shown in Appendix 1.

Session 1. The aim of the first session was to establish a sense of purpose within the group and to explain the role of an advisory group. The session was designed to develop understanding of the research and the group's role in it, clarify boundaries around ethics, safeguarding, and support, agree a group contract, and share the planned research summary. We held a group debate on whether schools should be expected to support young people with their mental health, to open up the topic and explore pupils' perspectives on this issue.

Sessions 2, 3 and 4. The focus of the second session was to develop an understanding of surveys as a research method and explore what makes a good or bad question. The aim was for the advisory group to help me formulate questions that were accessible and meaningful to the research participants. Time was spent understanding the different types of questions and determining which one is most appropriate when seeking certain information. Then the group were given two tasks: *Task 1*: Write a short survey to gather peer opinions on changing the school day to 10 am – 2 pm. They should try to include a variety of different question types and then pilot the survey among themselves. This activity took longer than expected and was carried over onto session 3. In the third session, they also completed Task 2, which involved developing two questions to determine what supports pupils in accessing mental health support in school, two questions to identify what makes it more challenging, and one open-ended question to ask about the changes pupils would make to the current support service. In session 4, I provided some example questions I wanted to ask, and advisory group members offered support on language and phrasing to ensure the questions were asked as clearly as possible to elicit the most useful responses.

While the benefits of working with an advisory group outweigh the difficulties (Leitch et al., 2007), the experience was challenging in a number of ways:

Environment – I was allocated the school library as a working space, which was set up with a number of small tables which could not be moved. This meant that pupils sat in existing friendship groups, leading to some distraction and lower concentration levels at times. Pupils were aware that I was not in a position of authority, and the large group made it challenging to keep all of them engaged. It was clear that some of the pupils attended the sessions as a preferable option to being in class, and they did not have a particular interest in the subject matter.

Timings – the school provided a generous amount of time with the pupils, offering two sessions per week, each lasting an hour. While this was a significant amount of time with the group, the nature of two separate sessions made it difficult to develop conversations, and it was hard to get momentum going. This presented an additional challenge, as different young people attended at different times.

Timetable – Due to the sessions falling at the end of the summer term, which was more acceptable to the school as pupils would not miss key lessons, several events and timetable changes impacted attendance. School trips, sports days, and transition timetables led to a number of planned sessions not taking place or having very few pupils in attendance.

4.6.2. Strand 1: Survey

Design of survey

It is not possible to achieve good survey data without well-written questions. Well-written questions are those that are clear and phrased in a way that is reasonable to expect participants to answer. Braun & Clarke (2013) recommend a) making them as short as possible; b) expressing them clearly and unambiguously; and c) using simple and appropriate language (pg. 140). As discussed previously, the questions were developed in conjunction with the Pupil Advisory Group, and then clustered by similar topics, opening with easier-to-answer demographic questions, before moving on to questions related to children's rights, awareness of current school provision, and ending with the questions that required the deepest thought about the changes that they would suggest (Braun & Clarke, 2013). Pupils were able to skip any questions they did not want to answer. A printed version of the survey is available in Appendix 2.

Piloting the survey

The survey was delivered through the Qualtrics software. School X ran a small pilot with ten pupils. The school selected the pilot group from a group of Year 9 and 10 school council members who completed the survey to ensure that the logic worked and that the required data were collected. A minor adjustment was made to the language of the final open-ended question following the pilot, as pilot survey responses indicated that the question was perceived as too broad for pupils to answer comfortably.

Administration, access and consent

Contact was made with the leadership team at School A, who agreed that pupils could participate in the data collection. The schools were then provided with consent forms and information sheets for parents and pupils, a Qualtrics link to complete the survey online, and instructions for completion. Teachers arranged administration on a class-by-class basis. The voluntary nature of the survey was emphasised to teachers, and the survey was designed to ensure that children provided opt-in consent and indicated their willingness to participate by answering the first question. If a child chose not to give their consent, the survey's logic directed them directly to the end. No questions in the survey other than the one relating to consent were mandatory, allowing pupils to skip any questions they did not want to answer. The first paragraph of the survey reminded pupils of the information sheet, the purpose of the research, how the data will be used, and their right to withdraw at any time.

Sampling and recruitment

As stated earlier in the chapter, non-probability sampling was employed with Year 9 pupils of the participating school. There were no exclusion criteria, and all pupils were given the opportunity to participate in the survey. Participants were given the option to opt out of completing it in the first question, which minimised the risk of pupils participating because they had been instructed to by a teacher.

Analysing survey data

The quantitative survey data were summarised using descriptive statistics. Bar charts and tables were used to visually display the information, where appropriate. A comparative analysis was conducted to compare data from School A with the wider Welsh sample from the WMCS survey, and statistical significance was assessed for relationships between key variables using Pearson's chi-square tests of independence. When investigating the influence of gender in data exclusively from School A, a Fisher's Exact Test was used to assess statistical significance. Very small numbers of participants selected "prefer to self-describe" or "prefer not to say" in response to the "what is your gender" question. Therefore, these categories produced low expected counts, which violated the assumptions of the test. To ensure the validity of the analysis, the test was conducted only on the male and female categories.

4.6.3. Strand 2: Semi-structured interviews

Design of questions

Several considerations were taken into account when developing the questions. It was important to use age-appropriate and inclusive language and to develop questions that elicited responses from participants about how they felt their rights were met at school, their opinions on mental health support systems at school, and the issues that pupils believed decision-makers needed to be aware of.

Interview guide

An interview guide was developed following the first round of survey data (see Appendix 3). This approach helped ensure consistency across interviews while allowing participants to discuss what they believed was important, and it provided the researcher with flexibility to ask probing questions (Bryman, 2016, p. 468).

Sampling, recruitment and consent

Purposive sampling provides in-depth understanding and deeper insights and is a common approach used in qualitative research (Braun & Clarke, 2013).

The sample size was intended to be approximately ten pupils, but it depended on the number of pupils who volunteered. The sample size was small, as representativeness was not a concern for this study, whereas the insights provided by participants were crucial. The interview sample was drawn from Year 9 pupils at School A, with inclusion and exclusion criteria established. The criteria were kept to a minimum to increase the demographic diversity of the sample (Robinson, 2013). The inclusion criterion was that the pupil must be a Year 9 pupil at the school; the only exclusion criterion was that the pupil could not currently be engaged with mental health support services. This was to reduce the risk of harm to a young person and was included in the ethical approval. All pupils who completed the survey were invited to email me to express their interest in taking part in an interview. The email address was also provided on information leaflets to allow pupils time to consider their decision.

Information leaflets were provided to all pupils outlining the study's purpose, what participation would involve, their right to withdraw at any time, and how anonymity would be protected, along with an invitation to participate in an interview. Self-selection bias (Costigan & Cox, 2001) suggests that individuals who volunteer to participate in research interviews may be more open and have a greater interest in the subject than the wider potential sample group. This could be a significant positive aspect of the study, as those pupils may have a stronger motivation to contribute to change. However, despite the intention for pupils to self-select for interviews via a link in the survey, there was no response, and it was necessary for school staff to approach pupils to take part. It is acknowledged that school staff, therefore, influenced which pupils were chosen to participate in the data collection. As a result, it is possible that participants may have been selected because they were known to support a particular viewpoint, or that those with alternative viewpoints may have been excluded from the selection process.

Conducting the interviews

Over two days, there were five paired interviews and two individual interviews, with participants opting to come along alone. Interviews began with introductions and an explanation of the purpose of the research, followed by a review of the information sheet and consent form. At this point, I reiterated the option to participate, stating that pupils did not have to answer any questions they did not want to, and that they could indicate this by simply remaining silent. Participants were reminded they were free to leave at any time without consequence or repercussion.

Interviews lasted between 30 and 60 minutes. Each one began with the same questions to establish rapport and help settle the participant, and as they were semi-structured, they generally followed a similar pattern. The questions appeared to be well understood by participants, and clarification was given if needed.

Analysing interview data

Due to the need to fit in with the school's availability, interview data collection was organised by the school at a time that was least disruptive to the pupils involved. This meant that there was less time between the completion of interviews and the delivery of the focus group than had been hoped for, as thematic analysis of the interviews was necessary before conducting the focus group. I transcribed each interview to familiarise myself with the data, making general notes and identifying initial themes. Transcripts were anonymised and imported into NVivo for coding. As the interview questions were aligned with my research questions, deductive coding (Terry et al., 2017) was employed. Using descriptive coding, parent codes were set that related to the research questions:

‘barriers’, ‘facilitators’, and ‘solutions’. Analytic coding was then used to identify the child codes linked to the parent code.

4.6.4. Strand 3: Focus group.

Design of focus group session

The structure of the focus group session was based on the thematic analysis of the survey and interview data. A semi-structured approach was employed to enable me to guide the session while also providing participants with the opportunity to raise issues that were important to them. Tasks were designed to support capacity building, and questions were open-ended to prompt more detailed responses from participants. These questions included small-group and whole-group discussion activities. Visual prompts of the identified themes were used as a stimulus for deeper discussion, and the session followed a sequential design. Participants first explored the barriers to accessing support and were then enabled to suggest solutions to overcome them. The session plan for the focus group is included in Appendix 4.

Sampling, recruitment and consent

Due to the need to complete the focus group before the end of the academic year, the school managed participant recruitment. This presented the same gatekeeping issues as outlined in the previous section on interviews. Prospective participants were provided with information sheets outlining the purpose of the research and explaining what participation in the focus group would entail, along with consent forms for both pupils and their parents. Research suggests that large numbers of participants in focus groups can make individuals feel less comfortable sharing their views and opinions (Liamputtong, 2011). Conversely, small groups also pose challenges due to their dynamics. Due to these issues, I requested a mixed group of eight to ten pupils. The resulting group consisted of six girls and three boys. The school was asked to ensure that the group was as diverse as possible, bringing a range of experiences and views.

Conducting the focus group

The aim of the focus group was to explore, in greater depth, the barriers and facilitators identified through the survey and interviews. It was conducted at the school during lesson time, and written consent was obtained from pupils and their parents prior to the focus group. The session was supported by having a teacher present in the room, although they remained separate from the focus group and did not take an active part in the discussion. While it was necessary to have a member of school staff in the room for behaviour management and safeguarding reasons, it is possible that this prevented pupils from speaking freely and critically about school issues without worries of consequences.

The session was lively, suggesting that the participants were relaxed and comfortable contributing to the conversation. To mitigate the disadvantages of focus groups discussed in the previous section, the session included a variety of activities, offering different mechanisms through which participants could contribute (Graham et al., 2018). Participants worked in self-selected groups of 3-4 to discuss the barriers to accessing mental health support, which had been identified through the thematic analysis of the survey and interview data. Thoughts were written on post-it notes and shared on a central image representing the barrier. These were then discussed as a wider group before the barriers were ranked from most significant to least significant. At times, particularly in the earlier stages of the focus group, some pupils were more vocal than others. This was managed by actively inviting contributions from quieter participants to ensure their views were included. The small-group work was effective in enabling all participants to share their ideas with people they were comfortable with. However, one limitation of using friendship groups was that pupils required prompting to remain on task. The collective setting was effective in reducing the sense of formality often associated with an interview, and several pupils who were initially quieter became more confident as the discussion progressed.

The risk of Groupthink (Janis, 1972) was mitigated by dividing participants into pairs or threes and asking them to discuss a topic within their cluster before sharing their perspectives with the main group. When small groups shared alternative views, they were reassured that differing perspectives were valuable in representing the wider school population.

There was another small-group discussion about how the barriers could be overcome, and participants were reassured that all suggestions were welcome at this stage. Again, ideas were shared on post-it notes and collated centrally. The group dynamic allowed for the development of ideas, and possible ways to overcome barriers or create facilitators were discussed in more detail, exploring the strengths and limitations of each. This was an important element of the process, as ‘animal therapy’ was put forward as one possible solution. It was necessary to have a candid conversation with the group about the reasons for and against this, the likelihood of it happening, and the wider considerations for the school leaders. Participants were then given five voting stickers and asked to vote for their preferred solutions, allocating their votes as they saw fit. The disadvantage of the voting method was that the vast majority of the group voted for introducing animal therapy and were reluctant to consider the alternative solutions. This was overcome by reassuring the group that the suggestion would be shared with school decision-makers, and then removing the option of animal therapy; after which, the vote was then rerun. The most popular options were explored in more detail.

Overall, the questions and tasks appeared to be well understood by the participants, and with the inclusion of short breaks between activities, pupils remained engaged for the duration of the focus group. They gave detailed responses, shared experiences, and debated with one another. Managing the time allocated to each task was one of the most significant challenges, as pupils wanted to discuss and debate their answers with one another. The session ran for 90 minutes.

When conducting the focus group, I paid close attention to how participants responded to questions and activities, allowing them the opportunity to speak about the issues they felt were most important, but moving the discussion on if there were any signs of discomfort. As per the ethical approval, I refrained from asking questions about service experience to avoid sharing sensitive information and moved the discussion forward quickly when participants showed signs of discomfort.

Analysing focus group data

The data were analysed using thematic analysis (Braun & Clarke, 2006). Braun and Clarke highlight that in using this method, the researcher will have an influence on the analysis of the data, which must be acknowledged. It was originally hoped that the advisory group would be involved in the analysis of the data; however, as discussed earlier in the chapter, the delay in data collection meant that the advisory group were no longer available to collaborate. I transcribed the focus group recording and imported the data into NVivo, using the same coding process as with the interviews.

4.7. Researcher reflexivity

My position as a researcher is informed by both my professional background and my personal experiences, which shaped my interest in children's rights and the importance of listening to young people within educational settings. Prior to undertaking this research, I worked closely with children and young people in roles that involved supporting mental health, safeguarding, and wellbeing, including work with a young person who later died by suicide. Following her death, there was surprise within the school that she had not accessed the available counselling service in school. This response prompted critical reflection on assumptions about access and help-seeking, and directly influenced my interest in exploring the barriers that may prevent young people from engaging with school-based mental health support.

These experiences also informed the assumptions underpinning this study. The research recognises that young people's experiences of school-based mental health support are shaped by wider structures, such as school systems, policies, and service provision, while also acknowledging young people's agency in navigating and responding to these contexts. This understanding supported an approach that values pupils' accounts as an important source of knowledge, while recognising that these perspectives are partial and situated. It also informed the decision to adopt a children's rights approach and a mixed-methods design, allowing pupils' views to be explored in depth and considered alongside broader policy and structural contexts.

Researcher reflexivity requires working reflectively to examine decisions made during the research process. It is necessary to recognise the impact of researcher values and take steps to minimise their influence (Evans, 2002). Informed by these professional and personal experiences, I advocate that children be regarded as the experts in their own lives, and therefore I respect their right to participate and be heard in decisions that affect them. I believe this right is rarely applied meaningfully within schools. It was necessary for me to set aside my expectations of the research findings and acknowledge the risk of elevating children's voices that aligned with my own views during data collection. I was aware that, consistent with my perspectives, it was my responsibility to use neutral language to provide participants with the information and space to form and communicate their own views, and to accept these views, whether or not they aligned with my own. I also remained mindful of the risk of framing questions in ways that would elicit responses that supported my own views in each method of data collection. The advisory group completed capacity-building sessions to establish their understanding of mental health support and participatory opportunities, then co-constructed the survey questions, which were piloted to check for leading wording. I developed a script for interviews that conveyed a neutral stance and avoided sharing my personal views with participants. The focus group was provided with top-level coded categories only and asked to interpret and rank them in order of significance. This prevented me from emphasising issues I believed would create the biggest barriers. I maintained an audit trail, including versions of instruments, and regularly debriefed with my supervisors to challenge my interpretations of the data. Throughout the process, it was necessary to reflect on the fact that, while it was important to me that all pupils have their opinions on mental health services heard by adults, not all pupils hold strong feelings or opinions about services they do not engage with.

4.8. Summary

This chapter summarises the research methodology and begins by explaining the critical realist stance underpinning the project. It outlines the rationale for employing a children's rights approach and a mixed-methods design. An account is provided of the advisory group's role, the development of the research instruments, the fieldwork, and the data analysis process. The chapter has discussed the ethical considerations and the reflective approach taken throughout.

The next chapter will outline pupils' perceptions of the barriers to accessing mental health support in school.

Chapter 5. Findings: Context and Barriers

5.1. Introduction

This section presents the results of the study and illustrates how they address the research questions. Two sets of quantitative results are presented. 74 Year nine pupils from School A completed the survey, and three of these survey questions were replicated in the WISERD multi-cohort study (WMCS), which generated 1614 responses from 11 secondary schools in Wales. The analysis is based on these responses. The inclusion of the WMCS data is used to contextualise School A against the national picture in Wales. In both surveys, pupils had the option to skip questions; therefore, the number of responses reported on may vary by question. Throughout the data, School A achieved more positive results than the wider Wales sample, which will be discussed in more detail in the Discussion chapter. The analysis of the qualitative data led to exploring if there was any relationship between gender and certain questions, with statistical tests used where appropriate.

The analysis in this chapter presents pupils' views on mental health support services in school, including awareness, availability and access, as well as concerns about stigma and male mental health. The following chapter goes on to identify facilitators and participants' suggestions for improvements to the service.

5.1.1. School-based mental health provision in the Welsh context.

Mental health support in secondary schools in Wales is delivered through a combination of school-based pastoral provision and externally commissioned services, rather than being developed exclusively by individual schools. Under the WSA Framework, schools work in partnership with local authorities, health boards, and third-sector organisations to provide a range of universal and targeted supports. This means that services such as counselling are often delivered within the school environment but provided by external organisations, commissioned at a local or regional level. Alongside this externally delivered provision, schools typically offer internal pastoral support through designated staff roles and curriculum-based approaches to emotional well-being.

5.2. Children’s rights context

As this research has taken a children’s rights approach, it was important to understand how well School A compares to the national picture in terms of the extent to which pupils feel their rights are respected. At the beginning of the survey, pupils were asked to rate their level of agreement with four statements about children’s rights that support their wellbeing and participation in school.

Table 4.2 below shows the proportion of pupils who agreed with each statement. Overall, respondents at School A had a more positive perception of the realisation of their rights than was found in the WMCS survey data.

Table 4.2 Views on areas of children’s rights, School A data comparison with WMCS data

	Disagree %		**Neither agree nor disagree %**		**Agree %**	
	School A	**WMCS**	**School A**	**WMCS**	**School A**	**WMCS**
I feel safe at school	10.0	19.1	17.2	35.6	72.8	45.3
School staff care about me	8.8	20.3	36.8	39.0	54.4	40.7
I feel listened to and respected at school	19.1	23.8	33.8	40.1	47.1	36.1
I have opportunities to make decisions about things that are important to me at school	11.8	22.0	26.5	38.4	61.7	39.6

School A (n=68), WMCS (n=1354)

Nearly three-quarters of pupils at School A agreed that they **felt safe at school**, with only a very small minority (10%) disagreeing with the statement. The qualitative data support the majority agreement that pupils felt safe, as evidenced in the semi-structured interviews, in which all pupils described their school as a safe place. When asked ‘what makes it feel safe?’ interview participants gave examples of structures in place that supported their sense of physical safety, such as the school gates and a visible teacher presence:

> *Like there's gates around and you need permission to go out and that*.

And,

> *If there's someone who's very easy to annoy and then I annoy them, I don't feel that scared because there are teachers around, so they won't do anything.*

They also reflected on how school supports their emotional safety:

> *I think if when the people live within the rules, it feels safe*.

Conversely, while maintaining that they felt safe at school, some pupils discussed being aware of other pupils' disruptive or antisocial behaviour that interrupted lessons. One participant referenced a recent incident, saying:

> *Like with kids that go out of lessons and run around, like there was a boy...that smashed the window in school. Like they should do something about it and not let him do that.*

Bullying was raised in about half of the interviews, with one participant explaining his own experience: *"There are bullying issues, but they get resolved very slowly, but they get resolved"*. Other participants spoke of an awareness of bullying more widely, such as this pupil, who explained:

> ***PARTICIPANT****: We don't like school, but it's not just because we're moody teenagers. It's because there are genuine issues that do go on.*
> **INTERVIEWER**: Which are...?
> ***PARTICIPANT****: Bullying*

Another participant stated, "Bullying. I just don't like school. There are slurs said that nothing is done about". This statement was raised at the very end of the interview, when the participants were asked if there was anything else they felt was important to say about young people's mental health in schools, leading to a short conversation about school culture.

When responding to the question about feelings of safety at school, the positive response from the School A survey was considerably higher than the proportion of positive responses from the WMCS survey. Out of the 11 schools that participated in the WMCS survey, fewer than half of participants reported feeling safe at school. This is comparable to previous research by Barrance and Hampton (2023), who compared findings from European countries in the Children's Worlds survey. Their research showed that Wales scored lowest on feelings of school safety, with only 42.7% agreeing with the statement "I feel safe at school". This also provides context for how high School A's scores were, with over 72% of respondents agreeing.

Over half of pupils who completed the survey at School A believed that "staff cared about them", higher than the two-fifths of respondents to the WMCS survey. Several of the examples of this from the qualitative data collection referred to members of the pastoral staff team with one participant explaining "*they're like there for you*" (interview), and another participant referencing that pastoral staff would follow up on issues that made them feel supported: "*if you told her something and then she'll sort of like check up on you now and again*" (interview). The proportion of respondents who disagreed with this statement in the WMCS survey was more than double that of School A.

The statement "I feel listened to and respected at school" received the lowest proportion of positive responses from School A, with just under half of the respondents agreeing and two-fifths disagreeing. However, the proportions of positive responses to this statement still compare favourably with the wider WMCS sample, where just over one-third of respondents gave a positive answer and nearly a quarter responded negatively. Research has shown that when pupils feel listened to and respected by their teachers, they are more likely to have a good relationship with them, which has a positive impact on their overall wellbeing (Littlecott et al., 2018).

The majority of participants at School A agreed that they had "opportunities to be involved with decisions that affect them", in contrast to two-fifths in the WMCS survey. This was reflected in the interviews, in which pupils spoke about opportunities to be involved in pupil participation initiatives. For example, one interview participant at School A spoke about the pupil voice opportunities they had had:

> *Part of the reason I'm signing up for so many groups that can change things is because I want to fix these sorts of problems. That's why I'm on school council and doing a Start Well award.*

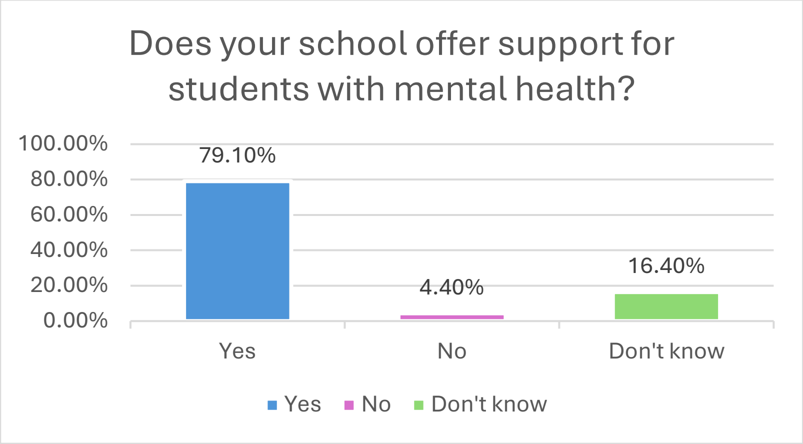
A very small minority at School A indicated that they did not have those opportunities. The high proportion of participants who agreed with this statement suggests that opportunities to be involved in decision-making are widely available but are not necessarily taken up by everyone.

5.3. Awareness of school-based support services

Knowledge that school offers support for mental health.

Survey participants in School A were asked whether they were aware that support for their mental health was available at school. Fig. 4.1 below shows the responses.

Fig. 4.1 Knowledge that School A offers support for students' mental health.



Almost four-fifths of participants knew that mental health support was available in school. In open-text responses and interviews, a number of services were named, including two counselling providers, the school nurse, social workers, youth workers, and pastoral staff members. A small number of participants also spoke about an area of the school dedicated to pupil wellbeing and pastoral care. A very small percentage of respondents believed there was no support for pupil mental health in school, and just under one-fifth responded that they 'didn't know'. It is possible that those who stated they did not know were aware that something was available, but uncertain about its exact nature.

Table 4.3 School A Responses to the question "Does your school offer support for students' mental health?" by gender.

	Boy	Girl
Yes	27	24
No	3	0
Don't know	9	0

(n = 63)

As discussed in the methods chapter, the gender categories of 'prefer to self-describe' and 'prefer not to say' were excluded from the statistical analysis due to the small numbers violating the conditions of the test. All female participants (100%) answered positively that their school provided support, compared to 70% of males. Male participants were more likely to be unsure or to believe that support was unavailable. This difference was statistically significant (Fisher-Freeman-Halton Exact $p < .001$, $N = 65$).

Awareness of the types of support services available.

Survey participants in School A were asked if they were aware of the availability of specific types of mental health support in the school. This question was replicated in the WMCS study. The results of each are shown in Table 4.4 below.

Table 4.4: Awareness of types of support offered in school. School A compared with WCMS data.

Type of support	**School A** *(n =68)*	**WCMS** *(n =1354)*
Specific lessons/tutor time for mental health support	49%	44%
Counselling	57%	70%
Support groups for specific issues	49%	33%
Pastoral staff (a staff member that you can go to for help)	63%	56%
Posters/displays about mental health or mental health charities	60%	57%
Something else?	13%	9%

Table 4.4 enables comparison between pupils' awareness of support services at School A and the wider WMCS sample, providing a national context against which the school-based findings can be interpreted.

A series of chi-square tests was conducted to compare the reported availability of mental health support between WMCS and School A. Across all five types of support, significant differences were found, with School A consistently reporting greater provision. Pupils at School A were more likely than those in WMCS to report that their school offered specific lessons or tutor time on mental health ($p < .001$), counselling ($p < .001$), support groups for specific issues ($p < .001$), pastoral staff ($p < .001$), and posters or displays about mental health ($p < .001$). These findings indicate that participants at School A reported higher levels of visible and structured mental health support, which were statistically significant.

Nearly two-thirds of pupils from School A confirmed that pastoral staff were available at the school, and almost as many respondents were aware of posters promoting mental health support organisations. There were similar, if slightly lower, levels of agreement about these categories in the WMCS results. Just over half of the participants from School A were aware of the provision of a counselling service in their school, which was proportionally significantly less than among those who took part in the WMCS survey, where almost three-quarters of respondents affirmed that counselling was available. It is interesting to note that, among the School A participants, the counselling service available in school was the only one of which they were proportionally less aware than their WMCS counterparts.

The least known services in both sets of results were the use of specific lessons or tutor time for mental health support and the availability of support groups for specific issues. Some of the WMCS responses to an open-text question about the availability of 'something else' included 'youth workers', 'peer mentoring', and specialist support systems. For instance, one respondent noted, 'I have autism, and I can go to a teacher in the base for help if I need it' (WMCS survey). However, the vast majority of qualitative answers to this question were 'I don't know'. It is not possible to say whether these pupils meant that they knew there was something else, but not what it was, or if they were unsure whether any additional service was available.

In the WMCS dataset, female pupils were significantly more likely than males to report that their school offered counselling ($p < 0.001$) and that a pastoral staff member was available for support ($p = 0.000$). They were also more likely than males to report awareness of posters or displays about mental health in their school ($p = 0.001$). Conversely, male pupils were slightly more likely than females to report access to support groups ($p = 0.030$). This difference was small but statistically significant.

5.4. Barriers

Do you know what to do to get support for mental health in school?

Survey participants in School A were asked if they knew how to access mental health support in their school. The results are presented below:

Fig. 4.2: Do you know what to do to get support for your mental health in school? School A. *(n=68).*

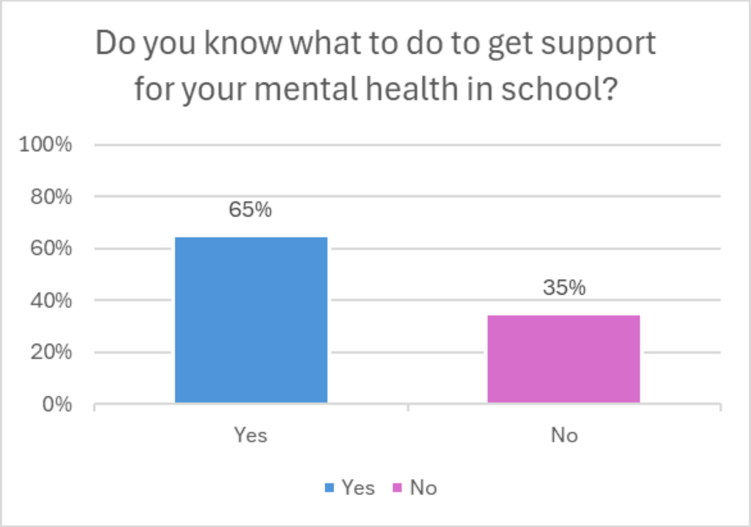


Figure 4.2 provides an overview of pupils' reported knowledge of how to access mental health support and is used to identify patterns of uncertainty that are explored in more depth through the qualitative data.

The graph above indicates that the majority of survey participants in School A knew how to access support for their mental health within the school. They were not asked to specify the steps they would take, so it is not possible to ascertain if their answers were accurate.

Of the 53 participants who knew that their school offered mental health support, 73.6% (n = 39) reported knowing how to access it, while 26.4% (n = 14) stated that they did not. This finding was raised during the semi-structured interviews, where one participant explained, "The support that we can access, we're not sure how to get to it and how to ask for it". In another interview:

> **INTERVIEWER***:* Is there support available here if you want it?
> ***PARTICIPANT:*** *Yeah*
> **INTERVIEWER***:* Brilliant, do you know what help is available?
> ***PARTICIPANT****: Not really*

These findings demonstrate that even when pupils are aware that services exist, not all know how to access them. This is consistent with research by Goodwin et al. (2023), which suggests that while pupils may receive education about managing their mental health through the curriculum, there is a lack of education about the availability of school mental health services and how they operate. This suggests that, in addition to prevention, there may be value in providing pupils with clearer information about service pathways, enabling them to seek support when needed. It should also be considered that for some pupils with limited awareness of services, this may be because they do not actually require any support and have therefore not engaged with available information. This was articulated by one participant in the WMCS survey who said, "*I don't know if they do anything that helps people because I don't really need help with anything*". Not all pupils who lack knowledge of services necessarily see this as a problem.

Table 4.5 School A responses to the question "Do you know what to do to get support for your mental health in school?" by gender.

	Boy	Boy %	Girl	Girl %
No	18	46%	4	16%
Yes	21	54%	21	84%

(n = 66)

84% of female participants in School A reported knowing how to access support, compared with 54% of males. Conversely, 46% of male participants stated they did not know what to do, compared with only 16% of females. Any responses from participants who preferred not to disclose their gender were excluded from analysis. A Fisher-Freeman-Halton Exact test was conducted, as appropriate for the small sample size, and despite the descriptive differences observed between gender responses, the test did not reach statistical significance.

What makes it hard to get support?

Survey participants in School A were asked what would make it hard to access mental health support in school. This question was replicated in the WMCS survey. The answers from both data sets are shown in Table 4.6 below:

Table 4.6: What would make it hard to get support with mental health at school?

	School A	WMCS
Not knowing how to get an appointment	53%	24%
The referral process	30%	11%
Worried that others will know	53%	32%
Location of the service – is it private, etc?	32%	6%
The waiting list	27%	16%
Times of appointments don't work for me	30%	8%
Anything not mentioned above	14%	17%

School A (n=68), WISERD (n=1354)

Table 4.6 is used to summarise the range of barriers identified by pupils and to highlight the most prominent concerns, which then informed the focus of the interview and focus group discussions.

As shown in Table 4.6, the most significant barriers identified in School A were not knowing how to get an appointment and worries that others would know, with just over half of respondents stating that these concerns would make it difficult for them to seek help. Approximately one-third of School A participants felt that the referral process, the location of the service and the times of appointments would present a barrier and just over a quarter of respondents said the waiting list would make it hard to get support. These barriers will be explored in more detail in the next section. In a qualitative response to 'anything not mentioned', one survey participant expressed the view that if they could change one thing about the current service to make it better, they would "*make it less obvious when someone's got an appointment*". Similarly to School A, 'worried that others will know' was the most commonly reported barrier among participants in the WMCS survey, with just over one-third reporting it. Almost a quarter of WMCS participants said that not knowing how to get an appointment would be a problem.

A series of chi-square tests was conducted to investigate gender differences in responses. Across all six categories, female participants were significantly more likely than males to identify barriers (p = 0.000). Qualitative responses to explain 'what else' included it being "*embarrassing*", and the service not being of good quality (either from personal experience or hearsay). Open text comments in the survey included "*I tried, they aren't any good",* and *"everyone that I have spoken to that has had counselling have said it was awful"*. Research has suggested that a positive experience of service use is a significant facilitator in any return to mental health support services (Rickwood et al., 2005). Vulnerability in talking to people about problems was raised with participants expressing that "*it's hard to say stuff*" and "*I don't like talking to strangers*". This finding is consistent with research by Fox & Butler (2007), who found that participants in their study reported feeling uncomfortable speaking to a stranger and that, without the trust of an established relationship, they did not feel that confidentiality was guaranteed.

5.4.1. Practical/pragmatic barriers

5.4.1.1. Waiting list

Table 4.6 previously showed that the waiting list for an appointment was a barrier to accessing mental health support at school for a quarter of survey participants in School A and a minority (16%) in the WMCS study. The theme was explored in more depth during the interviews, where several participants shared experiences of having to wait for an appointment:

> *I used to be in like Mind* [an externally commissioned counselling service delivered within the school]*, and I think I was on a wait list for that for, I don't know, about six months*.

Another interview participant reflected that the counsellor was not in school full-time and that there were more pupils wanting to meet with them than there were appointments available.

> *I don't know, it can take weeks, because like, some of them are quite busy. They only have like two or three appointments, so they can get quite a lot of people, and they only come in one day*.

Another pupil suggested that increasing the provision could help accommodate more pupils.

> *The reason why I couldn't get into Mind at first was because there was too many people. And so I think it helps when mental health can happen on multiple days…*

Participants expressed concern that the time spent waiting for an appointment could lead to people withdrawing from the waitlist before receiving treatment. An example of this was given during an interview, where a participant shared, "The *wait list was too long, so I just sort of gave up on it"*. Another participant supported this, saying:

> *By the time...you've got to the top of the waiting list, you've gotten over it and you've got like other ways to deal with it.*

There is limited research into the impact of waiting lists for counselling in schools, but Punton et al. (2022) suggest that, as with any medical intervention, symptoms such as stress and anxiety may worsen as the wait time increases. They also find that prolonged time on a waiting list is linked to disengagement or dropout from the service once treatment commences. The concerns raised about the waiting list for support are consistent with wider research, which highlights that shortages of mental health professionals and long waiting lists are barriers. It is worth noting that when asked to rank the identified barriers in order of significance, the focus group participants placed the waiting list as the least significant. However, any pupil currently engaged with a mental health support service was excluded from taking part in qualitative data collection due to ethical considerations. Those in the service may have had a different perspective on the significance of the wait time for services.

5.4.1.2. Location of the service/privacy

Table 4.6 above showed that the location of wellbeing services and a potential lack of privacy when attending them presented a barrier for a third of participants. This was given context through the interview process when one pupil explained that all wellbeing services were located in a specific area of the school, and that going to that area carried a risk of stigmatisation. He told me:

> ***PARTICIPANT****: Well, like some kids are like, as they walk like through the doors, some kids are like, think it's a special place and all of that, like for special needs and all of that.*

> **INTERVIEWER:** Yeah?
> ***PARTICIPANT**: So some kids might like feel like they don't want to be known as special, I guess.*
> **INTERVIEWER:** Yeah. So, it could be embarrassing for some kids?
> ***PARTICIPANT:** Yes.*

The language 'special needs' was replaced in Wales in 2021 with 'additional learning needs' (Welsh Government, 2021b) as a more inclusive and less stigmatising term. The participants' use of it suggests that if wellbeing is associated with being designed to support pupils with 'special needs', this could create a stigmatising barrier.

5.4.1.3. Times of appointments don't work.

During interviews, several participants raised that appointments conflicting with important or enjoyable lessons were an issue for them. One participant explained, "because like, it usually ended up being in lessons I like".

Another conversation during interview between two participants showed that sometimes the timing of support sessions was unfortunate:

> ***PARTICIPANT 1**: Well, I got taken out of music a few times a month.*
> ***PARTICIPANT 2:** I was taken out of English a lot. Which sucked because English is one of the things that I kind of need to be in.*

The concerns about people knowing of service use were amplified by being called out of class, which brought worries of stigmatisation for some participants. When asked in the survey, "What would make it easier to get support?", an open-text answer suggested "make it more secretive," implying that the possibility of others knowing they were seeking mental health support was uncomfortable. Examples provided by interview participants included being asked by other pupils why they were out of class, or worries that a peer would inform others, giving examples of this happening. One participant explained, "someone won't be in...and then their friend would go 'yeah, they're in therapy', it's like why? Why would you say that?".

In School A, pupils are currently called out of class via an appointment card system. A member of the school office team arrives at the classroom to call the pupil and allocates them a card that authorises them to be out of class during lesson time. Although this arrangement was not specific to counselling or mental health needs, and peers would not automatically be aware of it, it was still an unpopular arrangement for the majority of interview participants. There was a suggestion that it would be easier to access support in school if they could “make it less obvious when people have appointments” (survey), and there seemed to be sensitivity or self-consciousness among some that could make it harder for them to engage with support. Participants in one paired interview explained how it made them feel:

> ***PARTICIPANT 4:*** *Not everyone wants everyone in class to know you’ve got an appointment.*
> ***PARTICIPANT 3:*** *People are just coming to the classroom. Okay, I’ve got an appointment card for, and they’ll say it…It’s a bit like, embarrassing”.*

Not all pupils shared this view, with some saying that pupils were called out of lessons on a regular basis for various reasons, and classmates would not necessarily know that someone was receiving mental health support. Others pointed out that even if classmates did know, this should not present a barrier.

> **INTERVIEWER:** How does it feel if you’re called out of class? Does everyone know why?
> ***PARTICIPANT:*** *They just know that you are being called out of class, I don’t think they really know… I don’t know if I would care what people think…I think the need for support is probably outweighing what other people think.*

Additionally, some participants recognised that the system was effective in preventing missed appointments and in granting permission to be out of class, with one interview participant describing it as “*that bit… is very efficient*”.

5.4.2. Barriers relating to the school environment.

Getting an appointment was identified as the biggest barrier to receiving support in school A, and participants also identified several environmental challenges related to the school itself. As mentioned earlier, these included a lack of information about the services available and confusion about how to access them, as described by an interview participant who reflected on a lack of certainty about what each of the services entailed:

> **INTERVIEWER**: What is available here? What support?
> ***PARTICIPANT:*** *Like different, Mind and like, social workers*
> **INTERVIEWER:** Okay, and do they all do something a bit different? Do you know what each of them does?
> ***PARTICIPANT****: not really*

This suggests that while pupils are aware that support services are available to them, they lack a clear understanding of what these services entail and therefore what might be most useful to them if needed. During the focus group, one pupil raised the possibility that confusion might prevent someone from seeking support at all, saying, "*Some people might be confused, and the person doesn't tell anyone*". Pupils need access to information to make informed decisions about the choices they make; therefore, it is concerning to see that almost one-fifth of participants felt unsure about how to access support (Fig. 4.2). This finding lends weight to the research carried out by Hewitt et al. (2024), which highlights that this uncertainty is problematic because young people who do not understand the range of mental health interventions available are unable to make informed choices about the services they use.

One of the potential mechanisms to reduce the confusion felt by pupils would be clear signposting and information displayed, which some participants felt the school did well, as demonstrated by this interview participant:

> *There's like little boards around the school, like posters, that say, like stuff, like about who you can speak to and what you can do to help.*

However, there were mixed views on the effectiveness of this. Many of the interview participants were either unaware of information displays or felt the ones they knew of were ineffective, as explained by one interview participant, who said:

> *They should have more like bright posters like advertising, where you can get help, because they're all like the same kind of colour posters. They don't really stand out.*

This is consistent with existing research by Goodwin et al. (2023), who found that text-based communications, such as posters and leaflets, are not an effective way to share information with pupils, as they are unlikely to pay attention to or retain the information provided through that medium.

5.4.2.1. Lack of information and not knowing how to get an appointment

Some participants were unclear not only about the services available but also about how to engage with them. One interview participant tried to explain what he knew of the process that his friends had been through, saying:

> ***PARTICIPANT****: I think you could get an appointment, but it would be a little bit of a process before you could get one... I've never seen them in my life, but I think it's actually good.*
> **INTERVIEWER:** Can you talk me through that process? You said it'd be a bit of a process to get it.
> ***PARTICIPANT****: Yeah, because I've seen, like, loads of my friends have sometimes wanted to get counselling and things like that, but it took them a few weeks until they actually got it...I don't know what it was like because it wasn't me doing it.*
> **INTERVIEWER:** So you don't know what steps they had to follow?
> ***PARTICIPANT:*** *Yeah, I don't know why not...There's probably lots of parent or signings involved. I think that doesn't make it easier. It's important, but it doesn't help really.*

It is possible that this pupil was unaware of the process, as he stated he had never needed to follow it before; however, as it is a requirement for all secondary schools in Wales to provide pupils with access to a school-based counsellor, it is suggested that all pupils should understand how to engage with the service if needed. A lack of awareness about available support has been identified as a barrier in previous research (Barrow & Thomas, 2022). In their systematic review, the authors found that young people were unable to access support services due to a lack of knowledge about them and their functions.

5.4.2.2. Referral process

As discussed, interview participants reported being unclear about what they needed to do to be referred to someone in a mental health support role. There seemed to be a common belief among interview and focus group participants that an adult needed to refer them to such a service. When they believed they needed to go through an adult, there was sometimes uncertainty about who to approach. If they did know who to ask, there was a perception that it might not be a priority for that staff member to refer them. This was highlighted in a conversation between two interview participants:

> ***PARTICIPANT 2****: I don't know where we would get it from apart from our Head of Year, but that's about it.*
> ***PARTICIPANT 1:*** *You just go ask Miss X or something. I don't know.*
> ***PARTICIPANT 2:*** *No, I have no idea.*
> ***PARTICIPANT 1****: I feel like she's busy.*

When asked whom they would go to, the Deputy Head Teacher, form teacher and Wellbeing Officer were all named by different participants, although it is recognised that all staff members are likely to be clear on the process to follow once a young person requests support. Participants also expressed uncertainty about whether they should ask a parent to contact the school or approach an adult at school themselves. One participant stated that they would speak to the Deputy Headteacher, declaring, "I'd go speak to Miss R" (interview), but no other assertions were made. This lack of clarity mirrors findings from existing research, which identifies a lack of certainty about how to access help and whom pupils should speak to as a barrier (Radez et al., 2021).

The physical act of approaching an adult to ask for support was reported by several participants as something that would deter them from seeking support. One focus group member reported "*going up and telling people*" as a barrier. Reasons for the difficulty in approaching adults included a sense of vulnerability, which was demonstrated in responses in the WMCS survey where answers included: "*I don't know how to ask, and I don't know what to say*"; "*I'm too anxious to tell any adults*" and "*I get stressed when going to ask*". A lack of trust or poor relationships with teachers were also cited as reasons, with open-text survey responses including "*Don't trust the pastoral teacher*" (WMCS) and "*teachers have too much of an input in my personal issues*" (WMCS). Some other participants felt they had a good relationship with the relevant staff member and so did not see this as an issue. This was especially true when they were referring to a pastoral staff member.

In contrast to the confusion about which adult to approach for support with a referral, a key theme was a lack of pupil involvement in the process of referral – some pupils spoke of being referred to support services without any discussion, and there were a number of examples of parents requesting support on behalf of their child without involving the child in that process. One interview participant gave the example that, following a meeting his parents had requested with the school regarding concerns of bullying, the response had been for the school to provide counselling sessions:

> ***PARTICIPANT:*** *They just threw an appointment card at me; I walked over and met the person.*
> **INTERVIEWER:** Did you have to ask for the appointment?

> ***PARTICIPANT:*** *For Kooth? [a counselling provider at school A]. No, I was kind of thrown into it.*

Another focus group participant spoke of her parent requesting mental health support for her, and the counsellor not seeing it as an appropriate case:

> *You might not even need it at all because my mum tried getting me into it, and then the lady was like, you don't need it.*

Research highlights the potential consequences of this lack of involvement by the child. Davies (2018, p. 87) argues that when young people are referred to a service by adults without an appropriate discussion, this can negatively affect their experience of the support. They may be unclear about what is involved in the therapeutic process or uncertain about the reasons for their referral. These worries can lead them to see the referral as a punishment or to believe they are in need of 'fixing', making them reluctant to engage in the therapeutic work and perpetuating a negative sense of self.

5.4.2.3. Use of services

Survey participants in School A were asked whether they would consider using various support services within the school. The results are presented below:

Table 4.7 Likelihood of using different types of service? School 'A'.

	Unlikely	Neither likely nor unlikely	Likely
Specific lessons/tutor time	47.7%	31.3%	20.9%
Counselling	51.5%	21.2%	27.2%
Support groups	43.2%	29.8%	26.8%
Pastoral staff	41.7%	20.9%	37.3%

(n = 67)

5.4.3. Perceptions and experiences of counselling

Table 4.7 shows that 51.5% of respondents from School A said they would be unlikely to use counselling as a support service, the highest proportion of pupils selecting 'unlikely to use' across any category. 27.2% said they would be likely to use it. During interviews, there appeared to be a lack of clarity amongst participants about what counselling services are. This may be due to a misunderstanding about what counselling entails and who delivers the services. On occasions during the interviews, pupils would refer to members of staff in other wellbeing roles, such as youth workers, under the umbrella of counselling. In a conversation about counselling, one participant said:

> *I took like three sessions with a youth worker and then nothing more. And then something like, not very big happened, but like something in my life happened that like kind of changed my life a bit. And then I didn't know how to ask for more sessions*.

Analysis of the data indicated that some participants perceived the counselling services provided at school as of poor quality. This was raised in the open-text responses to the WMCS surveys, with one participant responding to the question about what made it difficult to seek help by stating, “the support isn’t good”. Two interview participants in School A also reflected that the counselling process had not been a positive or helpful experience for them.

> ***PARTICIPANT 1****: I've done counselling myself in the past, and from my experience, it probably doesn't do much.*
> ***PARTICIPANT 2****: It just takes you out of lesson.*

In the absence of pupils having a clear understanding of counselling and what it entails, it is not possible to judge whether the services provided are of poor quality or simply not what the service user expected. It is the perception that counsellors currently deliver the service in a standardised way that led one interview participant to suggest that the process of counselling should be tailored to each individual:

> *Maybe what counsellors should do instead of, like, what they do now...sometimes they like to take it slow. Some people like that, but like some people like straight to the point...some counsellors might approach something, like, you’re going to do this and then that’s going to fix it. But it might be the student doesn’t feel comfortable with doing that, and then it just makes it worse, I guess.*

The sense of one-size-fits-all approach is consistent with research that found that a lack of choice available to pupils meant they were obliged to take the service offered if they wanted additional support (Hewitt et al., 2024). The literature supports the need to adapt counselling methods when working with young people. Kirk et al. (2023) suggest that support should not be uniform for all service users, but rather tailored to the individual, taking into account their specific needs and preferences.

The perceived formality of counselling as a process was discussed as something this interview participant felt uncomfortable with:

> *But then when it comes onto counselling, I feel like that was too mature in a way. And it just kind of felt awkward.*

This suggests that the pupil was unable to form a comfortable relationship with the counsellor and did not feel able to influence the style or content of the sessions. Davies (2018) emphasises the importance of a child-led counselling process, with service users making decisions about the session and discussing topics that are important to them. Westergaard (2013) suggests that creating an emotionally and physically safe space, emphasising the significance of the therapeutic relationship, and adopting a flexible, person-centred, and creative approach are key components in conducting therapeutic work with young people. Fox & Butler (2007) suggest that when pupils have the opportunity to get to know the school counsellor outside of a therapeutic setting, for example, if the counsellor comes and speaks to the class about the service, this may help reduce the perception of them as a stranger and lessen trust issues. This was supported by research by Hewitt et al. (2024), who reflect that improved counsellor visibility could help reduce some of the ambiguity surrounding the counselling process, experienced by both pupils and staff, and help pupils develop trust in the counsellor. However, they went on to acknowledge that where pupils have increased contact with the counsellor and begin to perceive them as part of the school staff team, they may be reluctant to speak freely about school issues.

Some participants expressed fear that people outside of the counselling relationship would know their personal information. This suggests a lack of trust or confidence in the confidentiality of counselling sessions, as demonstrated in the responses to the WMCS survey: "*Sometimes they tell other teachers about it*" and "*they would tell your parents*". This could again be explained by a lack of understanding of the counselling service provided or a lack of trust in the counsellor. Some participants understood the need for conversations that raised safeguarding concerns to be passed on to other adults, but they brought that awareness into the counselling session with them, where it could influence what they shared:

> *Like if I said something to them, they would have to tell the Deputy Head, and the Deputy Head would have to tell Dad then. Like I told my counsellor something because obviously it's safeguarding reasons.* (Interview).

This could lead pupils to censor themselves and not talk openly about the issues for which they need support. This finding is consistent with broader research, which indicates that some school pupils perceive that conversations held in counselling may be shared with others beyond the counselling room (Doyle et al., 2017). As recognised by the participant above, there is a duty on counsellors to share anything that indicates a risk of harm. While this may be perceived as a limitation of the service by some potential users, the requirement for this to occur is stipulated in both school policy and safeguarding guidelines.

When discussing counselling, participants often refer to a wider range of services, typically those delivered on a one-to-one basis. This suggests that pupils view the process as the therapeutic element, rather than the specific person. While it is most important that pupils feel supported and benefit from these services, there are implications attached to this misconception. Without a full understanding of the purpose of each type of support service, individuals who do not feel they have sufficiently serious problems for counselling may avoid seeking any intervention. This finding is consistent with existing research; in a systematic review, McPhail et al. (2024) found that poor mental health literacy and misconceptions about mental health services contributed to pupils not engaging with counselling, as they had a limited understanding of what it was and did not consider it a possibility for themselves.

5.4.4. Perceptions and experiences of other school support services

Table 4.7 above illustrates the likelihood of survey participants using available school services. It shows that around half of the participants indicated that they would be unlikely to use any service offered in school. This cannot be assumed to reflect active opt-out; it may be due to having no concerns about mental health and consequently not having considered using such services. Specific lessons and tutor time, and support groups received the lowest number of positive responses; the reasons for this are explored below.

5.4.4.1. Specific lessons and tutor time

Table 4.7 shows that 47.7% of participants indicated they were unlikely to use specific lessons/tutor time as a supportive measure, and only 20.9% suggested this was a service they were likely to use. Of the affirmative responses, this category had the lowest positive response rate. Lessons are public and carry the risk of stigmatisation, bullying, and breaches of confidentiality by peers, which may account for why a significant proportion of pupils would choose not to engage with them as a support mechanism. The mixed response to these questions reflects the findings of existing research. Coombes et al. (2013) suggest that pupils have mixed attitudes towards lessons on mental health topics due to concerns about confidentiality and the skill of the teacher in delivering the lessons effectively. Chodkiewicz & Boyle (2016) highlight that the nature of group-based interventions is a ‘one size fits all’ approach, which Ng (2015) suggests cannot be optimal for all those who engage with it. Furthermore, the experience of group sessions is not comfortable for all pupils. Gee et al. (2020) suggest that when pupils are uncomfortable with the method of intervention, they may fail to see the benefit of engaging and, as such, be reluctant to do so.

5.4.4.2. Support groups

Although examples of such service provisions were mentioned in the surveys, Table 4.7 shows that 43.2% of pupils at School A indicated that they were unlikely to use support groups, while 26.8% agreed that they were likely to do so. School A’s website references an Equality and Engagement Officer who leads an Equality and Diversity group for pupils, and online drop-in sessions run by Mind are available to pupils. There is a significant lack of research into the role of support groups in supporting pupil mental health in schools. However, one study has found that where there are school-based interventions for specific marginalised groups, such as LGBTQ+, they can be effective in preventing or reducing mental health issues in pupils accessing them (McDermott et al., 2023). Gee et al. (2020) identify several challenges in the successful implementation of group mental health interventions in schools. They acknowledge that one of the key strengths of group work is the power of peer relationships, but managing behaviour in group work sessions and providing a space in which all young people can meaningfully participate is challenging.

5.4.5. Stigma

An issue raised repeatedly that overlaps with many of the barriers discussed is the stigma associated with experiencing poor mental health or seeking mental health support. Stigma was a significant concern for participants throughout all stages of data collection.

Worried others will know.

As discussed previously (Table 4.6), 53% of pupils in School A responded that 'worries that others would know' would make it difficult to use a school mental health service, which was significantly higher than the proportion of participants in the WMCS survey (31%). This is an interesting finding because, despite School A scoring higher in areas of children's rights and reflecting this in pupils' subjective wellbeing, this discomfort indicates that stigma attached to mental health is pervasive even in settings that proactively promote pupil wellbeing. This question was further broken down with participants in School A to identify which groups of people they were concerned about knowing; the same level of detail was not sought from participants in the WMCS survey.

TABLE 4.8: Would it concern you if the following people knew that you were using a support service? School 'A'. *(n=67)*

	Very concerned	**Uncomfortable**	**Not at all concerned**
Family	18%	19%	63%
Close friends	16%	25%	58%
Classmates	16%	36%	48%
Class teacher	9%	39%	52%
Other school staff	12%	36%	52%

As shown in Table 4.8 above, approximately half of the survey participants reported that they would be uncomfortable or very concerned if classmates, teachers and wider school staff knew about their use of a mental health support service. This is consistent with existing research showing that anxieties about being judged for having mental health difficulties and/or not being able to manage them independently are barriers to young people accessing support (Radez et al. 2021). Classmates were the group participants were most concerned would know about their use of a service, with 52% indicating some measure of discomfort with this. It should be noted that this figure may be higher in schools with higher bullying rates. Discussions with interview and focus group participants highlighted concerns that having mental health difficulties or seeking support for mental health would lead to teasing or bullying by peers, creating a barrier to help-seeking. Some of these concerns were based on perceptions of what might happen: "I'm worried about people using it as a way to tease you" (Focus Group participant). Another interview participant was more certain that peers would use it as a means of bullying them:

> ***PARTICIPANT**: I'm just scared that other people will find out.*
> **INTERVIEWER***:* Other pupils, do you mean?
> ***PARTICIPANT**: Because some people will like be quite mean about it.*

Others, however, were less influenced by the perceived judgements of their peers and prioritised their own mental wellbeing, opting to seek support regardless of others' opinions: "*I don't know if I would care what people would think*" (Interview).

48% of survey participants were uncomfortable with school staff knowing about their use of a service. One interview participant expressed a concern that a teacher's opinion of them might change if they disclose a need for help, saying:

> *And some teachers, like you say something to them and then they don't like look at you the same again.*

This is consistent with Rickwood's (2020) research, which finds that perceptions and/or experiences of poor responses from adults are a barrier to seeking help. Patte et al. (2024) also highlight that pupils may be concerned about changed perceptions and relationships with staff who find out about their mental health concerns. However, research shows that teachers feel that they are better able to support a child in receipt of therapeutic intervention if they are given some information about the needs of the child and the impact of their mental health condition (Shelemy et al., 2019b).

More positively, two-thirds of participants felt comfortable with their family knowing about their use of mental health services, and well over half of participants had no concerns about close friends knowing. This aligns with existing research, which indicates that these are the two groups with whom adolescents are most likely to have a close or trusting relationship, and thus they may be willing to discuss sensitive topics with them (White et al., 2024). They are also the groups most likely to first recognise changes in pupils' wellbeing (Migliorini, 2022), and the ones adolescents prefer to seek support from. Rickwood et al. (2015) suggest that seeking support from family and friends may, in fact, precede seeking help from professionals.

Fisher-Freeman-Halton exact tests were conducted to investigate any relationship between gender and the categories; male and female participants reported similar levels of concern about knowledge of service use, with the exception of a near-significant trend indicating that male participants may be more concerned about family awareness (Exact $p = 0.051$).

While there was some variation in who they were concerned about knowing, approximately half of the participants felt no embarrassment about engaging with a mental health service and were comfortable for any group of people to know, it may be that some of this group are accounted for by pupils who feel no need to access such services and so the question did not apply to them.

5.4.6 Gender differences

Although it was not a planned interview question, several participants raised the specific concern of mental health in relation to gender. When the topic was raised, it was explored in more detail. Many of the conversations centred on the perception that it is not socially acceptable for boys to express their feelings and emotions. During an interview, one participant described "toxic masculinity" as harmful to male mental health and explained its impact on his own ability to seek support, with the result that his mental health worsened.

> *Then, because of toxic masculinity, I just kind of kept it down. That led to kind of bad mental health, but yeah…*

He went on to suggest that less attention is paid to male mental health because of phrases like "*boys being boys*". Some of the male focus group participants were concerned about perceptions that poor mental health in boys was a sign of weakness, and it not being 'manly' to struggle with feelings or emotions. These stereotypes made it difficult for individuals to both acknowledge the need for support and to actively seek it. This is an area that has been previously researched, with similar findings. Haavik et al. (2019) suggest that boys are less likely to seek support than their female counterparts.

Furthermore, all the participants who expressed the view that fears of a negative response were a barrier to approaching adults for support were male. One of the reasons provided was a fear that adults would not take them seriously. Participants spoke of the reactions they expected if they approached an adult to request support, appearing to believe that some adults would minimise their concerns or dismiss them. One interview participant hoped that staff "*stop seeing it as a phase or something that will pass… Treat it like it's gonna be there for a while*". Another participant gave an impression of how he expected a teacher to respond if a pupil asked for mental health support: "*Do you actually want that? It's fine. You don't need that*" (interview). This may indicate that they felt their request would be rejected if they sought support, and therefore, would choose not to ask for it at all. Another contributor stated:

> *I feel like if I went and asked for help, nothing would really come of it. Or they'd be like "go ask your parents" or something like that* (interview).

This topic was explored in more detail with the focus group, who were asked if it might be harder for boys to seek support. One pupil expressed a sentiment that culturally "*boys are told to 'man up",* while another male pupil explained males are "*not as sensitive as females*". Highlighting the difficulties that boys might face in expressing emotions, a female participant stated that "*they're just scared of showing their feelings*". The group went on to list what might make it harder for boys to seek support, reiterating the findings from the interviews and alluding to perceptions that "*people think men are strong, never have any sad feelings, and people think men crying is pathetic*" (Focus group). The fact that there were possible repercussions from these perceptions was recognised by participants across interviews:

> **INTERVIEWER***:* Is it harder for boys to get help than it is for girls?

> ***PARTICIPANT**: Yes. Mainly because boys are told to like to man up or like, I guess the boys are fine or something.*

A member of the focus group suggested that "*males sometimes struggle more as they don't talk about their problems".* This is consistent with research suggesting that young men are socialised into concealing their emotions due to traditional ideals of masculinity (Stentiford et al., 2024). This perception of masculinity may have an impact on a male pupil's level of comfort in seeking support from a female counsellor. In response to the interview question "*What would you like decision makers to know*?", one interview participant expressed the view that boys may find it difficult to talk to a female member of staff about their worries. *"I think like, maybe a bit more men for counselling, because some people find it easier, like men on men"*. Research by Hewitt et al. (2024) highlights that the diversity of the counselling workforce is problematic, with the industry perceived as dominated not only by females but specifically by white, middle-class females. The small proportion of males in the counselling workforce has been recognised for several years. A survey conducted by the British Association for Counselling and Psychotherapy in 2014 revealed a significant gender imbalance within the counselling workforce, with 84% of registered counsellors being female and only 16% male (Brown, 2017). Existing research into the preference of therapist gender with adult men suggests that the majority did not have a preference about which gender therapist they saw, but for those that did, being able to see a therapist of their preferred gender had a significant impact on their levels of satisfaction with the service (Seidler et al., 2022). There is very little research into the preference for the gender of the therapist in males under the age of 18, and further investigation in this area could be beneficial. However, the need to tailor counselling services to adolescent males has been addressed in research by Boema et al. (2023), who identified a need for counsellors to have improved knowledge of masculinity and an awareness of the interpersonal styles of adolescent boys; for masculinity to be addressed, and for counselling to be adapted to better relate to adolescent boys.

5.5. Summary.

To summarise, this chapter has highlighted the facilitators that support access to school-based mental health provision, while acknowledging the ongoing structural and cultural barriers that shape pupils' experiences. Gendered patterns were evident: female participants were more likely to identify barriers, while males reported specific challenges to help-seeking. The next findings chapter will explore the identified facilitators and participant suggestions for making support more accessible and effective.

Chapter 6. Findings: Facilitators and Solutions.

Having identified the perceived barriers in the previous chapter, this chapter will explore the facilitators that support access and reflect on alternative viewpoints to some of those obstacles. It will then present participants' own solutions to the issue of access to school-based mental health support. While this chapter focuses on facilitators and pupil-identified solutions, these are often articulated in direct response to the barriers discussed in Chapter 5. References to barriers are therefore retained where necessary to understand how pupils conceptualise effective support.

6.1. Facilitators

6.1.1. Referral

As discussed in Chapter 5, some pupils felt that adults disregarded their autonomy by either minimising requests for support or acting without involving the child. However, not all participants saw adult involvement as a negative; one explained that his parents' intervention on his behalf had resulted in positive changes:

> *And then I'm told that my dad actually has been in school a lot to talk about it, and it's only just since this Christmas that they've started up emotional literacy, and I've been offered to Mind.*

Another contributor talked about her engagement in the process of referral, explaining how a member of the pastoral team had actively involved her in the choice of services available:

> **INTERVIEWER:** Did you choose which one that you wanted to go to?
> ***PARTICIPANT:*** *Yeah*
> **INTERVIEWER:** How did you make that decision?
> ***PARTICIPANT:*** *She...spoke about them...and would like...make you watch a video, which was all about Kooth, and then she had something that she'd like to say about all the different ones... and then another one came and spoke about them.*
> **INTERVIEWER**: ...That seems helpful...they gave you the information and you could choose from there, then? Did...you have a little bit of power then?
> ***PARTICIPANT***: *Yeah*

The participant shared that this involvement had brought her a sense of control in the process and empowered her with the knowledge she needed to make an informed decision.

Pupils involved in data collection were keen for an option of self-referral to mental health support, negating the need to speak to an adult. This option is currently available to pupils directly via the school website, where they can select an option to “request support”, triggering a referral to either the school pastoral officer or a specialist service. None of the participants at any stage of data collection made any reference to this, suggesting a possible lack of awareness and supporting their concerns about a lack of information regarding services and referral processes. There is research that supports the benefits of pupils having the option to self-refer to mental health support. Kirk et al. (2023) note that some young people benefit from being able to bypass gatekeepers, thereby avoiding the need to have sensitive conversations with more adults than necessary. Furthermore, there are benefits to mental health service providers because, when requesting support, the young person is likely to provide more detailed information in support of their referral, allowing for a more appropriate service match to be made from the outset. Similar findings were reported by Hewitt et al. (2024), who noted that while self-referral into counselling services provided autonomy to young people, the option for pupils to self-refer was not viewed positively by all staff, as they felt it reduced their ability to offer pastoral support. The option for self-referral could be effective in countering the ‘adult gatekeeper’ barrier and the perceived lack of autonomy among pupils.

Taken together, the findings suggest that referral processes can facilitate access when pupils are informed, involved, and supported, but that access remains uneven and often dependent on adult mediation. The data point to an underlying assumption within school-based systems that the availability of services equates to accessibility. In practice, however, pupils’ limited knowledge of referral routes constrains their agency, with access frequently reliant on adults acting as gatekeepers. Although self-referral options technically existed within the school context, the absence of references to them across all stages of data collection suggests that pupils were largely unaware of these routes. This supports participants’ concerns about insufficient information sharing and highlights a gap between policy or provision and pupils' lived experiences of access.

The findings also point to wider systemic issues, such as waiting lists and service capacity, which fall outside the scope of this thesis. While participants expressed frustration with perceived delays, this study does not seek to evaluate the effectiveness or resourcing of mental health services. Rather, it highlights how pupils experience and interpret these delays, and how such perceptions may discourage help-seeking. From a children's rights perspective, these findings highlight the need to ensure that young people are not only entitled to support in principle but also provided with accessible information and meaningful opportunities to participate in decisions about how and when that support is accessed.

6.1.2. Positive perceptions and experiences of support services

The variety of services on offer was highlighted as a strength by several participants. They spoke about two counselling providers, youth workers, and named staff members that they could talk to, as well as the emotional literacy lessons they had received in earlier years. Many pupils felt that there was a range of options available, and they would be able to find a service that best matched their needs, referring to the availability and accessibility of support as a facilitator, as explained by this interview participant:

> *I know they do they do offer stuff in school, which is awesome. It's also very helpful for people because if there's a particular issue in school, then it's easier access if they're doing it in school.*

The range of services and staff available for support is indicative of a universal approach to mental health support in the school. However, one pupil expressed during an interview that this approach felt tokenistic and did not provide any real benefits to pupils:

> *Like, there's an entire group in school, like an entire staff group about mental health. But even then, they are; it feels like they're not really trained to deal with it.*

In research conducted by Hewitt et al. (2024), a model was proposed that supported targeted interventions, such as counselling, being integrated into a universal approach to wellbeing, including prioritisation by leadership, staff training, and multi-agency working among key stakeholders. The research went on to suggest that pupils in need of mental health interventions should receive wrap-around care and be supported before, during and after their engagement with counselling. This highlights the benefits of a whole-school approach, where universal systems support a wider culture of wellbeing, reducing the need for targeted interventions and reinforcing their effectiveness when they are required.

6.1.3. Whole school approach to wellbeing

At all stages of data collection, participants proposed that they would like adults to ‘check in’ with them, but that this needed to be done with sincerity, and that the staff member should be open to an honest response from the pupil. For example, one interview participant recommended that staff “*Ask like, how you feel, like, properly?... They just say, ‘I need help with something small’. But it could be like a lot worse or something”*. This was also suggested in the survey, where one participant suggested that it would make it easier to get support if staff did “*check-ins with all students that are confidential*”. If adults were the ones to initiate a ‘wellbeing’ conversation with pupils, this could counter some of the stigma by making mental health conversations a natural part of school culture. This could have the dual effect of reducing anxiety about approaching adults and promoting anonymity, as all pupils are engaged in the same conversations. Having mental health support services embedded within the school is known to increase access and opportunities for pupils to connect with them (McPhail et al., 2024); these findings are consistent with this. One interview participant indicated that he was aware that he could approach a key adult and that it was helpful “*if you talk to your head of year, or person that registers you at the start of the day, they help quite a lot”*, but this example also relies on the pupil approaching the adult. This is reflected in the existing research by Mælan et al. (2019), who found that teachers who have a trusted relationship with a pupil can communicate care by expressing concern and asking a child how they are.

6.1.3.1. Specific lessons/tutor time/emotional literacy

The delivery of mental health support embedded within the curriculum is a key element of the WSA Framework. The delivery of Emotional Literacy lessons in Years 7 and 8 was positively referenced by many interview participants; most wished they were still receiving these lessons and felt they would still find them beneficial. During one interview, discussing emotional literacy sessions, one interview participant said:

> *It's helpful. They run it in ALN now...And it's just I think it's learning about how you deal with your emotions, and it's talking about things that worry you as well.*

Another interview participant went so far as to describe it as more helpful than counselling, explaining that:

> *It actually confronted the issues and helped teach about emotions and to deal with them. Whereas counselling, it's just, you can come in, you can vent and then...obviously if there's any things needed to be passed on and they'll do that.*

However, there were some inconsistencies in how participants described the emotional literacy sessions. Several pupils believed that sessions were no longer being offered now that they were in Year 9, but another pupil stated that they were receiving emotional literacy education again after a request from their parent for mental health support. There was also a lack of clarity about what was being referred to when pupils used the term 'emotional literacy', with one participant describing a one-to-one intervention, while others described small-group work. A pupil who had experienced emotional literacy education as part of a group felt that having other people there had been advantageous for her, saying: "*It definitely made me more comfortable being with friends as well... That there were other people with me that felt the same"* (interview). This finding is consistent with previous research by Gee et al. (2020), which found that one of the benefits of group work is the sense of belonging that comes from sharing experiences with those facing comparable difficulties, as well as the mutual support this can offer.

The benefits of discussing feelings and learning coping strategies, as described by participants, align with a small-scale study of the ELSA (Emotional Literacy Support Assistants) programme in two secondary schools in Wales (Krause et al., 2020). This research found that the programme offered several benefits, including increased resilience, improved emotional regulation, and enhanced engagement with school.

However, it also highlighted the possibility that pupils might become overly reliant on the staff member delivering the programme.

6.1.3.2. Support groups

A small number of less formal groups were mentioned by participants in data collection. These were generally brought up in passing rather than discussed as mental health support services, suggesting that, while enjoyable or beneficial, pupils may not consider them as having an impact on their mental health. One example was a drop-in wellbeing session run by the school's youth worker, available during some breaks and lunchtimes. One participant explained that she had joined this group that morning, stating:

> **PARTICIPANT:** *I went to a wellbeing art and craft thing. We did origami stuff, and it was fun. I know, obviously, it wasn't wellbeing as in 'it', but it was fun!*
> **INTERVIEWER:** It sounds it! Was it with a group of you?
> **PARTICIPANT:** *Well, every Monday there's this wellbeing thing that happens. I didn't know until I saw some posters of it. There was three of us. We just did kind of wellbeing stuff, and yeah...*

In addition to the sessions run by the school youth worker, there was also an Equality and Diversity group available, along with the online support sessions run by Mind, highlighted in the previous chapter. These were not mentioned by participants, although this may be because pupils do not associate mental health support with provisions for marginalised groups. They may also not recognise that an online group could be relevant to their school-based support services due to its remote nature.

As discussed in the previous chapter, gendered support was highlighted as important, and interview participants also discussed that School A had previously offered a 'boys group', which was no longer running. Two of the participants reflected on the fact that the group had paused when the member of staff who had responsibility for running it had left the school, as explained in the following quote:

> **INTERVIEWER***: Is there anything here that's specific to men's mental health?*
> **PARTICIPANT*:*** *There was, but then, like they left recently...*

Another participant who remained with the group through the changes felt that the group was no longer delivering the support that he was seeking, as he describes here:

> **PARTICIPANT*:*** *It was one of the main drivers for me when I first joined the male mental health group.*
> **INTERVIEWER:** They're becoming far more common now, as well, aren't they? Male mental health groups?
> **PARTICIPANT:** *Just after the person who founded our school's male mental health has now gone to a different place or retired. I'm not sure what it is. Yeah, the new leader [names Male teacher] has been expecting approval from the office or approval from the Head, or something to get on with doing it...*
> **INTERVIEWER***:* Okay. I hope you find that opportunity soon. It sounds like that group was really good for you.
> **PARTICIPANT*:*** *Yeah, it was the start of year nine when he finally took over, but I was just left year 8, going into year nine. Now I'm going towards year 10, and male mental health has done nothing in that gap.*
> **INTERVIEWER*:*** So, the male mental health group is that a pupil-led group?
> **PARTICIPANT*:*** *No, it's not.*
> **INTERVIEWER*:*** Who leads that group then?
> **PARTICIPANT*:*** *It was (female teacher). Now, it's (male teacher) who doesn't really know what he's doing.*

This demonstrates that, for these boys, they would engage with a service specifically aimed at them and see its value when it is run consistently, reflecting the section on gender in the previous chapter.

Taken together, these findings reflect a Whole School Approach to wellbeing in which mental health support is embedded across everyday interactions, curriculum-based provision, and targeted group interventions. Within this framework, support groups and informal wellbeing activities can be understood not as stand-alone services, but as complementary elements of a wider school culture that seeks to normalise conversations about mental health and reduce barriers to help-seeking.

6.1.3.3. Pastoral staff availability

Supportive staff members were perceived as approachable and a safe way to ask for help. When giving examples of supportive staff, pupils typically named members of staff with pastoral responsibility. The survey results, as shown in Table 4.6 (presented in the previous chapter), indicate that in School A, the most popular option for mental health support is pastoral staff, with 37.3% of respondents indicating that they would be likely to use this option. This was supported in interviews, where half of the participants referred positively to their connection with a member of the pastoral staff team.

Describing the pastoral team in his school, one interview participant said, “If you want, you can talk to these people, they’ll help you out”.

Referring to a member of the pastoral team, an interview participant explained, “*Like if you've got a problem, she’s always there, and if she doesn't know how to deal with it, then she’ll still try and help”*. Furthermore, some pupils indicated that they felt the pastoral staff would be able to support them with a range of problems, whether they related to school or not.

> *Well, you can always go to them when you’ve got a problem, like, whether it's to do with something that happened in school or outside of school. And they’re like, there for you and stuff like that.* (interview).

The word ‘always’ was used on several occasions, suggesting that pupils viewed the availability of this service as a strength. The constant presence in school of the pastoral team was highlighted throughout interviews as being effective in reducing barriers, as explained during one interview:

> *I feel like here is quite good for it because we've got like the whole school wellbeing type place that you can always go to if you’ve got a problem. So, you can always go to any of the people if you have a problem, things are not like right or if you feel unsafe about something. Like you can go here, and they’ll try and sort it out as soon as they can.*

This is consistent with existing research, which shows that pastoral staff can typically offer an informal, drop-in service and a safe physical space dedicated to wellbeing. This is underpinned by the opportunity for one-to-one time, allowing for the development of more open and trusting relationships. There is also evidence to suggest that if support staff are perceived by pupils to be ‘wellbeing specialists’, this can make pupils more likely to want to engage with them when needed (Littlecott et al., 2018). A key strength of the informal, drop-in nature of these embedded services is that pupils have some autonomy over when they access them, and as such, can avoid a public withdrawal from lessons (McPhail et al., 2024). The pastoral team offer a less formal service than those that require a referral, such as counselling, and, as members of school staff, pastoral staff are typically more familiar to pupils. This is consistent with existing research by Littlecott et al. (2018), which found that pupils have different perceptions of teaching and support staff (support staff being defined as any staff member in a non-teaching role). Teachers may be seen as authority figures and, as such, may be perceived as intimidating when addressing difficult or sensitive issues.

6.2. Proposed recommendations

The purpose of the focus group session was primarily solution-focused; to try and answer the research question, ‘How would young people make mental health support services in schools more accessible to students? The group identified a range of ways they believed the therapeutic environment could be improved, as well as barriers to access that could be removed and a small number of facilitators that could be introduced.

6.2.1. The therapeutic space.

In response to being asked, “If you were responsible for designing the mental health service in a school, what would it look like?”, some participants answered the question in its literal sense. Interview participants expressed a clear desire for physical comfort in the therapeutic space. They suggested soft furnishings, adjustable lighting, and minimal sharp edges, which would contribute to a sense of physical safety. Additionally, they proposed displays of pupil-designed artwork, fidget toys, crafts, and a ‘door to keep people out’, creating a sense of emotional safety. One described “Just like a nice, like a sensory room…with lava lamps”. Another wanted “Bean bags, and then storage like other arts and crafts and stuff and fidgets. Rug, a table, and then pens and stuff and the chairs”. A third pupil was able to contextualise why comfort was important: “I like the bean bags… I think like it's about you're comfortable while you're talking about it”.

In two of the interview’s participants responded by spontaneously drawing what they thought the counselling room should look like.

The first participant who took this approach verbalised her thought process as she drew. The room created was child centric, it contained a door which was specified “*to keep people out”,* toys, child friendly décor that included beanbags, pillows and a rainbow shaped carpet, “*cool things on the wall*”, circular tables and cabinets “*for toys or paper or whatever*”, book cabinets and books “*they could be like picture books*” and was described by the participant as “*peaceful*”. However, it is possible that a room of this design would be appealing to older pupils at the school.

A further visual representation was co-constructed by two female pupils during a paired interview. The interview took place in one of the rooms used by the school for wellbeing sessions, and the participants used this as a basis for their design. The participants who drew this example began with typically feminine details, such as suggesting it be painted in pastel pink. When asked if this was likely to appeal to boys, they suggested keeping the pastel colours but proposed more gender-neutral options, such as “maybe like pastel yellow, or this kind of green”. They identified things about the room they would keep: “I like stuff like that, like the artwork” (pointing to some pupil-created artwork displayed on the wall). As with the other drawing, there was a sense of avoiding a feeling of formality in the room, with suggestions of wooden storage furniture that would look less formal than a traditional metal filing cabinet, as well as comfortable chairs and bean bags. They also talked about creating a cosy environment, “the little things which are making it kind of cosy in there, fairy lights…maybe like mood lighting”, “blinds or close up the curtains” and “a nicer carpet, a fluffy rug”. The participants in this paired interview also discussed an Emotional Literacy notice board displaying an advice poster suggesting actions to take in response to certain feelings. The poster illustrates examples of emotional regulation techniques, such as drinking water or doing stretches if you’re feeling angry. The participants laughed about the poster, suggesting it was not helpful advice and referring to it as babyish, as they did not believe it would be useful for anyone of secondary school age. There were suggestions that having activities available, such as arts and crafts, books, and fidget toys, would be beneficial, as “some people like to fidget while they talk”. There is limited research into the use of fidget toys during lesson time, with mixed opinions on their effectiveness (Schecter et al., 2017). Potential benefits suggested are that they offer comfort or a distraction to the pupil. There is currently very little research on their use in the therapeutic process; however, comfort and distraction may be useful tools in a therapeutic setting. Participants acknowledged that discussing sensitive issues can be challenging, and some expressed the view that using fidget toys or engaging in activities could be beneficial.

Research by Sanders and Lehmann (2019) found that, as in this study, female pupils considered the ambience of the counselling room to be an important factor, whereas male pupils focused overwhelmingly on the quality of the counselling. For female pupils, comfort was identified as a key factor, with neutral colours, adequate lighting and the creation of a homely space. This research also recognises that the needs of different children in a counselling space may vary; however, there is a lack of evidence in this area.

It is clear that many of the smaller details relating to how the room looks and feels were important to many participants, and the suggestions made did not feel like elements of a stereotypical school environment. The rooms participants described were designed to evoke feelings of comfort, security, and informality, rather than simply being available spaces in the school. Sinclair (2020) agrees that the physical space and its feel are equally important to both the counsellor and the pupil, but they are often forced to compromise and use space that is less than ideal.

In their research on the ‘ideal’ counselling room, Sanders & Lehmann (2019) found an association between the physical space and a client’s feelings towards the counsellor and the counselling process. They identified that physical and emotional comfort were significant factors and that this comfort was established through the creation of a safe, welcoming and relaxed space. Although their research was conducted with adult participants, it also appears to have been important to the pupils at School A. One interview participant described one of the rooms used for counselling sessions as *“there’s a tiny one...which I quite like...it’s decorated nicer, you know?”,* confirming that the feel of the environment does make a difference for some pupils.

6.2.2. Removal of barriers

Pupils reflected on how the recognition and removal of existing barriers would support access to services. These are explained below.

6.2.2.1 Leaving the classroom.

As discussed in Chapter 5, participants at all stages of data collection raised the issue of leaving the classroom to attend mental health support sessions. So long as these sessions are held during lesson times, this is difficult to overcome, as being called from the classroom for any reason will draw attention. One interview participant recalled a text reminder service she had liked: “My mum used to get a text in the morning, and it would have like what lesson and what room”. She felt that, for her, this would be preferable to a member of support staff coming to the classroom and issuing an appointment card, although she acknowledged the rule that an appointment card was needed when out of lessons. This is consistent with research carried out by Fox & Butler (2007), who found that pupils leaving a classroom during lesson times often led peers to want to know where they were going. This made it difficult for counselling service users to keep private the knowledge that they were using the service. This issue was recognised in a statement issued by the BACP (British Association for Counselling & Psychotherapy), which called for improved access to school-based counselling services in Wales (BACP 2018). The statement emphasised the positive impact made by school-based counselling services, but also highlighted that some pupils had indicated that there was an element of shame in visiting the counsellor during lesson time and needing to leave lessons to attend the session. The School-based Counselling Operating Toolkit, published by the Welsh Government (2020) and the BACP, states that counselling services must be non-stigmatising.

6.2.2.2. Self-referral.

One of the most popular suggestions from a focus group member was a self-referral box for pupils to request support. This was a simple suggestion, as explained by a participant who said, “a shoe box to put ideas and worries in so you don’t have to be known would be helpful”. Although the suggestion was made in discussions about easing access to support, it is possible that the box would also serve as a means for pupils to air grievances without expecting staff follow-up. The box or boxes would be placed in a designated area and checked by staff on a periodic basis. This option would remove the barrier of needing to approach an adult, such as school staff or a family member, to ask for support, and would allow pupils to act autonomously. It also offers greater privacy, as the pupil can use the box at a time that is suitable for them. There is existing research into the effectiveness of this as an access mechanism by Davies (2018), who describes self-referral as ‘empowering’ for a child. Furthermore, King et al. (2012) suggest that a child who self-refers is demonstrating that they are open to starting the therapeutic process, which is vital for success.

6.2.2.3. Waiting list

During the focus group, it was suggested that, to mitigate lengthy waiting lists, those with a formal diagnosis of additional needs or mental health conditions could be prioritised for access to support services. One participant suggested “the waiting list should prioritise pupils with a diagnosis,” but did not clarify which diagnoses should be prioritised for support. One focus group member seemed to equate a diagnosis of neurodiversity with a need for mental health support, suggesting, “What if neurodiverse people are unable to get diagnosed or are waiting for a diagnosis?”. This led to a conversation among some of the group about what would happen to those who may be undiagnosed or waiting for a diagnosis of neurodiversity. There was also a more widely expressed concern that “if there's no diagnosis or obvious mental health difficulties, that can mean no help”. While there is no evidence to suggest that this perception is accurate, research does highlight a link between neurodivergence and school distress. Poor behaviour and school avoidance, resulting from undiagnosed additional needs, may lead to some pupils being prioritised for support services in schools (Connolly et al., 2023).

6.2.2.4. Improved information sharing.

Focus group participants were unanimous in the belief that the communication of available services, and specifically the means of accessing them, could be improved. The solutions offered were typically practical, with suggestions for more signposting, using displays in communal areas, and sharing information through assemblies. This way, all pupils received the same information and could choose whether it was applicable to them. One participant suggested that “important info like phone numbers should be displayed where it can be seen”; the use of TV screens in the entrance hall was also suggested in the focus group. Assemblies were not seen as the right source for all pupils, with one participant expressing, “Stop talking about it in school assemblies like almost EVERY DAY” (survey). This suggests that for those pupils who do not want, or need, to engage with the mental health services in their school, the information may be overpowering or repetitive.

6.3. Pupil suggestions

Throughout the data collection process, participants suggested various ideas that could be introduced to support engagement with mental health services. These are outlined below.

6.3.1. Animal therapy

This was raised in interviews and in the focus group as something pupils would like, and participants spoke of having previously enjoyed having animals at the school. Participants positioned the animal as a therapeutic tool and did not seem to consider that an adult might also be present during these sessions. This became clear when one of the reasons given in support of animal therapy was that it avoids the need to have a difficult conversation with adults. One participant explained, "There's a lot of people who prefer to talk to an animal than a person". It also lends weight to discussions about creating a comfortable environment and eliminating the risk of therapeutic conversations being repeated with anyone else. The group discussed the reasons for and against having therapy animals in schools, including pupils with allergies, and the considerations of how the animal should be treated by all pupils, which are referred to in the methodology chapter.

6.3.2. Personalised assessments

There was a clear message from the focus group that pupils' views on the support they receive should be taken into account, as they are the ones receiving the service. One focus group participant articulated this clearly: "Adults should not pick the mental health things because they are not the ones going through it". Their views on this issue align with the literature on 'pupil voice' discussed earlier, which argues that young people have a right to participate in decisions that affect them (Lundy, 2007) and, as such, should be consulted. Pupils suggested assessments they could complete to help ensure that the service they were matched with was one with which they were comfortable. One focus group participant had experienced something similar previously, saying:

> *I think I've got a good idea for the adult choosing thing. I remember at the start I went through an assessment thing to make sure that where I was going was suitable, so I think if they had some form of assessment thing, so that you could be more specific about where that person needs to be for mental health.*

The model suggested by Hewitt et al. (2024) in their research into the systems surrounding counselling services in schools advocates the approach of ‘the right therapy with the right counsellor at the right time’ and argues that maintaining a child-centred approach is necessary for the most effective therapeutic process, both in the referral process and in counselling delivery.

When animal therapy was removed as an option in the voting activity, the assessment form was voted by participants as the most popular suggestion, suggesting that it would have the greatest impact on their decision to access support services. As with the self-referral box discussed above, these assessments were viewed as a way for pupils to get an appointment without needing an adult to refer them.

6.4. Key points participants wanted decision-makers to know.

At the end of each interview, participants were asked if there was anything they thought decision-makers should know about young people and mental health (decision-makers were defined as anyone in a position of power, from teachers to politicians). The responses broadly fell into two categories. The importance of treating people and cases as individuals, and a reference to the need for the provision of support.

The importance of being seen as individuals came up in four of the interviews and appeared to be a message that participants strongly felt needed to be heard by adults: “*everyone is different*”, and “*Yeah, I'd say that everyone is different”*.

Recognition that young people each have a unique set of circumstances and feelings was important:

> *In most things, they’ll categorise all the mental health problems under, like sadness or depression. Like they won’t really, they won’t treat it differently.*

Finally, a recognition that young people are not simply young adults, and therefore require a service tailored for them:

> *We are all still teenagers. We don’t have the same mental health issues as some adults might. Like, yeah, they can come down to being named the same thing, but we would, I feel like we experience it differently than them*.

Additionally, participants felt that it was important that adults recognised and valued young people's need for support as expressed in the following quote:

> *I guess it does need to be sorted because if people don't talk about it, then it does get worse. …especially when you're in like High School and there's a lot more pressure… as well as a lot of different things that are changing. Like, I think if you don't talk about it, then it can be a lot more difficult than it needs to be.*

This is an insightful comment from the participant, as there is evidence that finds a link between poor mental health in adolescence and its continuation into adulthood (Jonsson et al., 2011; Johnson et al., 2018).

6.5 Summary

The findings show that while a significant proportion of pupils at School A are aware that mental health support is available in their school, their understanding of the specific types of service varies. Furthermore, many pupils expressed uncertainty about how to access the available support.

Several barriers to accessing mental health support were identified. These included a lack of information about services and referral mechanisms, concerns about stigma, and a worry that others, particularly classmates, would learn about their service use. Practical difficulties, such as the visibility of attending appointments when being called out of class, were also raised. The study also highlighted the importance of relationships with adults, with fears of not being taken seriously or experiencing negative judgment acting as a deterrent to seeking help.

Rather than presenting solutions as distinct from barriers, the findings highlight how pupils' proposals for improvement emerge from their experiences of constraint, limited agency, and uneven access to support.

The research identified several facilitators and recommendations for improvement. These included improved information sharing about available services through various channels, the availability of comfortable, non-formal therapeutic spaces, the removal of barriers, such as the public nature of leaving the classroom for appointments, and the introduction of self-referral methods to bypass the need to approach an adult.

Participants also advocated for the use of personalised assessments to match pupils with appropriate support.

Finally, it was important to the participants that decision-makers recognise the importance of treating young people as individuals with unique circumstances and acknowledge that their experiences may differ from those of adults. They highlighted both the importance of accessible support services and the potential for difficulties to worsen if left unaddressed.

The findings address the research questions in the following ways:

6.5.1. Research Questions

Having outlined the research questions earlier in the thesis, this section briefly summarises how the findings presented in Chapters 5 and 6 address each question.

1. What do young people think the barriers are to accessing mental health support in school?

Chapter 5 identifies several barriers to access, some of which are practical, such as perceptions of lengthy waiting lists and referral processes. Other barriers were linked to the school environment and included concerns about privacy and confidentiality, as well as stigma and mental health literacy. There were also gender differences; while many participants identified the same barriers, boys were likely to experience them differently due to gender stereotypes.

2. How would young people make mental health support services in schools more accessible to pupils?

Chapter 6 highlights pupils' suggestions to better facilitate access to support services. These included improved signposting and communication about services, recommendations for reducing stigma, and the introduction of self-referral mechanisms. Participants reflected positively on the role of pastoral staff and informal support.

3. What would a pupil-designed service in schools look like?

The final section of Chapter 6 presents participants' suggestions for a student-designed service. They discussed the importance of the therapeutic environment, the value of having choice and autonomy over the services they used, and emphasised the importance of a person-centred approach.

Chapter 7. Discussion

7.1. Introduction

This chapter discusses the study's findings in relation to existing literature and relevant policy frameworks, such as the UNCRC and the WSA Framework. It highlights key insights from the perspectives of young people on accessing mental health support in schools, which, as shown in the previous chapter, reveal misunderstood processes and perceptions of stigma. It will also discuss how pupils understand their experiences and navigate the systems around them. The chapter reflects on the uniqueness of the research setting (School A) and its implications for generalisability. The final sections explore the implications for policy and practice, highlight the study's strengths and limitations, and offer directions for future research.

Focusing on children's rights and participation, with practical implications for school practice and policy, the discussion is framed by Lundy's model of participation (2007), explored in the literature review, which conceptualises Article 12 of the UNCRC through four stages of participation: **Space, Voice, Audience**, and **Influence**.

- *Space* – the opportunity to express a view.
- *Voice* – being facilitated to express the view.
- *Audience* – the view should be listened to by those in a position to pay them regard.
- *Influence* – the view should be appropriately acted upon.

This model was designed to support the realisation of Article 12 of the UNCRC, which establishes the right of children to express their views and have those views considered in matters affecting them, with due weight given to their age and maturity. This means that children have the right to be heard in decisions that impact their lives. According to the model, rights relating to non-discrimination, having their best interests considered, guidance from adults, and the right to information are necessary to underpin the genuine realisation of Article 12. Therefore, the children's rights questions posed in the survey, relating to feeling safe, feeling cared about, and feeling listened to and respected, are essential conditions that support participation. These questions offer a useful lens for understanding the wider data. For example, pupils who do not feel respected, safe, or cared about may lack the emotional safety to express their views, undermining the *Space* and *Voice* components of the model. Lundy (2007) makes clear that participation relies on creating the conditions for children's views to shape the systems that affect them; therefore, this chapter will reflect on the extent to which the four components were met in the data. As these services are exclusively for pupils' use, it is vital that their views on the effectiveness of these systems are sought. Therefore, this study makes a valuable contribution to the field by gathering insights from young people about their experiences and opinions. Key findings were divided into the following themes: mental health literacy, gender, autonomy and the therapeutic experience. The interpretation of these themes frequently overlaps and is discussed in relation to each of Lundy's conditions for participation.

7.1.1 Positioning School A against the national picture:

The proportion of pupils in School A who felt that their rights to safety and participation were upheld was significantly higher than in the wider sample of schools. They also demonstrated greater awareness of the different types of support available than their peers in other Welsh secondary schools. The only service they were proportionally less aware of was counselling. This was a surprising anomaly, for which there are two possible interpretations.

1. School A is effectively meeting pupil wellbeing needs as part of the culture and WSA Framework. This means that pupils have less need to seek out specialist services and are therefore likely to be less aware of their existence.
2. Alternatively, School A provides a number of services, but this is a quantity-over-quality approach. Providing services without the underpinning mental health literacy that supports pupils to understand the differences between them or how to engage with them results in pupils feeling uninformed.

While this distinction between School A and other Welsh secondary schools highlights that these findings are not easily transferable to other settings, it raises the question of whether a school that scores so significantly above average in most areas has pupils who find it challenging to access support, what might the experience be of pupils who feel less safe and listened to in other schools? This suggests a need to consider policy-level implications that extend beyond individual school practices.

7.2. Space

This section will explore the extent to which pupils felt school was a physically and emotionally safe space in which to seek mental health support.

7.2.1. Stigma and visibility (emotional safety)

Stigma was a key barrier to accessing support in school. This was related to both anticipated and experienced stigma (Gronholm et al., 2018) and presented as a problem in both accessing the service and actively engaging with it. Participants were equally uncomfortable about classmates or school staff knowing of their potential service use, which chimes with previous research by Prior (2012), who suggested that pupils feel concerned about negative labelling by their peers and discriminatory reactions from staff. These concerns create emotional barriers to engagement. The earlier literature review revealed that this issue is not specific to School A and poses a challenge to the delivery of mental health support in schools more widely (Aguirre Velasco et al., 2020; Gronholm et al., 2018; Rickwood et al., 2005).

These findings suggest that while pupils have access to support services, there may be risks associated with engaging with them. This aligns with existing research, which highlights the role of peer judgement (Radez et al., 2021), fears of exposure (Fox &Butler, 2007), and concerns about adult responses (Patte et al., 2024) as school environment-related barriers to help-seeking.

The visibility of accessing support was particularly concerning for many participants, an issue compounded by being called from the classroom in front of peers. While previous research (Segrott et al., 2013) suggested that providing pupils with a generic appointment card to allow them to be out of class was beneficial, this study found that it still felt stigmatising to some pupils. There was also discomfort about being seen entering a wellbeing space, driven by perceptions of what others might think. Research by Duffy et al. (2021) suggests that privacy and avoiding the risk of interruption are vital to a positive experience for young people seeking mental health support in school.

Being identified by peers as needing help carries the risk of being labelled as vulnerable, weak, or different, and comes at a time when social acceptance is a primary objective for many adolescents (McElhaney et al., 2008). A substantial body of research examines the social benefits of 'fitting in' in school, including studies by Schall et al. (2014), Walker et al. (2017), and Whiting & Nash (2023). The stigma attached to seeking support for mental health means that some pupils face a choice between fitting in and seeking support. Anticipated stigma reduces the Space element of the theoretical model, highlighting a need for schools to ensure that discreet access is considered in practice.

7.2.2. Gender

Although girls also reported barriers to help-seeking, boys' accounts were more gender-specific, shaped by cultural expectations and the absence of support that felt relevant to them. Throughout the data, boys were clear that they found it challenging to seek support, due to social norms of masculinity and a lack of male role models in supportive roles. This meant that school did not feel like a safe space, either emotionally or physically, to seek help.

Cultural norms of masculinity made it difficult to admit a need for support; the social cost of doing so, as well as the risks of dismissal, made even those who felt able to ask consider whether it was worth it. The fear of being mocked or not taken seriously presented a significant barrier, which has a clear overlap with the stigma discussed in the previous section, but experienced in a way specific to boys.

Traditional gender expectations may discourage boys from expressing emotion or seeking help, and these norms may be unintentionally reinforced in school environments (Odenbring, 2019). There is evidence that teachers may unknowingly use gendered discourse, thereby reinforcing stereotypes (Pearson, 2021). In School A, there was a lack of male role models in wellbeing roles, and male participants highlighted this as a potential barrier. These issues not only make it more challenging for some boys to approach staff for support with mental health but also reinforce the idea that these spaces are not aimed at boys. These findings align with wider research on masculinity norms and adolescent boys (Haavik et al., 2019; Sagar-Ouriaghli et al., 2020; Sheikh et al., 2024).

The clear overlaps between gendered experiences of accessing mental health support and stigma, which result in unequal access to support for boys suggests that the appropriate response should not be to encourage boys to engage in the same way as girls, but to offer diverse and inclusive forms of support that meet boys' needs (Lynch et al., 2016; Rice et al., 2021; Boerma et al., 2023).

The knowledge that gendered norms are impacting on boys' emotional safety to seek support suggests that there is a need to address their equitable access to meet the Space component of the model.

7.2.3. Therapeutic experience

The therapeutic experience encompasses the impact of the physical environment, the format and approach used in a support session, and the relationship between the participant and the therapist.

A number of pupils spoke positively about non-traditional forms of wellbeing support, including creative activities and informal drop-ins. One pupil described attending a wellbeing session involving origami, which they found calming and enjoyable, even though it was not specifically framed as part of a wellbeing service. Research has previously demonstrated a relationship between creativity and wellbeing (Csikszentmihalyi, 2006; Kenning, 2015). Others described using drop-in spaces, such as the pastoral officer's office, in times of need. These sessions weren't necessarily framed as therapeutic by the participants, but they were still experienced as helpful, which resonates with previous research by Cardoso et al. (2012), which found that pupils experience such interactions as useful in school. This was a common thread among participants, who reflected positively on low-pressure, flexible forms of support. This was most common among those who had not used any formal interventions, such as talking therapies. This aligns well with the aims of the WSA Framework, which are to support pupil mental health by creating a culture of wellbeing and to improve access to support for those who need it (Welsh Government, 2021a).

One of the clearest strengths identified by participants was the range of wellbeing services on offer, including counselling, youth workers, wellbeing drop-ins, and trusted pastoral staff. Several pupils reflected on the range of choices available, which allowed them the autonomy to engage in ways that suited their preferences. However, because there is no mandated list of interventions that schools must provide, it cannot be assumed that other schools will mirror the services available at School A. While no such study exists in Wales, research based in the North of England (Patalay et al., 2017) found that the schools in their study differed in the mental health support they provided. This was attributed to financial constraints, capacity, identified need and prioritisation. The same issues are likely to apply in the Welsh context, and given that School A is particularly strong in its wellbeing offer, it may represent a “best-case” scenario rather than a typical one.

For some, traditional talking therapy felt uncomfortable. As such, the range of support services, which include informal and creative methods, provides pupils with several means of engagement, allowing children to participate in ways that suit their preferences. The location of the ‘Space’ is also important to consider; the current arrangement of a ‘wellbeing area’ in the school carries the risk of excluding those pupils who are not comfortable being seen in such a space. By including provisions other than talking therapies in a variety of locations, more ‘Spaces’ are created.

Participants' inference that support doesn’t have to look like a typical mental health provision to be helpful challenges the prevalent models of school-based support, which often centre on talking therapies. This echoes the literature showing that young people often value informal and relational forms of support (Lynch et al., 2023; Wadman et al., 2024) and aligns with the Welsh Government's WSA Framework, which encourages broad approaches to wellbeing rather than limiting them to talking and clinical models. Some young people favour activities that promote wellbeing indirectly, through activities that facilitate calming time or creative expression, such as mindfulness or art-based activities, rather than through structured, one-to-one conversations or counselling. Some pupils may never choose to access formal interventions such as counselling, but that does not mean they’re not engaging with support. Expanding the definition of what support should look like could broaden access, reduce stigma, and enable pupils to seek help with greater autonomy. The use of such approaches aligns with wider evidence on alternative methods, which can feel less stigmatising and emotionally safer for pupils who are not comfortable articulating their feelings verbally.

These approaches can be effective in supporting improvements in mental health by reducing feelings of anxiety and depression (Lahtinen & Salmivalli, 2020) and improving emotional regulation, self-satisfaction, and perspective-taking (Schonert-Reichl et al., 2015; Sibinga et al., 2016). Perhaps most importantly, in destigmatising mental health support, alternative methods are more likely to be perceived as fun and engaging (Coholic et al., 2020). This reinforces the importance of diversity in provision and how support is experienced. Schools that offer multiple methods of engagement, including informal or creative opportunities, not only reach a wider group of pupils and reduce barriers to participation, but can also address wellbeing at all stages, working to prevent the occurrence of issues, reduce the risk of them escalating and support those with more severe needs, as intended in the WSA Framework.

Participants reflected that they wanted an age-appropriate space where they could feel comfortable, with the ability to adapt it to suit their preferences. This resonates with Claussen (2018), who suggests that a sense of ownership over the support space can underpin the emotional safety needed to be vulnerable. Wider research indicates that the environment is an important factor in the pupil experience, but one that is often overlooked by adults (Segrott et al., 2013). In many instances, interventions have been modelled on those used in clinical settings (Glazzard & Stones, 2021). Copeland et al. (2023) emphasise the importance of providing a suitable space for counselling that supports privacy both upon entry and throughout the session, and is comfortable and well-furnished. As participants used the word 'counselling' interchangeably to refer to any one-to-one therapeutic intervention, this research suggests that this advice can be applied more widely. Allowing pupils some autonomy over their engagement with the room, with the ability to create a comfortable physical dynamic between themselves and the adult, could develop a sense of safety in a potentially vulnerable situation. This is supported by previous research (Davies, 2018; Sanders & Lehmann, 2019), which suggests that therapeutic environments should be person-centred and actively seek to reduce the inherent power imbalances between adults and children, while also creating an emotional connection. The development of a variety of low-pressure support services would increase the number of spaces available to pupils, widening entry points beyond traditional talking therapy.

7.2.4. Mental health literacy

Research suggests several key elements of mental health literacy should be taught to pupils. Good knowledge is a prerequisite for fulfilling the Space element of Lundy's model, particularly the emotional Space, by reducing anxiety and stigma. It should include understanding what poor mental health is, its signs and symptoms, associated conditions, and available treatments (Clark et al., 2020; Sheikh et al., 2024). Pupils should be taught about the availability of different types of support and how to access them (Helland Lindborg et al., 2024). This includes helping them understand what the support will involve, covering key details of 'who, what, where, when, and how', and the visibility of specialist staff in school can be a valuable addition (Helland Lindborg et al., 2024). Finally, mental health literacy should encompass an understanding of confidentiality and safeguarding processes (Van der Schyff et al., 2023). The findings suggest that this information was not readily available, and as such, the Space did not effectively promote the participation of all pupils in mental health services. A lack of understanding about the available services meant that some pupils chose not to engage with them. Without clarity, pupils may depend on adults to initiate help, limiting their autonomy and reinforcing gatekeeping. If services are diverse but poorly explained, young people may be hesitant to seek help or misunderstand what each service offers. This aligns with existing research, which shows that a lack of mental health literacy, particularly regarding how services operate and who can access information beyond the counselling session, can significantly reduce pupils' willingness to seek help (Goodwin et al., 2023; Haavik et al., 2019).

The findings suggest that the availability of a safe and accessible physical therapeutic Space is only one aspect of participation in service provision; pupils' perceptions and how they experience them emotionally should also be considered. Pupils need opportunities to contribute to the design of Spaces, ensuring they can participate in them effectively. It also demonstrates that meaningful participation is not possible without pupils having the mental health literacy to understand the nuances of mental health support services.

7.3. Voice

Where children are capable of forming their own views, Lundy (2007) emphasises that they are entitled to the appropriate support and information from adults to develop and express them. This section will discuss the themes of mental health literacy, autonomy, and the therapeutic experience, which are closely linked and will therefore be explored together. There were specific issues related to the impact of gender on the voice element, so that theme is discussed separately.

7.3.1. Mental health literacy, autonomy and the therapeutic experience.

Despite the broad range of available services, the identified lack of clarity around them suggests that pupils are not always adequately informed or empowered to express their needs and preferences, minimising the Voice element of Lundy's model.

As discussed, the data highlighted a disconnect between pupils' awareness of mental health services and their understanding of them. On several occasions, one-to-one conversations with a trusted adult were equated to 'counselling', suggesting that, for some young people, any therapeutic conversation may be framed as formal support. This reflects the point discussed in the previous Space section, namely that multiple types of interaction could be considered support. As discussed in Chapter 2, Jorm (2000) suggests that mental health literacy comprises six domains: recognising poor mental health, recognising risk factors, knowledge of prevention strategies, seeking and obtaining mental health information, identifying the most appropriate support, and accessing that support. Much of the existing literature on mental health literacy in schools focuses on the impact of universal interventions designed to improve knowledge and reduce stigma, rather than on pupils' experiences within individual domains (Ma et al., 2022). The data showed that not all of these domains appear to be met in School A. The three domains of mental health literacy – seeking and obtaining information, identifying appropriate support, and understanding how to access support – were not consistently experienced by all pupils. Pupils' descriptions of available support sometimes conflicted, and some pupils confused one service with another. While it is true that, as long as the young person benefits from engaging with a service, it is less important that they know exactly what that service is, this lack of clarity could hinder pupils' ability to make informed decisions about the support they seek. There was also uncertainty about the steps to access support at school, and surprisingly, there was no mention of the option for self-referral, despite this being available on the website. While School A had invested in making a variety of support services available and visible, this had not led to pupils feeling fully informed or confident about accessing them. This highlights a key issue that availability does not guarantee access and is consistent with existing literature. In a systematic review of the implementation of interventions within schools, Gee et al. (2020) identified a number of barriers related to the acceptability and practicality of the intervention, provider characteristics, and the impact of stigma and mental health literacy, echoing the findings from School A.

There was a strong theme in the data of pupils' desire for more control over how and when they accessed mental health support. Many pupils believed they had to be referred by a teacher or parent. Several were unsure what would happen if they requested a referral, and some explained that they had been referred without being involved in the decision-making process. The suggestion that support was imposed, rather than chosen, may limit a young person's sense of ownership over the process. Informed choice is central to autonomy when navigating support for emotional wellbeing (Gondek et al., 2016). These findings suggest a tension between adult actions, however well-intended, and the participatory rights of young people. Yet research has shown that staff support for pupil autonomy in decision-making and the prioritisation of their choices are facilitators in accessing support (Prior, 2012).

When adults act as gatekeepers to services, often for reasons intended to support them, this disempowers young people and undermines their autonomy. This has significant implications in the context of mental health. Research shows that young people are more likely to engage in support when they feel a sense of agency and ownership over the process (Davies, 2018; Kirk et al., 2023). When support is imposed, rather than sought, and person-centred, it may be met with resistance or disengagement.

Adult-led referrals often lacked consultation with pupils, and some participants reported feeling entirely removed from the process. Participants explained that they were not always given the opportunity to express their views on the support they would receive, suggesting a tokenistic level of participation at this stage.

Despite pupils being eager to have the opportunity to self-refer, there was a common assumption that support was available only through an adult, meaning they could not seek support on their own terms. No pupil mentioned the existing self-referral mechanism on the school website, suggesting that, even when autonomy is technically an option, it remains inaccessible, which links to the issues with mental health literacy discussed previously. Copeland et al. (2023) identify the benefits of self-referral in previous research, arguing that it should be one of several clear referral pathways into school-based counselling and that, when referrals are made by adults, they should involve the pupil. Churchman, Mansell & Tai (2020) found that a self-booking system for pupils, which allowed them to maintain choice over attendance, was experienced positively. Spratt et al. (2007) suggest that teacher referrals made without collaboration with the child are often based on instances of disruptive behaviour and overlook quieter pupils who are still in need of support. Without the opportunity to share their preferences or even give informed consent, the Voice element of the model is limited.

7.3.2. Gender

Additionally, it was found that boys did not always feel that their voices would be heard within wellbeing services. There was a lack of opportunities to form connections and be supported in talking, as there were no male role models in wellbeing roles or services. Research shows the importance of male pupils seeing diverse models of masculinity and male role models comfortably displaying commonly stigmatised traits, such as emotional expression and help-seeking (Claussen, 2018; Wilson et al., 2022).

Wong et al. (2017) identified a link in boys between conforming to masculine norms and poorer mental health, as well as reduced levels of help-seeking. Participants in their study reported that talking therapies and discussing emotions were either uncomfortable or that they felt unable to access them due to peer judgement. This suggests a need to develop gender-specific programmes that engage boys more effectively. Utilising systems and spaces that already have a degree of acceptability, such as sports, may support more positive engagement (Gwyther et al., 2019), aligning with the point that informal activities, even if not officially promoted as wellbeing initiatives, can still be beneficial.

Research shows the importance of making help-seeking more acceptable within masculine norms (Lynch et al., 2016). Changing deeply held narratives around gender roles is not something that can be resolved in a single setting, and therefore, providing support in spaces that are typically masculine is one option for reducing this barrier. Involving males in the development of services that are acceptable to them is another.

Creating the conditions that enable young people to speak and express their needs is a vital component of meeting the Voice element of the model. However, if pupils are not engaged with the service, and they are unlikely to be if they have not been involved in the process, then they are not being supported in expressing their views. In the context of School A, which presents as a good provider of wellbeing services, this raises questions about how decisions are made about which services are provided and highlights the need for young people to contribute to the conversation. Making help-seeking acceptable for boys is essential for their voices to be heard and can be addressed at both the local and policy levels.

7.4. Influence

The themes of gender, autonomy, and influence over the therapeutic experience are closely interlinked and will be discussed in one section.

7.4.1. Gender, autonomy and the therapeutic experience

The findings suggested that participants with direct experience of therapeutic services in school had not had the opportunity to input into the format of the sessions. While this was not raised as a problem by all participants, others reported being passive in the process, which they found unhelpful. This mirrored the experience of the pre-support referral process, as described above. Levels of choice and control experienced by adolescent participants in support services are an emerging area of research. In their study, Churchman, Mansell, and Tai (2020) argue that a sense of control, including choice over topics discussed, is vital for a positive experience. Copeland et al. (2023) highlight that services that support users in making decisions about service delivery were identified as positive attributes by service users.

In this study, pupils' views were neither sought nor considered in decisions about service provision or service design. These findings demonstrate that the therapeutic experience extends beyond the interaction between the ‘therapist’ (in this context, any adult providing a supportive service) and the service user. The physical environment, the dynamic of the relationship, and the sense of agency felt by the pupil shape the experience. As discussed earlier in the chapter, the perceived formality of traditional support services can be a barrier for some pupils or may fail to meet the needs of all those who use them. Without the opportunity to contribute to shaping the service they receive, it could be experienced as impersonal.

Research has demonstrated a number of benefits to respecting service users' preferences in therapy. In research with adults, better engagement and improved outcomes have been observed among service users whose preferences are accommodated (Swift et al., 2018), and a reduced likelihood of dropping out of the service has also been reported (Swift & Callahan, 2009). As discussed previously, there is limited research in this area with children, although the existing research suggests that when young people's preferences are considered, they feel empowered and have more positive experiences of support (Cooper et al., 2016).

During data collection, participants' suggested facilitators demonstrated that pupils had the ability to make reasoned suggestions about what they would find beneficial; what was lacking was the opportunity to have these suggestions heard by those with decision-making power. As explored in the literature review, Lundy (2007) suggests several reasons why pupils are not given the opportunity to share their views. She argues that adults lack belief in children's ability to make meaningful contributions; they fear giving children too much ‘power’; and some believe that participation requires more effort than it is worth. However, participants' proposals for small adaptations to the existing systems, rather than a complete overhaul, contradict each of these suggestions. Pupils' recommendations were realistic and pragmatic (Flutter, 2006); they did not abuse the power given to them, offering thoughtful and measured ideas, and the proposed changes required very little time or effort to implement. When pupils are not able to contribute to the shaping of services, their engagement suffers. A mechanism of co-design would address the Influence aspect of Lundy's model. However, as a school with well-considered wellbeing and participatory opportunities, such as School A, this suggests that such directives may need to originate from the policy level.

7.5. Audience

The elements of Voice and Space were found to be somewhat present in School A, with pupils given opportunities to express themselves across a range of wellbeing contexts. Additionally, participants indicated that, if available, they could engage meaningfully with the Influence aspect; however, the Audience element was less apparent. There was no evidence that pupils' views were actively sought, and when participants made suggestions, they felt they had been dismissed. Notably, participants did not refer to the absence of an Audience as a concern, nor did they suggest formalised mechanisms to share their views with decision-makers. This is surprising for a school that offers numerous pupil voice opportunities and may suggest a normalisation of tokenistic participation, where the average pupil is not accustomed to having their views actively listened to.

The absence of an audience in School A could be attributed to several factors. Pupils may lack trust in the existing systems, perceiving them as inaccessible or unresponsive to their viewpoints if previous attempts to speak up have gone unheard or had no impact (Stickney & Ventura, 2024). Alternatively, pupils may feel apathy towards opportunities for pupil voice. If pupil voice systems exist but pupils do not perceive them as leading to any meaningful change, they may not consider it a worthwhile undertaking (Fielding & Ruddock, 2002; McIntyre et al., 2005). This is not to suggest that pupils' views are not heard by decision-makers; rather, if they are, the feedback systems are not in place to inform them of it.

In the context of school mental health support, the decision-makers - the referrer and the service provider – constitute the ‘Audience’. If pupils are not asked about their needs or preferences at the point of referral, or throughout their engagement in the service, and their feedback is not used to shape services, then their participation is superficial.

When pupils are able to offer constructive opinions, but their views are not heard by someone with the power to act upon them, meaningful participation breaks down and becomes decorative (Tisdall, 2015; Lundy, 2018), which is contrary to Article 12 of the UNCRC, which states that children's views should be given due weight and consideration. Consequently, this suggests the need to mandate school pupil voice initiatives that include feedback systems at the policy level.

7.6. Summary

Lundy's model (2007) provides a valuable and widely adopted framework for applying children's participation rights. The findings of this study suggest that it could be further enhanced, particularly when applied to complex contexts with competing priorities, such as school-based mental health support. There may be value in incorporating the UNCRC principle of evolving capacities more closely into the model, as pupils' willingness and ability to participate in the support systems were closely linked to trust, emotional safety and previous experiences of being heard, all of which are likely to develop with maturity. Applying a developmental lens to the model would enable recognition that children and young people may require different forms and levels of support at various stages of their participatory journey.

7.7. Implications

Several potential implications have been identified, which will be discussed in relation to the themes of the findings.

7.7.1. Stigma:

Reducing stigma and building trust in confidentiality are essential for improving access to mental health support in schools. This could be supported by:

- **Normalising help-seeking:** While this is a greater issue than can be resolved at a single site, School A could consider promoting positive narratives around help-seeking, either through national or peer-led campaigns, and regular mental health discussions as part of the school culture, framing seeking support as a strength. This idea is somewhat supported by policy; one of the Areas of Learning in the Curriculum for Wales is Health and Wellbeing, which includes physical health and development, mental health, and emotional and social wellbeing as key components. However, the freedom to develop their own curriculum content presents a challenge for schools in deciding what to teach. Growing evidence suggests that early school-based mental health interventions often show significant benefits, including reduced mental health stigma and improved mental health knowledge (Chisholm et al., 2016; Simkiss et al., 2023).

- **Increase discretion and privacy** when accessing wellbeing services by reviewing how pupils are called from class and the visibility of entering wellbeing spaces. Alternatives such as text reminders or appointments timed to coincide with lesson changeovers may be beneficial in School A; however, they might not resolve the issues faced by other schools. Schools should consult with pupils and co-design systems tailored to their specific context. While stigma remains a barrier, efforts must also be made to ensure access is as discreet as possible.
- **Transparency about confidentiality**: all pupils should be aware of the bounds of confidentiality and what information may be shared by mental health service providers, with whom, and why, as part of their mental health literacy education. Concerns about confidentiality being breached present a barrier even before the point of access. It is also vital that all adults consistently apply confidentiality policies.

Challenges: The introduction of text-based systems to support discretion is likely to require investment in technology and may conflict with the school's mobile phone use policy.

7.7.2. Mental health literacy:

Ensuring that pupils understand all aspects of mental health, including recognising a need for support, and developing understanding about the support available and what it will be like experientially, may encourage their engagement with it.

- **Information sharing:** The data suggest that there is a need for schools to proactively inform pupils about the range of available services, including not just counselling but also informal check-ins, drop-ins, and creative activities. If schools collaborate with pupils to co-design information-sharing systems and materials that clearly differentiate between services and explain how to access each one, this could lead to more effective engagement with the wider school community. The data highlighted the need to avoid over-reliance on traditional forms of service advertisement, such as posters and assemblies.

- **Alternative methods of support:** If not already in place, schools could consider the inclusion of creative activities (such as art, music, and crafts) as regular parts of the wellbeing offer. Recognising the value of spaces that allow children to emotionally regulate without the need to talk or disclose, and providing access to a quiet, low-pressure space, can be beneficial. There is very little research in this area; however, a study on the use of Peace Spaces in Trauma-Informed Schools in America found that they were beneficial to pupils who needed to self-regulate or talk through their feelings with a trusted adult (Liang et al., 2023). Finally, there may be value in collaborating with pupils to co-design activities that reflect their own definitions of wellbeing. A study on student participation in designing learning environments in Finland (Makela et al., 2018) found that including pupil views significantly improved educational spaces. While not directly comparable to this study, this offers some evidence supporting the concept of pupil co-design.

7.7.3. Gender:

It is clear that some of the barriers experienced in accessing mental health support are felt more acutely by boys. In order to overcome this, schools could:

- **Train male staff** working in single gender spaces, such as PE lessons or subjects where traditional male norms may be prevalent, to promote positive mental health messaging and to offer wellbeing support.
- **Offer alternative forms of emotional support**, e.g. activity-based or practical, that don’t rely solely on verbal disclosure or emotional discussion.
- **Apply a gender perspective to mental health promotion**. Include boys in the design of information to be shared so that it is more likely to engage its target audience.

Challenges: Training staff in gender-sensitive approaches requires engagement from staff, some of whom may be resistant (Kidger et al., 2009). This may be more keenly felt if staff feel they have been singled out for such a role based on the subject they teach.

Specialist approaches may require specialist training, which has both time and cost implications for staff who participate.

7.7.4. Autonomy:

Participants were clear about their desire to take a proactive role in their support experience. To support this, schools could:

- **Make referral options clearer, more visible and more inclusive**. Pupils were unaware that self-referral was available through the school website. Greater promotion could help remove unnecessary gatekeeping.
- **Create low-barrier self-referral mechanisms.** The pupils' suggestion was for a physical drop box that they could access at their convenience, supporting anonymous and informal contact with support services. This could provide an accessible first step to support for those who are uncomfortable approaching an adult.
- Ensure that all staff are aware of the importance of involving pupils at all stages of referral, and actively including them in decisions about the service they receive.

Challenges: While the request for an anonymous drop box is low-cost, there are risks of misuse and legitimate concerns about safeguarding. Anonymous disclosures of a safeguarding nature make it very difficult for school staff to respond in line with safeguarding procedures and in the best interests of the child (Welsh Government, 2021d). This may cause schools to hesitate in introducing such a system.

7.7.5. Therapeutic experience:

To make mental health support in schools more effective and rights-respecting, schools should enable young people to contribute to the shaping of their therapeutic experience. When pupils are empowered to shape the environments and services they use, it indicates respect and a shift from an adult-led service to shared ownership, which is core to meaningful participation.

Schools could:

- **Involve pupils in co-designing the wellbeing spaces.** This could include decisions on layout, furniture, colour and resources.

- **Provide choice within sessions** – for example, seating options, activity-based alternatives to traditional talking, and flexibility in formats, which would give pupils some control over how they experience the support.
- **Gather and act on feedback** from those who use services; the option to provide this anonymously may make it easier for pupils to speak more honestly.

It is essential to recognise that pupils' therapeutic preferences may vary by age and developmental stage. Younger participants suggested a ‘child-friendly’ therapeutic environment with crafts and toys available, while older participants prioritised the ability to personalise the space through furniture and lighting to achieve a comfortable environment. Kagstrom et al. (2023) argue that brain development in childhood and adolescence should be taken into account when developing school-based interventions. This not only respects participation rights but also increases the likelihood that therapeutic experiences will be meaningful and effective across different age groups (O’Reilly et al., 2018).

Challenges: The involvement of pupils in the co-design of spaces and sessions is low-cost during the design phase; however, implementing design suggestions (and thereby fulfilling the Influence dimension of Lundy's model) may entail budget implications. Additionally, schools may face constraints due to the necessity to prioritise space and the building's physical structure. Weare (2015) recognises the difficulties faced by schools, noting that even those schools most committed to promoting pupil wellbeing will be limited by budgets, curriculum demands, and competing policies.

Chapter 8. Conclusion

This thesis has examined how pupils perceive and navigate school-based mental health support from a children's rights perspective. It employed a mixed-methods design comprising an advisory group co-designed survey, semi-structured paired interviews, and a focus group, and contextualising the findings with national survey data. It showed that pupils identify interlinked barriers related to access, stigma, and mental health literacy, with boys experiencing particular challenges within this. Pupils also highlighted existing facilitators such as informal wellbeing options and trusted pastoral staff, and advocated for the introduction of self-referral routes and a more person-centred approach with choice of modality. The thesis makes an original contribution by positioning adolescents as active collaborators, mapping their accounts to Lundy's Space, Voice, Audience, Influence framework, and offering pupil-led, practice-based recommendations for schools and policymakers.

8.1. Strengths of the study

The most significant strength of this study is that it offered specific recommendations for improvements made by young people, aligning with the rights-based approach. These recommendations could serve as a valuable tool in promoting improved access to and experience of early intervention mental health support in schools and be helpful to both school staff and policymakers. Evidence indicates that early intervention in mental health difficulties can help prevent or delay the development of more serious conditions (McGorry & Mei, 2018).

The study not only examined how pupils experience participation in the context of school-based mental health systems, but also modelled participatory principles in its design and delivery. The direct alignment with Lundy's model, outlined below, is a methodological strength.

A further strength was the choice of data collection methods. The use of semi-structured, paired interviews and focus groups helped address the power imbalance often experienced between researcher and participant, especially when involving adults and children. Protecting participants' emotional safety was a priority when discussing sensitive topics, reflecting ethical, child-centred research practice.

Co-production is known to have a number of benefits; it can be effective in developing pupils' knowledge acquisition skills (Honingh et al., 2018), is empowering for pupils (Clark & Laing, 2018), and research has shown that young people are effective messengers of the information they co-produce (De Rosis et al., 2020). Therefore, when pupils are positioned as collaborators, rather than subjects in research, the quality, relevance and legitimacy of findings are enhanced (Kirby & Gibbs, 2006; Lundy & McEvoy, 2012; Dixon et al., 2018)

8.2. Limitations of the study

While this study offers valuable insights into pupils' experiences of mental health support in one Welsh secondary school, several limitations should be acknowledged:

Access

The issue of access to research sites was problematic from the outset and necessitated compromises. The length of time it took to recruit a research school meant that the advisory group had finished formal education and left school before data collection was complete. Therefore, it was not possible to involve them in the data analysis as originally planned. Their inclusion in this aspect may have yielded different themes for exploration and deepened the understanding of participant experiences.

Sample size

The small-scale nature of the qualitative research, with only one school and a small sample of participants, limits the conclusions that can be drawn from it. As one of the only secondary schools in Wales willing to participate in the research, School A may represent a more proactive setting than is typical. As such, the findings should be interpreted with caution when generalising to other schools, particularly those with more limited provision. However, I sought to balance this by comparing School A with the Wales-wide WMCS survey data to indicate where School A aligns with, or diverges from, the wider picture.

The study was too small-scale to collect meaningful, detailed demographic data beyond gender. This limits the opportunity to explore how experiences may vary across intersections of identity. These factors may influence both access to and experience of mental health support.

Sample selection

There were drawbacks to each of the data collection methods.

Quantitative data collection - Pupils were given the option to participate in the survey. This approach was ethically sound and in line with the principles outlined in Article 12. However, those who engaged may have had an interest in the subject and therefore been more willing or able to reflect on wellbeing topics. Pupils with more negative experiences, or no experience, may have opted out and therefore been underrepresented.

Qualitative data collection - The option for pupils to self-select into semi-structured interviews was unsuccessful. As a result, participants were selected by the school staff. With such a selection, there is a risk that staff will nominate more articulate or cooperative pupils, potentially introducing bias into the results.

Concept mapping

Pupils had limited exposure to alternative models of mental health support services in schools, making it challenging for them to suggest more radical changes. If more time had been available, it would have been preferable to develop the focus group's understanding of other models of mental health support that they could draw upon. Further research which does this would be valuable.

As the final stage of data collection, it was intended to conduct a concept-mapping session with a cross-section of staff from School A to share participants' suggestions and consider their implications from an alternative perspective. Unfortunately, this was cancelled by the school, further minimising the Audience element of Lundy’s model (2007). A detailed report of findings and participant suggestions was shared with school leaders in place of this meeting (See Appendix 7).

Despite these limitations, the study provides a detailed understanding of how mental health provision is experienced in School A, and highlights themes related to access that are likely to be relevant in many other secondary schools.

8.3 Methodological contribution to Lundy's model

This study makes a methodological contribution to Lundy's (2007) model by exploring how its elements, Space, Voice, Audience and Influence, were realised in practice within school-based mental health research. While Lundy's model is frequently used to frame children's participation, there is little empirical work examining how it operates within school settings. By applying the model throughout the study's design, data collection, and dissemination stages, this research offers insight into both the possibilities and the limitations of realising participatory rights in this context.

Methodologically, this study demonstrates that Lundy's model can be embedded throughout the research process rather than applied solely as an analytical lens. The creation of a Peer Advisory Group, the co-design of research instruments, and the use of multiple, developmentally appropriate methods illustrate how Space and Voice can be actively facilitated in practice. The study also highlights the importance of Audience, not only in listening to young people but also in ensuring that their contributions are taken seriously and communicated to those with decision-making responsibility. Sharing findings and pupil-generated recommendations with school leadership represents an attempt to enact Influence.

The study identifies several challenges in realising Lundy's model in practice. Institutional constraints, limited access to decision-makers, and the cancellation of opportunities for staff engagement limited the extent to which Influence could be fully achieved. These tensions highlight the difficulty of translating participatory principles into practice within hierarchical systems and demonstrate that participation exists on a continuum rather than as a fixed outcome.

While opportunities for Space and Voice were actively created through multiple methods and the involvement of young people in shaping the research, the extent to which Audience and Influence could be realised was constrained by institutional factors beyond the researcher's control. In particular, limited access to decision-makers and changes to the planned dissemination stages limited the extent to which young people’s contributions could lead directly to change. By highlighting these tensions, this study contributes to a more realistic understanding of how Lundy’s model can be used in applied school-based research and emphasises the importance of reflexivity and transparency when working within a children’s rights framework.

8.4. Recommendations for future research

While this study provides valuable insights into pupils' experiences of school-based mental health support, it highlights areas that are worthy of further exploration:

The exploration of preferences for male therapists for adolescent boys and options for interventions that are acceptable within masculine norms. One such example would be the use of male staff in traditionally male spaces to identify and intervene in pupils' declining mental health.

Adolescents having their preferences sought and considered as part of the therapeutic experience. As acknowledged earlier in the chapter, this area of research is still in its infancy, and there is a need for greater understanding of its benefits across different settings.

Pupils' experiences of mental health support across a wider range of contexts, such as schools with survey results closer to the national average, and how different demographic factors influence the themes identified. This would help determine whether the findings from School A are transferable and how school culture affects access to services.

8.5. Concluding remarks

Pupils at School A had access to a relatively wide range of mental health support services, more than is typical in many Welsh secondary schools. However, despite the extensive provision, many pupils still experienced barriers to access and engagement. This suggests that even in a school with a comparatively developed provision, the existence of services alone is not enough to ensure accessibility or engagement.

The barriers experienced by pupils are interlinked: stigma, knowledge gaps, adult gatekeeping, and a lack of comfort create a system that is functional but not pupil-centred. Improvements suggested by pupils were rarely related to service provision specifically, but to factors that contributed to access and experience of the service. These findings highlight a fundamental disparity between provision and access. While there is a great deal of attention in school mental health policy paid to providing a range of available services and the outcomes of these, often less attention is paid to the barriers that prevent pupils from using them and the experiences they have. This indicates a risk that service provision may be superficial: they exist, but only a proportion of pupils feel safe, informed, or empowered enough to use them. Providing services but failing to remove the cultural and structural barriers risks widening inequalities in access.

School mental health facilities should be based on user experience, rather than service delivery. Improving these services requires a different approach, developing the systems to support pupils, alongside the pupils they are designed to help. Importantly, this study showed that young people's ideas about improving services were practical and achievable. They were rooted in being heard, being trusted, and being respected. A rights-informed approach, drawing on frameworks such as Lundy’s, offers a framework for this, ensuring that pupils have the Space and Voice to share their views and the Influence and Audience to act upon them. This study demonstrates that if young people are treated as the experts in their own lives, they have the capability to help shape services that are rights-compliant and effective.

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Appendices

Appendix 1: Session plans and capacity-building activities for the advisory group

Session 1 – introduction

Aims of the session –

- Meet the advisory group, establish a sense of purpose
- Develop their understanding of the research and their role in it, understanding ethical boundaries.
- Clarify my responsibility regarding safeguarding.
- Clarity around frequency and length of meetings, location and time
- Clarity for students about what to do and where to find support systems if they find the content triggering.
- Build capacity on schools role in supporting students mental health.

Resources

- Flip chart paper and marker pens
- Copy of ethical application
- List of actions to take if finding the content triggering and what contact details for support services for dissemination.

- Introduce myself and explain my research
    - Explain who I am and what I am studying for, give some background to choice of study and why I have chosen a participatory approach
    - Timescales I am working within
    - Ask group to introduce themselves or each other, sharing name, age, an interesting fact about themselves
- Form a group contract
    - Share the ethics process with the group, what it is and why I have to keep to the limits of my application approval
    - Explain my responsibility with safeguarding – if anything I hear causes me concern or I believe there to be a risk of harm to someone I must share this information and follow school safeguarding processes.
    - Agree on what must be confidential and what can be shared outside of the group, by asking group members to put forward ideas and facilitating a discussion.
    - Agree on group contract of rules (there will be some elements that must be included on this even if not suggested by group – in this instance have a preprepared list and suggest them to group, have discussion around them and make clear the importance of their inclusion.
    - Have group members sign up to contract, committing to keeping to it – this will be revisited at the start of each session.

- Share the planned research summary
    - To work with one secondary school in Cardiff to design research instruments to develop a better understanding of the barriers and facilitators to yr 9 students accessing counselling or mental health support provided by a second school. To use this information to co-design a model of support which can be applied and evaluated.

1. Advisory group development of online survey to find out what are the facilitators and barriers to accessing the support service in school. Seeking information on: Do students know that the service exists? How to access it? What would improve access from a student perspective?
2. Run survey in trial school. Survey to all year 9 students, allowing 1 month for collection and analysis of data.
3. Advisory group to develop interview questions for use with 10 students in trial school. Questions to be phrased to gather general information on seeking the opinions of facilitators and barriers to support, not seeking personal reflections and experiences of mental health support.
4. CM to conduct semi structured interviews with 10 students in trial school.
5. CM to negotiate with trial school about pilot implementation of recommendations.
6. Trial model of support
7. Resurvey – online survey to all year 9 students in trial school.
8. Reinterview same 10 students in trial school.
9. Evaluation of second data collection and action research project with advisory group.

    - Clarify my role and group members roles and responsibilities at each stage.
    - Share proposed frequency, length and location of meetings and agree with group.

- Plenary
    - Revisit contract, check for inaccuracies and confirm agreement
    - Revisit safeguarding and confidentiality policy
    - Share details and process for contacting support service if necessary
    - Share aims for next session
    - Check for any questions
    - Share my contact details

Session 2 – questionnaires

Session aims

- Agree the purpose of using surveys as a method
- Develop understanding of surveys as a research method
- Know what makes a good, and bad questionnaire
- Formulate questions for pilot survey

Resources

- Flip chart and marker pens
- Examples of types of questions
- Examples of bad questionnaires
- Proposed research questions

- Begin session by welcoming the group back, thanking them for their help and revisiting the contract and support services. Remind group members that participation is optional and they may leave at any time without explanation.
- Revisit safeguarding policy and confidentiality agreement.

- Why surveys?
    - Facilitate discussion about what information we are trying to gather and why surveys might be an appropriate method. Revisit research questions and discuss how a survey could help to answer them.
    - What should a survey do?
    - Mind map the benefits and potential pitfalls of using surveys with school children.
    - Discuss response rates – what can we do to get the best response rate possible? Feedback from group members about what might encourage them to complete.
- Types of question
    - Provide examples of each of the following types of survey question and facilitate a discussion about what kind of information you might use each to gather.
- Open question
- Closed question
- Multiple choice (choose 1, choose as many as appropriate)
- Likert scale (demonstrate the difference between 3, 5 and 7 response options)
- Rating scale questions
- Free text
- Making a survey useful
    - Share examples of bad survey questions, ask the group to discuss why they are ineffective and what could be done to improve them.

Bad questions include:

1. Double-Barrelled Question - a type of survey question that addresses more than one issue but provides for only one response.

- Example of a double-barrelled question: “How satisfied are you with our customer service and service delivery?

2. Loaded Questions - a type of question with inherent biases. This makes it difficult for the respondent to freely communicate his or her thoughts and experiences about the issue at hand.

- **Examples of loaded questions: “**Have you stopped cheating on exams?" The question implies that the respondent has cheated in the past. If the respondent answers yes, she agrees that she cheated in the past. If she answers no, then she is saying that she is still cheating.

3. Leading Questions - a type of survey question that subtly prompts the respondent to provide answers in line with predetermined responses. With a leading question, the researcher already knows what he or she wants you to say so they craft the question to make you respond exactly how they want. A leading question is a bad survey question because it leads to survey response bias and typically boxes respondents into a corner.

- Examples of leading questions - “Experts state that lectures are not the future of higher education. Do you agree?” By saying that experts think that something is a not a good idea, the respondents are led to conclude that their disagreement with the question goes against credible authorities.

- a Likert scale might be a better choice.

4. Negative Questions - a type of survey question that requires a negative answer for a positive response and a positive answer for a negative response. It is a bad survey question because it is complex and can confuse respondents.

- **Examples of negative questions in surveys “**I don’t enjoy using this product: True/False”

5. Vague Questions - A question that is uncertain or unclear. This type of question does not seek a specific response and it is usually too broad or poorly defined. Vague questions make it difficult to gather valid data.

- Examples of vague questions in surveys a) Do you think people enjoy using our product? Or b) Do we have the best product in the market?

- Coming up with questions for pilot survey
    - Refer back to research questions and work in 2 teams to come up with some potential questions to gather the information needed
    - Present the questions to the other team and try completing each other’s surveys. This should help to find out if the questions are worded clearly and will help us to get the information we require.

  - Discuss as a group what worked and didn't work, choosing the most effective questions for gathering the required information, refining them if necessary.
  - Create the questionnaire for use in trial school, agreeing as whole group on wording and type of questions to use at each stage.

- Plenary
  - Check in – is everyone happy with the discussions and decisions made?
  - Discuss with group what will happen next with survey (it will be run in yr 9 of trial school, who will have 2 weeks for completion). Once completed surveys are returned we will carry out data analysis.
  - Share aims for next session.
  - Revisit contact and options for support if necessary.

Appendix 2: Online survey – print version

Year 9 survey CC

Start of Block: Default Question Block

Hello This survey is part of research into your views on the mental health support services available to you at school. You do not have to take part, but if you do choose to you will not be asked to give your name and your responses are anonymous, **there is no way of identifying you from this survey.**   You will be asked questions about what would makes it hard and what would make it easier to access support for your mental health in school. **You will not be asked if you have ever tried to get support for your mental health**. There is an information sheet which gives more details about the purpose of the research which you should have received via email.   At the end of the survey there is an invitation to volunteer to **take part in an interview if you would like to speak more,** you will be able to bring a friend to this interview with you if you would like.   **Please confirm that you are happy to complete this survey by ticking the box.** I know that this topic can be difficult to talk about for some people, so you have also been emailed a factsheet giving details of support services you can contact if you need to.   You can stop the survey at any time if you choose by skipping straight to the end.   Thank you for taking part and helping to shape support services for students.

○ I agree to take part in this survey (1)

○ I do not agree to take part in this survey (2)

Skip To: End of Survey If This survey is part of research into your views on the mental health support services available t... = I do not agree to take part in this survey

Q1 What is your gender?

○ Boy (1)

○ Girl (2)

○ Prefer to self-describe (3) ____

○ Prefer not to say (6)

Q2 Were you described as male or female at birth?

○ Male (1)

○ Female (2)

○ Prefer not to say (4)

Q3 What is your ethnic group?

○ 1. English/Welsh/Scottish/Northern Irish/British (1)

○ 2. Irish (2)

○ 3. Gypsy or Irish Traveller (3)

○ 4. Any other White background (4)

○ 5. White and Black Caribbean (5)

○ 6. White and Black African (6)

○ 7. White and Asian (7)

○ 8. Any other Mixed/Multiple ethnic background (8)

○ 9. Indian (9)

○ 10. Pakistani (10)

○ 11. Bangladeshi (11)

○ 12. Chinese (12)

○ 13. Any other Asian background (13)

○ 14. African (14)

○ 15. Caribbean (15)

○ 16. Any other Black/African/Caribbean background (16)

○ 17. Arab (17)

○ 18. Any other ethnic group (18)

End of Block: Default Question Block

Start of Block: Block 1

Q1 How much do you agree with the statements below?

	Strongly disagree (1)	Disagree (2)	Not sure (3)	Agree (4)	Strongly agree (5)
I feel safe at school (1)	○	○	○	○	○
School staff care about me (2)	○	○	○	○	○
I feel listened to and respected at school (3)	○	○	○	○	○
I have opportunities to make decisions about things that are important to me at school. (4)	○	○	○	○	○

Page Break

Q2 Does your school offer support for students mental health?

○ Yes (1)

○ No (2)

○ Don't know (3)

Q3 Does your school offer any of these types of support? (Tick all that apply)

☐ Specific lessons/tutor time for mental health support (1)

☐ counselling (2)

☐ support groups for specific issues (3)

☐ pastoral staff (a staff member that you can go to for help) (5)

☐ posters/displays about mental health or mental health charities (6)

☐ something else? Please describe (7)

____

Q4 Do you know what to do to get support for your mental health in school? (If you are not sure tick 'no')

○ No (1)

○ Yes (2)

Q5 How likely is it that you would use the following services ***if you needed to?***

	Extremely unlikely (1)	Somewhat unlikely (2)	Neither likely nor unlikely (3)	Somewhat likely (4)	Extremely likely (5)
Specific lessons/tutor time (1)	○	○	○	○	○
Counselling (2)	○	○	○	○	○
Support groups (3)	○	○	○	○	○
Pastoral staff (4)	○	○	○	○	○

Q6 Would it concern you if the following people know that you are using a school mental health support service?

	Not at all concerned (1)	Uncomfortable (2)	Very concerned (3)
Family (1)	○	○	○
Close friends (2)	○	○	○
Classmates (3)	○	○	○
Class Teacher (4)	○	○	○
Other school staff (5)	○	○	○

Q7 Is there anything that ***would make it hard to get support with mental health at school?*** (Tick all that apply, and comment further if you want to)

☐ Not knowing how to get an appointment (18)

☐ The referral process (19)

☐ Worried that others will know (20)

☐ Location of the service - is it private etc? (21)

☐ The waiting list (22)

☐ Times of appointments don't work for me (23)

☐ Anything not mentioned above? (24)

☐ Not applicable (25)

☐ If you have ticked any of the boxes could you say a bit more about it in the box below? (26) ____

Q8 What would make things ***easier to get support?*** (Tick all that apply and comment further if you want to)

○ An easy referral process (10)

○ Easy to get an appointment (11)

○ Confidence that other people won't know (12)

○ Sure of privacy/confidentialty (13)

○ Location is good (14)

○ Appointment time work for me (15)

○ Anything not mentioned? Please describe (16) ____

End of Block: Block 1

Start of Block: Block 2

Q9 If you had the power to make a change to the mental health support available in your school what would it be?

____

Q10 Is there anything else on this topic that you would like to say?

____

End of Block: Block 2

Appendix 3: Semi-structured interview schedule

Introduction and Safeguarding:

My name is Ceri Morgans and I am doing a degree at Cardiff University. For my degree I am researching what pupils at your school think about the mental health support services in their school. You don't have to tell me anything personal if you don't want to. There are no right or wrong answers to any of the questions and if there are any questions you don't want to answer we can skip over them. We can also stop this interview at any time if you want to.

Everything you say will be kept confidential, unless you tell me something that makes me think you are at immediate risk of harm, then I have to tell someone. If there is anything you want support with I strongly advise you to speak to someone in school that you trust.

Interview questions

1. Tell me a bit about your school? *How long have you been at this school? Is it the only high school you've been to? Do you like it here? What's the best/worst thing about school?*
2. I'm really interested to know about pupils feeling safe in their school. In your view, what do you think makes a school safe or unsafe? *What could feeling safe at school mean for pupils? Prompts around feeling physically safe and emotionally safe*
3. Talking more specifically about mental health, do you think that this is an issue for young people today? *Could Covid have had an impact?*
4. Are schools somewhere that should support students with their mental health? *What might that look like?*

- *Is this something that would be in the environment such as posters and leaflets?*
- *Or something in the culture, where you hear it talked about? And see help available?*

BREAK IF NEEDED

- Options to support pupils with mental health could be a counselling service, specific lessons that talk about common mental health problems or a pastoral member of staff that students can go to for support. If we took those examples in your school do you think those services would look different if they had been planned by, or with students? *How?*
- *Pick one of the approaches (counselling/specific lessons/pastoral staff)*

- *Questions to consider – how can we maintain privacy and avoid other students knowing about the use of services? How can we make it safe for pupils to use services?*

5. Is there anything that you think decision makers (teachers, school leaders, local authority, politicians etc) should know or think about when designing services to be used by young people?

6. That is all of my questions and all the things I wanted to ask you about, is there anything you think I have missed or anything else that you would like to say?

Appendix 4: Focus group schedule

Student focus group.

Aims & outcomes:

Pupils understand current barriers to accessing mental health support services in school

Pupils discuss and identify potential solutions

Pupils choose most favourable solutions

Timing	**Activity**	**Resources**
5 mins	**Introduce session** Who am I? What is the study? Purpose of today.	
15 – 20 mins	**Warm up activity: Would You Rather?** Either stand up / sit down to answer or move to opposite sides of the room, if there is space and no accessibility issues. *Practice with three of these:* • Would you rather be able to slide down rainbows or jump on clouds? • Would you rather be able to stop time or go back in time? • Would you rather not ever have to go to school or never have to do chores for the rest of your life? • Would you rather live in an amusement park or a zoo? • Would you rather have to say everything that was on your mind or to never speak unless someone spoke to you? • Would you rather go to school 5 days a week and have all the holidays or go 2 days a week and never have a week off? **Agree or Disagree:** • **The voting age should be lowered to 14** • **Decisions made quickly are usually wrong** • **Schools should ask students to evaluate their teachers** • **Taking part is more important than winning** • **Students should have decision making power in schools** ***Opportunity to create the things we would rather!***	
25 mins	**Main activity: Barriers**	

	Present pictures representing different barriers as identified through survey and interview. Group discussion about what students think of these Work in pairs or small groups to rank the barriers from most to least significant. Share with wider group and discuss – see if we can reach a group consensus.	Barrier images Post it notes Pens
45 mins	**Final activity: Solutions** Have a discussion around what possible solutions students can identify. Write up as solution images Share my proposed resolutions and discuss Refine all possible solutions Vote! Using stickers, give each student 3 stickers, they can use them to vote for their preferred solution(s) in any way they choose.	Solution images Post its Stickers Paper Pens
5 mins	**Close** Explain next steps Will be shared with school staff before the end of term, school is not obligated to act upon any of the ideas but they will be made aware of all of them. Any questions? Thank for coming and taking part.	

Appendix 5: Ethical approval

Your ethics application for Exploring a student designed school mental health support service. A Youth Participatory Action Research project. has been given a FAVOURABLE OPINION

⍰

SOCSI - Ethics Office

Ceri Morgans

Dear Ceri Morgans,

Research project title: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.
SREC reference: 40
Link to applications.

The School of Social Science Research Ethics Committee reviewed the above application on the .

Ethical Opinion

The Committee gave a favourable ethical opinion on the basis described in the application form, protocol and supporting documentation.

Supporting Documents Received

Document Title, Date and Version Number

- Cardiff University information sheet advisory group 3.docx
- Cardiff University information sheet advisory group.docx
- Cardiff University information sheet interviews 3.docx
- Cardiff University information sheet interviews.docx
- Cardiff University information sheet survey parents.docx
- Cardiff University information sheet survey students.docx
- Consent-Form advisory group - parent.docx
- Consent-Form advisory group.docx
- Consent-Form interview - parents.docx
- Consent-Form interview students.docx
- ethics submission - April 23.docx
- ethics submission - amendment Feb 23.docx
- Opt out consent form - survey .docx
- Research integrity certificate.pdf
- SOCSI SREC Application Form 3.docx
- SOCSI SREC Application Form.docx
- Year_9_student_survey_Pilot.docx

Please ensure that you have uploaded all final versions of your research tools, information sheets and consent forms, if not already done so, before starting your data collection and when uploading documents, please ensure it's saved by name, date and version number.

****

Information to note

Additional approvals

This letter provides an ethical opinion only. You must not start your research project until all appropriate approvals are in place. Please note, all favourable reviews are conditional upon the following:

1. Research documents and data collection tools *– Final versions of all research documents (e.g. participant information sheets, consent forms, recruitment documents, etc.) and data collection tools (e.g. surveys, interview schedules, etc.) must be logged with the SREC prior to any data collection taking place. Applicants are also responsible for ensuring that any subsequent revisions or amendments made to research documents and data collection tools are also logged with the SREC (version control should be utilised by all projects).*

2. Health and safety *- Applicants must ensure that they have completed any health and safety risk assessments as needed prior to any data collection taking place. These risk assessments must be undertaken in accordance with Cardiff University policies and procedures.*

3. Disclosing and Barring Service (DBS) checks *- For research with vulnerable or 'at risk' populations, no data collection can take place until a relevant DBS has been secured and reviewed in line with Cardiff University policies and procedures. For students and lone researchers, you must confirm this information with the SREC. For larger research projects, Chief/Principal investigators are responsible for ensure that staff have relevant DBS checks before collecting any data and should keep a record of this information.*

4. Additional approvals *– It is your responsibility to check what approvals are needed for your research (including approvals from external stakeholders). You must not start your research project until all appropriate approvals are in place.*

Amendments

Any substantial amendments to documents previously reviewed by the Committee must be submitted to the Committee via the Review List for consideration and cannot be implemented until the Committee has confirmed it is satisfied with the proposed amendments.

You are permitted to implement non-substantial amendments to the documents previously reviewed by the Committee but you must provide a copy of any updated documents to the Committee via the Review List for its records.

Monitoring requirements

The Committee must be informed of any unexpected ethical issues or unexpected adverse events that arise during the research project.

The Committee must be informed when your research project has ended. This notification should be made via the Review List within three months of research project completion.

Complaints/Appeals

If you are dissatisfied with the decision made by the Committee, please contact socsi-ethicsoffice@cardiff.ac.uk in the first instance to discuss your complaint. If this discussion does not resolve the issue, you are entitled to refer the matter to the Head of School for further consideration. The Head of School may refer the matter to the Open Research Integrity and Ethics Committee (ORIEC), where this is appropriate. Please be advised that ORIEC will not normally interfere with a decision of the Committee and is concerned only with the general principles of natural justice, reasonableness and fairness of the decision.

Please use the Committee reference number on all future correspondence.
The Committee reminds you that it is your responsibility to conduct your research project to the highest ethical standards and to keep all ethical issues arising from your research project under regular review.

You are expected to comply with Cardiff University's policies, procedures and guidance at all times, including, but not limited to, its Policy on the Ethical Conduct of Research involving Human Participants, Human Material or Human Data and our Research Integrity and Governance Code of Practice .

Appendix 6: Sample consent and information sheets

1/12/2021

V. 2. Advisory Group

Cardiff University, School of Social Sciences Research Ethics Committee

Research Information Sheet: What support service do young people want for their mental health in school?

I would like to invite you to take part in a new research project looking at what makes it easier and harder for young people to access mental health support services in their school. This information sheet explains why the research is being done, and what is involved in taking part. Please read the following information carefully.

<u>Why is the research being conducted?</u>

The aim of this research is to explore how young people are able to access mental health support services in their school and what makes accessing the support easier or harder. It aims to use the information found to create a new mental health support service for pilot use in a secondary school. I am undertaking this research as part of my Professional Doctorate at Cardiff University. It is hoped that the findings of the research will be able to provide recommendations to improve school based mental health services in Wales.

<u>What does participation involve?</u>

- You will take part in the research process as co-researchers. This means that you will be seeking and analysing data from others, not providing your own data.
- You will be part of an advisory group of eight 'A' Level pupils and me. We will meet every 2 weeks for an hour at school.
- You will take part in sessions to develop your understanding of what schools can provide to support pupils with their mental health, and what they are restricted by.
- You will be supported to design survey and interview questions for pupils in year 9 in another school. We will work as a group to analyse the responses to the surveys and interviews and use the information to understand what makes it easier or harder for pupils to access a school mental health support service. Along with the group you will design a school based mental health service for pilot in another school. Once this has been tried out we will evaluate the service as a group.
- You will have the right to withdraw at any time and provided with support information to access if you need it.

<u>What will happen to the information from the meetings?</u>

I will keep a record of work produced, this could include photographs of the development process and prototypes. Any work created by you will remain your property, however I would be very grateful if I could utilise this at any launch event, presentations or conferences. All identifying information will be removed.

Anonymised written notes of meeting discussions will be kept.

All data will be stored securely, in line with the Data Protection Act. These will be securely stored for up to five years after the research has taken place in line with Cardiff University's data retention regulations.

I will analyse the information and use this as the basis for my Doctoral thesis. This may include use of non-identifiable extracts from the interviews. In the future, results from this project may also be used in published works and presentations at conferences.

<u>What will happen to my Personal Data?</u>

Personal data collected will include your name and contact details which will be recorded on your consent form. This will be anonymised in published research however you may choose to be identifiable at any launch events or presentations.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

The data will be processed for the duration of the research (1 year) after which time the researcher will anonymise all the personal data it has collected from, or about, you in connection with this research project, with the exception of your consent form. Your consent form will be retained for 5 years and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 1 year but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Digital personal data will be stored securely on password protected and encrypted University IT services, physical data will be stored in a locked cabinet up until the point of participant withdrawal from the research project. It will not be possible to withdraw any anonymised data that has already been published.

What happens to the data at the end of the research project?

Anonymised data collected during the research project may be published after the end of the research project. The data will not be used in any further research.

Confidentiality and safeguarding

I will not repeat anything that is said in the groups, unless you report an incident where someone's well-being is seriously at risk or where significant harm has already occurred. In this case I would follow the safeguarding procedures of your school. If this happens, I will first discuss it with you, as appropriate.

I wholly appreciate that some aspects of the research may be stressful, upsetting or triggering. You can refrain from taking part or request to withdraw from the research at any time. Furthermore, I will be providing a factsheet with information, help lines and online resources relating to experiences or concerns mental health.

Prior to each session I will provide a health warning and a check in to obtain verbal consent and affirmation that you are happy to continue. I will highlight the information on the factsheet and reiterate the pathways to access for any emotional support at the end of each session also.

The research has been given ethical approval by the School of Social Sciences Research Ethics Committee at Cardiff University.

Do I have to take part?

No. It is up to you to decide whether or not you take part. If you are happy to take part in the project, you will be given this information sheet to keep and you will be asked to sign a consent form.

Can I decide to withdraw from the study later on?

You are free to withdraw at any time up to the point of the thesis being submitted, without giving a reason.

Contact details

If you have any questions about the research now or in the future, please feel free to contact me, Ceri Morgans on morganscj@cardiff.ac.uk, Social Science Ethics on socsi-ethics@cardiff.ac.uk or either of my supervisors using the following details:

Dr Rhian Barrance
Supervisor
BarranceR@cardiff.ac.uk

Dr Raya Jones
Supervisor
JonesRA9@cardiff.ac.uk

If you are happy to take part in the research process, please sign the consent form.

CONSENT FORM

Title of research project: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.

SREC reference and committee:

Name of Chief/Principal Investigator: Ceri Morgans

Please initial box

I confirm that I have read the information sheet dated 01/12/2021 version 2 for the above research project.	
I confirm that I have understood the information sheet dated 01/12/2021 version 2 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my child's participation is voluntary and they are free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant). I understand that if my child withdraws, information about them that has already been obtained may be kept by Cardiff University.	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my child's data.	
I consent to the processing of my child's personal information (name, gender, age) for the purposes explained. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify my child from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I consent to having photographs of my child's work taken for the purposes of the research project and I understand how they will be used in the research.	
I understand that anonymised excerpts and/or verbatim quotes from my child's action research may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree for my child to take part in this research project.	

Name of participant (print)

Name of parent/guardian (print)._	Date	Signature
______________________________	______________________	______________________
_______		
Name of person taking consent (print)	Date	Signature

____

Role of person taking consent

(print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

CONSENT FORM

Title of research project: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.

SREC reference and committee:

Name of Chief/Principal Investigator: Ceri Morgans

Please initial box

I confirm that I have read the information sheet dated 4/10/2021 version 1 for the above research project.	
I confirm that I have understood the information sheet dated 4/10/2021 version 1 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant). I understand that if I withdraw, information about me that has already been obtained may be kept by Cardiff University.	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to my data.	
I consent to the processing of my personal information (name, gender, age) for the purposes explained to me. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify me from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I consent to being audio recorded/ video recorded/ having my photograph taken for the purposes of the research project and I understand how it will be used in the research.	
I understand that anonymised excerpts and/or verbatim quotes from my action research may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree to take part in this research project.	

________________________________ ________________________ ________________________

Name of participant (print) Date Signature

Contact email: ____

Name of person taking consent (print)	Date	Signature

Role of person taking consent (print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

01/12/2021

V. 2. Advisory Group

Cardiff University, School of Social Sciences Research Ethics Committee

Research Information Sheet: What support service do young people want for their mental health in school?

I would like to invite you to take part in a new research project looking at what makes it easier and harder for young people to access mental health support services in their school. This information sheet explains why the research is being done, and what is involved in taking part. Please read the following information carefully.

Why is the research being conducted?

The aim of this research is to explore how young people are able to access mental health support services in their school and what makes accessing the support easier or harder. It aims to use the information found to create a new mental health support service for pilot use in a secondary school. I am undertaking this research as part of my Professional Doctorate at Cardiff University. It is hoped that the findings of the research will be able to provide recommendations to improve school based mental health services in Wales.

What does participation involve?

- Taking part in an online survey to find out what would make it easier or harder for you to use a mental health support service in school.
- You do not have to take part. You have the right to withdraw at any time and be provided with support information to access if you need it.

What will happen to the information I provide?

The answers you give will be kept anonymous. They will help the research team to find out what might make it easier or harder for you to use a mental health support service in school. The research team will use this information to create a support service that meets the requirements of the students. The support service will then be piloted in your school and evaluated by the research team.

All data will be stored securely, in line with the Data Protection Act. These will be securely stored for up to five years after the research has taken place in line with Cardiff University's data retention regulations.

I will analyse the information and use this as the basis for my Doctoral thesis. This may include use of non-identifiable extracts from the survey answers. In the future, results from this project may also be used in published works and presentations at conferences.

What will happen to my Personal Data?

Personal data collected will include your age and gender. This will be recorded on your online survey.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

The data will be processed for the duration of the research (1 year) after which time the researcher will anonymise all the personal data it has collected from, or about, you in connection with this research project. Data will be retained for 5 years and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Data may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Digital personal data will be stored securely on password protected and encrypted University IT services, physical data will be stored in a locked cabinet up until the point of participant withdrawal from the research project. It will not be possible to withdraw any anonymised data that has already been published.

What happens to the data at the end of the research project?

Anonymised data collected during the research project may be published after the end of the research project. The data will not be used in any further research.

Confidentiality and safeguarding

As you will not be asked to include your name confidentiality is guaranteed.

I wholly appreciate that some participants may find aspects of the research stressful, upsetting or triggering. You can refrain from taking part or request to withdraw from the research at any time. Furthermore, I will be providing a factsheet with information, help lines and online resources relating to experiences or concerns mental health.

The research has been given ethical approval by the School of Social Sciences Research Ethics Committee at Cardiff University.

Do I have to take part?

No. It is up to you to decide whether or not you take part. If you are happy to take part in the project, you will be given this information sheet to keep.

Can I decide to withdraw from the study later on?

As the surveys are anonymous it will not be possible to withdraw them after they have been submitted online.

Consent.

If you are happy to proceed to the survey please tick this box.

☐

Contact details

If you have any questions about the research now or in the future, please feel free to contact me, Ceri Morgans on morganscj@cardiff.ac.uk, Social Science Ethics on socsi-ethics@cardiff.ac.uk or either of my supervisors using the following details:

Dr Rhian Barrance
Supervisor

BarranceR@cardiff.ac.uk

Dr Raya Jones
Supervisor
JonesRA9@cardiff.ac.uk

01/12/2021

V. 2. Advisory Group

Cardiff University, School of Social Sciences Research Ethics Committee

Research Information Sheet: What support service do young people want for their mental health in school?

I would like to invite your child to take part in a new research project looking at what makes it easier and harder for young people to access mental health support services in their school. This information sheet explains why the research is being done, and what is involved in taking part. Please read the following information carefully.

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The aim of this research is to explore how young people are able to access mental health support services in their school and what makes accessing the support easier or harder. It aims to use the information found to create a new mental health support service for pilot use in a secondary school. I am undertaking this research as part of my Professional Doctorate at Cardiff University. It is hoped that the findings of the research will be able to provide recommendations to improve school based mental health services in Wales.

What does participation involve?

- Your child will be asked to take part in an online survey to find out what would make it easier or harder for them to use a mental health support service in school.
- Your child does not have to take part. They have the right to withdraw at any time and be provided with support information to access if they need it.

What will happen to the information my child provides?

The answers given will be kept anonymous. They will help the research team to find out what might make it easier or harder for pupils to use a mental health support service in school. The research team will use this information to create a support service that meets the requirements of the students. The support service will then be piloted in your child's school and evaluated by the research team.

All data will be stored securely, in line with the Data Protection Act. These will be securely stored for up to five years after the research has taken place in line with Cardiff University's data retention regulations.

I will analyse the information and use this as the basis for my Doctoral thesis. This may include use of non-identifiable extracts from the survey answers. In the future, results from this project may also be used in published works and presentations at conferences.

What will happen to my Personal Data?

Personal data collected will include your child's age and gender. This will be recorded on their online survey.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

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The data will be processed for the duration of the research (1 year) after which time the researcher will anonymise all the personal data it has collected from, or about, your child in connection with this research project. Data will be retained for 5 years and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Data may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Digital personal data will be stored securely on password protected and encrypted University IT services, physical data will be stored in a locked cabinet up until the point of participant withdrawal from the research project. It will not be possible to withdraw any anonymised data that has already been published.

What happens to the data at the end of the research project?

Anonymised data collected during the research project may be published after the end of the research project. The data will not be used in any further research.

Confidentiality and safeguarding

As your child will not be asked to include their name confidentiality is guaranteed.

I wholly appreciate that some participants may find aspects of the research stressful, upsetting or triggering. Participants can refrain from taking part or request to withdraw from the research at any time. Furthermore, I will be providing a factsheet with information, help lines and online resources relating to experiences or concerns mental health.

The research has been given ethical approval by the School of Social Sciences Research Ethics Committee at Cardiff University.

Does my child have to take part?

No. It is up to you and your child to decide whether or not they take part. If you are happy for your child to take part in the project, you will be given this information sheet to keep.

Can I decide to withdraw from the study later on?

As the surveys are anonymous it will not be possible to withdraw them after they have been submitted online.

Consent.

All year 9 pupils will be asked to take part in the survey unless specifically requested not to by parents. If you do not wish your child to take part in this survey please return the **OPT OUT** form to the school. They will not be included in the completion of the survey.

Contact details

If you have any questions about the research now or in the future, please feel free to contact me, Ceri Morgans on morganscj@cardiff.ac.uk, Social Science Ethics on socsi-ethics@cardiff.ac.uk or either of my supervisors using the following details:

Dr Rhian Barrance
Supervisor
BarranceR@cardiff.ac.uk

Dr Raya Jones
Supervisor
JonesRA9@cardiff.ac.uk

If you are happy to take part in the research, please sign the consent form.

CONSENT FORM

Title of research project: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.

SREC reference and committee:

Name of Chief/Principal Investigator: Ceri Morgans

Please initial box

I DO NOT give consent for my child to take part in the survey	

______________________________ ______________________ ______________________
____

Name of pupil (print) Date Signature

______________________________ ______________________ ______________________
____

Name of parent/guardian (print) Date Signature

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

01/12/2021

V. 2. Interviews

Cardiff University, School of Social Sciences Research Ethics Committee

<u>Research Information Sheet:</u> What support service do young people want for their mental health in school?

You are invited to take part in a new research project looking at what makes it easier and harder for young people to access mental health support services in their school. This information sheet explains why the research is being done, and what is involved in taking part. Please read the following information carefully, you can talk about it with others if you would like.

Why is the research being conducted?

This research is being done to explore how young people are able to access mental health support services in their school, and what makes accessing that support easier or harder. I will use the information from all the interviews to come up with some ideas to share with your school. They might or might not use those ideas.

I am undertaking this research as part of my Professional Doctorate at Cardiff University. I hope that the information I get through my research will be able to improve school based mental health services in Wales.

What does participation involve?

- You will take part in an interview either on your own, or with a friend, whichever you prefer. It could last up to an hour, but it might not take this long.
- I will ask you some questions about what *might* make it easier or harder for you to access or have accessed a mental health support service in your school. **You will *NOT* have to talk about if, or why you have used, or wanted to use this service in your school before.**
- I will use the information from you and others to come up with some suggestions about what could be changed in school mental health services, to better meet pupil needs.
- I will meet with a group of your school staff to share these ideas which they might choose to use.
- You can withdraw at any time, without giving an explanation. You can leave and will be provided with support information to access if you need it.

What will happen to the information from the meetings?

I will audio record the interviews. This is so I can be accurate when writing up what was said. All identifying information will be removed.

I will store the data securely, in line with the Data Protection Act. I'll keep it for up to five years after the research has taken place in line with Cardiff University's data retention regulations.

I will analyse the information and use it as the basis for my Doctoral thesis. I might use parts of the interview in my writing, but you will not be identifiable. In the future, results from this project may also be used in published works and presentations at conferences.

What will happen to my Personal Data? – DATA PROTECTION

Personal data collected will include your name which will be recorded on your consent form. **This will NOT be shared in published research.**

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

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- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

The data will be processed for the duration of the research (1 year) after which time the I will anonymise all the personal data it has collected from, or about, you in connection with this research project, with the exception of your consent form. Your consent form will be retained for 5 years and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 1 year but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Digital personal data will be stored securely on password protected and encrypted University IT services, physical data will be stored in a locked cabinet up until the point of participant withdrawal from the research project. It will not be possible to withdraw any anonymised data that has already been published.

What happens to the data at the end of the research project?

Anonymised data collected during the research project may be published after the end of the research project. The data will not be used in any further research.

Confidentiality and safeguarding

I will not repeat anything that is said in interviews, unless you tell me something that makes me worried for your, or someone else's well-being or I believe there is a risk of harm or harm has already occurred. In this case I would follow the safeguarding procedures of your school. If this happens, we will first discuss it with you, as appropriate.

I understand that some participants may find aspects of the research stressful, upsetting or triggering. You can refrain from taking part or ask to withdraw from the research at any time. Furthermore, I will be providing a factsheet with information, help lines and online resources relating to experiences or concerns mental health.

Prior to each interview I will provide a health warning and a check in to obtain verbal consent and affirmation that all participants are happy to continue. I will highlight the information on the factsheet and reiterate the pathways to access for any emotional support at the end of each session also.

The research has been given ethical approval by the School of Social Sciences Research Ethics Committee at Cardiff University.

Do I have to take part?

No. It is up to you to decide whether or not you take part. If you are happy to take part in the project, you will be given this information sheet to keep and you will be asked to sign a consent form.

Can I decide to withdraw from the study later on?

You are free to withdraw at any time up to the point of the thesis being submitted, without giving a reason.

Contact details

If you have any questions about the research now or in the future, please feel free to contact me, Ceri Morgans on morganscj@cardiff.ac.uk, Social Science Ethics on socsi-ethics@cardiff.ac.uk or either of my supervisors using the following details:

Dr Rhian Barrance
Supervisor
BarranceR@cardiff.ac.uk

Dr Rachel Brown
Supervisor
BrownR14@cardiff.ac.uk

If you are happy to take part in the research, please sign the consent form.

01/12/2021

V. 2. Interviews

Cardiff University, School of Social Sciences Research Ethics Committee

Research Information Sheet: What support service do young people want for their mental health in school?

I would like to invite your child to take part in a new research project looking at what makes it easier and harder for young people to access mental health support services in their school. This information sheet explains why the research is being done, and what is involved in taking part. Please read the following information carefully and discuss it with others if you wish.

Why is the research being conducted?

The aim of this research is to explore how young people are able to access mental health support services in their school and what makes accessing the support easier or harder. It aims to use the information found to design a system to support access to the service. I am undertaking this research as part of my Professional Doctorate at Cardiff University. It is hoped that the findings of the research will be able to provide recommendations to improve school based mental health services in Wales.

What does participation involve?

- Your child will be asked to take part in an interview either on their own, or with one other pupil, which ever they prefer. The interview could last up to an hour, but it might not take this long.
- I will ask them questions about what *might* make it easier or harder for them to access, or have accessed a mental health support service in school. They will *NOT* have to talk about why they have used, or wanted to use this service in school before.
- The research team will use the information from your child and others to design a service which we think will meet pupils needs which could be used in school.
- Your child will have the right to withdraw at any time and provided with support information to access if they need it.

What will happen to the information from the meetings?

I will audio record the interviews. This is so I can be accurate when writing up what was said. All identifying information will be removed.

All data will be stored securely, in line with the Data Protection Act. These will be securely stored for up to five years after the research has taken place in line with Cardiff University's data retention regulations.

I will analyse the information and use this as the basis for my Doctoral thesis. This may include use of non-identifiable extracts from the interviews. In the future, results from this project may also be used in published works and presentations at conferences.

What will happen to my Personal Data?

Personal data collected will include your child's name and contact details which will be recorded on the consent form. This will be anonymised in published research.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
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may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

The data will be processed for the duration of the research (1 year) after which time the researcher will anonymise all the personal data it has collected from, or about, you in connection with this research project, with the exception of your consent form. Your consent form will be retained for 5 years and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 1 year but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Digital personal data will be stored securely on password protected and encrypted University IT services, physical data will be stored in a locked cabinet up until the point of participant withdrawal from the research project. It will not be possible to withdraw any anonymised data that has already been published.

What happens to the data at the end of the research project?

Anonymised data collected during the research project may be published after the end of the research project. The data will not be used in any further research.

Confidentiality and safeguarding

I will not repeat anything that is said in interviews, unless your child reports an incident where someone's well-being is seriously at risk or where significant harm has already occurred. In this case I would follow the safeguarding procedures of the school.

I wholly appreciate that some participants may find aspects of the research stressful, upsetting or triggering. Participants can refrain from taking part or request to withdraw from the research at any time. Furthermore, I will be providing a factsheet with information, help lines and online resources relating to experiences or concerns mental health.

Prior to each interview I will provide a health warning and a check in to obtain verbal consent and affirmation that all participants are happy to continue. I will highlight the information on the factsheet and reiterate the pathways to access for any emotional support at the end of each session also.

The research has been given ethical approval by the School of Social Sciences Research Ethics Committee at Cardiff University.

Does my child have to take part?

No. It is up to you and your child to decide whether or not they take part. If you are both happy to take part in the project, you will be given this information sheet to keep and you will be asked to sign a consent form.

Can my child decide to withdraw from the study later on?

Your child is free to withdraw at any time up to the point of the thesis being submitted, without giving a reason.

Contact details

If you have any questions about the research now or in the future, please feel free to contact me, Ceri Morgans on morganscj@cardiff.ac.uk, Social Science Ethics on socsi-ethics@cardiff.ac.uk or either of my supervisors using the following details:

Dr Rhian Barrance
Supervisor
BarranceR@cardiff.ac.uk

Dr Rachel Brown
Supervisor
BrownR14@cardiff.ac.uk

If you are happy for your child to take part in the research, please sign and return the consent form.

CONSENT FORM

Title of research project: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.

SREC reference and committee:

Name of Chief/Principal Investigator: Ceri Morgans

Please initial box

I confirm that I have read the information sheet dated 01/12/2021 Version 2 for the above research project.	
I confirm that I have understood the information sheet dated 01/12/2021 Version 2 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my child's participation is voluntary and they are free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant). I understand that if they withdraw, information about them that has already been obtained may be kept by Cardiff University. I understand that my child can bring a friend along to the interview if they choose.	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to the data.	
I consent to the processing of my child's personal information (name, gender, age) for the purposes explained. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify my child from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I understand that anonymised excerpts and/or verbatim quotes from my child's interview may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree for my child to take part in this research project.	

Name of participant (print)

Name of parent/guardian(print)	Date	Signature
Name of person taking consent (print)	Date	Signature

Role of person taking consent

(print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

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CONSENT FORM

Title of research project: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.

SREC reference and committee:

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I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify me from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I understand that anonymised excerpts and/or verbatim quotes from my interview may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree to take part in this research project.	

_____________________________ ______________________ ______________________

Name of participant (print)	Date	Signature

Contact email:

Name of parent/guardian(print)	Date	Signature

Name of person taking consent (print)	Date	Signature

Role of person taking consent

(print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

What you need to know about your interview…

Why am I here?

You have been invited to take part in an interview to talk about mental health support services in your school. I am a student at Cardiff University, and I am researching what makes it difficult, and what might make it easier to get help for your mental health in school. I hope to use your ideas to make suggestions to schools across Wales about what they could change to help more students.

What do I have to do?

I have some questions to ask you if you're not sure what to say, but I'm mostly interested in hearing what you have to say about the access to mental health support in your school. If you think it's important, I want to hear it!

I will audio record the interview so that I can type it up later. When I write it up you will be called 'Pupil 1,2,3' etc so no one will know what you said.

Your answers will be anonymous, I won't tell anyone what you said, unless there is a risk of harm to you or someone else, and then I will have to follow the school safeguarding procedure.

I'm a bit nervous

That's understandable! You can have a friend with you if that makes it easier and we don't have to talk about anything that you don't want to. If there is a question that you don't want to answer just say 'can we skip that one, please'. We can either miss it out completely or you can come back to it later if you want to. We can take a break when you need to, and you can stop the interview at any time, I won't mind.

There is lots more information about what will happen after the interview and what will happen with your information on the full information leaflet provided.

Independent support services

Here are some organisations you can contact if you need someone to talk to:

MEIC CYMRU

Online chat: meiccymru.org Use the online chat to talk to someone about anything you want

Freephone: 080880 23456 All calls are free, and they don't show up on your phone bill.

Text: 84001 Text at anytime for free

Childline

Freephone: 0800 1111 The quickest way to get support. Calls are free and don't show up on the phone bill.

Counsellor chat: Go to childline.org.uk/get-support/ and select counsellor chat

Message boards: Go to childline.org.uk/get-support/message-boards/

The Mix

Crisis messenger: text THEMIX to 85258 for in the moment support and problem solving. Service available 24 hours a day, 7 days a week and is free.

One-to-one chat: A team of helpline supporters help you to find organisations which might be able to help you further. **Available 4pm – 11pm, Monday to Friday only.**

01/12/2021

V. 2. Interviews

Cardiff University, School of Social Sciences Research Ethics Committee

Research Information Sheet: What support service do young people want for their mental health in school?

I would like to invite your child to take part in a research project looking at what makes it easier and harder for young people to access mental health support services in their school.

Why is the research being conducted?

The aim of this research is to explore how young people are able to access mental health support services in their school and what makes accessing the support easier or harder. It aims to use the information found to design a system to support access to the service. I am undertaking this research as part of my Professional Doctorate at Cardiff University. It is hoped that the findings of the research will be able to provide recommendations to improve school based mental health services in Wales.

What does participation involve?

- Your child will be asked to take part in a focus group along with other students. The focus group will last up to 90 minutes.
- I will share anonymised findings from interviews previously carried out for discussion with the focus group.
- Your child will have the right to withdraw at any time and provided with support information to access if they need it.

What will happen to the information from the meetings?

I will audio record the focus group. This is so I can be accurate when writing up what was said. All identifying information will be removed.

All data will be stored securely, in line with the Data Protection Act. These will be securely stored for up to five years after the research has taken place in line with Cardiff University's data retention regulations.

I will analyse the information and use this as the basis for my Doctoral thesis. This may include use of non-identifiable extracts from the interviews. In the future, results from this project may also be used in published works and presentations at conferences.

What will happen to my Personal Data?

Personal data collected will include your child's name and contact details which will be recorded on the consent form. This will be anonymised in published research.

Cardiff University is the Data Controller and is committed to respecting and protecting your personal data in accordance with your expectations and Data Protection legislation. Further information about Data Protection, including:

- your rights
- the legal basis under which Cardiff University processes your personal data for research
- Cardiff University's Data Protection Policy
- how to contact the Cardiff University Data Protection Officer
- how to contact the Information Commissioner's Office

may be found at https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection

The data will be processed for the duration of the research (1 year) after which time the researcher will anonymise all the personal data it has collected from, or about, you in connection with this research project, with the exception of your consent form. Your consent form will be retained for 5 years and may be accessed by members of the research team and, where necessary, by members of the University's governance and audit teams or by regulatory authorities. Anonymised information will be kept for a minimum of 1 year but may be published in support of the research project and/or retained indefinitely, where it is likely to have continuing value for research purposes.

Digital personal data will be stored securely on password protected and encrypted University IT services, physical data will be stored in a locked cabinet up until the point of participant withdrawal from the research project. It will not be possible to withdraw any anonymised data that has already been published.

What happens to the data at the end of the research project?

Anonymised data collected during the research project may be published after the end of the research project. The data will not be used in any further research.

Confidentiality and safeguarding

I will not repeat anything that is said in the focus group, unless your child reports an incident where someone's well-being is seriously at risk or where significant harm has already occurred. In this case I would follow the safeguarding procedures of the school.

I wholly appreciate that some participants may find aspects of the research stressful, upsetting or triggering. Participants can refrain from taking part or request to withdraw from the research at any time. Furthermore, I will be providing a factsheet with information, help lines and online resources relating to experiences or concerns mental health.

The research has been given ethical approval by the School of Social Sciences Research Ethics Committee at Cardiff University.

Does my child have to take part?

No. It is up to you and your child to decide whether or not they take part. If you are both happy to take part in the project, you will be given this information sheet to keep and you will be asked to sign a consent form.

Can my child decide to withdraw from the study later on?

Your child is free to withdraw at any time up to the point of the thesis being submitted, without giving a reason.

Contact details

If you have any questions about the research now or in the future, please feel free to contact me, Ceri Morgans on morganscj@cardiff.ac.uk, Social Science Ethics on socsi-ethics@cardiff.ac.uk or either of my supervisors using the following details:

Dr Rhian Barrance
Supervisor
BarranceR@cardiff.ac.uk

Dr Rachel Brown

Supervisor
BrownR14@cardiff.ac.uk

If you are happy for your child to take part in the research, please sign and return the consent form.

CONSENT FORM

Title of research project: Exploring a student designed school mental health support service. A Youth Participatory Action Research project.

SREC reference and committee:

Name of Chief/Principal Investigator: Ceri Morgans

Please initial box

I confirm that I have read the information sheet dated 16/06/2024 for the above research project.	
I confirm that I have understood the information sheet dated 16/06/2024 for the above research project and that I have had the opportunity to ask questions and that these have been answered satisfactorily.	
I understand that my child's participation is voluntary and they are free to withdraw at any time without giving a reason and without any adverse consequences (e.g. to medical care or legal rights, if relevant). I understand that if they withdraw, information about them that has already been obtained may be kept by Cardiff University. I understand that my child can bring a friend along to the interview if they choose.	
I understand that data collected during the research project may be looked at by individuals from Cardiff University or from regulatory authorities, where it is relevant to my taking part in the research project. I give permission for these individuals to have access to the data.	
I consent to the processing of my child's personal information (name, gender, age) for the purposes explained. I understand that such information will be held in accordance with all applicable data protection legislation and in strict confidence, unless disclosure is required by law or professional obligation.	
I understand who will have access to the personal information provided, how the data will be stored and what will happen to the data at the end of the research project.	
I understand that after the research project, anonymised data may be made publicly available via a data repository and may be used for purposes not related to this research project. I understand that it will not be possible to identify my child from this data that is seen and used by other researchers, for ethically approved research projects, on the understanding that confidentiality will be maintained.	
I understand that anonymised excerpts and/or verbatim quotes from my child's interview may be used as part of the research publication.	
I understand how the findings and results of the research project will be written up and published.	
I agree for my child to take part in this research project.	

Name of participant (print)

Name of parent/guardian(print)	Date	Signature
Name of person taking consent (print)	Date	Signature

Role of person taking consent

(print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

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I understand how the findings and results of the research project will be written up and published.	
I agree for my child to take part in this research project.	

____

Name of participant (print)

Name of parent/guardian(print)	Date	Signature
Name of person taking consent (print)	Date	Signature

Role of person taking consent

(print)

THANK YOU FOR PARTICIPATING IN OUR RESEARCH

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP

Appendix 7: Report provided to School A in place of staff focus group

Data collection report

Imagining a Student Designed Mental Health Support Service – Identifying the facilitators and barriers to accessing support in school.

Please note – detailed demographic data is not provided to avoid identification of pupils who were assured anonymity.

The main body of the report focuses on headline findings and possible explanations from the survey, semi structured interviews and the focus group session. Further information is included in the appendices.

Due to the participatory nature of the research, and the creation of a safe environment for pupils to speak freely, comments, opinions and judgements were not challenged or questioned, even where they seemed unrealistic.

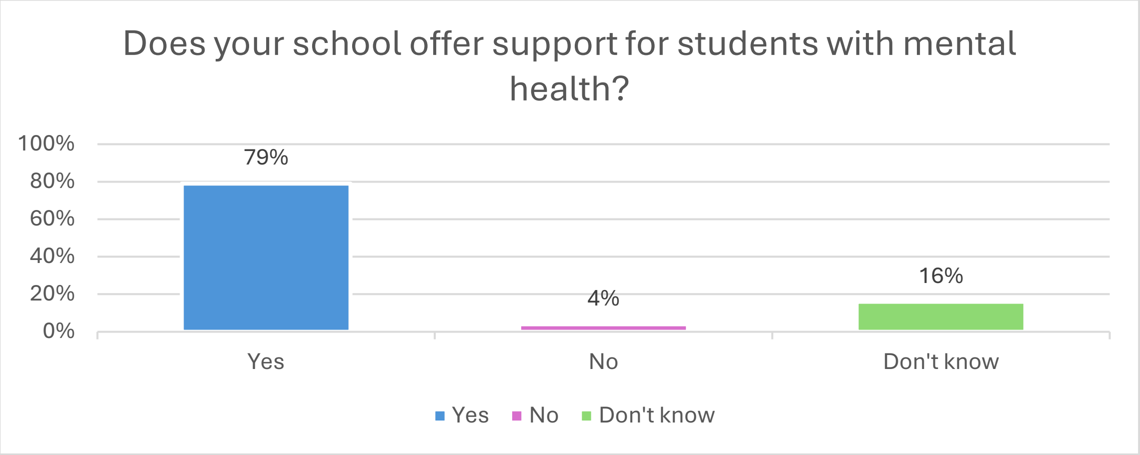
Survey

NB – a full list of questions and graphs is included in Appendix 1.

There were 74 responses to the survey. Pupils were asked questions related to children's rights, mental health services currently available, and their views on mental health support in school.

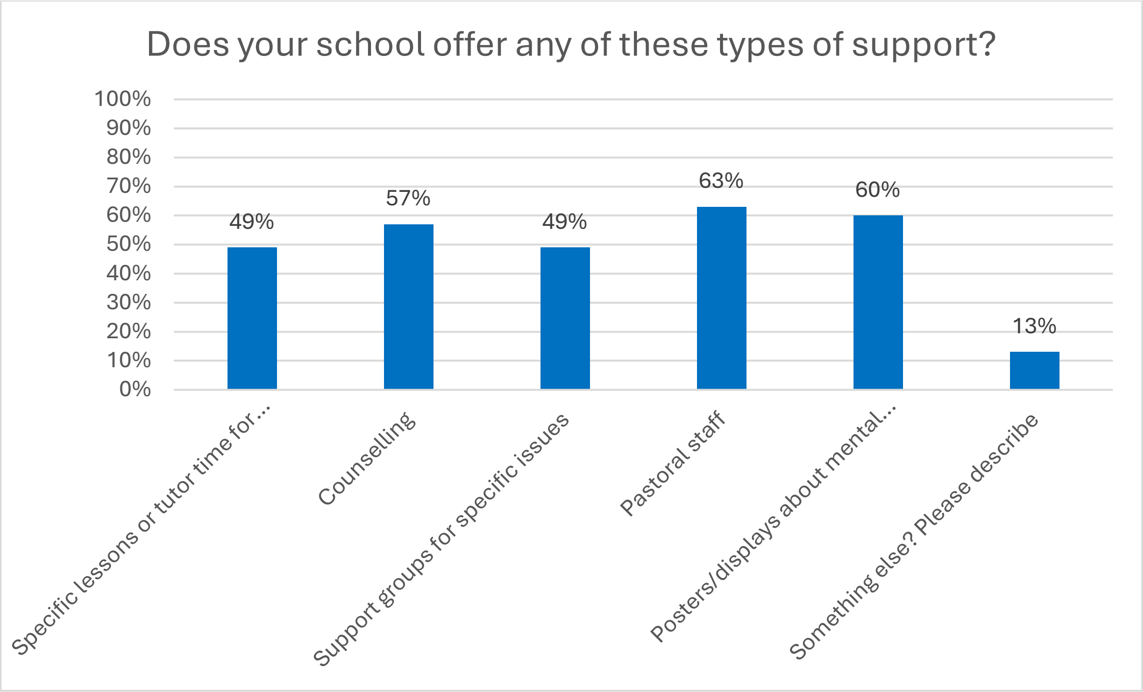
Questions specific to mental health support in school are reported on below:

Does your school offer support for students with mental health?



The vast majority of responses to this question were positive with only 4% of respondents who believed that support is not offered in school.

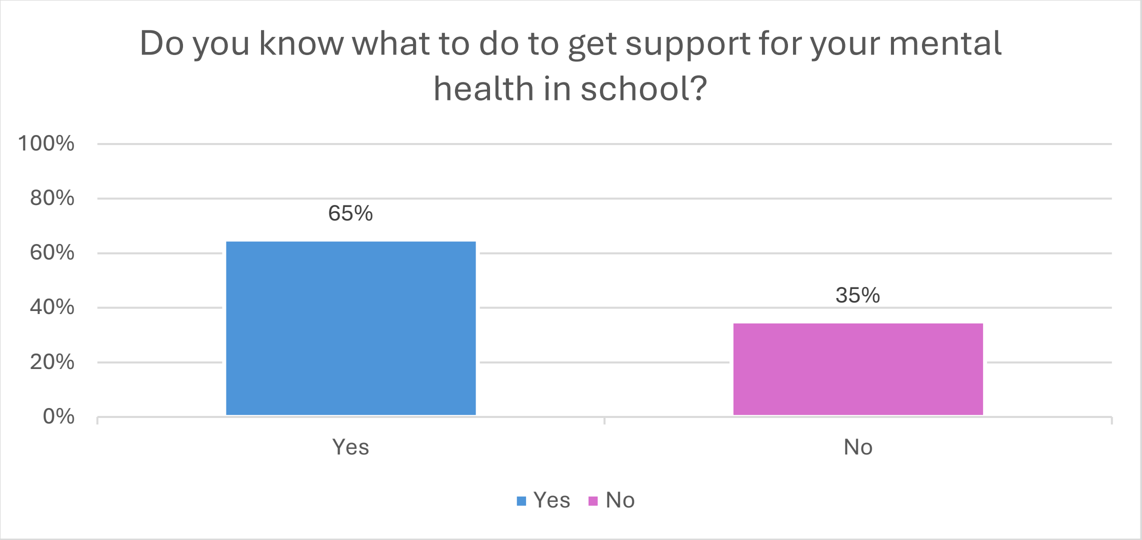
Does your school offer any of these types of support? (Multiple choice)



This question was designed to gauge pupil awareness of the types of support available. 68 pupils answered this question, the bars show the percentage of pupils who knew about each service:

"Something else" responses included Emotional Literacy classes, and talking to friends.

Do you know what to do to get support for your mental health in school?



The responses to this question indicate that although a high number of pupils are aware of the support available in school, some are unsure of how to access it.

It is worth noting here that pupils were directed to select 'no' if they were not sure of what to do.

How likely are you to use the following services? (Multiple choice)

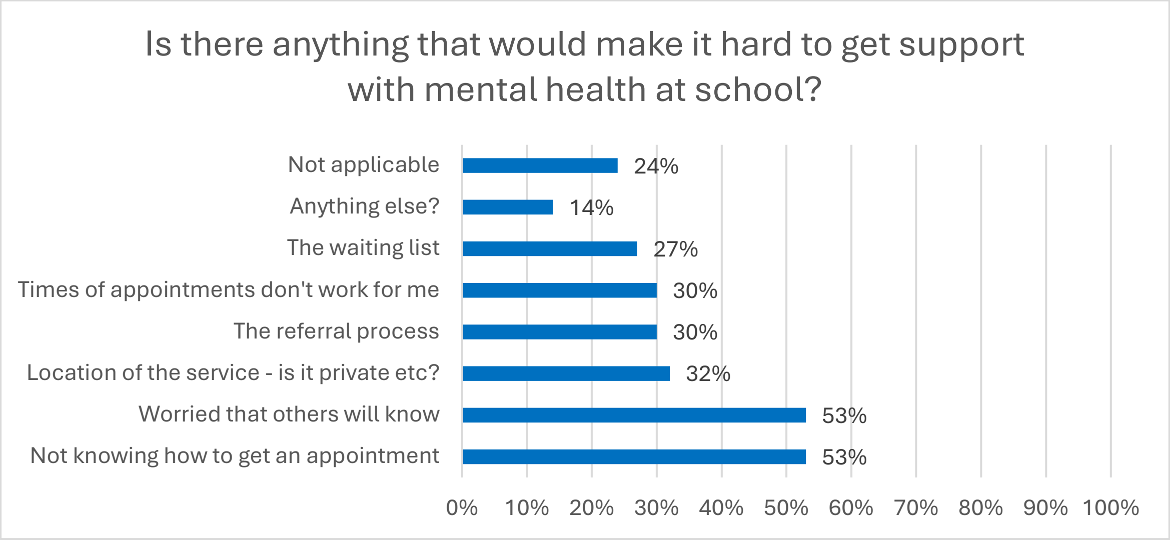
	Positive responses	Negative responses
Specific lessons/tutor time	**14**	**32**
Counselling	**18**	**34**
Support groups	**18**	**29**
Pastoral staff	**25**	**28**

Respondents indicated that they would be most likely to use pastoral staff: this could be due to the private, but informal nature, and pupils having some control over when they use the service. The pastoral service also offers the advantage of being part of the school. Pupils may be familiar with these staff where counsellors are likely to be strangers. Staff knowledge of the school may also make it easier to talk about school related issues.

This was a multiple choice question, and therefore each pupil may have said that they are highly likely, or highly unlikely to use all services.

The number of respondents was quite small so it's not advisable to generalise, but it is interesting to note that there were no large differences between the 4 options other than those discussed.

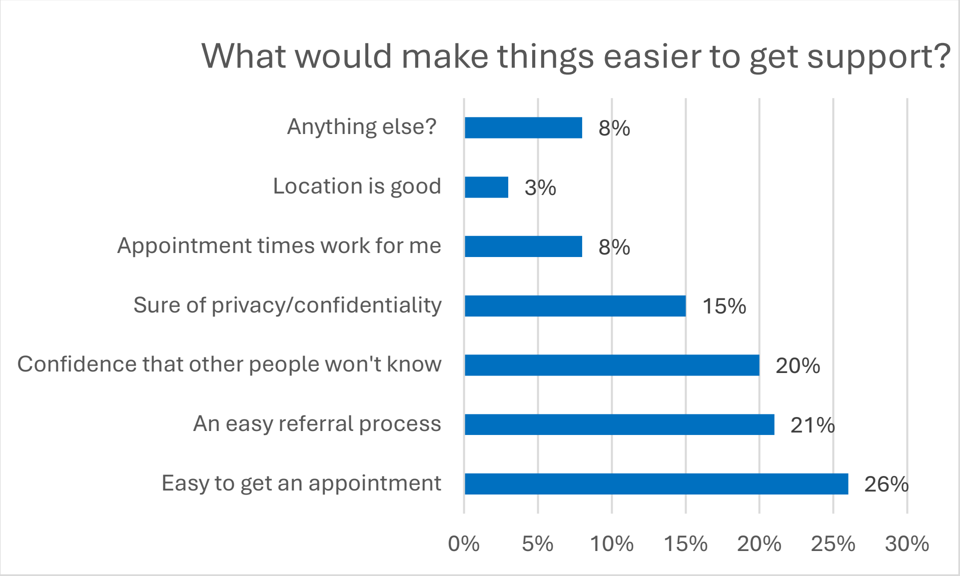
Is there anything that would make it hard to get support with mental health at school? (Multiple choice)



From biggest barrier to smallest:

The respondents identified not knowing how to get an appointment and concerns that others would know about their help seeking as the biggest barriers to getting support. There was less concern about the location of the service, the referral process and the times of the appointments, and the lowest reported barrier was the waiting list.

What would make it easier to get support?



The things that would make the biggest difference were, in descending order, ease of getting an appointment, an easy referral process, confidence that other people won't know, certainty of privacy/confidentiality, appointment times that work for the pupil, and the least important was the location of the service.

Interviews

14 pupils were interviewed across the two campuses. Six of these interviews were carried out in pairs and two pupils attended alone. The interviews were semi-structured so there were some key, open, questions included in all interviews whilst allowing pupils the freedom to talk about what was important to them.

Questions were asked about:

- Safety in school
- Is mental health a concern for young people?

- Is school somewhere that should support pupils with mental health?

- What might look different if mental health services in schools were designed by pupils?

- What makes is easier and harder to get support in school?

- Is there anything you would like to tell decision makers about youth mental health?

Key points

All pupils described school as a safe place, but some talked about an awareness of other pupils disruptive or anti-social behaviour interrupting lessons, and damage to property. About half of the pupils referred to bullying, although few of these spoke of personal experiences.

All pupils were able to name at least one member of staff that they would feel comfortable approaching for support.

All pupils felt that mental health was a concern for young people today, and that issues such as anxiety and depression were more becoming more commonplace. They explained this as being linked to social media and associated pressures.

None of the pupils interviewed felt that there were any lasting effects from Covid and lockdowns.

All the pupils interviewed felt that schools are somewhere that should support pupils with mental health, but most felt that it was of equal importance to education, not more important. One pupil talked about the link between being happy and being able to learn.

I asked pupils about what a pupil designed mental health support service would look like which led to a focus on what they think a counselling room should look like. See images in Appendix 2.

Thematic analysis of the interview data resulted in the following categories:

Adult perceptions of mental health - this included things like adults (parents and school staff):

- minimising the issues, pupils talked of adults using phrases like "*it's just a phase. Stuff like that"*
- pupils feeling judged by adults after they had shared something "*and some teachers, like you say something to them and then they don't look at you the same again"*
- adults having a narrow understanding of mental health "*they'll categorise all mental health problems under like sadness or depression".*

The facilitators to accessing mental health support were:

- The pastoral team *"if you want you can talk to these people, they'll help you out"*
- A named person to go to *"if you talk to your head of year, or person that registers you at the start of the day, they help quite a lot"*
- Information displayed. *"There's like little boards around the school, like posters, that say, like stuff, like about who you can speak to and what you can do to help"*

The room:

- Visual representations focused heavily on a child friendly environment, with beanbags or soft furnishings, child friendly décor, adjustable lighting and comfort.
- Pupils suggested availability of fidget toys, arts and craft materials etc that they could use during the session for creativity or relaxation while talking. This could suggest an awareness of ways to regulate their emotions while talking about difficult things.
- One interview participant liked the pupil displayed artwork currently on display and wanted more of this.
- Pupils talked about not talking across a desk from an adult and avoiding the use of formal furniture like filing cabinets.

Male mental health came up as a topic of its own across several of the interviews.

One pupil described "*toxic masculinity"* as being bad for male mental health, and said he felt like less attention is paid to male mental health because of phrases like *"boys being boys".*

When asked if it might be harder for boys to seek support one pupil expressed a concern that culturally *"boys are told to 'man up".* Please note, this was not an example specific to the school but a cultural stereotype.

Variety of services is a real strength of the school and pupils clearly appreciated the options available. They talked about Kooth, Mind, Youth workers, named staff that they could talk to, and spoke highly of emotional literacy lessons they'd had in earlier years, which they wished were continuing.

Barriers which included:

- Waiting lists: "*the shortest waiting list was like four, six months"*
- A lack of clarity: "*the support that we can access we're not sure how to get to it and how to ask for it."*
- A lack of information: "*There's a lot of services around. But they don't really tend to make them very obvious"*
- Pupils not being involved in the process: *"Some counsellors might approach something. Like, you're going to…do this and then that's going to fix it. But it might…be, the student doesn't feel comfortable with doing that and then it just makes it worse..."*

What would you like decision makers to know?

Decision makers were defined as "adults in school on a local level up to Members of the Senedd and Welsh Leaders".

These are verbatim quotes of what the pupils said:

*"Really, like, how you feel, like, properly? It's like some people don't talk to them (*referring to adults/decision makers*). They just say, "I need help with something small". But it could be like a lot worse, or something."*

"*We are all still teenagers. We don't have the same mental health issues as some adults might. Like yeah... I feel like we experience it differently to them."*

"But then when it comes onto counselling, I feel like that was too mature in a way. And it just kind of felt awkward."

"I think like, maybe a bit more men for counselling, because some people find it easier, like men on men."

"if like teachers are…trying to be more supportive I want them to understand that kids who are like, if they're struggling or whatever, they'll be angry. And if

they're angry, the fact that they're angry will make them more angry. You know, they don't want to be angry."

"Maybe, not look at them as if they're not, like, safe, normal, I guess. And some teachers, like, you say something to them and then they don't like look at you the same again."

Focus Group

The focus group discussion was solution focused with the aim of coming up with suggestions that might reduce some of the barriers identified.

The themes identified throughout the interviews were presented and broken down into specific difficulties before using a problem-solving activity to come up with possible solutions.

Using images to represent the barriers the focus group was presented with the themes identified through interviews. Using post it notes which they could stick onto the images, they were asked to state what they thought the specific issues might be within each barrier.

Next, working in small groups the pupils were asked to rank the barriers in what they felt was order of significance. They are presented here in the averages of order as decided by the pupils, running from most significant to least with the pupil suggestions to overcome them:

For a full list of barriers and suggestions please see Appendix 3

Embarrassment

There were two distinct elements within this – stigma and vulnerability.

Barriers: Pupils described concerns about others knowing about the need for, and access to mental health support, and the possible implications of that, for example, one pupil stated that they were *"Scared of others knowing and telling other people about issues".*

They also talked about worries about opening up about problems and sharing with others. A pupil explained that “*telling people about my worries*” was difficult for them.

Suggestions: Suggestions were focussed on how pupils could best leave the classroom for an appointment while maintaining privacy. One pupil suggested that teachers *“be discreet about the pupil leaving the room”.* This was also raised on a number of occasions through interviews.

Adults leading decisions

Barriers: Pupils stated that adults currently lead the decisions related to mental health support and expressed that they wanted more control over the support provided, with one pupil saying “*Adults should not pick the mental health things because they are not the ones going through it”.*

Examples were given of pupils being referred for mental health support because adults suggested that it would be helpful, when the pupil felt it was not necessary. A pupil thought that *“Parents making the choice may prevent people who need it from getting it. The child may not even need therapy”.* Another pupil stated that she had been referred for counselling as requested by her mother, but that she didn’t feel a need for it.

Suggestions: The focus group talked about the need for pupils to be involved in the decision-making process about the need for support, and the form that the support takes. The group suggested an assessment that they could complete to express their preferences about the support received.

Confusion

Barriers: The barrier here was confusion about what help was available and how to access it. One pupil raised the possibility that confusion might prevent someone from seeking support at all: *“some people might be confused, and the person doesn’t tell anyone”.*

During interviews one pupil expressed that they thought it was a good idea that QR codes were displayed as a means to accessing information but felt that this was in conflict with the school mobile phone policy.

Suggestion: The group suggested that more clarity was needed around what support is available and who pupils should talk to to ask for it.

Lack of information

Barriers: The answers here were similar to those in the previous category of confusion, mentioning a lack information and not enough publicity.

Suggestions: Ideas were practical and focused on where information could be displayed. *"Important info like phone numbers should be displayed where it can be seen".* TV screens in the entrance hall were one suggestion.

Waiting list

Barriers: Barriers identified here were less about personal experience and more focused on perceived worries that getting an appointment might take too long and the implications of that. Referring to counselling one pupil said *"It's a good idea but could take ages".*

Suggestions: One suggestion was to *"have more staff on the job".* There was also a conversation that those with a diagnosis of neurodiversity could be prioritised for support, with a suggestion of the *"waiting list should prioritise pupils with diagnosis".* This led to a concern among some of the group about those who may be undiagnosed, or waiting for a diagnosis of neurodiversity not getting the support they need.

It was interesting to note here that several pupils equated neurodiversity with a need for mental health support.

Getting an appointment

Barriers: Barriers mentioned here were primarily around the physical act of approaching an adult to ask for support. *"Going up and telling people"* was reported by one pupil as something that would stop them seeking support.

Suggestions: Ideas focused on signposting to support and suggestions of ways that pupils could request support without having to approach an adult. One pupil suggested that *“a box for appointment slips”* would be helpful.

Male Mental Health

Within the focus group we spoke at length about the issue of support for male mental health.

Barriers: There were a number of barriers identified to boys seeking support for their mental health which were related to it not being safe for boys to display weakness. A female pupil explained *“Males sometimes struggle more as they don’t talk about their problems”.*

Suggestions: While there was resistance to offering gender specific mental health support “*I don’t think separating mental health for genders is a good idea – transgenders, non-binaries etc would feel uncomfortable*”; anything that supports boys to seek support for mental health is worthy of consideration. When asked what might be helpful a male pupil suggested *“I think like, maybe a bit more men for counselling, because some people find it easier, like men on men”.*

Some pupils referred to a male mental health support group run previously which had been helpful.

Solutions

The use of animals as therapeutic intervention came up a number of times throughout interviews and the focus group. The advantages and disadvantages of this were explored with the focus group, including care and safety of any animals. Pupils felt that there were times when it would be easier to talk things through with an animal than an adult: they did not specify why this was but it could be related to guaranteed confidentiality, wanting to talk rather than receive advice, or difficulty being vulnerable in front of authority figures etc.

I asked the focus group to vote for their preferred solutions from those suggested in the previous activity. Each pupil was given 3 stickers to vote with and asked to vote with them in any way they chose, e.g. using all three votes for one solution, or putting one sticker each on three different solutions that they would like to see.

Animal therapy was included as an option in the first round of voting and inevitably won by a landslide! Therefore, we recorded this result and ran a second round of voting based only on the remaining solutions.

The solutions that were shortlisted in the second round were:

- **Improved information sharing** – this was about making contact information readily available in a range of formats – posters, printed information such as booklets provided to all pupils, assemblies. *This only received one vote which possibly reflects the fact that this already happens.*
- **A checklist** – a short form that could be completed by pupils allowing them to express preferences about the type of support they would like e.g. practical help or talking therapy, individual or group work, if there is a specific gender of adult, they would be more comfortable working with etc.
  This received 3 votes.
- **Information gathering/self-assessment** – a suggestion of pupils being able to outline the issues they are struggling with prior to being paired with a support service so that they could be matched with the appropriate support from the outset.
  This received 11 votes.
- **Anonymous self-selection** – This was a suggestion of a shoe box or similar that pupils could put a slip of paper in requesting support without the need to approach an adult directly.
  This received 18 votes.

The checklist, self-assessment and self-selection box link well together and it is interesting to note that while adults leading the decision-making process was one of the biggest barriers identified at the beginning of the focus group, there was greater support for adults allocating support (based on information provided by pupils) than there was for pupils specifying the support they want. This suggests that pupils want to be involved in the decision making process and to have a discussion about the options available to them.

There were other suggestions that came up during the activity but were not directly linked to the barriers. These were:

- use of an art table/fidget corner or chill space.
- Mindful colouring.
- Several suggestions of movie and snack times to relax.

There was also a request to make talking about mental health more fun, using relaxation techniques such as the suggestions outlined above, and asking direct questions about how they are feeling.

Options

In addition to those solutions voted for by pupils there are some additional options that could be considered in response to pupil feedback.

These are my suggestions based on the things that pupils said they would find helpful and my development of their ideas.

Support for boys – It may be worth asking male pupils what type of support they would feel comfortable accessing and finding ways to challenge the stigma that boys feel about asking for help.

This could include things such as male staff taking on the role of ‘mental health champions’, promoting positive messaging and modelling healthy behaviours.

Training for some male staff in courses such as mental health first aid, or similar. These staff could be made known to pupils as someone who could be approached. Having these staff in a range of roles and departments across the school would increase accessibility.

School involvement in national campaigns related to male mental health.

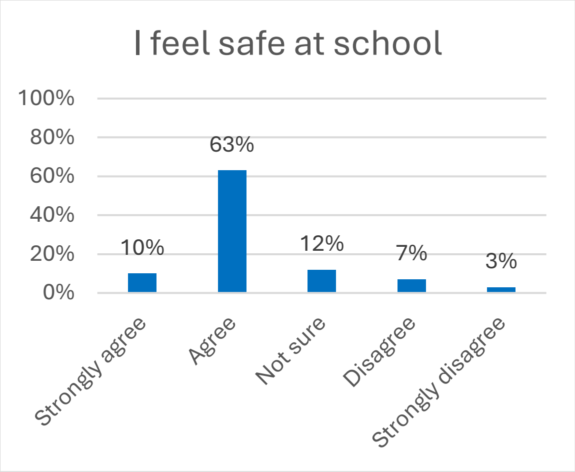
Requesting support – consider the option of pupils having the ability to request support without the need to approach an adult initially. This could be through the use of referral form and collection box as suggested by pupils, or through QR codes displayed around the school.

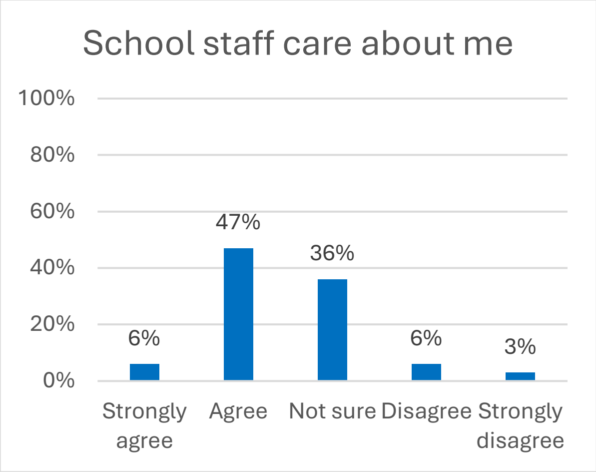
Pupil choice – consider the introduction of a system that allows pupils to specify the type of support they may be interested in within reasonable bounds. This could include choices between individual or group support, in-person or online, problem solving or listening etc. While it will not always be possible to meet requests it may support pupils feeling of autonomy in the process.

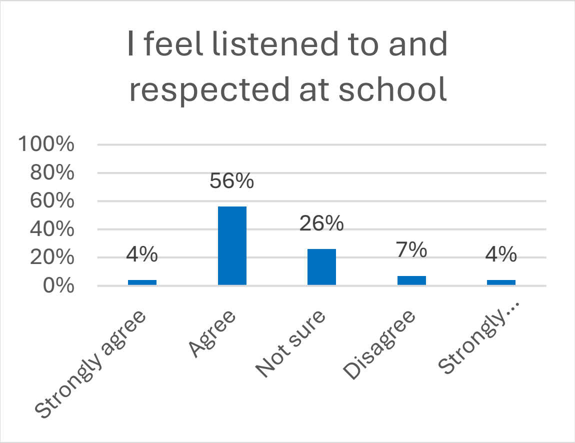
Attendance at support sessions – consider ways in which pupils can be called from the classroom to attend support sessions that are discreet.

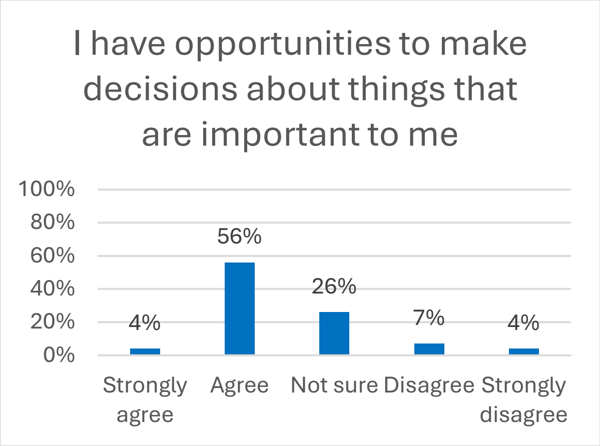
APPENDIX 1

Children’s Rights questions

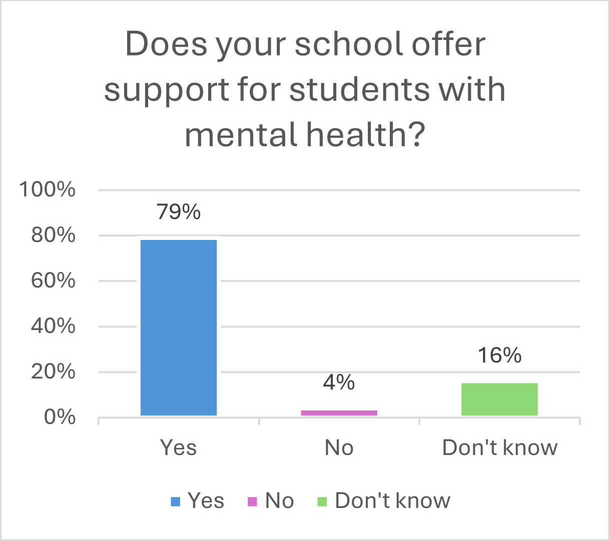

I feel safe at school
100%
80%
60%
40%
20%
0%
10%
63%
12%
7%
3%
Strongly agree
Agree
Not sure
Disagree
Strongly disagree

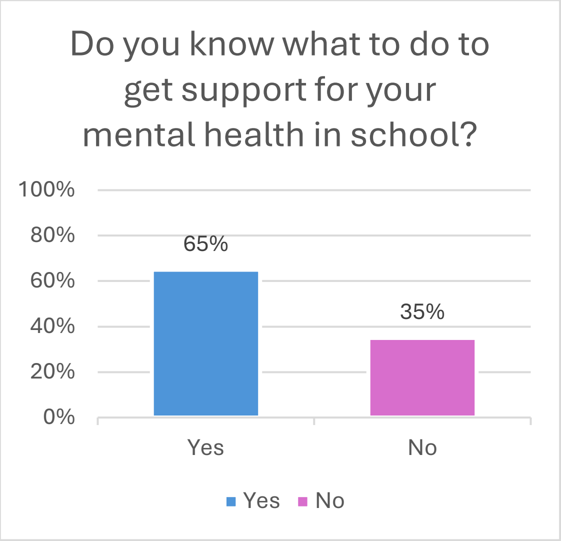

School staff care about me
100%
80%
60%
40%
20%
0%
6%
47%
36%
6%
3%
Strongly agree
Agree
Not sure
Disagree
Strongly disagree

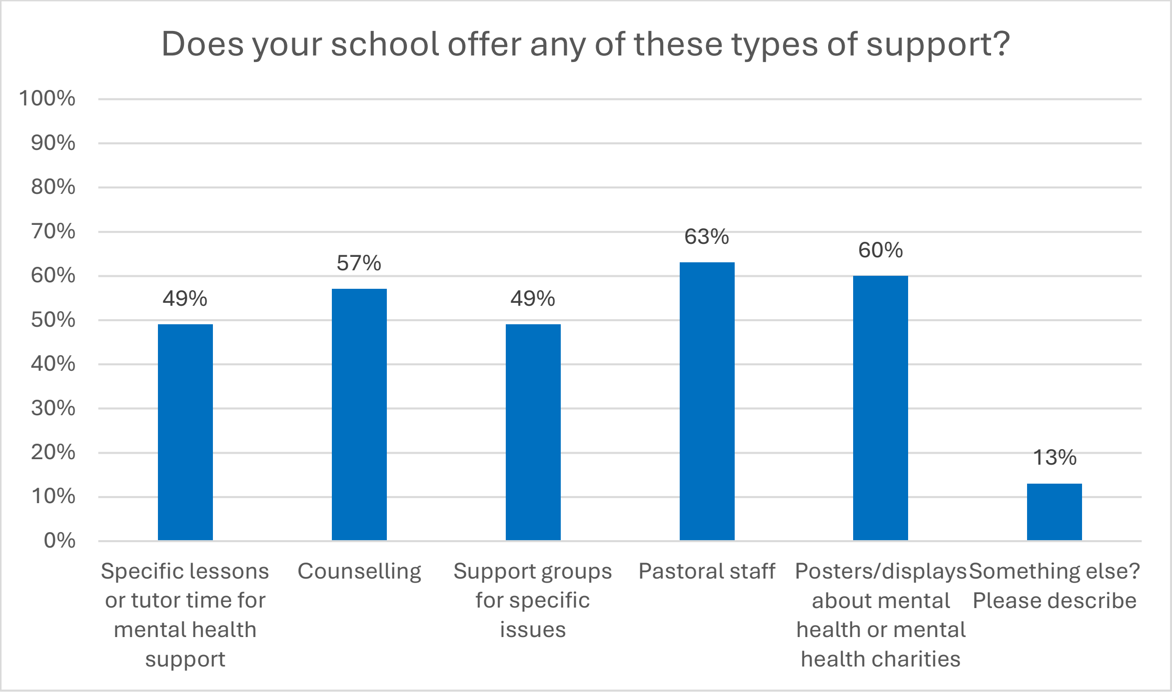

I feel listened to and respected at school
100%
80%
60%
40%
20%
0%
4%
56%
26%
7%
4%
Strongly agree
Agree
Not sure
Disagree
Strongly…


I have opportunities to make decisions about things that are important to me
100%
80%
60%
40%
20%
0%
4%
56%
26%
7%
4%
Strongly agree
Agree
Not sure
Disagree
Strongly disagree

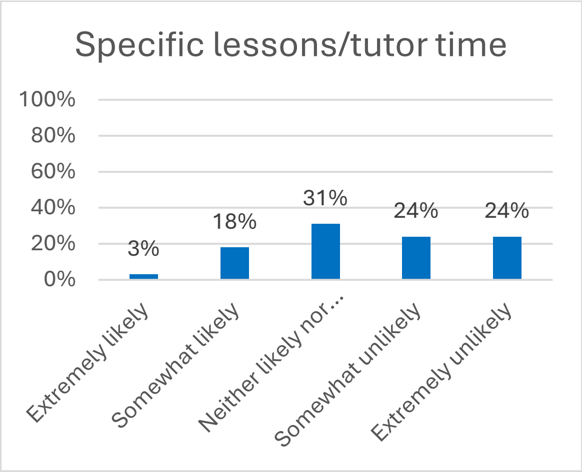
Access to support in school

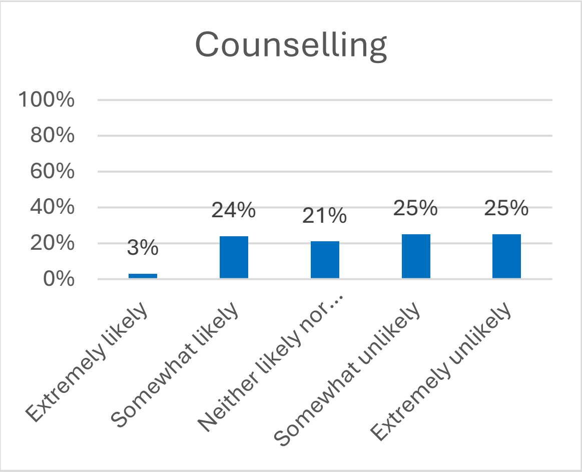


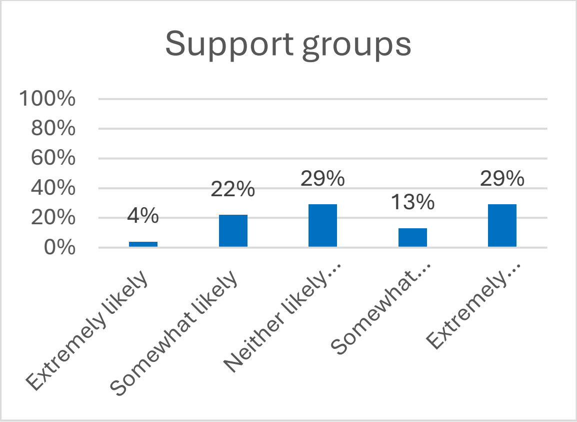


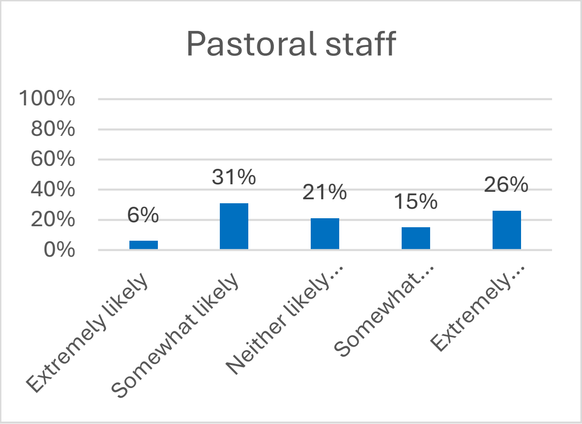


How likely are you to use the following types of support?

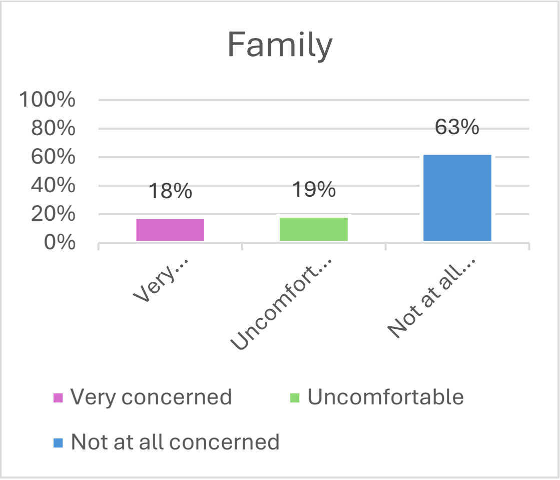


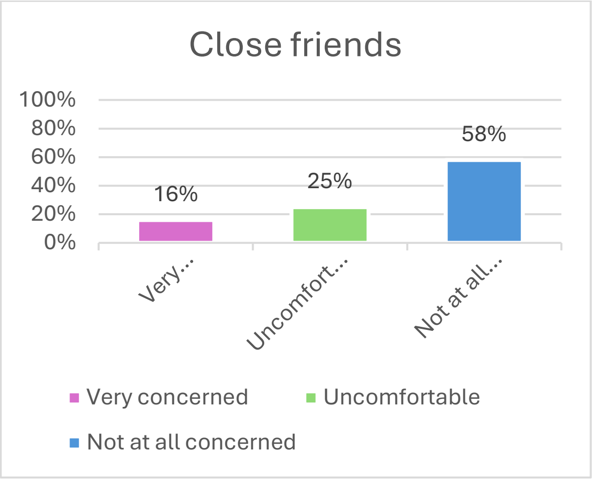


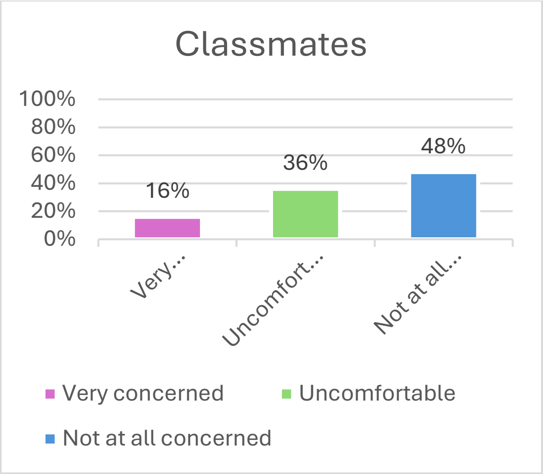


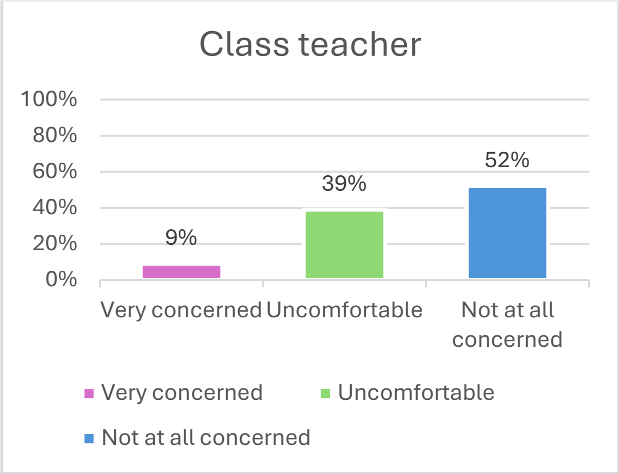


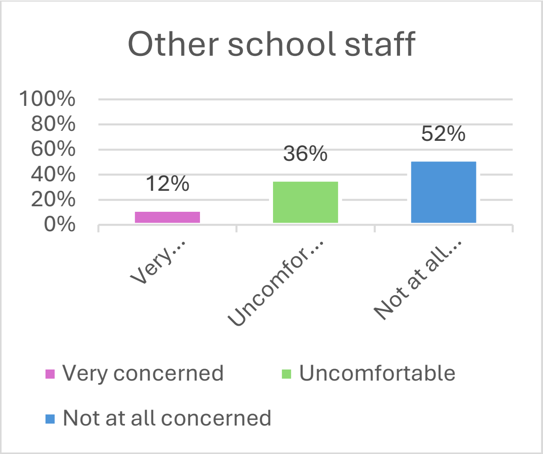
Would it concern you if the following people knew you were using a school mental health support service?



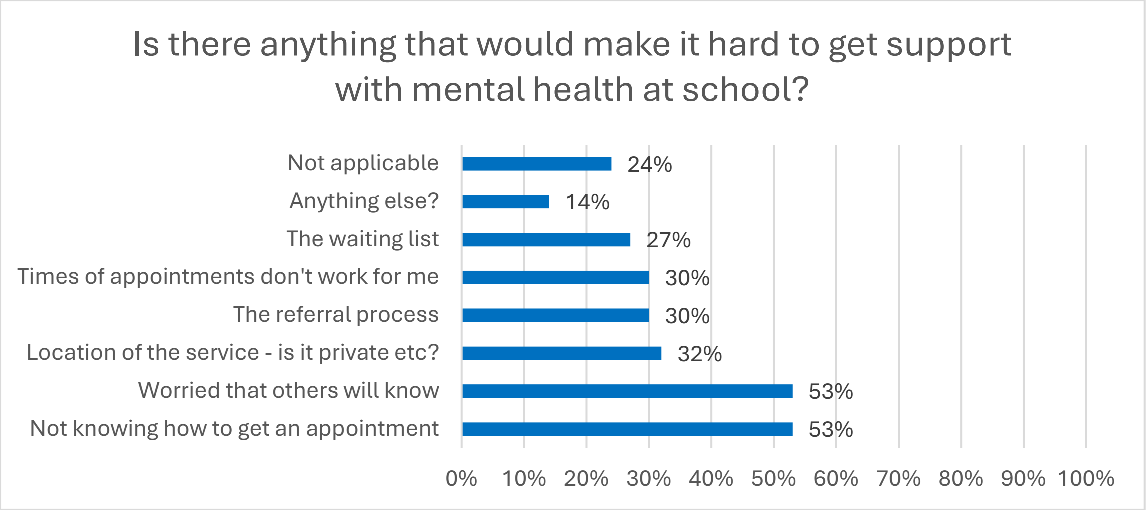






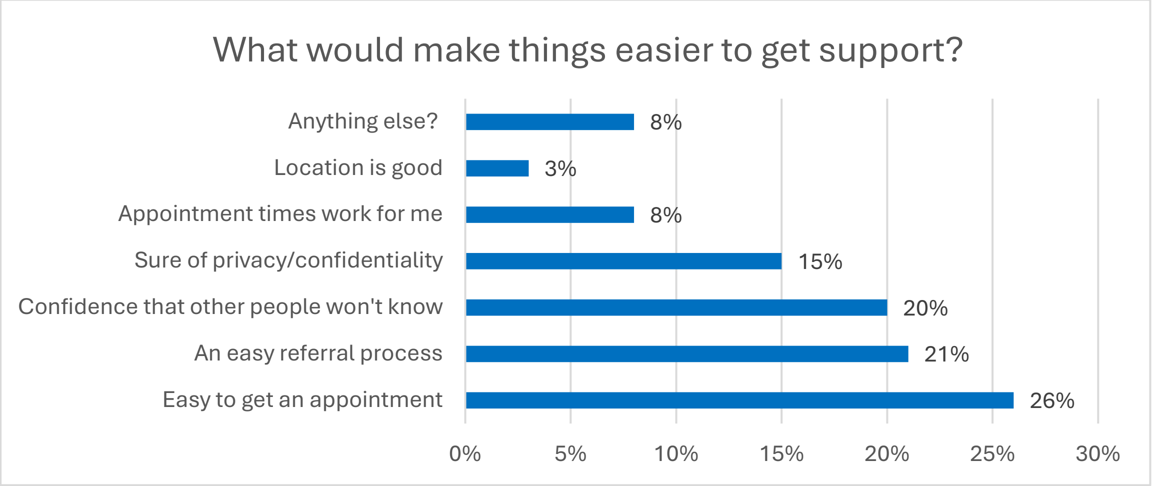


Is there anything that would make it hard to access support in school?



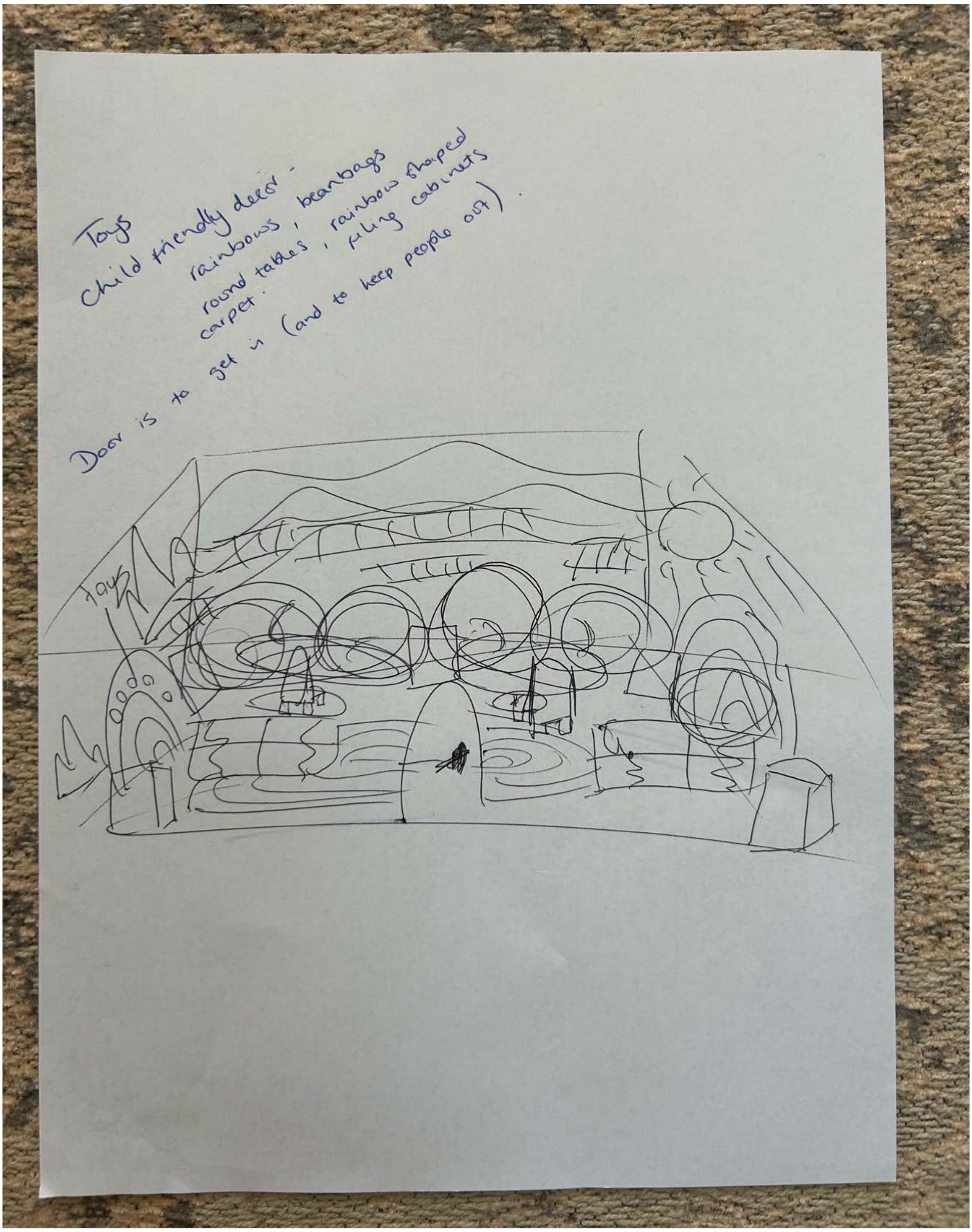
Other reasons given included *“The school has long waiting lists and the way to book an appointment is through a QR code, this is all good except the fact that phones are banned”.*

Is there anything that would make it easier to get support with mental health at school?



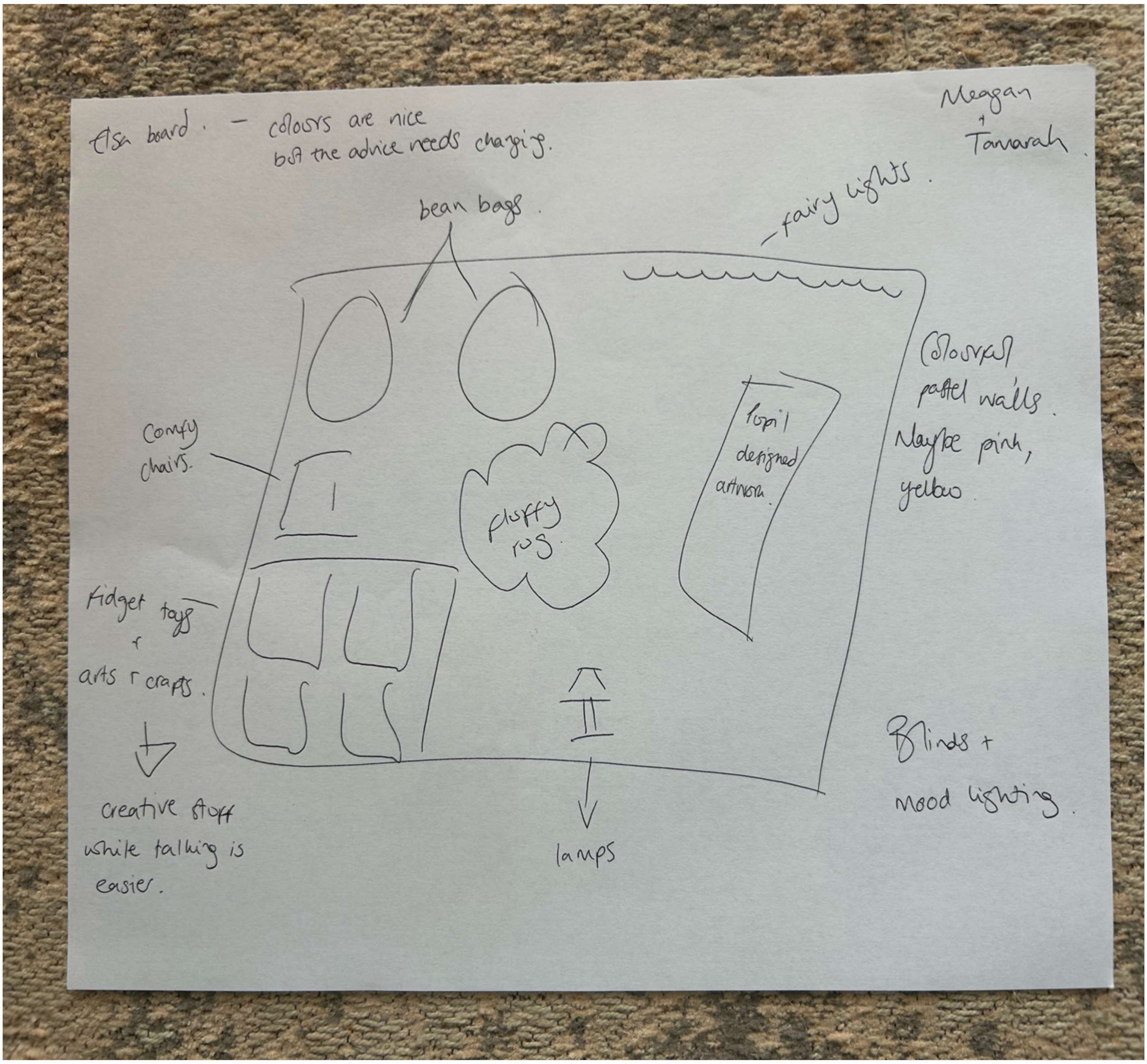
Other reasons given included *“Make it less obvious when people have appointments”; “get to go on phones during break”; “Make it more known of who you go to to get an appointment”; “don't always all minorities to trample over those who may not be as "different' as them just because they have more special needs”; “stop talking about it in school assemblys like almost EVERY DAY”; “Make it private”; “check ins with all students that are confidential”.*

APPENDIX 2



Toys
Child friendly decor -
rainbows, beanbags
round tables, rainbow shaped
carpet. filing cabinets

Door is to get in (and to keep people out).


Elsa board. – colours are nice
but the advice needs changing.
Meagan
+
Tamarah.
bean bags.
fairy lights.
Colourful
pastel walls.
Maybe pink,
yellow.
comfy
chairs.
Pupil
designed
artwork.
fluffy
rug.
fidget toys
+
arts + crafts.
creative stuff
while talking is
easier.
lamps
Blinds +
mood lighting.

APPENDIX 3

Below is the full list of barriers and solutions given by the focus group in activity one.

Embarrassment

Barrier	Solution
Embarrassment about the way you look and where you come from	Be discreet about the pupil leaving the room
Worried about people using it as a way to tease you	Have a quiet word with your teacher so they can move you out secretly without peers knowing
Telling people about my worries	
Scared of others knowing and telling other people about issues	
Sharing my info with other people	
May not feel open to sharing due to sensitivity	
Scared of other people knowing personal info	

Adults leading the decision-making process

Barrier	Solution
Children need choice	Have something like parliament and vote on it
Might not even need support but is stopping others from getting it	Have personalised assessments and chats about what kind of mental health things we want
We should choose	Assessment to decide which mental health service the person should have or what they think they would like
Parents making the choice may prevent people who need it from getting it. the child may not even need therapy.	
Adults should not pick the mental health things because they’re not the ones going through it	

Confusion

Barrier	Solution
Some people might be confused and the person doesn’t tell anyone	Make more clear who to talk to and what help is available
May be confused on who to talk to	

Confusion go and ask people	
Where to go to get help and who	

Lack of information

Barrier	Solution
Where to go/who	Important info like phone numbers should be displayed where it can be seen
Lack of information, not being told nothing	Display board
Not enough 'publicity'	Use the TVs we have to display
	Have more publicity/signposting or assemblies
	Stick mental health numbers on the side and back of a bus

Waiting list

Barrier	Solution
Time may make things worse	Have more (exact word unclear) staff on the job
It's a good idea but could take ages	Waiting list should prioritise pupils with diagnosis
Waiting too long so you forget or go somewhere else	But what if neuro diverse people are unable to get diagnosed or are waiting for a diagnosis
If no diagnosis/obvious mental health difficulties – no help	

Getting an appointment

Barrier	Solution
Trying to book when you're both free	Clear signposting to where to get support
Going up and telling people	Prioritise those with a diagnosis
Being anxious to approach new people	A box for appointment slips
	Shoe box to put ideas and worries in so you don't have to be known

Male mental health

Barrier	Solution
"not as sensitive as females"	They should express their feelings
Males sometimes struggle more as they don't talk about their problems	Not get the right support
They're just scared of showing their feelings	I don't think separating mental health for genders is a good idea – transgenders/non-binaries etc would feel uncomfortable
Thinking they can't be upset	Get one for females as well
Men: people think men are strong, never have any sad feelings and people think men crying is pathetic	Have a female one

	Create a female mental health thing as well