Stigma related to targeted school-based mental health interventions: a systematic review of qualitative evidence

Petra C. Gronholm[1,2*], Elizabeth Nye[3], and Daniel Michelson[4]

[1]Personal Social Services Research Unit, London School of Economics and Political Science, UK

[2]Health Service and Population Research Department; Institute of Psychiatry, Psychology and Neuroscience; King's College London, UK

[3]Centre for Evidence-Based Intervention, Department of Social Policy & Intervention; University of Oxford, UK

[4]Centre for Global Mental Health, Department of Population Health, London School of Hygiene & Tropical Medicine, UK

***Corresponding author:** Dr Petra Gronholm, Personal Social Services Research Unit, London School of Economics and Political Science, Houghton Street, London WC2A 2AE, UK. +44(0)20 7955 6093, p.c.gronholm@lse.ac.uk

Introduction

One in ten children and young people (CYP) experience mental health problems (Polanczyk et al., 2015), and mental disorders constitute the greatest cause of non-fatal burden of disease for CYP aged 10 to 24 years (Gore et al., 2011). Early mental health problems often persist or recur in later life: around half of adults with mental disorders identify the first onset before the age of 15 years (Kim-Cohen et al., 2003). Despite the prevalence and negative impacts of mental health problems among CYP, most go untreated (Merikangas et al., 2011). Low levels of specialist service use are reported even by CYP with severely impairing mental disorders (Dey and Jorm, 2017; Merikangas et al., 2011). This unmet need for mental health care is recognised as a global public health concern (Patel et al., 2007; Polanczyk et al., 2015).

School-based mental health services have been recommended as a way to increase access to evidence-based interventions (Thorley, 2016). Although a substantial number of school-based mental health intervention trials have been undertaken, relatively little consensus has emerged about optimal programme design elements, with particular debate centred around questions of targeted versus universal provision (Rapee et al., 2006). Previous reviews have shown that targeted interventions (i.e., those focused on students who are at risk for, or currently presenting with mental health problems) are associated with stronger and more durable effects on mental health outcomes (Sanchez et al., 2018; Werner-Seidler et al., 2017). On the other hand, universal interventions have been advocated to enable wider coverage for students with diverse needs and ensure closer integration with school curricula (Fazel et al., 2014).

CYP’s service preferences and expectations have been relatively overlooked in discussions about school mental health programming (Dickinson et al., 2003; Segrott et al., 2013). It is notable that many targeted school-based mental health interventions have been transported from clinical settings (Rapee, 2000), with limited involvement of CYP at formative stages of development. This is important, because the school environment presents its own distinctive challenges for ensuring acceptable programme delivery.

In particular, issues of mental illness-related stigma are crucial to ensuring that mental health interventions are socially acceptable to the intended recipients (Corrigan, 2004; Schomerus and Angermeyer, 2008; Thornicroft, 2008). It has been argued that schools provide a familiar, non-stigmatising service setting, and that school-based services can normalise help-seeking and subsequently increase students’ utilisation of support and reduce associated stigma (Baruch, 2001; Thorley, 2016). Other commentators have countered this view, by suggesting that school-based mental health services risk stigmatising participants by singling them out for attention in various ways, including the use of standardised tools for “screening” students against specified mental health criteria (Lupien et al., 2013; Rapee et al., 2006; Weems et al., 2014; Werner-Seidler et al., 2017).

The empirical evidence on stigma and school-based services is likewise mixed. Some quantitative studies have failed to identify evidence of stigma associated with participation in targeted school mental health provision (Martinsen et al., 2016). However, stigma has also been identified as a common barrier inhibiting students’ help-seeking from school counselling services (Chan and Quinn, 2012). Students have also reported stigma-related concerns due to the visibility of accessing school-based mental health support in proximity to peers and teachers (Baruch, 2001; Buchholz et al., 2015; Gronholm et al., 2017; Segrott et al., 2013).

More systematic, contextualised evidence is needed to reconcile these apparently disparate findings and inform future directions in intervention development and implementation. In particular, qualitative methods have been advocated in mental health stigma research more generally (Link et al., 2004), and may offer important insights into help-seeking processes and the influence of anticipated and experienced mental health stigma in schools (Evans et al., 2015). However, no previous systematic review has directly addressed this topic, and qualitative approaches have been relatively underutilised in school mental health programme evaluations to date.

The current study therefore focused on a systematic review of qualitative sources in order to address the following research questions: (1) to what extent do students experience stigma due to screening positively for/participating in targeted school-based mental health interventions (TSMHIs)?; and (2) what are the consequences of potential stigma for students' engagement with TSMHIs and associated screening?

Methods

This review complies with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement (Moher et al., 2009); see Supplement 1 for the PRISMA checklist. The review protocol was developed a priori, and registered at PROSPERO Centre for Reviews and Dissemination (ID CRD42016039541).

Search strategy and selection of studies

Five electronic databases (PsycInfo, EMBASE, Medline, CINAHL, ERIC) were searched in August 2017. Subject headings and keywords were related to the following terms: stigma (e.g., stigma, discrimination, labelling) AND school-based interventions (e.g., school-based health care, school counselling, school health treatment) AND children/adolescents/students (e.g., child, adolescent, youth, pupil, student) AND mental health (e.g., mental health/illness/disorder, emotional/behavioural difficulties) (see Supplement 2 for the full search strategies). These searches were limited to studies published in English.

Initial screening of the database search results considered studies' titles, abstracts and keywords. Full-text reports were obtained for all potentially relevant studies and screened against the full inclusion criteria. Two authors (PCG and EN) independently screened the first 50% of relevant results at both screening stages. Discrepancies were resolved via discussion. The first author completed independent screening of the remaining results and reports, once a consistent screening approach was established.

Citation and reference searches were carried out for all relevant papers identified through the database searches. The authors of these papers and other content experts were contacted for recommendations regarding further publications to consider for inclusion. Study authors were contacted for necessary clarifications. In practice, this was done on one occasion, to confirm whether two articles considered the same data from a single study.

Inclusion criteria (see Table 1) were data-based, peer-reviewed articles reporting on qualitative studies, or qualitative components of mixed-methods research studies. The included studies were required to report on issues of stigma in relation to students' participation in TSMHIs or students' experiences of being selected as a suitable participant for such support. In terms of informants, these qualitative data could be reported by students who had been screened for or had participated in TSMHIs, or other informants (e.g., parents, teachers, service providers) who reflected on students' experiences linked to being screened for, or participating in, TSMHIs.

Papers describing experiences and processes described as any kind of stigma related to mental health were relevant for inclusion. We also included papers reflecting on processes that were not explicitly described as stigma, but were deemed by this review team to reflect processes corresponding with Link and colleagues' conceptualisation. The latter considers stigma in terms of six inter-related processes: distinguishing and labelling differences; stereotyping; separating people into in- and outgroups based on these differences/stereotypes; emotional reactions following these processes; status loss and discrimination amongst those labelled; and these processes taking place within a power context favoring the stigmatiser (Link et al., 2004; Link and Phelan, 2001).

(TABLE 1)

Data extraction, analysis and synthesis

Data were extracted on study design, study population, school setting, characteristics of the intervention, and descriptions of stigma in relation to experiences of intervention participation and/or screening. Experiential data were extracted from participant quotes and authors' interpretations and summaries regarding stigma, as reported in the included studies' results sections (Thomas and Harden, 2008).

The data extraction process and assessment of methodological quality were conducted by the first author. Accuracy was verified by a co-author (EN), who independently checked the data extraction and quality ratings for a third of the studies.

Methodological quality of the included studies was assessed using the qualitative items of the Mixed Methods Appraisal Tool (MMAT) (Pluye et al., 2011). The MMAT assesses papers on two generic core quality criteria (is the research question clear, and do the collected data allow addressing the question) as well as four methodology-specific quality dimensions (for qualitative research these are: relevance of data sources; appropriateness of data analysis; consideration of contextual factors to study findings; and consideration of researchers' influence on study conduct). Articles were assigned one point for each criterion that was fulfilled, and half a point for each partially met criterion. These points were summed to produce an index based on the proportion of total criteria met (i.e., 0%=no criteria met; 100%=all criteria met). No studies were excluded from the initial synthesis process due to a low methodological quality score.

We followed established guidelines for thematic synthesis of qualitative data in systematic reviews (Thomas and Harden, 2008). Relevant textual data were extracted verbatim from the articles, and transferred into qualitative analysis software (NVivo 10; QSR International). Initial descriptive codes were generated through line-by-line inductive open coding. Codes were iteratively indexed and sorted to create descriptive themes. These themes were continuously related and restructured, until an analytical framework emerged that accurately and comprehensively reflected the data, while providing a meaningful interpretation of these data in view of our research questions. This process was led by the first author, and validated through consensus discussions with co-authors.

Results

The search produced 3463 non-duplicated results, of which 3396 were excluded following initial screening. Full-text articles were accessed for the remaining 67 results; 59 articles were excluded following assessment against full eligibility criteria. Eight articles met review inclusion criteria. Figure 1 depicts this article selection process using the PRISMA flow diagram.

(FIGURE 1)

The eight articles included in this review were based on seven studies, representing an aggregate participant sample size of n=219. An overview of the included articles is provided in Table 2 (see Supplement 3 for full details on the included articles, and Supplement 4 for the excluded full-text articles).

All of the included studies considered interventions for secondary school students (age range 12-17 years); no eligible studies focused on the experiences of younger children in primary school. Most studies (5 out of 7) addressed early interventions for students experiencing emotional distress in the context of psychosocial stressors. These interventions were described as ‘school mental health services’ (Huggins et al., 2016), ‘school counselling services’ (Prior, 2012a, 2012b), an intervention to enhance protective factors for young people experiencing change, loss and transition events and early signs of emotional distress (Dickinson et al., 2003), an intervention for students with social and emotional difficulties in school and family settings (Evans et al., 2015), and a school-based emotional support service for ‘young people with emotional difficulties/mental health issues, which had the potential to cause a crisis or have a negative effect on emotional well-being' (p. 219) (Segrott et al., 2013). Only two studies (Garmy et al., 2015; Kvist Lindholm and Zetterqvist Nelson, 2014) focused on programmes with an explicit diagnostic focus, both involving cognitive-behavioural interventions for students at risk for depression. Four of the referenced interventions were delivered in groups and three were delivered individually. Most studies (5 out of 7) reported data regarding stigma associated with TSMHIs from service users, one reported data from school guidance counsellors, and one reported data from a combination of service users and providers.

(TABLE 2)

Methodological quality

All articles met $\geq$50% of the MMAT criteria, suggesting generally good quality overall. The most common methodological limitations were: a lack of consideration about the researchers' potential influence on study conduct and/or results; a lack of information about reasons for non-participation in the study; and insufficient attention to contextual factors that might affect interpretation of findings. Table 2 lists the methodological quality scores for each included article.

Thematic synthesis

Three overarching themes were identified: (1) "anticipated and experienced stigma"; (2) "consequences of stigma"; and (3) "mitigating strategies". These themes and associated subthemes are discussed in turn; studies that correspond to each theme are presented in italicized brackets, with further illustrative quotes provided in Table 3.

(TABLE 3)

Anticipated and experienced stigma

The first theme captured reports of both anticipated and experienced stigma in relation to their engagement with TSMHIs. These concerns reflected three subthemes: negative labelling, discriminatory reactions, and concerns regarding confidentiality.

Negative labelling

Contact with TSMHIs was considered to be revealing of mental health status, leading to negative labelling from peers *(Huggins et al., 2016; Prior, 2012a).* Two types of negative characterisations were indicated: labels that emphasised difference and deviation from the norm (e.g., “weird”, “abnormal”, “deviant”), and labels that reflected stereotyped attitudes towards people with mental health difficulties (e.g., “psycho”, “mental” or “mad”) *(Prior, 2012a, 2012b).* Negative labelling was generally described in relation to others’ views, but it was also evident in how some students described their own difficulties and identities. For some students, this extended to an internalised a sense of personal incompetence and associated feelings of guilt and shame, reflective of self-stigmatising processes *(Prior, 2012a, 2012b)*.

Discriminatory reactions

Stigma was also evident in anticipated and experienced hostile reactions from peers, including overt bullying and teasing, and feeling rejected, judged, and dismissed *(Huggins et* *al., 2016; Prior, 2012b).* Teachers and counsellors were also perceived as a source of discrimination, with accounts of students feeling "hated" and being treated unequally due to contact with TSMHIs *(Evans et al., 2015; Prior, 2012b).*

Compromised confidentiality

Confidentiality issues were raised with respect to intervention providers and peer confidants. Students expressed concerns that counsellors might divulge details of their mental health to others; friends were also considered at risk of breaking confidentiality, in the event of a falling out *(Prior, 2012b).*

Consequences of stigma

The second theme reflected consequences of stigma-related concerns, and included three subthemes: anticipatory anxiety, restricted disclosure, and distancing from support.

Anticipatory anxiety

Students described fear about negative reactions and a high level of uncertainty when anticipating and initiating contact with TSMHIs. This anxiety was discussed in relation to concerns of labelling and discrimination specifically, albeit it could also stem from the demands of the intervention itself (e.g., having personal conversations and direct contact with an unfamiliar person) *(Prior, 2012a, 2012b).*

Restricted disclosure

Another stigma-related barrier to engagement with TSMHIs was evident in reports of restricted disclosure of difficulties, with fears of negative consequences of disclosure underpinning some students' reluctance to be fully open during counselling sessions *(Prior, 2012b).*

Distancing from support

Stigma-related concerns also resulted in students rejecting available support. For example, one student had stopped attending school counselling, as private matters discussed during sessions has been shared among school staff, raising the prospect that stigmatising information about service use might also reach peers *(Prior, 2012b).* Students also resisted the negative connotation of being singled out for support *(Garmy et al., 2015),* and distanced themselves from stigmatising aspects of TSMHIs by downplaying their own need for support and potential benefits of TSMHIs *(Kvist Lindholm and Zetterqvist Nelson, 2014).* In so doing, some students rejected stigmatising labels for themselves while still applying them to others *(Prior, 2012a).*

Mitigating strategies

The third theme described strategies endorsed by CYP to mitigate the likelihood and/or impact of stigma in relation to engaging with TSMHIs. Subthemes reflected: applying alternative constructions for psychological support, increasing choice and control, and ensuring confidentiality and building trust.

Applying alternative constructions for psychological support

There was evidence that students responded favourably when the core content of interventions emphasised relational aspects with providers and practical coping with everyday problems (e.g., talking, listening and problem-solving), in preference to more clinical and biomedical constructions of mental health, illness and therapy *(Prior, 2012b),* which were perceived as more stigmatising. This resonated with students' everyday concerns, and helped to normalise the experience of receiving psychological support *(Prior, 2012a).*

One study described how stigma in relation to TSMHI had been avoided when the service was structured around the metaphor of “life as journey”, emphasising resources needed to “travel” through life and avoiding terms directly related to “mental health” *(Dickinson et al., 2003).* Another study reported on overt efforts by intervention developers to construct a positive targeting experience*,* with the intervention framed as providing care, a sanctuary amidst chaotic lives, and access to support and attention for students experiencing social and emotional problems *(Evans et al., 2015).* This conceptualisation was discussed as avoiding undesirable, stigmatised positions of failure and rejection among referred students.

Increasing choice and control

Positive, non-stigmatising experiences were also discussed in terms of choice and control in help-seeking. The framing of students as proactive service consumers rather than passive recipients of care was helpful in rejecting critical peer attitudes, and encouraged students to assert their right to seek support *(Prior, 2012a)*. Such framing was described both in terms of how intervention providers explained TSMHI engagement to students, and how students viewed their own help-seeking *(Prior, 2012a, 2012b).* Strategies to provide students a sense of control regarding whether or not they wanted to inform others about their TSMHI appointments were also mentioned *(Segrott et al., 2013).*

Ensuring confidentiality and building trust

Given the sensitivities around disclosure of mental health difficulties and service use in schools, it is not surprising that confidentiality and trust were frequently mentioned as key considerations for overcoming stigma-related barriers. Improved privacy was discussed in relation to the physical environment where TSMHIs were provided, for example by avoiding rooms with clear glass windows that made counselling sessions visible to others *(Huggins et al., 2016).* Enhanced confidentiality was also discussed in terms of using discreet methods, such as passes for generic appointments, to signal that a student needed to leave class *(Segrott et al., 2013).* To build trust, it was deemed important to ensure that students were clearly informed about intervention procedures, and particularly about how privacy and choice would be managed *(Prior, 2012b).* It was also highlighted that students require time to get to know and trust intervention providers, for example by allowing time for initial informal conversations without the pressure of an immediate therapeutic discussion *(Segrott et al., 2013).* These strategies facilitated engagement with TSMHIs, as once a sense of confidentiality and trust was established students felt able to fully engage with the support and discuss their difficulties *(Prior, 2012b).* Service providers likewise described how their ability to provide effective support was dependent on the extent to which students perceived them to be trustworthy and respectful of confidentiality *(Huggins et al., 2016).*

Discussion

This review aimed to derive systematic evidence about the potentially stigmatising effects of TSMHIs. We searched for and synthesised data on (1) students' experience of stigma due to screening positively for/participating in TSMHIs, and (2) the consequences of stigma for students' engagement with TSMHIs. Drawing from eight articles, reflecting on seven eligible studies, primarily based on secondary school samples, we found evidence of negative labelling by peers and others and self-stigma, alongside fears of discriminatory reactions and stigma-related concerns regarding compromised confidentiality. Consequently, some students were apprehensive about initiating contact with TSMHIs. We also identified reports of students restricting disclosure and otherwise distancing themselves from intervention providers, in order to limit negative stigma-related consequences.

Overall, these findings resonate with earlier suggestions that school-based service provision can be stigmatising (Lupien et al., 2013; Rapee et al., 2006; Weems et al., 2014; Werner-Seidler et al., 2017), and corroborate reports that proximity of peers is a key factor contributing to students' fear of mental health stigmatisation (Baruch, 2001; Buchholz et al., 2015; Gronholm et al., 2017; Segrott et al., 2013). Other research has shown that many young people prefer to cope with mental health difficulties by sharing these concerns with peers (Gronholm et al., 2017; Gulliver et al., 2010; Rickwood et al., 2007, 2005). These findings illustrate the complicated dynamics facing students in the school environment, where peers can represent both a valued source of support and a source of concern regarding negative labelling and other discriminatory behaviours.

We found stigma-related barriers to service use at multiple stages, from initial contact to continued engagement with TSMHIs, illustrating how pervasively stigma can compromise efforts to increase access to mental health care. It also highlights the need to understand and intervene with stigma at multiple stages of students' engagement with TSMHIs, for these efforts to reach their full potential.

Findings also provided indications of relevant strategies to mitigate stigma-related concerns. This included an emphasis on ecological relevance and accessible terminology (e.g., problem-solving in everyday situations) over biomedical constructions in the social marketing of mental health interventions. The importance of avoiding stigmatised language around “mental health” has been emphasised in previous research with young people (Martinsen et al., 2016; NUS Scotland, 2011; Time to Change, 2013). Providing clear advance information is also important for clarifying expectations and resolving uncertainties about the content and delivery of interventions, which may otherwise cause anticipatory anxiety and risk disengagement (Bone et al., 2015; Gulliver et al., 2010; Stafford et al., 2016).

In addition, students preferred engaging with TSMHIs when they felt this was their choice and they were in control. Personal agency is particularly salient in the context of adolescent development (Meeus et al., 2005), and has been discussed as a key consideration in intervention development for this cohort (Sclare and Michelson, 2016). It may therefore help to reframe the position of service users as assertive, active agents, rather than passive recipients of mental health care (Chamberlin, 2005; Prior, 2012a). In practice, this could be achieved by discussing information from screening assessments directly with individual students, and exploring whether the results are personally relatable. This approach would be consistent with principles of therapeutic assessment (Finn and Tonsager, 1997) which emphasises processes of self-verification (confirmation and validation of needs), self-enhancement (communicating that an individual is valued) and self-efficacy (supporting new insights into less well understood problems and potential solutions). Combined with self-referral routes (Michelson et al., 2016), this could provide a way of mitigating intrusive and unwelcome screening strategies where students feel negatively singled out (Greenberg et al., 2001; Humphrey and Wigelsworth, 2016; Offord et al., 1998). Stigma-related concerns were also mitigated by specific assurances about confidentiality and the development of trust in relationships with intervention providers. This corresponds with previous reports of stigma-related concerns in other service settings (Best et al., 2016; Buchholz et al., 2015; Gronholm et al., 2017).

In terms of directions for future research, despite the strong relevance of stigma in relation to school-based mental health service provision (Lupien et al., 2013; Rapee et al., 2006; Weems et al., 2014; Werner-Seidler et al., 2017) we identified a relatively small number of studies for in inclusion in this review. This indicates a need for further research exploring how stigma might affect students' experiences and preferences for mental health support in school settings. In particular, only one of the included studies focused directly on the screening process (Evans et al., 2015), which is key to the implementation of targeted support. We also note that none of the included studies were conducted as a part of intervention trials, but instead reflected evaluations of routinely implemented services. Efforts to evaluate the feasibility and acceptability of trial interventions could constitute a useful platform for examining possible stigma under controlled conditions.

Comparative research on mental health stigma across different service settings is also needed. Although we found evidence for stigma in relation to TSMHIs, this does not imply that school-based provision is any more stigmatising than other service delivery formats. Indeed, previous research has suggested that young people may perceive schools as providing a familiar and safer environment for service delivery compared to clinics or community settings such as youth centres (Sclare et al., 2015). However, it also appears that certain aspects of the school environment may be associated with higher perceived risks of stigmatisation, particularly in relation to information sharing, confidentiality, and the proximity of peers. Future research should aim to examine stigma across different settings, to obtain a clearer understanding of young people's service use preferences and how stigma-related concerns could best be mitigated across contexts.

Furthermore, all studies identified for this review involved secondary school students aged at least 12 years. This reflects previous findings that mental health provision is relatively more common in secondary schools compared to primary schools (Sharpe et al., 2016). However, given that both mental health problems (Green et al., 2005; Merikangas et al., 2009) and stigma (Coleman et al., 2009; Pitre et al., 2007; Wahl, 2002) are known to manifest among younger children, future research should examine potential stigmatising influences in relation to TSMHIs in younger samples.

It is also notable that most studies identified for this review did not reflect on the role of ethnicity in relation to potential experiences of stigma and TSMHI participation. Given how the experience of stigma might vary based on individuals' cultural or ethnic backgrounds (Yang et al., 2007), this influence warrants further research attention in relation to stigma associated with school-based mental health support.

Strengths and limitations

To our knowledge, this is the first review to examine potential stigma associated with students' engagement with TSMHIs, providing an important synthesis of the available qualitative evidence in this area. Critically, our review focused on young people's actual experiences of TSMHIs. It has been remarked that much of the existing literature on mental health service stigma for young people rests on hypothetical actions and attitudes in relation to different mental health care scenarios (Prior, 2012a), in contrast to a focus on actual lived experience. Our review consolidates evidence in this important and under-studied area.

However, our findings must be considered in view of certain limitations, including the relative scarcity of surveyed evidence. Although we employed a comprehensive search strategy involving screening multiple databases (augmented by reference checks and expert consultations), it is possible that our search did not capture all articles relevant for inclusion in this review, particularly as we only included published journal articles. We also note that some studies were relatively over-represented in our data analysis while others provided less raw data, due to the varying richness of descriptions in the primary papers. Furthermore, due to the relatively small number of included studies, it was not feasible to conduct subgroup analyses for different age groups, school settings, or types of service delivery. Finally, as all evidence considered for this review came from high-income and Western countries, the applicability of our findings to other contexts is also unclear.

Conclusions

Given the recent push towards school-based services to expand access to mental health care for children and young people, it is essential to understand how stigma-related concerns might compromise such efforts and how these challenges can be overcome. This review of qualitative evidence advances our understanding of stigma in relation to targeted mental health interventions in schools, and thus provides a valuable contribution to the literature which has to date been characterised by mixed and scattered evidence. The findings of this review can inform efforts to mitigate stigma-related barriers to students' engagement in targeted mental health support, and also serve to guide future research in this area.

Acknowledgements

None

References

Baruch, G., 2001. Mental health services in schools: the challenge of locating a psychotherapy service for troubled adolescent pupils in mainstream and special schools. J. Adolesc. 24, 549–570. https://doi.org/10.1006/jado.2001.0389

Best, P., Gil-Rodriguez, E., Manktelow, R., Taylor, B.J., 2016. Seeking Help From Everyone and No-One: Conceptualizing the Online Help-Seeking Process Among Adolescent Males. Qual. Health Res. 26, 1067–1077. https://doi.org/10.1177/1049732316648128

Bone, C., O'Reilly, M., Karim, K., Vostanis, P., 2015. "They"re not witches. ...' Young children and their parents' perceptions and experiences of Child and Adolescent Mental Health Services. Child. Care. Health Dev. 41, 450–458. https://doi.org/10.1111/cch.12161

Buchholz, B., Aylward, S., McKenzie, S., Corrigan, P., 2015. Should youth disclose their mental health challenges? Perspectives from students, parents, and school professionals. J. Public Ment. Health 14, 159–168. https://doi.org/http://dx.doi.org/10.1108/JPMH-03-2015-0008

Chamberlin, J., 2005. User/consumer involvement in mental health service delivery. Epidemiol. Psichiatr. Soc. 14, 10–14. https://doi.org/10.1017/S1121189X00001871

Chan, S., Quinn, P., 2012. Secondary school students' views of inhibiting factors in seeking counselling. Br. J. Guid. Counc. 40, 527–543. https://doi.org/10.1080/03069885.2012.719603

Coleman, D., Walker, J.S., Lee, J., Friesen, B.J., Squire, P.N., 2009. Children's beliefs about causes of childhood depression and ADHD: a study of stigmatization. Psychiatr. Serv. 60. https://doi.org/10.1176/appi.ps.60.7.950.

Corrigan, P.W., 2004. How stigma interferes with mental health care. Am. Psychol. 59, 614–25. https://doi.org/10.1037/0003-066X.59.7.614

Dey, M., Jorm, A.F., 2017. Social determinants of mental health service utilization in Switzerland. Int. J. Public Health 62, 85–93. https://doi.org/10.1007/s00038-016-0898-5

Dickinson, P., Coggan, C., Bennett, S., 2003. TRAVELLERS: A school-based early intervention programme helping young people manage and process change, loss and transition. Pilot phase findings. Aust. N. Z. J. Psychiatry 37, 299–306. https://doi.org/10.1046/j.1440-1614.2003.01181.x

Evans, R., Scourfield, J., Murphy, S., 2015. The unintended consequences of targeting: Young people's lived experiences of social and emotional learning interventions. Br. Educ. Res. J. 41, 381–397. https://doi.org/10.1002/berj.3155

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

Finn, S.E., Tonsager, M.E., 1997. Information-gathering and therapeutic models of assessment: Complementary paradigms. Psychol. Assess. 9, 374–385. https://doi.org/http://dx.doi.org/10.1037/1040-3590.9.4.374

Garmy, P., Berg, A., Clausson, E.K., 2015. A qualitative study exploring adolescents' experiences with a school-based mental health program. BMC Public Health 15, 1074. https://doi.org/10.1186/s12889-015-2368-z

Gore, F.M., Bloem, P.J.N., Patton, G.C., Ferguson, J., Joseph, V., Coffey, C., Sawyer, S.M., Mathers, C.D., 2011. Global burden of disease in young people aged 10-24 years: a systematic analysis. Lancet 377, 2093–102. https://doi.org/10.1016/S0140-6736(11)60512-6

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R., 2005. Mental health of children and young people, 2004. London: Palgrave MacMillan.

Greenberg, M.T., Domitrovich, C., Bumbarger, B., 2001. The prevention of mental disorders in school-aged children: Current state of the field. Prev. Treat. 4, 1–62. https://doi.org/10.1037/1522-3736.4.1.41a

Gronholm, P.C., Thornicroft, G., Laurens, K.R., Evans-Lacko, S., 2017. Conditional Disclosure on Pathways to Care: Coping Preferences of Young People at Risk of Psychosis. Qual. Health Res. 27, 1842–1855. https://doi.org/10.1177/1049732316680337

Gulliver, A., Griffiths, K.M., Christensen, H., 2010. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. BMC Psychiatry 10, 1–9. https://doi.org/10.1186/1471-244X-10-113

Huggins, A., Weist, M.D., Mccall, M., Kloos, B., Miller, E., George, M.W., 2016. Qualitative analysis of key informant interviews about adolescent stigma surrounding use of school mental health services. Int. J. Ment. Health Promot. 18, 1462–3730. https://doi.org/10.1080/14623730.2015.1079424

Humphrey, N., Wigelsworth, M., 2016. Making the case for universal school-based mental health screening. Emot. Behav. Difficulties 21, 22–42. https://doi.org/10.1080/13632752.2015.1120051

Kim-Cohen, J., Caspi, A., Moffitt, T.E., Harrington, H., Milne, B.J., Poulton, R., 2003. Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. Arch. Gen. Psychiatry 60, 709–717.

Kvist Lindholm, S., Zetterqvist Nelson, K., 2014. “Apparently I’ve Got Low Self-Esteem”: Schoolgirls’ Perspectives On a School-Based Public Health Intervention. Child. Soc. 29, 473–483. https://doi.org/10.1111/chso.12083

Link, B.G., Phelan, J.C., 2001. Conceptualizing Stigma. Annu. Rev. Sociol. 27, 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Link, B.G., Yang, L.H., Phelan, J.C., Collins, P.Y., 2004. Measuring mental illness stigma. Schizophr. Bull. 30, 511–541. https://doi.org/10.1093/oxfordjournals.schbul.a007098

Lupien, S.J., Ouellet-Morin, I., Trépanier, L., Juster, R.P., Marin, M.F., Francois, N., Sindi, S., Wan, N., Findlay, H., Durand, N., Cooper, L., Schramek, T., Andrews, J., Corbo, V., Dedovic, K., Lai, B., Plusquellec, P., 2013. The DeStress for Success Program: effects of a stress education program on cortisol levels and depressive symptomatology in adolescents making the transition to high school. Neuroscience 249, 74–87. https://doi.org/10.1016/j.neuroscience.2013.01.057

Martinsen, K.D., Kendall, P.C., Stark, K., Neumer, S.P., 2016. Prevention of Anxiety and Depression in Children: Acceptability and Feasibility of the Transdiagnostic EMOTION Program. Cogn. Behav. Pract. 23, 1–13. https://doi.org/10.1016/j.cbpra.2014.06.005

Meeus, W., Iedema, J., Maassen, G., Engels, R., 2005. Separation-individuation revisited: On the interplay of parent-adolescent relations, identity and emotional adjustment in adolescence. J. Adolesc. 28, 89–106. https://doi.org/10.1016/j.adolescence.2004.07.003

Merikangas, K.R., He, J., Burstein, M.E., Avenevoli, S., Case, B., Georgiades, K., Heaton, L., Swanson, S., Olfson, M., 2011. Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbitity Survey Adolescent Supplement (NCS-A). J. Am. Acad. Child Adolesc. Psychiatry 50, 32–45. https://doi.org/10.1016/j.jaac.2010.10.006.Service

Merikangas, K.R., Nakamura, E.F., Kessler, R.C., 2009. Epidemiology of mental disorders in children and adolescents. Dialogues Clin. Neurosci. 11, 7–20.

Michelson, D., Sclare, I., Stahl, D., Morant, N., Bonin, E.M., Brown, J.S.L., 2016. Early intervention for depression and anxiety in 16-18-year-olds: Protocol for a feasibility cluster randomised controlled trial of open-access psychological workshops in schools (DISCOVER). Contemp. Clin. Trials 48, 52–58. https://doi.org/10.1016/j.cct.2016.02.003

NUS Scotland, 2011. Breaking the silence. The follow-up report to Silently Stressed. National Union of Students Scotland, Edinburgh, Scotland.

Offord, D.R., Kraemer, H.C., Kazdin, A.E., Jensen, P.S., Harrington, R., 1998. Lowering the Burden of Suffering From Child Psychiatric Disorder: Trade-Offs Among Clinical, Targeted, and Universal

Interventions. J. Am. Acad. Child Adolesc. Psychiatry 37, 686–694. https://doi.org/10.1097/00004583-199807000-00007

Patel, V., Flisher, A.J., Hetrick, S., McGorry, P., 2007. Mental health of young people: a global public-health challenge. Lancet 369, 1302–13. https://doi.org/10.1016/S0140-6736(07)60368-7

Pitre, N., Stewart, S., Adams, S., Bedard, T., Landry, S., 2007. The use of puppets with elementary school children in reducing stigmatizing attitudes towards mental illness. J. Ment. Heal. 16, 415–429.

Pluye, P., Robert, E., Cargo, M., Bartlett, G., O'Cathain, A., Griffiths, F., Boardman, F., Gagnon, M.P., Rosseau, M.C., 2011. Proposal: A mixed methods appraisal tool for systematic mixed studies reviews.

Polanczyk, G. V., Salum, G.A., Sugaya, L.S., Caye, A., Rohde, L.A., 2015. Annual Research Review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. J. Child Psychol. Psychiatry Allied Discip. 56, 345–365. https://doi.org/10.1111/jcpp.12381

Prior, S., 2012a. Overcoming stigma: how young people position themselves as counselling service users. Sociol. Health Illn. 34, 697–713. https://doi.org/10.1111/j.1467-9566.2011.01430.x

Prior, S., 2012b. Young people's process of engagement in school counselling. Couns. Psychother. Res. 12, 233–240. https://doi.org/10.1080/14733145.2012.660974

Rapee, R.M., 2000. Group treatment of children with anxiety disorders: outcome and predictors of treatment response. Aust. J. Psychol. 52, 125–129.

Rapee, R.M., Wignall, A., Sheffield, J., Kowalenko, N., Davis, A., McLoone, J., Spence, S.H., 2006. Adolescents' Reactions to Universal and Indicated Prevention Programs for Depression: Perceived Stigma and Consumer Satisfaction. Prev. Sci. 7, 167–177. https://doi.org/10.1007/s11121-006-0035-4

Rickwood, D.J., Dean, F.P., Wilson, C.J., 2007. When and how do young people seek professional help for mental health problems? Med. J. Aust. 187, 35–39.

Rickwood, D.J., Deane, F.P., Wilson, C.J., Ciarrochi, J., 2005. Young people's help-seeking for mental health problems. Aust. e-Journal Adv. Ment. Heal. 4, 218–251.

Sanchez, A.L., Cornacchio, D., Poznanski, B., Golik, A.M., Chou, T., Comer, J.S., 2018. The Effectiveness of School-Based Mental Health Services for Elementary-Aged Children: A Meta-Analysis. J. Am. Acad. Child Adolesc. Psychiatry 57, 153–165. https://doi.org/10.1016/j.jaac.2017.11.022

Schomerus, G., Angermeyer, M.C., 2008. Stigma and its impact on help-seeking for mental disorders: what do we know? Epidemiol. Psichiatr. Soc. 17, 31–37.

Sclare, I., Michelson, D., 2016. Innovations in CBT for young people: Improving access and outcomes for vulnerable youth, in: Menzies, R.G., Kyrios, M., Kazantzis, N. (Eds.), Innovations and Future Directions in the Behavioural and Cognitive Therapies. Australian Academic Press, Samford Valley, QLD, pp. 34–38.

Sclare, I., Michelson, D., Malpass, L., Coster, F., Brown, J., 2015. Innovations in Practice: DISCOVER CBT workshops for 16-18-year-olds: Development of an open-access intervention for anxiety and depression in inner-city youth. Child Adolesc. Ment. Health 20, 102–106. https://doi.org/10.1111/camh.12060

Segrott, J., Rothwell, H., Thomas, M., 2013. Creating safe places: an exploratory evaluation of a school-based emotional support service. Pastor. care Educ. 31, 211–228. https://doi.org/10.1080/02643944.2013.788062

Sharpe, H., Ford, T., Lereya, S.T., Owen, C., Viner, R.M., Wolpert, M., 2016. Survey of schools' work with child and adolescent mental health across England: a system in need of support. Child Adolesc. Ment. Health 21, 148–153. https://doi.org/10.1111/camh.12166

Stafford, V., Hutchby, I., Karim, K., O'Reilly, M., 2016. "Why are you here?" Seeking children's accounts of their presentation to Child and Adolescent Mental Health Service (CAMHS). Clin. Child Psychol. Psychiatry 21, 3–18. https://doi.org/10.1177/1359104514543957

Thomas, J., Harden, A., 2008. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Med. Res. Methodol. 8. https://doi.org/10.1186/1471-2288-8-45

Thorley, C., 2016. Education, Education, Mental Health. Institute for Public Policy Research, London, UK.

Thornicroft, G., 2008. Stigma and discrimination limit access to mental health care. Epidemiol. Psichiatr. Soc. 17, 14–19. https://doi.org/http://dx.doi.org/10.1017/S1121189X00002621

Time to Change, 2013. Time to Change Children and Young People's programme. Interim pilot evaluation results; April 2012 to September 2013. Time to Change, London, UK.

Wahl, O.F., 2002. Children' s Views of Mental Illness: A Review of the Literature. Psychiatr. Rehabil. Ski. 6, 37–41.

Weems, C.F., Scott, B.G., Graham, R.A., Banks, D.M., Russell, J.D., Taylor, L.K., Cannon, M.F., Varela, R.E., Scheeringa, M.A., Perry, A.M., Marino, R.C., 2014. Fitting Anxious Emotion-Focused Intervention into the Ecology of Schools: Results from a Test Anxiety Program Evaluation. Prev. Sci. 16, 200–210. https://doi.org/10.1007/s11121-014-0491-1

Werner-Seidler, A., Perry, Y., Calear, A.L., Newby, J.M., Christensen, H., 2017. School-based depression and anxiety prevention programs for young people: A systematic review and meta-analysis. Clin. Psychol. Rev. 51, 30–47. https://doi.org/10.1016/j.cpr.2016.10.005

Yang, L.H., Kleinman, A., Link, B.G., Phelan, J.C., Lee, S., Good, B., 2007. Culture and stigma: Adding moral experience to stigma theory. Soc. Sci. Med. 64, 1524–1535. https://doi.org/10.1016/j.socscimed.2006.11.013