

## **Want to improve school mental health interventions? Ask young people what they actually think**

### **Abstract**

As part of the recent ‘therapeutic turn’ in education, schools are now commonly seen as a place for mental health guidance and support. This often involves *interventions* – special curricula of lessons or activities (e.g. counselling sessions), which aim to either prevent mental health problems or manage those that have already started. Running these interventions in schools makes good sense: rates of mental health problems in young people are rising, and large numbers can be reached in this setting. However, evidence for the effectiveness of such interventions has been mixed. One way to improve how helpful and useful they are, we argue here, would be to ask young people themselves what they think about these programmes. This involves collecting *qualitative* data: gathering in-depth information about young people’s experiences and opinions, rather than relying solely on numerical data, such as rating scales. The small number of existing published qualitative studies in this area show that many young people do find these interventions helpful, but that there are issues that warrant careful attention. For example, some young people can feel worried or vulnerable during classroom-based exercises, and others don’t see how the interventions are relevant for their own lives. Here, we explore this literature and recommend two avenues for future work: ask more young people what they think of existing interventions, and get them involved in the design of new ones. Together, this will put young people’s voices at the heart of school-based mental health interventions.

## **Introduction**

Imagine that you are a teenager, sitting in a classroom at your school, having a mindfulness lesson. It's part of the school day, and the teacher – maybe a teacher you know, maybe someone new from outside – explains mindfulness to you. They say that mindfulness is the state of being aware of the present moment without judgement, and that it can help you manage stress and difficult emotions. Together with your classmates, you then practice some mindfulness exercises. You might, for example, be asked to focus very carefully on the sensory experience of eating a raisin or a piece of chocolate, or you might be asked to simply shut your eyes, feel your feet on the ground, and bring your attention to your breathing. As you sit through this lesson, you are not only learning about mindfulness, you are also participating in something bigger: the recent so-called 'therapeutic turn' in education (Wright, 2014).

This refers to the recent widespread enthusiasm, in the UK and in many countries around the world, to use schools as a place to promote wellbeing and to prevent and treat mental health difficulties in young people. This makes good sense: schools play a central role in young people's lives and are where they spend a great deal of their time. Schools increase access to mental health guidance and services for everyone, including disadvantaged pupils who might otherwise be less likely to access such support. It's also what young people want: in a recent survey, 93% of participants aged 11-19 years thought that the topic of mental health and wellbeing should be taught at school (Cortina et al., 2021). This is all particularly important right now, as mental health problems are increasing: 16% of 5- to 16-year-olds had a potentially diagnosable mental disorder in 2020 (Vizard et al., 2020), up from 11% in 2017 (Sadler et al., 2018).

Mental health information in schools comes in many forms, such as a poster in the corridor about seeking support, a private conversation with a teacher, or an assembly on World Mental Health Day. But our focus here is *interventions* – a special curriculum of lessons or activities (e.g. counselling or peer mentoring sessions), which have usually been designed by mental health professionals or academic researchers, with a specific goal such as improving wellbeing or resilience, or reducing low mood or anxiety. Mindfulness, as described above, is a popular focus, but interventions can also be based on cognitive behavioural therapy (CBT), in which students learn about the relationship between thoughts, feelings and behaviour. Other interventions might focus on yoga, promoting positive thinking or techniques for how to cope with stress. These interventions can be *universal* – meaning they are taught to everyone in a class, or *targeted* – taught to a smaller group of students considered to have a specific need or difficulty (such as those who are already struggling with their mood).

A lot of time, effort and money goes into designing and delivering these interventions, so it's crucial to understand whether they actually work at improving young people's mental health. For example, if you ask a class of teenagers to sit through 10 lessons teaching them how to cope with low mood, has their mood actually improved by the end of the course or have they learnt useful coping strategies that they can draw on if the need arises in future? The answer is a tentative yes: interventions do often help young people. But there are a number of issues.

To start, universal interventions appear to have less of an impact than targeted ones – possibly because some individuals who take part in universal interventions don't actually need much help at all, or because the benefits of universal interventions are not measurable in short-term studies. But targeted interventions have their own problem: they involve identifying a small group of students and asking them to participate in a different activity to

their classmates, and research shows that selected students sometimes feel stigmatised for this: they report being bullied or mocked by their peers, or sometimes feel a personal sense of guilt and shame (known as ‘self-stigma’).

Second, when interventions do work, the average improvement in symptoms tends to be small and short-term (Gee et al., 2020; Werner-Seidler et al., 2021). This may be because researchers still don’t have a good grasp of ‘what works for whom’: maybe these lessons are really helpful for some young people and not at all for others, but we don’t understand who these groups are yet. The evidence so far has various suggestions for how to improve effectiveness – such as using external professionals to deliver the lessons rather than teachers, sticking closely to the lesson plans, and embedding interventions in a broader school climate that supports young people and promotes their wellbeing. These all help, to an extent. But we suggest here that, in addition, we need to be doing something else more often: ask young people what they actually think of all this.

When researchers ask for young people’s feedback after a school intervention, they often do this with *quantitative* data – numbers, essentially. The participants are asked to read statements like, ‘I found the lessons helpful’ or ‘I enjoyed the course’, and state how much they agree on a scale of, for example, 1 (Strongly disagree) to 5 (Strongly agree). Similarly, changes in symptoms are often measured using numerical scales. Quantitative evaluation like this tells you whether the intervention ‘worked’. It is useful as a broad-brush check to see whether young people improved or got something out of the programme. But when you only ask for numbers, you lose a lot of the detail. We argue that what we also need more of is *qualitative* evaluation – very broadly, evaluation that captures young people’s experience in words rather than numbers.

Qualitative data is usually gathered by interviewing participants, either alone or in focus groups, or by asking them to write down their thoughts in open-ended text boxes. The goal of qualitative research is to understand in-depth what a person's *experience* of a phenomenon is, and what their opinions, perceptions and views are. When you ask people to evaluate an intervention in words rather than numbers, you gain a far more detailed understanding about what the individual thinks and feels. You can understand their own suggestions for how interventions might be improved, their perceptions of how the intervention affected them (beyond what a researcher might decide to measure), and their thoughts about *why* the intervention affected them, including perceived helpful and unhelpful aspects, and their likes and dislikes. Qualitative research helps you to understand why young people might not have engaged with an intervention or why implementation was not successful, including unearthing potential unintended consequences. Thus, it increases the chance that you will capture opinions and viewpoints that you might miss using only numerical scales. When it comes to school-based mental health interventions, qualitative research is a key path through which we can improve these programmes. It will also help answer the question of what works for whom, as it can help us much more fully understand why interventions sometimes work really well, and why they sometimes don't.

We're certainly not the first to suggest this. Researchers have already made efforts to gather young people's views through qualitative methods, and we will draw on this work below. But the insights gleaned from this existing work show that we need to do and publish much, much more of it. Below, we therefore consider four questions that should be explored (or explored more) with qualitative techniques, and then suggest how this might be achieved.

## **1. What do young people think about practical classroom exercises?**

Classroom exercises – such as breathing exercises or group discussions – are common in school-based mental health interventions. In general, research shows that young people like hands-on practical exercises like this, more so than the parts of the lesson where the teacher explains the theory and ideas behind the approach. For example, some young people report that in-class mindfulness practices are relaxing, and that they like discussing their feelings with classmates (Bannirchelvam et al., 2017). In another study, children aged 7-11 years who participated in a CBT-based course even expressed a desire for longer lessons, to allow more time to do hands-on activities (Skryabina et al., 2016).

However, these exercises have to be done in front of classmates, and this can have important implications, especially for secondary school students. Adolescence is a period of huge psychological change, during which young people become more self-conscious and more concerned about the opinions of their peers. For some adolescents at least, doing exercises in front of classmates can therefore be stressful or difficult. In one study, for example, some participants described feeling uncomfortable during practical mindfulness exercises that involved closing their eyes, because they felt unsafe not being able to see their classmates (Hailwood, 2020). Relatedly, a study that evaluated a yoga intervention found that some participants, particularly boys, were worried about being judged by their classmates (Conboy et al., 2013). One participant said: ‘I didn’t get as much out of it because I was more focused on what my friends would think about me while I’m doing the yoga’. This is crucial: it’s irrelevant how good these exercises are in theory if young people find them socially unacceptable (or worse, unsafe) to do in front of their peers.

Other programmes encourage young people to share private thoughts and feelings in class, and this too can make some students feel vulnerable. For example, one study asked teenage girls in Sweden what they thought about the DISA (Depression In Swedish Adolescents) programme, which is designed to prevent depressive symptoms (Lindholm & Zetterqvist Nelson, 2015a). It's based on CBT principles, and includes group discussion exercises in which participants reflect together on the relationship between their thoughts, feelings and behaviour. In other words, it requires young people to talk about themselves in front of their classmates. When interviewed afterwards, teenage girls who had taken part in DISA say they felt conflicted about this aspect of the course. In one respect, they found it helpful to discuss their difficulties as a group and felt closer to their classmates as a result, but they also said it was stressful to share private information, particularly for the girls who were bullied or who had difficult relationships with their peers. One participant said: 'It depends on whether the group consists of people who are reliable or not but you can never know that. Like among youth there's a lot of trash talk going around all the time so you can never really trust anyone you don't know well... there are a lot of people who like to put others down and well spread talk around'. This concern is not unfounded: in another study, one participant described how a worry that he had discussed in a mindfulness class was then shared on social media (Hailwood, 2020).

Understanding how practical exercises are actually experienced by young people could help researchers to design and adapt interventions so they are more enjoyable and acceptable, and potentially more effective. For example, to reduce feelings of self-consciousness, it should be clear that students don't have to share their thoughts in a group discussion if they don't feel comfortable. Ground rules could be set at the outset of sessions to remind participants about respect for others and confidentiality, or participants could be given opportunities to reflect

on their thoughts and experiences more privately (e.g. reading handouts or completing worksheets). This solution can be tricky though: research has shown that interventions work best when the staff delivering them stick closely to the guidelines; if adjustments are made on an ad-hoc basis, they could make the intervention less effective. A better solution might be to do away with personal group discussions altogether, and focus on the experiences of real or fictitious students outside the immediate classroom. For instance, one evaluation of the Teen Mental Health First Aid programme in Australia – which is designed to help young people support their peers who have mental health problems – found that participants particularly liked watching videos of other young people describing their lived experience of such difficulties (Johnson et al., 2021). Whatever approach is taken, the viewpoint and developmental needs of adolescents should be considered during classroom-based activities, ideally when the intervention is being designed so that changes don't have to be made on an ad-hoc basis. This speaks to the importance of piloting interventions prior to widespread roll-out, as well as to the value of working with young people to co-design interventions, which we discuss further below.

## **2. Do young people use and benefit from the interventions in their everyday lives?**

It is important to understand how young people think and feel during the course, but qualitative research can also clarify whether they continue to use the suggested strategies after the course has finished. The small body of existing qualitative research indicates that many young people do continue to use the techniques they were taught to manage their mental health. One study of primary school children, for example, found that many of them used mindfulness techniques to manage situations in which they experienced difficult emotions, such as before a test or after an argument with a sibling (Bannirchelvam et al., 2017). In another study, some of the participants (aged 7-11) who completed a CBT-based



course reported using the techniques after the programme had finished, such as changing ‘red’ (anxiety-increasing) thoughts to ‘green’ ones (Skryabina et al., 2016). Qualitative studies also show that some young people report lots of subsequent benefits after completing these programmes: they feel better about themselves, are better able to manage their emotions, have improved relationships with others, and feel that they have more techniques to solve their problems.

However, some young people don’t seem to do much at all after the course has finished, and it’s equally important to understand their experiences. In fact, evidence suggests that *not* implementing the strategies might actually be relatively common. For example, one study asked adolescent participants how frequently they used each of four techniques after the mindfulness course had finished (e.g. doing a mindfulness practice in bed to help them fall asleep); for three of the four practices, although there was a range of responses, the most common response category was that they ‘never’ used the technique (Kuyken et al., 2013).

Future qualitative work would help researchers unpack why this is. It could be that the techniques are only helpful for certain individuals with specific difficulties. For example, one participant who took part in a yoga and mindfulness intervention stated that she didn’t use the techniques afterwards because they couldn’t help her with her specific problem, namely anger in herself and others: ‘No, because I haven’t really done [any of the exercises]. It didn’t help me because I ... like I can’t, you can’t breathe through it. ‘Cause my friend makes me angry. My family has bad anger’ (Dariotis et al., 2016). It also remains unclear the extent to which young people find the techniques learned through school-based interventions useful for navigating major stressful events in their lives, such as parental divorce, bereavement, or illness, or high levels of mental distress. For these individuals, generic universal interventions

that promote ways of coping with stress may not be enough; targeted interventions that are specifically designed to help with these experiences may be more beneficial.

In contrast, some young people may not use the strategies they've learnt because they feel that they don't need them. For example, some teenage participants who took part in the DISA intervention said that the course might be useful for other young people, but not for them, because they didn't personally experience negative thoughts and were not 'unwell' themselves (Lindholm & Zetterqvist Nelson, 2015a). This highlights a complex challenge for universal interventions: by definition, they are delivered to all young people, which will include some individuals with serious mental health difficulties and/or external life stress, but also many young people who do not have significant levels of mental health problems or major life stress. More future studies should assess which young people do and don't make use of the exercises after the course has finished, and why that might be, and how this may differ between universal and targeted interventions. It would also be useful to follow up the participants some time later, for example 6 or 12 months after the end of the course.

Researchers could explore the degree to which young people remember the techniques that they learnt, and whether they used them in times of need at a later date, even if they did not use them soon after the intervention.

### **3. Do interventions meet the needs of diverse populations of young people?**

Qualitative data would also provide more detail about how young people with different demographic characteristics experience school interventions, including those from marginalised or minority groups. To date, existing qualitative evaluations have often been limited in this respect. For example, in many studies, the majority of (or all) participants are either white, middle class or both, or the study doesn't provide ethnicity or socioeconomic

status (SES) information. But individual characteristics may have an important impact on how the intervention is experienced or how effective it is. For instance, LBGT+ individuals are more likely to get bullied and harassed by their classmates, compared to their heterosexual cisgender peers (Kahle, 2020), and they also report feeling less safe at school (Rose et al., 2018). This has obvious potential consequences for their experience of classroom-based mental health interventions, which can involve discussing or at least thinking about private emotions, self-identity, and relationships with peers. There have been calls for school counsellors to have better training on the unique needs of LBGT+ individuals, and for schools in general to have a better understanding of how to help these young people feel safer. The best way to improve school-based mental health interventions for LBGT+ young people, therefore, would be to ask for their input and feedback, particularly regarding the extent to which they feel safe participating, and the applicability of the concepts and exercises to their lives. More generally, the degree to which the experience of interventions varies by different demographic characteristics, such as ethnicity, gender or SES, is an important avenue for future qualitative (and indeed quantitative) research.

#### **4. Are there any downsides to interventions?**

The goal of school-based mental health interventions, of course, should be to improve young people's mental health. Although specific approaches vary, interventions often teach young people to recognise and label their emotional states (e.g. 'sadness', 'anger'), and then to manage or alter them in some way (e.g. by carrying out a mindfulness breathing exercise). Learning about emotions in this way can be very helpful: it is a key principle for established, effective therapeutic approaches, such as CBT. It can help young people recognise difficulties that they may be experiencing and explain to others how they are feeling, and young people themselves generally report finding this aspect of school-based mental health interventions

meaningful and practically useful. However, it is crucial that we have a good understanding of whether these interventions might sometimes unintentionally make some people feel worse, even in a minority of cases. Again, this is exactly the kind of question that can be carefully probed with qualitative approaches.

First, it's possible that learning about mental health might make young people think that common emotions and experiences, such as exam stress and mild anxiety, are psychologically abnormal or medical issues. Emphasising certain language (e.g. diagnostic labels such as 'depression' and 'anxiety') could encourage some young people to interpret common emotions in this way. In turn, this can send them the message that they are by default vulnerable and fragile, instead of resilient and capable (Ecclestone, 2007). If the right balance is not struck, then encouraging groups of young people to focus on their emotions might actually make them feel worse. There is some evidence to support this idea: negative emotions can be contagious (as can positive ones), and adolescents in particular are likely to be influenced by their peers. Young people can influence one another to self-harm, and there are media guidelines about how to discuss suicide because of the well-documented phenomenon of copycat suicides. There is also the phenomenon of 'co-rumination', in which friends who excessively, unproductively discuss their problems together can end up feeling worse. For example, one study found that co-rumination was associated with later increased symptoms of depression and anxiety in adolescent girls (but not boys; Rose et al., 2007).

Together, this all suggests that messages that come from both mental health interventions and peers might meaningfully affect how young people view or label their emotional experiences.

Surprisingly little research has actually directly assessed whether school interventions might make some young people feel worse. One review of qualitative studies found that young

people sometimes criticised the negative framing of school-based mental health interventions (Bastounis et al., 2017). For example, adolescents who completed a CBT-based programme found much of the course useful, but commented that trying to identify negative thoughts in class made them feel low, even when they had initially felt positive (Garvey et al., 2015). In another study evaluating the same programme, one participant said: ‘I mean, it’s like you start thinking like that... that you have low [thoughts] because they bring it up all the time, negative thoughts and that you should change that all the time. But those who sort of have positive [thoughts], they start thinking negative in the end’ (Lindholm & Zetterqvist Nelson, 2015b). Interventions therefore have the nuanced task of teaching emotional awareness and coping skills without inadvertently teaching participants to ruminate on their feelings in an unhelpful way that might make them feel worse. Asking for young people’s feedback could help to determine when, how, and for whom increased distress might occur, and what could be put in place to mitigate or manage this.

### **How to gather and incorporate young people’s perspectives**

Here, we suggest how existing qualitative research could be expanded upon to provide richer, more useful evidence for improving future interventions. First, future research should try and canvas the experience of students with a wider range of experiences and opinions of the intervention, including those who dropped out or who did not like the programme. Existing qualitative evaluations often ask for feedback by asking participants, at the end of the intervention, to volunteer to take part in an additional study. This might mean that only students who are enthusiastic about the intervention sign up to talk about it more. One way to solve this problem could be to ask all students to rate numerically how much they liked the course or how helpful they found it. Researchers could then use this quantitative information to invite students with a range of opinions to participate in qualitative interviews to share

their thoughts in more depth. Ideally, the interviews should be conducted by independent researchers who don't have a stake in the intervention or ongoing involvement with the pupils at school (i.e. not a teacher); this should encourage young people to share their thoughts and feelings openly and honestly.

Future studies should also try to gather feedback from a larger, more diverse population of young people. It would be unwise to drastically change any intervention based on the opinions of a small number of self-selecting participants. One study, for example, interviewed 42 young people who took part in a CBT-based programme, out of a total of 5,030 participants (Taylor et al., 2014). While reasonable for a qualitative sample size, given the time, capacity, and budget that in-depth qualitative research often requires, this still potentially misses many important viewpoints. Future evaluation studies should therefore endeavour to explicitly ask for feedback from a wide range of students, including those across different school settings, from diverse sociodemographic or cultural backgrounds, with varying experiences of mental health difficulties, and with differing views on and experiences of the intervention. Open-ended surveys could facilitate this: this would still be qualitative data, but would allow a larger number of participants to be reached than are typically recruited for focus groups or interviews (Braun et al., 2021).

Research that evaluates interventions could also be improved if it specifically asked young people how they have interpreted the language and concepts taught to them during the course. In other words, researchers should not only ask what participants liked and didn't like, but also what they understood. This is important because the limited studies to do this have shown that young people don't necessarily absorb the intended message of the intervention. For example, after a course of mindfulness lessons, young people were asked in focus groups

what they thought mindfulness ‘was’ (Hailwood, 2020). A core concept of mindfulness is awareness – observing and noticing your internal and external experience without judgement – but this definition was rarely conveyed in participants’ answers. Instead, some participants described mindfulness as a technique for controlling your emotions (for example, one student said, ‘It controls what’s inside’), which is arguably the exact opposite of how mindfulness should be understood.

Another study asked 15-year-olds about their understanding of the words ‘anxiety’ and ‘depression’ in general, although not in the aftermath of a specific school intervention (Lindholm & Wickström, 2020). The researchers found that participants tended to give these words new meaning, adapting them from how they were originally intended as diagnostic terms. For example, some participants used the terms ‘anxiety anxiety’ and ‘real anxiety’ to distinguish anxiety as a clinical phenomenon from anxiety as an everyday emotion (e.g. one participant said, ‘I have anxiety but I don’t have real anxiety sort of’). In addition, the term ‘anxiety’ was often used synonymously with ‘feeling low’, even though, in mental health research, ‘feeling low’ is considered a key aspect of depression rather than anxiety disorders. Language is always evolving, and it’s understandable that young people develop their own interpretation of the terms they have been given. However, when it comes to sensitive mental health interventions, this can lead to difficulties, such as diagnostic labels being diluted or undervalued for the young people who need them the most. This suggests that future research should therefore closely monitor how the messages and language of these programmes have actually been understood by young people, and adjust them in future interventions as necessary, to ensure that these terms are used in as helpful a way as possible.

**Involve young people at all stages of intervention design and research**

A second way to ensure that young people's perspectives are included is to involve them from the outset in the design, implementation and evaluation of an intervention. This is known as *co-production*, an approach that involves designing, delivering and evaluating services in collaboration or partnership with people who use or have used similar services. The oft-used mantra of co-production is 'nothing about us without us' (Charlton, 2004). Co-production is valuable because young people are experts by experience and therefore have a meaningful and different perspective to academics or policymakers. Young people can personally benefit from the process too: for example, by gaining new skills, developing their self-confidence and meeting new people.

A small number of studies have demonstrated that co-production can be used for school-based mental health interventions. For example, a targeted intervention for depression had extensive input from young people with experience of the disorder, parents, teachers and clinicians (Pile et al., 2021). This included an initial workshop about the overall approach of the study and detailed discussions about the intervention's content and delivery (the intervention involved one-to-one therapy using a technique called 'imagery rescripting', in which people are taught to recall negative memories in a more helpful way). A number of adaptations were made on the basis of this input, including some that were specifically relevant to the school setting, such as encouraging participants to take time to process the therapy session before returning to class and maximising the sense of safety felt while having therapy in a school (rather than clinical) setting. However, to date, most co-production work involving school-based mental health interventions has focused on targeted interventions. A key target for future research is therefore to implement co-production principles when designing universal interventions, as well as to assess whether co-production improves outcomes, acceptability and engagement.



When doing so, the school context should be fully taken into account. Co-production usually helps to redress the power imbalance that exists between those who design or deliver interventions and those who use them, but there is an added complexity when trying to do this in the context of school-based interventions. To quote one group of researchers, youth-led research within schools occurs ‘in a hierarchical institution often characterised as a mechanism for social control and reproduction of social inequalities’ (Ozer et al., 2013). Evidence to date suggests that this limits the extent to which young people can communicate their ideas and effect change. One study found that young co-researchers who worked within schools described several challenges, including negative responses to their ideas from staff, limited resources, and a sense that adults dictate which of their concerns should and should not be discussed (Kohfeldt et al., 2011). These findings should be taken into account when determining how to co-produce school-based interventions with young people, which by definition must take place within the existing boundaries and structures of the school, to try and maximise a sense of usefulness and empowerment within young collaborators.

## **Conclusion**

Over the last decade, school-based mental health interventions have proliferated as a means of promoting wellbeing and preventing or treating mental health problems in young people. Evaluations indicate that these interventions can be effective, but they do not help everyone. One way to improve their effectiveness would be to gather more qualitative data about how young people themselves experience these interventions, during the design and delivery phases, as well as after the course has taken place. The limited existing published qualitative research indicates that many young people do find school-based mental health interventions meaningful and useful, but some participants express concerns, such as feeling self-conscious

or vulnerable during classroom-based exercises. In order to maximise the effectiveness of these programmes, researchers should gather in-depth data on the experiences of a diverse range of young people, and integrate this carefully into the design, implementation and evaluation of future interventions.

The call we make here for more qualitative data complements and extends debate around the philosophical questions, concepts and approaches that are in focus elsewhere in this special issue. For example, the philosophical tradition of phenomenology primarily focuses on analysing and understanding an individual's lived experience, which is often reflected within qualitative research. There is also overlap with the philosophical concept of epistemic injustice – the notion that some individuals may wrongfully be excluded from knowledge that affects them. This is particularly relevant when we discuss the extent to which young people are involved in the design, implementation and evaluation of school-based interventions. Lastly, we touch on a broader philosophical question relating to the language used in mental health interventions in schools, which is covered in more detail elsewhere in this collection. Qualitative research methodology is underpinned by and works in harmony with philosophical theory; together, the two disciplines can be used to design school-based mental health approaches that best serve all young people.

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