Brief Behavioural Activation (Brief BA) in secondary schools: a feasibility study examining acceptability and practical considerations

Article

Accepted Version

Brief Behavioural Activation (Brief BA) in secondary schools: A feasibility study examining acceptability and practical considerations

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Manuscript accepted for special issue publication in Educational & Child Psychology, Sept 2018, accessible at https://shop.bps.org.uk/publications/publication-by-series/educational-and-child-psychology.html

Abstract

Aims: This paper reports on a feasibility study of delivering Brief Behavioural Activation in schools, focusing on acceptability, demand, implementation, practicality, adaptation and integration.

Rationale: Depression in adolescence is a common and serious mental health problem, with long-term negative impacts on social and academic functioning. In the UK, access to evidence based psychological treatments is limited and training and employing therapists to deliver these is expensive. Treatments are typically offered in specialist Child and Adolescent Mental Health services (CAMHs) following a General Practitioner (GP) referral, yet few depressed young people seek help from their GP or other health professionals. In the UK there are current proposals to significantly increase the role of schools in providing access to mental health treatment for children and young people but currently there is little evidence that this is acceptable, feasible or effective.

Behavioural Activation (BA) is an evidence-based treatment for depression in adults. BA has recently been adapted for young people (Brief Behavioural Activation; Brief BA, Pass & Reynolds, 2014). The adaptation is developmentally sensitive, acceptable to parents and young people, links behaviours to values and is highly collaborative.

Method: Brief BA was introduced into five schools where feasibility data were collected. Brief BA was delivered by four therapists from differing professional backgrounds and experience.

Findings: Initial data suggest that Brief BA is feasible to deliver in schools. Brief BA was integrated successfully with some adaptation, demand was high, and the service was highly acceptable to students, parents and school staff.

Conclusions: This study provides early evidence to support the use of Brief BA to treat adolescent depression in schools, with clear learning points for future feasibility evaluation.

Introduction

Adolescent depression

Depression in adolescence is a common mental health problem. Around 2.5% of young people have an episode of depression at any one time, both in the UK (Ford *et al*., 2013) and worldwide (Polanczyk *et al*., 2015). Rates of depression rise steeply at the onset of puberty, particularly in girls (Hankin *et al*., 1998). Both clinical and subclinical depression predict many adverse outcomes including depression and other mental health problems in adulthood (Dunn & Goodyer, 2006; Naicker *et al*., 2013), poor academic attainment and lower lifetime income (Fergusson *et al*., 2005; Fergusson *et al*., 2007).

The core symptoms of depression in young people are depressed mood or irritability, and/or loss of interest or pleasure (anhedonia). Additional symptoms include sleep and appetite disturbances, fatigue, psychomotor changes, cognitive disturbances, negative self-perceptions and suicidal ideation (American Psychiatric Association, 2013). Irritability is often misinterpreted as a sign of behavioural difficulties; this can be particularly common in males who may feel less comfortable describing feelings of sadness or low mood (Kilmartin, 2005). Cognitive and motivational disturbances are also common (Orchard *et al*., 2017) leading to difficulties with concentration and completing academic tasks.

Access to treatment

In the UK, access to evidence based psychological treatments is mainly provided by specialist Child and Adolescent Mental Health services (CAMHs). However, only a small proportion of young people in psychological distress seek help (Gulliver *et al.*, 2010) and there are significant barriers to young people seeking and receiving help including perceived stigma, infrequent contact with health services, waiting times and lack of knowledge about mental health (Plaistow *et al*., 2014). Even if a young person does receive a referral to CAMHs, many services have high thresholds for acceptance and long waiting times for accessing treatment (Frith, 2016).

For these reasons, it is critically important to make evidence-based treatments more acceptable and accessible to young people. One promising route is through schools (Humphrey & Wigelsworth, 2016). Almost all young people spend extensive time at school, for most of the year, and for many years. Schools are increasingly encouraged to improve support and treatment to students with mental health difficulties but there is limited evidence to guide decision-making. Many UK schools offer non-directive counselling and consult with educational psychologists about students of concern, suggesting that schools can accommodate therapeutic services. Delivering interventions within a school setting may have an additional benefit of involving school staff in identifying students with mental health problems, providing a more integrated approach to interventions and awareness of contextual factors relevant to the presenting difficulties.

The Department of Health (DoH) and Department for Education (DfE) recently published a joint plan to provide mental health support and treatment in schools (DoH & DfE, 2017). This would include new mental health support teams working directly in schools and colleges to provide early intervention and ongoing help for mild-moderate mental health difficulties. However, the exact way in which these teams will operate, the types of interventions offered and how they can be evaluated has not been determined.

There are a range of promising treatments for common mental health problems in children and young people. These include Brief Behavioural Activation (Brief BA; Pass & Reynolds, 2014), a structured, time-limited treatment for depression in adolescents. Brief BA can be successfully delivered in CAMHs by a range of professionals (Pass *et al.,* 2017) including non-specialist clinicians (Pass *et al.,* 2017). It is brief and manualised, suggesting that it might be suitable for delivery in schools by a range of professionals thereby extending the range of therapeutic options available to students at school. In addition, psychologists already working in schools and colleges would be ideally placed to deliver this treatment and/or supervise other staff with appropriate training.

Scope of the study

This study evaluated the feasibility of delivering Brief BA in schools as a way of increasing access to psychological therapy for help seeking adolescents with symptoms of depression. Bowen *et al*. (2009) propose that a feasibility study is useful in a number of situations, including when community partnerships need to be established and when an intervention has had positive outcomes but in a different setting; both of which apply to Brief BA in schools. The current paper focuses on six of the eight areas of feasibility research proposed by Bowen *et al*. (2009): acceptability; demand; implementation; practicality; adaptation; and integration. We aim to answer the initial feasibility question 'Can Brief BA be delivered in schools?' Future publications will evaluate the effects of Brief BA in schools on a range of outcomes including self-reported depression symptoms, general functioning, and school attendance and attainment (i.e. to consider the final two areas of focus in feasibility work, expansion and limited efficacy-testing; Bowen *et al*., 2009).

Method

Participants

Thirty-two young people aged 11 to 18 (22 girls, 10 boys, 83% White British) received Brief BA treatment at school. All were fully informed about the nature of the study and treatment, including the ability to withdraw at any time. Written assent (for 11-15yr olds) or consent (for 16-18yr olds) was collected from all students, along with written consent from a parent/carer. In this feasibility study the inclusion criteria were broad so that we could assess the maximum likely demand and general acceptability of the treatment. Our inclusion criteria were:

- Elevated symptoms of depression assessed by self-report (RCADS depression subscale or SMFQ) or diagnostic interview (K-SADS)

- Help seeking (identified by school staff or from the 'Would you like help?' questionnaire)
- Parental consent and contact details for parents

Exclusion criteria were:

- Currently receiving psychological or psychiatry treatment
- Diagnosis of ASD, ADHD, eating disorder, ODD/CD, psychotic symptoms or learning difficulties (young people were referred to services where targeted treatments for these difficulties were provided)

Schools

Five schools took part in this pilot study between April 2016 to September 2017. All are mixed sex, state secondary schools (age 11-18) with comprehensive entry and with catchment areas representing a variety of socio-economic backgrounds. They varied in size from 700 – 1800 pupils and Ofsted ratings ranged from 'Good' to 'Requires improvement'.

Brief BA therapists

Four therapists delivered Brief BA in schools. They were a Clinical Psychologist (LP) who initially trialled the treatment in schools, an Educational Psychologist (MS) taking a one-year CBT course, and two recently qualified Psychological Wellbeing Practitioners (PWPs; SB, MJ), trained to deliver low intensity psychological treatments with adults. The PWPs were given additional training to work with young people. Brief BA therapists received weekly supervision from a Clinical Psychologist (LP, who for her cases received supervision from another Clinical Psychologist).

Intervention

Brief BA is based on the behavioural theory of depression with a focus on reinforcement (Lewinsohn, 1974). Brief BA focuses on increasing positive reinforcement for non-depressed behaviours (Lejuez *et al*., 2011; Pass *et al*., 2016). It includes six to eight face to face sessions delivered twice or once a week. The therapist and young person work collaboratively to identify the young person's personal values, then identify, plan and engage in activities in line with these values. This increases positive reinforcement for non-depressed behaviour, decreases negative reinforcement for depressed behaviour and improves mood by increasing the proportion of intrinsically rewarding activities. Routine measures to monitor symptoms, functioning, and experience of treatment are collected at every treatment session (see Pass *et al.*, 2017) and parents are involved to support and reinforce positive behaviour change.

Procedure

Young people with symptoms of depression were identified in a variety of ways. Some were identified by teaching and pastoral staff, others replied positively to a school survey of mental health (where students were informed this would lead to them being identified for possible interventions like Brief BA). In all cases a school staff member briefly discussed the study with students and parents before gaining consent to pass on contact details to the study team. Once identified all parents and young people were given information about the treatment. All potential participants were assessed at school to confirm depression symptoms. Parents were contacted by telephone before and after assessment, and parental and young person written consent was obtained for treatment to be delivered at school and for routine outcome measures to be collected and used for evaluation purposes. Therapy sessions were delivered during the school day and scheduled around the school timetable. Sessions were audio-recorded and routine outcome measures were collected at each session. Young people received four to eight sessions of treatment at school, and a review session around four weeks after the final treatment session.

Measures

The following measures (all with good psychometric properties and valid for use with adolescents) were used to help determine demand, by identifying low mood/depression symptoms and a desire to seek help for these difficulties:

The Short Mood and Feelings Questionnaire (SMFQ: Angold *et al.*, 1995). The SMFQ was used on school wide surveys to screen for possible mood difficulties (a score of 8 or above is suggestive of mood difficulties; Angold et al., 1995).

Would you like help? Questionnaire. On the school-based surveys, students were invited to identify if they would like help for low mood/depression and other difficulties (anxiety, bullying, eating difficulties, keeping up with schoolwork, self-harm, suicidal thoughts).

Diagnostic interview. Following screening (via staff referrals or surveys), young people took part in an abbreviated diagnostic interview to establish depression symptoms and diagnoses based on the depression section of the DSM-5 version of the Kiddie Schedule of Affective Disorders and Schizophrenia (K-SADS; Kaufman *et al*., 2013).

Risk assessment and safety plan. At assessment, all young people were asked about risk to self (including self-harm, suicidal thoughts and plans/actions), risk to others and risk from others. Where any risk was identified, a safety plan (practical worksheet outlining ways to keep themselves safe and who to contact if feeling distressed) was completed and included emergency contact information and helpline numbers. Risk information was shared with the school safeguarding team and parents/carers (following school-specific safeguarding policies), including any additional advice on how caregivers could keep the young person safe (e.g. increased supervision, removing access to means of harm).

Revised Child Anxiety & Depression Scale (RCADS; Chorpita *et al*., 2000). The RCADS is a 47 item screening measure of anxiety and low mood in young people, and was completed before and after treatment.

Session by session measures. Young people completed routine outcome measures at each session (in line with the CYP IAPT requirements in healthcare settings). These were the RCADS depression subscale, Outcome Rating Scale (Miller & Duncan, 2000); and Session Rating Scale (Duncan et al., 2003). These are used to monitor change and discussed in each session with the young person and in supervision (see Pass *et al.*, 2017 for details).

Additional data on feasibility

Other data were collected to assess demand and acceptability, including numbers of schools approached, number of students screened, uptake of Brief BA assessments and treatment, and session attendance. Regular (at least termly) meetings were held with key staff at each school to assess all aspects of feasibility and determine whether it was possible to continue Brief BA in each school. This also enabled learning from other school sites to be shared, and school-specific adaptations identified.

Results

In this section each of the six aspects of feasibility (Bowen *et al*., 2009) appropriate to this stage of the study is evaluated in turn.

Demand

A key factor in a feasibility study is to assess demand for the proposed intervention. For this study, demand was measured by the level of need for a specific depression/low mood intervention, as identified in the school setting. Initially school pastoral teams made direct referrals of students who appeared to be struggling with mood problems and did not meet any of the exclusion criteria. However, feedback from school staff suggested that

many lacked confidence in identifying students with depression symptoms and had very little protected time to consistently manage the referral process.

A second route to identify young people via screening was trialled in one school. Students (N = 356, 63.9% of Year 7-13 students, excluding Year 11 who were on exam leave) completed the Short Mood and Feelings Questionnaire (SMFQ) and were asked if they would like to receive help for a range of difficulties, including low mood/depression (the 'Would you like help?' questionnaire). On the SMFQ, 110 students (31.8% of those with sufficient data) scored above the threshold for potential low mood difficulties (a total score of 8 or higher). Of these, 22 students (18.2%) indicated that they would like help for low mood/depression while another 17 (15.5%) reported they were already receiving some form of help for this. This method also identified 88 students who wanted help for other issues (e.g. bullying, keeping up with schoolwork, anxiety). This led to an increase in workload for the school safeguarding team which was not problematic in this school but could raise capacity issues in other schools.

Acceptability

Feasibility also relies on schools being willing to collaborate on a specific mental health intervention, and for students and parents to be willing to take part. The initial barrier with schools was getting the study information to the most relevant (and senior) member of staff, so they understood the potential benefits of providing an evidence-based treatment for depression, as well as resource implications for the school, e.g. the workload demands on their staff team. Once this was made clear to the school, all who were approached agreed to take part.

Table 1 outlines the flow of participants through each stage of the Brief BA in schools process. Acceptability of school based Brief BA assessments was extremely high, with all parents who could be contacted (*n* = 39, 98%) and 95% of young people contacted providing consent for this. Engagement of young people in Brief BA treatment has also been excellent, indicating that the approach is highly acceptable to young people. Thirty-four

students were assessed and 32 were suitable for Brief BA and started treatment (with 100% of young people and parents taking up the offer of treatment in school). The use of routine outcome measures (ROMs) has also been received positively by students and parents. All cases (100%) have paired data from at least two contact points, and over 90% of cases have ROMs completed at every session, indicating that it will be possible to closely monitor outcomes to evaluate the effectiveness of this approach to treating depression.

[Table 1 about here]

By September 2017, 30 young people (94%) had completed treatment and had attended all sessions (one student stated he "couldn't be bothered" to attend one of his Brief BA sessions during a heatwave, but this was re-arranged and he attended the remaining sessions). Two (6%) cases ended treatment early. One Year 11 girl disclosed a significant eating disorder during Brief BA treatment and was referred to specialist CAMHs for treatment. One Year 10 girl had poor school attendance and challenging relationships with school staff and withdrew from treatment as her school attendance reduced further. The Brief BA therapist liaised with her mother and recommended a GP appointment to seek referral to specialist CAMHs.

A key finding from school review meetings was that school staff reported significant additional benefits from having mental health expertise in the school setting. For example Brief BA therapists have provided an urgent assessment after a student disclosed suicidal thoughts and preparatory acts to a teacher. They have also facilitated referrals to specialist CAMHs for a young person with psychotic symptoms, to counselling services for bereavement, and to social care for support for a young carer. As a result these additional roles have now been integrated into the Brief BA therapist job plan, given this input is seen as so valuable by schools.

Implementation & Practicality

Even when a new treatment and delivery approach is acceptable to stakeholders and there is sufficient demand, it will not be feasible unless the treatment can actually be implemented and it is practical to do so. Several factors have significantly affected the feasibility of implementing Brief BA in schools (see Table 2). Of these the most critical is visible and direct support from the school senior leadership team. This ensures that resources and systems are in place to identify, assess, and treat young people. After two terms we had to withdraw resources from one school where the senior leadership were not involved, and a major staff restructuring led to loss of pastoral leads who had been the main contacts for the therapy team. This meant Brief BA was not feasible within this specific school setting, as it was not possible to implement Brief BA in way that was safely co-ordinated with the school pastoral support system. Implementation has been much more successful in schools where there is direct involvement by school leaders. We have learnt that it is essential that ownership of the project is shared by the leadership team; school staff turnover is high and other forms of collaboration are very vulnerable to staff changes.

A second critical aspect of implementation is managing risk in the school setting in line with school safeguarding procedures. Suicidal ideation is a common symptom of depression in young people (Orchard *et al*., 2017), and self-harm and other risky behaviours are also frequently reported. As indicated in the Measures section, a thorough risk assessment was conducted with each student at the initial assessment, including direct questions about self-harm, suicidal thoughts and plans/actions. Risk assessment was also included in every treatment session. Asking explicitly about suicidal thoughts and acts highlights, but does not increase, risk (DeCou & Schumann, 2017). In the NHS these risks are typically managed by a multi-disciplinary team working with parents/caregivers. In contrast, schools hold the duty of care while young people are in their establishment. This means that in each school the project lead (LP) confirmed exact risk management procedures and identified specific safeguarding procedures. All therapists were trained to manage risk and had access to a senior clinician (LP/SR) for immediate supervision if needed. Schools have been very receptive to the structured risk procedure followed by Brief

BA therapists, and particularly welcome the expertise on assessing and managing student self-harm and suicidal ideation.

[Table 2 about here]

Adaptation

Some adaptations of Brief BA were necessary to accommodate the school setting and environment. The collaborative and voluntary principles of psychological therapy (Roth & Pilling, 2008) can be challenging to convey in the school setting where most activities are not optional for students. To help reinforce the voluntary nature of Brief BA this was explicit in all written materials and voiced by therapists repeatedly throughout treatment.

In NHS settings parents are invited into specific Brief BA treatment sessions. This is because parents can play a significant role in overcoming barriers to treatment (Michie *et al.*, 2011) and provide positive reinforcement to behaviour change, which is key to the success of Brief BA. However, this is not practical when therapy is provided at school. Therefore, regular phone/email contact with parents was arranged before starting treatment. This provided a clear communication channel to manage any emerging risk and to support and guide parents to positively reinforce healthy behaviour and minimise negative reinforcement for depressed behaviour.

Brief BA in schools aims to offer brief treatment to young people who have symptoms of depression that interfere with their life, as soon as possible. Delivery in schools means that some aspects of the treatment need to be flexible. This included the length of sessions (which needed to fit into one lesson) and the timing and frequency of sessions (which needed to fit with the student's timetable). Students who completed Brief BA treatment in schools typically received 7 sessions (mean = 6.9, range 4 – 8, vs the standard treatment length of 6 – 8 sessions), with the average session length around 45mins. Some sessions were condensed if they started late (most often due to students forgetting about the appointment but wanting to attend when they were reminded), to avoid running into the next lesson. Keeping to timetabled lesson slots for sessions was important to minimise disruption

to academic activities and maintain the positive relationship between Brief BA therapists and school staff. With these adaptations, Brief BA was generally able to be delivered within a typical school half term and thus has a clear beginning and end point which helps students and school staff prioritise attendance.

Overall, from our current data on acceptability and implementation it appears that Brief BA can be adapted to fit the school setting. Once outcome data are available, it will be important to consider the effectiveness of Brief BA when delivered in this adapted format.

Integration

One of the key challenges and tests of feasibility has been to integrate Brief BA in the school system, and to balance the different and sometimes conflicting targets and priorities of healthcare and education systems. Integration is most straightforward when the priorities of the health and education system align and can be clearly identified. For example, in one school in which we were piloting Brief BA, a recent Ofsted report identified that the school needed to improve student attainment. This led to the school targeting student attainment more closely and linking that more explicitly to the outcome data that the Brief BA project would collect. This in turn has led to a renewed and greater commitment to supporting the delivery of Brief BA to students.

Brief BA therapists can also support individual students to change behaviours at school because they are embedded within this setting. For example, as part of Brief BA young people identify their own values so that they and the therapist can identify behaviours that are consistent with these values and can be increased. Students often identify values associated with education or with their future career aspirations (e.g. ‘getting good grades’; ‘doing well in school’; study to become a vet’; ‘I want to lose my reputation for being naughty at school’). The role of the BA therapist is to help the young person to identify ways to change their behaviour in a way that will support these values. Brief BA includes the use of problem solving strategies to support behaviour change. Examples of solutions identified by students and therapists include seeking out a teacher for specific academic advice, getting a

book from the library, and planning a revision timetable. Once identified these positive behaviours can be immediately reinforced by the therapist, and quickly fed back to school staff teams. This further links the therapy component of Brief BA with the educational priorities of the school, highlights the student's desire and commitment to change to school staff, and helps teachers and other school staff to provide additional positive reinforcement to the student.

Brief BA can also highlight specific actions where the school can support positive behaviour change by their students. For example, one Year 10 male student with symptoms of depression and a poor attendance record at school was referred for Brief BA. Through treatment he identified a personal value of 'getting a good education', which seemed at odds with his attendance record. He continued to be punished for late attendance by the school. In the context of therapy, a key problem that maintained poor attendance was identified; discussion between the student and therapist revealed he could not tell the time and that no-one in his family was helping him wake up on time to get to school. This allowed a direct solution to his time-keeping difficulties that was supported by the school and the therapist. It also highlighted additional safeguarding concerns regarding parental neglect, which were fed back to school and social care.

Conclusions

This feasibility study suggests that Brief BA can be delivered successfully in schools. Students, parents and school staff find the treatment acceptable and there is a demand and need for prompt treatment of depression and low mood. Some minor adaptations to the delivery of Brief BA were required to deliver the treatment in schools. Once in treatment the vast majority of students engaged very well. Screening for Brief BA identified a number of young people with other difficulties who could be rapidly referred for specialist treatment. Adherence to treatment (indexed by attendance at sessions) was extremely high, as was completion of routine outcome measures. Careful risk assessment and management is critical when working therapeutically with depressed young people. Risk must be managed

in a way that is acceptable to all stakeholders and clearly defined from the outset, with therapists following school specific policies and accessing regular, high quality supervision. The delivery of treatment for depression in schools was most successful when there was a strong collaboration between the therapy team and the senior management team in the school. Ongoing commitment and liaison was also necessary as well as a therapy delivery model that was closely linked into the school pastoral support team.

Overall these data show that delivering Brief BA in schools is feasible. It has the potential to increase access and acceptability of treatment for low mood in young people through increasing the number and range of professionals who can deliver the treatment. If further data evidence effectiveness, this feasibility study could inform new service delivery models for children and young people's mental health services.

Word count: 5665 (including all tables and references)

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Tables

Table 1: Student uptake of Brief BA in schools

Procedure	**Number (% of possible total)**	**Details**
Offered Brief BA assessment	40	
Accepted Brief BA assessment	34 (85%)	No longer at school or leaving shortly (n =2); Student declined offer (n = 2); Already receiving lots of input so mutually agreed not to assess (n = 1); Yet to make contact with parents (n = 1)
Completed a Brief BA assessment	34 (100%)	
Suitable for Brief BA	32 (94%)	Accepted by CAMHs (n = 1); Experiencing psychotic symptoms so referred to CAMHs (n = 1)
Engaged in Brief BA	32 (100%)	
Completed full Brief BA treatment	30 (94%)	Started CAMHs treatment for eating disorder (n= 1); Challenge engaging in school setting (n =1)
Additional Brief BA team input	3	Referral to CAMHs towards end of Brief BA (n = 2); request for young carer assessment (n = 1)

Table 2: Systemic factors facilitating and hindering Brief BA in schools

Facilitating factors	Hindering factors
Direct input from Senior Leadership team	Input only from lower level school staff who lack power to effect major changes
Explicit shared goals between school and Brief BA team	Competing priorities for education and health teams
School commitment to emotional wellbeing	Significant structural changes to pastoral staff roles and responsibilities
Dedicated admin support in school	Lack of communication about involvement of other services with individual students
Clear expectations about what mental health support can and cannot be delivered	Students referred due to non-mental health issues
Early evidence of benefit to individual school	
Brief BA team understanding school ethos and are or become embedded in the system	