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Exploring the experiences of young people completing the YP-CORE to capture clinical need on a digital counselling platform

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Abstract

Background

Assessing clinical mental health needs through standardised mental health assessment measures is commonplace within young people's mental health services. To date, any investigation into the use of such measures within online services has been limited.

Aims

The aim of this research is to contribute to the knowledge-base of young people's willingness to complete voluntary standardised mental health assessment measures and how the accuracy of the information derived may be improved. Methods Participatory action research was utilised to conduct semi-structured interviews with young people (N=6). Questions were developed using the frameworks of the Theory of Planned Behaviour and Self-Determination Theory. The data were analysed using thematic analysis, to develop global themes in response to the research aims.

Findings

Global themes identified (N=6) from six interviews referring to the areas of motivation and experience include '*Drivers*', '*Behavioural Preferences*', '*Outcomes of Being Honest*', '*Discomfort*', '*Internal harmony*', and '*Self-sabotaging beliefs*'.

Conclusions

The findings from this small scale research demonstrate the need for transparency online, to instill trust in those completing standardised mental health assessment measures. This may be implemented through co-designed visual materials which contribute to the young people's understanding of how the data collected through assessment will be used and what the response of the service will be following assessment.

Key Words: Digital mental health; Young People; Mental Health Services; Online Assessment; Standardised Measures.

Implications for Practice and Policy

- Within online practice, the role of trust extends that of the therapeutic relationship and is essential in the use of collection of standardised mental health assessment measures within online services.
- Users of online mental health services experience uncertainty, conflict and discomfort when first engaging with services. More research is required to understand the use of design to enable transparency and create ease in this help-seeking process.
- Using standardised mental health assessment measures online raises online-specific uncertainties around data privacy which need to be catered for to enable reliable data collection.
- This research contributes to the sparse evidence reviewing the experiences of young people of using standardised mental health assessment measures online. Within an increasingly online world, this research provides understanding of the first interaction an individual has with an online mental health service.
- With the transference of many face to face settings to online due to the global COVID-19 pandemic, these findings will be of interest and significance to practitioners and services who have not previously offered online provision.

Introduction

Standardised mental health assessment measures are typically a series of set questions used to differentiate mental health symptoms, risk, or levels of clinical severity within a population (Moriarty, 2002). Alongside clinical judgement, the use of mental health assessment measures, in a number of forms, is one of the most important steps in identifying the needs of an individual and how they can be addressed by the practitioner working with the individual within therapeutic settings (De Jong et al., 2014). Such measures are used as part of a systematic approach to ensure that mental health services and practitioners are able to effectively allocate resources to meet the health needs of their clients (Valenstein et al., 2009; Wright et al., 1998). Without a needs based assessment, there is also a real challenge to demonstrate subsequent outcomes, which has become more routine practice in mental health settings, since the implementation of the Improving Access to Psychological Therapies (IAPT) programmes for both adults (IAPT) and young people (CYP-IAPT), and the routine outcome measures (ROMs) associated (Clark, 2011; Wolpert et al., 2012).

When it comes to counselling services for young people (YP), assessments can be self, practitioner, parent or teacher completed (Hall et al., 2019). There is a central focus on emphasising the self-reported outcome measures implemented as part of CYP IAPT, supplementing these with stakeholder-reported measures. Further, with the implementation of the Mental Health Services Data Set (MHSDS; NHS Digital, 2020) in the UK, which sees a central flow of administrative data, mental health assessment and outcome measurement is widespread as a means to assess need, as well as to meet central reporting requirements. Self-rated assessment measures were once considered unreliable

with too much dependence on the understanding and judgement of the individual. Today, however, we are more likely to recognise YP as well placed to describe their own experience, and in many ways might be able to provide the truest assessment of what is going on for them at any given moment ([Edwards et al., 2016](#); [Rickwood et al., 2007](#)). YP hold a unique viewpoint to their lives, rather than one which is confined to specific settings such as school, home, or the therapy room ([Lewis and Lindsay, 1999](#); Riley, 2004). Through this unique and accurate position, YP are able to contribute meaningfully to assessment within a therapeutic space, where their contribution to the process is as valuable to the practitioner as it is to the individual ([Deighton et al., 2014](#); [Sturgess et al., 2002](#)). Further, the UN Rights of the Child (Alderson & Montgomery, 1996) stipulates that YP's views should be considered in all elements of care as soon as they are able to express themselves; this is not contingent on age or ability.

Using self-report standardised mental health assessment measures in mental health settings is not novel, but using them in online therapeutic environments is less well evidenced. The addition of illustration within a computerised version of the Strengths and Difficulties Questionnaire proved to support the individuals' completion of the measure, demonstrating validity when used online ([Truman et al., 2003](#)). The participants in this study reported ease of use of the computerised version, as well as using the range of response options rather than a binary yes/no which was favoured more by the paper-based respondents. More recently, in focusing on the evidence burden for remote online use of standardised mental health assessment measures, Sefi and Frampton found there to be acceptability and applicability of three different measures when used in such an environment (2020). Beyond measures, evidence offers insight into general attitudes towards remote online support services.

One area of potential concern is safety online, specifically in regards to privacy, data quality and duty of care to those sharing information ([Abdelhamid, Gaia & Sanders., 2017](#); British Psychological Society, 2007; Buchanan & Hvizdak, 2009). There are fewer opportunities for in-person clarifications and expectation management online, a process which if not managed can lead to poorer adherence to intervention and a reduced rate of improvement (Bell et al., 2002). This may also affect the credibility of a service, which, along with the ability to motivate users and reduced waiting times, are important requirements for engagement with remote online services ([Musiat, Goldstone & Tarrier., 2014](#))

Reliability of the data collected through online counselling services is central to supporting clinical practice and contributing to population level data ([Sharples et al., 2016](#)). With the use of standardised mental health assessment measures indicating a greater level of need when collected online (Mindel et al., 2021), the question of reliability and validity of results is evermore crucial when considering the transference of measures validated in face-to-face (f2f) settings to online ([Buchanan, 2002](#)). Reliability extends beyond the measure itself to the users' experience of completing a measure. Perceptions of the use of standardised measures, largely reflecting the views of practitioners, parents, and carers suggest there are both a number of concerns and benefits to the experience.

Concerns include the simplicity of 'tick-box' assessments, the subjective experience of the recipient on the day of completion, the complexity of language within measures, and whether there was adequate privacy and confidentiality (Black et al., 2020; Merry et al., 2004; [Moran et al., 2012](#)). Benefits of standardised mental health assessment measures have been noted as a means of individuals feeling in control

of their process, aiding disclosure, providing point of reflection to recognise problematic (or not) behaviours, and a means of relatability whereby individuals felt less alone with their problems ([Demkowicz et al., 2020](#); Martin et al., 2011; Merry et al., 2004; [Rodgers, 2018](#); [Unsworth et al., 2011](#)).

The concerns and benefits with self-report assessments mentioned have been identified within either f2f settings, or using computers on-site with the intervention. There is little such research exploring both remote usage of standardised mental health assessment measures, and the reasons the use of such a measure elicits a higher level of need than found in f2f settings (Mindel et al., 2021). One theory underpinning the evidence for greater need online is the disinhibition effect, whereby people appear to feel freer in their disclosure as a result of the online environment (Suler, 2005). Anonymity has been cited as an enabler for such honesty, through creating a protective wall for a user to be more candid in response (Joinson, 1999). Furthermore, a common trope in the media is that YP feel the pressure to exaggerate their need in order to access help which could play out in an online setting with YP exaggerating their responses to the assessment measure ([The Telegraph, 2018](#)). The Care Quality Commission (2018) in the UK found that often YP would be at crisis point by the time they were accessing services, and with anxiety and depressive symptoms acting as a predictor of distress when completing mental health questionnaires there are risks associated with presenting YP with mental health assessment measures online ([Batterham et al., 2018](#)). Without understanding more about the experience of YP, it is unclear which of these assumptions are true for them, how reliable the data is, and how best to proceed with collecting assessment measures online.

With limited evidence which demonstrates the perceptions and experience of using standardised mental health assessment measures from YP themselves, this study aims to contribute to this gap. As discussed, prior research has demonstrated both concerns and benefits to using standardised mental health assessment measures in clinical environments; whether these are true for online services is as yet undetermined. We have identified two key concerns that are both under researched and essential for the meaningful use of mental health assessment measures in online mental health services:

1. The motivation of service users to complete voluntary self-report measures.
2. Assessment measures being completed truthfully in order to produce reliable data.

The scope of this study focuses on the experience and reliability of standardised mental health assessment measure completion. This study seeks to explore two research questions. a) What motivates young people to complete a standardised mental health assessment measure? b) What are young people's experiences of completing assessment measures online? With the aim to provide recommendations for the successful and meaningful use of standardised mental health assessment measures within an online therapeutic service.

Methodology

Method

This study took an action research approach, where the researchers are 'insiders' of the participating organisation and undertook the work with a desire to improve the outcomes of practice (Kemmis et al., 2014), as well as contribute knowledge to the field of online health assessment. Working within online mental health platform, Kooth, the researchers had a deep understanding of the user journey through the onboarding and assessment phase. Kooth delivers asynchronous and synchronous professional mental health support to 10-25 year olds across England and Wales in addition to content-based peer support. YP self-refer to the service, and directly following their registration, they are asked to complete the Young Persons CORE (YP-CORE; Twigg et al, 2009); they have the opportunity to skip the assessment measure if they choose to. The YP-CORE is a standardised assessment and outcome measure, consisting of 10-items adapted from the Clinical Outcomes in Routine Evaluation - Outcome Measure for use with YP (CORE-OM; Evans et al., 2000). The CORE assessment measures were developed as a means of recognising the 'core' of a client's distress with questions covering wellbeing, commonly experienced symptoms and social functioning (MHF & Core Systems Group, 2016). The YP-CORE covers the same topics but offers young person friendly language in a shorter format than the CORE-OM (Twigg et al., 2009). For example, "My thoughts and feelings distressed me", "I've thought of hurting myself" and "I've felt unhappy"; with five options of response based on frequency.

Using qualitative research methods, we developed a semi-structured interview schedule influenced by the elements of the Theory of Planned Behaviour and Self-Determination Theory to explore the experiences and motivations of the participants (Ajzen, 1985; Hagger & Chatzisarantis, 2009).

Ethical Consideration

This study was given a favourable opinion by the ethics committee and the University of Exeter, recognised by the application number eCLESPsy001442. Participants were invited to read an information sheet before deciding whether to take part in the study, which informed them of their voluntary status and ability to withdraw from the study at any time. Kooth is an anonymous service, so rather than ask participants to share any identifiable information, their online username was used to authorise their consent to a number of statements within the online synchronous interview process.

Researcher Positionality

This research was designed and conducted by two authors (removed for review), who are researchers at the online mental health service that this research was situated within. The researchers are committed to contributing evidence and knowledge to the field of digital mental health intervention, both as a requirement of their professional roles, and out of choice through having taken on these roles. Their research is positioned within the desire of wanting to better understand the mechanisms of usage of remote digital support and explore the meaning behind data collected through the service. Within this research the authors (removed for review) were interested in understanding why the outcomes from standardised mental health assessment measures might be different online - an answer to which would not necessarily result from the study. To support an objective approach to the interpretation of the analysis they worked with the third author (removed for review) who is a researcher sitting outside of the organisation. This offered a broader perspective on the work and its position within the mental health and counselling

literature.

Participants

A self-selecting sample was recruited through Kooth using an article published in the online magazine feature of the platform, which appeared on the homepage 'feed' of the users. Though self-select sampling can introduce a bias, this method was chosen in favour of collecting the richest experience of users, for which it was considered that those most willing to take part would provide ([Sharma, 2017](#)). YP were able to express interest through the feedback page on the site, which was fed through to the research team who screened them for inclusion criteria. Participants were individuals who were newly registered and therefore would have recently been asked to complete the measure. The service is inclusive of populations of children as young as 10 years old. However, due to the risks related to the nature of the service, and the anonymous status of the service users, ethical approval for this work was sought to engage with an older cohort of YP. Inclusion criteria consisted of an age limit of 16 to 25 years old, and being recorded as a recently registered user, which was defined as having registered in the four weeks prior to expressing interest to participate. There were no incentives offered for participation in the research. Each participant who expressed interest was screened by the service's clinical psychologist who made a professional judgement as to whether there was any risk of harm to the individual by taking part. Participants were not excluded on the grounds of having chosen not to complete the assessment. Over a three month period, 26 individuals aged 16-22 years expressed interest in participating, with six females aged 18-21 years responding to a follow up email and taking part in the study interviews. With 71% of Kooth users identifying as female this sample of females is representative of a large part of the service ([Frith, 2017](#)), only

14% of those who expressed interest were male , with none following through to interview.

Data Collection

Semi-structured interviews were conducted via text-base synchronous messaging through the Kooth platform with each individual. The use of text-base synchronous messaging facilitated by Kooth allowed participants to be interviewed in the context location of the topic of the study while remaining anonymous as they are within the service, and provided a ready-made transcript of each interview (Childs & Peachey, 2013). Semi-structured interviews were chosen for their ability to extract the nuance of the individual experience and to offer the flexibility to collect a greater breadth of subjective experience than structured interviews (Fontana & Frey, 2000). A topic guide was used consisting of four sections for investigation: Motivations, Expectations, Experience and Goals. *Motivations*, *Expectations* and *Goals* were influenced by the TPD and SDT to inform questions focused on choice, perceived behavioural control, attitudes and subjective norms (Ajzen, 2011; Hagger & Chatzisarantis, 2009). *Experience* questions were broader including the simple question of ‘What was your experience of sharing this information with the service?’ as well as a question concerning how honest participants felt they were able to be in relation to our interest in the reliability of completion.

Without any audio or visual cues from participants’ text-based interviews, we found that responses could be brief at times, however the semi-structured nature of the interviews allowed for further exploration with the participant beyond their immediate response. Following the six interviews and a review of the data collected, it was

determined that the interviews had provided sufficient data to generate rich responses to our research questions (Braun & Clarke, 2019).

Data Analysis

A reflexive approach to thematic analysis was used to construct meaning from the data, consistent with the six steps advocated by Braun and Clarke (2020). A largely inductive approach was used for identifying latent codes and themes from within the data. An inductive approach was used due to the fluidity of understanding motivation and experiences, and because there is limited theory or evidence available examining these topics in conjunction with online mental health assessments. The first and second authors familiarised themselves with the data before coding the interviews with codes referring to *experiences* and *motivations*. Next, these codes were grouped together under categorising themes, and finally global themes were determined for the groups of codes through discussion of two researchers and consultation with a further two members of the wider research department to define the findings of this study.

Findings

Sample

The age, gender, and ethnicity of the six individuals responded to the follow-up email inviting them to interview, and partook in the study are demonstrated in Table 1.

[Table 1]

[Table 2]

[Table 3]

In line with the research questions being explored, the findings are organised into the two key concepts explored through the interview questions. The first set of themes refer to motivation and the second refer to experiences.

Motivation

As shown in Table 2, three global themes were derived to help understand what motivates individuals to complete an online assessment measure: (1) *behavioural preferences*, (2) *drivers* and (3) *outcomes of being honest*.

Behavioural Preferences

Half of the participants indicated that they usually answer questionnaires, either because they enjoy the process or believe that they exist for a purpose, for example, one user said 'I usually answer questionnaires' (P5) sharing further, 'they are usually in place to help someone or a particular cause' (P5). One preference of two of the interviewees was to do it now [upon registration to the service] rather than later, P3 shared, 'I don't like postponing things'.

Drivers

Participants suggested that they were motivated to fill in the measure based on two key drivers of 'personal goals' and 'service expectations'. Personal goals which motivated users to complete the assessment included a desire to access the service: 'I was in need of support and was at the point where I was willing to do anything to try and feel a bit better and get some help' (P5). In addition to being driven by entry to the service, and overcoming this barrier, getting the task of disclosure out the way through a simple questionnaire was a motivating factor

for completion. P2 shared, 'answering them would save me from explaining it all later on' (P2), and likewise, P1 told us 'I wouldn't have to do them later down the line' (P1). This ease of disclosure was further explained by P1 who said, 'it would show how I was feeling so I didn't have to tell anyone' (P1).

Service expectations relate to what participants would receive as a result of completing the measure. This included tailored support from the service appropriate to their needs, with one user stating '[the service] would have a clearer idea of my case and thus would know better how to help me' (P3). Other expectations reflected a similar want such as having the counsellors within the service know more about the individual, P2 shared 'I think it would've helped the counsellors to know what sort of position you were in'. Following this was the expectation of a personal response that would be prompted depending on the assessment outcome. P4 stated this explicitly, saying 'if something in there was concerning that somebody would reach out and say 'we noticed this, are you okay?''.

Outcomes of being honest

The outcomes of completing the assessment was described as a motivator for completion. The main outcome cited was the benefit reaped from being honest, such as being able to receive the most appropriate help. P2 and P3 were motivated by this outcome to complete the assessment truthfully. P3 shared 'I knew there was no point on lying considering they're here to help me so I tried to answer as accurately as I could.' For others there were unintended positive consequences of being honest that participants reflected on during the completion process, such as being able to 'think clearer and see the problem from an outsider's perspective' (P6). Two

participants identified the value of measures to the service and themselves, with honest responses enabling accurate monitoring of them over time 'I like to see if my answers change over time.' (P4)

Experiences

As shown in Table 3, three global themes were derived which offer insight into the experiences of individuals completing a standardised mental health assessment online: *discomfort, internal harmony, and self-sabotaging beliefs.*

Discomfort

Discomfort in some form was shared by all interview participants, defined by two organising themes of 'internal conflict' and 'emotional labour'.

Internal conflict among the participants was largely related to how to respond to the questionnaire, how to be honest, and whether to be honest. P1 and P2 shared specific concerns around data privacy and the nature of information collection online, 'I didn't really understand where my information was going to go, or how many people would see it.' (P1). They followed on with saying 'I've had a lot of bad experiences with safety especially with confidentiality and safety' (P1), highlighting a similar uncertainty about sharing information, but for a more specific experience related reason than general data uncertainty. For others the conflict in being honest when responding to the assessment was less about their information and more about the outcomes of their response, with concerns around evoking worry (P4) or how the responses would be used by the service. The other side to this conflict was evident with participants recognising the value in being honest within the

assessment, 'In the end I think I put the most accurate answers I could because I had to be real with myself in order to get the help I need' (P2). P2 made it clear through saying 'I did feel quite a lot of instinct to underplay my responses' that when there was an inclination to divert from an honest response, this was likely to be an underplay of feelings rather than an exaggeration.

The YP we spoke with had all come to the service seeking some form of help, whether from their peers or a professional, and were having a 'help-seeking' experience at the time of completing the online assessment. They described the emotional effort required to complete the assessment by citing the specific emotions evoked through the process, P2 expressed 'it did panic me slightly', and P1 similarly shared 'I actually felt nervous', and through the work required to complete the questions. Four participants acknowledged the laborious nature of identifying their feelings at the time, 'I had to really focus into how I was feeling' (P2), 'I do often find me second guessing myself' (P5).

Internal Harmony

In a dichotomy with discomfort, participants experienced internal harmony as both a reflective experience and through the ability to disclose some of their vulnerabilities through a predetermined form. Every participant mentioned something about the usefulness of the process, and how filling in the measure helped them acknowledge feelings and identify their personal needs: 'It helps me to understand my emotions' (P4), 'seeing it on paper (or on a screen) helps to clarify how I am feeling' (P6). One individual found it 'relaxing' (P4) in the knowledge that completing the assessment would mean they would be able to access the service for help, while for others the comfort came in the ease of completing a form rather than sharing their difficulties in

words, 'it helped me a lot to check a box instead of bringing it up in words' (P2). Not every participant thought about their peers but for those who did, the belief that peers were going through the same process was an area of reassurance 'It made it a little easier to answer the questions if other young people have' (P1).

Self-sabotaging beliefs

This theme was defined by a number of negative or false beliefs YP had about themselves during assessment completion. A number of participants did not feel deserving of help due to a fear that they were exaggerating their feelings, that they would somehow take support away from their peers, or that their struggles were insufficient to warrant help, P4 shared concern when saying 'I didn't want people to be worried about me when there's other people who need help' (P4). There was a notable theme of individuals being socialised to down-play their feelings, 'it was instinct to say I'm fine' (P2) as this is their norm when conversing with their social networks.

Discussion

The aim of this research was to understand both what motivates YP to complete standardised mental health assessment measures online, and what their experiences of doing so are. Through this research, we intend to contribute to the knowledge concerning the experience of YP choosing to complete standardised mental health assessment measures online, and the collection of reliable clinical data. Through inductive thematic analysis, we derived six global themes from a homogeneous sample of YP.

Motivations to complete online assessments

Research into the use of standardised mental health assessment measures online is still in its infancy, with few measures developed specifically for the remote online environment. The nuances of how online use differs from a f2f setting or how critical it is to develop online-specific measures, is as yet unknown, which poses further transferability questions between these two contexts. This is a recommended area for future research. Participants expressed a belief that standardised mental health assessment measures exist online to serve a purpose and that they should be filled-in regardless of other goals, which supports the high levels of acceptability recognised when using these measures online (Sefi & Frampton, 2020).

Additionally, there was a belief that by completing an assessment measure there would be a subsequent personalised journey from the service. This suggests that through prior experience, as suggested by some participants, or as a result of instinct, there is a motivation to complete measures based on what the individual will receive as a result. Managing expectations and what the true next steps will be following measure completion are critical to ensuring adherence with, and the success of, an intervention (Bell et al., 2002). This suggests that if beliefs about the response expected after completing a standardised mental health assessment measure are a motivator, there is an increased importance on creating transparency surrounding 'what happens next' to an individual following completion of an assessment measure.

An online environment provides a pause point for users to choose how honest they want to be based on considerations of trust, safety, and deservedness of help. In line with Joinson's (1999) findings of more candid responses online, one participant explicitly cited the anonymous nature of the platform as an enabler to being honest.

While we're not able to confirm that every account of responses would be an honest one, our findings suggest that assessment data collected online is a true reflection of the individual's experiences of their need. This suggests that higher rates of need found within online populations are likely to be as a result of another online factor rather than over-catastrophe or exaggeration of response (Mindel et al., 2021). As demonstrated through the varying emotional states our participants recalled to have been in, it is unknown in what emotional state an individual will present with when they come to register for or use an online service (Epstein & Klinkenberg, 2001). Our findings suggest that it is more common that a heightened emotional state is likely in this situation and that completion of a measure in this moment can elicit uncertainty, discomfort and internal conflict. Consequently, offering choice and control to the user in these moments to reduce any potential discomfort that might arise from collection from a standardised mental health assessment measure is important. One such example is providing users with the ability to skip the standardised assessment measure if they are not ready to complete it, providing a means of control over the information they wish to provide (Dillman et al., 1999), and signifying to the user that they have a choice.

Our findings suggest that help-seeking can be challenging and emotionally difficult, but among the uncertainty and discomfort, there was a clear sense of internal harmony experienced. This was largely due to individuals having the opportunity to reflect, become more aware of their feelings, and gain a different perspective on their emotional state. This aligns with helpful reflective experiences and the enablement of easier disclosure documented within studies in f2f settings (Martin et al., 2011; Rodgers, 2018). This suggests that using measures which have been designed and tested in a f2f environment can result in a similar experience for users when applied

to an online setting. Though some discomfort was noted from all participants, the helpfulness of the process supports other evidence that it is more likely that distress will decrease through completing a mental health assessment than increase ([Batterham et al., 2018](#)). This is an area that requires continued investigation in order to understand more about transferability of measures between context, and how they can offer a therapeutic experience to the user in an online space.

Determinants of Honesty

Contrary to expectation, little was said in relation to the disinhibition effect of online spaces, with only one participant citing anonymity as a facilitator of honesty (Suler, 2005). In contrast to what we know about the disinhibition effect, the YP in this study were more likely to divert from honesty as a result of their desire to downplay their responses than exaggerate them or disclose more deeply. This happened as a result of other things such as being primed to be 'fine' as they would be in usual social contexts, or due to an initial cautiousness of the service. There were, however, several motivating factors participants shared in favour of being honest; largely users want to get more out of their experience with the service. We know from prior research that credibility is an important factor in the acceptability of computerised self-help support ([Musiat, Goldstone & Tarrier, 2014](#)). As such, to know that service users have an expectation of how responding honestly will support them in achieving appropriate support, if such an expectation is not recognised could affect the way YP interacts with services online.

We suggest that trust is a necessary component to eliciting honest responses, managing service expectations, and supporting the service user adequately. When an individual is initially asked to self-disclose information to the service we found an

experience from participants of uncertainty and conflict. The role of trust is critical to self-disclosure, and while uncertainties around privacy are common with regard to technology ([Abdelhamid, Gaia & Sanders., 2017](#); [Joinson et al., 2010](#)), this is particularly important when interpreting the reliability and validity of the mental health data collected. A key area around which mistrust or uncertainty arose was specifically about data collection and privacy of that data. Recent examples of where a child-centred, co-designed approach to privacy online have demonstrated such an approach as an effective means of producing written and visual materials suitable to alleviating the uncertainty around data and consent (Livingstone et al., 2019). We would suggest that online mental health services aimed at YP take this same cooperative and collaborative approach to design the necessary materials exploring the collection and use of data at different stages within the service.

Trust develops through relationships, and while research suggests that therapeutic alliance and a relationship with the platform does form over time (Hanley et al., 2019), assessing clinical need often occurs during registration prior to engagement with the platform, suggesting the need for trustworthiness to be embedded early in the person-to-platform relationship. We found self-sabotaging beliefs to be another reason an individual would feel conflicted in completing an assessment truthfully; they felt as though other people deserved help more than themselves, or they were not 'bad' enough. This is particularly pertinent for universal online services where no referral is required; we would suggest there is a duty for online services to be clear about the inclusivity of service users, and availability of support. We have not focused on web-design in this study, and would recommend further investigation in this area to understand how to build trust online for service users experiencing a heightened emotional state.

Strengths and Limitations

Limitations include the limited diversity in the sample. This was as a result of time constraints and restrictions of communication means used to protect service users' anonymity. While we were satisfied that the interviews were rich enough to address the research questions, the sample was undoubtedly homogenous and does not offer experience from users with diverse backgrounds. The exploration of these research questions with a more diverse sample may have resulted in further depth and insight, through the development of additional themes or sub themes. Those who were part of this study had also all completed the standardised mental health assessment measures, and it would be valuable to understand more about why those who choose not to complete assessments make that choice in order to increase inclusivity of completion. As a result of the behavioural preferences of our sample group there is a chance the experiences represented are of those who have prominent voices rather than those who are typically harder to reach or who are often less heard. Additionally, there is potential that those who did take part may present with expectation bias which may have influenced not only their decision to participate but also the content of their responses. For example, those who believe there to be a perceived benefit of taking part or an expectation that this may in turn influence the support they did or did not receive in any way, may be more likely to volunteer to share their experiences. A further limitation concerns comparisons with f2f experiences which have been drawn from other studies rather than working with a comparison group within this study. Elements of comparison have been selected based on their relevance to this study, for a truer comparison to be made between the experiences of f2f and online service users, we would recommend a comparator group who complete the same

standardised mental health assessment measures and are of similar demographic characteristics to the online sample group.

There were several strengths to the design of this study including the ability to keep participants anonymous and conduct interviews within the parameters of the service, enabling us to access honest accounts of experiences which might otherwise have been compromised. This choice of design allowed us to effectively safeguard participants supporting greater inclusion in the study, with individuals presenting with high risk clinical needs still able to take part. YP were asked to participate in the research within a close proximity of signing up and were therefore able to provide rich recollections of their motivations and experiences. The recommendations made through this study, despite the small sample size, are universally recognised design suggestions for online interaction, which have been clearly reinforced through what the study participants have told us about their experiences. Through our focus on YP we are able to contribute the nuance of their unique experience and represent what matters to them when it comes to accessing mental health support, in contrast with current evidence largely relating to f2f and other stakeholder perceptions.

Conclusion and Further Research

Despite the exponential growth of the internet over the past 10 years, there is a lack of evidence for a blueprint online mental health service for YP. This study contributes to the exploration of assessment measurement, the data from which can assist in forming the blueprint for services. We found transparency and building trust key to eliciting honest responses to standardised mental health assessment measures and

therefore reliable data. We would suggest enabling choice through the ability to skip assessment measures and return to them later. As a means of improving transparency and trust surrounding data privacy and service expectations, we suggest providing written and visual aids to explain how data collected from standardised assessment measures is going to be stored. The focus of this study was on a needs based assessment at the point of registration for the service user, such assessment measures can also be used to assess outcomes throughout online interventions, to understand an individual's interaction with routine outcome measures online we would suggest this is a focus for future research. A standardised mental health measure as used in this study will not capture the idiosyncratic nuance of idiographic measures which (Ashworth *et al.*, 2019), when used in combination, may increase the motivation for measure completion, we would recommend this approach for future investigation. Finally, following the expression of discomfort expressed by our participants, we would encourage further enquiry into this experience, with a view to understanding how this process can be designed to be more sensitive to an individual's needs. It may be that the findings from research on mental health assessment measures in f2f settings is applicable to online settings and vice versa, but the nuances in the differences between the settings warrants specific research within each respective setting; as such, further research into how these measures are used and function in an online setting is paramount. With the transference of many f2f settings to online due to the global COVID-19 pandemic, these findings will be of interest and significance to practitioners and services who have not previously offered online provision.

References

Abdelhamid, M., Gaia, J., & Sanders, G. L. (2017). Putting the focus back on the patient: how privacy concerns affect personal health information sharing intentions. *Journal of medical Internet research, 19*(9)

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In *Action control* (pp. 11-39). Springer, Berlin, Heidelberg.

Ajzen, I. (2011). The theory of planned behaviour: Reactions and reflections.

Ashworth, M., Guerra, D., & Kordowicz, M. (2019). Individualised or standardised outcome measures: a co-habitation?. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(4), 425-428.

Batterham, P. J., Calear, A. L., Carragher, N., & Sunderland, M. (2018). Prevalence and predictors of distress associated with completion of an online survey assessing mental health and suicidality in the community. *Psychiatry research, 262*, 348-350

Bell, R. A., Kravitz, R. L., Thom, D., Krupat, E., & Azari, R. (2002). Unmet expectations for care and the patient-physician relationship. *Journal of General Internal Medicine, 17*(11), 817-824

Black, L., Mansfield, R., & Panayiotou, M. (2020). Age Appropriateness of the Self Report Strengths and Difficulties Questionnaire. *Assessment, 1073191120903382*.

Braun, V., & Clarke, V. (2019). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales.

Qualitative Research In Sport, Exercise And Health, 1-16.

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative research in psychology*, 1-25.

British Psychological Society (2007). Guidelines for ethical practice in psychological research online.

Buchanan, T. (2002). Online assessment: Desirable or dangerous?. *Professional psychology: Research and practice*, 33(2), 148.

Buchanan, E. A., & Hvizdak, E. E. (2009). Online survey tools: Ethical and methodological concerns of human research ethics committees. *Journal of Empirical Research on Human Research Ethics*, 4(2), 37-48.

Care Quality Commission. (2018). Are we listening? Review of children and young people's mental health services. The Stationery Office. Retrieved 12 November 2020, from

https://www.cqc.org.uk/sites/default/files/20180308b_arewelisting_report.pdf.

Childs, M., & Peachey, A. (Eds.). (2013). *Understanding learning in virtual worlds*. Springer Science & Business Media.

Clark, D. M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *International review of*

psychiatry, 23(4), 318-327.

Deighton, J., Croudace, T., Fonagy, P., Brown, J., Patalay, P., & Wolpert, M. (2014). Measuring mental health and wellbeing outcomes for children and adolescents to inform practice and policy: a review of child self-report measures. *Child and adolescent psychiatry and mental health*, 8(1), 1-14.

De Jong, K., Timman, R., Hakkaart-Van Roijen, L., Vermeulen, P., Kooiman, K., Passchier, J., & Busschbach, J. V. (2014). The effect of outcome monitoring feedback to clinicians and patients in short and long-term psychotherapy: A randomized controlled trial. *Psychotherapy Research*, 24(6), 629-639

Demkowicz, O., Ashworth, E., Mansfield, R., Stapley, E., Miles, H., Hayes, D & Deighton, J. (2020). Children and young people's experiences of completing mental health and wellbeing measures for research: learning from two school-based pilot projects. *Child and Adolescent Psychiatry and Mental Health*, 14(1), 1-18.

Dillman, D. A., Carley-Baxter, L., & Jackson, A. (1999). Skip pattern compliance in three test forms: A theoretical and empirical evaluation. *The social and economic sciences research center technical report*, (99-01).

Edwards, M., Lawson, C., Rahman, S., Conley, K., Phillips, H., & Uings, R. (2016). What does quality healthcare look like to adolescents and young adults? Ask the experts!. *Clinical Medicine*, 16(2), 146

Epstein, J., & Klinkenberg, W. D. (2001). From Eliza to the Internet: A brief history of computerized assessment. *Computers in Human Behavior*, 17(3), 295-314.

Evans, S., Greenhalgh, J., & Connelly, J. (2000). Selecting a mental health needs assessment scale: guidance on the critical appraisal of standardized measures. *Journal of Evaluation in Clinical Practice*, 6(4), 379-393.

Fontana, A., & Frey, J. H. (2000). The interview: From structured questions to negotiated text. *Handbook of qualitative research*, 2(6), 645-672.

Frith, E. (2017). Online mental health support for young people. *The Education Policy Institute*. Retrieved 4th November 2020, from <https://epi.org.uk/publications-and-research/online-mental-health-support-young-people/>

Hagger, M. S., & Chatzisarantis, N. L. (2009). Integrating the theory of planned behaviour and self-determination theory in health behaviour: A meta-analysis. *British journal of health psychology*, 14(2), 275-302

Hall, C. L., Guo, B., Valentine, A. Z., Groom, M. J., Daley, D., Sayal, K., & Hollis, C. (2019). The validity of the Strengths and Difficulties Questionnaire (SDQ) for children with ADHD symptoms. *PloS one*, 14(6), e0218518.

Hanley, T., Sefi, A., Grauberg, J., & Prescott, J. (2019). *A Positive Virtual Ecosystem: The Theory of Change for Kooth*. London.

Joinson, A. (1999). Social desirability, anonymity, and Internet-based questionnaires. *Behavior Research Methods, Instruments, & Computers*, 31(3), 433-438.

Joinson, A. N., Reips, U. D., Buchanan, T., & Schofield, C. B. P. (2010). Privacy, trust, and self-disclosure online. *Human-Computer Interaction*, 25(1), 1-24.

Kemmis, S., McTaggart, R., & Nixon, R. (2014). Introducing critical participatory action research. In *The action research planner* (pp. 1-31). Springer, Singapore.

Lewis, A., & Lindsay, G. (Eds.). (1999). *Researching children's perspectives*. McGraw-Hill Education (UK).

Livingstone, S., Stoilova, M. and Nandagiri, R. (2019) *Talking to children about data and privacy online: research methodology*. London: London School of Economics and Political Science.

Martin, A. M., Fishman, R., Baxter, L., & Ford, T. (2011). Practitioners' attitudes towards the use of standardized diagnostic assessment in routine practice: a qualitative study in two child and adolescent mental health services. *Clinical Child Psychology and Psychiatry*, 16(3), 407-420

Mental Health Services Data Set. (2021). Retrieved 11 March 2021.

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set>

Merry, S., Stasiak, K., Parkin, A., Seymour, F., Lambie, I., Crengle, S., & Pasene Mizziebo, E. (2004). Child and Youth Outcome Measures: Examining current use and acceptability of measures in mental health services and recommending future

directions. *Auckland, New Zealand: Health Research Council.*

MHF & Core Systems group. (2016). Core system user manual. Retrieved 20 November 2020. <https://www.pfcounselling.org.uk/wp-content/uploads/2016/01/CORE-System-User-Manual.pdf>

Mindel, C., Oppong, C., Rothwell, E., Sefi, A & Jacob, J. (2020) Assessing the need of young people using online counselling services: how useful are standardised measures? Manuscript accepted for publication.

Moriarty, J. (2002). Assessing the mental health needs of older people: systematic review on the use of standardised measures to improve assessment practice. *King's College London.*

Moran, P., Kelesidi, K., Guglani, S., Davidson, S., & Ford, T. (2012). What do parents and carers think about routine outcome measures and their use? A focus group study of CAMHS attenders. *Clinical Child Psychology and Psychiatry*, 17(1), 65-79.

Musiat, P., Goldstone, P., & Tarriner, N. (2014). Understanding the acceptability of e-mental health-attitudes and expectations towards computerised self-help treatments for mental health problems. *BMC psychiatry*, 14(1), 1-8

NHS Digital. (2021). Retrieved 11 March 2021. <https://digital.nhs.uk/>

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems?. *Medical journal of Australia*, 187(S7), S35-S39.

Riley, A. W. (2004). Evidence that school-age children can self-report on their

health. *Ambulatory Pediatrics*, 4(4), 371-376

Rodgers, B. (2018). More than just a measure: Exploring clients' experiences of using a standardised self-report questionnaire to evaluate counselling outcomes. *New Zealand Journal of Counselling*, 38(2).

Sefi, A. & Frampton, I., (2020). Testing, testing, one, two, three: Service user evaluation of three standard measures of mental health and well-being in an online counselling and support service for children and young people. *Counselling & Psychotherapy Research*, (00), 1-8.

Sharma, G. (2017). Pros and cons of different sampling techniques. *International journal of applied research*, 3(7), 749-752.

Sharples, E., Qin, C., Goveas, V., Gondek, D., Deighton, J., Wolpert, M., & Edbrooke-Childs, J. (2017). A qualitative exploration of attitudes towards the use of outcome measures in child and adolescent mental health services. *Clinical child psychology and psychiatry*, 22(2), 219-228

Sturgess, J., Rodger, S., & Ozanne, A. (2002). A review of the use of self-report assessment with young children. *British Journal of Occupational Therapy*, 65(3), 108-116

Suler, J. (2005). The online disinhibition effect. *International Journal of Applied Psychoanalytic Studies*, 2(2), 184-188.

The Telegraph. (2017). *Gps Telling Children To Exaggerate Mental Health Symptoms If They Want NHS Treatment*. Retrieved 14 October 2020 from: <https://www.telegraph.co.uk/news/2018/03/08/gps-telling-children-exaggerate-mental-health-symptoms-want/>

Truman, J., Robinson, K., Evans, A. L., Smith, D., Cunningham, L., Millward, R., & Minnis, H. (2003). The strengths and difficulties questionnaire. *European child & adolescent psychiatry*, 12(1), 9-14

Twigg, E., Barkham, M., Bewick, B. M., Mulhern, B., Connell, J., & Cooper, M. (2009). The Young Person's CORE: Development of a brief outcome measure for young people. *Counselling and Psychotherapy Research*, 9(3), 160-168

Unsworth, G., Cowie, H., & Green, A. (2011). Therapists' and clients' perceptions of routine outcome measurement in the NHS: A qualitative study. *Counselling and Psychotherapy Research*, 12(1), 71-80

Wolpert, M., Fugard, A. J., Deighton, J., & Görzig, A. (2012). Routine outcomes monitoring as part of children and young people's Improving Access to Psychological Therapies (CYP IAPT)—improving care or unhelpful burden?. *Child and Adolescent Mental Health*, 17(3), 129-130.

Wright, J., Williams, R., & Wilkinson, J. R. (1998). Development and importance of health needs assessment. *Bmj*, 316(7140), 1310-1313.

Valenstein, M., Adler, D. A., Berlant, J., Dixon, L. B., Dulit, R. A., Goldman, B & Sonis, W. A. (2009). Implementing standardized assessments in clinical care: now's the time. *Psychiatric Services*, 60(10), 1372-1375.

Supplementary Tables

Table 1. Demographic information of the study participants

Participant	Age (years)	Gender	Ethnicity
P1	18	Female	White British
P2	18	Female	White British
P3	21	Female	Any other white background
P4	17	Female	White British
P5	18	Female	White British
P6	17	Female	White British

Table 2. Themes of motivations from thematic analysis of interview transcripts.

Global themes	Sub themes	Organising Codes	Quotes
Drivers	Personal goals	Desire to access the service	<i>'I was in need of support and was at the point where I was willing to do anything to try and feel a bit better and get some help' (P5)</i> <i>'it would show how I was feeling so I didn't have to tell anyone'(P1)</i>
		Easier to disclose	
	Service expectations	Expectation of tailored support	<i>'I guessed someone was going to talk to me' (P2)</i> <i>'Have a clearer idea of my case and thus would know better how to help me' (P3)</i>
		Desire for a counsellor to know about the	

	individual	
	Expectation of personal interaction	
Behavioural preferences	Tendency to complete questionnaires	<i>'I would always fill out the questions' (P4)</i>
	Other people are completing it	<i>'there must have been a good enough reason for them to be there an for me to answer them' (P1)It</i>
	Trusting the purpose/Believing there is a good reason	<i>'I like answering those types of questions' (P6)</i>
Outcomes of being honest	Receiving help	<i>'I had to be real with myself in order to get the help I need' (P2)</i>
	Enables Monitoring	<i>'helps to clarify how I am feeling' (P6)</i>
	Positive unintended consequences	

Table 3. Themes of experiences from thematic analysis of interview transcripts.

Global themes	Sub themes	Organising Codes	Quotes
Discomfort	Internal conflict	Desire to be honest	<i>'I was a bit sceptical about answering them' (P1)</i>
		Outcome related uncertainty	<i>'I thought to myself - do I answer them honestly?' (P1)</i>
		Socialisation of 'i'm fine'	<i>'I did feel quite a lot of instinct to underplay my responses' (P2)</i>
		Information related uncertainty	
		Conflicted in responding honesty	
	Emotional labour	In heightened emotional state	<i>'it made me worry more than needed' (P1)</i>
		Evokes negative feelings	<i>' I had to really focus into how I was feeling' (P2)</i>
		Laborious to identify feelings	<i>'do often find me second guessing myself' (P5)</i>

Internal harmony	Helpful enablement of reflection	<i>'Seeing it on paper helps to clarify how I am feeling' (P6)</i>
	Peers norms are comforting	<i>'It helps me to understand my emotions' (P4)</i> <i>'I feel like it was helpful' (P2)</i>
	Evokes positive feelings	
	Ease of disclosure	

Self sabotaging beliefs	Untrustworthiness	<i>'I've had a lot of bad experiences with safety especially with confidentiality and safety' (P1)</i>
	Not deserving of help	<i>'it was instinct to say I'm fine' (P2)</i>
	Socialised to downplay feelings	<i>'I always feel that there's somebody else who need the help more than I do' (P4)</i>
