VOLUME 1

Supporting Student Emotional and Mental Health Needs in a Secondary School: Staff Understanding and Self-Efficacy

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ABSTRACT

An exploration of what individuals understand emotional and mental health to be is generally absent from literature, despite the definitional difficulties surrounding this. Secondary schools are thought to play a critical role in the support of adolescent emotional and mental health needs, However, several barriers to them doing so have been identified in the literature. Furthermore, secondary staff self-efficacy in relation to providing support to student emotional and mental health needs has not been explored in research. This study explored the views of staff employed in a range of roles in a secondary school who identified as supporting student emotional and mental health needs on a day-to-day basis. Using semi-structured interviews that were transcribed and analysed using Thematic Analysis, the study aimed to explore staff understanding of emotional and mental health. Using Bandura's self-efficacy theory, it aimed to explore the factors influencing staff's self-efficacy beliefs in relation to supporting student emotional and mental health needs.

Findings suggested that staff could not identify the difference between emotional and mental health, which is consistent with the literature. Understanding of mental health was mostly consistent across the sample, and with common public discourses (for example, a deficit model), although there was some individual difference. Previous experience of perceived success in providing support was influential to self-efficacy beliefs. Additionally, lived experience of mental health difficulties was perceived as influential due to enhanced understanding. There was some variation in the sources of information perceived to most greatly influence self-efficacy beliefs. Consequently, self-efficacy was found to be an individualised construct, which is consistent with Bandura's assertion that the influence of different sources of information on self-efficacy beliefs depends on how the information is

cognitively appraised at the level of the individual. Implications for the Local Authority and Educational Psychology practice, as well as further research are considered.

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LIST OF ABBREVIATIONS

	Abbreviation Used
Department for Education	DfE
Department for Education and Employment	DfEE
Department for Education and Skills	DfES
Department of Health	DoH
Educational Psychologist	EP
Local Authority	LA
National Children's Bureau	NCB
National Institute for Health and Care Excellence	NICE
Office for National Statistics	ONS
Office for Standards in Education, Children's Services and Skills	OFSTED
Personal, Social and Health Education	PSHE
Special Educational Needs Co-ordinator	SENDCo

CHAPTER ONE: INTRODUCTION

The research study presented in this Volume was undertaken as part of the three-year professional training programme in Applied Educational and Child Psychology. This programme was undertaken at the University of Birmingham between 2015 and 2018. For the second and third year of the programme I was on placement as a Trainee Educational Psychologist in a West Midlands Local Authority (LA). The study was conducted in a school within the LA that I regularly worked in. The study explores secondary staff's understanding of emotional and mental health, and their self-efficacy beliefs in relation to supporting student needs.

1.1 Study Rationale

There were two reasons why I decided to undertake this study. Firstly, the provision for social, emotional, and mental health needs (SEMH) in schools has been a salient point of discussion and action-planning both nationally and within the LA. At a local level this has been motivated in part by the city's successful bid for Headstart funding in 2016. It has also been influenced by an increase in permanent exclusions within the LA, which led managers within the Children and Young People Directorate to identify a need to build school capacity in relation to supporting student SEMH needs. Within the Educational Psychology Service, I have been involved in work to develop a pathway for school-based SEMH support for schools to use. With the agreement of the Principal Educational Psychologist, it was felt the present research study would complement this area of work within the LA. This study focuses on the understanding of, and school-based support provided for, adolescent emotional and mental health needs.

My second motivation came from my own experiences both professionally and within the voluntary sector. Before commencing this professional training programme, I trained and worked as a secondary school teacher, subsequently teaching in a range of specialist provisions. My reflections on that time and my transition to the profession of Educational Psychology highlighted three key points. Firstly, secondary school staff often interact and support young people with significant emotional and mental health needs on a more frequent basis than 'trained' mental health professionals. Secondly, school staff appear to vary in their confidence in supporting students in this way, and thirdly, how my own sense of capability in providing this support was associated with a number of personal factors and experiences, as well as school-related influences.

Previous research on the provision of support for emotional and mental health needs in schools has focused on staff views and the activities they undertake. While this research has identified barriers to providing support such as time and resources, it has not provided an in-depth account of what factors influence self-efficacy beliefs in relation to this role at the level of the individual. Research has not explored staff's understanding of emotional and mental health, nor has it provided an in-depth understanding of staff experiences in one school as it has involved one to two staff in specific roles across several schools. It is consequently hoped that the present study's findings will provide a unique contribution this field of research.

1.2 Study Context

The research was carried out in a secondary school I have worked in regularly since January 2017. The school is in a city with a population of approximately 257,000. It is a mainstream secondary-school that became part of an Academy Trust in April 2018. The school is on a

border with two LAs and its' population of 1000 students is drawn from both. Most students are from a White British background and very few students speak English as an Additional Language. Around a quarter of students are in receipt of pupil premium (as they are looked after by the Local Authority and/or free school meals), which is in line with the national average. Following the most recent Ofsted inspection in 2016, the school was graded as 'requires improvement' in all areas. In 2017 25% of students achieved Grade 5 or above in English and Maths, compared to the LA average of 35.6% and the England average of 39.6%. This information indicates that the school is deemed a low-performing school according to national averages in a number of areas.

Around 90% of my involvement with young people in the school has been in relation to an emotional or mental health need. Anecdotally, having consulted colleagues working in other secondary schools in the Local Authority, 90% of involvements relating to emotional and mental health needs is a higher proportion than many schools, although they reported an upward trend in this nature of work.

1.3 Study Aims

The research study has two aims. The first is to explore the perceived self-efficacy beliefs of secondary staff in a range of roles in relation to supporting student emotional and mental health needs, using Bandura's (1977) self-efficacy theory. It will explore factors that staff perceive influence their self-efficacy beliefs in this area, and which of these are considered most important. The second aim is to explore secondary staff's understandings of emotional and mental health, and it is hoped this will contextualise how staff perceive their role in relation to providing support.

1.4 Key Concepts

Self-efficacy is defined as the "belief in one's ability to organise and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3). Devised by Albert Bandura in 1977, self-efficacy theory is part of social cognitive theory, which states that individuals acquire knowledge through their interactions with, and observations of, their environment. Self-efficacy theory is an explanation of how four sources of information (mastery experiences, vicarious experiences, social persuasion, and affective state) can influence an individual's beliefs in their ability to succeed in specific situations or accomplish certain tasks. The theory accounts for human agency, as well as the influence of social factors. Self-efficacy theory will be described in more detail in chapter four.

1.5 Research Questions

Three research questions were devised, which followed a review of the literature on conceptualisations of emotional and mental health, the role of schools in supporting adolescent emotional and mental health, and the views of secondary staff in providing such support. The questions are presented below:

1.   What do secondary staff in a range of roles understand emotional and mental health to be?

2.   Based on Bandura's (1977) self-efficacy theory, what factors do staff perceive influence their self-efficacy in relation to supporting student emotional and mental health?

3.   How strong are staff's self-efficacy beliefs in relation to providing support for student emotional and mental health through preventative activities, early identification, and ongoing support?

1.6 Methodology

This is a small-scale, exploratory study that uses a qualitative approach to explore key areas with a small group of secondary staff within the same secondary school. The staff were in a range of roles and were chosen as they supported students with emotional and mental health needs on a regular basis. Semi-structured interviews, comprising of a series of questions, were used to explore staff's understanding of emotional and mental health, strength of self-efficacy beliefs in providing support, and factors influencing these.

1.7 Structure

This Volume comprises of seven chapters including the current one.

In chapters two to four a review of literature relevant to the current study is presented. Literature searches were carried out using the University of Birmingham's online library search function, called 'Findit@Bham'. This search engine has access to 1.8 million print books, 500,000 eBooks, and 50,000 subscription and open access electronic journals (University of Birmingham, 2018). Search terms were used, such as 'school and self-efficacy and adolescent mental health or mental wellbeing' and 'staff and secondary school and self-efficacy'. To ensure relevant and current literature informed the review, empirical studies were only included if were published after 2000. Some older literature was included if it was considered of historical relevance (for example, Marzillier and Eastman's (1984) critique of Bandura's self-

efficacy theory), described a theoretical or methodological framework (for example, Bhaskar, 1978) or have also been referenced in recent literature (for example, Thompson, 1994).

Chapter two outlines the definitional difficulties surrounding mental health due to its inextricable links with changing cultural values. It then presents the findings of the large-scale 'Attitudes to Mental Illness' survey (TNS BRMB, 2015) to provide an overview of the English public's views and understanding of mental health. Two further definitional difficulties are then explored: the relationship between a deficit model of mental health and positive mental health, and the links between emotional health and mental health.

Chapter three presents research on the prevalence of mental health difficulties in adolescence and factors potentially influencing this. It then outlines why schools are considered to be well-placed to provide support for emotional and mental health, as well as some limitations to this provision. Finally, the chapter considers national policies and guidance documents published since 2001 that have influenced the expectations on schools in terms of what needs they are expected to support and what their provision should look like.

Chapter four focuses on Bandura's (1977) self-efficacy theory; offering a critique of this. It then considers the relevance of self-efficacy for school staff, particularly in relation to stress and burn-out. The chapter concludes by outlining relevant research on secondary staff views on supporting student emotional and mental health.

Chapter five outlines the methodology used to address the research aim and explore research questions. The ontological and epistemological stance of the researcher is described, and how this impacted on the study design. The development of the interview schedule and process of data collection are presented, as well as considered ethical issues. The chapter concludes with

a description of the process of thematic analysis (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006) used and the challenges of using this analytic approach.

Chapter six presents the research findings and highlights the themes identified through thematic analysis (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006). Key extracts from the data are presented to illustrate, and links made to the relevant research.

Chapter seven, the final chapter, explores what the research findings offer in relation to the research questions. The methodological limitations of the study are outlined, as well as the implications of findings for schools and Educational Psychologists in relation to planning to build staff capacity to support student emotional and mental health.

CHAPTER TWO: CONCEPTUALISING EMOTIONAL AND MENTAL HEALTH

Despite a wealth of research on mental health and the reported high prevalence of mental health difficulties in the United Kingdom[1] and around the world[2], a universal definition of the concept is lacking, as highlighted in the quotation below from the World Health Organisation (2001).

"Mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualisation of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively."

Difficulties establishing a universal definition can thus be attributed to the influencing role culture plays in the classification of experience (Andary, Stolk and Klimidis, 2011). This is easiest considered in terms of cultural artefacts, such as the semantics of language used, as well as cultural practices.

In their position paper on mental health promotion MacDonald and O'Hara (1998) argued it would be easier to identify what activities promoted or demoted mental health by studying specific examples, rather than attempting to deduce good practice from abstract or arbitrary definitions of 'mental health'. This pragmatic stance undoubtedly has advantages in identifying

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[1] According to McManus *et al* (2009) 'Adult psychiatric morbidity in England, 2007: results of a household survey', approximately 1 in 4 people will experience a mental health problem each year.

[2] According to the World Health Organisation (2017) more than 300 million people around the world live are experiencing depression, which is an increase of more than 18% between 2005 and 2015

beneficial practical strategies. However, it arguably sidesteps the issue of definition, which is also characteristic of most global research literature pertaining to mental health[3]. Instead, there is a globalised use of uniform terminology such as 'depression' (frequently unaccompanied by a definition) and associated measures with no acknowledgement to the cultural context in which these phenomena are studied.

In this chapter I will first explore why there is a need for cultural specificity in definitions of mental health, before presenting what the current cultural climate appears to be in England in terms of attitudes and understanding. Two prominent themes in the research will then be explored: the use of the deficit model in conceptualisations of mental health, and the ill-defined distinction between emotional health and mental health. The chapter concludes by presenting a definition of mental health.

2.1 Defining Mental Health: The Need for Cultural Specificity

Burton, Pavord and Williams (2014) state "meanings around mental health are culture bound and are subject to change" (p. 5). Weare (2000) argued this was because mental health is a social construct formed by "our values, preconceptions and assumptions about the nature of health and illness, of the nature of society, the place of the individual within the society, and what constitutes normality" (p. 13). An example of the way in which constructs of mental illness can change is The Diagnostic and Statistical Manual (DSM, referred to in April 2018), which is now in its fifth amended form since 1952. Furthermore, the estimated prevalence of depression ranged from less than 1% to 17% in the mid-to-late 20th Century (for example,

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[3] For example, see Burckhardt *et al* (2016); Livheim *et al* (2014); Melynk *et al* (2011); Scholten *et al* (2015); Stallard *et al* (2012); and Wijnhoven *et al* (2013)

Cohen and Fairbank, 1938, and Brown and Harris 1978), which may be associated with changes in the conceptualisation of symptoms and severity.

Rogler (1993) asserted that the expectations and constraints of a culture influenced how distress is experienced or perceived by individuals. Andary, Stolk and Klimidis (2011), writing on cross-cultural experience of mental health and illness, affirmed this argument by writing that culture played a part in the meaning people gave to phenomena. Consequently, Andary, Stolk and Klimidis highlighted the need for mental health professionals to pay attention to "the client's idiom of distress" during assessment (2011, p. 16).

Empirical evidence to support the need for cultural specificity can be found in research into the experience of depressive symptoms. The vast majority of studies that have assessed depressive symptoms in samples from different cultural backgrounds have not been able to establish full measurement invariance, meaning that while there were commonalities, cultural biases and cross-cultural differences were also present in the data[4]. This finding has also been supported by studies that have examined constructs of positive mental health cross-culturally (Tucker *et al.,* 2006; Yang, Li and Xia, 2012, Bieda *et al*, 2017). In Bieda *et al* study, for example, the structure of constructs such as social support, happiness, life satisfaction, positive mental health and resilience were the same across cohorts of German, Chinese, and Russian university students studying in those countries. However, there were cultural differences within responses that Bieda *et al* concluded could be attributed to differing cultural expectations and limitations around mental health.

While cross-cultural conceptualisations of mental health are not the subject of the present study, there is a need to be aware of the culture in which mental health is being studied for the reasons

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[4] For example, Baas *et al.,* 2011; Crockett *et al*, 2005; Guerra *et al,* 2015; Nuevo *et al.,* 2009; Wu *et al.,* 2012).

outlined above. This is pertinent given the arguably Western bias in research on psychopathology and conceptualisation of mental health as embodied in the DSM-V (Andary, Stolk and Klimidis, 2011).

2.2 Views on Mental Health in England

A long-existing stigma surrounding mental health difficulties has continued to impact individuals in recent years: For example, in Time to Change's (2008) survey of life experiences for individuals with mental health difficulties (mental health service users), 87% reported being affected by some form of discrimination. In 2007, Time to Change was established. Run by the charities Mind and Rethink Mental Illness, it is a voluntary organisation aiming to 'end mental health discrimination' across England by working with employers, communities, schools, and the media (Time to Change, 2018a). In 2016, Corker *et al*, commissioned by Time to Change, published a follow-up to the original 2008 survey, which found that average levels of discrimination reported by service users fell from 41.6% in 2008 to 28.4% in 2014. Time to Change (2018b) interpreted this finding as a demonstration of the positive impact of the organisation's work. In 2011 the UK government committed £20 million funding to Time to Change to continue its anti-stigma campaign (DoH and Social Care, 2011b).

No research could be found exploring the English public's attitudes towards adolescent mental health. The most recent large-scale survey of the English public's attitudes towards, and understanding of, mental health was the 'Attitudes to Mental Illness' survey carried out by TNS BRMB (2015). The survey was conducted in England with 1736 individuals aged over 16 via face-to-face interviews at their home. They had been selected using a quota sampling strategy. 14 surveys of this kind had been conducted since 1994. In terms of methodological limitations,

it is noteworthy that: the use of face-to-face interviews may have introduced a social desirability bias in responses.

The survey highlighted increased public understanding of conditions associated with mental illness, although this was only measured through knowledge of terminology. The findings indicated that attitudes towards people experiencing mental illness were more positive than in 1998: respondents acknowledged that mental illness was not primarily caused by a lack of self-discipline or will-power, and there was a need for sympathy, and to provide care. Most respondents acknowledged that 'virtually anyone can become mentally ill' (93%).

Respondents were generally accepting of inclusion in the community (for example, a large majority reported locating a mental health facility in a residential area did not downgrade the neighbourhood) and in social circles (for example, the intention to maintain relationships with individuals experiencing mental health difficulties). However, tolerance appeared more limited of people with a previous or current mental health problem assuming roles of responsibility. Only 29% agreed that 'most women who were once patients in a mental hospital can be trusted as babysitters' and 16% agreed with the statement that 'anyone with a history of mental health problems should be excluded from taking public office'. This may be partially explained by the finding that 36% of respondents thought that people with a severe mental health problem could not fully recover.

While 80% of respondents agreed with the statement that 'as far as possible, mental health services should be provided through community-based facilities' (75% in 1994), 16% felt that 'a person should be hospitalised as soon as he or she showed signs of mental disturbance'. Interestingly, agreement with the statement 'mental hospitals are an outdated means of treating people with mental illnesses' decreased between 1994 (42%) and 2014 (35%).

In summary, the survey would suggest that the public in England generally have tolerant and inclusive attitudes towards people with mental health difficulties. There has been an increase in public knowledge regarding the range of conditions affiliated to mental illness, although the survey gave no indication as to whether respondents possessed any knowledge of conditions other than the diagnostic terminology.

2.3: Defining Positive Mental Health

Most research focusing on evaluating mental health has measured this in terms of mental *disorder* (Vaillant, 2012): implicit in this focus is the assumption that 'average' or non-disordered mental health equates to 'good' or 'positive' mental health. Since the late 1950s, researchers have challenged this assumption through attempts to conceptualise and evaluate positive mental health as something other than the absence of illness. According to the dual continuum model, mental illness and mental health belong to two separate but correlated dimensions. Findings from studies support the existence of a dual continuum[5]: Keyes, Dhingra, and Simoes' (2010) study, for example, which utilised separate measures for mental illness and mental health, found that gains in positive mental health predicted declines in mental illness, and losses of positive mental health predicted increases in mental disorder.

Keyes (2007) theorised there were three components of positive mental health: emotional well-being, positive psychological functioning or psychological well-being, and social well-being. These components were thought to integrate hedonic and eudemonic components. The hedonic tradition refers to subjective wellbeing; an individual's desire to maximise pleasure and

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[5] For example, see Greenspoon and Saklofske (2001); Huppert and Whittington (2003); Keyes, Dhingra and Simoes (2010); Keyes (2005); Suldo and Shaffer (2008); and Westerhof and Keyes (2008).

minimise pain from the perspective of maximising the good in his or her life (Henderson and Knight, 2012). This refers to positive affect, sense of satisfaction with important domains in an individual's life, and low levels of negative moods and emotions (Diener, 2000). The eudemonic tradition refers to psychological well-being whereby virtue and effort are considered essential parts of happiness (Kashdan, Biswas-Diener and King, 2008). In other words, positive mental health is thought to be a combination of feeling good and functioning well in life (Gilmour, 2014).

Jahoda (1958) put forward a widely-accepted conceptualisation of mental health that identified six components. She defined these as attitudes towards the self, self-actualisation, integration, autonomy, accurate perception of reality, and environmental mastery. These were presented without empirical support, although Blatt's (1964) study provided support for Jahoda's conceptualisation. Vaillant (2012) outlines seven models of positive mental health that have been suggested since the mid-20th Century (p. 94 – 98). He labels these as 'mental health as above normal' (as indicated through a Global Assessment of Functioning), 'mental health as the presence of multiple human strengths', 'mental health as maturity', 'mental health as positive emotions', 'mental health as socio-emotional intelligence', 'mental health as subjective well-being', and 'mental health as resilience'. In a longitudinal study of the cross-correlation of five of these models[6], Vaillant and Schnurr (1988) found significant correlations between each model and the four others. Furthermore, each model was found to be a predictor of mental health assessed 15 years later.

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[6] The models examined were 'mental health as above normal' (as indicated through a Global Assessment of Functioning), 'mental health as maturity', 'mental health as socio-emotional intelligence', 'mental health as subjective well-being', and 'mental health as resilience'.

2.4 Terminology: Emotional Health or Mental Health?

Weare (2000) commented that health and educational professionals used the terms 'emotional wellbeing' and 'mental health' interchangeably. This still appears to be the case in recent research, where both are often used within the same article[7]. Writing about emotional health, Coleman (2009) argued there was little consensus about what the term meant, whereas Coombes *et al* (2013) recorded five common terms used to describe emotional health: emotional and social intelligence, emotional literacy, emotional and social competence, emotional and social well-being, and mental health.

The distinction between emotional health and mental health is an ill-defined area. Some authors argue 'emotional health' has been used in place of 'mental health' to avoid the negative association of the latter (eg. Coombes *et al*, 2013); underlining the perceived interchangeability of the two. However, this is not consistent across the literature. The DfES and DoH (2004, p. 7) described emotional health as forming "part of the wider concept of mental health, which encompasses both the promotion of positive mental health and also tackling of mental health difficulties". With its focus on activities this definition offers little clarity as to what emotional health constitutes, particularly in relation to mental health. Recent research literature on emotional health has done little to clarify the distinction, with the use of measures typically associated with the symptomology of a range of mental health difficulties[8]. Inherent to these studies was a focus on the presence or absence of a 'problem', akin to the body of research using the term 'mental health'. If longevity of difficulties was taken as an indicator of a distinction between emotional health and mental health, this does not appear consistent in the

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[7] See, for example, Hanley, Winter and Burrell, 2017.

[8] See for example, Denny *et al* (2011) measurement of emotional health in terms of 'depressive symptoms'; Wadman *et al* (2011) measurement in terms of 'anxiety' and 'depressive symptoms'; and Eisenberg, Gower and McMorris' (2016) measurement in terms of 'internalising problems', 'self-harm', 'suicidal ideation' and 'suicide attempt'.

research. For example, Hermann *et al* (2018), makes reference to "repeated and continuing emotional problems".

This conceptual difficulty thus appears to be overlooked in research. One recent theoretical model from the field of positive psychology where both 'emotional health' and 'mental health' were referred to as distinct concepts was Timofejeva, Svence and Petrulite's (2016) paper on Social and Emotional Health. In this paper, Timofejeva, Svence and Petrulite outlined a new psychological construct, 'Covitality' that subsumed other psychological constructs, as shown in Figure 1. Timofejeva, Svence and Petrulite proposed mental health interacted with social emotional health, although the mechanisms by which this may occur were not described. Furthermore, emotional health was aligned with social health, and so no clarification was given on emotional health as a distinct construct.
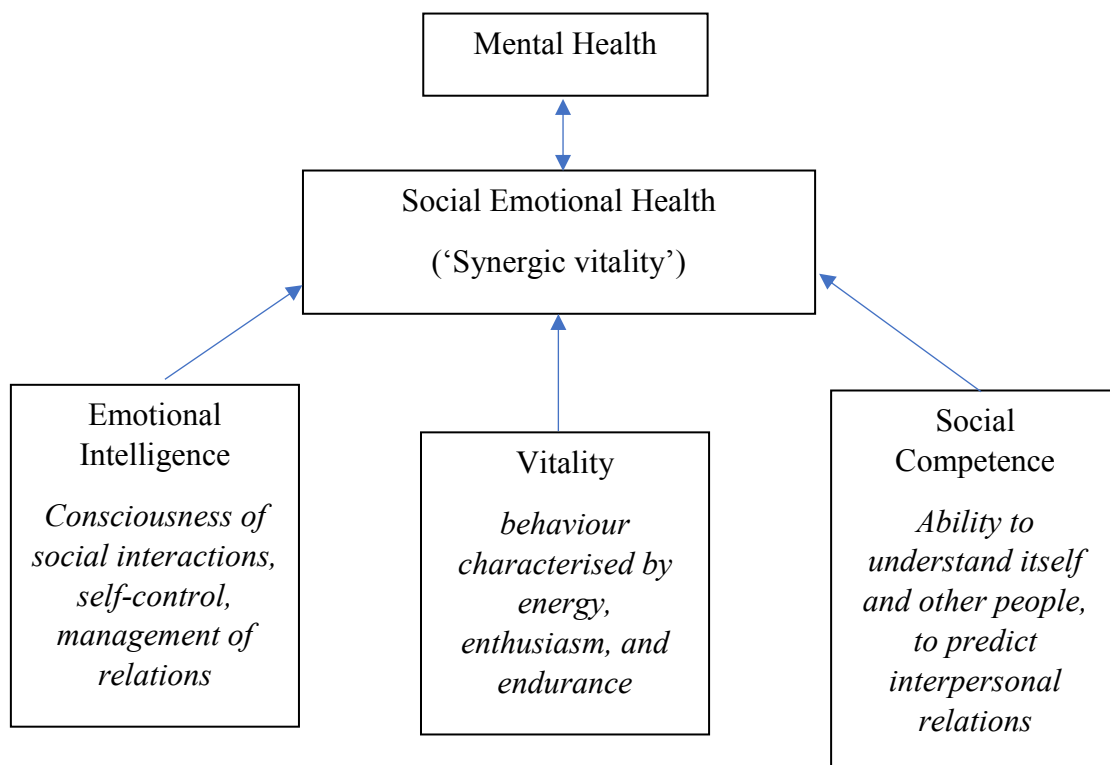
Figure 1: Theoretical model on social emotional health connection with similar psychological constructs (Adapted from Timofejeva, Svence and Petrulite, 2016)

In summary, Timofejeva, Spence and Petrulite's (2016) model offers little clarity on the distinction between mental health and emotional health: The proposed interaction between the two is not described and, rather than being considered as a distinct construct, emotional health is aligned with a social component.

2.5 A Definition of Mental Health

Despite definitional ambiguity, there are common themes in the literature on the components of mental health. To operationalise this term for the purpose of the present study, the following definitions will be used. Firstly, MentalHealth.gov's (2017) definition of mental health will be used:

> "Mental health includes our emotional, psychological, and social well-being. It also helps determine how we handle stress, relate to others, and make choices."

This definition was chosen as it is written and used in a UK context and avoids qualitative statements in relation to good or poor health.

The UK literature also refers to mental health in terms of risk and resilience, according to a model put forward by Pearce (1993). He defined three areas of risk of mental health difficulties; environmental or contextual, the family, and the young person or child, as well as resilience factors such as self-esteem and social skills (Burton, Pavord and Williams, 2014). This model has been referred to in recent literature, such as the 'Mental Health and Behaviour' (DfE, 2016) document. Pearce's (1993) model is outlined in Figure 2.

Risk Factors (Child/Young Person)	Genetic influences, learning difficulties, specific development delay, communication difficulties, difficult temperament, gender identity conflict, chronic physical illness, neurological disorder, academic failure/poor school attendance, low self-esteem
Risk Factors (Family)	Early attachment/nurturing problems, parental conflict, family breakdown, inconsistent/unclear discipline/hostile and/or rejecting relationships, significant adults' failure to adapt to child's changing developmental needs, physical, emotional, and sexual abuse, parental mental and/or physical illness, parental criminal behaviour, death and loss, bereavement issues relating to family members or friends
Risk Factors (Environmental/Contextual)	Socioeconomic disadvantage, homelessness, disaster, discrimination, violence in the community, being a refugee/asylum seeker, other significant life event
Resilience Factors	Secure attachments, self-esteem, social skills, familial compassion and warmth, a stable family environment, social support systems that encourage personal development and coping skills, a skill or talent

Figure 2: Pearce's (1993) mental health risk and resilience model, as presented in Burton, Pavord and Williams (2014)

2.6 Summary

In summary, defining mental health is complex as it necessitates cultural specificity, although this is not widely acknowledged nor addressed in research literature. The result is a universal use of terminology that may not be appropriate, as well as the interchangeable use of terminology such as emotional health and mental health due to an absence of adequate definition. Given the lack of clarity in the writings of researchers, it would perhaps be unsurprising if government policies on the topic of mental health reflected a similar state of affairs. To operationalise the term for the purpose of this research, a definition has been outlined. In the next chapter, the role of schools is considered in relation to supporting adolescent emotional and mental health.

CHAPTER THREE: ADOLESCENT MENTAL HEALTH AND THE ROLE OF SECONDARY SCHOOLS

While concern for the mental health of young people has been a high priority on the political agenda in the UK for a number of years (Cowie *et al*, 2004), recently it has been described as a national priority and major public health concern (DoH and NHS England, 2015). Diagnosable mental disorders are thought to exceed the prevalence, impact and persistence of all other health conditions (Friedli and Parsonage, 2007) and are estimated to cost the UK economy £105 billion a year (Centre for Mental Health, 2010). In this chapter I will outline key research findings in relation to adolescent mental health in the United Kingdom. I will then consider the role of schools in relation to this issue, before examining key policies.

3.1 Adolescent Mental Health

Adolescence appears to be a critical period in terms of mental health as research suggests there are associations between adolescent mental health and later life experiences. A commonly-cited statistic is that up to 50% of lifelong mental health problems are thought to emerge by age 14 (Kessler *et al*, 2005), however, it should be noted that the sample for this study was restricted to English-speaking residents of the United States. Jones' (2013) study of a British cohort found that adolescents with a 'common mental disorder' such as depression and anxiety were more than two and a half of times more likely to have a mental disorder at age 36 compared with mentally healthy teenagers.

According to the most recent national data on UK adolescent mental health, which was gathered via a large-scale representative survey in 2004, it was estimated around 13% of male 11-16 year-olds and 10% of female 11-16 year-olds experienced a mental health disorder (Green *et*

al, 2005). Research suggests that some mental health difficulties may be particularly prevalent during adolescence. The prevalence of self-harm, for example, is thought to increase during adolescence (Hanley, Winter and Burrell, 2017), with an estimated 10% of young people aged 15 to 16 engaging in this behaviour (Cowie *et al*, 2004). Research suggests that adolescent mental health difficulties have high comorbidity with risky behaviours that have physically harmful consequences, such as alcohol abuse, drug use, and risky sexual behaviour (DoH, 2013; Royal College of Psychiatrist, 2010; Marmorstein *et al,* 2010).

Research has identified groups of young people that may be at increased risk of developing mental health difficulties. For example, young people with learning difficulties, an Autism Spectrum Condition, and those from disadvantaged backgrounds (Green *et al*, 2005). According to the DfE and DoH (2015) almost two-thirds of children in care have special educational needs and nearly half have a diagnosable mental health disorder. Green *et al* (2005) found an association between adolescent mental health difficulties and ethnic background. Over 14% of survey participants from a black ethnic background had a diagnosable mental health difficulty, whereas approximately 10% of participants from a white ethnic background and only 3% of participants from an Indian ethnic background did.

Statistics regarding the prevalence of adolescent mental health problems are outdated, particularly as the trend over the last few decades has been towards increased prevalence of difficulties (for example, Collishaw *et al,* 2004; Street, Anderson and Plumb, 2007). Recent data trends suggest this trend may have continued: for example, school staff perceive mental health difficulties as increasingly prevalent in schools (for example, Hanley, Winter and Burrell, 2017). While factors that may contribute to an increased prevalence of adolescent mental health difficulties are multiple and complex (Thorley, 2016), potential explanatory

factors have been cited; many of which align with Pearce's (1993) model of risk and resilience in the general population. Potential explanatory factors are listed in Table 1.

Potential Explanatory Factor	Source
Increased levels of public knowledge of mental health difficulties due to a mental health agenda in media and government health awareness programmes. These have included the Targeted Mental Health Service (2008-2011) and Social and Emotional Aspects of Learning programme (2010).	Burton, Pavord and Williams (2014)
Increased help-seeking from adolescents due to anti-stigma campaigns such as Time to Change, which may have led to increased diagnosis rates.	Thorley (2016)
Parental ill-health impacted by changing levels of socioeconomic disadvantage	Green *et al* (2005) Thorley (2016) Gardner *et al* (2012)
The impact of digital technologies that could provide platforms for negatively impacting behaviours such as cyberbullying, reinforcement of harmful behaviours via websites, and sexting.	Thorley (2016)
Increased educational pressures	Thorley (2016) Hutchings (2015) Weare (2000)
The impact of austerity measures, such as increased levels of deprivation experienced by families and decreased support resources available both within schools and from external agencies.	Hanley, Winter and Burrell (2017)

Table 1: Overview of potential explanatory factors for increased prevalence of adolescent mental health difficulties

Emotion regulation is thought to have a causal role in the development of many mental health difficulties (Aldao, Nolen-Hoeksema and Schweizer, 2010; Berking and Whitley, 2014; O'Driscoll, Laing and Mason, 2014). Thompson (1994) defined emotion regulation as the ability to monitor, evaluate, and modify emotional reactions. Researchers have argued some

features of adolescence associated with emotion regulation may mean adolescents are particularly vulnerable to developing mental health difficulties. Developments in the cognitive, social and physiological domains are thought to precede the ability to regulate emotions, which may leave many young people underequipped to manage the emotional impact of stressors to which they are exposed (Zernan *et al*, 2006).

Furthermore, whereas a younger child's reduced emotion regulation capabilities may be counterbalanced by the external emotion regulation provided by caregivers or attuned adults (Burckhardt *et al*, 2016), adolescents are more likely to reject such support as they pursue independence (Arnsten and Shansky, 2004). Consequently, many young people may experience high numbers of stressors with insufficient internal or external emotion regulation capabilities. To illustrate the potential impact of this situation, researchers have found that symptoms of depression and anxiety increase during adolescence (Meltzer *et al*, 2000; Green *et al*, 2005). However, this trajectory of symptoms during adolescence may not be stable (Natsuaki *et al*, 2009).

Biological developments during adolescence may also impact on the development of mental health difficulties. Puberty is characterised by intense hormonal activity that is associated with two hormonal systems; the hypothalamic-pituitary-adrenal and hypothalamic-pituitary-gonadal axes (Jaffe, 1998). Puberty is thought to begin when genes prompt the hypothalamus to stimulate the pituitary gland. This gland then produces human growth hormone, which prompts hormones such as estrogen, testosterone, androgen and thyroxine to be produced (Jaffe, 1998).

While the onset of mental illnesses is best considered from an ecological perspective, considering both individual and environmental factors, a number of associations have been found between puberty and the onset of some mental illnesses. Anxiety disorders, bipolar

affective disorders, depression, eating disorders, psychosis (including schizophrenia) and substance misuse most commonly emerge during adolescence (see, for example, Hafner *et al*, 1989; Kessler *et al*, 2005). Following exploration of changes at this time, researchers theorise that the sex steroids released during puberty (estrogen and testosterone) may play a role in the onset of some mental illnesses (for example, Giedd, Keshavan and Paus, 2008; Yazici *et al*, 2013). For example, the onset of affective and anxiety disorders during adolescence is thought to be impacted, at least in part, by hormonal changes and hormone receptor changes. While an approximately equal prevalence of depression, anxiety and panic disorders between males and females has been found pre-puberty, post-puberty it is thought two females to every male experience a disorder. As pubertal status has been found to predict this sex difference in prevalence better than chronological age, it is thought sex hormones play a role (for example, Patton *et* al, 1996; Haywood and Sanborn, 2002; Angold and Costello, 2006).

Despite the prevalence of mental health difficulties during adolescence and the way in which these can persist into adulthood, (ONS, 2008; Marmorstein *et al*, 2010), up to three-quarters of young people with diagnosable mental health difficulties do not receive appropriate early intervention (Children's Society, 2008). Over the last two decades, emphasis has been placed on the role of schools in recognising and supporting adolescent mental health and this is the focus of the next section.

3.2 The Role of Schools

Hanley, Winter and Burrell (2017) argued that schools have become a focal point of government policy regarding adolescent emotional and mental health, not least due to the negative impact poor emotional and mental health can have on academic success (Cowie *et al*,

2004). The focus on schools is evident in recent documents such as the DoH's (2015) 'Future in Mind', and the DoH and Social Care, and DfE's (2017) "Transforming Children and Young People's Mental Health Provision: a Green Paper". Both documents highlight the roles schools are expected to play in promoting and supporting adolescent mental health.

A number of reasons have been put forward regarding schools' suitability for promoting and supporting adolescent emotional and mental health. In the 2017 Green Paper (cited above) it is argued that the school environment is well-suited to implementing a graduated approach to identifying needs and implementing interventions. Furthermore, it is argued that the school environment is non-stigmatising, which may make interventions more acceptable to young people and their parents. This was also identified by Wisdom, Clarke and Green (2006), who found that adolescents were frequently concerned about confidentiality, stigmatisation and rejection, and reported preferring non-medical interventions such as speaking to school pastoral staff.

The close geographical proximity of schools may also be beneficial: Calear and Christensen (2010) found that cost, time and location were barriers to accessing support that were frequently cited by families of adolescents. Furthermore, the amount of contact school staff have with young people, as well as opportunities to learn about their stresses, cultural values and typical home situations (Creed, Reisweber and Beck, 2011) means that schools are well-placed to play a role in the promotion and support of mental health.

While schools are well-placed, potential barriers can impact this work. Macklem (2011) summarised these as material resources, human resources, school cultural barriers (the differing beliefs and attitudes of individuals in school systems), family barriers, technical complications (for example, when and how to implement support in the school day), and cultural barriers (for

example, groups of students may receive less attention than needed). Weare (2000) argued that an increasing emphasis on performance, league tables and school accountability within the education system could undermine schools' motivation to recognise young people's emotional needs. She raised the issue of responsibility, whereby staff in educational settings may assume the responsibility for a young person's social development and emotional maturity lies with their parents or specialist outside agencies. Weare stated that many health services had conceptualised mental health as an individual rather than a social issue, which has meant understanding and action on mental health has been the remit of professionals rather than non-trained people. She also argued that schools could see work relating to emotional development as something only relating to children already experiencing difficulties. While Weare wrote this nearly 20 years ago, much of this is consistent with the findings of recent studies (for example, Hanley *et al*, 2017).

In 2015, NCB-Weare proposed an evidence-based framework for a whole-school approach to providing effective support in promoting social-emotional wellbeing and supporting mental health problems[9]. However, evidence from other studies call the effectiveness of elements of this framework into question. In Denny *et al* (2011) study in 96 New Zealand secondary schools, for example, no association was found between positive school climate[10] and better student emotional wellbeing. Furthermore, there was no association found between senior management reports of health-promoting organisational practices and policies of the school, and student risk-taking behaviours or depressive symptoms.

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[9] The framework consisted of adopting whole-school thinking, prioritising professional learning and staff development, developing a supportive policy, implementing targeted programmes and interventions (including curriculum), implementing targeted responses and identifying specialist pathways, and connecting appropriately with approaches to behaviour management (NCB-Weare, 2015, p. 4).
[10] School climate measured in terms of connectedness to school, academic expectations, safety, and student participation in decision-making (Denny *et al*, 2011)

The Social and Emotional Aspects of Learning (SEAL) is an example of a universal-level school programme that was aimed to promote the development and application of five areas of emotional intelligence, as defined by Goleman's (1995); namely, self-awareness, self-regulation, motivation, empathy, and social skills. SEAL consisted of a framework for school improvement, rather than a manualised programme for schools to use (Humphrey, Lendrum and Wigelsworth, 2010). While allowing flexibility in how the programme tenets were applied in individual school systems, it is possible this freedom of interpretation negatively impacted effective implementation in some settings. Humphrey, Lendrum and Wigelsworth's (2010) DfE-commissioned evaluation of the SEAL programme in Secondary Schools found that the programme did not significantly impact pupils' social and emotional skills, general mental health difficulties, pro-social behaviour or behaviour problems. Furthermore, pupils' reported trust and respect for teachers, liking of school and feelings of being supported significantly decreased during the implementation of SEAL, although pupils' feelings of autonomy and influence significantly increased. Authors concluded the programme's lack of success could be attributed to a lack of structure and consistency in delivery, as well as a lack of financial and human resources.

Kidger *et al* (2011) systematic review found no strong evidence that the school environment had a significant influence on adolescent mental health. For example, the six studies that measured environmental factors at the school level yielded no significant effect on emotional health or suicidal behaviour. Only one study that measured the impact of implementing a programme (SEAL) demonstrated a marginally significant effect on wellbeing. One limitation of the studies was that the outcome measures focused on mental ill health, rather than wellbeing: It may be that the approaches studied improved elements of wellbeing without significantly reducing symptoms of mental ill health.

Finally, the DoH and Social Care and DfE's (2017) 'Green Paper' concluded that there was limited evidence for the long-term effectiveness of universal prevention approaches on mental health outcomes related to suicide and self-harm, depression and anxiety, and alcohol and drug misuse at 12 months post-intervention.

Studies have indicated some potentially beneficial ways of working. Approaches such as peer mentoring have shown some promising results, although there remains an insufficient evidence base at present (DoH and Social Care, and DfE's (2017). Denny *et al* (2011) found that schools where staff reported higher levels of wellbeing were associated with fewer depressive symptoms among students; indicating that the provision of support for staff is beneficial (also because it has been associated with lower levels of teacher burnout (Grayson and Alvarez, 2008)). The findings of studies presented here suggests that, when single elements of support provision (for example, school climate) are examined in isolation, their impact is limited. The provision of school-based support for emotional and mental health needs is thus complex and requires schools to implement many complementing approaches simultaneously. The next section reviews the expected role of school in more detail, as has been outlined in key documents.

3.3 Key Public Documents

Over the last two decades the UK Government and other professional bodies have published a wealth of documents providing guidance on how to support child and adolescent emotional and mental health needs. These documents have either been written specifically for schools or have incorporated schools as a target audience in considerations of a broader mental health framework. A timeline of some key documents can be seen in Table 2.

Year of Publication	Publication Title
2001	'Promoting children's mental health in early years and school settings' (DfEE, 2001)
2003	'Every Child Matters' framework (HM Treasury, 2003)
2005	'National Healthy Schools Status: a Guide for Schools' (DfES and DofH) – a formalised direction for schools to follow the principles set out in 'Every Child Matters'
2005	'Healthy Minds: Promoting Emotional Health and Well-being in Schools' (Ofsted, 2005)
2009	'Social and Emotional Wellbeing in Secondary Education' (NICE, 2009)
2011	'No Health without Mental Health' (DoH and Social Care, 2011a)
2013	'Personal, Social, Health and Economic (PSHE) Education (DfE, 2013)
2014	SEND Code of Practice (DfE and DoH)
2015	'Future in Mind' (DoH and NHS England) 'Promoting children and young people's emotional health and well-being: A whole-school and college approach' (Public Health England)
2016	'Mental Health and Behaviour in Schools' (DfE)
2017	'Transforming Children and Young People's Mental Health Provision: a Green Paper' (DoHand Social Care, DfE)

Table 2: Overview of some key documents on children and adolescent emotional and mental health that make reference to schools

One interesting feature is the shift in terminology. The DfEE (2001) made explicit reference to 'mental health'; calling for schools to be involved preventative work, as well as early identification and intervention in relation to mental health needs. All four documents produced between 2005 and 2009 referred to 'emotional health' rather than 'mental health'. Among these, the 'Every Child Matters' framework outlined four areas schools were encouraged to promote: Personal, Social and Health Education (PSHE), healthy eating, physical exercise, and emotional health and wellbeing (including bullying). Ofsted's (2005) 'Healthy Minds: Promoting

Emotional Health and Well-being in Schools', written following visits to 72 schools, called for additional training for the high proportion of staff deemed to have insufficient knowledge of emotional health difficulties. A recommendation for schools to form better partnerships with external agencies was also made. NICE's (2009) guidelines for promoting social and emotional well-being recommended a whole-school approach, sufficient curriculum coverage of relevant topics, systematic assessment of student wellbeing, partnership working with families and outside agencies, and sufficient training on social and emotional wellbeing.

From 2011, authors resumed using the term 'mental health' (Public Health England, 2015, used the term 'emotional health' 62 times and 'mental health' 102 times in the document, despite its title). 'No health without mental health' (UK Government) referred, for the first time, to the need for parity of esteem, whereby mental health should have equal priority to physical health. This concept was incorporated into the Health and Social Care Act (HM Government, 2012). In the SEND Code of Practice (DfE and DoH, 2014) the term 'Social, Emotional and Mental Health' (SEMH) replaced 'Behavioural, Emotional and Social Difficulties' (BESD). The omission of 'Behaviour' from the updated terminology highlighted a desire to focus on the needs potentially underlying an individual's behaviours, rather than the behaviours themselves. This is the first listed document written by professionals from within both health and education.

'Future in Mind' (DoH and NHS England, 2015) referred to both schools and the NHS; setting out the direction of future work regarding children and young people's mental health and wellbeing. This is the first listed document to incorporate both health and education professionals as its audience. Schools were directed to promote resilience, prevention and early intervention through a whole-school approach and a named mental health lead in schools. It was acknowledged that links between services for children's mental health and learning disabilities needed to be strengthened, and that training for school staff was needed. The initial

plan was to implement the recommendations of the Carter review of Initial Teacher Training (Carter, 2015) and commission a sector body to produce a framework of core content for Initial Teacher Training that would include child and adolescent development. In the same year the Mental Health Services and Schools Link Project was launched (NHS England, 2015). Funded by the Department for Education and NHS England, pilot projects were set up in 255 schools, whereby schools had a single point of contact in CAMHS. The aim of the project was to enable more joined-up working between schools and health services. Despite the positive impact made through this project (DfE, 2017), limited resources were available to expand it further.

In 2016 the DfE produced non-statutory guidance entitled 'Mental Health and Behaviour in Schools', which outlined the responsibilities for schools and guidance on implementing a graduated response to need. As well as the reinforcement of familiar themes such as the role of schools in universal and early intervention work, the need for additional training for all staff, and the need for collaborative working, a number of other interesting points were made. Firstly, schools should be supported by specialist agencies to promote positive mental health, as well as support 'severe' difficulties. Secondly, promoting resilience should be adopted as a method of preventing mental health problems. Thirdly, schools should use standardised measures such as the Strengths and Difficulties Questionnaire (SDQ) to help staff "judge whether individual pupils might be suffering from a diagnosable mental health problem" (DfE, 2016, p. 6). While the use of a form of assessment to identify needs is important, the recommended use of an assessment in relation to 'diagnosable' mental health problems is ethically unsound, particularly as the SDQ is an indicative, rather than diagnostic tool, and considered in light of the limited staff knowledge (as conceptualised in terms of a training need) identified in the same document.

In January 2017 the Government announced it was allocating funding so that every secondary school in England could be offered Mental Health First Aid Training (Gov.UK, 2017). As part of this training teachers and staff would receive advice on how to deal with issues such as depression and anxiety, suicide and psychosis, self-harm, and eating disorders. It is envisaged all secondary schools will have received the training by 2020, which further delays the development of a school workforce deemed as capable to address an issue that is attracting ever-increasing concern in professional and public spheres. In December 2017, The DoH and Social Care, and DfE produced "Transforming Children and Young People's Mental Health Provision: A Green Paper". This paper acknowledged the difficulty schools experienced in accessing support for those with social, emotional and mental health difficulties. With £300 million funding allocated over the next five years, two key proposals for schools were outlined: the assignment of a Designated Senior Lead for Mental Health in all schools, the creation of Mental Health Support Teams who could provide a point of contact for schools from within NHS Mental Health Services. Other proposals were to cut waiting times for support to four weeks, review Initial Teacher Training, make Relationships and Sex Education compulsory (and possibly PSHE), as well as continue the anti-stigma campaign, such as Time to Change, which had received government funding in 2011 (DoH and Social Care, 2011b).

While the proposals were described as a welcome start by some (for example, Young Minds, 2017), one concern raised was that the Green paper made no reference to the need to support children develop social and emotional skills throughout their education using evidence-based techniques, nor was there any commitment to providing evidence-based parenting programmes to families (Centre for Mental Health, 2017).

3.4 Summary

Adolescence appears to be a critical period in the development of mental health difficulties. Due to their high-level access to young people, as well as their capacity to provide support in a non-stigmatising way, secondary schools are well-placed to support adolescent emotional and mental health. Over the last two decades guidance has been produced as to how schools may fulfil this role, although the evidence base to support universal approaches is limited. Many themes have remained consistent (prevention, early identification, the need for training and collaborative working), which may suggest that schools continue to struggle in providing this support. In recent years, there has been a shift back to using the term 'mental health' as opposed to 'emotional health' and increased emphasis on collaborative working between education and health professionals. Most recently, it has been acknowledged that schools struggle to access support for students due to the availability of services.

In the context of an increasing need amongst adolescents for emotional and mental health support, secondary staff are attempting to fulfil their responsibility of providing that support with seemingly limited evidence on what is effective, as well as limited access to external services. In light of this, it is important to consider secondary staff's perception of their role in relation to supporting student emotional and mental health, and some of the factors influencing this. This topic explored in the next chapter.

CHAPTER FOUR: SECONDARY SCHOOL STAFF SELF-EFFICACY

If an individual feels unprepared to undertake elements of his or her professional role, this can be a significant source of stress. Reinke *et al* (2011) found this to be the case in relation to teachers' provision of student emotional and mental health support: feeling professionally unprepared was a significant source of stress, which could elevate the risk of burnout. While this study was undertaken in elementary schools in the United States of America, it is considered this finding may have applicability to English secondary school teachers due to the many potential similarities of experience between teaching in those contexts although this is as of yet unestablished in research. Consequently, ensuring secondary school staff feel capable of undertaking their role of promoting emotional and mental health, early identification of difficulty, and providing support to young people, should be paramount.

According to Bandura's (1977) theory, self-efficacy is the "belief in one's ability to organise and execute the courses of action required to produce given attainments" (Bandura, 1997, p. 3). In the context of secondary school staff's provision of support for student emotional and mental health needs, it is important to understand the nature of their individual self-efficacy beliefs regarding this element of their role, as well as the factors influencing these.

In this chapter, I will outline Bandura's (1977) self-efficacy theory and critique this. I will then present the research evidence in relation to occupational self-efficacy, stress and burnout, before considering the existing research on secondary staff self-efficacy in supporting student emotional and mental health needs.

4.1 Bandura's (1977) Self-Efficacy Theory

Bandura's (1977) self-efficacy theory is part of social cognitive theory (Bandura, 1977), which states that individuals acquire knowledge through their interactions with, and observations of, their environment. Social cognitive theory (Bandura, 1977) states that people exercise some influence over their actions (Bandura, 2006). Accordingly, self-efficacy theory makes three assumptions regarding the nature of human agency. Firstly, human adaptation and change is rooted in social systems, thus agency operates in a network of social influences: people are both producers and products of social systems. In a similar vein, the self is socially constituted, however, individuals partially contribute to what they become and what they do by exercising self-influence. Thirdly, human agency is made up of three factors; behaviour, interpersonal factors (cognitive, affective and biological states), and the external environment, although not all three are of equal strength. In this sense, self-efficacy influences an individual's goals and behaviours and is affected by environmental conditions (Schunk and Meece, 2006).

Bandura (1997) argued that human agency was the exercise of personal control, which enabled individuals to predict events and shape them to their liking. However, this personal control is not exercised universally in all situations; that is to say, people choose to exercise control for the benefits they gain in doing so. While efficacy beliefs are propositional and concern an individual's perception of what they are capable of doing, outcome expectations (judgments regarding the likely consequence of an action) also impact behaviour.

The effects of an individual's self-efficacy beliefs can be many. Beliefs influence the course of action selected, the effort given to endeavours, perseverance and resilience in the face of adversity, coping patterns (cognitive and affective), and the level of accomplishment reached. Whereas an individual with high self-efficacy is likely to trust their own abilities, motivate

themselves and demonstrate perseverance in challenging situations (Bandura, 1997; Luszczynska, Gutiérrez-Doña, & Schwarzer, 2005), an individual with low self-efficacy is likely to experience self-doubt and anxiety; experiencing demanding tasks as threatening (Bandura, 1997).

4.1.1 The Structure of Self-Efficacy

Self-efficacy is concerned with what you believe you can do with the skills you have under different circumstances, rather than the number of skills you have. Efficacy beliefs incorporate different types of capability, such as the management of thought, affect, action and motivation. While self-efficacy beliefs are multi-dimensional, they are domain-specific. Bandura (1997, p. 36) defined the efficacy belief system "not as an omnibus trait but as a differentiated set of self-beliefs linked to distinct realms of functioning". Efficacy beliefs in one task or context are not necessarily generalisable to another: it is dependent on the extent to which situations resemble each other, and the extent to which task demands are known. Both of these factors will enable an individual to identify whether any skills he or she has are common to both tasks.

Efficacy beliefs can vary in terms of their strength (individuals with a strong belief in their capabilities are more likely to persevere despite difficulties), generality (some beliefs may apply to specific tasks, where as some may apply to a wider range of activities), and level (from simple task demands through to taxing demands).

4.1.2 Sources of Self-Efficacy

Once people develop a mindset about their efficacy in given situations, they act on their established self-beliefs without further reappraising their capabilities (Bandura, 1997). Bandura outlines four sources of information that can contribute to efficacy beliefs; highlighting that multiple sources may operate simultaneously. Changes in efficacy beliefs are, however, attributed to the way in which the information is cognitively processed, rather than the information itself. The four sources of self-efficacy information proposed by Bandura (1977) are outlined below.

Enactive Mastery Experiences

These are the most influential sources of efficacy information as they provide authentic evidence of the personal resources an individual can employ to succeed. The extent to which this 'evidence' impacts efficacy beliefs is influenced by the relative weight given to factors such as preconceptions about capabilities, perceived difficulty of the task, the amount of effort expended, the amount of external help received, and the way in which these experiences are cognitively organised and reconstructed in memory.

Vicarious Experiences

Efficacy beliefs can be impacted by the transmission of competencies through modelling by others, and comparison with what others achieve. This is partly due to the absence of 'absolute' measures of adequacy for many tasks, which means people appraise their capability in relation to others' achievement instead. Factors that may impact the influence information from this source has on efficacy beliefs is performance similarity (whether the person modelling is perceived to be of a similar or only slightly higher ability), attribute similarity (perceived similar personal characteristics to the model that are assumed to be influential to their capability), and

multiplicity and diversity of modelling (seeing different people model and succeed in different situations).

Verbal Persuasion

This refers to occasions where individuals are influenced or persuaded by others that they possess capabilities. While it is thought the power of verbal persuasion alone is limited in terms of bringing about long-lasting increases in efficacy beliefs, it can be impactful if the positive appraisal given is realistic. The effect of information from this source on efficacy beliefs may be mediated by the way in which performance feedback is framed, the perceived credibility of the 'other' providing the appraisal, and how discrepant the appraisal is from the individual's own beliefs regarding his or her capabilities.

Physiological or Affective States

While an individual's physiological and affective state does not directly impact on efficacy beliefs, it can affect the way that information regarding efficacy is cognitively processed. Bandura argued that the impact physiological state has is influenced by the perceived source of activation, the level of activation (facilitatory or debilitating to functioning), and construal biases (attentional, interpretive and memory biases associated with pre-existing efficacy beliefs). Bandura stated that affective state can impact on self-efficacy judgment, for example, impacting how events are interpreted, cognitively organised and retrieved from memory.

4.2 Critique of Bandura's (1977) Self-Efficacy Theory

While Bandura's (1977) self-efficacy theory has been used extensively in research since his seminal paper, the theory has been critiqued in two respects. Firstly, Tryon (1981) and Biglan

(1987) have critiqued Bandura's methodology to explore the relationship between self-efficacy beliefs and behaviour, particularly as the theory is built on a body of research that suggests efficacy expectations correlate highly with actual behaviours. Tryon (1981) argued that Bandura's experimental procedure did not account for alternative explanations of this effect, such as social reinforcement contingencies. In Bandura's procedure, efficacy expectations were operationally obtained (ie. By asking the subject if they would perform behaviour X) and high levels of congruence were reported between subject responses and actual behaviours, which was interpreted by Bandura as confirming the influence of efficacy expectations on behaviour. However, Tryon identified this assumed relationship did not account for a body of literature that demonstrated the influence of context on responses during such behavioural approach tests (for example, Bernstein, 1973; Bernstein and Nietzel, 1973 and 1974; Smith, Diener and Beaman, 1974, and Tryon and Tryon, 1974). In other words, the congruence between verbalised efficacy expectations and actual behaviour could also be explained by the highly structured situation participants were in, as well as the close monitoring by 'authority figures' (Tryon, 1981).

Biglan (1987) critiqued Bandura's theory from a behaviour-analytic perspective, specifically Bandura's assertion that efficacy expectations determined behaviour approach. Biglan argued that, as the research supporting this assertion consisted of correlations between reported efficacy expectations and other behaviours, the use of two measurements relating to two responses from the same individual could not establish a causal relationship between the two. Biglan wrote a relationship between self-efficacy and behaviour was possible; stating that a correlation between the two was inevitable as they were both responses of the same organism (also Moore, 1984). However, he argued that self-efficacy theory minimised the role of environmental factors that could provide an alternative explanation.

Marzillier and Eastman (1984) critiqued self-efficacy at a conceptual level, arguing that Bandura's distinction between efficacy expectations and task outcomes was not plausible. They argued that any distinction made was not straightforward as "complex activities contain within them not only acts but the outcomes of those acts" (p. 259). In other words, as human activity is a "continuous interchange between behaviour and environmental response (outcome)" (p. 259), an individual's assessment of his or her ability to complete tasks inevitably took into account the likely outcomes.

In summary, criticisms have been made of aspects of Bandura's (1977) self-efficacy theory, although Biglan (1981), Marzillier and Eastman (1984) explicitly stated their support for the theory as whole. An adequate response to Marzillier and Eastman's (1984) critique could not be found in the literature. However, a body of more recent research has emerged that has found associations between self-efficacy beliefs and behaviour across a number of settings[11], which may serve as some response to Biglan's (1981) and Tryon's (1987) critiques.

4.2.1 Self-Efficacy in Recent Research

Bandura's (1977) self-efficacy theory continues to be used to inform research in a number of fields. Recent examples of research in education that have incorporated the theory are Seon Ahn, Bong and Kim's (2017) study on the impact of social models on students' cognitive appraisal of self-efficacy information in relation to academic self-efficacy beliefs. Further examples are Cave *et al* (2017) study on the self-efficacy beliefs of students learning English

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[11] See, for example, Tzur, Ganzach and Pazy (2016), as well as the following meta-analyses: Stajkovic and Luthans (1998) and Moritz, Feltz, Fahrbach, and Mack (2000).

as a second language, and Unrau *et al* (2018) meta-analysis of the impact of reading interventions on reading self-efficacy.

4.3 Self-Efficacy in Schools: Associations with Stress and Burnout

Shoji *et al* (2015) defined occupational self-efficacy as the "confidence one can employ the skills necessary to deal with job-specific tasks and cope with job-related stress, and its consequences". A body of research in schools has found a relationship between self-efficacy, stress, and burnout, however, there are two limitations to this research. Firstly, it has focused only on teachers, despite the wide range of roles fulfilled in educational provisions. Secondly, measures of teacher self-efficacy have not incorporated activities relating to student emotional and mental health. The limited breadth of previous research means there is no evidence to present in relation to the self-efficacy of individuals in a range of roles, nor in relation to supporting student emotional and mental health. However, teachers have been found to be particularly vulnerable to work-related stress, psychological distress, and burnout (eg. Johnson *et al.,* 2005 and Kyriacou, 2000) and it is appropriate to present the findings of this research, despite the evident limitations, as many of the identified stressors associated with the teaching role are arguably also inherent to those in other roles within a school.

Time pressures, administrative demands, lack of human and technical resources and a perceived imbalance between efforts and rewards (e.g. Griva & Joekes, 2003; Kyriacou, 2001; Unterbrink *et al.,* 2007; van Dick & Wagner, 2001) are examples of potential stressors that have been attributed to the teaching role but could equally apply to those in other roles. There is also an expectation that teachers model successful control of their own emotions at all times, suppressing any feelings of impatience or anger (Beatty, 2000), which arguably creates high

'emotional labour'; defined as 'the effort, planning and control needed to express organisationally desired emotion during interpersonal transactions' (Morris & Feldman, 1996, p. 987). This could equally apply to a number of roles within the school setting.

Zee and Koomen's (2016) meta-analysis of teacher self-efficacy and stress found strong, negative correlations between teacher self-efficacy and stress: Teachers with high self-efficacy experienced less job-related stress and fewer student stressors. However, it is not clear what causal relationship may exist between self-efficacy and stress.

Burnout is thought to result from long-term occupational stress (Jennett, Harris, and Mesibov, 2003) and consists of emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach, Jackson and Leiter, 1996). Research has found that teacher self-efficacy is strongly associated to burnout; correlating negatively with emotional exhaustion and depersonalisation (eg. Evers, Brouwers, and Tomic, 2002; Skaalvik and Skaalvik, 2007; Skaalvik and Skaalvik, 2010). This association has been found to be stronger for teachers than those in some other professions, such as health care (Shoji *et al*, 2015). The relationship between self-efficacy and burnout is unclear. Bandura (1997) and Evers, Brouwers, and Tomic (2002) argued that low teacher self-efficacy could lead to feelings of burnout. Bandura (1997) stated that teachers with low self-efficacy were more likely to perceive threats in their environment and magnify the threat of these, as well as dwell on their coping deficiencies. Skaalvik and Skaalvik (2007) and Shoji *et al* (2015), however, argued that the relationship between self-efficacy and burnout may be reciprocal, whereby self-efficacy could be a protective factor for burnout or low levels of burnout may contribute to high self-efficacy.

In summary, research has found associations between teacher self-efficacy, stress, and burnout. However, this research has not extended to the range of roles fulfilled in a school, nor

specifically considered the provision of support for student emotional and mental health. The next section presents the evidence available regarding school staff views on providing this support, which makes no reference to self-efficacy.

4.4 Secondary School Staff Views on Supporting Student Emotional and Mental Health

Although school provision for student emotional and mental health has been the focus of numerous government policies over the last 20 years, only a small number of empirical studies could be found that explored UK school staff's views on this topic.

In 2008 Connelly *et al* distributed questionnaires to headteachers and pastoral care teachers in different school settings in Scotland. The study aimed to gain an understanding of teachers' responses to student emotional needs. The authors concluded that participants experienced a lack of clarity regarding their role boundaries, as well as routes of referral. The study focused on activities undertaken by participants regarding response to emotional needs, rather than participants' self-efficacy in doing so.

Rothi, Leavey and Best (2008) conducted semi-structured interviews with one teacher from a range of 30 English schools. The study aimed to explore whether teachers felt it was their responsibility to identify student mental health problems, and whether they had sufficient training to do so. The findings suggested participants wanted "expert" advice regarding the recognition and support of needs and were reluctant to use diagnostic labels as it was perceived beyond their expertise.

Kidger *et al* (2009) interviewed 14 staff in English schools that had a range of roles (for example, Teaching Assistants and PSHE Co-ordinators) with a designated responsibility for activities promoting emotional health and well-being. The study sought participants' views on

providing support for student emotional health and well-being. The findings indicated that participants felt teaching and emotional well-being were linked but this was not a view held by all staff in their school. This was felt to be impacted by a lack of support for staff wellbeing. Participants considered there was a need for a whole-school approach to facilitate a culture shift, as well as staff training.

Only two empirical studies could be found that had been carried out since the DfE's and DoH's (2014) amended Code of Practice was implemented. Newham *et al* (2017) undertook a study in North East England to ascertain what measures were needed to prevent risks of mental illness onset; interviewing different community stakeholders including school staff. The authors concluded that schools needed additional guidance as to what their role was, as well as comprehensive staff training. The findings highlighted school staff experienced difficulties distinguishing between behaviour that may indicate a potential mental health concern, and that which was attributable to a developmental phase.

Hanley, Winter, and Burrell (2017) explored how schools were supporting student emotional health in a time of austerity. Case studies in three Manchester schools were undertaken and a range of staff identified as supporting student emotional health were interviewed. Hanley, Winter and Burrell found that, in all three schools, people in a wide range of roles were involved in supporting student emotional well-being. The authors concluded that participants perceived they were required to bridge a gap where services were not available, and the need to do this was increasing due to the impact of socioeconomic factors such as deprivation and welfare reforms. Participants felt that this need was not always recognised by Ofsted, who prioritised academic attainment.

4.5 Concluding Synthesis and Research Questions

Emotional and mental health are frequently used terms that can have, however, diverse definitions. Adolescence is a critical period in the development of life-long mental health difficulties. The provision of support for student emotional and mental health needs is a long-standing expectation for secondary schools, particularly due to their location, access, and ability to provide support in a non-stigmatising way. Despite this expectation, there is little evidence to outline effective practice in schools and previous research on school staff views indicates they continue to feel ill-equipped in this area.

Self-efficacy is a belief in one's ability to achieve chosen tasks and it accounts for notions human agency as well as environmental conditions. While associations between self-efficacy beliefs, stress and burnout have been found within the teacher population, no research could be found regarding the self-efficacy of school staff in a range of roles, nor in relation to supporting student emotional and mental health needs.

The lack of research focusing on this area led to the development of three research questions. These are presented in Table 3, with the rationale for each.

Research Question	Rationale
What do secondary staff in a range of roles understand emotional and mental health to be?	Terminology such as 'emotional health' and 'mental health' is used frequently and often interchangeably, including in governmental guidance documents for schools. However, there are no universal definitions of these terms due to the need for cultural specificity. Previous research does not highlight this definitional difficulty and previous research on school staff views has not explored their understanding of the terms 'emotional health' and 'mental health'. Exploring this is key to understanding what school staff aim to do in providing support for emotional and mental health needs, as well as the perceived task demands associated with activities.

Based on Bandura's self-efficacy theory, what factors do staff perceive influence their self-efficacy in relation to supporting student emotional and mental health?	Previous research has identified environmental conditions that affect school staff's ability to provide support (for example, time and resources) in a range of settings that does not capture the variation in resources available in specific settings. Previous research has not explored individual factors influencing human agency, such as self-efficacy (Bandura, 1977). Previous research has found associations have been found between self-efficacy, stress and burnout amongst teaching staff. Most previous research has focused on the views of senior management or staff with a designated pastoral role, despite the recent identification that staff in a range of roles may support student emotional and mental health (Hanley, Winter, and Burrell, 2017).
How strong are staff's self-efficacy beliefs in relation to providing support for student emotional and mental health in the activities they undertake?	To plan next steps to increase staff self-efficacy in providing support, it is important to understand what they will find of value. Current government guidance recommends training, however, some studies have found no correlation between teachers' training on adolescent mental health and their self-efficacy beliefs (eg. Officer, 2009).

Table 3: Research questions and the rationale for these.

CHAPTER FIVE: METHODOLOGY

5.1 Introduction

In this chapter I will outline the aims of the current research project and the questions explored. I will then state my ontological and epistemological stance, before outlining the research design used, and the reasons for using semi-structured interviews as the data collection method. Following this, I will describe how the interview schedule was developed and improved as a result of the pilot study. Information is provided detailing the recruitment of participants, sample, the interview procedure and also potential ethical issues. At the end of the chapter I will outline my approach to data analysis.

5.2 Research Aims and Research Questions

The aims of the research project were to explore secondary staff's understanding of emotional and mental health, and to explore their self-efficacy beliefs in relation to supporting student emotional and mental health needs using Bandura's (1977) self-efficacy theory. To investigate these aims, the following research questions were developed:

1. What do secondary staff in a range of roles understand emotional and mental health to be?
2. Based on Bandura's self-efficacy theory, what factors do staff perceive influence their self-efficacy in relation to supporting student emotional and mental health?
3. How strong are staff's self-efficacy beliefs in relation to providing support for student emotional and mental health needs?

The research questions were generated following a review of the literature, which has been presented in chapters 2 to 4. The rationale behind these research questions is presented at the end of chapter 4.

5.3 Ontological and Epistemological Stance

Ontology concerns the nature of reality (Cohen, Manion and Morrison, 2011), that is to say, what knowledge exists and how it exists (Goodley and Smailes, 2011). Goodley and Smailes (2011) state that epistemology is concerned with how we know what exists. Consequently, beliefs regarding ontology and epistemology are related as "claims about what exists in the world imply claims about how what exists may be known" (Scott and Usher, 1996, p. 11). My ontological stance is that reality is stratified, which is Bhaskar's (1978) assumption, and my epistemological stance is Bhaskar's (1978) Critical Realism. Both of these are outlined in the sections below.

5.3.1 Ontology

Different ontological viewpoints exist; varying from an assertion that individuals have direct access to an objective reality, to the view that 'reality' is a sociohistorical construct and no objective reality exists. In *A Realist Theory of Science* Bhaskar (1978) put forward an alternative standpoint; that reality was stratified. According to this conceptualisation, natural mechanisms, events and experiences constituted three overlapping domains of reality; the real, actual and empirical. A key assumption of Bhaskar's conceptualisation is that natural

mechanisms must be independent from the events generated, if we assume they go on existing and acting in their normal way outside of the experimentally closed conditions that enable us

to identify them. A visual representation of Bhasker's stratified reality can be seen in Figure 3, incorporating Bergin, Wells and Owen's (2008) descriptions.

What exists, whether it is experienced or not. Consists of mechanisms, experiences, and events.

What happens when mechanisms of the real are activated. Consists of experiences and events.

Real

Actual

Empirical

Only what we experience. Consists of events.
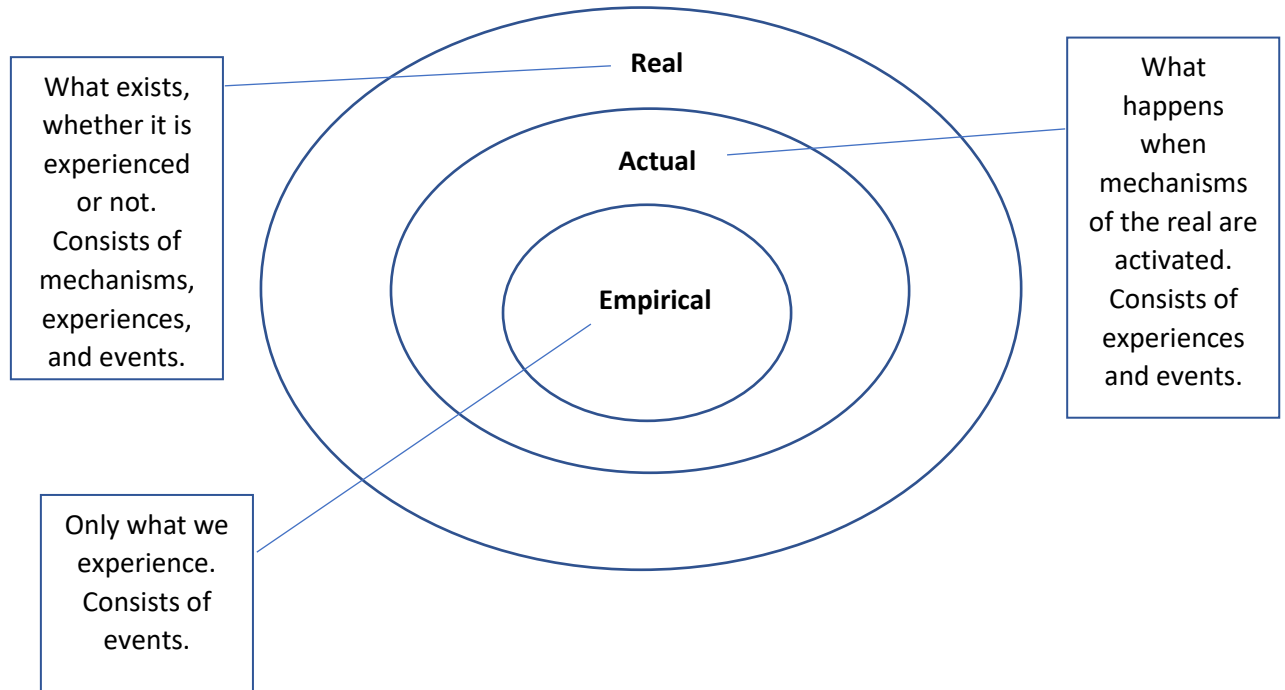
Figure 3: Bhaskar's (1978) stratified reality, adapted from Elder-Vass (2004)

The aim of the present study was to explore some of the mechanisms (for example, individual and environmental factors) that influenced secondary school staff's self-efficacy beliefs in relation to supporting student emotional and mental health.

5.3.2 Epistemology: Critical Realism

Critical Realists argue that "human knowledge captures only a small part of a deeper and vaster reality" (Fletcher, 2017, p. 182). Another key tenet is that both social structures and human

agency exhibit causal powers, and it is the task of research to explore their interaction (Archer *et al*, 1999).

In line with a Critical Realist stance, I have made three assumptions that have guided the methodological design. Firstly, Bhaskar (1978) condoned the use of existing theory as a starting point and the theoretical framework for this study was guided by Bandura's (1977) self-efficacy theory, as well as other literature presented in chapters 2 to 4. However, as all theories are fallible (Scott and Bhaskar, 2010), I assumed that the literature presented in chapters 2 to 4, as well as explanations of phenomena provided by the research participants and my interpretation of these were only the best-available descriptions of reality. This also informed the combined deductive and inductive approach I took to data analysis: I began with theory from existing theory from the literature (deductive) but also sought to uncover new ideas from the data (inductive).

Secondly, I assumed I could uncover causal mechanisms (from the 'actual' realm of reality – see Figure 3) through the activities that they govern (Bhaskar, 1978) (as experienced in the 'empirical' realm of reality – see Figure 3). By exploring *how* individuals conceptualise emotional and mental health, and their self-efficacy beliefs, and *why*, the study aims to uncover "underlying mechanisms that cause events rather than the events themselves" (Matthews, 2003, p. 63).

Thirdly, I assumed qualitative methods were essential due to the relationship thought to exist between social structures and human agency, whereby both have causal powers (Archer, 2003). I assumed the Self consisted of a "continuous sense of self or reflexive self-consciousness" (termed as "inner dialogue") (Archer, 2003, p. 19), which meant individuals are not irreducible

to human norms (Cruickshank, 2003). To capture the individual nature of this inner dialogue, a qualitative approach was chosen for this study.

5.4 Research Design

According to Robson (2002) the following components need to be considered when designing research; the aim and purpose of the research, the research questions, epistemological stance, ethical considerations, and relevant literature. These were taken into account when designing the current study.

5.4.1 Exploratory Research

This is a small-scale, exploratory study. Schools are unique both in terms of their student and staff population, the community in which they are situated and the nature of the systems and processes used within-school. Consequently, it was considered appropriate to conduct the research in one secondary school, in order to control for these environmental factors. As the research took place in one school with a small sample of staff it can be described as small-scale. The study can be described as exploratory due to the aims of the research, which were to explore secondary staff's understanding of emotional and mental health, and to explore their self-efficacy beliefs in relation to supporting student emotional and mental health needs using Bandura's (1977) self-efficacy theory. As mentioned above, a qualitative approach was taken to meeting the research's aims.

5.4.2 Qualitative Research

Qualitative research can be defined as "the interpretative study of a specified issue or problem in which the researcher is central to the sense that is made" (Banister *et al*, 1994, p. 2). There are two key components of this definition: firstly, an acknowledgement of the researcher's active role in the research, both in terms of the social context (Thomas, 2011) and the researcher's own biases and interpretations (Creswell and Plano Clark, 2011). Secondly, the role of interpretation in 'discovering knowledge' due to an assertion that direct study of an object is impossible and consequently, representations of the world are always mediated (Banister *et al*, 1994). Both components are relevant to the present study. As a Trainee EP I have been working in the school studied for over a year and am a known individual within the school setting. Secondly, the research may be influenced by my own interpretations and biases, influenced by previous experiences working in the school and in other schools nearby.

There are three potential challenges in conducting qualitative research. Firstly, quality in quantitative research is considered in terms of notions of validity and reliability (Banister *et al*, 1994), and these are not attainable in qualitative research in the same way. To ensure quality in the present research study, Meyrick's (2006) guidance was followed (see Appendix 1).

Secondly, as qualitative studies tend to use small samples, they cannot be said to use representative samples (Willig, 2013), which has implications for notions of generalisability of findings. However, qualitative research identifies the experiences available within a culture or society, even if it gives no indication as to how many people may share the same experience (Willig, 2013). If the assumption is followed that experiences are at least partially socially constituted, which aligns with a Critical Realist stance, it follows that "each individual mode of appropriation of the social … is potentially generalisable" (Kippax *et al*, 1988, p. 25).

The third challenge is the way in which the researcher's biases and interpretations may influence the research due to the way the problem is theorised (Banister *et al*, 1994). The issue of subjectivity is arguably key to all research, however, the central position of researcher reflexivity in qualitative research means there should be transparency in how the researcher's subjectivity has structured the way in which the subject under study is defined. This will be addressed more fully later in this chapter.

5.4.3 Context of Research

Demographic information about the school in which the study was undertaken is outlined in Table 4. While information on the numbers of students with emotional and mental health difficulties was not available, around 90% of my involvement with students had been in relation to this area of need, which was anecdotally estimated to be the same or higher than most other secondary schools in the LA. The school employed three pastoral managers and was supported by a school nurse on a weekly basis, as well as the Educational Psychology Service. It did not employ a counsellor.

Total population in the Local Authority (2017)	257,000
Number of Mainstream Secondary schools in LA	20
School population	1,000 (drawn from across two Local Authorities due to a border)
Ethnic demographic	Predominantly White British. Very few students with English as an Additional Language.
Pupil premium/Free school meals	Around 25%, which is line with the national average
Ofsted rating (2016)	"Requires Improvement" in all areas
Percentage of students achieving Grade 5 in English and Maths	25%

Percentage of students achieving Grade 5 in English and Maths (LA average)	35.6%
Percentage of students achieving Grade 5 in English and Maths (England average)	39.6%

Table 4: School demographic information

5.5 Data Collection Using Semi-Structured Interviews

Two methods of qualitative data collection were considered; individual semi-structured interviews and focus groups. The use of focus groups for data collection was discounted for three reasons. In focus groups, which are a form of group interview, the data emerges through the interaction of the group (Cohen, Manion, and Morrison, 2011). Firstly, I was concerned that the data collected may reflect collective efficacy, whereas my research questions aimed to explore individual efficacy. Secondly, I was concerned there may be a social desirability bias, whereby participants shared views perceived as acceptable to other participants. Thirdly, I felt participants may be more reluctant to share information, particularly potentially emotive content, due to the absence of anonymity and confidentiality.

Semi-structured interviews are a widely used method of data collection in qualitative research in psychology, partly due to their compatibility with several data analysis methods (Willig, 2013). Willig (2013) described an interview as a "conversation between two people whose interaction with one another generates the data to be analysed" (p. 29) and some researchers have argued interviews are "one of the most common and powerful ways in which we try to understand our fellow human beings" (Fontana and Frey, 2000, p. 645) as "talking and listening is a part of everyday human experience and is a key way in which we understand our own and others' worlds" (Hugh-Jones, 2010, p. 77). In a semi-structured interview, the topics to be covered, sequence and wording of questions are outlined in an interview schedule (Cohen,

Manion, and Morrison, 2011). The advantage of semi-structured interviewing is that the use of an interview schedule increases the comprehensiveness of the data and incorporates a level of systematicity in data collection (Cohen, Manion, and Morrison, 2011). It also allows the researcher to clarify participants' responses and explore these further through follow-up questions. Furthermore, it was considered that the use of individual semi-structured interviews may facilitate more open discussion regarding sensitive topics such as mental health, pupils, and individual's sense of their own capabilities.

5.5.1 Interview Schedule Design

Robson's (2002) guide to devising an interview schedule was used. At the start of the interview I explained the purpose of the interview, both verbally and in writing (Participant Information Sheet, Appendix 5). This was followed by a non-threatening question requiring a 'yes' or 'no' response, which asked participants to confirm they supported student emotional and mental health needs on a regular basis. Then there was the main body of the interview and, at the end of the interview, participants were asked if there was anything further they would like to add as a 'cool-off' question. Finally, participants were thanked for their participation. A copy of the interview schedule used in the pilot study can be found in Appendix 2.

The main body of the interview consisted of four topics. The first was a contextualisation question that asked participants to describe their role in the school. This was asked to explore what activities participants perceived they undertook in the school and the purpose of these. The second question topic was conceptualisations of emotional and mental health. The aim of these questions was to explore what participants understood emotional and mental health to mean, as well as how they perceived it in students. As well as being an under-explored topic, it

was thought these aspects may influence the activities participants undertook, as well as the demands they associated with activities.

The third topic related to participants' perceived self-efficacy in relation to supporting student emotional and mental health. Participants' knowledge of the term 'self-efficacy' was checked and a definition provided. Following clarification of the term, participants were asked to rate themselves on a Likert scale from 1 to 10 (1 = low self-efficacy, 10 = high self-efficacy). A standardised tool was not used as the scale was intended to guide subsequent discussion, rather than provide comparative measurements. Alongside this, participants were asked why they had chosen that rating and why they had not scored themselves lower or higher. Subsequent questions explored perception of responsibility to provide support and limitations around this, as well as the activities carried out by participants and known gaps.

The final topic explored factors influencing participants' self-efficacy beliefs, using Bandura's (1977) theorised sources of self-efficacy information to structure questions. The influence of mastery experiences was explored using questions on previous training, knowledge, and successful experiences of providing support. Vicarious experiences were explored through questions on where participants perceived their ability to provide support in relation to others in the school and why. Verbal persuasion was explored through questions on the attitudes and encouragement of others within the school. The impact of affective state was explored through a question on day-to-day feelings regarding provision of support. For the final question, participants were asked to identify one thing that would have the biggest impact on how able they felt to support students.

5.5.2 Challenges of Interviewing

Five potential challenges to using interviews as a method of data collection were identified and steps were taken to address these. Firstly, it was noted that interviews can be time-consuming, which may impact on the willingness of individuals to take part (Robson, 2002). To negotiate this, all participants were made aware of the approximate length of the interview. I planned my interview schedule to ensure I was realistic regarding the number of questions that could be asked within the agreed timeframe and this was reviewed following the pilot study.

Secondly, I was aware the interview data may be impacted by a social desirability bias in terms of the information participants disclosed. While it is impossible to completely control for this, I aimed to create a non-judgmental, supportive atmosphere in interviews to minimise the risk.

Thirdly, data is co-constructed as interviews rely on an interaction between two people, and so the interviewer also plays a role in the production of data (Hugh-Jones, 2010). I was aware my own biases and views could enter the data through, for example, which aspects of responses I chose to follow-up. I adhered to the interview schedule as far as possible and reflected on the purpose of asking additional follow-up questions before doing so.

Fourthly, prior relationships with interviewees could impact the amount and nature of information they were comfortable to disclose (Banister *et al*, 1994). I was aware I worked with three participants on a very regular basis, one less frequently, and had not worked with two participants. To address this inequality, I made efforts to build relationships with the less familiar participants prior to the interview day.

Finally, it was possible I may overinterpret or misinterpret the data, which could impact data analysis (Banister *et al*, 1994). To address this, I asked clarification questions where needed and used summarising through the interviews to check my interpretation of what had been said.

5.5.3 Recruitment

The original intention of the study had been to explore the views of subject teachers in a secondary school who did not have a designated pastoral role aside from form tutor. While attempts were made to recruit subject teachers from two schools, these were unsuccessful. In the first school two emails were circulated to teaching staff (two weeks apart) and I presented the project at a staff meeting. I was unable to recruit any participants through this process and, consequently, the same process was repeated in another secondary school. This was also unsuccessful which, on reflection, may be partially attributed to my inclusion of the term 'mental health' as opposed to 'well-being'.

Having decided to widen my inclusion criteria, I returned to the first school and, through discussion with the school's Pastoral Managers, roles were identified that were involved in supporting student emotional and mental health needs on a day-to-day basis. Individuals in these were roles were approached using the recruitment processes outlined below and the aim was to interview individuals in a range of roles. A purposive sampling method was used as individuals were approached who were judged as possessing "the particular characteristics being sought" (Cohen, Manion, and Morrison, 2011, p. 156).

An email advertising the research study was sent to individuals in the roles identified, which included Pastoral Managers, Heads of Year, the SENDCo, Learning Support Assistants, Teaching staff, and Learning Mentors. This was a total of approximately 70 staff. A copy of the email advertisement can be found in Appendix 3. Staff who expressed an interest in participating in the research were contacted and a mutually agreeable date and time for the interview was agreed.

5.5.4 Pilot Study

Once the interview schedule had been devised, it was piloted with one participant to ensure the questions were understood and elicited the right areas of information. Any changes were informed by my own reflections and the participant's feedback.

The first recruited participant agreed to pilot the schedule and was told her data would be included in the analysis if no significant changes were subsequently made to the schedule. The participant fed back that the questions were clear and understandable, however, one question was rephrased to ask participants to describe the relationship between emotional and mental health, rather than define the two separately. A copy of the amended interview schedule can be found in Appendix 4.

As this information was captured during the pilot interview through additional questioning, this interview was included in the analysis.

5.5.5 Sample

Six members of school staff agreed to take part and interview arrangements were made with them individually. Two participants had a solely pastoral role (Pastoral Managers), two had both pastoral and academic responsibilities, and two had solely academic responsibilities. None of the participants were members of the senior management team, and none were full-time teaching staff. All participants identified they gave students support for emotional and mental health needs on a regular basis. All six participants were female and from a White British background.

According to Fugard and Potts' (2015) guidelines for sample sizes in thematic analyses, six participants classifies as a small sample. The sample was not representative of all roles within the school, particularly as no full-time teaching staff participated. However, the roles of those who participated were reflective of Hanley, Winter and Burrell's (2017) findings regarding who provided support for emotional wellbeing in secondary schools. While the range of roles was not as extensive as those interviewed by Hanley *et al* (2017), it was considered sufficient to provide an insight into individuals' self-efficacy beliefs in the provision of support to students.

5.5.6 Interview Procedure

All participants were interviewed individually in a private room in the school. The average interview length was 44 minutes. The shortest interview was 23 minutes and the longest interview was 56 minutes. All interviews were recorded using a Dictaphone.

A few days before each interview, participants were given a 'Participant Information Sheet' (see Appendix 5), which outlined the purpose and benefits of the study as well as details relating to the interview process, data storage, withdrawal from the study, and confidentiality and anonymity. Contact details for the researcher and supervisor at the University of Birmingham were also provided. At the interview, participants were provided with another copy of the 'Participant Information Sheet' and given an opportunity to ask questions. They were then asked to sign the 'Consent Form' (see Appendix 6). Among other details, the consent form highlighted participants' right to withdraw at any point, up until one month following the interview.

5.5.7 Ethical Considerations (Consent, Debriefing, Confidentiality, Risks)

The University of Birmingham's Application for Ethical Review was completed prior to commencing the study, which adheres to the University's process of gaining ethical approval for research. A copy of the Application can be found in Appendix 7 and ethical approval was received on 19th September 2017. No recruitment of participants or data collection took place before this date.

The British Psychological Society's (BPS) Code of Human Research Ethics (2014) outlines four principles: respect for the autonomy, privacy and dignity of individuals, scientific integrity, social responsibility, and maximising benefit and minimising harm (p. 6 to 11). This research complied with those four principles. Ethical issues considered during the design of the research, as well as data collection, are outlined in Table 5, as well as steps taken to address these.

Ethical Issue	Steps taken to negotiate this
Valid Consent (Section 4 of the BPS Code of Human Research Ethics, 2014)	Participants were given a copy of the Participant Information Sheet a few days prior to the interview, which was reviewed at the start of the interview. Participants were given an opportunity to ask questions at the start of the interview. Participants were then asked to sign a consent form indicating they were aware of key aspects of the research project.
Adequate Debriefing (Section 8 of the BPS Code of Human Research Ethics, 2014)	An identified risk was that reflecting on their perceived ability to provide support may negatively impact participants. Participants were passed information about support networks were available and were informed that disclosures around their own mental and emotional health that may mean they could be considered a risk to themselves or others would be passed on to their line manager. This did not need to be actioned following any interviews. Participants were also given

	an opportunity to ask questions at the end of the interview.
Confidentiality (Section 5 of the BPS Code of Human Research Ethics, 2014)	Participants' names were not linked to their interview: Each interview was allocated a number and only the researcher knew which number corresponded to which participant. Only the researcher had access to the raw data and it is unlikely participants could have been identified from transcripts. All paper materials were kept in a locked filing cabinet in an LA office. The recordings were removed from the Dictaphone to an encrypted USB as soon as possible and deleted from the Dictaphone. Recordings were transferred from the USB to a password-protected file on the researcher's university account as soon as possible.
Addressing Risks (Section 3 of the BPS Code of Human Research Ethics, 2014)	Identified risks were minimal. The first risk related to the potential induction of negative feelings in relation to the interview subject matter. This was addressed using steps outlined in 'Debriefing' above. The second risk related to ensuring anonymity in a single case-study design. Direct quotations were not used in the write-up if they referred to a unique personal experience. Role terminology deemed to be specific to the school was replaced with a generic term (eg. 'Pastoral Manager').

Table 5: Identified Ethical Issues and Steps taken to negotiate these

5.6 Thematic Analysis

Thematic analysis is used across many disciplines including psychology as a method of identifying, analysing and reporting patterns within data in rich detail (Braun and Clarke, 2006). According to Braun and Clarke (2006) a theme should capture "something important about the data in relation to the research question and represent some level of patterned response or meaning within the data set" (p. 82). The identification of themes is facilitated by coding, which involves recognising something ('seeing'), encoding it (seeing it as an important moment), and

interpretation (Boyatzis, 1998). There are two methods of identifying codes in the data; inductively, from the data itself, or deductively, from prior research or theory (Braun and Clarke, 2006).

Thematic analysis was chosen for three reasons. Firstly, Willig (2013) argues it is well-suited to exploring people's conceptualisations or ways of thinking about social phenomena, which was an aim of the current study. Secondly, while not tied to a theoretical approach (Willig, 2013). Braun and Clarke (2006) assert thematic analysis aligns with a Critical Realist approach as it can be used to explore the ways the social context impacts on the meanings individuals make of their experience. Thirdly, as it is a flexible approach, combined deductive and inductive data analysis could be used (for example, Fereday and Muir-Cochrane, 2006), which is consistent with the Critical Realist assumption that existing theories are fallible and can be improved upon.

A number of authors have written on the process of thematic analysis (for example, Boyatzis, 1998, and Crabtree and Miller, 1999). Braun and Clarke's (2006) six-step approach was used in the current study, however, this was supplemented by Fereday and Muir-Cochrane's (2006) approach which combined inductive and deductive analysis.

5.6.1 Combined Inductive and Deductive Thematic Analysis

To answer my research questions, a combination of inductive and deductive thematic analysis was used. Deductive analysis was considered appropriate due to the use of Bandura's (1977) theory to explore self-efficacy beliefs, as well as my own theories on participants' understanding of emotional and mental health, derived through the literature presented in chapters 2 and 4.

A potential weakness of deductive thematic analysis is that codes are not derived directly from the raw data and are not developed specifically in relation to the context of the data (Boyatzis, 1998). To allow themes to emerge directly from the data, which was considered important due to the number of previously unresearched aspects (for example, school staff's understanding of emotional and mental health), inductive coding was also used. This would also allow for existing theories to be refined.

The following sections describe in detail the process used to analyse the data collected.

5.6.1.1 Developing a Code Manual

A code manual organises segments of similar or related text, which can assist in data interpretation (Crabtree and Miller, 1999). For this study, the code manual was developed prior to in-depth familiarisation with the data to minimise the unintentional introduction of initial ideas generated from reading the data. The manual was based on the research questions and literature presented in chapters 2 to 4, relating to sources of information related to self-efficacy beliefs and common themes in conceptualisations of emotional and mental health.

Codes were written according to Boyatzis' (1998) guidelines and were identified by; the code label or name, a definition of what the code concerns, and a description of how to know when the code occurs in the data. An extract of the code manual is presented in Figure 4.

Code Name	Description and Use
Deficit model	The absence of, or reduction in, a skill or quality that is directly or indirectly attributed to mental health. This code does not apply to a negative consequence of a mental health difficulty.
Risk factor	An individual characteristic, family characteristic, or contextual characteristic

	whose presence is perceived as having a potential negative impact on mental health.
Resilience factor	An individual characteristic, family characteristic, or contextual characteristic whose presence is perceived as supporting or protecting mental health.

Figure 4: An Extract of the Code Manual

5.6.1.2 Data Familiarisation

I transcribed each interview, focusing on the content rather than linguistic features: non-verbal utterances and pauses were not included in the transcript. The transcripts were checked against the original audio recordings for accuracy. Each transcript was read several times and I noted initial ideas in the margin about key ideas in the data. A transcript of Pastoral Manager 1's interview can be found in Appendix 8.

5.6.1.3 Generating Initial Codes

Firstly, the code manual was checked to determine whether the codes were applicable to the raw data (Boyatzis, 1998). During this stage, one transcript was coded solely using the predefined codes. The results were discussed with a colleague with experience of using thematic analysis. No modifications were made to the code manual.

Following this, the codes were applied to the remaining five transcripts to identify meaningful sections of text. Coding was not confined by the preliminary codes, although it was guided by them. As all six transcripts were coded, inductive codes were assigned to themes emerging from the data. For the transcript used to test the code manual, this was completed as a separate process. The inductive codes either expanded a code from the manual or were separate from

the predetermined codes. Once this was complete, all extracts assigned to each code were read to ensure the code name was an accurate description. An extract from the Learning Support Assistant's coded manuscript can be found in Appendix 9.

5.6.1.4 Connecting Codes and Identifying Themes

During this phase code names, along with a brief description of each were written on pieces of paper and organised into provisional "theme piles" (Braun and Clarke, 2006). At this stage, three broad thematic areas were identified that related to each research question. An example of a "theme pile" relating to the knowledge described to influence individuals' self-efficacy can be found in Appendix 10.

To answer Research Questions 1 and 2 (relating to understanding of emotional and mental health, and factors impacting self-efficacy) the decision was made to search for themes across the data set, rather than comparing or contrasting roles. Firstly, this was due to the nature and size of the sample (ie. Most roles were only represented once in the sample of six participants), which could undermine conclusions made. Secondly, it was hypothesised that a number of factors described as impacting individuals' self-efficacy, such as barriers in relation to school systems, would be common to a number of participants (which was supported by previous literature such as Hanley *et al*, 2017).

In order to make sense of the data collected in relation to Research Question 3 (strength of perceived self-efficacy beliefs), however, it was necessary to compare and contrast roles. This was due to the variation in the data collected.

5.6.1.5 Reviewing Themes

The provisional themes were reviewed to ensure they met Patton's (1990) dual criteria for appraising categories; internal homogeneity and external heterogeneity. Accordingly, the data within themes should be meaningfully coherent, and there should be clear distinctions between themes. Following Braun and Clarke's (2006) framework, this was conducted in two phases. Firstly, all coded extracts assigned to each theme were read to check they formed a coherent pattern. At this stage one theme, relating to activities undertaken by school staff, was separated from its initial grouping. At the second stage, all themes were reviewed to assess whether they were an accurate representation of the meanings identified in the data.

5.6.1.6 Defining and Naming Themes

Braun and Clarke (2006) describe the aim of this stage as identifying the essence of each theme and ensuring themes were not too diverse or complex. To achieve this, all extracts within each theme were reviewed to ensure the theme was accurately labelled. then extracts within themes were organised into a "coherent and internally consistent account" (Braun and Clarke, 2006, p. 22). At this stage, no thematic content was altered.

5.6.2 Challenges with Thematic Analysis

Boyatzis (1998) outlines three potential obstacles to effective thematic analysis. These are presented in Table 6, with steps taken to reduce the impact of each.

Potential Obstacle	Steps taken to reduce impact
Projection: *The researcher's attribution of their own emotion or attitude to another person*	Use of a code manual and good inter-reliability established for this. Reflecting on the purpose of inductive codes and ensuring they adhered closely to the raw data. Reflecting on my own views and opinions to ensure I did not project these onto participants.
Sampling: *An unknown contamination of the data with other factors*	Establishing a protocol for interviews by using an interview schedule.
Mood and style of researcher	I developed and used a consistent set of codes Codes were clearly defined to ensure consistency in my judgments Transcripts were reviewed a few times on different days

Table 6: Boyatzis' (1998) obstacles to effective thematic analysis

5.7 Summary

This chapter has outlined the methodology and methods used to meet the research aim and explore the research questions. chapter six will present the findings of the study, drawing links with the literature reviewed in chapters two to four.

CHAPTER SIX: FINDINGS AND DISCUSSION

6.1 Introduction

This chapter outlines the findings of the present study. The findings are presented as themes, which were identified through thematic analysis. There were four areas of findings; understandings of emotional and mental health, school-based activities, factors affecting self-efficacy beliefs, and strength of self-efficacy beliefs. These will be presented in turn with key extracts from the raw data. Themes are not ranked or ordered as it was deemed unhelpful to imply some themes were more significant than others, particularly as the more frequent occurrence of some themes may have been impacted by the nature of the interview questions. First, a description of each theme will be presented with key data extracts. Subsequently, findings will be summarised in relation to the three research questions and links made to the literature detailed in chapters two to four.

6.2 Findings – Understandings of Emotional and Mental Health

Six themes were identified concerning interviewees' understanding of emotional and mental health. These themes are represented visually below in Figure 5.
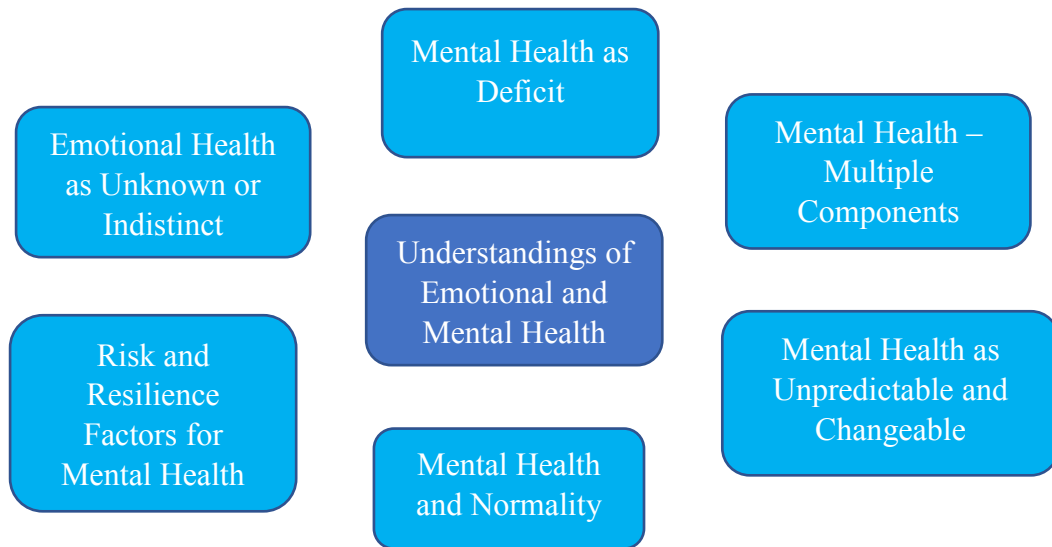
Figure 5: Thematic Map of Participants' Understandings of Emotional and Mental Health

6.2.1 Theme 1: Emotional Health as Unknown or Indistinct

Five participants referred to emotional health in relation to mental health. This was explicitly addressed in the interview schedule, although it was omitted in one interview as an oversight. While one participant had not heard of the term 'emotional health', the other four outlined a close connection with mental health, which was described by some interviewees in terms of a causal effect (quotation 1) or similarity in the presentation of need (quotation 2). The SENDCo assimilated the two, before drawing a distinction (quotation 3). Despite both terms being used when posing questions, participants predominantly referred to 'mental health' throughout the interview. Key quotations to illustrate this are presented in Box 1.

1. I think they're very similar. Or they interlink. If your mental health isn't great, it's going to knock your emotional." (Pastoral Manager 1)

2. "I would say they're quite closely connected. I'm not sure how I would differentiate in certain kids whether they've got mental health needs or emotional needs." (Pastoral Manager 2)

> 3. "I think emotional health and mental health are very much the same sort of thing. I think we're probably more what you class as emotional health – children can't deal with their emotions." (SENDCo)

Box 1: Examples of participants' comments relating to the link between emotional health and mental health

6.2.2 Theme 2: Mental Health as a Deficit

All participants referred to mental health in terms of deficits, often with the use of diagnostic labels (quotations 1 and 2). The SENDCo was the only participant to refer to positive mental health (quotation 3). In three interviews reference was made to a lack of skills, such as self-awareness or coping (quotations 4 and 5). Key quotations highlighting this are presented in Box 2.

> 1. "A lot of the mental health we see here is probably anxiety, low moods, depression, and it links to self-harm um suicidal tendencies and thoughts." (Pastoral Manager 1)
>
> 2. "I suppose to me mental health is more of a label – being able to actually label you know that they're bipolar or schizophrenic or some sort of disorder." (Interventions Teacher)
>
> 3. "I think the way we view mental health in school is possibly not by looking at what is positive mental health, it's by seeking out what is negative, viewed as negative mental health." (SENDCo)
>
> 4. "I think now what it is with her is um she's more aware of her mood swings." (Learning Support Assistant, talking about a relative's experience)
>
> 5. "The child will come and offload themselves and be very just not as resilient as they normally would. The slightest thing they can't cope with and they're having meltdowns," (Pastoral Manager 2)

Box 2: Examples of participants' comments on mental health as a deficit

6.2.3 Theme 3: Mental Health and Normality

Five participants referred to a relationship between mental health and normality, although this was conceptualised differently. The SENDCo understood the presence of a mental health difficulty as normal and exhibited in everyday behaviours (quotation 1). However, the Interventions Teacher and Learning Support Assistant juxtaposed mental health issues with being 'normal' (quotations 2 and 3). Three participants described mental health in terms of normal adolescent development (for example, quotation 4). The Learning Support Assistant highlighted the difficulty distinguishing between a mental health difficulty and typical adolescent behaviour (quotation 5). Key quotations highlighting this are presented in Box 3.

---

1. "Believe it or not you've got mental health issues, you just don't even know it yet. No you actually have – do you prop your cushions up before you go to sleep at night?...that's part of what you need to do in your mind to put things right, routines, it's all on a spectrum." (SENDCo)

2. "You may get somebody who may be bipolar but actually have normal mental health, but it's just occasionally that it goes astray." (Interventions Teacher)

3. "Speak to adults and children alike you know in a similar way. That's what I would think of a, for wont of a better word, of a normal mentality." (Learning Support Assistant, when asked what constituted good mental health).

4. "I think sometimes students find that (putting things in context) very difficult. Because everything's all-consuming I think when you're that age, when it's so intense and it's..nobody else feels like you do." (Head of Year)

5. "But it's difficult because, being in a high school, there's so many hormones, and they're changing so rapidly, so quickly. So, do you sometimes read into things that aren't there, you know? It's hard." (Learning Support Assistant)

Box 3: Examples of participants' comments on the relationship between mental health and 'normality'

6.2.4 Theme 4: Mental Health as Unpredictable and Changeable

All six participants referred to mental health as unpredictable or changeable in some way. Five participants, such as the Learning Support Assistant, Pastoral Manager 2, and the Head of Year, described the unpredictability of how difficulties can present, both within individuals and between individuals (quotations 1 to 3). The Pastoral Manager 1, SENDCo, and Learning Support Assistant referred to how difficulties could be masked or hidden within individuals and between contexts (quotations 4 to 6). Key quotations highlighting this are presented in Box 4.

---

1. "When she's up there, she's as high as a kite. So it's very, there's extremes you see." (Learning Support Assistant)

2. "Sometimes it's low mood, sometimes they might self-harm, sometimes they'll display negative behaviour, sometimes they'll just completely have an erratic outburst, sometimes they'll just completely breakdown and be really emotional. Lots of different ways." (Pastoral Manager 2)

3. "Sometimes you don't know what's going to present to you." (Head of Year)

4. "But you don't always know what's going on behind closed doors." (Pastoral Manager 1)

5. "I think it's really difficult. I think the children are very good at disguising that." (SENDCo, when asked how to recognise poor mental health)

6. "Obviously we don't get to see that at school cause I think it's in that home life you get to see the extremes," (Learning Support Assistant)

Box 4: Examples of participants' comments on the intangible nature of mental health

6.2.5 Theme 5: Mental Health has Multiple Components

All participants referred to mental health consisting of multiple components. Five, such as the Learning Support Assistant and Pastoral Manager 1, referred to a cognitive component, which was associated with decision-making and negative focus of attention (quotations 1 and 2). Four

participants, such as the Interventions Teacher and Learning Support Assistant, described an affective component of mental health; associating good mental health with positive emotions, and poor mental health with negative emotions (quotations 3 and 4). Five participants, such as the SENDCo and Learning Support Assistant, referred to a relational component of mental health, whereby good mental health was linked to friendships and social competence, and poor mental health with isolation and social difficulties (quotations 5 and 6). Key quotations illustrating this are presented in Box 5.

---

1. "I look at mental health as people who struggle with normal everyday decisions and thought processes." (Learning Support Assistant)

2. "We often do three goods, you know 'tell me three good things that happened today', so they can walk out and focus on those as opposed to dwelling on anything negative." (Pastoral Manager 1)

3. "You'd go, 'actually they come across happy'." (Interventions Teacher, describing students with good mental health)

4. "I automatically think that someone with mental health issues becomes more depressed more easily, more down, more of a worrier." (Learning Support Assistant, describing students with poor mental health)

5. "So they do have a social group, they do have other interests. They're involved in lots of things, they're not in isolation…" (SENDCo, describing students with good mental health)

6. "I would expect them to be loners. People who find it difficult to keep friends and hold on to them." (Learning Support Assistant)

Box 5: Examples of participants' comments on the multiple components of mental health

All participants linked mental health and behaviours; associating good mental health with engagement in learning and academic success (quotations 7 and 8), and poor mental health with disengagement, withdrawn, and disruptive behaviours (quotations 9 and 10). Key quotations highlighting this are presented in Box 6.

Descriptions of students with good mental health:

7. "So it would appear to be the student who seems to be academically achieving well." (SENDCo)

8. "I think you'd see involvement, you'd see engaging in the activity, in the learning that's taking place." (Interventions Teacher)

Descriptions of students with poor mental health:

9. "Definitely a deterioration in their behaviour or their conduct or their engagement." (Pastoral Manager 2)

10. "Sometimes it's only when there's behaviour points starting to kick off" (Head of Year)

Box 6. Examples of participants' comments on the association between mental health and behaviour

6.2.6 Theme 6: Risk and Resilience Factors for Mental Health

The Pastoral Manager 2, Head of Year, and SENDCo referred to the potentially negative impact of environmental factors on mental health (quotations 1 to 3). These were associated with social interaction, current and previous home experiences, and school pressures. Four participants referred to at least one resilience factor for mental health. Four participants, such as the Head of Year and Learning Support Assistant, described the role of verbal communication; associating verbal expression with reducing mental health difficulties, and a lack of verbal expression with increased difficulties (quotations 4 and 5). Three participants, such as the SENDCo and Head of Year, referred to resilience; conceptualising the perceived increase in adolescent mental health difficulties with decreased resilience (quotations 6 and 7). Resilience was associated with the ability to problem solve and move forward from situations. The SENDCo described the importance of developing skills from early childhood, which she

perceived had been negatively impacted by changes to the primary curriculum (quotation 8).

Key quotations are presented in Box 7.

Risk Factors:

1. "Especially mine because my priority year 11 are the pupil premium kids which are the kids who have got disadvantaged backgrounds or for whatever reason are on the pupil premium list." (Pastoral Manager 2, when asked if she thought it was her responsibility to support student emotional and mental health needs)

2. "And even just trying to fit in and conform – that causes them so many issues such as, you know, one day they're friends with one set of people and quite comfortable and they feel ok then you know something happens, kicks off, and they don't want to come in because they think people are talking about them, which then causes them anxiety and that brings all sorts of things in." (Head of Year)

3. "The pressure created and that need to achieve academically is also creating more issues around academic achievement." (SENDCo)

Resilience Factors:

4. "Sometimes it's just, they need to chat. Once they've got things off their chest, they need to say what they've got to say, their anxiety levels come down." (Head of Year)

5. "Tend to be quieter…not willing to express themselves so much." (Learning Support Assistant, describing students with poor mental health)

6. "We've got a lot of students nowadays who don't often, parents don't often put them in situations that are difficult or uncomfortable. They don't build those skills to be able to work out how to get through…the resilience." (SENDCo)

7. "I don't think the children that are growing up these days are quite as resilient as I feel we were, or whether it's a different… you know whereas when I was growing up it was a case of 'just get on with it'. (Head of Year)

8. "Primary was very much focused around building social skills, putting elements of risk, providing opportunities for outdoor learning. Whereas now I think another reason why we have more issues here is there's, there was a bit of a gap being bridged previously, and there's not now." (SENDCo)

Box 7: Examples of participants' comments on risk and resilience factors for mental health

6.3 Findings – School-Based Activities

While not an explicit factor impacting self-efficacy beliefs, participants described their beliefs in relation to the activities they carried out on a day-to-day basis. This seemed important to participants and formed the content of exploring how they engaged in supporting student emotional and mental health needs. Consequently, these descriptions provided important contextual information and are presented below in Theme 7. Participants also described their motivations for providing students with support through these activities, which are presented in Theme 8. The themes are presented visually in Figure 6.
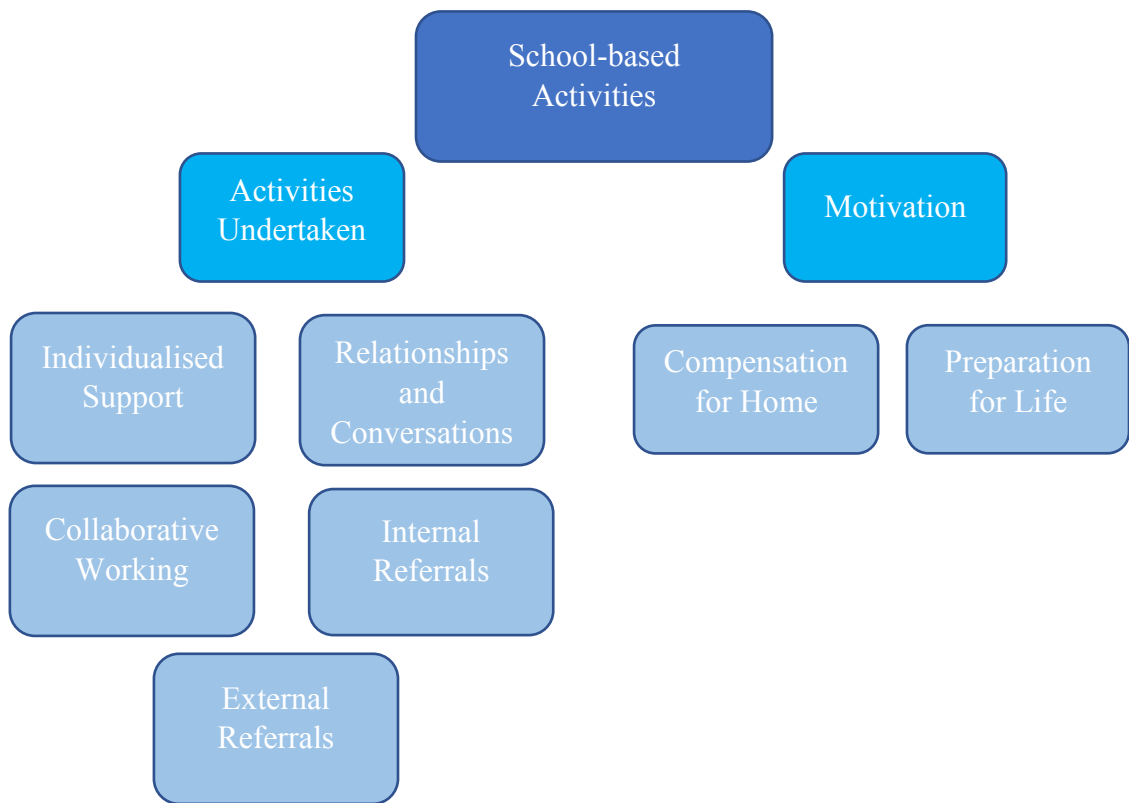
Figure 6: Thematic Map of Activities Undertaken and Motivations for Doing so

6.3.1 Theme 7: Activities Undertaken

Participants described five activities they undertook; building relationships and having conversations, providing individualised support, working collaboratively, making internal referrals, and making external referrals. Each activity is outlined below.

6.3.1.1 Relationships and Conversations

Five participants referred to building and maintaining relationships with individual students as a regular activity aimed to support student emotional and mental health needs. The Head of Year and Learning Support Assistant described the importance of rapport in enabling students to feel they could disclose difficulties (quotations 1 and 2). Pastoral Manager 1 emphasised the need to regularly respond to non-emotional or mental health related requests from students to build and maintain the relationship (quotation 3). Relationships were described as having a monitoring purpose, as is alluded to by the Interventions Teacher (quotation 4). Key quotations are presented in Box 8.

---

1. "You know if there's a particular student would not go to a particular member of staff because they just haven't got that rapport with them." (Head of Year)

2. "I would say X wouldn't be very good. Um he doesn't have a rapport, he doesn't have that kind of rapport with kids." (Learning Support Assistant, when asked who might not be in as good a position as her to support student emotional and mental health needs)

3. "I'm never going to say 'that's not me' you know I will sort it for them. I don't want to break that confidence either that they've got. Cause you never know when they might need to open up… it's just forming those relationships and retaining them." (Pastoral Manager 1)

4. "You have to know that person and certainly here you can't prejudge 'well that's not normal behaviour' because actually for that person it might be. And it's a case of you just don't understand how they are and what's happening." (Interventions Teacher)

Box 8: Examples of participants' comments on the importance of building relationships to providing support

Five participants described conversations with students as central to the provision of support in terms of both identifying and reducing difficulties (quotations 5 to 7). Key quotations are presented in Box 9.

> 5. "Sometimes it's just, they need to chat. Once they've got things off their chest, they need to say what they've got to say, their anxiety levels come down." (Head of Year)
>
> 6. "You know when a student is ok and ticking along nicely but you can also see other triggers like something that's completely out of character for them. And then I'd start by obviously having a discussion." (Head of Year)
>
> 7. "In terms of my current role, it's more about being available, and being able to be. Them knowing that you will listen to what they've got to say, even if it's something quite difficult or something they're not very proud of or they don't like." (SENDCo)

Box 9: Examples of participants' comments on the role of conversations

6.3.1.2 Individualised Support

Four participants referred to the need to plan individualised support due to the difference in individual needs. However, the Head of Year and SENDCo described this as difficult to navigate due to a perceived lack of structure in identifying next steps in comparison to Safeguarding procedures, and the immediacy of the need staff were presented with (quotations 8 and 9). Key quotations illustrating this are presented in Box 10.

> 8. "I suppose in the Safeguarding things you know you're looking at… a particular area of Safeguarding. And you think 'yes it slots into that bit'. Whereas with mental health I think um it's not all the same…one size doesn't fit all. And I know it doesn't. But it's then sort of knowing sort of where to direct somebody who needs that extra support." (Head of Year)
>
> 9. "I try and follow a bit more procedure than you would. But equally, if you've got a child presenting in front of you…it's difficult." (SENDCo)

Box 10: Examples of participants' comments on the challenges for providing individualised support

6.3.1.3 Collaborative Working

Four participants referred to collaborative working as key to providing support. This was described in relation to information sharing to inform joint, proactive planning (quotations 11 and 12). Reference was made to collaborative working with other staff in school, however, the importance of working with parents was described most frequently (quotations 10 to 12). Key quotations highlighting this are presented in Box 11.

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10. "So whatever we do here, unless that is directly mirrored by the parent and they buy into whatever it is that is being suggested, a lot whatever you do can be undone……it relies upon a partnership between school and parents." (SENDCo)

11. "I've got sort of 2 or 3 students whose parents come in and they tell you everything…. And that helps me a little bit to understand more what I need to do in school." (Head of Year)

12. "You'd be forward planning, you'd be looking, going 'right', you'd be getting a plan in for it. 'Oh look' …. 'he's got behaviour points again in this week, shall we get mum in. Right if we get mum in, we'll do this, this, and this'. If it doesn't…you'd be putting things in place as how we are now – we have to deal with the here and now." (Pastoral Manager 1, describing the benefits of collaborative working with staff)

Box 11: Examples of participants' comments on the role of collaborative working

6.3.1.4 Internal Referrals

All participants described a referral system within the school structure. For participants without a designated pastoral role (for example, the Interventions Teacher), this was described as sharing concerns or the content of conversations with staff with a designated pastoral responsibility, who were perceived as holding greater amounts of information on students' circumstances (quotation 13). For participants with a pastoral responsibility (for example, Pastoral Manager 1), this system was described as a trigger for further information gathering (quotation 14). No formal processes were described and 'referrals' were received from multiple

sources, including other staff, students experiencing difficulties, and their peers (for example, quotation 14). This was in addition to participants' own observations of students. Key quotations highlighting this are presented in Box 12.

---

13. "I very often have a chat to (SENDCo) …'. So I run everything past her more because she's DSL and actually their five minutes here with me might be the tip of an iceberg that she knows more about." (Interventions Teacher)

14. "Staff would actually refer if they were concerned or they'd come and talk to us and explain they've got a few concerns. Then we will probably go round and speak to teachers perhaps just a general check on how that child's getting on with their work, with how they're sort of, how they are with peers, how they are with staff, how they interact. And just ask a few questions around staff, and then go from there. Or sometimes other students will say 'I'm worried about this person, I'm worried about my friend'. Or other times you just notice somebody from their behaviours." (Pastoral Manager 1)

Box 12: Examples of participants' comments on an internal referral system

6.3.1.5 External Referrals

Four participants described making referrals to external agencies for extra support for students perceived to present with needs greater than could be met by school staff alone. All descriptions included reference to a limitation in these agencies. These were expressed as a lack of number and range of services including those aimed at early intervention (quotation 15), long waiting times for appointments (quotation 16), and a lack of consistency in agency workers (quotation 17). Key quotations illustrating this are presented in Box 13.

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15. "We need services in between… where you're putting things in place, you're being preventative as opposed to reactive." (Pastoral Manager 1)

16. "I think there should be more agencies for us to actually refer to. And then, them having to be um getting an appointment within a reasonable time. Cause if you've actually you know identified there's a problem, that's one of the biggest challenge. Then it's going, 'right well I've … I've got a problem, now how do I deal with it?'

> and then to find it's like 6 months down the line or several weeks before, and you can then you can talk yourself out of it." (Head of Year)
>
> 17. "And consistency. So we've got children who've seen 3 or 4 different people and have had to explain the same story over and over again." (SENDCo)

Box 13: Examples of participants' comments on the limitations of referrals to external agencies

6.3.2 Theme 8: Motivations for School-Based Support

The Interventions Teacher and Learning Support Assistant referred to their role, and the role of school, in preparing students for life and conceptualised this in terms of exposing them to a challenge of some kind (quotations 1 and 2). The SENDCo described limitations in school's ability to develop the problem-solving skills that may be incorporated in resilience, for example (quotation 3). Key quotations are highlighted in Box 14.

> 1. "I would never be anything other than honest with a student unless anything – obviously not personal stuff – if you know well this is the case where yeah that's what life's about, that's what's going to happen." (Interventions Teacher)
>
> 2. "So again that's different teaching styles. But you're going to get that, life is like that, so they have to learn to deal with that. That everyone's different in a way." (Learning Support Assistant)
>
> 3. "And there's a lot of talk in schools about 'Rs' – 'oh let's do resilience … they're going to do a group task and we're all going to make a mask in a group and we're going to show how we can use our resilience to solve a problem'. But it's so fake – it's such an unrealistic situation that does not bridge the gap between actually children trying things, doing things, getting outside, doing stuff with their families, interacting with other people, not doing so well at something but then overcoming it physically and mentally. You just can't replace that." (SENDCo)

Box 14: Examples of participants' comments on school as preparation for life

Three participants referred to the role of school as compensating for a lack in a student's family life, which was associated with the provision of non-judgmental emotional support and

guidance (quotations 4 to 6). The Head of Year and Interventions Teacher perceived their provision of support in terms of a parenting role (quotations 7 and 8). The SENDCo, however, questioned the perceived expectation on schools in relation to parenting (quotation 9). Key quotations illustrating this are in Box 15.

---

4. "And if I say 'I've only got two minutes to talk' it sort of echoes what's going on at home as well." (Pastoral Manager 1)

5. "Because if they're not getting the support at home or home aren't capable of supporting them, then they need someone to talk to in school and to advise them on what's best going forward." (Pastoral Manager 2)

6. "They (students) know at school that we've got an obligation to listen, and that we do have to do something about it. And it's a safe place to do that, and to share information they wouldn't necessarily do maybe at home. Cause they're not sure people … different family members might have different reactions…" (SENDCo)

7. "I think a lot of what I do is just that I'm a mum and a grandmother. And I wouldn't like, I wouldn't like to think that anybody wouldn't treat my child … with the same respect." (Interventions Teacher)

8. "In a way you're a bit like parents in the day. And you know I would hate if – cause I've got two daughters – I would hate to have felt that they'd gone to school in a state without somebody they could talk to." (Head of Year)

9. "I do think there's a lot of expectation that school parents children, rather than parents parenting. So our role is to parent as well as teach I think is a view of the parents as well." (SENDCo)

Box 15: Examples of participants' comments on school compensating for home and the role of the parent

6.4 Findings – Factors Affecting Self-Efficacy Beliefs

Three themes were identified that related to factors influencing interviewee's self-efficacy beliefs in the provision of support for student emotional and mental health. These themes are represented visually below in Figure 7.
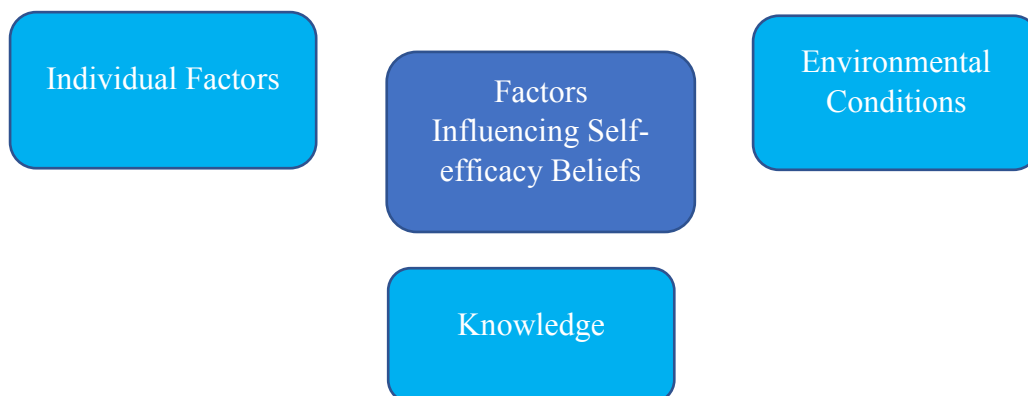
Figure 7: Thematic Map of Factors Influencing Participants' Self-efficacy Beliefs

6.4.1 Theme 9: Knowledge

Two types of knowledge were described by participants as influencing self-efficacy beliefs; knowledge of students, and knowledge of mental health. Knowledge of mental health was gained from their own experiences, from 'experts', and from colleagues.

6.4.1.1 Knowledge of Students

Three participants referred to knowledge of students' circumstances as impacting the support that could be provided. The Interventions Teacher, who did not have a designated pastoral role, described having limited knowledge as impacting how she might approach situations whilst maintaining confidentiality (quotation 1) and this was also alluded to by Pastoral Manager 2 (quotation 2). Pastoral Manager 1 perceived that in some cases she held a unique body of knowledge about students due to perceived 'lone' or solo working, which seemed to result in high levels of perceived responsibility (quotation 3). Key quotations to illustrate this are presented in Box 16.

1. "But because you don't know that background you can't um make allowances for it at the end of the day." (Interventions Teacher)

2. "We also took the member of staff aside and explained that she'd been through a lot, without disclosing all the information um and that she was sensitive around males, which made him kind of speak to her in a different voice." (Pastoral Manager 2)

3. "As now, if I was off or I was on a course or anywhere, my knowledge wouldn't be there unless I was constantly feeding into or giving the background." (Pastoral Manager 1)

Box 16: Examples of participants' comments on having and sharing knowledge about students

6.4.1.2 Knowledge of Mental Health From own Experiences

Four participants referred to having knowledge of supporting mental health needs through previous experiences of doing so (for example, quotation 4), which were related to their professional role and personal life. For three participants, experience was linked to more perceived competence. The Learning Support Assistant, however, who perceived her husband had been more able to support a close relative experiencing panic attacks, reported less perceived competence (quotation 5). The SENDCo and Learning Support Assistant referred to limited opportunities to have relevant experiences as impacting on competency in providing support (quotations 6 and 7). All participants were able to describe a time when they felt they had been able to support student emotional and mental health needs. Pastoral Manager 1, however, noted the role of feedback from others in identifying whether her actions had had a positive impact (quotation 8). Key quotations highlighting this are presented in Box 17.

4. "I would hope that what I've done so far, the experience I've gained so far…" (Head of Year, talking about her previous success in providing support)

5. "Even though I've experienced it myself I would say it was my husband that dealt with it more than I did … my husband was better than me, way better than me." (Learning Support Assistant)

6. "The more you're faced with experiences, the better you are at dealing with things cause you've faced it before. So I suppose experiences are good but you know that doesn't always happen." (Learning Support Assistant)

7. "Everybody's had different experiences. So no there are people who aren't well equipped to deal with it. It's really variable and as I said very personal." (SENDCo)

8. "I think because we do it every day you don't realise what an impact you have on on those children's lives. And it's only when the parents or whoever will say afterwards, or you get a card at the end of the year they've just sort of like put a big piece in there about what you've done you think 'oh god, I didn't even realise I did that'." (Pastoral Manager 1)

Box 17: Examples of participants' comments on the influence of previous professional and personal experience on providing support

The Head of Year, SENDCo and Pastoral Manager 1 referred to the influence of lived experience of emotional and mental health needs on their perceived competency in providing support (quotations 9 to 11). Whilst a lack of direct experience was not described as a barrier to empathy, it was perceived as a barrier to understanding. Key quotations to illustrate this are presented in Box 18.

9. "Even if I'll go home and read about a situation, if you've not been in that situation I think it is often difficult to understand. For example, you know, you could say self-harming. Me personally, I don't .. It would be something I couldn't do. So I'm looking thinking 'I don't know if I'm advising you the right way'. I don't know, I don't understand personally how you get that urge to do that." (Pastoral Manager 1)

10. "If I've not necessarily felt anything like that, it's hard to know how to guide them and what to do. I can only empathise but I don't necessarily understand." (Head of Year)

11. "I've had mental health issues – I had depression um and I would I'm pretty sure my mum's had undiagnosed depression…so I can kind of recognise some of the things that I see and how, and why students make connections. Cause having done that myself, I can see how you think like that." (SENDCo)

Box 18: Examples of participants' comments on the influence of lived experience on providing support

6.4.1.3 Knowledge of Mental Health From 'Experts'

Five participants referred to the role of qualified professionals as providing the 'correct answer' on how to support students (quotation 12). This was juxtaposed with participants' perspective that they were guided by their 'gut instinct', which was described as varying between individuals and consequently, to be treated with caution (quotations 13 and 14). While three participants (for example, Pastoral Manager 2 in quotation 15) perceived they could be upskilled in the provision of support through training, the other three (for example, the Interventions Teacher and SENDCo in quotations 16 and 17) described how training may have a limited perceived impact due to the vast range of mental health needs and how far removed training could be from real life. When asked what relevant training they had received, five participants said they had Safeguarding training. Key quotations are presented in Box 19.

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12. "And we're not trained counsellors. So sometimes you don't know if you're doing, if you're actually doing them any good." (Pastoral Manager 1)

13. "You act on instinct you see more than what you should and shouldn't do. And everyone's instinct is a little bit different." (Learning Support Assistant)

14. "None of us have ever formally had that training – we're all working off instinct I would suggest, which isn't .. so you are wary of how much you say, how much you recommend." (SENDCo)

15. "I think we should do some CBT… again it's another method of exploring why the kids are behaving the way like they're behaving and if that would give us any ideas of how we could work with the kids." (Pastoral Manager 2)

16. "You don't think 'oh I did that training course and I must be really careful and look out for signs of sitting with your head down or you know fiddling your hands in your lap like I am at the moment'. Because life just doesn't present things in the same way." (Interventions Teacher)

17. "Yes but knowing what that would be … because of the range of the types of students that we've got and why, their reasons for why they feel like they do are so wide-ranging, it's quite difficult." (SENDCo, when asked what training may be beneficial)

Box 19: Examples of participants' comments on qualified experts, gut instinct, and the need for training

6.4.1.4 Knowledge of Mental Health From Colleagues

Four participants referred to using colleagues as a source of knowledge on providing support, either through direct observation in training (quotation 18) or discussions with colleagues in the same or related roles (quotations 19 and 20). Key quotations highlighting this are presented in Box 20.

18. "Re-enacting them, conferences of how, how people are, and just looking at how other people deal with certain, how they conduct themselves, how they deal with it, what they would do. And that's always interesting to observe how people do things." (Pastoral Manager 1, talking about useful aspects of training)

19. "There's obviously going to be people who present themselves in front of me that I think 'ah I haven't got a clue, I need to go get advice on this'. And then I'd probably go and ask other people and like Pastoral Managers." (Head of Year)

20. "I mean we definitely all chat about you know certain pupils and you know someone will say 'well this is how I deal with that pupil, this is how I deal with that one.'" (Learning Support Assistant)

Box 20: Examples of participants' comments on using colleagues to gain knowledge

6.4.2 Theme 10: Individual Factors

Five participants referred to the ability to support student emotional and mental health needs in terms of a personal characteristic, such as their 'nature' or a personality trait (quotations 1 to 4). Pastoral Manager 2 referred to the mental health of individual staff members as imposing a potential limitation on the support they were able to provide (quotation 5), which may be indicative of the emotional labour of the role. Key quotations highlighting this are shown in Box 21.

1. "I think it's just it's not even part of your job description, I just think it's human nature to nurture and support." (Interventions Teacher)

2. "You do put yourself second cause you know if you've got an upset child you can't say 'I'm off on my lunch break now, can you wait half an hour?'. I couldn't, it's not in my nature." (Pastoral Manager 1)

3. "I also support the younger students to feel comfortable coming to me if there's a clash with personality with the other Behaviour and Learning Managers." (Pastoral Manager 2)

4. "I'd say (SENDCo) to be honest um I think maybe (Pastoral Manager) as well. She's very, she seems to have a calming way about her … I suppose it comes down to personalities doesn't it?" (Learning Support Assistant, when asked who might be in a better position to provide support)

5. "We've got some members of staff who are suffering depression that I'm aware of." (Pastoral Manager 2, when asked who might not be in as good a position to provide support)

Box 21: Examples of participants' comments on personal factors influencing the provision of support

6.4.3 Theme 11: Environmental Conditions

Participants described factors influencing their self-efficacy beliefs that were associated with environmental conditions. These were school-specific structures, as well as wider, more remote systems, such as the education system.

6.4.3.1 School-Specific Factors

Four participants referred to limited resources at a school-level, both monetary and human, as influencing their self-efficacy beliefs in their ability to provide support (quotations 1 and 2). Key quotations are presented in Box 22.

1. "The money to spend on some of the resources that we need for the kids." (Pastoral Manager 2, when asked what she would change or improve to increase her self-efficacy beliefs)

> 2. "Ultimately I think we need more of us. And that would help. We're in a reduced team and then if people are off sick it has a knock-on effect." (Pastoral Manager 1)

Box 22: Examples of participants' comments on resource limitations

All six participants referred to needing more time to feel better able to provide support. This was described as more time to spend with students, the length of time needed to bring about change in students (quotations 3 and 4), and the time students had available to seek support (quotation 5). Four participants (for example, the Pastoral Managers) described how their ability to provide support was impacted by other duties (quotations 6 and 7). Key quotations to illustrate this are presented in Box 23.

> 3. "The one big thing we're working with at the moment you know isn't an overnight thing, is resilience." (Pastoral Manager 1)
>
> 4. "I think we don't have enough time or opportunity to generally address the issue with students and give them some general strategies for dealing with it. There's not enough time within the curriculum to allow students to fail and learn from the mistakes cause there's so much to get through." (SENDCo)
>
> 5. "There's a lot of pressure put upon, especially in my older kids, especially Year 11, with the workload. They haven't got a lot of time to see me." (Pastoral Manager 2)
>
> 6. "Because we have so many other responsibilities and we have to be in certain places at certain times." (Pastoral Manager 2)
>
> 7. "It all depends on .. it sounds awful .. it all depends on how the day's going and what the workload is." (Pastoral Manager 1)

Box 23: Examples of participants' comments on the role of time in providing support

All participants referred to having a responsibility for providing support (quotation 8), however, three participants described how this was not adopted throughout the school; naming senior leadership and some teaching staff as having mixed attitudes (quotations 9 to 11). While all

participants reported a sense of responsibility, all acknowledged limitations to providing support (quotation 12), regardless of whether they had a designated pastoral role. Key quotations are presented in Box 24.

8. "But it's everybody's job to support the kids that are in schools, the students, and each other, the staff too." (Interventions Teacher)

9. "I don't think they understand as much as they should understand or how much we'd like them to understand." (Pastoral Manager 2, describing the senior leadership team)

10. "I think if you spoke to half the staff they'd say 'nobody deals with mental health here', and then I think another half of the staff would say 'well yeah everybody deals with it, we're all dealing with it all the time.' I think it very much depends on the staff's personal experiences themselves and what they deem to be mental health." (SENDCo)

11. "I think some people probably focus more on the academic side of things and feel that we're there, so we'll just … pass to us." (Pastoral Manager 1)

12. "But of course our role is only up to a certain point and then it's passed on." (Head of Year)

Box 24: Examples of participants' comments on school-based factors influencing self-efficacy

6.4.3.2 Wider Systemic Factors

Three participants referred to an observed increased prevalence in adolescent emotional and mental health needs (quotations 13 and 14). However, the SENDCo appeared to doubt the authenticity of the needs some students presented with; citing social media as a medium by which students copied behaviour (quotation 15). Key quotations to illustrate this are presented in Box 25.

13. "It seems to be happening more and more I think with youngsters." (Learning Support Assistant)

14. "I think from what I've seen over the years, I think the students are suffering more with mental health issues now." (Head of Year)

15. "I also think that we've also seen a rise in a trend for appearing to have issues, when actually it's more of a copycat system. So with the use of mobile phones, there's a lot of sharing of sometimes photographs of children self-harming. Um or speaking about their thoughts um and sharing it amongst each other." (SENDCo)

Box 25: Examples of participants' comments on increasing prevalence of adolescent mental health difficulties

The SENDCo and Pastoral Manager 1 referred to pressures from the education system as influencing their self-efficacy beliefs. These related to the impact that the current structure of national exams have on students (quotation 16), as well as the way in which a school's success was quantified (quotation 17). Key quotations highlighting this are presented in Box 26.

16. "And the schools are very measured academically. There's no measure for pastoral." (Pastoral Manager 1)

17. "The linear exams that we have focus on this one opportunity in life to get everything right um that education keeps hammering at kids really, really doesn't set them up well." (SENDCo)

Box 26: Examples of participants' comments on the influence of the education system

6.5 Findings – Strength of Self-Efficacy Beliefs

The fourth area of findings related to the strength of perceived self-efficacy beliefs participants attributed to themselves in relation to providing support, and their reasons for this. Participants were asked to rate their self-efficacy beliefs on a scale of one to ten, whereby 'one' signified low self-efficacy and 'ten' signified high self-efficacy. They were then asked to describe their reasons for this rating, and later were asked what factors were key to improving their self-

efficacy beliefs. This information is presented below for each individual participant, organised by level of designated pastoral role.

Factors described as key to improving individual self-efficacy are represented visually below in Figure 8.
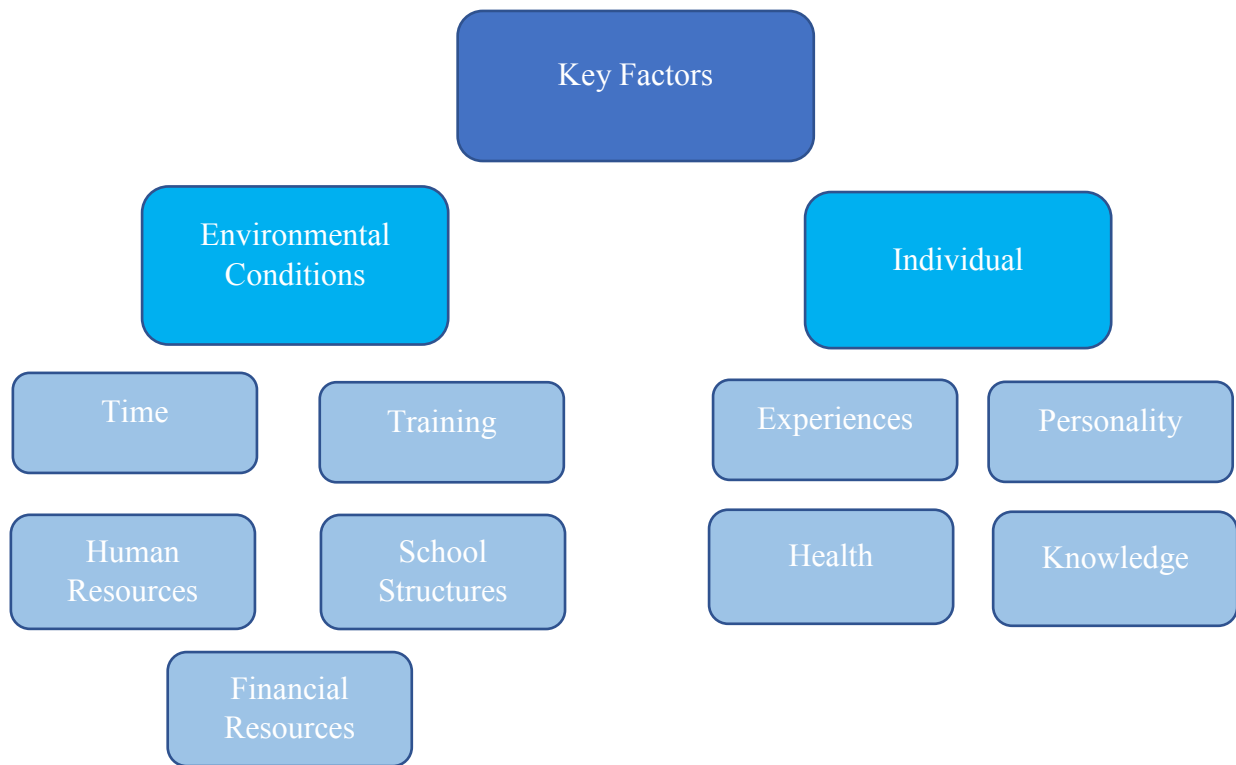
Figure 8: Thematic Map of Most Important Factors Influencing Participants' Self-efficacy Beliefs

6.5.1 Staff With no Pastoral Designation

Interventions Teacher

Self-efficacy Rating	7 or 8
Reasons for Rating	Have time and some flexibility in the use of time Not a higher rating as there are some constraints on time
Key Factor for Improving Self-efficacy	More time – for herself and other staff

Learning Support Assistant

Self-efficacy Rating	2 or 3
Reasons for Rating	Not frightened to have a conversation but worried about making things worse.
Key Factor for Improving Self-efficacy	More knowledge, but also more experiences in providing support.

6.5.2 Staff With Pastoral and Non-Pastoral ('Academic') Designation

Head of Year

Self-efficacy Rating	6 or 7
Reasons for Rating	Knowledge gained through previous experience, which meant she felt better able to identify students' 'norms'. Not a higher rating as it depended on the individual's response or engagement with her personally.
Key Factor for Improving Self-efficacy	More time, and on-site access to an 'expert'.

SENDCo

Self-efficacy Rating	6 or 7
Reasons for Rating	No formal training but previous professional and personal experience. Perceived ability to deal with it day-to-day but not provide treat someone or provide a long-term plan.
Key Factor for Improving Self-efficacy	Time and training for all staff so they have a baseline knowledge of mental health needs and do not make situations worse.

6.5.3 Staff with Solely Pastoral Designation

Pastoral Manager 1

Self-efficacy Rating	Either 2 or 9
Reasons for Rating	Dependent on workload – if there was a need to deal with Safeguarding incidents, there was more limited time to talk to students.
Key Factor for Improving Self-efficacy	More staff, re-organisation of some school structures to facilitate joint working and improved information sharing.

Pastoral Manager 2

Self-efficacy Rating	Either 5 or 7/8
Reasons for Rating	5 when in poor physical health, which meant students needed to repeat what they had said. 7/8 when in good health but not higher due to restraints on time.
Key Factor for Improving Self-efficacy	More staff needed to 'share burden' and more money needed for resources.

The variation in participants' self-efficacy ratings could not be accounted for by level of pastoral designation within their role. Ratings and the reasons for assigning them were individualised, although there were some common themes. All six participants considered environmental conditions when assessing their self-efficacy beliefs. However, four participants also referred to individual factors such as personality or knowledge gained through previous experiences.

6.6 Summary of Findings by Research Question

The findings regarding each research question are presented below and links made to the relevant literature.

RQ 1: What do secondary staff in a range of roles understand emotional and mental health to be?

The present findings were consistent with the literature in several ways. Firstly, participants' difficulty identifying emotional and mental health as distinct concepts is reflected in much of the research literature, which appears to use the two terms interchangeably (for example, Newham *et al*, 2017). It also echoes the Department for Education and Department of Health's (2004) definition of emotional health as forming "part of wider concept of mental health" (p. 7) and Rothi, Leavey and Best's (2008) finding that school staff found it difficult to distinguish between Emotional and Behavioural Difficulties and mental health difficulties. Despite both terms being used when posing questions, participants referred to 'mental health' throughout the interview. This appears to reflect the terminology that has been used in government documents since 2011 (for example, 'No Health without Mental Health', DoH and Social Care, 2011) and that which is used in well-publicised media campaigns such as 'Time to Change'.

Secondly, participants' conceptualisation of mental health in terms of deficit reflects the majority of research on evaluating mental health, which has measured this in terms of mental disorder (Vaillant, 2012). It also reflects the position of recent large-scale surveys of public attitudes, such as TNS BRMB (2015), which focused on attitudes to mental illness. The use of diagnostic labels by participants is contrary to Rothi, Leavey and Best's (2008) study, where teachers in a range of schools were reluctant to use diagnostic labels as it was considered beyond their expertise.

Thirdly, participants' conceptualisation of mental health incorporated cognitive, affective, relational elements, which links with MentalHealth.gov's (2017) definition. Participants made associations between mental health needs and behaviour, which is underlined both in the SEND

Code of Practice (DfE and DoH, 2014) and 'Mental Health and Behaviour in Schools' (DfE, 2016). Behaviours were specific to the school system (academic achievement/disengagement). Considering the culture-specific nature of mental health (Burton, Pavord and Williams, p5), such descriptions fit with the culture of a school.

Fourthly, participants referred to risk and resilience factors for mental health difficulties. Risk factors were described at the family and school context level but not at the individual level. Resilience factors, however, were conceptualised at the individual level (verbal expressive skills and problem-solving skills), although the impact of environmental contexts on developing problem-solving or coping skills was acknowledged. Participants' reference to secondary school being too late to begin developing appropriate skills echoes Newham *et al* (2017) finding where participants felt working with children in primary schools would have greater likelihood of preventing the onset of difficulties.

Two aspects of the present findings had not been previously mentioned in the reviewed literature on school staff views. Firstly, mental health was described by participants as unpredictable and changeable. This suggests participants saw mental health as a personalised, frequently shifting state, which reflects Ganga and Kutty's (2012) definition of mental health as a "dynamic state of wellbeing". References were made to hidden or unavailable information. Awareness that information may be concealed may be indicative of a perceived remaining stigma, which has previously been endemic in the UK (Time to Change, 2008) but, so data would suggest, is now less apparent (TNS BRMB, 2015).

Secondly, participants described the relationship between mental health and normality in different ways. One participant positioned mental health difficulties as part of everyday life, which seemed one step further than TNS BRMB (2015) findings that the majority felt

difficulties could happen to anyone. Two others positioned mental health difficulties as outside of the norm, creating a sense of 'otherness'. There was a difficulty in distinguishing between mental health and normal development that was attributed to the adolescent population staff were working with. School staff's difficulty in distinguishing between a potential mental health difficulty and a developmental phase was also identified in Newham *et al* (2017) study. This appears to be a longstanding area of difficulty and was also identified in Ofsted's (2005) 'Healthy Minds: Promoting Emotional Health and Wellbeing in Schools'.

RQ 2: Based on Bandura's (1977) self-efficacy theory, what factors do staff perceive influence their self-efficacy in relation to supporting student emotional and mental health?

Schunk and Meece (2006) stated self-efficacy influences an individual's goals and behaviours and is affected by environmental conditions. Accordingly, participants reported factors that were related to environmental conditions and individual factors.

Environmental Conditions

Four environmental conditions were described as impacting on self-efficacy beliefs. One was time limitations, which was consistent with Hanley, Winter and Burrell's (2017) findings. In the current study, the need for time was described in terms of relationship building and maintenance, which was considered a key activity in the identification of difficulties and the provision of support. In terms of the identification of difficulties, participants relied on detecting changes in personal norms, which was consistent with Rothi, Leavey and Best's (2008) study.

Limited knowledge of students' circumstances was named by participants as a limiting factor to the provision of support.

A second condition was the limited availability of external services to refer students to. While the Mental Health and Behaviour (DfE, 2016) guidance, for example, advises schools to seek support from external agencies, participants described limitations in the range of services available, and waiting times for involvement. This is consistent with Newham *et al* (2017) finding, for example, that participants perceived a lack of support from external agencies.

A third condition was the challenges of working within the current education system, notably the focus on academic measures and linear exams. This was consistent with Hutchings' (2015) finding regarding the negative impact of academic pressures on adolescent well-being, as well as Hanley, Winter and Burrell's (2017) statement that Ofsted had a reduced emphasis on emotional support in their assessment and inspection criteria, with just one-third of a sample of reports after September 2015 making direct reference to mental health and emotional wellbeing (as evidenced in Thorley's (2016) report).

A fourth condition was the perceived increasing prevalence of adolescent mental health difficulties, which was consistent with Collishaw *et al* (2004) findings, as well as Hanley, Winter and Burrell's (2017) report of school staff perceptions. A number of potential explanatory factors for this have been put forward, as outlined in chapter 3.

Self-efficacy
The factors impacting self-efficacy beliefs are summarised below according to Bandura's (1977) four sources of self-efficacy information.

Mastery Experience:

Participants referred to the role of previous experience providing support impacting their self-efficacy beliefs, although one participant described not always knowing if they had had a positive impact due to the lack of feedback. Lived experience of difficulties also seemed important. One participant who had experienced mental health difficulties described feeling she had a greater understanding of students' experience, whereas other participants cited their lack of lived experience as creating a barrier to understanding.

Vicarious Experience:

Participants referred to gaining knowledge regarding how to support students from discussions with colleagues in school, as well as through observing others in training.

Social Persuasion:

While all participants described a perceived responsibility to provide support, none referred to receiving encouragement from others in school to support students in this way. The pastoral managers described they were 'expected' by senior leadership to support students, rather than encouraged.

Affective State:

Descriptions of the impact of affective state on self-efficacy were largely absent from interviews. One participant described the experience of depression as a reason why staff would not be in as good a position to her to provide support. However, her reasons for this were not explored. It is possible this was a reference to the emotional labour involved in providing support, which would be consistent with NCB-Weare's (2015) argument that it is hard for staff

to be genuinely motivated to promote emotional and social well-being in others if they feel uncared for or burnt out themselves.

The Role of Personality:

One factor mentioned that did not align with Bandura's (1977) sources of information was the impact of personal characteristics such as personality on self-efficacy beliefs. However, this was consistent with Hanley, Winter and Burrell's (2017) view that the provision of this sort of support and interaction was more likely to be dependent on the personality of the staff member than any professional training.

RQ 3: How strong are staff's self-efficacy beliefs in relation to providing support for emotional and mental health needs?

The strength of self-efficacy beliefs in relation to supporting student emotional and mental health needs varied. While the Learning Support Assistant reported feeling less self-efficacious, others scored themselves in the mid- to higher-range. Both participants with designated pastoral and non-pastoral elements to their role rated their self-efficacy around the same strength, although direct comparisons are difficult as a standardised scale was not used. Both pastoral managers noted a fluctuation in their self-efficacy, dependent on external factors such as workload.

Generally-speaking, however, designation of pastoral role did not seem to be associated with strength of self-efficacy belief. It appeared to be an individualised construct that was influenced by different factors for different participants. While all participants mentioned personal and systemic factors in relation to self-efficacy, they were attached different degrees of importance. For some, personal factors, for example knowledge and experience, were described as

impacting significantly on their self-efficacy, whereas for others systemic factors such as time and resources were more important. This finding is consistent with Bandura's (1977) theory, that states the impact of sources of self-efficacy information is determined by how the information is processed and the weight it is given at the level of the individual. Consequently, blanket or 'one-size-fits-all' measures taken to improve an individual's self-efficacy beliefs in relation to supporting student emotional and mental health in secondary schools are unlikely to be effective for all staff.

6.7 Development as a Practitioner Researcher

A reflective journal was kept throughout the data collection period to support my development as a researcher and interviewer. Soon after each interview, I noted my initial thoughts on the process. As most of the interviews were conducted on different days, I was also able to listen to recordings prior to the next interview to build on my initial thoughts. These reflections allowed me to develop my interview technique and I perceived I was more accomplished in the final interview than the first.

My reflections focused on the effectiveness of my questioning and rapport building for eliciting relevant information. I tried to identify where the phrasing of questions had been effective and where alternative phrasing was needed. I also considered where I may have missed opportunities to ask relevant follow-up questions and what may have influenced my decision-making at that point. My reflections also focused on identifying where biases may influence the interview. For example, I experienced frustration following an early interview during which a participant had not disclosed experiences that I had previously observed. I noted that my prior

knowledge of the school and its activities may directly impact my phrasing of questions or the

follow-up questions asked and was mindful of that during subsequent interviews.

CHAPTER SEVEN: CONCLUSIONS AND IMPLICATIONS

7.1 Introduction

The overarching aims of the study were to explore secondary staff's understanding of emotional and mental health and, using Bandura's (1977) theory, explore staff's self-efficacy regarding supporting students with such needs.

In this concluding chapter, I will assess the implications of the findings in light of the literature presented in chapters two to four, and theoretical underpinnings of the study.

7.2 Answering the Research Questions

The implications of findings are presented below for each research question.

RQ 1: What do secondary staff in a range of roles understand emotional and mental health to be?

There was a high level of consistency across participants' descriptions, despite an absence of training in this area. Without using terminology, participants identified elements of mental health associated with cognition, affect, social, and behaviour. Some also referred to risk and protective factors. There were, however, some individual differences in understanding, such as the relationship between mental health and 'normality'. An implication is that, while there may be a lot of commonality in understanding of mental health, this should not be assumed in both research and interactions with secondary school staff.

Participants' views reflected two common discourses. Firstly, there was an ill-defined distinction between emotional and mental health, which was represented in much of the academic literature and public policy documents (for example, DfES and DoH (2004), and Hanley, Winter and Burrell, 2017). Participants' use of diagnostic terminology represented a medicalised model of mental health, which may be reflective of the increased co-working between schools and medical professionals recommended in recent publications (for example, DoH and Social Care and DfE, 2017). While one participant referred to positive mental health, all described mental health using a deficit model. This appeared to impact the nature of activities described, which centred around planning for difficulties.

All participants were motivated to support students, although some participants expressed a view that, in doing so, schools were compensating for what should be provided by home. The way in which participants described mental health as changeable, unpredictable, individualised and potentially 'behind closed doors' indicated they may feel they have a substantial task on their hands. It is easy to see how the fluid nature of mental health may create confusion for secondary school staff, coupled with unclear distinctions between difficulty and 'normal' adolescent development.

RQ 2: Based on Bandura's (1977) self-efficacy theory, what factors do staff perceive influence their self-efficacy in relation to supporting student emotional and mental health?

Many of the environmental conditions, such as the challenges of the current education system, increasing prevalence of student difficulties, limited time and resources, and mixed staff attitudes had been mentioned in previous studies (for example, Macklem, 2011; Hanley, Winter

and Burrell, 2017). Time was perceived as key to the core support activity of building and maintaining relationships. Limited access to external services was also described, which was found in studies such as Hanley, Winter and Burrell (2017). All participants described referring concerns to someone else, either within school or externally. In this sense, they appeared to perceive themselves as a 'hub' whose function was to detect difficulties and refer to those perceived as having greater expertise. This indicates a school-specific role delineation determined by the resources and perceived capabilities available in the school, which Thorley (2016) argued is the product of increased school autonomy without measures to boost capacity or accountability. The implication is that without clear, school-specific guidance on core activities associated with supporting student emotional and mental health needs, schools are likely to individually decide levels of provision based on other systemic factors (for example, human resources).

Factors impacting self-efficacy had not been previously identified in the literature. Consistent with Bandura's (1977) theory, mastery experiences appeared to be a key influence on self-efficacy beliefs and were described in terms of a knowledge base gained through experienced successes in the provision of support. However, other important factors were described as previous lived experience and personal characteristics. Previous lived experience of mental health difficulties was perceived as contributing to increased understanding of students' needs. Personal characteristics such as personality traits and gender also impacted self-efficacy in relation to the ability to build relationships with students. The implication of this is that personal factors also influence self-efficacy in a professional role.

A notable absence from interviews was any description of the emotional impact of providing support. This could be attributed to the questions asked, nature of the interviewer-interviewee relationship and the interview context. However, it raises questions regarding how individuals

demarcate their professional and personal selves. As has been outlined above, the provision of support for emotional and mental health needs involves personal as well as professional characteristics. It is thus inevitable that providing support impacts at a personal level and vital that supportive forums are created for staff to acknowledge and discuss this to support their own well-being.

RQ 3: How strong are staff's self-efficacy beliefs in relation to providing support for emotional and mental health needs?

There was variation in self-efficacy beliefs amongst participants, as well as the factors they described as impacting these. Three participants referred to environmental conditions such as limited time as having an important influence on their self-efficacy beliefs. The other three participants, however, referred to personal characteristics and lived experience. This variation is consistent with Bandura's (1977) theory, which states that the impact of information on self-efficacy beliefs is determined by the way it is cognitively appraised by individuals and the importance attached to it. The implication of this finding is that individuals' self-efficacy beliefs in relation to supporting student emotional and mental health needs may be most effectively improved via a personalised approach rather than whole-staff training. This is expanded upon in the following section.

7.3 Unique Contribution

The unique contribution of this research relates to the finding that self-efficacy beliefs regarding the provision of support for student emotional and mental health needs is a personal, individualised construct. This undermines the effectiveness of group or whole-staff training in

positively impacting individuals' self-efficacy and indicates that activities to address these beliefs should account for individual factors such as previous professional and personal experiences, and personality characteristics. For this reason, the use of a supportive, individualised approach such as a coaching model may be a more appropriate method of increasing self-efficacy beliefs. This is discussed further in later sections.

7.4 Implications for Schools

Findings highlighted a number of environmental conditions that impacted staff self-efficacy. Some of these, such as the challenges of working in the current education system and limited access to external services, can only be addressed minimally at the level of individual schools. However, schools have more influence over the organisation of school systems to promote good information sharing and joint working in relation to supporting student emotional and mental health, which were identified as impacting factors on self-efficacy.

As working with parents was a frequently-cited example of joint working, schools should take steps to build positive relationships with parents. While common-sense strategies such as open and regular communication between school and parents apply, Barr and Saltmarsh (2014) found that parents' perception of the attitudes, communication and leadership practices of head teachers played an important role in fostering and maintaining parent-school relationships. This indicates that school leadership should take an active role in parent engagement, as well as implementing effective school organisational structures. This has also been recommended by NICE (2009) and Public Health England (2015).

Self-efficacy in relation to providing support for student emotional and mental health needs is influenced by both personal and professional characteristics on self-efficacy in providing

support. Consequently, the personal impact of this role is inevitable and it is recommended schools implement supportive systems to enable staff to acknowledge and off-load the impact of this work in order to manage the emotional labour. This has also been recommended by NCB-Weare (2015) and Public Health England (2015).

7.5 Implications for Educational Psychology Practice

Firstly, the findings indicate EPs have a role to work systemically with schools; supporting key staff to plan support for student emotional and mental health needs in terms of specific activities, as well as identifying specific tools and processes that will enable schools to provide support in a structured way. While recent guidance for schools has been given in 'Mental Health and Behaviour' (DfE, 2016), this lacks a specificity that some participants in the present study desired but struggled to find due to their understanding of mental health as changeable and unpredictable, for example.

Secondly, EPs have a role in increasing the self-efficacy of school staff in supporting student emotional and mental health needs. The findings of the present study have highlighted a need to empower individuals so that they are confident they have the skills needed to provide support. Findings suggest this needs to be achieved through a model that can account for individual experiences and understanding. One model that may facilitate this is coaching, which is defined as "a collaborative, solution-focused, result-orientated and systematic process in which the coach facilitates the enhancement of work performance, life experience, self-directed learning and personal growth of the coachee" (Association for Coaching, 2015). This definition highlights the strengths-based nature of coaching which avoids negative terminology such as 'skills deficit', as well as endorsing collaborative and personalised goal-setting.

There are a small number of studies on the positive impact of coaching in the educational sector (for example, Green, Grant and Rynsaardt, 2007 and 2010; Madden, Green, and Grant, 2011; and Adams, 2016). Two studies conducted in the United States explore the use of a training and coaching model to upskill teaching staff in supporting child social and emotional development. Using a training and consultation model, the 4Rs program aimed to support elementary teachers to teach social and emotional skills as part of the literacy curriculum (Brown *et al*, 2010). The BRIDGE (Bridging Mental Health and Education in Urban Elementary Schools) model aimed to upskill elementary school teachers in mental health practice using consultation and coaching (see Cappella *et al*, 2011; Cappella *et al*, 2012). Both models showed some promising initial effects on teachers' perceived emotional ability in the classroom (Brown *et al*, 2010), teacher-student relationships (Cappella *et al*, 2012) and student academic self-concept (Cappella *et al*, 2012). However, the long-term effects of neither model have been evaluated, nor have the models been evaluated in subsequent studies. Furthermore, the models have only been trialled in provisions educating pre-adolescent students.

Adams (2016) argued EPs are well-placed to implement coaching due to the wealth of psychological models and approaches "that can underpin and bring depth to the coaching relationship" (p. 235), such as theories of learning and motivation. EPs are also well-placed due to their knowledge of the context in which school staff are working in (the education system and individual school systems).

7.6 The LA Context

The findings of the present study were consistent with what is known about the LA context. While participants described some strategies for identifying difficulties, they were concerned

about "getting things wrong" in terms of support, which may make situations worse for young people. In terms of how they described their support activities, they viewed themselves as hubs who passed issues to more "expert" external professionals; referring to more generic activities such as conversations as a form of providing school-based support.

Recently, the LA Educational Psychology Service developed a pathway for school-based SEMH support. The findings of the present study were consistent with the reports involved in developing and receiving training on the pathway. While most felt relatively confident in identifying student difficulties, they were not sure how to implement support. The question of 'what next?' post-identification of difficulty appears to be a common difficulty, at least locally. It seems that the provision at a national level, predominantly through Mental Health First Aid training, has centred on identifying needs rather than planning support. Documents aimed to provide guidance on this matter, such as 'Mental Health and Behaviour in School' (DfE, 2016) are vague.

The findings from the present study, as well as reports from the wider LA context, suggest there is now a need to move towards supporting schools in planning and implementing specific activities to support students, rather than further advice in identifying difficulties.

7.7 Limitations

The study is considered to have value, as the literature reviewed in chapters two to four indicated no study on school staff views had explored their understanding of emotional and mental health, nor their self-efficacy in supporting students' needs. However, there are a number of limitations that may have impacted the research, which are presented below.

<u>Sample:</u>

Firstly, the sample size was small, which could mean the views gathered are not representative of all staff. This is also possible as all participants were females from a white ethnic background, which was not representative of all school staff.

Secondly, no teachers were interviewed as none were willing to participate, which meant that the views gathered were not representative of all staff identified by Pastoral Managers as supporting student emotional and mental health needs on a day-to-day basis. Furthermore, no members of senior leadership were interviewed as they were not identified by Pastoral Managers as directly supporting student emotional and mental health needs on a day-to-day basis. Consequently, the data gathered lack an oversight of the relevant activities taking place in the school, which could have been provided by someone in senior leadership role. However, this was not the focus of the study. It may have been that those in a senior leadership role supported students through everyday activities, although this would not be consistent with some data collected. The identification of relevant roles was done through discussion with only Pastoral Managers and it is possible that discussion with individuals in different roles may have produced different views. The list should have been checked with staff in different roles.

<u>Data Collection:</u>

The use of a recording device may have been a limitation as after one interview a participant disclosed information regarding the senior leadership team that she had not done during the interview. This means that the data may not be a wholly accurate representation of individuals' views and experiences due to self-monitoring, for example. While processes of confidentiality, anonymity, and data storage had been clarified prior to the interview, this self-monitoring may

have occurred due to her knowledge I had agreed to share key findings with the senior leadership team.

Secondly, I had established working relationships with some participants but not all. This may have impacted the amount and nature of information participants disclosed. Attempts were made to build rapport with all participants prior to the interview. However, the data may not be a wholly accurate representation of individuals' views.

Thirdly, there was no way of measuring whether the strength of self-efficacy beliefs was associated with actual performance in the provision of support. Whilst this was not the focus of the study, it would be important to explore whether self-efficacy beliefs were associated with successful performance of activities associated with providing support, to identify the importance of self-efficacy in relation to this role.

Research Design:

The research was conducted in one setting with a small sample size. Consequently, it is not clear how representative individual's views are of staff in other settings in the LA, although previous anecdotal evidence (outlined in The LA Context) suggests some similarities.

7.8 Directions for Future Research

The voice of secondary teachers was absent from this study (aside from participants who also had some teaching responsibilities) due to their lack of engagement. This may be influenced by a number of factors, such as their perceptions of their role (ie. Whether it extends to providing student emotional and mental health support) or their own well-being. It may also have been

impacted by the use of the term 'mental health' when presenting the research project. Further research is needed to explore the views of secondary teaching staff (without a designated pastoral role) in this area. It may be more effective to present the study in terms of 'student well-being', rather than using the term 'mental health'.

This study was founded on the assumption that self-efficacy may be associated with actual behaviour in the provision of support, as well as stress and burnout. However, it was beyond the scope of this study to explore this relationship (individuals' actual behaviour in the provision of support, stress, and burnout) and further research is needed in this area.

The findings of the present study suggest self-efficacy in supporting student emotional and mental health needs is an individualised construct and it is argued this may be best impacted through individualised approaches such as coaching. One direction of future research would be to implement a coaching model with the aim of improving secondary school staff self-efficacy in supporting emotional and mental health needs and evaluate the effectiveness of this using pre-determined criteria.

7.9 Final Comment

This study has met the aims of identifying secondary school staff's understanding of emotional and mental health, and identifying factors impacting their self-efficacy beliefs in supporting students' needs in this area using Bandura's (1977) self-efficacy theory. The findings indicated an understanding of emotional and mental health that is mostly consistent with discourses in the public domain. However, there were some individual differences. Mastery experiences in the provision of support were found to influence self-efficacy beliefs, as well as lived experience and personal characteristics. Consistent with previous literature, several

environmental conditions were reported to influence self-efficacy. Findings highlighted that self-efficacy is an individualised construct and measures to improve beliefs should consider individual experiences and understanding, such as through a coaching model.

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APPENDIX 1

Meyrick's (2006) Quality Framework for Qualitative Research. Taken from her paper 'What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality'
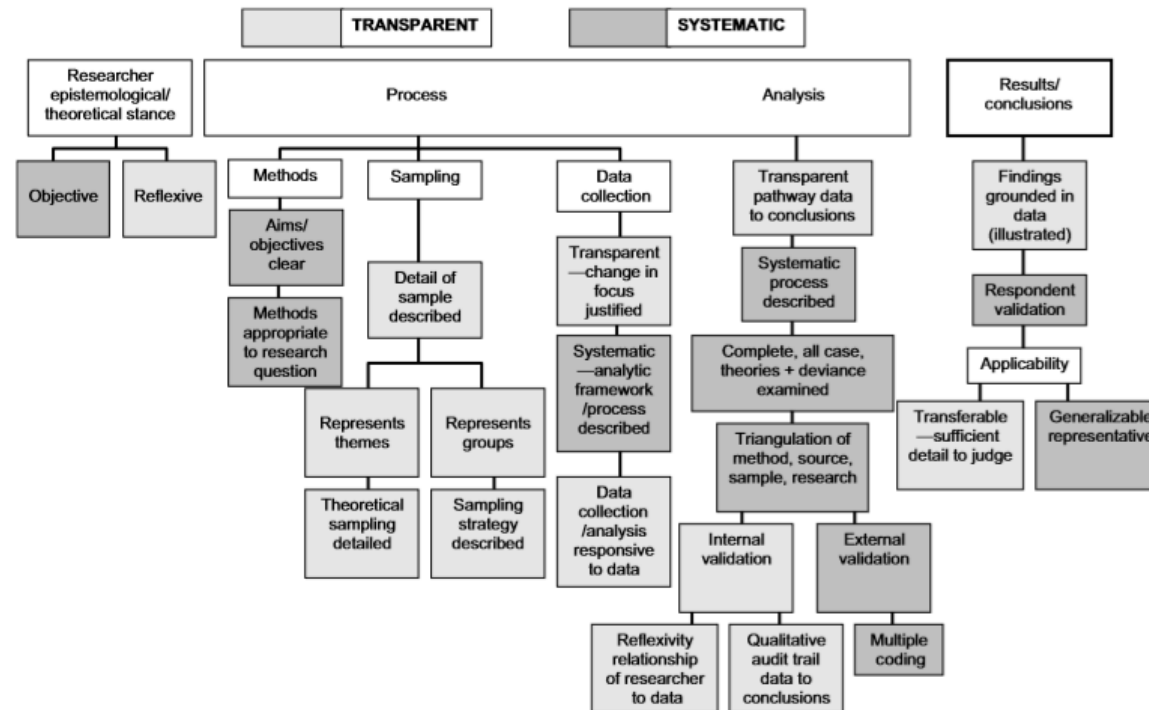
APPENDIX 2

Pilot Interview Schedule

Topic	Possible Questions	Possible Follow-up Questions (Prompts)	Probes
Conceptualisation of emotional and mental health	How would you define emotional health?	**Provision of definition of emotional health if needed** ("*a positive state of wellbeing which enables an individual to be able to function in society and meet the demands of everyday life",* Mental Health Foundation) How would you know if someone had poor emotional health? How would you know if someone had good emotional health?	Try to think about how a person may be thinking, feeling and acting if they had good/poor emotional health.
	How would you define mental health?	**Provision of definition of mental health if needed** ("a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community", World Health Organisation) How would you know if someone had poor mental health? How would you know if someone had good mental health?	Try to think about how a person may be thinking, feeling and acting if they had good/poor emotional health.
	What might a student with good emotional and mental health think/feel/do in a classroom?	How might they be behaving? Why might they be behaving like that?	Try to think of students you teach who you might describe as having

			good emotional and mental health.
	What might a student with poor emotional and mental health think/feel/do in classroom?	How might they be behaving? Why might they be behaving like that?	Try to think of students you teach who you might describe as having poor emotional and mental health.
Perceived self-efficacy in supporting student emotional and mental health	What do you think self-efficacy is?	**Provision of definition of self-efficacy if needed** ("an individual's belief in his or her ability to succeed in specific situations or accomplish a task", Bandura, 1986) What do you think of that definition?	
	Have you received any training in relation to emotional and mental health?	What training have you found particularly useful? What training have you found less useful?	
	On a scale of 1 to 10, where 1 is not at all able and 10 is very able, how able do you think you are to support student emotional and mental health on a day-to-day basis?	Could you explain why you've chosen that rating? Why did you not rate yourself higher? Why did you not rate yourself lower?	Try to choose a number that represents where you perceive your current ability to be.
	How do you feel about supporting student emotional and mental health?	As a classroom teacher, do you think you have a role in supporting student emotional and mental health? Are there particular times or situations when you feel more/less able to provide support?	

	What do you already think/feel you are able to do to support student emotional and mental health?	How would you identify if a student potentially had emotional and mental health difficulties? What would feel able to do if you identified a student with potential difficulties? What kinds of things would you do to support a student with difficulties?	Try to think what you might do on a day-to-day basis as a classroom teacher.
	Is there anything else you think would also help support student emotional and mental health that you don't do at the moment?	What are the barriers to doing these things currently?	
Factors perceived to influence self-efficacy in supporting student emotional and mental health	Has there been a specific time where you've felt able to support students' emotional and mental health?	Could you tell me more about that time.	
	How do you rate your abilities to support students' emotional and mental health in comparison to other teachers in the school?	Could you explain why you rate yourself in this way in comparison to other teachers?	
	Are you encouraged to support student emotional and mental health by others in the school (for example, by other teachers or school leadership)?	What kinds of things do others in the school do to encourage you?	
	Do you think you have sufficient support and knowledge to support students' emotional and mental health?	Could you tell me more about this?	
	What particularly affects how able you feel to support student and emotional health?	Could you tell me more about this?	
	If you could change or improve one that thing that would make the most difference to how able you felt to support student emotional and mental health, what would that be?	Could say why you've chosen that? Is there anything else that would make a difference?	

APPENDIX 3

Recruitment Email

Dear Staff at (School Name),

I'd like to invite you to take part in a research project exploring how confident and able secondary school staff feel to support student emotional and mental health needs. I have been working in the school since January 2017 and am a Trainee Educational Psychologist working at Wolverhampton Educational Psychology Service. The research project forms part of my qualifying doctorate in Educational and Child Psychology at the University of Birmingham.

I'd like to gain the views of staff on their understanding of emotional and mental health; how confident and able they feel to support student emotional and mental health; and what they think influences how confident and able they feel in this area. **This would be via an interview, which would last approximately 45 minutes, and would be arranged at your convenience.**

Please read the attached information sheet containing further information about the project. **If you wish to be involved, please email me at** ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ **by Friday 13ᵗʰ October.**

Thank you for considering this. If you have any questions or wish to speak to me regarding further information before registering your interest, please contact me on ▮▮▮▮▮▮▮▮▮ or by email on ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮. You may also contact my supervisor Dr Jane Leadbetter at the School of Education, University of Birmingham on j▮▮▮▮▮▮▮▮▮▮▮▮ or ▮▮▮▮▮▮▮▮

Kind regards,

Natalie Dobbie

Trainee Educational Psychologist

Postgraduate Researcher – Doctorate in Applied Educational and Child Psychology

APPENDIX 4

Amended Interview Schedule

Topic	Possible Questions	Possible Follow-up Questions (Prompts)	Probes
Contextualisation	Could you describe your role in the school?	What are your specific roles and responsibilities?	
Conceptualisation of emotional and mental health	How would you define mental health?	**Provision of definition of mental health if needed** ("a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community", World Health Organisation) How would you know if someone had poor mental health? How would you know if someone had good mental health?	Try to think about how a person may be thinking, feeling and acting if they had good/poor mental health.
	Can you see any difference between mental health and emotional health?	Can you see any similarities between the two in terms of thoughts/feelings/behaviours?	
	If a student had good emotional/mental health, what might you see in school?	How might they be behaving? Why might they be behaving like that?	Try to think of a student you've come across who you might describe as having good emotional and mental health.
	If a student had poor emotional/mental health, what might you see in school?	How might they be behaving? Why might they be behaving like that?	Try to think of a student you've come across who you might describe as having poor emotional and mental health.

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Perceived self-efficacy in supporting student emotional and mental health	Have you heard of self-efficacy? If so, how might you define it?	**Provision of definition of self-efficacy if needed** ("an individual's belief in his or her ability to succeed in specific situations or accomplish a task", Bandura, 1986)	
	On a scale of 1 to 10, where 1 is not at all able and 10 is very able, how able do you think you are to support student emotional and mental health on a day-to-day basis?	Could you explain why you've chosen that rating? Why did you not rate yourself higher? Why did you not rate yourself lower?	Try to choose a number that represents where you perceive your current ability to be.
	How do you feel about supporting student emotional and mental health?	In your role, do you think you have a responsibility to support student emotional and mental health? Why/not? Are there particular times or situations when you feel more/less able to provide support?	
	What do you already think/feel you are able to do to support student emotional and mental health?	How would you identify if a student potentially had emotional and mental health difficulties? What would you feel able to do if you identified a student with potential difficulties? What kinds of things would you do to support a student with identified difficulties?	Try to think what you might do on a day-to-day basis.
	Is there anything else you think would also help support student emotional and mental health that you don't do/aren't able to do at the moment?	What are the barriers to doing these things currently?	
Factors perceived to influence self-	Have you received any training in relation to supporting student emotional and mental health?	What training have you found particularly useful?	

efficacy in supporting student emotional and mental health		What training have you found less useful?	
	Has there been a specific time where you've felt able to support a student's emotional and mental health?	Could you tell me more about that time. How did that make you feel?	
	Do you think there are staff in school who may be *more* able to support student emotional and mental health?	Why do you think this way about these individuals?	
	Do you think there are staff in school who may be *less* able to support student emotional and mental health?	Why do you think this way about these individuals?	
	Are you encouraged to support student emotional and mental health by others in the school (for example, by school leadership)?	What kinds of things do others in the school do to encourage you? How do you feel about this?	
	Do you think you have sufficient knowledge to support students' emotional and mental health?	Why so/not?	
	Do you think you have sufficient support to support students' emotional and mental health?	Why so/not? What forms of support are important?	
	What particularly affects how able you feel to support student and emotional health day-to-day?	Could you tell me more about this?	
	If you could change or improve one that thing that would make the most difference to how able you felt to support student emotional and mental health, what would that be?	Could say why you've chosen that? Is there anything else that would make a difference?	

APPENDIX 5

Participant Information Sheet

Research Project Information Sheet

Perceived Efficacy and its Sources: Secondary Staff's Self-Efficacy in relation to Supporting Student Emotional and Mental Health in a Secondary School

Background Information

This information sheet has been sent to you because we are looking to recruit eight secondary staff in a range of roles who would be willing to take part in a research project run by a postgraduate research student (Natalie Dobbie) at the University of Birmingham. Before you decide if you would like to take part, please read this information sheet so you understand why the research is being conducted and what it will involve. If you would like further information, or would like to ask any questions about the information given, please contact the researcher (Natalie Dobbie), using the contact details at the end of this sheet.

Purpose of this study

Research has shown that schools are well-placed to provide support for adolescent emotional and mental health. However, research from 2010 has also shown that, although staff consider this important, they often do not feel capable of providing students with this support for a number of reasons.

The purpose of the study is to explore secondary staff's current level of self-efficacy in relation to supporting student emotional and mental health. In this study, self-efficacy is defined as *an individual's belief in his or her ability to succeed in specific situations or accomplish a task"*. It also aims to explore what influences staff's belief in their capabilities and what they think might improve their self-efficacy.

Why have I been asked to participate?

You have been asked to take part because you work in the school and are involved with providing day-to-day support for students in some capacity. It does not matter if you are employed on a part- or full-time basis.

Do I have to take part?

No. You will only participate in the study if you want to.

What will happen if I agree to take part?

The information will be collected via individual interviews with the researcher.

If you agree to take part, you will be contacted by the researcher to set up a time for the interview. Before the interview starts, you will be asked to sign a consent form for your participation in the study. The interview will only take place if this form is signed.

When and where will the interview take place?

The interview will take place at the school at a time that is mutually convenient to you and the researcher in February 2018. This could be during your PPA, before or after school. It is estimated the interview will take 45 minutes.

What are the possible benefits of taking part?

This research project will help us understand secondary staff's views regarding their capabilities to support student emotional and mental health, and what influences this. This could help inform future research, and could be useful in enabling schools to plan more effectively what activities need to be undertaken to improve staff's self-efficacy in this area, where this is needed. The interviews are not aimed to test knowledge, but to give staff an opportunity to voice their views on this topic.

What are the possible risks of taking part?

There are two minimal risks to you in taking part in this research project.

The first risk is that some of the interview questions are designed to explore your views on your professional capability in providing emotional and mental health support, which may cause you to experience some feelings of distress or anxiety during or after the interview. Interviews will be conducted individually with the researcher and a great deal of care has been taken to phrase the questions in a sensitive manner.

If this should occur, the following options will be available to you:

- You have the right to end your participation in the study at any time
- With your consent, your concerns will be passed on to an appropriate member of staff within the school by the researcher
- At the end of the interview you will be given contact information for the Education Support Partnership and Samaritans. Both organisations provide confidential emotional support.

If, during the interview, you should disclose information about your mental health that meant you could be considered a risk to yourself or others, this information will be passed on to your line manager. If you should disclose information about a student's mental health that meant he or she could be considered a risk to him/herself or others, this information will be passed on to his or her Behaviour and Learning Manager.

The second risk is that, as all data will be gathered in the same school, it is possible that when reading any write up of the research, people within the school may recognise you have taken part. The following measures will be taken to ensure your anonymity:

- A summary of participants will be given in the methodology section of the write-up. This will refer to numbers of males and females who took part, and that participants were in a range of roles (subjects will not be identified).
- If a direct quotation from your interview is used, you will be identified as, for example, 'Participant A'.
- Direct quotations from interviews will not be used if they refer to a unique personal experience, or a scenario in which an individual young person could be identified.

If I change my mind, can I withdraw from the study?

Yes. If you wish to withdraw from the study prior to the interview, you can inform the researcher via email and your consent form will be destroyed. If you wish to withdraw from the study during the interview, you can inform the researcher in person and any data already collected will be destroyed. You can withdraw from the study up to one month after the date of the interview by informing the researcher via email. The data already collected will be destroyed.

You do not have to give a reason for withdrawing from the study at any point.

Will my information be kept confidential in the study?

Yes. The researcher complies with the Data Protection Act (1998) in relation to handling, processing and destroying all participants' data. All data collected will be kept strictly confidential, and all data will be kept anonymously so that no participant can be identified. The data will be destroyed 10 years after the research has been completed. All data will be kept securely in the interim period.

Paper copies of data (for example, consent forms) will be stored securely at Wolverhampton Educational Psychology Service. Digital copies of data (for example, audio recordings of interviews and their transcripts) will be stored securely on an encrypted memory stick.

What will happen to the results of the study?

A summary of the key findings will be shared with you on an information sheet. This information will also be shared with the other participants. A copy of this will be sent to the Head Teacher.

The results of the study will be written up as part of the researcher's thesis for the Doctorate in Applied Educational and Child Psychology. The study may be written as a journal article and submitted for publication to a relevant professional journal. The work may be presented at conferences. Your name, the name of other research participants, and the name of the school will remain anonymous at all times. Some information about you and the school will be included: your sex, your position within the school, and a brief description of the school i.e. mainstream, size of student population.

Who is organising the research?

The research is organised by the University of Birmingham and Wolverhampton Educational Psychology Service.

Who should I contact if there is a problem?

No problems should arise for you as a result of participating in this study. However, if a problem were to arise, the researcher (Natalie Dobbie) or the research supervisor (Dr Jane Leadbetter) can be contacted between 9am to 5pm, Monday to Friday. Contact details are at the end of this information sheet.

Who has reviewed the study?

The research project has been reviewed and approved by the Humanities and Social Science Ethical Review Committee at the University of Birmingham.

What do I do next?

If you are willing to take part or have further questions, please contact the researcher (Natalie Dobbie) using the contact details below, or speak to one of the Behaviour and Learning Managers.

Contact details for further information

Natalie Dobbie (Doctoral Researcher, University of Birmingham and Trainee Educational Psychologist, Wolverhampton City Council): ⬜⬜⬜⬜⬜⬜ OR ⬜⬜⬜⬜⬜⬜

Dr Jane Leadbetter (Research Supervisor, University of Birmingham) ⬜⬜⬜⬜⬜⬜

Dr Rebecca Sharpe (Supervising Educational Psychologist, Wolverhampton City Council)

Thank you very much for taking the time to read this information sheet and considering participating in this study.

APPENDIX 6

Consent Form

Study Title: *Perceived Efficacy and its Sources: Secondary Staff's Self-Efficacy in relation to Supporting Student Emotional and Mental Health in a Secondary School*

Please read and complete the participant consent form.

|	Yes	No
I have read and understood the project information sheet		
I have had an opportunity to ask questions about the project		
I agree that my voice will be recorded during the interview		
I confirm that, as part of my professional role, I am involved in providing students with some level of support on a day-to-day basis.		
I understand my participation in the study is voluntary. I understand I can withdraw from the study prior to the interview, at any point during the interview, or up to one month after the interview. If I decide to withdraw from the study before the interview, my consent form will be destroyed. If I decide to withdraw from the study during or after the interview, all interview data will also be destroyed.		
I understand that, if I want to withdraw from the study, I do not have to give any reasons for doing so.		
I agree that the results of the study will be written in a report as part of the researcher's university thesis and may subsequently be published in an academic journal. I know that neither my name, nor the name of the school, will be included in these reports. I understand that basic details about me (ie. Sex and my role) will be summarised in the methodology section but will not be attributed to any direct quotations from my interview. I understand that direct quotations from my interview will not be included in the write up if they refer to a unique personal experience, nor if a young person could be identified.		
I understand that I disclose information about my mental health that means I could be considered a risk to myself or others, this information will be passed on to my line manager. If I disclose information about a student's mental health that means he or she could be considered a risk to him/herself or others, this information will be passed on to his or her Behaviour and Learning Manager.		
I agree that the data I provide can be stored securely by the researcher for ten years.		

Staff's name: …………………………………..…………………………..

Staff's signature: ………………………………………………………………..

Date …………………………………

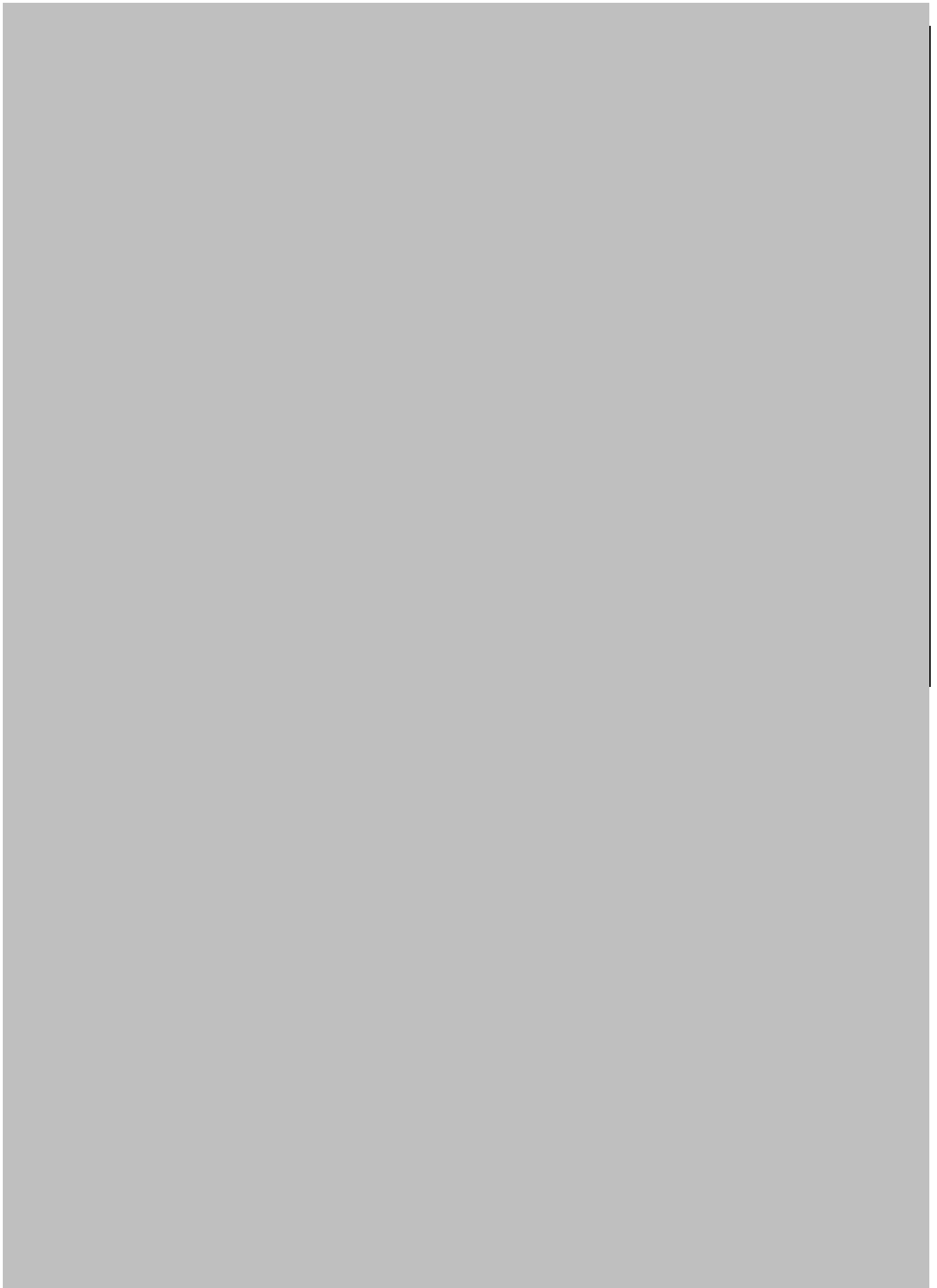Researcher's signature: …………………………………………………………………..
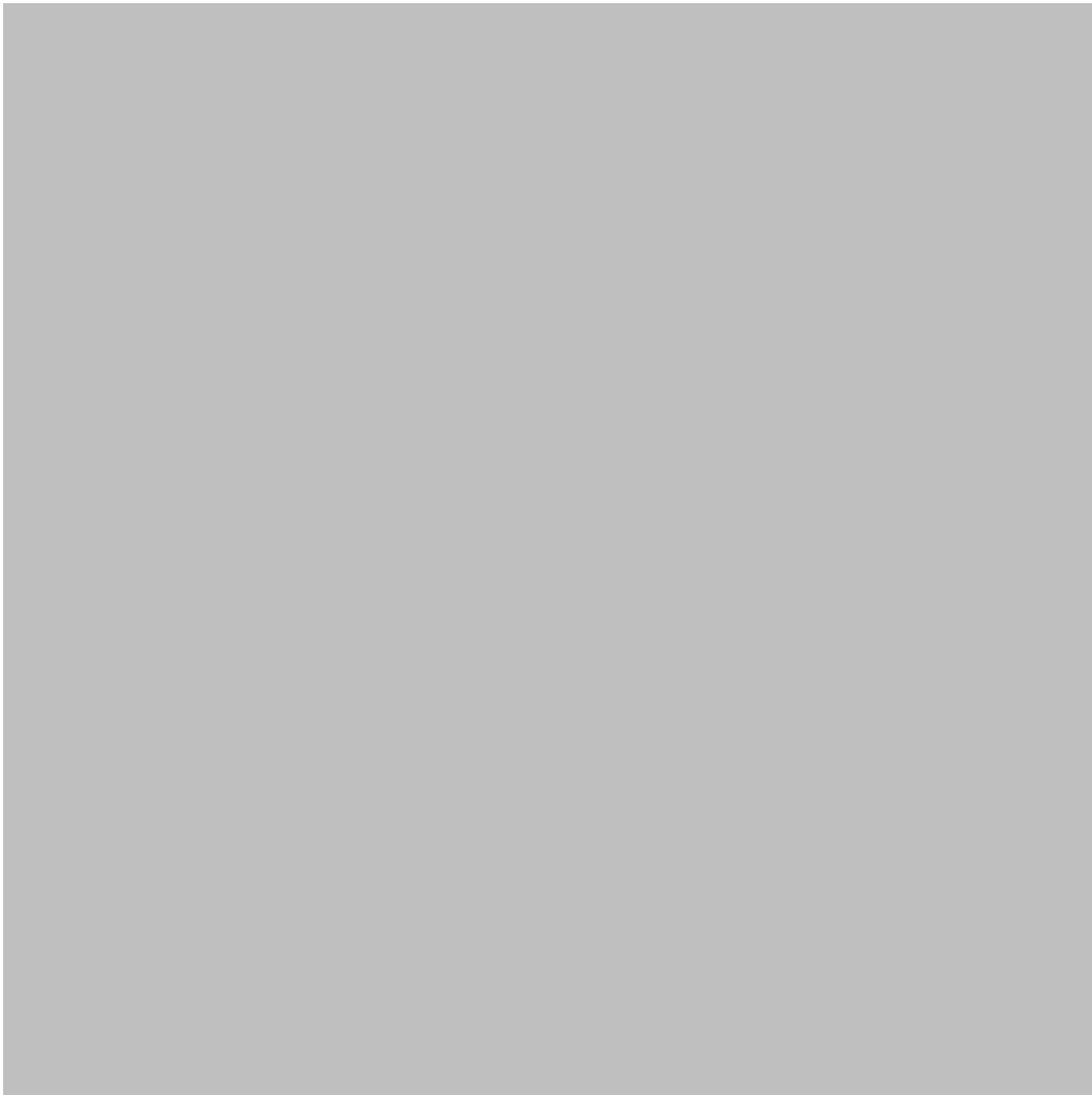
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APPENDIX 7

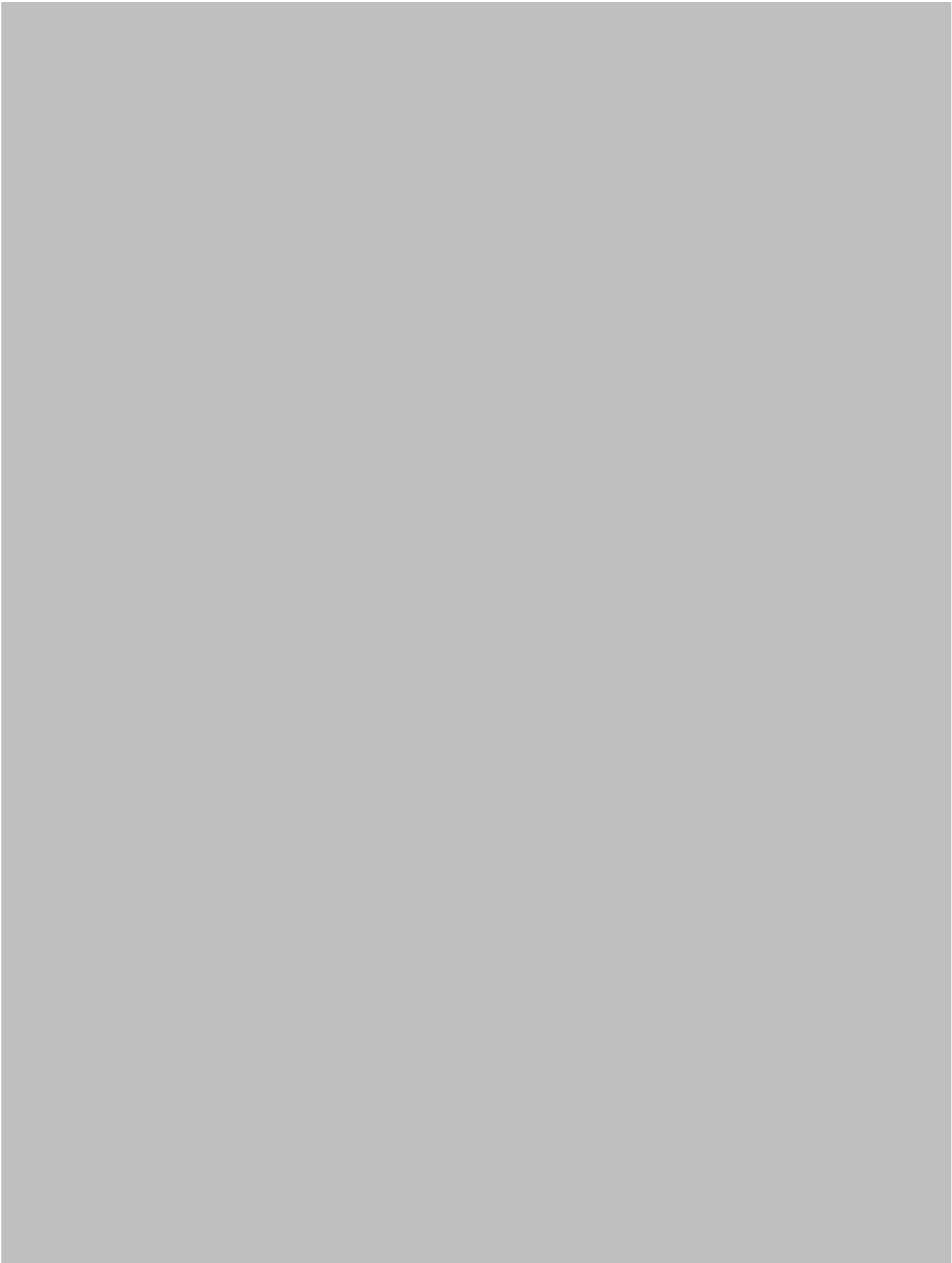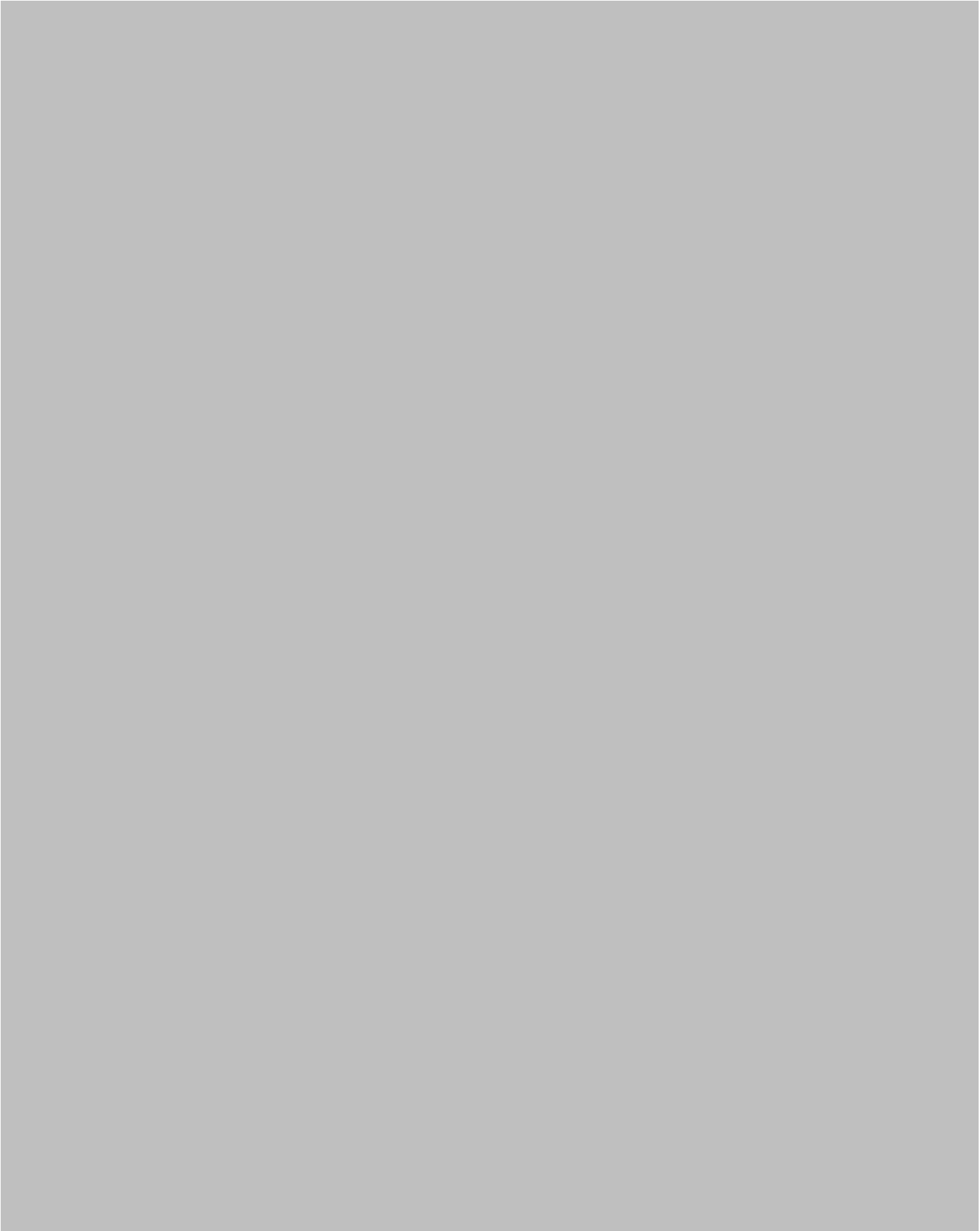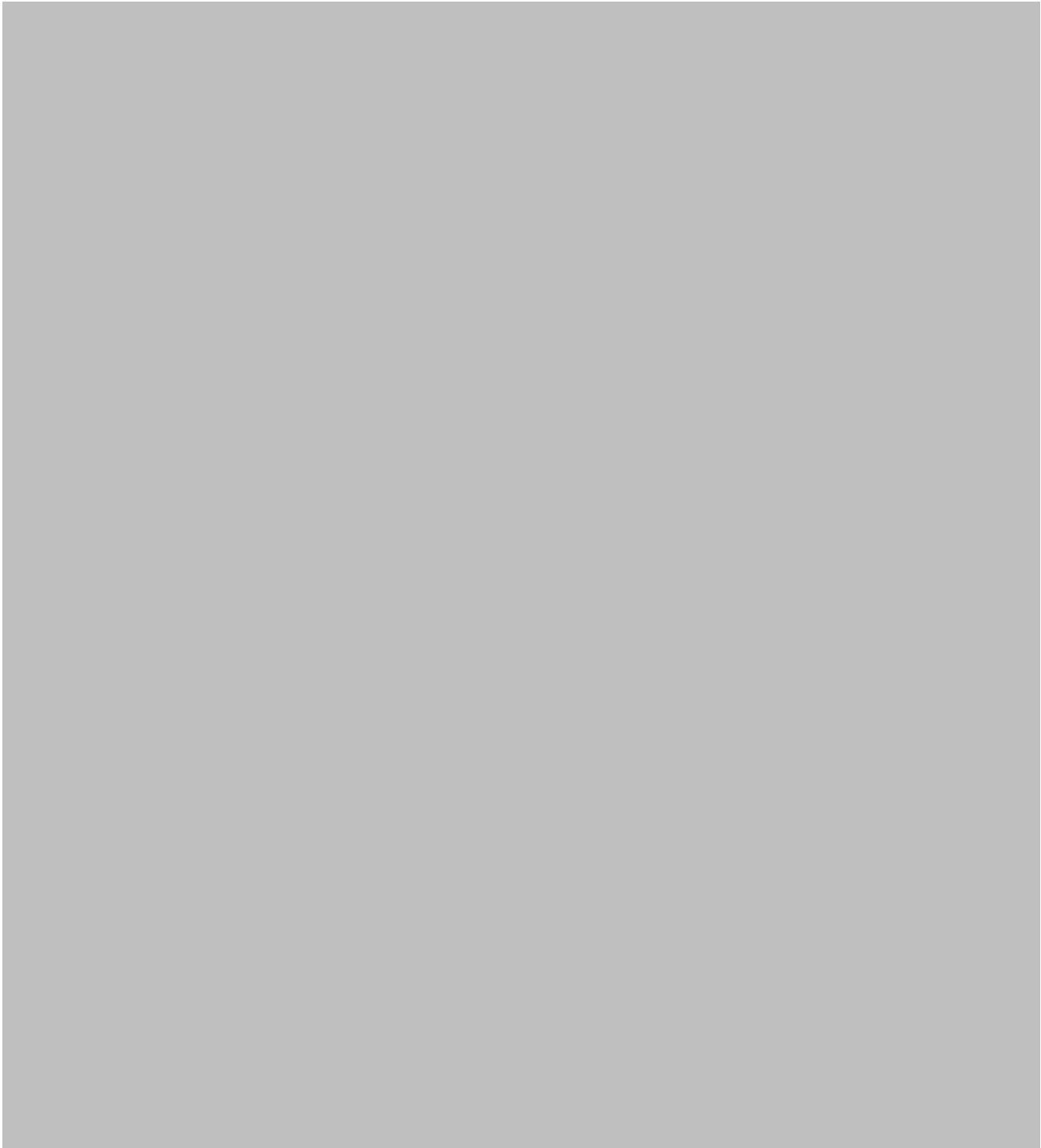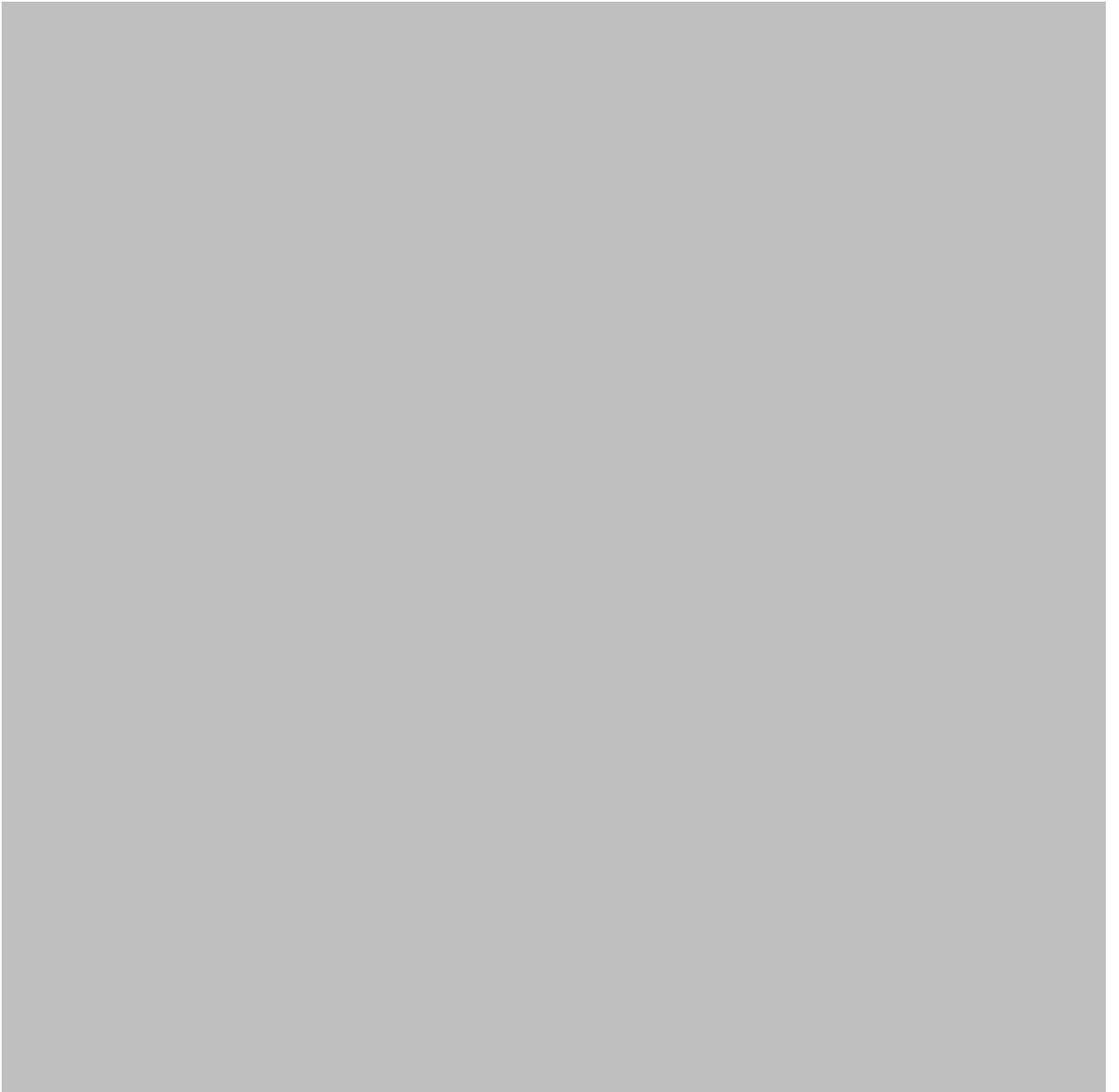## Application to University of Birmingham for Ethical Review
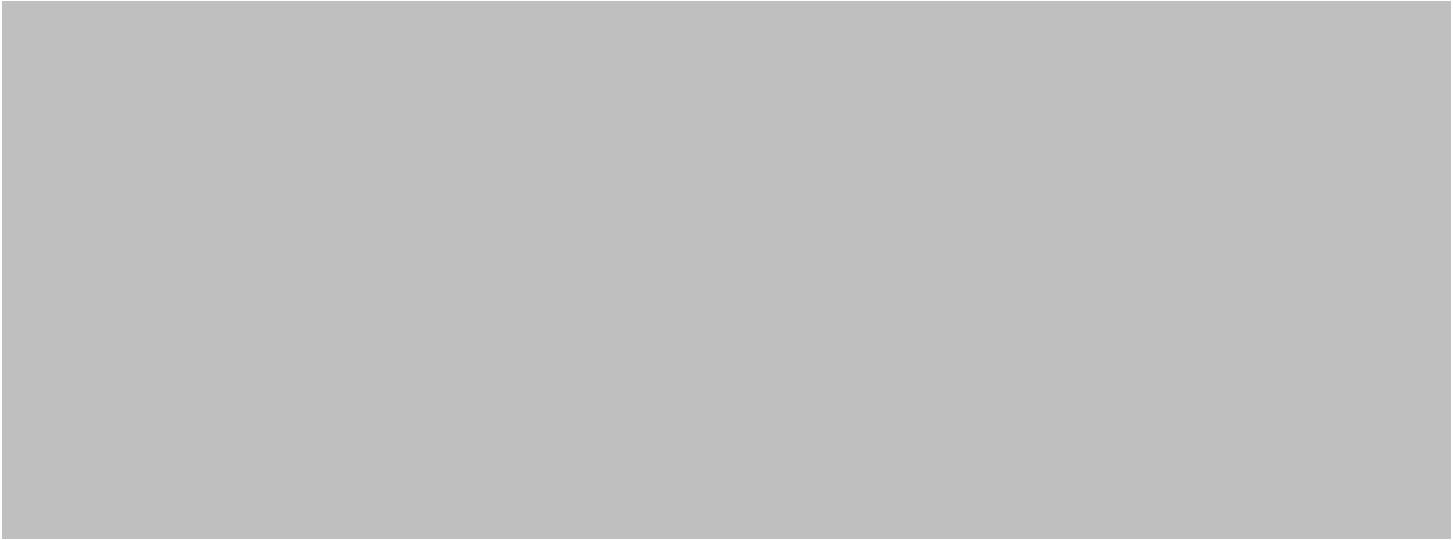
APPENDIX 8

Exemplar Transcription (Pastoral Manager 1)

Volume 1 Interview Transcription, Interview 1

Length: 35 minutes 27 seconds

ND: So just a bit of background then, could you describe what your role is in school?

Int: Behaviour and Learning Manager, working with um Looked After Children as well. Also Safeguarding and attendance

ND: That's quite a lot (both laugh). So what kind of things do you do as part of all that, would you say?

Int: It varies – it's sort of like day to day reactivity, it's general contact with parents. Um obviously safeguarding is completely reactive to whatever comes in .. needs logging. All the information, getting the relevant people involved. Um attendance is a day to day – if they're absent, what the plan is, where are we going to go, tracking um keeping a track on who's below, who's 90%, updating the tracker so I know where everybody's at. And just getting parents working with the school. Contract or going legal if we have to.

ND: Are they all kind of interlinked in some way do you think, or do you think they feel quite distinct?

Int: They do link up. It's often students.. so, some of my cases in Year 7, or I've worked with them in Year 7 and I know the background anyway, so it links with Safeguarding. Often there's correlation between safeguarding and attendance if they're not in and stuff, so it does link. And like the Child in Need Plans or CP. Again like you know, there is often children that aren't *here* at the moment. They're often the ones that aren't in school

ND: That makes sense. Ok. So the next bit's kind of looking at um … and obviously you do like Behaviour and Learning, kind of like pastoral type stuff. Um just looking at what you..how you..if I said mental health to you, what would you kind of think of? How might you define it?

Int: Um a lot of the mental health we see here is probably anxiety, low moods, depression, and it links to self-harm um suicidal tendencies and thoughts. That's the main bulk things but then on the other side is parents' mental health needs as well. And the one big thing we're working with at the moment you know isn't an overnight thing, is resilience. And that's one a lot of the things we feel

that our students haven't got. But if parents haven't got it, you know it's very difficult to instil that into your children.

ND: Yeah exactly, it's like a bit of a cycle yeah?

Int: Yeah.

ND: So how would you know…just a little bit around mental health difficulties..how do you think you'd know if a young person had good mental health, what might you be seeing? PAUSE And you can answer 'don't know'

Int: I don't fully know .. you know when you sort of like recognise certain..you'd see certain successes? Wouldn't you. You'd go 'actually they come across, they come across happy'. That would be one of the things you'd be looking at. But you don't always know what's going on behind closed doors.

ND: No that's the thing isn't it. But I guess like you said, they're succeeding at things, like they're having success, and they seem like they're quite happy in themselves, that's generally what you're looking at.

Int: Yeah

ND: Do you see any difference between mental health and emotional health? Or do you think they're kind of the same?

Int: I think they're very similar. Or they interlink. If your mental health isn't great, it's going to knock your emotional. You're going to question and struggle.

ND: So we've talked a bit around what you might see if a student had good mental health, how…you obviously come into contact with a lot of students that don't have particularly good mental health… so what kinds of things are you seeing there? I know you've mentioned some things like anxiety and stuff. What kinds of behaviours are you seeing?

Int: We get an awful lot of neediness really. You know, talk them through, hold their hands through situations, take them to places, if they wouldn't go by themselves to. That's just for Year 7. Um if they've forgotten their PE kit they wouldn't initiate dealing with that situation themselves. It would be.. we get very upset children, parents on the phone about it and really it was just really you just need to go to your PE teacher and say 'I've lost my PE kit'. But it gets blown out of proportion and then that's where it gets worse and that's where I'm talking about sometimes the parents don't

always help if you know what I mean. They're trying to help but they're almost taking away from that child forcing them to stand on their own two feet a little bit.

ND: Do you think then they're trying to do too much for the child there (yeah) and solve the problem for them, rather than getting them to solve it themselves?

Int: Yeah. Often children will contact their parents to let them know somebody's been mean to them and then the parent will ring up quite upset that their child's upset. Which is… you know they're .. their emotions. And it blows out of proportion from there as opposed to 'just come to us, just say'. And the children do know that, they'll say to us .. approachable and 'I know it's fine to come in'. But they do feel like they have to check. They don't want to be in trouble at home, they don't want to upset at home. But they have actually just got a close relationship with home that they have to check with parents first.

ND: Is that more, do you think that's more the case cause obviously you deal with Year 7. Is it more the case at that point ..

Int: Yeah. I think it's hard for parents in Year 7 cause they've lost that regular contact. They haven't got those regular conversations on the playground. Um it's hard for them to accept sometimes that their child is growing up you know and that the child has also got a few more independence as well. So they're starting to get into those scrapes of walking home and having an argument with somebody and it's not actually, it's big to that child at that time. But on a scale of 1 to 10 on the next day, where's it ranking. It's not as high and it's actually dealt with quite quickly.

ND: It's just like that keeping things in perspective

Int: Yeah

ND: If I said the word self-efficacy to you, have you heard of that?

Int: No

ND: No, ok. What it's basically talking about a person's belief in how able they are to do something. And how confident they are to do something. So for you day to day, if you think about on a scale of 1 to 10, so 1's like not feeling very able at all and then 10's feeling able…

Int: (interrupts) I think I've got a lot of students that don't have the confidence or, because we talk so openly about anxiety, asking for help. I think a lot of students now, they'll come in and say 'I've got anger management issues'. They sort of self-diagnose and then give themselves a label. And we do

get a lot of that. And I think that's their own self-esteem – it's easy to put a label. So we do get a lot of wanting to put a label on it to say they need help and support. So they will ask for support but we take away that 'helping yourself' as well. But there is a lot of..

ND: Do you think a lot of it, they go straight to asking for support then, or do they try and sort it out..

Int: It all depends on the child. Some will..you've got a lot of cases where they will struggle quietly and then you've got others where they'll come in and go 'I've got this, this, this, and this'. And I think that's quite hard for a child to recognise themselves. That they have actually got all of these. It might actually just not be the best at something. And it's acknowledging and understanding you've got to put the work and practice to be good at something first. You know, and everybody's starting from …there are certain subjects here that children have never done before. Some children you know have done Science in school but they've not done Science in senior school. And to come in and do that, they are starting from zero. And they're having to build it up. So a lot of children will be like 'I'm no good at this, I'm not very good' or struggle with this, struggle with that. But it's building that confidence.

ND: And that takes time doesn't it

Int: Yeah. But a lot of children don't..'I think I've got a learning need, I think I need a TA' or 'I need this, I need that'. Actually you just need to practise. And it's just their self-doubts really.

ND: Yeah, that makes sense. I guess for you, sort of like supporting student emotional and mental health needs day to day, how able do you feel to do that? So if 1 was feeling not very confident, 10 was feeling very confident about it, how able do you feel to do that day to day?

Int: I do do it. We'll work, we'll encourage. It all depends on…it sounds awful..it all depends on how the day's going and what the workload is. So some days I can say 'oh my god, we'll be there supporting that child, 10 out of 10'. You know we'll do whatever we can. But then the next day if we've got 2 or 3 big Safeguardings I can't give that child that…some of those children just need that regular check in.

ND: Yeah. So on *those* days when you sort of…

Int: Feel like you're letting them down yeah. You just think 'I haven't got that time to sit and talk to you for 10 minutes'. Which is probably all that child needs

ND: But you haven't got capacity at that time

Int: No

ND: No. So would you put yourself a bit lower down on the scale at that point (yeah). Where would you put yourself?

Int: Some days it would be a 9, other days it would probably be a 2. Because there's nothing worse than talking to a child with them knowing that you're going 'ok, ok, no problem that's fine, alright then, ok'. Cause that..that's done more harm than good. And for them to know that you haven't got time to talk to them, that's demoralising and makes them not feel .. One, they don't feel worthy of your time and two, it's rejection isn't it? It's not very nice.

ND: So it sounds like, for you, kind of being honest with them about when you have got time, when you haven't got time (yeah) is quite important? Do you get more… so you said like 2 or a 9. What tends to come out most often do you think, or is it a real mix?

Int: It's a real mix. We do..as a team we do try our best and.. and the other time is, you don't want to talk in front of the children, cause it's not always appropriate. People won't open up and say what they feel, what they, actually what they've come in to say. And often you find out there's some underlying needs at home or stuff. You know, nan might be really ill in hospital and mum's having to do all the journeys and out looking after her a lot. And actually that child just feels like they're left to it at home and it's a complete norm – they're not used to spending all that time by themselves. And then it's, they've missed a homework and it's that knock-on effect cause parents are probably quite fraught at home.

ND: So it sounds like a lot comes in…

Int: And if I say 'I've only got 2 minutes to talk' it sort of echoes what's going on at home as well.

ND: So I guess like, it sounds like compared to what's..sometimes you're trying to like counter that (yeah) what's going on at home a lot of the time, well not a lot of the time, but some of the time (yeah).

So in terms of supporting student emotional and mental health, do you think it's part of your role in school – do you see it as one of your responsibilities?

Int: Yeah

ND: Yeah? Why do you think that might be?

Int: Pastoral's such a wide, open ..there's no sort of..it covers everything that's sort of not academic. And the schools are very measured academically. There's no measure for pastoral. There's no, you start work, you finish that work. It's everyday it's ongoing. And you can't just say 'right you're fixed now, we've done that, we've completed that work' cause actually a lot of it needs..just a little bit adding on, reassurances, reminders to keep doing what they're doing. Stuff like that.

ND: So it's like little and often almost isn't it?

Int: Yeah

ND: Are there certain kinds of things that you feel more able to provide support for than others?

Int: Yeah there's probably certain aspects of levels of understanding. Even if I'll go home and read about a situation, if you've not been in that situation I think it is often difficult to understand. For example, you know, you could say self-harming. Me personally, I don't…it would be something I couldn't do. So I'm looking thinking 'I don't know if I'm advising you the right way'. I don't know, I don't understand personally how you get that urge to do that. And it's.. do you know when you feel like you actually need to read up on different cases or sug or look up suggestions on how to work with that cause you've never experienced that.

ND: Yeah so it's kind of like

Int: Cause you do draw from your own life experiences but if you've not experienced things. But then everybody has different emotions. For example, like bereavements. You know, every child and every family is set up differently and how they react to different people's deaths. And that's very, very difficult to work around.

ND: So it sounds like there's a bit of a balance between sort of drawing on like as you said your own experiences but being aware that people might respond in different ways and there are going to be gaps (yeah) if you've not experienced something

What would you..how do you think you would identify.. So if you..obviously you've got like 1000 kids here..how would you go about identifying if a student had or thought a student had emotional and mental health difficulties?

Int: Um staff would actually refer if they were concerned or they'd come and talk to us and explain they've got a few concerns. Then we will probably go round and speak to teachers perhaps just a general check on how that child's getting on with their work, with how they're sort of, how they are with peers, how they are with staff, how they interact. And just ask a few questions around staff, and

then go from there. Or sometimes students other students will say 'I'm worried about this person, I'm worried about my friend'. Or other times you just notice somebody from their behaviours, how they're doing things, or how they've withdrawn from situations. And you pick up from there.

ND: So you're looking for like changes in behaviour sometimes

Int: Yeah

ND: Do you um cause there's a few things there, say referrals from teachers, from other students, or what you've noticed. Do you get students coming up themselves (yeah). Is there anything that tends to happen more often like in terms of you getting that information?

Int: Quite often the students will bring themselves in.

ND: So I guess, if you've identified a student might be having difficulties, what happens next? What do you do?

Int: Um it really really does vary. The problem is now we haven't got anywhere particularly to refer for extra support for students. There's not many counselling services we can access. Um CAMHS we do that but the waiting list is so long. Um then we've got the issue here of being on the edge, on the border. So if we're trying to access certain things for a Walsall child, it's easier for us to access for a Wolverhampton child. But just because that child lives a few metres past the school on the other side, doesn't make them less worthy. It's just harder to access. And there's different ways in which you can access it. But we just we end up trying to support between form tutors, Heads of House, and ourselves. Conversations, working with parents. If we do need to we will you know seek support through social care. But other things we do try and support ourselves.

ND: So it sounds like you're working when that happens you're working with a number of different people aren't you, it's not just you by yourselves, you're working with a team. And then outside agencies as and when available.

Int: It's just not yeah that many to go to.

ND: So is there anything else you would like to be able to do in terms of providing support that you feel you can't at the moment?

Int: I think actually there needs to be more counsellors where students you know can access in schools. Um our school nurse is probably inundated constantly with students who just need to offload from somebody who's not school and not home. They just need that.. and we're not trained

counsellors. So sometimes you don't know if you're doing, if you're actually doing them any good. It's just experience or reading that child of how they seem to react when you work with them. But that is something that I think .. we just need more services. We need services in between …before they get ..I can't think of the phrase..that in between, where you're putting things in place, you're being preventative as opposed to reactive. And that's where we're missing that whole chunk. And that would probably help.

ND: Is it that bit between sort of being ok and CAMHS (yeah) that bit in the middle. I mean talking about at certain times you don't feel confident in saying the right thing and whatever. Have you received any training on supporting emotional and mental health?

Int: A little bit. We probably could access more but then it's that catch 22 really because it's having the time out of school to go to it.

ND: What kind of stuff have you had training on already then?

Int: I've done all the safeguarding. So that covers a fair bit in its own way. Um a lot of it is what we've read up ourselves. Um we haven't been to that many, that many courses.

ND: Is there anything you would find beneficial in an ideal world in terms of training?

Int: Um probably is, I'm trying to think.

ND: Don't worry if nothing springs to mind..

Int: No

ND: No? That's alright. Ok. The safeguarding stuff, you said a lot of aspects were kind of covered in that. Did you find that useful?

Int: Yeah cause a lot of the stuff that I've done, it'd be how to sort of like you know. I personally didn't enjoy it or like it but you do need to know, you're looking at different cases, what's happened. Also, re-enacting them, conferences of how, how people are, and just looking at how other people deal with certain, how they conduct themselves, how they deal with it, what they would do. And that's always interesting to observe how people do things.

ND: Yeah definitely. Has there been a specific time when you've felt able to support kind of a student's mental health in school

Int: Um yeah there has been. You know there's students that you try not to but they do become fairly reliant on you. They just need that that regular check in and know that you're there. So some would, some still just pop in on a daily basis just to say hi, give me a catch-up on how they're..a bit of a summary on how they're going on, what the day's done. We often do 3 goods, you know 'tell me 3 good things that have happened today', so they can walk out and focus on those as opposed to dwelling on anything negative. It's like 'right, tell me some positives' and then we'll just talk on those and they can reflect on that afterwards really. And see that actually there are good things that happen. Bad things don't always happen. They've had a bad time, and bad things have happened but it's identifying that there is some good going on as well.

ND: And I guess having those concrete examples of things where it's like you've put in support and that's actually worked quite well, has that impacted how your confidence in providing support in the first place or not really?

Int: I think every child's different. You don't know sometimes whether….there's no right or wrong. You're only going off um actually..I think because we do it every day you don't realise what an impact you have on on those children's lives. And it's only when the parents or whoever will say afterwards, or you get a card at the end of the year they've just sort of like put a big piece in there about what you've done you think 'oh god, I didn't even realise I did that'. And that's quite, you know, we don't ask for any recognition or thanks or anything like that. You just want them to be ok. But every so often you do get stuff where you're like 'oh gosh, didn't realise it meant that much to you'. But it does. So yeah that is nice.

ND: Is there any staff in the school who you think might be in a better position to support student emotional and mental health than you are presently?

Int: Maybe the SENDCo

ND: Why would you say that?

Int: Um just cause they might be able to access things in different ways or understand things through a learning need and understand why they you know might struggle with something.

ND: So is it that kind of incorporation of learning and pastoral (yeah). Ok.

Int: But you know not really, we sh we've all got that it's behaviour, everything, all that remit, it's still under everybody else's remit as well so I don't think there's any body extra or on top that..we've all got that responsibility.

ND: So do you think everyone in the school would feel the same responsibility?

Int: I think they would refer it to us predominantly. Everything you know the main, they would look to us to support them. But yeah they all should have that responsibility.

ND: So in terms of like, do you think there's anyone in the school that might feel less able to support student emotional health for different reasons?

Int: Um I think some people probably focus more on the academic side of things and feel that we're there, so we'll just …. Pass to us.

ND: Does that happen, is that to do with a specific role in the school? Like, for example, teachers – would they.. do many teachers sort of deal with that themselves or do you get…?

Int: Some do. It depends on them and how they are. Some will pass it direct to us and we'll go from there.

ND: Ok. Do you feel you're encouraged by school leadership to support student emotional health, mental health?

Int: I think they see it as our job. End of.

ND: So they see it as your job but it's not particularly encouragement as such? (shaking head) No, ok. How do you feel about that?

Int: It's..we understand, we've been told it's not measurable. It's not recognised – you can't see always see the impact. You can see the impact if you don't do it but you don't always see the impact if you do do it. So it's not recognised all the time.

ND: Ok. Do you think.. cause you said there there's an understanding of that, if your support doesn't happen, there's an impact on learning (yeah), is that seen and understood?

Int: Yeah

ND: The next one was about having enough knowledge to support student emotional and mental health and you've kind of already covered that a bit already haven't we. Do you think, I think we've already covered a bit of this as well, do you think/feel you've got enough support and resources to do, to provide that support at the moment?

Int: Ultimately I think we need more of us. And that would help. We're in a reduced team and then if people are off sick it has a knock-on effect. But people can't help being ill and I think with the type of

job you deal with you deal with students, you're in a school, and it's very demanding constantly. So people are going to be, to be ill.

ND: It sounds a little bit about maybe doing your job there's maybe a limited capacity to look after yourselves as well (yeah) in that respect cause ….

Int: You do put yourself second cause you know if you've got an upset child you can't say 'I'm off on my lunch break now, can you wait half an hour'. I couldn't, it's not in my nature.

ND: That makes sense. How do you think having more people would help?

Int: I actually think here we worked better as a team when we had one of us attached to each house. So you had your specific students you worked with the Head of house. We had that regular contact so there almost sort of 2 of you working. One of you knew constantly what was happening. As now attached to year groups we don't have that contact with Heads of House so the communication isn't. There isn't the time for the communication as when we were sharing an office with them, you'd probably bombard them with information or there'd be stuff going on in the office that you would notice or be aware. Or when we were sharing an office, BLMs, if one of us wasn't in or if somebody popped in, we'd all speak and there'd be other people aware of what's happening. As now, if I was off or I was on a course or anywhere, my knowledge wouldn't be there unless I was constantly feeding into or giving the background or.

ND: So it sounds like it's almost the way it's…

Int: Quite fragmented now as opposed to.. we're not working as the team we …. Just because we haven't got that time to sit down and time to meet on a regular basis. Cause they've got a full time teaching timetable. And we obviously haven't. But it's getting that regular set time to see them and speak to them.

ND: How did that work – when you were with the Head of House then – how did that communication help particularly?

Int: You'd be forward planning, you'd be looking, going 'right', you'd be getting a plan in for it. 'Oh look he's got X amount, look how many behaviour' or 'he's got behaviour points again in this week, shall we get mum in. Right if we get mum in, we'll do this, this, and this'. If it doesn't..you'd be putting things in place as how we are now we have to deal with the here and now.

ND: So it sounds like working like that you could be more proactive in what you're doing, rather than now you kind of end up firefighting a lot of the time (yeah). Ok. And I guess if you had vertical houses

as well, cause you're working with the same kids all the way through I'm guessing? Did that make a difference?

Int: Yeah you do sort of like they cluster families all in that house as well. So you know you do know, you do know the score. So now I'll still have children that worked with me that were in my house. They will still come to me to let me know that they've got a hospital appointment the next day. They know it's not me they're supposed to bring it to but

ND: You're the familiar face in school

Int: Yeah they do. And I'm never going to say 'that's not me' you know I will still sort it for them. I don't want to break that that confidence either that they've got. Cause you never know when they might need to open up. Or vice versa, I might need them to you know give me some information about what's happened somewhere else in school. It's just forming those relationships and retaining them.

ND: And that takes work doesn't it

Int: Yeah it's not an overnight.

ND: No. And it sounds like the way you work at the moment, you're, you've almost got more relationships to try and maintain than you might have done previously because you've got all across the year group, and plus the other ones from how things were (yeah) as well.

Int: I don't see the year group particularly as like form time I get to see, at least I can walk into a form room and see, deal with things. As a year group I don't, we don't see them. Cause they're still in their houses. So it's like a different

ND: Does that make it more difficult to monitor how kids are doing? Cause if you can just walk in to one room and you kind of instantly got a bit of a you can check in with I don't know 30 of them at once, and see how they're doing. Do you get the same opportunity now?

Int: I'd have to go into a lesson and lessons are different for checking in pastorally. That's how they are in that lesson, they might be different in another lesson.

ND: Yeah. So in terms of I guess what affects you being able to support student emotional and mental health, there's a few things by the sounds of it that you've mentioned. So like other demands, sort of like feeling like you have to like if safeguarding crops up then you have to be quite reactive

(yeah), there's a bit around the communication systems and how they work now? Like, is that cause there's not so much team work…team work is a little bit more difficult now than it used to be

Int: Yeah. We're all so busy and we don't, we don't always see each other. So, short of communicating via email, which sometimes you just need to have a conversation as opposed to emailing…you don't fully, you don't always write down everything that you need to say. Or how people interpret that situation. Sometimes you just need to go 'right, just to let you know, this has happened with this student, it sorted – I don't need you to do anything, but you just need to be aware'. But this one, it's just having those check ins more than anything.

ND: Yeah, that makes sense. Ok, so last question. If you could change or improve one thing that would make the most difference in terms of how able you felt to do your job, with that in terms of supporting student emotional and mental health, what would it be?

Int: Going back to being attached to a house and having the staffing. That would make a lot of difference.

ND: And again, that's to do with forward planning (yeah) and communication, yeah?

Int: Yeah

ND: Is there anything else that would make a difference?

Int: Us having 2 people that are working in close contact. But you can take on different roles within that. With that child of how you..one can do the nurturing bit, the other one can do the strict bit and you both constantly know, and the child does, where every body's at. As to me speaking and playing that role, then relaying the information back to the head of house. The head of house you know, it just turns into a longer, longer cycle really.

ND: In terms of looking after … like you say you always put yourself second…does that help as well, if you're working in twos on the same thing?

Int: I think it helps you as a person to sometimes offload and that you know that stuff is happening and everybody's where they're at as opposed to thinking 'I need to tell that person' and making a note that you need to speak to them, what you need to speak to them about. You feel like everyone is in the picture of what's happening.

ND: Anything else?

Int: I don't think so.

APPENDIX 9

Exemplar Coded Extract (Learning Support Assistant)

Int: I look at mental health as people who struggle with um normal everyday decisions, and thought processes. I automatically think that someone with mental issues becomes more depressed more easily, more down, more of a worrier. That's what I see mental issues as. Not quite in control of their thinking. That's what I kind of think. Um it seems to be happening more and more I think with youngsters. I have experienced it first hand with my eldest er she's 23 now, she's much better a lot better actually but I think she still has issues with er it's like a switch gets flipped that kind of thing.

INTERRUPTION 2:45 TO 3:45

ND: Right, so you were talking about you had experience of ...

Int: Yeah I found it difficult to cope with. My husband was better than me, way better than me because again I think he's suffered a bit with er panic attacks which is what my daughter was suffering with panic attacks. But now she's er she doesn't have panic attacks anymore but I think it's because she controls it and at one stage she did go on medication depression er.

INTERRUPTION 4:20 TO 31

Int: Um but I think now what it is with her is um she's more aware of her mood swings. When she's low she's rock bottom. Even the slightest thing that doesn't go her way kind of thing she's rock bottom. And then you have to build her back up again. When she's up there, she's as high as a kite. So it's very, there's extremes you see, so that's one that I've experienced personally. Obviously we don't kind of get to see that at school cause I think it's in that home life you get to see the extremes, you know what I mean. You get the flip, you get the flip

ND: Yeah, but you're maybe not seeing the full range (at school)?

Int: Yeah, the low to the high... that sort of thing. You're just getting it, you get more of a flip I think and that switch at school.

Natalie Dobbie	Deficit model, MH – cognitive ▼
Natalie Dobbie	MH – Affective component
Natalie Dobbie	MH cognitive component, MH ▼
Natalie Dobbie	Adolescent MH – increased ▼
Natalie Dobbie	Personal experience of ▼
Natalie Dobbie	Recovery from MH difficulties
Natalie Dobbie	MH - unpredictability
Natalie Dobbie	Reflection on previous ▼
Natalie Dobbie	Lived experience of person ▼
Natalie Dobbie	MH - Controllability
Natalie Dobbie	Self-awareness – ▼
Natalie Dobbie	MH - unpredictability
Natalie Dobbie	MH – different presentation ▼
Natalie Dobbie	MH - Unpredictability

APPENDIX 10

Exemplar 'Theme Pile' (Factors Influencing Self-Efficacy – Knowledge)

<table>
<tr><td colspan="2" align="center">KNOWLEDGE</td></tr>
<tr><td align="center">FROM SELF</td><td align="center">FROM OTHERS</td></tr>
<tr>
<td>
Previous experiences of providing support
Impact of negative experiences
Impact of positive experiences
Role of feedback in gauging 'success'
(Links: Mastery experiences)

Lived experiences of mental health difficulties
Lived experience = greater understanding
No lived experience = reduced understanding
(Links: Mental health and normality? Mental health 'behind closed doors'?)
</td>
<td>
Training
Observation
Discussion
(Links: Vicarious Experience)

Colleagues
Discussion with others in same role
Discussion with others in Pastoral role
(Links: Vicarious experience, staff attitudes, role delineation)

'Experts'
Experts external to school
Experts = 'correct' answer
Experts vs gut instinct
(Links: Medical model, 'real life' gut instinct vs textbook)
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