HOW CAN YOUNG PEOPLE, AGED 14 -16 YEARS WITH MENTAL HEALTH PROBLEMS, BE BETTER SUPPORTED IN MAINSTREAM EDUCATION?

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ABSTRACT

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Title: How Can Young People, Aged 14-16 Years with Mental Health Problems, Be Better Supported in Mainstream Education?

Although research suggests that learning and well-being are synergistic there is a lack of research focusing on the school experiences of children with intrinsic mental health problems. The aim of this research was to explore how these children perceived they could be better supported at school. The additional perspectives of their parents and teachers gave further insight into their worlds. The research objective was to examine how schools and Child and Adolescent Mental Health Services (CAMHS) could strengthen their assistance. A qualitative design was used, underpinned by a social constructionist theoretical framework. Fourteen children were recruited via CAMHS. Children, parents and teachers participated in semi-structured interviews. Data was analysed using thematic analysis.

The findings indicated, to thrive emotionally and academically, these children needed to feel they belonged at school. This was pre-requisite to accepting enhanced individualised support. A sense of belonging was only apparent when the child was free from victimisation (bullying, discrimination and stigmatisation) and had good peer and teacher relationships. Belonging was promoted by increasing the child's emotional security, which was enhanced by promoting teacher mental health knowledge, nurturing teacher and peer relationships and sensitively ensuring disclosure and confidentiality. When the children accepted assistance, they valued support that empowered them to cope resiliently at school. For example, practical one-to-one teacher help and CAMHS assistance in deciding what personal information should be shared with the school, along with emotional help with school problems.

In conclusion, schools must promote a safe caring ethos, whereby emotionally literate teachers balance child well-being with attainment goals. Schools and CAMHS should tackle school distress and promote child resilience together. Presently, a lack of resource and time can prevent this, so more directives and mechanisms are needed. At the heart of this planning should be the child's voice, as presently support is predominantly adult driven.

ACKNOWLEDGEMENTS

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Abbreviations

ADHD   Attention Deficit Hyperactivity Disorder

ATW   Active Tutorial Work

AS   Autistic Spectrum

ASCL   Association of School and College Leaders

BEAT   Beating Eating Disorder (the name of an Eating Disorder Charity)

BERA   British Educational Research Association

BESD   Behavioural Emotional Social Difficulties

BEST   Behavioural and Educational Support Teams

CAF   Common Assessment Framework

CAMHS   Child and Adolescent Mental Health Services

CASEL   Collaborative for Academic, Social and Emotional Learning

CBT   Cognitive Behavioral Therapy

CPA   Care Programme Approach

CY IAPT   Child and Young People Improving Access to Psychological Therapies

DCSF   Department for Children Schools and Families

DfE   Department for Education

DfES   Department for Education and Skills

DH   Department of Health

DSM   Diagnostic and Statistical Manual (of Mental Disorders)

EBD   Emotional Behavioural Difficulties

EIPS   Early Intervention Psychosis Team

EQ   Emotional Intelligence

ES   Educational Staff

GAG	General Annual Grant
HAS	Health Advisory Service
IAPT	Improving Access to Psychological Therapy
ICD	International Classification of Diseases
LCG	Lay Consultancy Group
LD	Learning Difficulty
LDR	Local Research Development
NASUWT	National Association of Schoolmasters Union of Women Teachers
NCCP	National Centre for Children in Poverty (USA)
NCLB	No Child Left Behind (USA policy)
NHS	National Health Service
NICE	National Institute of Excellence
NIMHE	National Institute of Mental Health in England
NMC	Nursing Midwifery Council
NOS	National Office of Statistics
NRes	National Research Ethics Service
NSPCC	National Society for the Prevention of Cruelty to Children
NSSI	Non-suicidal Self-Injurious Behaviour (NSSI)
NUT	National Union Teachers
OCD	Obsessional Compulsive Disorder
OFSTED	Office for Standards in Education
OSS	One Stop Shop
P	Parent Participant
PATHS	Promoting Alternative Thinking Strategies,

PIS	Patient Information Sheet
PMHW	Primary Mental Health Worker
PMT	Parent Management Training
PSHE	Personal Social Health Economic Education
RAP	Resourceful Adolescent Programme
RCT	Random Controlled Trials
SAFE	Sequenced, Active, Focused, Explicit
SDQ	Strengths Difficulties Questionnaire
SEAL	SEAL Social and Emotional Aspects of Learning
SEL	Social Emotional Learning
SEN	Special Educational Needs
SENCO	Special Education Needs Coordinator
SSB	Safety Seeking Behaviour
TA	Teaching Assistant
TaMHS	Targeted Mental Health in Schools
UK	United Kingdom
UNICEF	United National Children's Emergency Fund
USA	United States of America
WHO	World Health Organisation
YP	Young Participant

THESIS PREFACE

The primary focus of this thesis was on the needs of the British adolescent school child with identified mental health difficulties. International empirical evidence is frequently cited throughout this thesis, but because educational and health systems vary globally, the historical, political and contextual considerations are narrowed down to the United Kingdom's schooling and healthcare system. It may also be noted that differing terms such as 'children', 'young people', 'child', 'adolescents', 'teenager' and 'pupils', have also been used interchangeably throughout this thesis. This is because it reflects their different usage in society; for example, teachers may refer to children as 'pupils' and parents make reference to 'their children'.

The format of this thesis is conventional, in that Chapter 1 provides the reader with an introduction to the broader empirical literature pertaining to this study's line of enquiry and the personal motivators that have made carrying out this study meaningful. Chapter 2 focuses more directly on school mental health, firstly detailing how schools in the UK commonly support pupil well-being. Then it moves on to discuss the specialist interventions that have been carried out globally in more recent years by educationalists and other specialists allied to mental health, like Child and Adolescent Mental Health Services (CAMHS). Chapter 3 centres on the methodological issues that were considered when carrying out this study. This chapter discusses the rationale for using qualitative methods and the special considerations needed when carrying out research with young people.

The study's findings are presented in two chapters. Chapter 4 presents the global theme 'Belonging verses Alienation' and Chapter 5, the global theme "Promoting Resilience via Individualised Support". A critical evaluation of the findings and their implications on service delivery follows in Chapter 6, along with some discussion of the study's methodological limitations and implications for further research. The thesis ends by outlining the research recommendations and providing the reader with a concise conclusion.

CHAPTER 1: THE BROADER CONTEXT OF THE STUDY:
THE EMPIRICAL AND PERSONAL DRIVERS

1.0.   Introduction

This chapter broadly outlines the reasons for carrying out this research and then breaks down into parts the contextual information pertaining to this study. Firstly, reader clarity is promoted by defining key thesis terms and then justification for this research is indicated by outlining the demographic, economical and empirical literature that relates to child and adolescent mental health. Secondly, the commonalities connecting professionals interested in pupil mental health, from both schools and healthcare are outlined, along with some discussion about the challenges faced when working in partnership. This chapter ends by moving away from the empirical literature to reflexivity, outlining my own motivation for carrying out this study.

1.1.   Broad Area of Investigation

Worldwide it is estimated that up to 20% of children and adolescents suffer from mental health problems, with more children suffering in silence (Green et al, 2005; Mental Health Foundation, 2005). Many warn if serious action is not taken, in future years this figure is likely to rise (Patel et al, 2007; UNICEF, 2007). This is why child well-being and mental health is now a key global agenda (Collishaw et al, 2004; Maughan et al, 2008; Rees and Main, 2015; UNICEF, 2013). A plethora of global strategic policy dictates that schools have a central part to play in promoting the well-being and mental health of children (Braddick et al, 2009; Stephan et al, 2007; Kutash et al, 2006; Salmon and Kirby, 2008; Weist and Murray, 2007). The reason is that children spend a significant amount of time at school, allowing teachers to carry out health promotional activities, and enabling supporting agencies, interested in promoting mental health, easier access to the child population (Weare, 2007). Further rationale for schools supporting pupil mental health is provided by the empirical evidence dictating that good school experiences and higher school attainment can protect a child from emotional harm in later life (Coleman and Hagell, 2007; Public Health England, 2014), and mental health and learning are intrinsically linked, in that good mental health positively influences

learning and poor mental health has the opposite effect (Bonell et al, 2014; Zins et al, 2007).

To date the global research investigating aspects of school well-being and mental health have mainly focused on promoting well-being and preventing mental health problems, with less emphasis on supporting and treating school children already experiencing mental health problems. An abundance of evidence does, however, exist recommending the need for more proactive interventions to support this group of children. This is because the longer the duration of a child's mental health difficulties the more likely they will become seriously unwell, which diminishes their life chances and predicts more morbidity in later life (The Children's Society, 2013; DfE, 2015a).

In order to promote, prevent, better detect and support pupil mental health, schools require assistance. This is because the primary agenda of a school is teaching and learning, and addressing anything else requires further resource and expertise (DCSF, 2009a; Taylor, 2013). Agencies such as Child and Adolescent Mental Health Services (CAMHS) are well placed to support schools with their mental health agenda. Conversely schools are well placed to support CAMHS with their services strategic aim, which is to promote service capacity and improve the health outcomes of more children. Strong collaboration between the two agencies can therefore ensure more children receive mental health promotional advice and that any mental health difficulty can be more quickly detected, thus ensuring children receive appropriate early intervention (DCSF/DH, 2008); DH, 2015).

Despite the benefits of this type of partnership working, at this present time differing work cultures, languages, parallel agendas and financial priorities make multi-agency working problematic (Pettitt, 2003; Shucksmith et al, 2005; Vostanis et al, 2011). The broad aim of this research, therefore, was twofold; to explore how children identified with mental health problems can be better supported with their education, and also how specialist services like CAMHS may better assist schools in this task, therefore, exploring the complexities of partnership working at a time when children's mental health is a concerning issue.

1.2. Defining Key Concepts and Terms

As highlighted above, the agencies supporting child well-being use differing languages, therefore semantics can have the potential to confuse (Children's Society, 2012; Salmon and Rapport, 2005; Wolpert et al, 2014). For this reason it is important to clearly outline the terms and definitions used in this thesis. Firstly, the common generic terminology is outlined in section 1.2.1, and then the terms more common to education and health are outlined in sections 1.2.2 and 1.2.3.

1.2.1. Generic Terms

Well-being and emotional well-being are commonly used modern terms. These concepts are, however, notoriously difficult to capture and define because they are so broad and multi-dimensional (Humphrey, 2011; Watson et al, 2012), hence there are now a plethora of differing definitions. Well-being can, however, be considered as an umbrella term encompassing many aspects of a person's quality of life. Definitions, like Dodge's (2012), place it on a spectrum, in that it has the potential to fluctuate from positive to negative at any time. Dodge's definition of well-being is:

'*A state of equilibrium or balance that can be affected by life events or challenges*"

(Dodge et al, 2012, p.222).

Emotional well-being is one aspect of this broad concept. The National Institute of Clinical Excellence's (NICE) definition of emotional well-being also alludes to it sitting on a spectrum, by suggesting it is:

"*A state of happiness and confidence and is the opposite of depression*"

(NICE, 2009, p.6).

The term 'mental health' is frequently referenced by those promoting, protecting and supporting the well-being of children. The World Health Organisation (WHO) defines mental health as:

"*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 her or his community*".

(World Health Organisation, 2005, p. XVIII).

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This term "mental health" is criticised, however, for being more allied to the healthcare arena and therefore less familiar to those working in other sectors. Resilience is, therefore, a term that is now gaining popularity because it is not affiliated to any one discipline, but when defined is similar to mental health, in that it refers to a person's ability to cope with life, and deal with life's adversities (Children and Young People's Mental Health Coalition, 2012).

1.2.2. Educational Terms

Educational terminology is purposefully broad because over the years it has deliberately emphasised educational functioning over and above medical or psychological disorders, with the 1981 Education Act asserting this emphasis (Cooper and Jacob, 2011a). There has also been much debate around the terms used as they are not easy to encapsulate and define (Cole, 2006). Others also highlight how this terminology can be confusing to those who are less familiar with education (Weare and Gray, 2003). To promote clarity, therefore, the key terms used in this thesis are outlined and defined in Table 1 below.

Table 1: Common Educational Terms

Term	Definition	Source
Special Educational Needs (SEN)	"Children have special educational needs if they have a learning difficulty which calls for special educational provision to be made for them". The SEN Code of Practice (2001) identifies four categories of need: "Learning and cognition; Speech, language and communication; Sensory and physical impairment; Behavioural, emotional and social difficulties (BESDs)".	Education Act (1996) Section 3.12, p. 177 & SEN Code of Practice, p.6.
Behavioural Emotional Social Difficulties (BESD)	"Pupils who present disturbing and/or disruptive behaviour that interferes with social functioning and academic engagement and progress at school".	DCSF, (2008a), p.12.
Emotional and Behavioural Disorder (EBD)	"Children and young people who demonstrate features of emotional and behavioural difficulties, who are withdrawn or isolated, disruptive and disturbing, hyperactive and lack concentration; those with immature social skills and those presenting challenging behaviours arising from other complex special needs".	DCSF (2008a). p.12.
Learning Difficulties (LD)	"Pupils who have a significant greater difficulty in learning than the majority of persons of his age, and /or have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children of the same age in schools".	Education Act (1996) Section 3.12, p. 177

1.2.3. *Health Terms*

A decline in a child's emotional well-being can develop into more serious mental health problems if unrecognised or untreated (Atkinson and Hornby, 2002). Healthcare practitioners use various terms to describe emotional and psychological difficulties. Terms commonly used interchangeably throughout this thesis are 'mental health problems' or 'mental health difficulties. These terms both refer to a diverse range of emotional and behavioural problems that may cause a young person distress (Claveirole and Gaughan, 2011).

The difference between a mental health problem and a mental health disorder, or mental illness, is the severity of the problem and its duration and persistence, taking into account the child's age and what is happening in their life at that time. The Office of National Statistics use the International Classification of Diseases definition of mental disorder, which is:

"*A clinically recognised set of symptoms or behaviours associated in most cases with considerable distress and substantial interference with personal function*".

(Green et al, 2005, p. 2).

Green et al, (2005, p.8) categorise children's mental health disorder into four groups:

- Hyperkinetic disorders characterised by hyperactivity, impulsiveness and inattention.
- Conduct disorders characterised by temper outbursts, arguing with parents, disobedience, telling lies, fighting, bullying, cruelty and criminal behaviour.
- Emotional disorders that include depression, separation anxiety, specific phobias, social phobia and generalised anxiety.
- Less common mental health disorders that include eating disorders, tics and autism.

Diagnostic language is sometimes used by healthcare practitioners. The ICD-10 (WHO, 2007), or the DSM-V (American Psychiatric Association, 2013)[1] manuals aid medical staff to classify clinical symptoms into a psychiatric diagnosis or mental illness. Diagnostic

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[1] The International Classification of Diseases, Tenth Edition (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) are both clinical cataloging systems which are standard tools to diagnose mental health disorders.

terms used in this thesis are briefly outlined in Appendix 1. It is, however, important to highlight that many children seen by CAMHS are not diagnosed or labelled with a psychiatric disorder.

1.3. Prevalence and Detection of Children's Mental Health Problems

It is estimated that 10-20% of children will experience a mental health problem at some time during their childhood (Braddick et al, 2009). In the UK, survey statistics suggest that 11.5% of young people aged between 11 and 16 have a significant mental health disorder (Green et al, 2005) (see Table 2). Furthermore, it is estimated that 1 in 5 children diagnosed with a mental health disorder have more than one disorder (Green ibid).

Table 2: Prevalence Figures Based on the UK Child Mental Health Survey (2005)

Type of Disorder	5-10 year olds (% of children) Aged from 5 -10 years		11-16 year olds (% of children) Aged from 11-16 years	
	Boys	Girls	Boys	Girls
Emotional disorders (depression and anxiety)	2.2	2.5	4	6.1
Conduct disorders	6.9	2.8	8.1	5.1
Hyperkinetic disorders	2.7	0.4	2.4	0.4
Less common disorders	2.2	0.4	1.6	1.1

It is estimated that 75% of children experiencing emotional difficulties are neither detected nor supported (Ford, 2008). Many studies have stressed the importance of detecting psychological difficulties in young people; for instance, an American study investigating teenage suicide, highlighted how severe emotional difficulties are often not detected. In this study, 90% of teenagers who committed suicide had a mental health problem, but none were receiving support or treatment prior to the time of suicide and yet all were attending school on a daily basis (Shaffer and Gould 2000 *in* Hawton and Herringen 2000). When it comes to detecting mental health problems

amongst school children much of the emphasis to date has been placed on pupils with more obvious signs of emotional behaviour difficulties (EBD) and those who display their behaviours extrinsically, for example, conduct or hyperkinetic disorders as these problems are more visible (Cooper, 2010). It is, however, acknowledged that more needs to be done to help and assist the pupil with less visible intrinsic mental health problems, for example the child who is quietly introverted, but experiencing mood or anxiety problems (Cooper ibid; Kutash et al, 2011; Reddy and Newman, 2009a).

1.4. The Economical Cost to Society

The trend of rising mental health problems amongst the young is now a concerning economic issue, because the cost to society is rising. In 2007, The Kings Fund estimated that mental health problems amongst the young cost the British economy £143 million, but by 2026 the number of children with mental health problems will increase by 13.3%; consequently this will increase in 2026 to £237 million (McCrone et al, 2008). Furthermore, the burden to society is greater if a child's mental health problems persist into adulthood, as an adult requires additional welfare and housing support. This provides further evidence for ensuring that the mental health of the nation's children is addressed as early as possible (Knapp, 2011; Parsonage et al, 2014; Scott et al, 2001).

1.5. Mental Health Problems in Adolescence

Statistics highlight there is a rise of mental disorders in adolescence, with prevalence rates being 11.5% compared with 7.7% in younger children (Green et al, 2005). The prevalence of emotional disorders such as anxiety, depression, anorexia nervosa and bulimia nervosa increases in adolescence (Kessler et al, 2007). These findings, therefore, emphasise the need for adolescents to receive additional school support. This is constrained, however, as secondary schools are often large, complex institutions which can often compromise any additional support (Wigelsworth et al, 2011; Lendrum et al, 2013; Weare and Nind, 2011).

Supporting children in this age group is further hindered by the limited understanding of why mental health problems amongst the adolescent population continue to rise. Some researchers in the field suggest there is an array of complicated bio-psychosocial factors predisposing young people to experience mental health problems. For instance,

advances in Functional Magnetic Resonance Imaging (fMR) technology have led to one biological theory that gives insight into some of the complexity of supporting adolescent mental health. It has been found that the brain during adolescence is going through a major rewiring process, whereby the emotional cortex (the limbic system) and intellectual parts (the frontal lobe) are being connected. It is during this process that the teenager has a reduced ability to use emotional and cognitive processing together, thus making them more impulsive and emotionally responsive to social stimuli. This provides one explanation as to why some teenagers find it difficult to regulate their negative emotions and are prone to adopt risk taking behaviours (Giedd, 2008).

Other researchers have linked the rise in teenage mental health factors to complex psychosocial factors in our society, such as changes in family structure, pressures to consume, and growing economic inequality (Claveriole and Gaughan, 2011). Surveys suggest that today's youth are subject to more adult pressures and worries than previous generations. For example, the National Office of Statistics (NOS) recently highlighted today's youth are more likely, than previous generations, to worry about their appearance and school work (Beaumont, 2013).

1.6.   The Interface of School and Mental Health Problems

Substantial research demonstrates a strong association between mental health problems and other school difficulties (Emerson and Hatton, 2007). For instance, it has been found that up to 40% of children who have a learning difficulty or disability also have a diagnosable mental health problem (Vedi and Bernard, 2012). Overlapping factors predisposing a child to developing mental or learning problems are being male, from a poor social status, suffering economic hardship, or experiencing conflict in the family or within their community (Bradley and Corwyn, 2002). Stressful factors like experiencing loss, bereavement or divorce, or being a carer also impact negatively on mental health and learning (DfE, 2015a: McLaughlin and Hatzenbuehler, 2009). Evidence suggests these children also have a higher risk of being excluded from school, having low school attendance (Parry- Langdon, 2008) and underachieving academically (LeFever et al, 2002; Loe and Feldman, 2007). This is because learning difficulties often lead to misbehaviour which causes the child to disengage with their learning and mental health problems, like hyperkinetic problems, can often cause the child to struggle with their

learning. These facts are not unique to Britain; for instance, American statistics demonstrate similar trends (Blackorby and Cameto, 2004). These commonalities provide good rationale for agencies to share knowledge and information about children, as an abundance of evidence suggests these children are more likely to struggle to succeed in life (O'Connor et al, 2011; NCCP, 2006). It must be emphasised, that approximately 60% of children with mental health problems will not have visible learning or school difficulties, so their distress may prove more difficult to detect and therefore the need for more partnership working to detect more subtle problems.

1.7.   The Challenges of Joint Working

Joint working can be complex and challenging. Agencies have differing theoretical foundations resulting in divergent cultures, priorities and agendas. Differing culture determines why teachers and healthcare professionals have different skill sets and working priorities; for instance a school's primary focus is on improving academic performance, whereas CAMHS focus is on improving health and preventing disease. Consequently, for agencies to work together and share a common secondary agenda, such as the promotion of child mental health, they must firstly develop a better perspective of each other's roles and standpoints (Cooper and Jacob, 2011a). For example, Vostanis et al, (2012) points out the need for CAMHS workers to learn more about educational issues. Educational academics such as Cooper and Jacob (2011a) highlight the need for teachers to explore in more depth the impact of mental health problems on the child's academic learning.

There is an argument that, in order to promote more inter-agency collaboration, more policies must be developed to ensure service integration (Ford et al, 2005). There must also be normalising of language and terminology to enable services to communicate more effectively with each other (Children's Society, 2012; Salmon and Kirby, 2008). This language barrier is also known to impact negatively on research and the dissemination of knowledge, in that if conducted with one perspective in mind, either aimed at an audience schooled in education or health, subsequent differing terminology can make it difficult for other disciplines to interpret. This lack of convergence also runs the risk of work being duplicated (Pettitt, 2003). This impedes the progress of developing effective

school-based programmes that suit the needs of all the agencies, thus supporting both children's education and well-being (Worrall-Davies and Cottrell, 2009). One example of this lack of convergence is provided by Hoagwood and Erwin (1997), who reviewed 64 school-based interventions to promote well-being and found that only 24 measured pupils' academic outcomes.

The turn of the millennium has seen more work being carried out in British schools centring on pupil mental health. This has been driven by government policy and legislation, like 'Every Child Matters' (DfES, 2003) and 'The Children's Acts' (1989 and 2004), which have encouraged agencies to work together. Since 2011, however, UK school-based activity relating to mental health has slowed down. This is partly due to the voting in of a new government, whose principal objective was to reduce public expenditure. CAMHS and schools are now going through instability, which is especially common when financially constrained (Milbourne, 2005). The introduction of new financing models in both education and health have added to this instability e.g. in education; pupil premiums, and for schools wishing to obtain academy status the General Annual Grant (GAG) and in health; 'payment by results'. The Government's answer to delivering quality services in a time of constraint, however, is to encourage a big society culture, whereby agencies and businesses support each other in order to improve life outcomes for all. The aim is to improve the quality and reach of services, ensuring they are cost effective and value for money. This research is, therefore, timely in that it wishes to explore the impact of society on the young people themselves and how they may be better assisted in this time of constraint.

1.8.   Personal Drivers to Carry out This Study

Interest in this area was not only driven from the empirical evidence outlined above, but also assisted by my own motivation, stemming from personal and professional experiences. My personal motivation was derived from being a mother and stepmother to four teenage children. From afar I have observed how school has protected my children in adversity. My own children have experienced their parents' divorce and my stepchildren divorce and bereavement, and it is through these difficulties that school, I believe, has been a major stabilising factor in their lives. Sometimes, however, I have

watched them struggle when at school, especially when trying to articulate any difficulty they are experiencing, and it is during these difficult times that I have witnessed my sons express anxiety, sadness and frustration. As a parent I have often had to process these complex dynamics play out from afar because like many teenagers, my children prefer their parents not to get involved. Consequently I too have felt frustrated, and wished that school staff could move away from their entrenched traditional beliefs and simply try to understand their pupils. This is my personal reason for wanting to know how schools can better support children when they are most vulnerable and when they are teenagers, under pressure to perform and experiencing adversity elsewhere in their lives.

My professional background has also influenced my motivation to carry out this line of enquiry, in that many of the children who I have supported as a CAMHS clinician have, like my sons, voiced concerns about school. I have noticed that the type of school support these pupils receive is often inconsistent, in that some schools support the child and interface with CAMHS well, whereas other schools neglected to do this. In these cases, the child and their family often experience additional strain. As a lecturer in Mental Health Nursing, I am also continually reminded by my post-graduate students, many of whom have active involvement in the school mental health agenda, the need for educational professionals, like teachers, to know more about a child's mental health in order that they can better assist pupils with mental health problems.

1.9. Summary

Child mental health is presently a concerning issue, especially as global statistics suggest mental health problems are particularly pronounced amongst children of adolescent age, possibly because they face several bio-psychosocial life challenges. This, therefore, indicates the importance of ensuring that the mental health of these children is well supported and it is schools, with the support of external agencies that are felt to be strategically well positioned to offer more assistance. Supporting young people in larger more academically target driven secondary schools and overcoming the challenges of multi-agency working does, however, make carrying out partnership work more complicated.

The next chapter focuses specifically on the generic school support commonly provided to all British secondary school children and also outlines the less comprehensively available, specialist's school support that have been trialled globally to support pupil mental health.

CHAPTER 2: PROMOTING EMOTIONAL WELL-BEING AND MENTAL HEALTH AT SCHOOL

2.0.   Introduction

This chapter contextualises the school mental health and well-being agenda by primarily focusing on the role schools play and how CAMHS has evolved to assist them. The chapter is divided into three parts. The first part outlines how the secondary schools pastoral care agenda has evolved over the years to support pupil well-being. This demonstrates the broad remit of the schools' pastoral care provision and some of the complexities associated with supporting the well-being of children alongside that of the schools primary agenda, teaching and learning. The second section focuses more specifically on some of the specialist global school programmes, introduced in recent years, which have focused on either pupil well-being or mental health. The final section of this chapter focuses specifically on the role CAMHS plays in assisting schools to promote, prevent and support pupil mental health. It must be noted this chapter discusses the historical evolution, relevant evidence, political reforms and policy under differing themed headings. These are, however, closely entwined and therefore inevitably will overlap.

2.1.   School Pastoral Support

Schools, through their pastoral care programmes, have a long history of providing emotional assistance and support to pupils (Weare and Gray, 2003). Presently there is a wealth of evidence suggesting the more effective a schools pastoral care support, the more improved school behaviour, attendance, attainment and pupil well-being will be (Charlton and David, 2012). Currently in the UK the pastoral care system has evolved into a complex web of multi-dimensional support that encompasses many components, from arranging sporting activities and careers advice, to assisting children with specific learning, behavioural, emotional or social difficulties. Nowadays, 98% of schools offer pastoral support (DH, 2015), with every school staff member having some form of devolved pastoral care duty. Most schools also employ specialist staff that attend to pastoral care needs only. The schools' key pastoral care responsibilities to these children are discussed in sections 2.1.1 – 2.1.5.

2.1.1. Behaviour Management

Behaviour and its management in school is considered a chief pastoral concern (DfE, 2010; DfE, 2014a DfE, 2015a; DfE, 2015d). Discipline and control is considered one of the earliest pastoral care priorities, dating back to the 1950s, when schools were becoming larger, hence more control was needed in order to safeguard pupil welfare (Calvert, 2009). Today, effective behaviour management is still considered by many to be the bedrock of a good school, because without discipline, pupils feel unsafe and insecure at school and are subsequently unable to learn (DfE, 2010; DfE, 2015d). Even today pupil behaviour is one of Ofsted's key judgment areas for measuring a school's overall effectiveness and performance (Ofsted, 2015a and 2015b).

How behaviour is best managed in schools, however, remains a contentious issue (Cooper, 2005; Stuart and Agar, 2011). One school of thought advocates the use of 'harder-line' discipline tactics such as exclusion and isolation, in order to tackle the rise in challenging behaviours (DfE, 2010; DfE, 2012). Another school of thought advocates the use of 'softer control tactics' that aim to promote discipline and attendance through the teaching of emotional skills, e.g. increasing the understanding of self and others (DfES, 2005; NICE, 2009). It may be argued that the harder-line tactics are more historically entrenched in school culture. They are, however, not highly regarded by those who specialise in emotional and behavioural difficulties. This is because there is lack of evidence justifying their use. It is also argued that this type of approach is likely to induce negative pupil attitudes and perpetuate problems rather than help (Cooper, 2005). Those specialising in mental health argue that these methods neglect to tackle the root of a behavioural or emotional difficulty (Weare and Nind, 2011). Today's statutory school exclusion guidelines acknowledge this viewpoint and state that disruptive behaviour can be an indicator of unmet needs, therefore schools should try and identify the underlying reasons for a pupil's problem as early as possible, and to consider a multi-agency holistic assessment that goes beyond the pupils' learning (DfE 2015a).

The problem, however, is that pupils with emotional and behavioural problems are often excluded from school (Children and young People's Mental Health Coalition 2012), because teachers find these pupils difficult to manage (Reddy and Richardson, 2006).

Part of this problem is because teachers are not able to link a child's behavioural difficulties with psychological distress and, therefore, are unaware of the importance of ascertaining the child's holistic problems so that they can be better managed at school (Loades and Mastroyannopoulou, 2010; Moldavsky et al, 2013).

2.1.2. Individual Counselling

It was in the 1960s that schools first recognised the need for a more interpersonal style of support to engage pupils who were struggling emotionally (Calvert, 2009). At this time, The Newsom Report (1963) recommended that teachers should be trained as humanistic counsellors (Baginsky, 2004), as this form of counselling was considered to be less intensive than traditional psychotherapy and was relatively easy to implement. In the main, at this time, school counselling failed to embed itself in school culture (Baginsky, ibid; Robinson, 1996). This may have been because schools were financially constrained and counselling was a costly commodity, or part of the problem may have been due to teachers lacking the confidence to support pupils with complex emotional problems (Bor et al, 2002).

In recent years, there has been a call for a revival in school counselling (DfE, 2015c, DH, 2015). For example, the Public Policy Research report 'Thursday's Child' suggests that every UK school should have a counsellor, in recognition of the fact there is a rising number of children experiencing emotional distress (Sodha and Margo, 2007). At present, specialist counselling services are more likely to be established in schools rather than teachers adopting a dual role of teacher/counsellor (Baginsky et al, 2004; McKenzie et al, 2011).

Research carried out in this area suggests that school teachers and older pupils find school counselling helpful (Cooper et al, 2005; Cooper et al, 2013; Fox and Butler, 2007; DfE, 2015a; DfE, 2015c; McKenzie et al, 2011), and that school counselling services can prevent deterioration of mental health (Fox and Butler, 2009; McElearney et al, 2007; DH, 2015). It is argued, however, that counselling is a costly commodity, and to justify its expense, the effectiveness of the counselling approach must be more robustly evidenced, with randomised controlled trials being recommended (Cooper, 2009; McKenzie et al, 2011). More research is also needed to address how these services best

sit within an inter-agency framework, as there is little evidence suggesting school-based services can help those with complex mental health presentations, or if school counselling services are better suited to help pupils experiencing adverse life events like parental divorce or bereavement (Fonagy, 2002; McKenzie et al, 2011).

2.1.3. Tutorial Support

For some time, schools have been aware that pupils gain personal and academic benefits from having the assistance of a supportive form or tutorial teacher (Cooper and Jacob, 2011a), with the form tutor often being described as the 'foundation stone of the pastoral system' (Best, 1990, p.15). An abundance of research exists dictating that teachers who possess supportive qualities, and who aim to further the personal development and academic learning of their pupils, are significantly more likely to engage them in learning, increase their confidence and subsequently make a positive impact on their academic ability (Buyse et al, 2008; Larusso et al, 2008; McDonald et al, 2005).

It was in the 1970s and 1980s that schools began experimenting with pastoral curricula, tutorial programmes and form teaching. At this time this type of curricula aimed to help teachers expand on their ability to not only promote pupil learning but also promote the pupils' personal development (Best, 1990; Calvert, 2009). Active Tutorial Work (ATW) was an early example of this type of teaching support (Baldwin and Wells, 1979-81). It was facilitated by a form teacher in specially scheduled time. The teachers received direction, via a manual, which contained clear teaching guidance and lesson activities. This enabled them to move away from didactic teaching to pupil-centred group activities. These activities encouraged debate and reflection about personal ideas, attitudes and motivations in life. This debate ultimately aimed to promote pupil maturity by encouraging pupils to become more independently involved in their own learning (Harwood, 1989).

Education has learnt key lessons from this type of tutorial support; one lesson being that pupils benefit from peer group activity, as when harnessed properly, peers can serve as reinforcers and effective role models to each other (Barth et al, 2004). This form of peer-assisted learning is still well utilised today and is an underpinning philosophy supporting

many academic and pastoral learning activities that are adopted in schools (Baker et al, 2004; DuPaul et al, 1998; Falk and Wehby, 2000). Another key lesson learnt was that teachers are well placed to support more than just the academic needs of their pupils, but are also good emotional supporters and life coaches (Hutchinson, 1991; Weist and Murray, 2007). Despite the strong evidence supporting the teacher's pastoral role, in more recent years the pastoral role of the teacher has been put under threat, as teachers are under pressure to focus their attention on pupil attainment (Power, 1996; Shucksmith et al, 2005).

2.1.4. Promoting Health

Schools play a primary role in promoting children's health, as school curriculums aim to promote better, physical and mental well-being. In the 1990s schools became more involved in health promoting activities. This was because the Government commissioned the report 'The Dearing Review' (1994), which gave schools permission to reduce their mandatory national curriculum, as the curriculum at the time was perceived to be too complex and prescriptive. Its slimming down enabled teachers to move away from a total focus on pupil attainment, to adopting a flexible curriculum able to consider the learning and personal needs of all pupils, as well as the special needs of some. Also at this time, the World Health Organisation (WHO) was advocating a shift from health promotion centring on the individual, to a focus on developing healthy communities. Schools were considered the ideal health promoting 'setting' (WHO, 1999). This gave schools a stronger rationale to concentrate their attentions on health promotion, and it was the Health Promoting Schools Project introduced in Britain in 1998 that placed schools at the centre of this public health drive.

Many schools in the UK have strived for 'healthy school status', especially during the time when it was a government target and schools received government funding. To obtain this status, the school must demonstrate a good whole school approach[2] in the areas of Personal Social Health Economic (PSHE) education[3], healthy eating, physical

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[2] A whole school approach is a cohesive, collective and collaborative school action. Approaches range from whole school approaches to healthy eating (for example SEED), to approaches that aim to improve mathematics via a whole school learning programme.

[3] Personal, social, health and economic education is a planned programme of learning that helps children and young people grow and develop as individuals, family members and good citizens.

activity, emotional health and well-being (DH/DfESb, 2004; DfE, 2013; OFSTED, 2010 and 2013). PSHE is, however, a non-statutory subject and schools are under no obligation to promote pupil health despite there being an abundance of research suggesting the healthier the child the better their attainment (PSHE Association, 2013; DfE, 2015a). Furthermore schools no longer have the incentives they use to obtain healthy school status because government funding is no longer available (Bonell et al, 2014).

Research suggests that those schools that have been successful in promoting health at schools, however, are those that have moved from a sole emphasis on classroom learning to one of multi-dimensional school/community enrichment activity, with work undertaken in partnership with other community agencies (DfE, 2013; OFSTED, 2010). OFSTED have reported, however, that schools do not promote mental health as much as physical health, and that they struggle in some areas of PSHE education, namely sex and relationships, drugs, alcohol, eating disorders and mental health (Ofsted, 2013). A recent systematic review of these programmes by Langford et al, (2014) highlighted that not enough is known about the impact these programmes have on the child's learning ability. Neither is enough known about the long-term outcomes of the programmes, or the adverse effect they can have (Langford, ibid). For instance, do healthy eating programmes impact negatively on a child's dietary habits?

2.1.5. Safeguarding

Over the last two decades, schools have strengthened their safeguarding procedures dramatically, and it is now a pastoral priority for every school to assess and manage children who are at risk of harm from others or to themselves. It is estimated that 1 in 5 secondary school age pupils will have been severely neglected, physically attacked, or sexually abused at some point during their lives (NSPCC, 2011). These children are significantly more at risk of developing mental health problems (Maniglio, 2009; Martin et al, 2010).

Legal acts and key enquiry reports such as the death of Victoria Climbie (Brandon et al, 2008; Laming, 2009), and government policies such as the Every Child Matters, have all played their part in shaping how schools safeguard the physical, psychological and social welfare of their pupils. For instance, the Children's Act of 1989 recommended that

pastoral support should be offered to any child who is vulnerable to, or at risk of, abuse or neglect. An abundance of reports, policies, and acts, have followed this legislation, leading to the development of school safeguarding protocols which are all underpinned by the principle that it is everybody's responsibility to protect and promote children's welfare. Agencies are, therefore, advised to work together, in order to fulfil their statutory safeguarding duty, which is to keep children safe by supporting their well-being, identifying the children and families most in need and providing support and help as early as possible (DCSF; 2009b; DCSF, 2013; Munro, 2011). It has been highlighted that because safeguarding is now a key issue in schools, this has led to schools adopting a risk adverse culture (Calvert, 2009). To ensure and restore an equilibrium schools require assistance from supporting external specialist agencies. This enables schools to share the burden and is key to good safeguarding practices. This emphasis has subsequently seen an emergence of stronger partnerships between schools and other agencies.

2.2.   Specialist School Programmes

In recent years schools have increasingly adopted new methods of supporting children with emotional and behavioural problems. The driver of change is the strong empirical evidence that suggests when pupil emotions are positive this has a positive impact on learning; in contrast negative emotions impede motivation and commitment to learn (Guerra and Bradshaw, 2008; Morrison-Gutman and Vorhaus, 2012; Durlak et al, 2011; Zins et al, 2007). Specialist programmes are either universal, selected or indicated. Universal programmes target all pupils and are taught to the whole class or via school enrichment activities. Selective programmes target pupils who are considered to be more at risk of developing problems, for example, a child considered to be more predisposed to depression because they have experienced family divorce or bereavement or have a parent with mental illness (Beardslee et al, 2011; Porter, 2008). Indicated programmes target pupils who exhibit subclinical signs of a mental health disorder like ADHD. Selected and indicated programmes are normally delivered to a selected population of pupils, in specially scheduled lessons.

2.2.1. Universal Social Emotional Learning (SEL) Programmes

A multitude of school-based programmes have been developed worldwide to promote the emotional well-being, mental health and resilience of all school pupils (Durlak et al, 2011; Humphrey, 2013). The rationale for developing these programmes originated from research suggesting that those who possess a higher level of social and emotional competence are more likely to cope when faced with life's difficulties (Challen, 2011). Most SEL programmes are based on one or more of the following theories: Goleman's emotional intelligence (EQ) theory (1995) which aids in the promotion of pupil emotional literacy; positive psychology theory, which places an emphasis on a pupil's strengths rather than their weaknesses, hence promoting resilience (Linley et al, 2006; Seligman et al, 1995) and cognitive behavioural theory, which aims to promote pupil awareness into how uncomfortable thoughts, feelings and behaviours can be better regulated (Stallard, 2009).

The universal programmes that focus on promoting the emotional well-being of every pupil are known as social emotional learning (SEL) programmes. Most universal SEL programmes originated from the USA (Weare and Nind, 2011). This is because US government policy, like 'No Child Left Behind Act 2001' (NCLB, 2002) and 'Achieving the Promise' (New Freedom Commission on Mental Health, 2003) ensured that work in this area was well resourced and supported. SEL work carried out in Australia and Europe has also accelerated in recent years, and this now complements the expanding evidence base.

An example of a well evidenced universal SEL programme that is now globally delivered, is the Promoting Alternative Thinking Strategies (PATHS) programme. Developed in the US, it is underpinned by Goleman's EQ theory and grounded in the science of children's brain development. PATHS aims to enhance pupil self-awareness, empathy and motivation, enabling pupils to manage their emotions and feelings more effectively. Additionally pupils are encouraged to set life goals and make responsible decisions. Interpersonal communication is improved by focusing on co-operation and conflict resolution skills. Evaluation of programmes like PATHS suggests that pupils can benefit in a number of ways. Pupils post-programme are reported to be more able to discuss and manage their feelings (Riggs et al, 2006). They report less sadness and depression

(Kam et al, 2004), and teachers report improved academic engagement (Greenberg et al, 1995). Further evidence for SEL programmes was provided by Durlak's comprehensive, meta-analysis of 213 school-led SEL programmes targeting children from 5 to 18 years of age. The SEL programmes reviewed were all compared with either a no treatment or an intervention control. Durlak concluded that SEL programmes can impact positively on social emotional competency and academic learning (Durlak et al, 2011). It must be noted, however, that most of the evidence for SEL is American and evidence of its effectiveness has been obtained by introducing interventions in the primary school setting, with comparatively little evidence of the effectiveness in the secondary phase of education (Wigelsworth et al, 2011).

Universal SEL programmes have been subject to criticism by some who believe that not enough is known on how children are naturally programmed to deal with emotional distress, therefore hypothesising that SEL programmes are unhealthy because they may undermine a child's natural response to deal with psychological difficulties (Craig, 2007; Ecclestone and Hayes, 2009). Research by Twenge (2013) supports this theory by highlighting how past US school-based programmes aiming to promote children's self-esteem have done more harm than good in that they have promoted pupil introspection and unhappiness rather than well-being.

The UK introduced a universal SEL programme in 2007/2008, known as Social Emotional Aspects of Learning (SEAL)[4], involving 90% of the nation's primary schools and 70% of secondary schools (Humphrey et al, 2010). This programme aimed to improve behaviour and reduce attendance problems (DfES, 2005). It was found that, compared to controls the SEL programme had poor secondary school outcomes, as it failed to impact significantly on pupils' social and emotional skills and mental health difficulties, and had no significant effect on their pro-social behaviour (Wiglesworth et al, 2011). The SEAL intervention has been found, however, to have a positive influence on younger pupils' emotional literacy (Adi et al, 2007a; Hallam, 2009), with others in the UK reporting how

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[4] SEAL is "a comprehensive, whole-school approach to promoting the social and emotional skills that underpin effective learning, positive behaviour, regular attendance, staff effectiveness and the emotional health and well-being of all who learn and work in schools" (DCSF, 2007, p.4).

SEAL programmes targeting younger children at risk have also positively influenced these children's social and emotional skills (Humphrey, 2013).

These findings, therefore, indicate SEL intervention has better outcomes with primary pupils suggesting younger children are more open to attitude and behavioural changes than secondary school children (Browne et al, 2004; Weare and Nind, 2011; Wolpert et al, 2011). Secondary school SEAL intervention is, however, more complex, which confirms Blank's opinion that despite SEL programmes being successful in the USA context, transferability should not be assumed (Blank et al, 2010). A number of factors have been attributed to the failure of SEAL; firstly, the implementation of the strategy was problematic, in that time and resource was constrained (Humphrey et al, 2010) and having to deal with the complexity of the busy attainment driven secondary school culture whereby well-being was secondary (Wigelsworth et al, 2011). Other reasons for the negligible impact of the intervention have been attributed to the underpinning philosophy of SEAL and how EI theory in itself may be flawed (Wigelsworth ibid). There is also a belief that the findings were influenced by limitation in the research design, e.g. an overreliance on pupil self-report questionnaires and the inability to randomly select schools (Wigelsworth, ibid).

2.2.2. *Universal Psychiatric Anti-Stigma Programmes*

Some schools have introduced specialist universal programmes that aim to promote an anti- mental health stigma message. This is because mental health problems can be perceived as a disgrace, setting a person apart from others, ultimately spoiling and disturbing one's identity, thus leading to shame (Pietrus, 2014) and alienation (Time to Change, 2013). It is this stigma which often prevents many young people from seeking help with their mental health difficulties (Corrigan and Watson, 2002; Corrigan et al, 2014).

Attitudes and beliefs, however, are notoriously difficult to change, especially as today's children are frequently exposed to negative portrayals of mental disorders (Wilson et al, 2000). Anti-stigma school programmes aim to combat these negative attitudes. They frequently target children aged 14-18, as it is at this age that their personal value systems are developing, because they are beginning to understand concepts outside

their own direct experience, and are taking more responsibility for their own behaviour (Time to Change, 2013).

A number of psychiatric anti-stigma classroom programmes have been trialled globally. Recent RCT's suggest that this type of classroom intervention can reduce psychiatric stigma by improving pupil attitudes and decreasing stereotypical beliefs (Economou et al, 2012; Pinfold et al, 2003). In England, the time to change an anti-stigma discrimination programme has also been trialled, with preliminary findings suggesting that tackling mental health discrimination can impact positively on the attitudes of 14-18 year olds. It can also help children with mental health problems (Time to Change, 2013). A robust Canadian systematic review does, however, suggest that some programmes can convey key messages about stigma poorly and therefore can do more harm than good. For instance, the more effective programmes contain plenty of student-led activities, involving real people with lived experience of mental disorder telling expertly their story of recovery and hope. It is, therefore, concluded the content of the programme and how it is delivered is often what dictates a programme's success (Pietrus, 2014). Furthermore it is recommended that this type of classroom intervention should not be a one-off intervention, but be an integral part of the school's supportive provision (Pietrus, ibid). It is, therefore, clear that in order for schools to accommodate such time intensive activity within their curriculum, outside assistance is required and financial assistance secured. Ultimately, even when this is in place, the impact of these types of programmes on children's help-seeking behaviour, in the long-term, remains inconclusive (Griffiths et al, 2014).

2.2.3. Universal and Targeted Programmes Focusing on Depression

Pupils who sit silently without divulging their worries can pose a significant challenge to teachers. Pupils can come across as unresponsive, withdrawn, passive or unmotivated which, in turn, can lead to teacher frustration (Shucksmith et al, 2005). School-based interventions that focus on this type of difficulty are limited (Reddy and Newman, 2009a). This is mainly because, as stated in Chapter 1, teachers find it difficult to detect less visible forms of distress, like depression (Cooper, 2010; Cowie, 2004; Stallard, 2013; Weist et al, 2007). Mental health experts do, however, highlight the importance of detecting this type of emotional distress as early as possible, because the longer the

duration of the symptoms (e.g. low mood, inability to concentrate, low self-esteem, social withdrawal and hopelessness), the more at risk the young person is of developing more entrenched and severe mental health problems such as major depression, self-harming behaviour, eating disorders or substances misuse (Weist et al, 2007). This evidence, therefore, clearly delineates why schools need to play their part in early detection and secondary prevention of internalised problems (Evans et al, 2004; Stallard and Buck, 2013).

A number of programmes focusing on low mood, depression and anxiety have been developed globally. In the main, these programmes aim to promote pupils' resilience, well-being, confidence and self-esteem. Their objectives are to identify early signs of depression and/or anxiety (NICE, 2009) and introduce CBT strategies that can be used in everyday life to regulate difficult feelings, thoughts and behaviours, by challenging negative cognitions, introducing problem-solving skills and relaxation techniques (Stallard, 2009). These programmes, through psycho-education, also teach pupils the benefits of adopting a healthy lifestyle like taking exercise or a healthy diet (NICE, 2005; 2009).

Systematic reviews of universal, selected and indicated programmes that focus on low mood and depression are still, however, inconclusive on the specifics of any particular approach. This is often because of the lack of methodological rigour in their evaluation. Areas of weakness include the lack of control groups, poor fidelity and choice of primary and secondary measures (Calear and Christensen, 2010; Craig, 2007; Cuijpers et al, 2006; Horowitz and Garber, 2006; Merry et al, 2004; Weare and Nind, 2011; Zeidner et al, 2002). There are, however, some school-based programmes that are more robustly implemented than others, examples of which are the Australian Resourceful Adolescent Programme (RAP) and the US PENN Resilience Programme. This is because they are manualised, which has improved the fidelity of these programmes and led to them being more frequently replicated around the world.

Despite the robustness of the manualised implementation, the programme's effectiveness remains inconsistent. Some have reported positive outcomes (Gillham et al, 2006; Merry et al, 2004; Shochet and Ham, 2004), while others report an in-significant

impact (Brunwasser et al, 2009; Horowitz and Garber, 2006; Harnett and Dadds, 2004). Overall though, the programmes do have a successful impact on pupils who commence the programme with elevated signs of depression, as their symptomology is usually reduced post-programme (Gillham et al, 2012; Harnett and Dadds, 2004; Horowitz and Garber, 2006). In contrast there is limited evidence on the impact of universal programmes upon the general population of school children not reporting clinical signs of depression (Gillham et al, 2007; Sheffield et al, 2006).

Considering the above evidence, it may be argued that universal programmes are not economically viable, as they are not proven to be effective and are considered a costly commodity when targeting all. It is therefore argued selected or indicated programmes are more economical for these reasons (Shucksmith et al, 2007; Shochet and Ham, 2004). There are, however, some drawbacks of the selected and indicated interventions, in that these often have a poor uptake and a high attrition rate. Many link the unpopularity of these programmes to stigma (Shochet and Ham, 2004; Rapee et al, 2006). This is because they invariably involve selection by screening and this then places young people more at risk of 'feeling singled' out by their peers. Universal programmes on the other hand are less stigmatising (Rapee ibid). Recruitment is less problematic, plus universal programmes have the potential to positively influence a silent population of needy pupils who have not been observed to have worries (Cooper, 2010). The question therefore is, can this type of programme protect a pupil against adversity in later life? As yet empirical evidence is inconclusive as to the longer-term benefits of such programmes (Challen, 2011). One early study carried out by Gillham and Reivich (1999) did indicate that a school-based programme designed to prevent depressive symptoms in children faded after two years.

In the UK, Stallard and colleagues have considered carefully the lessons learnt from the global literature, when implementing a depression focused programme in the UK. Researchers choose to carry out a large scale randomised control trial of a selected RAP adapted CBT school-based programme, that aimed to support pupils aged 12-16 at high risk of depression. The programmes outcomes were compared to the schools standard PSHE curriculum. Stallard et al's study is particularly interesting because, despite the programme being adapted to suit the UK school context the programme was found to

have limited effect in reducing symptoms of depression, with Stallard stating it may indeed '*increase reporting of symptoms*' (Stallard et al, 2013, p.53). Programme evaluations have also suggested financially the benefits of running these programmes are difficult to determine but are likely to be insignificant (Anderson et al, 2014).

2.2.4. *Universal and Targeted Programmes Focusing on Anxiety*

Cooper (2010) suggests that the learning difficulties of anxious pupils are on par with pupils with behavioural difficulties (Cooper, 2010); therefore, there is a firm rationale for children with these difficulties to be better supported at school. In contrast to depression, evidence suggests that school-based programmes focusing on anxiety have consistently successful outcomes (Essau et al, 2012; Kraag et al, 2006; Neil and Christensen, 2007). Programmes focusing on anxiety aim to reduce the physical and psychological signs of anxiety by introducing the pupil to some CBT skills (Miller et al, 2010).

One of the most highly regarded replicated school-based universal programmes for anxiety is known as FRIENDS. This is an Australian derived, universal CBT programme, looking to promote the emotional well-being of all pupils by focusing on decreasing symptoms of anxiety and raising mood and promoting resilience. Australian trials have suggested the programme can reduce anxiety and boost pupil self-esteem (Barrett et al, 2006; Webster-Stratton et al, 2008). A robust German replication of a FRIENDS programme has also reported programme success, in that it reduced attendee's anxiety and elevated their mood. It was also noted that the younger children immediately benefited from the programme, whereas older children (11–12-year-olds) demonstrated a reduction in anxiety at their 6 and 12 month follow-up assessment (Essau et al, 2012). A small UK pilot of FRIENDS has also found FRIENDS to be effective in reducing symptoms of anxiety and boosting primary school pupil self-esteem (Stallard et al, 2007). The National Behaviour Support Service (NBSS) in Ireland, has also reported that a FRIENDS programme, delivered in 12 primary schools, has seen a significant reduction in younger children's anxiety levels (Henefer and Rodgers, 2013). Secondary school evaluations of the FRIENDS programme are, however, less conclusive with evaluations reporting negligible impact (Green, 2013).

As well as the FRIENDS programmes there are a plethora of other CBT school-based programmes which aim to reduce pupil anxiety, promote happiness and well-being. The programmes that show greatest promise are the relaxation training programmes and other more contemporary approaches like mindfulness and yoga classes, all of which are well received by pupils (Hilt-Panahon et al, 2007; Huppert and Johnson, 2010). Neuroscience supports such approaches as fMR scans of the brain show that mindfulness meditation can successfully alter the structure and function of the brain to improve the quality of both thought and feeling (Weare, 2013). Research in this area, despite being in its infancy, shows promise in that it indicates that mindfulness has beneficial effects on a child's mental health, and their ability to learn (Burke, 2010; Huppert and Johnson, 2010).

2.2.5. Universal and Targeted Programmes Focusing on Conduct and Hyperkinetic Problems

The educational literature suggests that, compared to supporting pupils with inwardly expressed behaviours such as depression and anxiety, teachers feel better equipped to deal with acting out disruptive pupil behaviours (Cooper, 2010). This may be because they are well practiced at managing classroom rule violation like defiance and aggression, and they are more aware that this type of behaviour can signal deeper routed mental health problems. For example over activity, inattentiveness and impulsivity can be linked to neurodevelopmental disorders like (ADHD). These pupils do, however, present teachers with a number of classroom management challenges, for example they can be prone to criticising or antagonising their peers, not complying with teacher instructions or exhibiting angry outbursts in the classroom (DuPaul et al, 2011a; Miranda et al, 2006; Power et al, 2012). It is these behaviours that teachers often find most stressful (Cooper and Jacob, 2011a; DfE, 2010). Evidence also suggests that these pupils are more likely than their peers to have concurrent learning difficulties (DuPaul, 2011b; Masten, 2005).

Empirical evidence recommends a combination of special school, classroom and individual methods to support children with these difficulties. This is known as multi-component intervention (Farmer et al, 2002; Miranda et al, 2006; Wilson et al, 2001). Multi-component interventions have been found to improve classroom attention and

disruptive behaviour (DuPaul et al, 2011a; Stoltz et al, 2012). For instance, universal SEL programmes can sit alongside selective or indicative programmes. PATHS is a SEL programme which has been found to have a positive impact on absenteeism, exclusions and challenging behaviours (Greenberg et al, 1995; Waddell et al, 2007), with an increase in pupil self-control and on task behaviour being reported by teachers (Van Lier et al, 2004; Waschbusch et al, 2005). Although it is clear that universal and targeted approaches are stronger in combination, especially when supporting a child deemed as high risk, there needs to be clearer direction as to the correct balance of targeted and universal intervention, because this has still not been determined (Adi et al, 2007a; Weare and Nind, 2011; Vostanis et al, 2013).

The content and delivery of any form of specialist programmes are important considerations in their planning, as this is a predictor of outcome. Durlak et al (2011) uses the acronym SAFE to describe the delivery of a gold star standard programme, in that it should ideally be **s**equenced, **a**ctive, **f**ocused and **e**xplicit. These programmes place an emphasis on social skills training, via role play and simulated problem-solving techniques. SAFE enables pupils to practise their cognitive and behavioural skills in a nurturing classroom environment, which can bolster pupil confidence in practicing of new skills in true situations (Durlak and Dupre, 2008; Greenberg et al, 2003). The objective of the programme should be to enhance the child's resilience and focus on their strengths rather than on their defects, as these have been found to improve attitudes towards school and learning, thus raising school grades (Durlak et al, 2011). Conversely, programmes aimed at reducing pre-existing negative behaviours, via instructional and didactic methods using fear-inducing tactics, have less favourable outcomes (Browne et al, 2004, Reddy et al, 2009b). Much of the research to date on the impact of SAFE school-based intervention has, however been based on younger children, for which reason it is not fully understood whether this equally benefits adolescents (Miranda, 2006; Stoltz et al, 2012).

Classroom discipline methods constitute another important part of the multi-component intervention. These should place an emphasis on allowing the child to rectify their behaviour by introducing them to self-monitoring tools (Durlak and Wells, 1997; Miranda et al, 2006; Wilson et al, 2001). A good example of this type of behavioural

method is the 'Good Behaviour Game' (Cooper and Jacob, 2011a; Poduska et al, 2008). Additionally, Stoltz (2012) recommends these children should also receive one-to-one support from a friendly teacher, as this ensures that they are supported emotionally. Many teachers, however, remain unaware that children exhibit internalising emotional problems too (Gilliom and Shaw, 2004; Masten et al, 2005). Programmes tackling extrinsic distress have consequently been criticised for not targeting comorbid intrinsic difficulties (Cutuli et al, 2006; Jaycox et al, 1994).

2.2.6. *Parental Involvement in School Programmes*

The family's role in precipitating and perpetuating pupils' social, emotional and behavioural difficulties is well known (Kazdin, 2002; Breinholst et al, 2012), and positive parenting is a strong protective factor (Kumpfer and Alvarado, 2003). This is also associated with school success (Power et al, 2012). Bronfenbrenner (1979), in his seminal text, proposed the ecological context theory, suggesting that a child exists in a microsystem, with the family being one of the closest proximal influences. Therefore, when supporting the child, it is important to consider the wider influences of the microsystem and not just consider the child in isolation. Family therapists refer to this as a systemic approach, which views the child in a social context, thus exploring complex family interplay and resolving problems by finding solutions that avoid blame and labelling.

Many reviews of school-based emotional well-being interventions have concluded that engagement with and support from families is more helpful than approaches which focus on the pupil alone, for instance when promoting pupil mental health (Wells et al, 2003), when moderating stress (Adi et al, 2007a; Bogels et al, 2008: Breinholst et al 2012), reducing violence and bullying (Adi et al, 2007b; Blank et al, 2010), addressing conduct problems (Waddell et al, 2007; Valdez et al, 2005) and enhancing learning (Christenson, 2004; Sheridan et al, 2001). These findings advocate that all schools should work with parents to promote better educational outcomes. Such engagement may be low key, for example, parents being encouraged to help with homework, or taking an active part in parent/teacher consultation. Home-school links are strengthened by simple parent school communications like the 'daily report card', which has proven to be beneficial for children with ADHD (Murray et al, 2008).

Parental management training (PMT) and positive parenting programmes like the 'Triple P' and 'Teen Triple P' programme (Ralph et al, 2006; Sanders et al, 2000) have also been introduced into some schools for children with conduct problems. These programmes are usually delivered by skilled therapists, and aim to train parents in techniques that can better enable them to manage their children's challenging behaviour by reinforcing desirable ones. At present though, school-based parent interventions are rare, as the majority of these programmes are carried out in community settings and have not yet been fully adapted to school delivery (Cooper and Jacob, 2011a). In addition, researchers such as Zwi (2011), who has evaluated community-based parent training programmes targeting parents of ADHD children, suggest it is still too early to conclude that parent training can have positive effects on a child's ADHD symptoms or to improve their academic performance. Nevertheless, evidence does suggest that they can lead to reduction in parental stress and increase in parental confidence.

There is however the occassional study which has piloted a school-based programme with additional pupil and parent support. An example of this is the PENN Resiliency Programme, which targeted children with depression and their parents. When this programme was evaluated with an extended family component it was reported that the additional family intervention enhanced the programme's success in that it more successfully reduced depressive symptomology than the pupil programme only (Gillham et al, 2006).

Reviewers of these parent/pupil programmes point out that, although multi-component programmes show promise, at present there is a lack of evidence to suggest they are wholly successful (Durlak et al, 2011; Wilson et al, 2001). What their evaluations do, however, highlight is the difficulty in engaging parents of children with mental health problems (Barkley 1998; Breinholst et al, 2012; Waschbusch et al, 2005). Reports like YoungMinds and Cello's 'Talking Taboos' (2012) indicate a major reason for this, which is parents often feel heavily implicated for their child's problems, thus experience guilt and shame and feel stigmatised, as a result of which they do not readily seek or accept help.

2.3.   Whole School Programme Focusing on Anti-bullying and Violence

Parents are not the only strong proximal influencers of a child's microsystem; school is as well (Allen, 2011). Children also worry about school, a key concern being school bullying (Bond et al, 2001). There is no legal definition of bullying. Olweus' (1993) definition of school bullying is, however, cited frequently in the literature, which is that of being victimised and exposed repeatedly over time to the negative actions of one or more other pupils. Research suggests that 7 children out of a class of 30 will be bullied (Children and young People's Mental Health Coalition 2012), with victims of bullying being more susceptible to mental health problems (Bond et al, 2001; Freeman et al, 2009; Meltzer et al, 2011). Conversely, children with mental health problems such as ADHD and conduct disorder are more likely to be perpetrators of and victims of bullying (Unnever and Cornell, 2003).

Research indicates that school bullying and violence are often not spoken about, hence are not visible and, therefore, are a hidden danger (Mishna and Alaggia, 2005; NSPCC, 2010; Witney and Smith, 1993). To strengthen the school's ability to promote and protect the physical and emotional well-being of all pupils, school bullying policies increasingly state that schools must feel safe, and that bullying must be addressed as a collective challenge and not as a problem rooted in the individual (European Charter for Democratic Schools without Violence, 2004). A multipronged approach is thus recommended to combat bullying and violence. The gold star method is to adopt a 'whole school community approach' (Anti-bullying Alliance et al, 2014; BERA, 2013; Mitchell et al, 2014), as when successfully implemented, bullying and school violence can be reduced (Blank et al, 2010; Cowie and Jennifer, 2007; Garrard and Lipsey, 2007; Hahn, 2007; Ttofi and Farrington, 2011; Smith, 2013 Vreeman and Carroll, 2004; Wells et al, 2003).

Systematic reviews indicate though that many anti-bullying and anti-violence whole school approaches are unsuccessful (Ferguson et al, 2007; Jacques et al, 2011; Smith et al, 2004). This is because embedding whole school can be complex (Wells et al, 2003; Durlak et al, 2011; Weare and Gray, 2003, Weare and Nind, 2011). Therefore, to successfully embed a whole school anti-bullying ethos, action must be taken at several levels, from good leadership, to forging good community relations and successful

delivering multi-component interventions. These aspects are discussed in more detail below.

2.3.1. Leadership

Good leadership is considered a key factor contributing to whole school success (DfE, 2015a; DfE, 2015d; Orphinas and Horne, 2006; Weare, 2004), as this leads to an emotionally intelligent institution whereby the school successfully promotes a caring, nurturing school climate (Glover et al, 1998; Hawkins et al, 1992; Klein et al, 2012; Velesquez et al, 2013; Zullig et al, 2011). Strong leadership should provide attention to the emotional well-being of all in the school, both staff and pupils (Hamre and Pianta, 2001). The happier pupils and staff feel, the more likely they are to feel an affiliation to their school. It is this dynamic that can successfully reduce challenging behaviours and why specialists in the field highlight the importance of the whole school ethos being more thoroughly explored (CASEL, 2011; Jacques et al, 2011).

Lack of strategic direction in the implementation of a whole school philosophy can shroud the progress of the whole school initiative (Glover et al, 1998). For this reason, leaders should ensure that school policy focuses on all aspects of bullying, for instance cyber, racial and sexually oriented bullying (Children and Young People's Mental Health Coalition, 2012; DfE, 2015d). Anti-bullying policies in UK schools are legal requirements. This is essential as research has shown when a country is not legally obligated to adopt anti-bullying strategies, policy is sporadic and is often not maintained (Smith and Ananiadou, 2002).

2.3.2. Building Community Relations

Positive whole school ethos promotes strong community links and advocates partnerships with external agencies. The whole school ethos is "it takes a village to bring up a child" (Willert and Lenhardt, 2003), which is especially important when promoting anti-violence campaigns (Bucher and Manning, 2005, Chamberlain, 1996; Cowie and Jennifer, 2007; OFSTED, 2012). Community coalition also provides the school with further opportunities to carry out multi-modal interventions. A good example of community sector involvement in combatting school bullying is the CyberMentors project, which offers either online mentoring support to children or an offline in-school

mentoring service. Evaluations of CyberMentors suggest that it has reduced the incidence of bullying and violence in schools by 40%, and has reduced exclusion rates by 31% (Banerjee et al, 2010; Mentoring and Befriending Foundation, 2010).

Another important community dimension is engaging parents (DfE, 2015d). This involves developing creative ways to engage and involve parents. Ttofi and Farrington in their 2011 meta-analysis of school anti-bullying interventions highlight how effective home-school links and regular parent meetings alongside other school-based interventions lead to more effective whole school anti-bullying success.

2.3.3. Multi-Component Interventions

Research evidence suggests that universal SEL programmes can impact positively on the number of bullying and violent incidents being reported within the school (Adi et al, 2007b Caplan et al, 1992; Greenberg et al, 1995; Wells et al, 2003). This is because these programmes can positively influence the individual pupil and school environment via the promotion of conflict resolution skills (Garrard and Lipsey, 2007). Ideally, however, universal programmes should sit alongside selected and indicated programmes which aim to tackle school bullying and violence from differing angles. The problem is that at present there is a lack of school-based programmes in the UK focusing solely on youth crime and antisocial behaviour (Ross et al, 2010). There are, however, more programmes that focus on bullying, helping both victims and perpetrators of bullying. Peer mediation is another method which can reduce the effects of bullying (Cowie and Hutson, 2005). Another intervention designed to tackle pupil conflict more effectively and now being used in many schools, is restorative justice (Hopkins, 2004). Research carried out in schools suggests it can effectively reduce bullying by 27% and exclusion by 45% (Garner, 2008). To maximise such success, the restorative justice strategies must be sustained over the long term (Adi et al, 2007b; Browne et al, 2004). Having so many anti-bullying and anti-violence programmes in existence globally makes it difficult for schools to choose which programme to implement. Furthermore caution is needed because not all the programmes are well evidenced; for instance some programmes have resulted in adverse effects, in that more bullying is reported, with more bullying incidents occurring (Weare and Nind, 2011).

2.4. Comprehensive Child and Adolescent Mental Health Services (CAMHS)

Children's mental health services in the UK, unlike schools, have a relatively short history. These have been shaped by policy and newly found empirical knowledge, which over the years has dictated changes in service delivery and clinical practice. CAMHS origins can be traced back to the 1920s and the child guidance movement (Cottrell and Kraam, 2005). CAMHS were, however, not recognised as a specialist psychiatric service in their own right until the 1950s (Hersov, 1986), and were not radically reformed and overhauled until the 1990s when the Health Advisory Service recommended a new four tiered service model (see figure 1 below) (National Health Service Health Advisory Service, 1995). This model was designed to ensure children and their families had access to a comprehensive range of mental health support according to their level of need. This allowed CAMHS to move away from its traditional service model that saw it sitting solely as a specialist service, by enabling the service to support more children experiencing different levels of mental health difficulty and allowing children and families easier access to the service. CAMHS capacity, therefore, had to be promoted by making more agencies responsible for the welfare of children (HAS, 1995). From this, evolved the comprehensive CAMHS model, see figure 1, which aimed to commission more robust seamless mental health provision (The National Health Advisory, 1995; The National Service Framework, DH/DfES, 2004a).

Figure 1: The 4 Tier Model of CAMHS

Tier 4 - children with severe mental disorders
Highly specialist

Tier 3 - **children with mental disorders**
Professionals working together as a close multi-disciplinary team (MDT).

Tier 2 - children at risk or with mild emotional/ behavioural or mental health problems
Professionals allied to mental health who come from various disciplines.

Tier 1 - all children
Professionals who are likely to be the first point of contact with the child. e.g. GPs, teachers, youth workers.

CAMHS services continue to commission more comprehensive CAMHS, whereby universal, targeted and specialised services aim to ensure every child receives quicker, more effective access to CAMHS services and the evidenced interventions they require. (DCSF/DH, 2008; DH, 2015; House of Commons Health Committee; 2014). CAMHS, however, are still relatively small in size and cover wide geographical areas so ensuring a seamless easily accessible service is a continual challenge. Services, therefore, continue to evolve to suit need and demand. Currently for example, many CAMHS services are moving away from the tiered model, because it has been criticised for being too inflexible to meet the individualised needs of differing clients (DH, 2015; Wolpert et al, 2014).

As well as adopting new service models CAMHS services also need to reach out to more children by adopting new ways of working. Schools play a crucial part in this, especially as they enable CAMHS to expand their community provision in a number of none stigmatising and innovative ways (Pugh and Statham, 2006; Scott et al, 2001). Some of the specialist programmes that CAMHS practitioners have helped to deliver in schools have already been outlined in earlier sections of this chapter; sections 1.4.1 to 1.4.4 will, however, discuss more specifically how CAMHS have consulted and liaised with schools

in order to bridge the interface of primary care and specialist services, by increasing skills and capacity to assist more children in need.

2.4.1. Bridging the Gap: The Primary Mental Health Worker (PMHW)

A new interfacing role known as the PMHW was recommended in 1995. The purpose of the new role was to help CAMHS services more effectively bridge tier 1 services, mainly schools (Health Advisory Service, 1995). This professional role is now primarily a consultative, supervisory and training role; however, PMHWs also undertook some interventional work with children and their families (Gale and Vostanis et al, 2003; Hickey et al, 2010).

Evaluations of the PMHW role have suggested that this has been successful in interfacing with schools, through training and supervision which enhanced the skills and confidence of tier 1 staff. PMHWs have also been pivotal in identifying more children with mental health problems and offering early supportive interventions (Atkinson et al, 2010; Bradley et al, 2009; Callaghan et al, 2003; DCSF/DH, 2008). PMHWs can also reach out to a larger number of children with low level mental health problems, who might not otherwise have received support from specialist services (Atkinson et al, 2010, Hickey et al, 2010). The introduction of this new role has also reduced referral to tier 3 CAMHS by enhancing the process of tier 2 service screening, therefore preventing delays in treatment by ensuring that children receive the most appropriate care (Atkinson et al, 2010). In contrast, there is limited evidence on how this is perceived by school staff (Hickey, ibid). Some CAMHS have reported difficulties in introducing PMHWs, by reporting team tensions and conflict because of role ambiguity or misinterpretations, and this has, unfortunately, led to retention and recruitment problems (Atkinson et al, 2010). Due to these problems, CAMHS should define clear goals and strategic direction in order that senior professionals working in the PMHW role are well supported and can achieve their full potential (MacDonald et al, 2004). The concern, however, is the lack of any further national strategy, as since Atkinson's positive evaluation of the role in 2010 there has been no further strategic direction. Furthermore, the current socioeconomical climate which has led to a loss of resources at the interface, has put the role in jeopardy.

2.4.2. *Tier 1 and 2 Collaborative School Interventions*

The National Advisory Service similarly recommended that CAMHS should expand and develop their tier 2 delivery. The core business of tier 2 services is to support tier 1 professionals in recognising and preventing mental health problems. Tier 2 services offer early assessment and direct, briefer evidenced clinical interventions to children and their families with less defined emotional symptoms and problems. Tier 2 services, by linking and consulting with tier 1 services, may also assist in improving detection of mental health difficulty and in fast tracking referrals to specialist services when required (NICE, 2005; Worrall-Davies et al, 2004). Statistics indicate that these services have reduced referrals to tier 3 service, therefore enhancing the capacity of CAMHS as a whole, and ensuring that tier 3 teams are better equipped to support children with severe difficulties (Barnes et al, 2006; DCSF/DH, 2008). Nevertheless, evidence ascertaining the true impact of tier 2 service development on schools is lacking; this may be because of the lack of uniformity in national service delivery, with some counties offering more school support than others (Salmond and Jim, 2007). More specific projects carried out by tier 2 CAMHS in schools do, however, provide a better insight into the potential benefit of collaboration and joint working initiatives between CAMHS and schools, examples of which is the One Stop Shop 'OSS' project, Behavioural and Education Support Teams (BEST) teams and the Targeted Mental Health in Schools (TaMHS) project. These projects have all aimed to promote the mental health and well-being of school pupils, as well as offering early treatment intervention.

OSSs are purposefully situated in easy to reach locations, many of which are in secondary schools. They are commonly run by School Nurses or PMHWs and provide young people with convenient access to mental health advice and support. Trained OSS workers are able to identify difficulties, offer support or sign post care to other agencies and, when complex needs are identified, act as a gate keeper to specialist CAMHS. OSS are in the early stages of implementation, but pilot data suggests that they have been well received by young people (DH/Public Health England, 2013). It is emphasised, however, that for these projects to be implemented successfully, staff not conventionally trained in mental health, such as school or paediatric nurses, must receive appropriate training, as evidence suggests that many tier 1 workers do not

presently feel suitably skilled to deal with the complex cases that they are often presented with (Leighton et al, 2003).

Another example of a collaborative consultation and support initiative, especially funded up until 2006, and one which CAMHS practitioners were actively involved in, was the 'Behavioural and Education Support Teams (BESTS). These teams of multi-disciplinary professionals, jointly consulted together to support children and young people, aged 5-18 years of age, who were considered to have or to be at risk of developing behavioural or emotional problems (Halsey et al, 2005). Evaluations of BESTS suggested they successfully supported primary school and secondary schools by identifying the children and families who were deemed most at risk and in need of support. BESTS offered whole school support as well as group or more intensive individualised care. It was often CAMHS practitioners who played a key part in providing this support (Salmon and Kirby, 2008). BESTS saw an improvement in pupil behaviour, attendance, as well as a decline in exclusions (Hallam et al, 2005).

A major multi-agency initiative taken up by selected schools between 2008 and 2011 was the TaMHS project, which was a collaborative initiative that aimed to promote the mental health of school pupils, by providing timely early and targeted specialist intervention to school children aged 5-13, who were at risk of developing mental health problems (DCSF, 2008b). TaMHS' work in many cases also extended the remit of the (SEAL) programme by providing more targeted SEL work. The TaMHS evaluation suggested that compared to schools not implementing TaMHS, when this initiative was carried out in schools, it impacted successfully on primary school children's behaviour with behavioural problems reducing (Wolpert et al, 2011). TaMHS did not, however, influence their emotional problems nor did it have an impact on older secondary school children with either emotional or behavioural problems (Wolpert, ibid). The project did, however, strengthen the collaboration between schools, CAMHS and other helping services. National projects like TaMHS and BESTS have, therefore, reached some promising findings, but they are unlikely to continue in their previous form because funding is no longer available. This has been found to be a constant hindrance for similar short term initiatives.

A service that is, however, presently receiving government funding is the Improving Access to Psychological Therapies (IAPT) programme. IAPT was introduced in 2006 to provide evidence-based psychological treatment to adults suffering from depression and anxiety, therefore giving an alternative to medication (DH, 2009). The IAPT service expanded in 2011 to broaden its remit to include children and young people (CYP IAPT). Unlike adult IAPT, whereby new services were developed, CYP IAPT set out to promote the comprehensiveness of CAMHS services, building a more collaborative relationship between children, young people, families and therapists and improving the quality of care in its existing services, already located in health, social care, education and the third sector (Bala and Maguire, 2011; Wolpert et al, 2012). Existing staff were then trained in evidence-based treatments, namely Cognitive Behavioural Therapy, Parent Training programmes, Family Therapy and Interpersonal Psychotherapy. All the psychological treatments are approved by NICE and aim to support the recovery of children and young people with mental health problems (Badham and YoungMinds, 2011) and all intervention is routinely monitored so outcomes of treatment can be measured. IAPT is likely to have an impact on CAMHS delivery from tier 1 through to tier 4; however, as yet it is early days as to how it will impact upon schools. A recent CYP IAPT does suggest, however, that progress is being made in counselling provision in schools (NHS, IAPT Newsletter, Sept 2014, p.5).

2.4.3. Promoting Recovery in Collaboration

Government policy places an emphasis on the need for CAMHS to promote the best evidence-based care (DH, 2010a; DH, 2011; DH, 2013; DH, 2015). It has been suggested that children with mental health problems such as ADHD and conduct disorders benefit from what is termed multi-modal psychosocial interventions or a variety of interventions together (Evans, 2006; NICE; 2013; Power et al, 2012). For example, children with ADHD and conduct disorders benefit from a combination of home and school-based activity (Cooper and Jacob, 2011a). Children diagnosed with ADHD should ideally receive school-based intervention, parent training and pharmacological treatment (NICE, 2008). Delivering co-ordinated multi-modal treatments is, however, complex because of the need for joint funding and agreements; therefore, collaborative consultation between schools and other agencies is recommended to ensure an

individualised care package is planned and managed more efficiently (DuPaul et al, 2011b; LeFever et al, 2002; Salmon and Kirby, 2008; Stoltz et al, 2012).

Worrall-Davies and Cottrell (2009) highlight that when children with complex mental health needs require the help and support of differing agencies, a professional, acting as a key worker, should co-ordinate services, thus improve the quality of life for the child and family. This role forges better relationships between services, leading to quicker access when required. This reduces the stress levels of all who are concerned; professionals and the family. For instance, BESTS have successfully offered intensive key worker support to individual children and their families when they have more complex difficulties (Halsey et al, 2005).

Pettitt (2003) also highlights the importance of CAMHS workers adopting a key worker role in order to bridge the divide between education and health, as this leads to improved child behaviour, peer relationships and academic attainment. The evaluation of TaMHS has also found that secondary school children with identified problems benefit from greater inter-agency working. (Wolpert et al, 2011). This evaluation cites the Common Assessment Framework (CAF)[5] meeting as a good working example of a collaborative multi-agency working model that can be utilised effectively when pupils are experiencing mental health problems. CAF meetings aim to meet the additional needs of pupils who are not progressing at school because of a broad range of BESD or learning difficulties (excluding child protection issues). The CAF process is a voluntary process which requires the school to work in close partnership with the pupil, their family, and any key professionals supporting the child's welfare. It is, however a voluntary process (Children's Workforce Development Council, 2009; Easton et al, 2011; Wolpert et al, 2011).

2.4.4. *CAMHS Training and Education Initiatives*

Government Policy recommends that school teachers are tier 1 mental health professionals (DfES, 2003; DH/DfES 2004b; DH, 2006). In this role they should assume responsibility in the early identification of children with mental health problems and

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[5] The Common Assessment Framework is a standardised process whereby practitioners can identify a child's or young person's needs early, assess needs holistically, deliver coordinated services and review progress.

refer them for appropriate support as required (Adelman and Taylor, 2006; Rothi et al, 2006). Many highlight, however, that teachers feel inadequately prepared (Gowers et al, 2004; Leighton, 2003). A number of health sector training initiatives have been developed for tier 1 practitioners. An example of one well evaluated training programme, adapted for training teachers in depression detection, is the 'Mental Health First Aid' course. This was developed in Australia in 2001 and has now been rolled out in over 7 countries, one of which is the UK (Jorm and Kitchener, 2010). This short intensive course has proven to be successful in impacting positively on teacher confidence, knowledge, attitudes and skill acquisition in mental health and led to positive changes in teacher behaviour (Jorm et al, 2010).

Another key tier 1 worker, who assists school staff in supporting the most emotionally vulnerable youngsters in schools, is the school nurse (Leighton, 2003). Some CAMHS training programmes have targeted school nurses in helping them to improve their ability to detect mental distress and/or mental disorders like depression. These training courses are well evaluated and appear to bolster the confidence, skills and knowledge of school nurses (Leighton, ibid). Many argue, however, that school nurses need more enhanced training in complex mental health needs for which post-graduate university courses are more appropriate (Haddad et al, 2010). Furthermore there is an argument that the school nurse role needs more clarity as they often feel pressurised from both sectors.

Training the tier 1 workforce in mental health detection and management is problematic, as at this time of austerity, releasing staff to attend training is sometimes not feasible; therefore, in recent years there has been a move towards e-learning packages for non-health professionals. One example is MindEd, funded by the Department of Health and developed by the Royal College of Paediatrics and Child Health and written by experts in child and mental health as part of the child and young people's IAPT programme. This aims to help educational staff to recognise and support children and young people with mental health problems. The e-portal includes specific support material in relation to helping adults to identify children with a mental condition. The question, however, is whether e-learning is sufficient as this does not

allow for the sharing of knowledge and experiences, which are important when identifying subtle emotional signs of distress.

Less evidence is available on training programmes for CAMHS practitioners about education (Vostanis et al, 2010). Training provided by those in education around school difficulties could provide excellent shared learning opportunities, and a forum for professionals to meet and gain a better understanding of each other's roles and language (Hulme and Cracknell in Campbell and Groundwater-Smith, 2010). Other than the conventional conference forum, cross multi-disciplinary training for CAMHS and education workers is scarce (Vostanis et al, 2010).

2.5. Summary

An abundance of evidence has been illustrated in Chapters 1 and 2 that highlights the need for secondary schools to play a central part in supporting the emotional well-being and mental health of the nation's children, as this promotes health, life chances and learning. The challenges, however, are that this adds another component to an already busy and diverse school agenda, which prioritises teaching over pastoral support. Requesting that schools alone detect, promote and support the mental health of their pupils is not feasible, hence the need to work in partnership with other agencies. Together the best methods of assisting these children can be identified and the gaps in interagency provision revealed.

The evidence reviewed so far has outlined a range of interventions to protect, prevent and support child mental health, including specialist universal and targeted programmes, whole school approaches and individual interventions. What is, however, consistently missing amidst this literature is the voice of the young person experiencing intrinsic mental health difficulty, their thoughts, feelings and wishes, especially in the stressful secondary school years. This research, therefore, aimed to reveal the seldom heard voice of these children exploring their perception of need across their life domains so that their viewpoint can be considered when identifying the gaps in the school and health provision offered to this large and vulnerable young population.

CHAPTER 3: METHODS

3.0. Introduction

This chapter critically discusses the research methods used when carrying out this study. It begins by outlining the primary question alongside the core aims and objectives of the research, all of which have been framed in relation to the underpinning theoretical perspective. Contextual information and justifications for decisions made regarding sampling are presented in section 3.4. The data collection methods and how these were shaped following preliminary consultation and trialling are discussed in section 3.5. Following this, in section 3.6, there is a full account of the analysis procedures. Given the sensitive nature of the research and the potential vulnerability of the population studied, a great deal of attention was paid to the ethical parameters of the research. The ethical considerations, especially in relation to carrying out research with children, are therefore discussed in section 3.7. The importance of ensuring the quality of a qualitative research study has been acknowledged from study commencement to finalisation hence the study's quality markers are critically discussed in the final section of this chapter: section 3.8.

3.1. The Research Question, Aims and Objectives

The proposed research question has guided the parameters of this study (Robson, 2011), and the literature outlined in Chapters 1 and 2 has confirmed the suitability of these parameters and how the research question may be answered. The primary research question proposed was:

How can young people aged 14 -16 years of age, who are identified with emotional mental health problems, be better supported in mainstream education?

The parameters dictated the focus of this study be on young people aged 14 -16 years, with intrinsic distress and in mainstream education. Some of the rationale for this has already been presented in Chapters 1 and 2, in that mental health problems amongst children of this age rises (Green et al, 2005). The chief reason for this focus was the apparent lack of research carried out in the field examining or exploring the needs of young people with intrinsic emotional difficulties (Cooper, 2010; Reddy and Newman,

2009a). The emphasis on mainstream education was influenced by other researchers highlighting the complexity of supporting the well-being of young people in larger secondary school institutions (Best, 2007; Kyriacou, 2001; Wigelsworth et al, 2011).

How this primary question should be answered was determined by the lack of research exploring the perceptions of young people with identified mental health problems in the school setting (Cefai and Cooper, 2010; O'Reilly et al, 2012; Sellman, 2009; Simons, 2014), and hence why the emphasis of this study has been on obtaining the rarely heard 'voice' of these children. This focus is further supported by society as a whole, which at the time of undertaking this research, has begun to place a heavy emphasis on ensuring the voices of vulnerable children should be heard and taken seriously. This has been escalated by major reports such as Lampard's (2014) inquiry into the NHS's failings in dealing with matters concerning Jimmy Savile, and serious case reviews like Daniel Pelka's (2013), all of which highlight what can occur when adults do not listen to children (Gray and Watt, 2013; Lock, 2013).

The literature also dictated that the adults closest to vulnerable children (their parents and school teachers) should also have their say, as many researchers in the field have stressed the important part parents and teachers play in supporting these children, both educationally and psychologically (Hill and Taylor, 2004). Yet it has been highlighted that their viewpoint is rarely reported (Reinke et al, 2011: Sawyer, 2011). Obtaining the viewpoint of parents and teachers also abided by a common ground rule proposed by many specialists who work within the child and family arena. This is that children cannot be understood alone and must be considered in the ecological microsystem they live within (Bowen, 1978; Waddell et al, 2005). The theory is that children do not develop and function in isolation but are influenced through their relationships and interactions with others, especially their family, school teachers and friends (Bronfenbrenner 1979; Zins, et al, 2004).

The aims of the research were therefore:
- To explore the perceptions of young people experiencing intrinsic emotional mental health problems, ascertaining what they perceive they require and need in order to feel better supported at school.

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- To explore the additional perceptions of the adults closest to these children (their parents and supporting teachers) in order to obtain a broader insight into these children's requirements and the challenges these adults face when supporting the education of these children.

The objectives of this study were:

- To enhance understanding of this population of young people's perceived needs, by ensuring their voice can be obtained, heard, acknowledged and disseminated, therefore ensuring that their say may play a part in influencing future research and directives that relate to their school lives and their mental health.

- To enhance understanding of how the education and healthcare sectors may better support this population of young people and also provide further insight into how they may work better together to support the needs of these children.

3.2. The Qualitative Design

In order to capture the voice and perceptions of this unique population of school children, a qualitative research design was adopted, as this acknowledges the complexity of capturing human experience. It is the recommended method when exploring, discovering and revealing people's experiences and perceptions (Corbin and Strauss, 2008). This design allowed for the popularly held adult beliefs about what children need, to be put aside, and the present layers of understanding peeled back in order to get a better insight into the true perceptions of what the young people who are living with mental health problems feel they need today.

Qualitative and quantitative research are both logical, quantitative however, differs in research design in that it uses numbers to reveal knowledge (Holloway and Wheeler, 2010); whilst qualitative generates knowledge via a philosophical interpretation or critique, of words (Fossey et al 2002). It is this knowledge that has the potential to reveal hidden truths and myths about life and provide new insights that can either complement previously generated research, or dispute other researchers' findings (Fossey ibid).

An indication of using a qualitative design is that this allows data to be generated in words, commonly allowing for intuitive and empathetic engagement with participants

(Robson, 2011). This is especially advantageous when carrying out research with vulnerable populations, particularly when exploring sensitive topics like 'mental health' (Bryman, 2008). Qualitative designs offer a flexibility that ensures that issues are safely explored. Quantitative methods can also be used to investigate perceptions, but they lack the advantage of having the interpersonal engagement with the research subjects, and therefore risk being insensitive and hence not ideal when exploring delicate sensitive issues with vulnerable patients (McCosker et al, 2001).

Qualitative research encompasses a broad range of traditional methodological perspectives, all of which are underpinned by particular philosophical or epistemological positions (Robson, 2011). This study adopted a qualitative design utilising a thematic approach, which has a modern history in comparison to the more traditional qualitative approaches. It has, only recently, been recognised as a distinctive qualitative method in its own right, mainly elevated to this status by work carried out by Braun and Clarke (2006). They emphasised its unique strengths, in that it is a more general qualitative approach, because it is epistemologically flexible (O'Reilly et al, 2013b), therefore a particular philosophical orientation is not dictated. This allows the researcher to be more flexible in their research design, which is particularly advantageous when carrying out research with vulnerable children (Freeman and Mathison, 2009).

3.3. The Theoretical Framework

A qualitative study using a thematic design must remain consistent in its epistemological position (Cresswell, 2007). A prerequisite, therefore, is that a theoretical framework is adopted, as this helps to construct and direct the study, from its beginning to its end (Braun and Clarke, 2013). Adopting a framework also ensures the data is analysed consistently (Braun and Clarke, ibid). It was, therefore, important to be transparent about the theoretical framework to inform the reader as to how the research knowledge has been studied and derived (Anfara and Mertz, 2006; Bryman, 2008; Caelli et al, 2003; Madill et al, 2000; Meyrick, 2006).

The theoretical framework that underpinned this study was a macro social constructionist stance. Macro social constructionists advocate that human beings are bound up by cultural, historical, political, economic and linguistic influences (Grubrium

and Holstein, 2008). It holds the perspective that humans make sense of their world through complex sociological and psychological processes that are both unconscious and conscious (Burr, 2003). This interactional process is what enables people to learn and how society as a whole forms its knowledge and it is knowledge that exerts power (Berger and Luckmann, 1966; Cuncliffe, 2008; Hruby, 2001). It is argued that this largely unnoticed phenomenon is one that constructs our reality and how we make sense of our world (Berger and Luckmann, 1966).

Macro social constructionism forms the basis of many studies exploring children's experiences (Fraser et al, 2004; James et al, 1998; Waller, 2009). This is because there is a widely held viewpoint that childhood, and indeed parenthood, are social constructed phenomena and are subject to change depending on the knowledge and discourse of the day (Greig et al, 2007; Roy-Chowdhury, 2010). This is why social researchers recommend that the realities of children are revisited at regular intervals (Gergen, 2001), as children in contemporary settings will have different life experiences and perceptions to children from previous generations (Coyl, 2009; Duckett et al, 2008; Holland et al, 2008). For example, a popular viewpoint held by macro social constructionists studying previous generations of children was that their lives were controlled and shaped by their adult carers. This was based on the theory that true child identity did not exist in its own right because it was repressed by the power of the adult, and that childhood was merely a preparation stage for adulthood (Holland ibid; Walkerdine, 2004). Conversely, those studying modern day childhood identity have proposed that children and young people are not as strongly influenced by adult power as they used to be, and appear to be more autonomous in their thinking (Waller, 2009; Christensen and O'Brien, 2003). Therefore by adopting a macro social constructionist epistemological position this contemporary thinking about child identity can be analysed in more depth. Thus an analysis underpinned by macro social constructionism is timely, because present international and national legislation advocates that children must have a legitimate say in social, educational and health reform.

Macro social constructionism is also known to be a useful theoretical framework to obtain a better insight into the human experience of illness, disability (Anastasio and Kauffman, 2011; Priya, 2012) and resilience (Ungar, 2004), as it can reveal the subtle

nuances of suffering and healing, and the complexities that surround illness in today's society (Priya, ibid). This was particularly pertinent because this study hoped to reveal more about how young people experienced their mental health problems, how they coped and/or suffered at school and how they made sense of these experiences considering society's influence.

3.4. Sample and Context

This study used a selective purposive sampling technique, which is a commonly used qualitative sampling method (Patton, 1990; Tong et al, 2007). The use of purposive sampling ensured that the participants recruited to this study were based upon the requirements of the research questions (Robson, 2011). The school pupils living with mental health problems were at the heart of this study; however, the additional perceptions of the adults closest to them provided a deeper insight into the unique experiences of these young people, giving more insight into this group of children's holistic needs (Greig, 2007). This cumulative layered approach to data collection although not usual to qualitative research is useful, because it can explore more than one perspective on a particular matter (Ringstad, 2010) and this can promote research rigour (Corbin and Strauss, 2008). Figure 2, below, details visually this cumulative approach to data generation.

Figure 2: Data Generation

Data Set 1
Young People (YP)

Data Set 2
Parent (P)

Combined data generates a deeper understanding of the young participants' school lives, their influences and their experiences.

Data Set 3
Education Staff (ES)
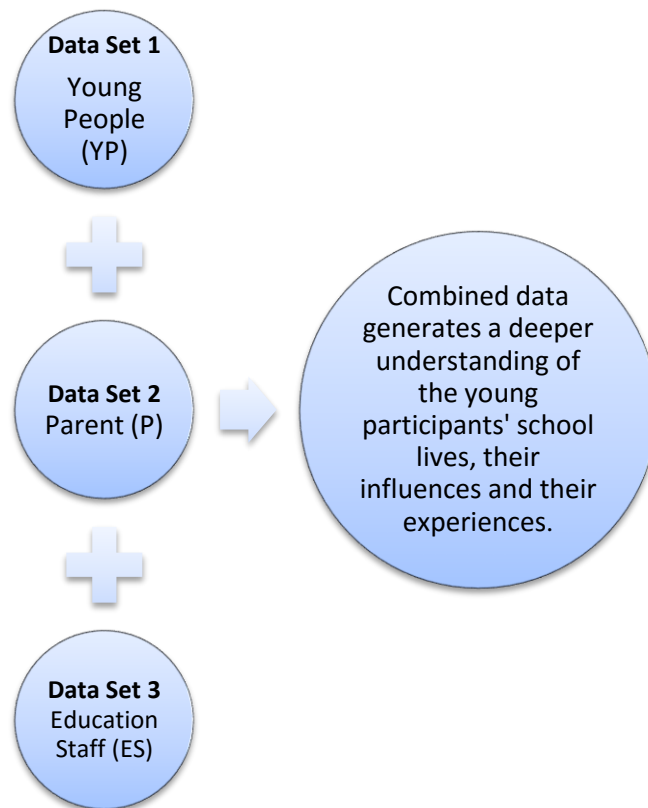
3.4.1. Sample Size

In keeping with qualitative design the data was drawn from a small sample (Fossey, 2002, Holliday, 2002), as the emphasis was on obtaining rich revealing information rather than generalising the research findings to the wider population (Holloway and Wheeler, 2010). The final sample size was determined by the sampling adequacy marker of data saturation. This marker of saturation allows qualitative researchers to judge if sufficient data has been obtained to address the research question. This occurs when the data reveals nothing new; no new ideas, beliefs, themes or topics (Francis et al, 2010). It is considered by some to be the gold star standard indicating the sample size for qualitative methods (Guest et al, 2006) and is commonly the marker that dictates cessation of data collection when carrying out research with children (O'Reilly and Parker, 2013).

Saturation of data set 1 and 2 was achieved at 11 participants, with three additional participants being recruited to each data set for certainty. Francis et al (2010) advise that three additional interviews are conducted to test for thematic saturation after it is concluded that the thematic saturation point has been reached. Once saturation is confirmed, it is considered unethical to collect further data, as no new relevant knowledge is likely to be obtained, and this potentially can waste participants' time (Francis ibid). A sample size of 14 was also in keeping with Guest et al (2006), who recommend 12 qualitative interviews.

The rule of thematic saturation could not be used when marking the cessation of the educational staff (ES) interviews. This was because the educational staff recruitment process dictated that interviews would naturally cease when the young participant interviews ended. Recruiting to this sample was not as straightforward as anticipated, with many reasons complicating data set 3 recruitment (see Table 3). A sample size of nine did, however, yield sufficient and useful data to support the young people's data, which was the focal area of this study's enquiry.

3.4.2.   Inclusion and Exclusion Criteria, and Sample Characteristics

Purposive sampling dictates that a narrow inclusion and exclusion criteria be adopted when carrying out a study. This ensures the right people, best suited to answer the research question, are asked to participate in the study (Bryman, 2007; Tong et al, 2007; Tuckett, 2004). Table 3 gives a summary of the inclusion and exclusion criteria. Aspects more explicitly linked to consent and capacity is marked by an asterisk and these are discussed further in section 3.7.2 of this chapter.

Table 3: Inclusion and Exclusion Criteria

Data Set	Inclusion Criteria	Exclusion Criteria
1 (YP)	• Aged 14 -16 years. • In mainstream education. • Identified by CAMHS as having mental health difficulties, whereby distress was predominately internalised. • Domiciled with parents. • Consented to participate and parental consent was also obtained*.	• Diagnosed with autism or having a primary diagnosis of ADHD or Conduct Disorder. • No longer receiving CAMHS support. • Any family (child or parent) who required interpreting services. • A looked after child not domiciled with parents. • A child deemed to be too unwell to take part in the study*.
2 (Ps)	• Parent(s) of a young person who has consented to participate. • Domiciled with their child. • Consented to participate and provided their assent for their child to participate*.	• Any family (child or parent) who would have required interpreting services. • Any parent who did not have the capacity to consent*. • Foster parents or guardians of a child.
3 (ES)	• Named as a supporting school staff member by a family who took part in the study. • Educational staff working in the mainstream education and employed by the school. • Consented to participate*.	• Special school settings staff, i.e. teaching teams from CAMHS or pupil referral units. • Any staff member whereby the Head of School did not give permission for them to take part*.

The 14 young people all had a significant mental health problem which warranted CAMHS input. Many of the participants had co-existing emotional, behavioural and learning difficulties. Children with a primary diagnosis of ADHD were purposefully excluded from the study because their behaviour was likely to be more visible and easier to detect (Dupaul et al, 2011a; Power et al, 2012). Children diagnosed with autism and co-occurring mental health problems were also excluded as their problems are known to be complex and more difficult to evaluate (The National Autistic Society, *You need to know campaign,* 2010).

The inclusion and exclusion criteria also dictated that the young participants be domiciled with their parents; looked after children were therefore excluded. This was because empirical evidence proposes these children have unique problems which require separate study (Whiting and Robert, 2004; Winter, 2006). Two long-term

adopted children were included because they had been stably domiciled with their adopted parents, for over seven years. It was interesting to note that these children did not identify many more differing school issues to those identified by children from one parent or blended families. Table 4 outlines the characteristics of data set 1, detailing their age, key diagnosis, any co-existing difficulties and study level (GCSE/ 'A' level).

The selection criteria for parents to participate in this study were less complex, in that the main inclusion criterion was that their child had consented to participate in the study. Families were excluded if they required interpreting services, for either the child or the parent, as this small scale study did not have funds secured for this service. In total, 16 parents were interviewed, as two interviews were conducted with both parents present. Table 5 outlines the main characteristics of data set 2.

Table 4: Characteristics of Data Set 1 (Young People)

Young People Data Set 1	Sex F = Female M = Male	Age	Identified Mental Health Problem	Learning difficulty √ = Yes X = No	GCSE/ A Level Study
YPc	F	14	Anxiety with Obsessive Compulsive Disorder (OCD)	√	GSCE
YPf	F	15	Anorexia Nervosa and anxiety disorder	×	GSCE
YPg	M	16	Anxiety with Post-Traumatic Stress Disorder	√	GCSE
YPj	F	16	Depression and self-harming behaviour	×	GCSE
YPu	F	15	Anxiety	×	GSCE
YPw	F	15	Depression	×	GSCE
YPa	M	16	Depression and self-harming behaviour	×	A Level
YPk	M	14	Anxiety	×	GSCE
YPb	F	15	Depression and self-harming behaviour	×	GSCE
YPz	F	16	Anorexia Nervosa	×	GSCE
YPx	F	16	Anxiety	×	GCSE
YPe	F	16	Depression and anxiety	√	A Level
YPn	F	15	Depression and past psychosis	×	GSCE
YPd	F	16	Depression and self-harming behaviour	×	GSCE

Table 5: Characteristics of Data Set 2 (Parents)

Parent Data Set 2	Parents interviewed M = Mother F = Father	Supporting ES named √ = Yes × = No	Named ES participated in study
Pu	M	√	√
Pz	M	√	√
Pm1 and Pm2	M & F	√	√
Pf	F	√	√
Pq	M	× *(Family chose not to name a teacher)*	
Pa	M	√	√
Pb	M	√	√
Ph	M	√	× *(School did not respond to communication)*
Ps1 and Ps2	M & F	√	√
Pk	M	√	× *(Teacher made redundant)*
Pg	M	√	× *(Head Teacher refused permission)*
Pn	M	√	√
Px	M	√	√
Po	M	√	× *(School did not respond to communication)*

The inclusion and exclusion criteria for the participating school staff dictated that they were recruited from mainstream schools. Nine educational staff participants were successfully recruited from 8 out of the 10 schools the children attended across one county in England. Table 6 outlines the key characteristics of data set 3 and the school they were recruited from.

It was important that all the ES participants were named as a 'supporting' school staff member, because a fundamental part of this design was to explore what the young people themselves perceived to be supportive. The initial research proposal dictated that a teacher be named; however, during the early participant interviews it became apparent that some young people (n=4), did not wish to name a teacher but felt happy to name another member of their school staff. As the central focus was on the young participant's viewpoint, a decision was made to interview any named school staff. Tuckett (2004) noted that this type of change in the research protocol is not uncommon when adopting a purposive sampling method, because matters and problems frequently unfold during the research process.

Table 6: Characteristics of Data Set 3 (Educational Staff)

ES Data Set 3	Form Tutor √ - Yes X - No	Educational Role	Last School Ofsted Inspection Category O = Outstanding G = Good RI = Requires improvement
Ti	√	Teacher	RI
Ty	√	Teacher	G
Ts	X	Teacher	O
Tc	X	Teaching Support	G
Te	X	Teaching Support	G
Tr	√	Teacher	O
Tw	√	Teacher	G
Tm	X	Teaching Support	O
Tk	√	Teacher	RI

3.4.3. Recruitment Procedure

This study used a gatekeeper approach to recruit participants, as this ensured that children and their parents were safely and sensitively recruited. The definition of a gatekeeper is a person who has the authority to deny or give permission to a researcher to access the population they want to study (O'Reilly et al, 2013b). Many consider the

gatekeeper approach to be useful when recruiting child participants (Emmel et al, 2007; Carroll-Lind et al, 2006; Wiles et al, 2005).

When it came to recruiting data sets 1 and 2 three gatekeepers were identified. Two were situated in CAMHS services and one at an additional NHS recruitment site, (the Early Intervention Psychosis Service (EIPS). All sites were located in the same county. The EIPS was identified as a recruitment site later in the study, as young people under the age of 18 attending this service had CAMHS clinicians overseeing their care. The three gatekeepers were all senior nurse managers, and all were experienced in Child and Adolescent Mental Health.

Recruitment took place between September 2011 and October 2013. The gatekeeper approach was found to have key benefits, in that recruiting through CAMHS gatekeepers ensured that only children with 'identified' mental health problems participated in the study. CAMHS gatekeepers also ensured that families were safely recruited in that the capacity of children and their families could be assessed by expert practitioners. (See section 3.7.2 which explains capacity and consent in more detail). If a child or parent became distressed, or suggested that they were being harmed in any way, a CAMHS clinician was well placed to intervene using the dictated NHS safeguarding measures. The other advantage of having CAMHS gatekeepers was that they were able to provide key demographic information relating to a consenting family (e.g. their social situation, the child's diagnosis, and any known family or school difficulties). It is particularly important to gather as much detail about vulnerable participants prior to the researcher's contact, so that any potential problems can be more sensitively managed and any undue distress prevented (O'Reilly et al, 2013b).

Another personal benefit of recruiting via CAMHS was that I had already forged good collaborative links with these services when carrying out a lecturer/associate therapist role. Strong links like this are known to aid the recruitment process, possibly due to the gatekeepers having more confidence in the researcher's ability (Morrow and Richards, 1996; O'Reilly et al, 2013b; Wanat, 2008). For instance, in my own case gatekeepers were aware of my clinical expertise and felt assured I was governed by the Nursing Midwifery Council's (NMC) professional code of conduct.

In order to ensure the safe and sensitive recruitment of school staff the NHS ethics panel who approved this study also recommended the use of educational gatekeepers. This recommendation acknowledged that teachers are amongst some of the most overstretched and stressed professional workers (Adera and Bullock, 2010; Kyriacou, 2001; Weare and Nind, 2011). A gatekeeper ensured they too would be safely and sensitively recruited, and that any teacher deemed vulnerable would not be asked to participate in the study. In this instance the gatekeepers were Heads of school or Principals. Notably, only one head teacher refused access to a staff member, due to concerns about the teacher's workload.

The steps carried out to recruit participants to this study are outlined in figure 3 below. An important part of the recruitment process was obtaining the participants' informed consent, and this is discussed in more detail in section 3.7.2 of this chapter.

Figure 3: Recruitment Process

Gatekeeper, in collaboration with CAMHS clinicians, considered the inclusion and exclusion criteria, and identified suitable participants.

Gatekeeper approached parents for their consent to participate in the study and their assent for their child to be invited to take part. **(No further action was taken if parents did not give their consent).**

If parent permission was obtained, the gatekeeper invited the child to take part and their consent was sought. **(No further action was taken if the child did not give consent.)**

Upon consent from parent and child, the gatekeeper contacted the researcher, providing demographic information.

Researcher contacted family to arrange a time and place for interview. **(No further action taken if family at this point no longer wished to participate).**

Child interviewed and then parent(s). If it was the famiy preference, they were interviewed together.

Researcher asked if family were happy to name a supporting school staff member who could be approached. **(No further action taken if family did not wish to name a staff member).**

Researcher contacted the Head of School for permission to approach the named staff member **(No further action taken if permission not granted. Data analysed without the ES perspective).**

Following Head permission, the researcher approached the school staff member to obtain their consent **(No further action taken if consent not given. Data analysed without ES perspective).**

If consent was given, the researcher arranged a time and date for interview to take place at the participant's school

3.5.   Data Collection and Preparation

The primary method of data collection was by a semi-structured interview. This is the most widely used method of collecting qualitative data (Bryman, 2008) especially when gathering sensitive personal information from vulnerable populations (DiCicco-Bloom and Crabtree, 2006; Kvale and Brinkmann, 2009; Roulston, 2010) and children (Mauthner, 1997; Kortesluoma et al, 2002). The semi-structured interview method has the key advantage in that it prioritises the individual being interviewed by sending them a clear signal that their thoughts and experiences are of value. This is especially important for children (Freeman and Mathison, 2009). Social constructionists carrying out children's research emphasise how the research interview allows young people to have more control in the research process, enabling them to speak in their familiar language about the concepts and subjects that interest them. Consequently, any data obtained is more inclined to be co-constructed through a process of collaborative engagement and conversation between child and researcher rather than the data being totally steered from the adult's perspective (Freeman ibid).

The reason for limiting the length of the interview to approximately 40 minutes was decided following discussion at planning stage with school and CAMHS staff. CAMHS staff felt that this timeframe considered the child's vulnerabilities, for instance their ability to concentrate, and the preciousness of the child's and parent's time, especially as many participants were preparing for exams. Meetings with teachers also highlighted that school staff interviews should be a maximum of 40 minutes, as this was consistent with the statutory time they had free for lesson planning. This imposed time limit was not a problem because it is not unusual for qualitative researchers to carry out just one single short semi-structured interview (DiCicco-Bloom and Crabtree, 2006). Additionally experts in child interviewing support the use of short interviews (Kortesluoma et al 2002).

The relatively short period of time to engage with young and adult participants, along with the challenges of engaging meaningfully with the young people, did, however require that special attention be paid to developing, revising and piloting the interview. The proposed research methods were improved upon by adopting participatory research methods. Young people were firstly involved in the development of the

interview tool (five vignettes). Some young people were then asked to comment on the research protocol and the interview content via consultation groups, and finally, on a one-to-one basis when being involved in pilot interviews. This section will detail how these participatory methods influenced this study's development.

3.5.1. Interview Tool: Film Vignettes

It is recommended that any researcher carrying out research with children should develop an interviewing tool kit (Punch, 2006; Teachman and Gibson, 2013). This may consist of photos, pictures, stories, song lyrics or poems (Barker and Weller, 2003; Mauthner, 1997). The interview design kit should aim to enhance the young participant's engagement with the interviewing process. Any tools used should, therefore, be innovative and imaginative in order to add variety and interest to the interview, as this helps to maintain the child's interest and engagement (Cameron, 2005; Hill, 1997). Tools should also look to promote the participants' comfort, enabling them to more easily express their view and therefore any tool should be interactive rather than extractive (Barker and Weller, 2003; Petrie et al, 2006; Punch, 2002). An additional challenge when developing this study's interviewing tool kit was developing suitable tools to engage with teenage participants. This was because it was important any used tool or activity should not be considered childish, as this could lead to the young person disengaging when interviewed (Cameron, 2005; Fraser et al, 2004; Teachman and Gibson, 2013).

Considering the above an interviewing tool kit was developed consisting of five digitally developed film clip vignettes. These were presented in a similar format to a 'YouTube' clip and were shown to the young participants on an iPad. Film clips were chosen over the more traditional written style of vignettes such as poems or written scenarios because modern technology is known to be a more powerful medium to engage with teenagers (Harden et al, 2000). In addition, researchers exploring sensitive issues with teenagers have reported that film clips often promote a more relaxed interview atmosphere and subsequently this can increase the participant's confidence in expressing their views. This ability to feel relaxed when speaking about sensitive topics is especially important when the interviewer is unknown to the young person (Barter and Renold, 2000; Hughes, 1998; Poulou, 2001; Punch, 2002; Wilks, 2004).

A number of challenges were considered in developing fit for purpose vignettes. For instance, Wilson and While (1998) have emphasised the importance of the vignette depicting the young participants' world as opposed to that of the adult researcher. Barter and Renold (2000) and Jenkins et al, (2010) highlight how this type of media can also run the risk of being distant from social reality and if constructed badly, can then run the risk of becoming a source of amusement, thus detracting from the line of enquiry rather than allowing participants to engage with it. It is for these reasons, when developing the vignettes, that participatory research methods were used as young people's expertise and knowledge had the potential to safeguard against such problems arising.

This study sought the assistance of a youth drama group in the production of the vignettes. These young people were amateur actors, aged 14 to 16 years, i.e. the same age of the intended sample. They wrote, developed, and then filmed and directed the vignettes in a school. Their input made the film clips more realistic, in that they were a depiction of modern school life based on their experiences. As recommended by Barter and Renold (2000), the vignettes were purposefully designed to be short and simple (no longer than two minutes in duration). This ensured the research participants had space to define their own situation in their own terms, and were able to express their own views and perceptions, rather than the vignette influencing their beliefs (Barter ibid). (A copy of the USB card containing the film clips is inserted in the back cover of this dissertation). Six short vignettes were made but only five were used. Each vignette depicted a range of emotionally charged school scenarios; these being:

- Vignette 1 – Darren, 15 years, who arrives late to class looking down and fed up.
- Vignette 2 – Katie, 14 years, who is shy and becomes anxious about class group activities.
- Vignette 3 – Joe, 16 years, who gets emotionally upset in class and throws his school bag against the wall.
- Vignette 4 – Kirsty, 16 years, who gets upset and tearful when receiving her exam results.

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- Vignette 5 – Kara, 16 years, who is disruptive in class and answers back[6].
- Vignette 6 – Sam, 16 years, who bullies his classmate during a group drama activity.

3.5.2. Consulting with Young People

Young people can be marginalised and excluded from the process of knowledge production by virtue of their age, (Gallagher, 2004). It is, therefore, recommended that the social constructionist researcher should consult with young people about their proposed methodology and methods prior to their study being conducted (Barker and Weller, 2003; Gallagher, 2004; Willmott, 2010). This can safeguard against doing research, underpinned by adult assumptions on children rather than exploring themes that interest them (Hood et al, 1996).

Another participatory research method this study adopted was lay involvement (Macaulay et al 1999). This ensured the research design and protocol could be further improved prior to carrying out pilot interviews. Young community members were encouraged to share their expert knowledge of being a young person by participating in a Lay Consultancy Group (LCG). Two LCG's were formed, both comprised of willing, articulate teenagers who, to my knowledge, did not have any identified emotional difficulties. One LCG consisted of six youngsters, aged 14 to 16 years, from a rowing club. The other consisted of five 14-year-olds from a scout group. Those who participated in the LCGs commented on the participation information sheets, the interview schedule and the film clip vignettes. The key lessons learnt from the two LCGs were:

I. The vignettes were open to free interpretation and did have the potential to stimulate debate pertinent to the topic under investigation. Feedback from the LCGs suggested the vignette scenarios represented adequately modern day school life, and that the scenarios were plausible, as the LGCs could identify with the scenarios portrayed. They felt however, that the soundtrack over the vignettes should be reviewed and made more youth friendly.

II. It was originally planned that an ice breaker exercise should start the interview, as this acknowledged the literature which highlighted that, the first part of a research

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[6] This vignette was not used as this type of behaviour was not commonly exhibited by the children interviewed.

interview is critical (the first 5 -10 minutes), because this is when the participant is likely to feel their most uncomfortable (DiCicco-Bloom and Crabtree, 2006). Following LCG meetings, however, the ice breaker exercises were deemed unnecessary and too time consuming. Although considered to be fun by the LCG, they also felt these exercises risked being too childish when undertaken by one participant alone. Instead they suggested that the young people's interview should start with a short period of general conversation about school interests and hobbies.

III. Those who participated in the LCGs had reservations about the teacher interview schedule revolving around the vignettes, as they felt that teachers were unlikely to be truthful about what really happens at school. Young people recommended instead that teachers should be asked broader more explorative questions.

3.5.3   Pilot Interviews

Piloting of the semi-structured interview is recommended prior to its application (Kortesluoma et al 2002; Sampson, 2004). It was, however, considered unethical to test the interview process on a vulnerable population of young people with mental health problems. This was because part of the pilot interview process involved them commenting on how they felt about talking about sensitive school topics and how I, the interviewer, made them feel when questioned. The interviews were therefore piloted on four consenting young people, who nearly met the inclusion/exclusion criteria, in that they were aged 14-16 years, in mainstream education but were not experiencing any mental health problems. The parent interviews were piloted on these children's parents. The educational staff interviews were piloted on two secondary school teachers. Minor and major alterations were made to the research protocol following these pilots. Table 7, below, gives a summary of the amendments.

Table 7: Revision of the Interview Schedule Following Pilot

Data Set	Key decisions made about the interview schedule following pilot
1 (YP)	• The vignettes should be used as a non-mandatory tool to aid the interviewing process. • The Interview Guide and structure should be reviewed to make the child interview schedule the same as the adult schedules. • Clinical communication skills should be used, as they helped in more effectively engaging young people at interview.
2 (P)	• Vignettes should not be used as parents could not relate to them. • Clinical communication skills should be used as they were found to more effectively support parents during the interview, especially when conveying more sensitive issues.
3 (ES)	• Young people should be recruited from CAMHS and not schools. • The educational staff interview schedule should be reviewed in order to ensure educational terminology, more familiar to them, be used rather than health terms. • The vignettes should not be used during the educational staff interview, because teachers, when asked about the vignettes, felt their knowledge was being tested. This confirmed the LCG opinion that they needed to be asked broader more explorative questions.

The most significant changes made to the research protocol were a change in the recruitment site and a change in the child interview schedule. The rationale for these changes is discussed in more detail below.

The two teacher pilot interviews highlighted that the original proposed recruitment school site risked recruiting a sample of children that were not best placed to provide data that would answer the research question. The reason for this was that teachers were not always aware of the pupils' mental health problems and also had difficulty in identifying those with mental health issues. The statements, below, illustrate these issues:

> *Pilot Interview 1*
>
> *Teacher: "I think lots of staff simply accept attention seeking behaviour, poor behaviour, and persistent low um level disruption as part of the character of an individual rather than looking at the cause".*

Pilot Interview 2

Teacher: "I am sometimes surprised when we get a psychiatric report back on a child and I will think that doesn't tally with what I see and I think".

Interviewer: "So some kids you know don't overtly show their psychological distress. Is it sometimes missed?"

Teacher: "I suppose I wouldn't know if I had missed it or not"

The above excerpts demonstrate the difficulty teachers had in distinguishing behaviour from emotional distress. It is likely that the all-encompassing terms teachers use like "Behavioural, Emotional and Social Difficulties (BESD)" that describe many types of problematic pupil presentations, ranging from low level disruption to severe psychological distress, do not help teachers in distinguishing between emotional and behavioural difficulties. It was, therefore, felt that recruiting via schools and teacher gatekeepers could risk collecting an inappropriate sample of '*naughty*' children, who were not the focus of this study.

Teacher pilots also revealed that secondary schools did not always have good home-school links, and that teachers did not always have adequate knowledge of the child's family situation. A review of parental engagement practices has highlighted that secondary schools often struggle to forge links with parents, especially with the families of vulnerable pupils (Goodall et al, 2011). One known reason for this is that parents may feel blamed or stigmatised for their child's difficulties, thus resulting in resistance to voice any problems to school staff (Goodall ibid; Meltzer et al, 2011). This was supported by the pilot teacher interviews, as the quote below exemplifies:

Pilot Interview 1

Teacher: "They do not cope with their child's problems very well, because they don't want the stigma of being labelled as somebody with difficulties… there is, however, a resistance to engage and that resistance may also be modelled in the parents as well, because the parents do not want school support."

This statement implies that teachers often did not have sufficient knowledge of pupil's home lives and the vulnerability of a family. Statements such as this therefore raised

concerns whether a teacher gatekeeper could adequately assess the parents' capacity to give informed consent to take part in the study. Consequently it was decided following teacher pilots to recruit the participants through NHS CAMHS, as stated in section 3.3.2, with CAMHS gatekeepers, therefore ensuring that the appropriate children were recruited to the study, and that families were recruited sensitively and safely.

The pilot interviews also indicated that the child interviews and schedules needed to be changed. The originally proposed child interview schedule was different to that of the adult participants, in that it was structured around the five vignettes. Pilot interviews indicated, however, that this discouraged the young participants from talking freely about what mattered to them. Therefore, a key interviewing rule was not being considered, i.e., that the richest interview data is captured when the questions emerge from the interviewee's dialogue (DiCicco-Bloom and Crabtree, 2006). This rule is further emphasised when interviewing children, as they should be free to express what matters to them (Freeman and Mathison, 2009; Mauthner 1997). Considering this, it was decided that the vignettes should not be used if the participant appeared to be freely responding and guiding the interview dialogue. Nevertheless, the pilots demonstrated that the vignettes were a useful tool when a young person was struggling with dialogue.

Piloting also ensured that interviewing skills were practiced and alternative ways of engaging with the young participants could be experimented with. It was particularly important to do this because there was limited time to engage with young participants during the interview. A blend of techniques, learnt at interviewing workshops, were practiced along with the experimentation and adaptation of clinical therapeutic techniques, learnt when undertaking clinical work in child and adolescent counselling mental health, namely motivational interviewing (MI) and solution focused therapy (SF). The rationale for using MI and SF techniques was that broader clinical research has found that these approaches can more successfully engage vulnerable children in therapy (Cameron, 2005; De Jong and Berg, 2008; Pichot and Dolan, 2003). This maybe is because there is no room for power in the engagement process, in that MI encourages the therapist to adopt a subordinate approach, with an empathetic reflective stance, using a lot of positive affirmation and reflective listening (Miller and Rollnick, 2013). SF

methods centre on the child's strengths rather than deficits, and problem-free talk is recommended to initially engage the client (Lethem, 2002). The underpinning philosophy of these approaches fitted well with the social constructionist viewpoints on carrying out interviews with children, therefore making sense to adopt in order to better engage the young participants with the interviewing process. I was mindful, however, of the literature that highlights the key danger of clinicians adopting a dual clinician researcher role. This is that there is a risk of falling into the trap of wishing to help the participant rather than maintaining an enquiring stance (Hart and Crawford-Wright, 1999). For these reasons I audiotaped and transcribed the four YP lay pilots, and critically appraised each interview as recommended by Kvale (1996). In doing this, I reflected on my own interviewing practices, identifying and addressing weaknesses. A summary of my identified weaknesses were:

I. I found that my adult beliefs, experiences and language could sometimes lead to misinterpretation of the child's perspective. Steps were subsequently taken to minimise misinterpretation by checking via clarification statements, that a young participant had understood what I was asking, and likewise using a clarification statement to check out any teenage terminology or language that I was unfamiliar with.

II. I found that I would often repeat a question. This practice then led to the lay pilot participants saying something to please me, as they thought they had said something wrong. Birbeck and Drummond (2007) have highlighted this phenomenon, noting that it is common to children when being interviewed. To prevent this practice, I would use a summary reflection prior to asking a differently worded question. I also considered other methods of ensuring the young participants felt empowered to express their own perceptions, and were as free from my influence or adult coercion. I therefore attempted to promote symmetry in the interview relationship by following the recommendations of Freeman and Mathison (2009, p.61), who advise the researcher to adopt "the least adult role". For example, introducing themselves as a student researcher instead of using an official working role. Also prior to interview commencement the young participant should be reassured by a statement that emphasises there

are no right or wrong answers to the research questions, and instead it is their viewpoints that are of interest. I, therefore, carried forward these recommendations when doing my own research interviews.

III.   I found I would sometimes use leading questions. It is important to refrain from this practice as this form of questioning can be perceived as subtle adult coercion. This can, in turn, threaten to distort the power balance between the child and the researcher, because the young participant is led to believe they should answer the question in a certain way (Kvale and Brinkmann, 2009). I may not have been able to rectify this style completely; however, any data obtained via a leading question was highlighted at the transcribing stage and omitted from the analysis.

3.5.4.   *The Interview Guide*

The semi-structured interview is the primary research tool recommended when exploring sensitive topics with vulnerable participants (Freeman and Mathison, 2009). It is more frequently organised around a set of predetermined open-ended questions, with other questions emerging from the resulting dialogue between interviewer and interviewee (DiCicco-Bloom and Crabtree, 2006). Preliminary consultation and pilot testing of the interviews led to the development of a clearer and more concise interview structure. It was concluded that the three participants' interviews should be the same length (40 minutes) and the guides be closely linked to the broad research question stated on page 44, with similar participant sub-questions, as outlined in Table 8 below.

Each participant interview, therefore, was framed similarly in that it focused on what they perceived the school's strengths to be, the weaknesses or difficulties encountered at school, what was needed at school and the perceived barriers that hindered these needs being met (see appendix 2: The interview guide). The Interview Guide also contained prompt questions which were slightly differently phrased, depending on the participant being interviewed.

Framing all three participant interviews in this way created a clearer and more consistent interview framework. This approach also ensured issues were more thoroughly explored as data was accumulated, layer by layer, from the different

participants. The broad questions also allowed the participants room for more spontaneous expression of what mattered to them. Spontaneity is known to enrich the interview (Kvale, 2006). Additionally, the less rigid interview framework ensured there was more flexibility to ask the participants about themes or topics that had emerged in previous interviews (Bryman, 2008; Fossey et al, 2002).

Table 8: Participant Sub-Questions

Data Set	Participant Sub-Questions	
Young People	a)	What did they perceive to be helpful and unhelpful at school and why?
	b)	What did they perceive their needs to be at school and why?
	c)	What did they perceive constrained their needs and why?
Parents	a)	What did they perceive as helpful and unhelpful school support for themselves and their child and why?
	b)	What did they perceive the needs of their child to be at school and why?
	c)	What did they feel constrained their child's needs being met at school and why?
Educational Staff	a)	What did they perceive as helpful and unhelpful in school, classroom and teaching intervention for pupils with emotional difficulties and why?
	b)	What did they perceive the needs of this group of pupils to be and why?
	c)	What did they feel constrained the needs of these pupils and why?

The only difference between young people's interviews and those of adult participants was the use of film clip vignettes. These were sometimes utilised with the young people to aid exploration. The vignettes proved to be a valuable tool when a young participant was showing signs of uneasiness, or reverting to minimal responses such as '*yes', 'no', 'don't know'* or silences. In these instances the vignettes allowed the participant to talk more comfortably, in the third person about the fictional character depicted in the vignette. This would often then lead them naturally to share their personal school situation (see appendix 3: an extract illustrating how a vignette was used during interview). The vignettes also proved to be a useful medium when the young participants would stray from the topic under investigation, in that they quickly re-focused their attention on the topic. This was useful for young people with impaired concentration or pressured excitable speech. The film clip vignettes were used in nine

out of the 14 young participant interviews, and these participants tended to be younger, aged 14 and 15.

3.5.5. The Interview Setting

Tong (2007) highlights the importance of ensuring the context in which the data was collected is described, because this can illuminate why the participants responded in a particular way. Eleven out of the 14 young people and parent interviews were carried out in the family home. Three families chose to be interviewed in a private room at their local CAMH services, and all educational staff who participated in this study were interviewed at their school. It was originally envisaged that young people and their parents would be interviewed at their local CAMHS service. It became apparent, however, when commencing the interviews that most of the participating families had a preference to be interviewed in their own home. It was important that participants were not inconvenienced by the interview process, so permission was sought from the Local Research Development office for participants to be interviewed at home.

The home environment is known to be an appropriate setting for research with young people, because of its comfort and convenience (Parker and O'Reilly, 2013). A chief disadvantage is that it can be unpredictable (MacDonald, 2008), as there can be many distractions, which can impact negatively on data collection (Jones, 2008). Negotiating private space in the family home can be difficult, especially in situations where some family members lack respect for a young person's right to privacy (MacDonald, 2008). A key methodological challenge, therefore, in interviewing young participants and their parents at home was ensuring that the interview environment was as private and relaxed as it could be. To achieve this, I politely asked all family members, prior to the interview, if they were happy for key living space, like the lounge, conservatory or dining room to be occupied for the interview duration.

In the main, securing private space in the home was not found to be difficult, and distractions were limited to pets or young children wandering into the room. If the interruption was perceived to be an invasion of privacy, by either participant or myself, the interview was suspended for a short duration until the situation was resolved. Other participant interviews carried out at either CAMHS or schools were carried out in a

private room. Even there, however, there were some interruptions. For example, clinical or school staff wandering into the room in error, or in the case of interviews being carried out at school, bells and fire alarms disrupting the interviewing process.

An unanticipated benefit of carrying out the young participants' and parent interviews in the home and the teacher interviews in schools, was that it gave me a further window into the participant's lives. For instance, whilst waiting for teaching staff in school receptions, I read notice boards, absorbed the school atmosphere and observed the interaction of pupils and teachers going about their daily business. Whilst sitting in the young people's homes, I had a brief first hand glimpse into their social status and their family relationships. My thoughts and opinions were written in a reflective diary and were considered when analysing the data.

3.5.6. *Interview Data Capture*

This study used audio recording to capture the words spoken by the participants in their interviews, as this is a recommended method when carrying out qualitative research adopting a thematic design (Braun and Clarke, 2013). Audio recording was preferred to video recording, because it considered the mental health vulnerabilities of this particular young participant group. For example, mental health problems are often known to impact negatively upon an individual's anxiety, confidence and self-esteem levels which can be linked to body image sensitivities (Petersen, 1994; Steese et al 2006). Video recording might, therefore, be more anxiety provoking for this particular group of youngsters.

The interviews were recorded using a small discreet digital audio MP3 player. The limitation of this form of data capture was that it was not able to capture the body language of the participants. Therefore, as recommended by Braun and Clarke (2013), immediately following the interview, field notes were recorded onto the MP3 player. These notes detailed the context of the interview, any distractions and disruptions, and recalled observations related to the participant's body language and emotions during the interview.

3.5.7. *Interview Transcription*

Transcription of audio recorded interviews is considered a necessary first stage of data analysis (Bird, 2005; Lapadat and Lindsay, 1999; O'Connell and Kowal, 1995). Transcription involves the researcher converting spoken word into verbatim text, which in this form can serve as a memory aid (Braun and Clarke, 2013). There is, however, a school of thought that argues against transcription because it is at this point the original data is most likely to be skewed (Davidson, 2010; Jaffe, 2007; Kvale 1996; Lapadat, 2000). This is because paralinguistic and vocal variety is lost in transcription. Also, spoken words run the risk of being converted in meaning by incorrect punctuation or the misinterpretation of a word (Braun and Clarke, 2013). Generally, though, it is common practice for qualitative researchers to transcribe audio recorded data, as it allows for more robust examination of what participants have said (Bryman, 2008; DiCicco-Bloom and Crabtree, 2006; O'Reilly and Parker, 2014).

There are various levels of transcription and debates regarding how to represent participants' spoken words (Corden and Sainsbury, 2006). These vary from light verbatim transcription systems to detailed specialised methodologies such as the Jefferson system. The transcription system used for this data was Braun and Clarke's (2013) orthographic transcription which is a recommended method when carrying out a thematic social constructionist study. Orthographic transcription recommends that the digital transcripts should have little or no punctuation. Non-verbal utterances, like "*um*" and "*ah*" and paralinguistic factors such as coughing, sneezing, and laughing, as well as pauses, should be noted on the transcript, and that any words that are difficult to interpret are withheld from the transcription (see appendix 4: an extract from one transcript[7]. Poland (1995) recommends that close attention is also paid to reflexivity during the transcription process. Reflective notes were therefore recorded on a digital device and re-listened to when transcribing. During transcription any possible poor interviewing practice or potential misinterpretations by myself or the participant, were

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[7] For ethical reasons a full transcript is not included in this thesis. This is because permission was only granted from participants to use none identifiable extracts from their interview. Furthermore the exclusion of full transcript is a safeguard against deductive disclosure.

also highlighted in red pen and reflexive notes made, therefore ensuring any notes were taken into consideration when analysing the data.

One of the limitations of the transcription process is that it can be time consuming, but is considered a crucial part of the research process (Bird, 2005; Bryman, 2008). It is therefore recommended that transcription should be carried out by the researcher themselves (Tilley, 2003). I transcribed all the data obtained from the young participants and their parents, as I acknowledged this data was the study's central focus. A professional transcriber did, however, assist with the transcription of six teacher interviews. These transcripts were, however, revisited and carefully checked by the researcher as recommended by Bryman (2008).

3.6. Data Analysis

As stated earlier in this chapter, this qualitative study adopted a thematic design. Thematic Analysis is a commonly used process to analyse this type of data (Braun and Clarke, 2006). Thematic Analysis is known to work well with a social constructionist theoretical framework (Braun and Clarke, ibid) and is particularly useful when examining differences and similarities across a number of interview data sets (Joffe and Yardly, 2004). It is also a favoured analysis method when carrying out research that aims to be disseminated to a broader lay audience (Braun and Clarke 2013). This is because, compared to other more traditional analytical methods, it possesses less complicated research rhetoric which can complicate dissemination, as the findings are more difficult to disseminate in universal comprehendible terms (Boyatzis, 1998; Crabtree and Miller, 1999). The issue of being able to disseminate findings in universal terms, was an important consideration when developing this study, as it was perceived this study's findings may be of interest to a broad range of multi-agency professional or lay persons all involved in promoting and supporting the well-being and mental health of children.

Thematic Analysis is sometimes referred to as Pattern Analysis (Braun and Clarke, 2013). It is a logical, systematic approach to code, categorise and theme emerging patterns in the data, in order to formulate knowledge and accurately report the data (Boyatzis, 1998; Braun and Clarke, 2013). Coding begins the analytical process by taking a segment of the accumulated data, either a word, sentence or paragraph and assigning it a

concept that describes similar segments of data (Robson, 2011). These codes are then grouped together into categories which form patterns or themes containing relevant data that assists in providing answers to the research question (Braun and Clarke, 2006).

3.6.1. The Analytical Process

Thematic Analysis generally commences at the beginning of the last interview and ceases at data collection (Braun and Clarke, 2013). This study's analysis began at the end of data collection (March 2013) and was completed in March 2014. The thematic process was made as rigorous as possible, by adopting an eleven-step analytical process outlined by O'Reilly and Parker (2014). This systematic process incorporates within it Boyatzis' (1998) first, second and third order coding, and also places great emphasis throughout on reflexivity and the importance of being transparent in describing and justifying any deviations from the analytical process (O'Reilly et al, 2013b; Poland, 1995).

NVivo 10 was the computer software that was used to help organise, store, search and condense the large amount of data (audio recordings of interviews, verbatim transcripts and reflexive memos). NVivo is known to enhance the robustness of the coding and categorising process especially when analysing large amounts of qualitative data (Bryman, 2008; Edhlund and McDougall, 2012; Robson, 2007). Figure 4 gives details of the sequence of data set analysis and when NVivo software was used. NVivo also allowed for some qualitative data also to be presented in a numerical form, which is now a more commonly accepted qualitative practice (Fossey et al, 2002).

Figure 4: The Analytical Process

Revising the data	• The research questions, raw interviews, transcripts and reflective notes revisited, listened to and re-read. This was important because data can be lost in the transcription process (Dicicco-Bloom and Crabtree, 2006; Robson, 2011). • Further reflective notes were made when undertaking this task.
1st order coding	• Complete coding was then undertaken. This is a process termed by Braun and Clarke (2013, Pp 206) whereby each transcription is examined sentence by sentence with segments of verbatim assigned to an existing or new code. • NVivo computer software assisted in this process; each code was entitled and put into a NVivo folder known as a node. Each node then served as a container of information. This stored all the accompanying narrative, and any reflective memos relating to the code.
2nd order coding	• Each data set was examined separately and any identified codes were grouped together into categories. This enabled patterns to emerge. New NVivo node folders were used and data was re-structured into categorised nodes that had hierarchies known as subnodes. • Braun and Clarke (2006) recommend the use of visual representations to help sort the codes into categories and themes. Mind mapping tools aided in this task by presenting the data visually. Free hand drawing was also used in order to enhance the analysis.
3rd order coding	• Each categorised data set was examined to identify key themes. A thematic network exercise helped to achieve this (Attride-Stirling, 2001). Data not directly linked to the analytical question was shifted and placed into an obsolete folder.
Repeat 3rd order coding	• An additional step was added to the analytical process because this study was complicated by having to consider three participant data sets. This analytical step involved examining the themes across all three data sets and carrying out a second mapping exercise. • Presenting the data visually on a linear chart, the similarities and differences in the data set perspectives helped to determine which data would not be reported in this thesis.
Write up and Analysis	• The relevant themes that addressed the research question were identified. Quotations from the data were abstracted in order to support and validate the identified themes (Bryman, 2008; Corden and Sainsbury, 2006) and these were analysed.
Analysis and thesis write up	

3.6.2. *Promoting Analytical Trustworthiness*

Qualitative research is often a non-linear, complicated and unpredictable undertaking (Sinkovics and Alfoldi, 2012). Part of what makes it unpredictable is that at the analysis stage it involves data reduction (Attride-Stirling, 2001). It is, therefore, important to be as transparent about this process as possible, so as to demonstrate the trustworthiness of the data. There are, however, no clear rules as to how the qualitative researcher should do this (Sinkovics and Alfoldi, 2012). Specialists in qualitative analysis recommend methods that can help promote analytical transparency, some of which were used when analysing this study's data; these methods are outlined below.

The first part of the data organisation process was to organise the data using the first order codes, and to collapse them into second order codes. Table 9 below details the number of first and second order codes. This process resulted in 42 second order codes in the young person data set, 64 second order codes in the parent data set and 50 second order codes in the teacher data set.

Table 9: First and Second Order Coding

	Data set 1 - YP	Data set 2 - P	Data set 3 - ES
First order codes	232	188	127
Second order codes	42	64	50

The second stage of data organisation was to collapse these second order codes into third order codes or themes. The overarching themes were encapsulated into a global theme. 'A thematic networking exercise' was carried out as recommended by Attride-Stirling (2001, Pp 388), to aid the organisation of analysis. This provided an opportunity to revisit the raw data, so that it could be scrutinised and rechecked, thus ensuring it had been interpreted correctly. Figures 5 and 6 detail the two thematic networking exercises.

Figure 5: Thematic Map 1 - Global Theme 1
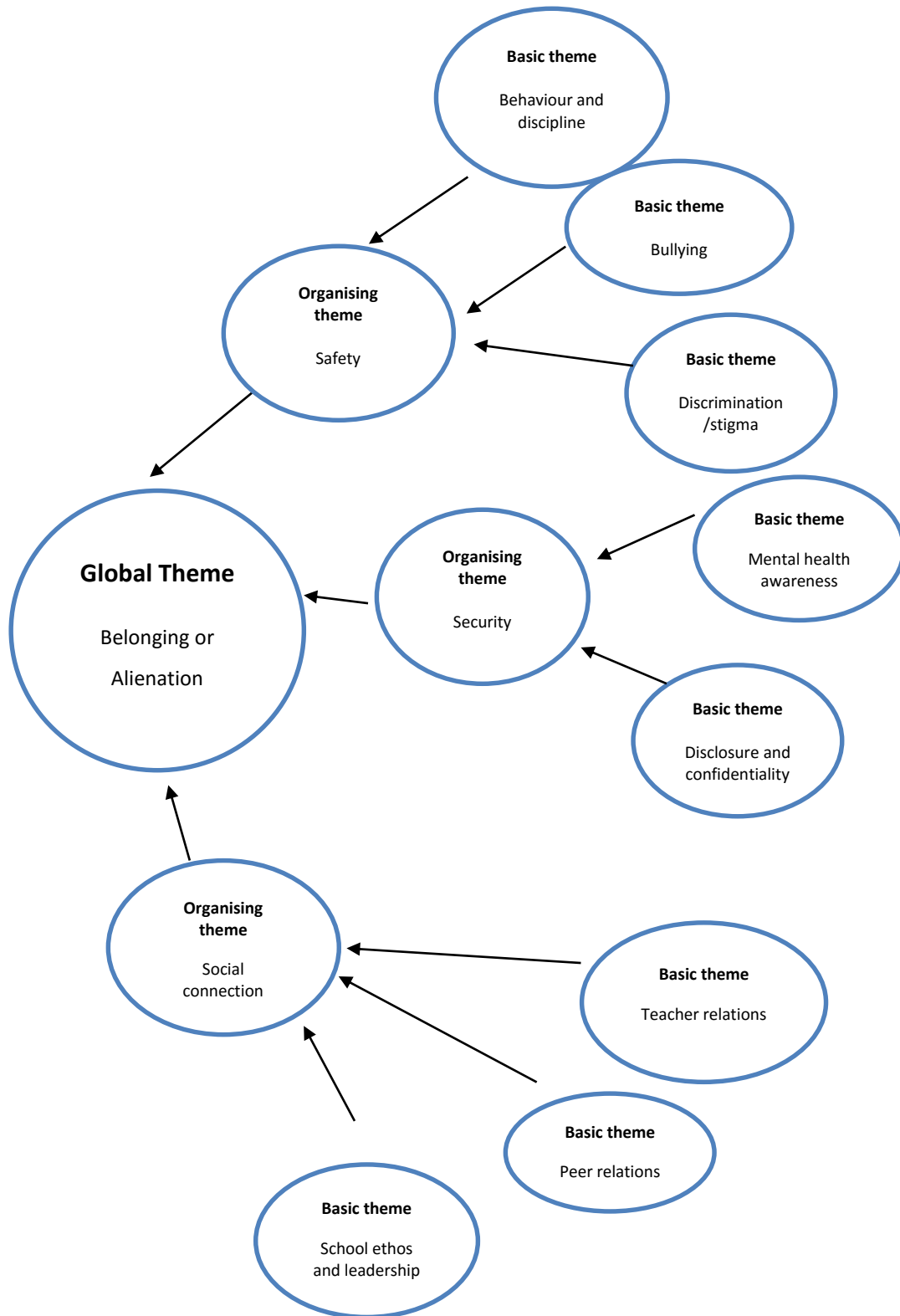
Figure 6: Thematic Map 2 – Global Theme 2
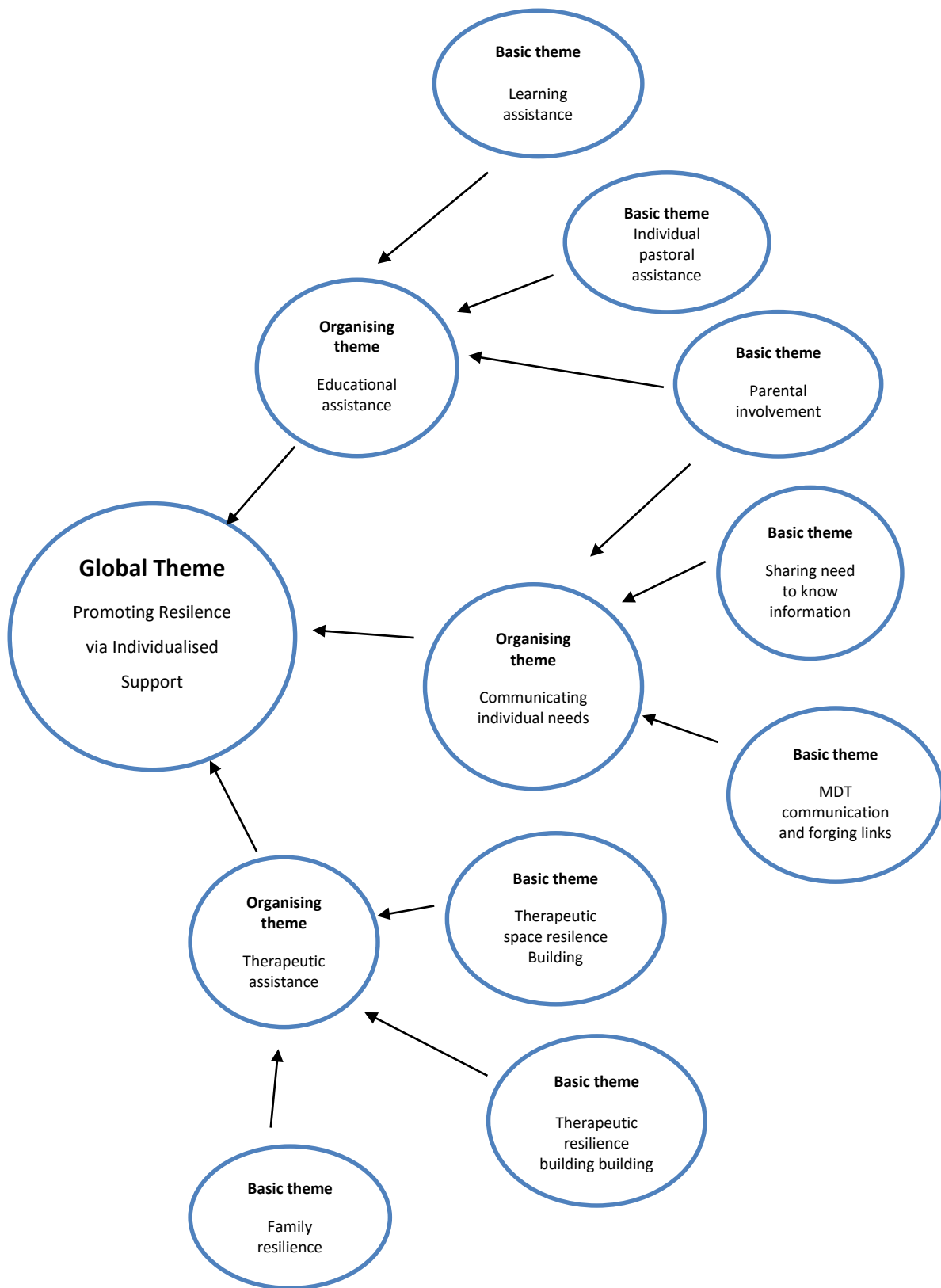
The final stage of the data organisation process was to begin the analytic process by comparing and contrasting the themes between and across groups of participants and developing an analytic argument that conveyed the meanings held in the participant narratives. This final stage of data analysis used numerical data to help identify the proportion of disconnection and convergence in thinking of the overall sample. Although numerical data is not commonly encouraged in qualitative research (Pyett, 2003), there is a contemporary school of thought that allows for some quasi-numerical presentation. This is as long as it adds value, is legitimate and complements the research (Maxwell, 2010). A simple mapping exercise post third order coding enabled the reduced data, already established into grouped categories to be plotted onto a cumulative frequency graph which was adapted from Francis et al, 2010, p.1241). The frequency graph (figure 7) along with a bar chart converting frequency into percentages (figure 8), helped better identify adult and child shared beliefs and ensured that the child perspective remained at the heart of this study, as data, more pertinent to the parents and educational staff, but rarely mentioned by the young people, when plotted in linear format was more clearly demonstrated. Figure 7 and 8, below demonstrate, for instance, how four themes 'discipline and behaviour' 'school leadership', 'parental involvement' and 'family resilience', were frequently referenced by either the parents or educational staff, but were rarely spoken about by children. This data was therefore not extensively reported on in this thesis.
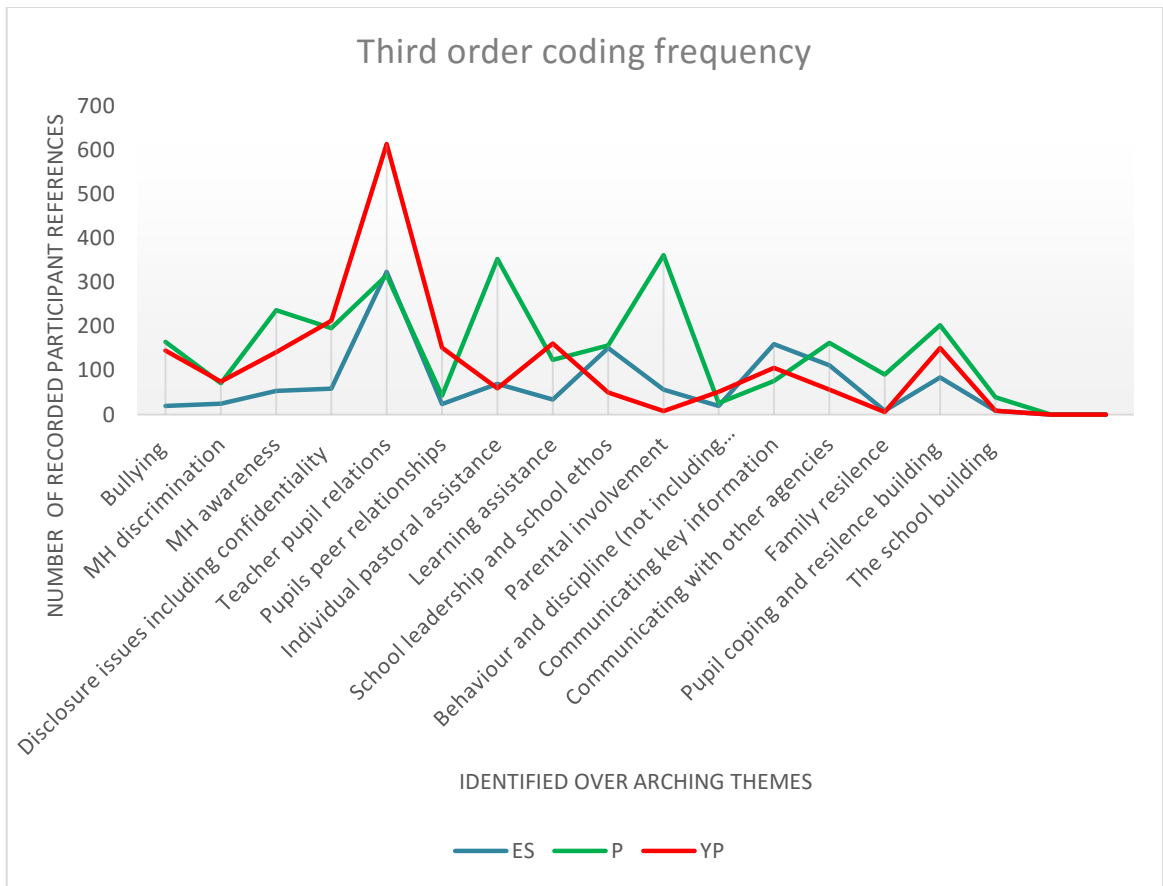
Figure 7: Third Order Coding Frequency Chart
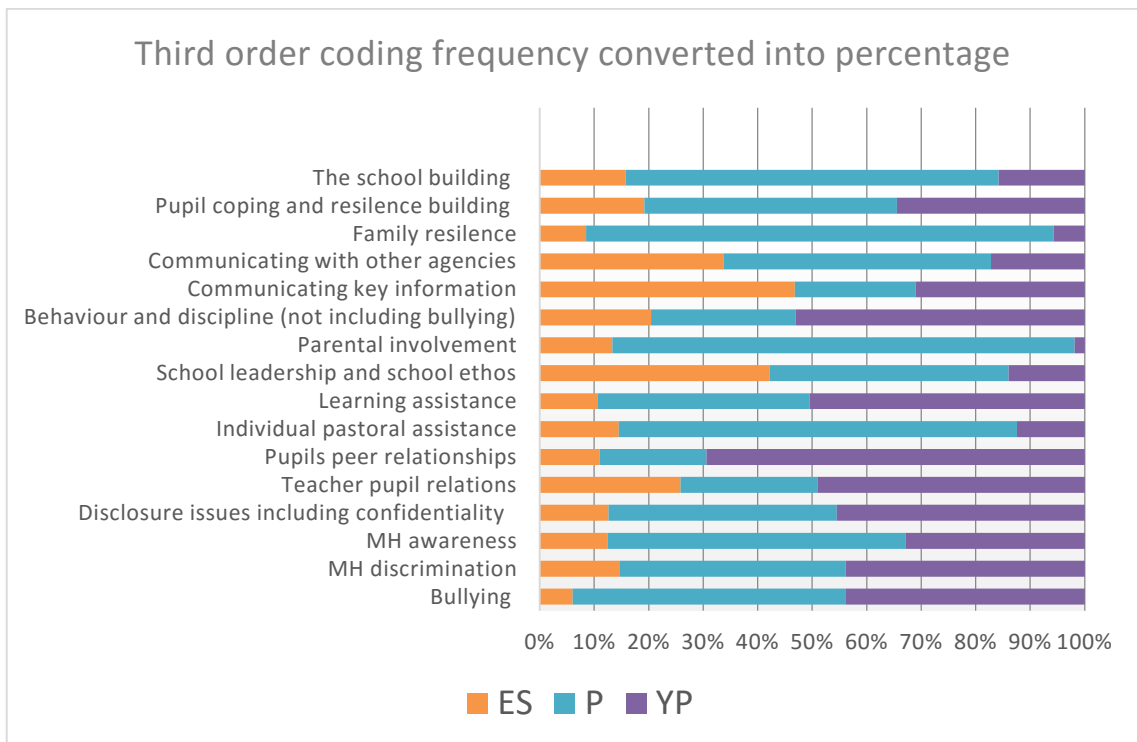
Figure 8: Third Order Frequency Converted into Percentages

3.7. Ethics

A research proposal was submitted in July 2010 to the University of Leicester College of Medicine, Biological Sciences and Psychology Committee for Research Ethics concerning Human Subjects (Non-NHS) in July 2010. This proposal sought to recruit the sample through schools. For reasons already explained in section 3.5.3, it subsequently became necessary to recruit the sample through CAMHS. A proposal was, therefore, submitted to the NHS National Research Ethics Service (NRes), as NHS patients would be participating in the study. Ethical approval for this study was obtained on 6th June 2011 (see appendix 5: confirmation of ethical opinion). In line with the NHS protocol the Local Research and Development office granted permission to access NHS patients in the locality on the 22nd July 2011 (see appendix 6: study approval letter). This process ensured that all the NHS statutory safeguarding requirements were undertaken i.e. obtaining a research passport and a CRB Criminal Records Bureau check (now referred to as DBS, Disclosure and Barring Service).

3.7.1. Confidentiality

Maintaining confidentiality and protecting anonymity when carrying out qualitative research can be a challenge, as there is not only a risk of external breaches to wider society, but also internal breaches (Kaiser, 2009). Internal breaches can lead to a risk of deductive disclosure, whereby confidentiality and anonymity is no longer protected because the researcher inadvertently reveals certain characteristics, or unique identifiers of an individual participant, which then enables other participants to identify them (Tolich, 2004). Adopting precautionary methods to guard against such breaches is known to significantly reduce the risk of harm (Morse, 2001). Although it is argued that absolute confidentiality and anonymity cannot be assured (Wiles et al, 2006), nevertheless, every precaution must be taken when carrying out research with vulnerable populations, as it is they who will face harmful consequences if their identities are revealed (Baez, 2002).

Typically, to safeguard against external confidentiality breaches, routine precautionary measures that focus on protecting the participant's anonymity were used. This study adopted a number of safeguards. For instance, measures were taken to ensure that any stored demographic or participant interview data were anonymised by using

respondent codes instead of participant names. These codes were only known to myself and not documented anywhere. Written data was 'cleaned', so identifiable participant characteristics were removed. The Participation Information (PIS) forms highlighted additional precautionary measures, for example reminding participants prior to interview not to name people or places and, when interviewing in the home, highlighting to participants that the interview would be suspended if a third party was to interrupt and the interview would only recommence when appropriate to do so (Ritchie and Lewis, 2003). As per ethical guidelines participant data was stored securely (Robson, 2011). All digital files were stored using an encrypted password. Personal details or any other traceable data was also cleaned from any digital files stored on the computer. MP3 audio files were transferred to a passworded computer after each interview. Following transfer of the material, the original files were immediately deleted from the recording device. Hard copies of the signed consent forms and any field notes, containing personal participant data such as name and address, were also secured in a locked filing cabinet accessible by myself only.

More challenging, however, was ensuring internal confidentiality and guarding against deductive disclosure (Tolich, 2004). This was because I was interviewing three participants' children, parents and school staff members all of whom were linked. A number of steps were taken to safeguard against deductive disclosure. One being that the child, their parent and supportive teacher were purposefully made more difficult to link together. This was done by assigning each participant a random number and letter. The tables listing the data set characteristics (see section 3.4.2) were separated, so that participants could not be easily distinguished by the participants themselves. Furthermore when presenting the findings any personal details or characteristics that risked any participant identifying another participant were omitted, by citing the participant verbatim and then stating *(omitted);* a footnote was attached highlighting the omission. This practice was, however, carried out infrequently, as Wiles (2005) highlights that omitting or changing the data can impact upon data trustworthiness and therefore should be limited. I also made a decision, following the first participant interview that despite the consent form saying:

> *"I would also like to talk to one of your teachers or school staff members that you feel has supported you at school. They will know you have named them as a supporting teacher/staff member, but I will not share any further information that you or your parents tell me, with them".*

I decided to withhold the patient's name from the named educational staff so as to protect the child and parents internal confidentiality, thus safeguarding them from any potential stigmatisation or retribution. This decision was taken despite 13 out of 14 families naming a supporting teacher/staff member, whom they were happy for me to approach and for me to give them their name. Arguably it was the participants' right to decide if their identity should be disclosed, but I was mindful of the literature which suggests that children do not often understand the meaning of confidentiality (Hurley and Underwood, 2002; O'Reilly et al, 2012). I was therefore ethically and morally responsible for ensuring no harm came to the participants. Other researchers have highlighted the importance of not being complacent when carrying out qualitative research with children because similar ethical problems can arise following ethical approval and when carrying out field work (O'Reilly et al, 2013b).

The ethics of confidentiality and anonymity are particularly important when involving young people in research, as there is not only a moral but also a legal responsibility to report potential harm which may override any other concern (Taylor and Adelman, 1998). The limitations of my ability to maintain confidentiality were reiterated to participants, using the statement below, which is contained on the young person PIS form (see appendix 7: Young people's PIS form).

> *"Any personal information I collect from you will remain confidential. The only time I need to break this rule is if you say anybody is being hurt in any way. In this situation, I would need to speak to a member of the CAMHS team".*

3.7.2. Obtaining Consent

Obtaining informed consent from participants to take part in the study ensured that each participant had given their voluntary consent and that this had been obtained safely and sensitively, minimising any form of coercion. Ensuring voluntary consent required participants to have the competence to understand any of the information

given to them about the study: therefore, an understanding of their capacity to weigh up the advantages and disadvantages of participation was needed. Another important part of the consenting process was ensuring that clear and concise information was provided about the nature and purpose of the study, so that participants were fully informed of what taking part meant and involved.

This study used the CAMHS gatekeepers to ascertain the child's and parents' intellectual and mental competency to take part in the study, as they had good knowledge of the families they worked with. They were also best placed to carry out this assessment because they were familiar with the legal framework of the Mental Health Capacity Act (Mental Capacity Act, 2005), which helped guide assessment of patient capacity to make treatment decisions. [8] I was dependent on the gatekeepers to assess the young person's mental and intellectual capacity to voluntarily take part in this study despite the fact that all children were over the age of 14 and relatively likely to be competent to give informed consent (Morrow and Richards, 1996). The reason they were attending CAMHS, however, was because their mental health was unpredictable and, therefore, they were vulnerable to relapse. This could inadvertently impact upon their capacity to give informed consent. Only one potential young participant's mental state deteriorated following informed consent; the gatekeeper, therefore, deemed them not to have the mental health capacity to take part in the study.

One of the gatekeeper's tasks was to ensure that potential participants were fully informed about the nature, purpose, benefits and risks of taking part. This information was conveyed via the PIS form in a face-to-face meeting with the gatekeeper. This meeting ensured that participants had the time to discuss any aspect of the study and ask questions (Stafford and Smith, 2009). The young peoples and parents PIS and consent forms adhered to the Medical Research Council (2004) Guidelines (*MRC Ethics Guide: Medical research involving children)* and the NHS Ethics Guidelines (2011) (see

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[8] A child's capacity is assessed by the clinician asking the following questions: Can the child understand the information given to them? Can the child retain this information long enough to be able to make a decision? Can the child weigh up this information and make a decision? Can the child communicate their decision back to you?

appendix 7, 8, 9 and 10). A key recommendation of this guidance is that a young person's PIS form should be shorter and more concisely written than an adult PIS form. All the forms stressed the importance of participants having freedom of choice to take part in the study and detailed their right to withdraw their consent at any time. It was also important that potential participants were given time to think about their decision prior to signing the consent form (Wiles et al, 2005). After consent was given to the gatekeeper, participants were also able to discuss the nature and purpose of the study with myself, when I made initial contact with the family. This followed the recommended ethical protocol for obtaining consent, which is that it should be a continuing process rather than a single occurrence (Alderson and Morrow, 2004; Wiles et al, 2005; Stafford and Smith, 2009).

When seeking informed consent, the gatekeepers approached the parents prior to approaching their child. The reason was that ethical guidelines advise that when involving a vulnerable group, such as children with illness, permission from their parents must be sought first before approaching their child (Allmark, 2002; Rossi et al, 2003). This also acknowledges UK law which states that children under the age of 18 are not fully autonomous, and parents are able to overrule the child (Heath et al, 2007). To safeguard against coercion, the family was reminded by the gatekeeper that if they or their child did not wish to participate this would not impact on their child's CAMHS care.

Many studies carrying out research with children ask parents for their informed consent and the child's assent (O'Reilly et al, 2013b). Assent refers to the notion that the young person complies with or implies agreement to engage in the research. To participate in this study any potential child participant, however, was asked for their informed consent. This was consistent with the social constructionist viewpoint when carrying out research with children, in that it assures the young participants felt valued and empowered, and were not made to feel they were being treated differently from the adults participating in the study (Freeman and Mathison, 2009).

As discussed in section 3.4.3 of this chapter, educational staff were recruited safely and sensitively by also adopting a gatekeeper approach. Each head teacher was contacted via an email. The PIS and consent form, plus the NRes approval letter were attached to

the email. Following permission from the head teacher consent was provided to contact the staff member. I then made initial contact with the prospective participant via the telephone. I fully informed them about the study and then sent them an email with the PIS form (see appendix 11) and a consent form (see appendix 12).

3.7.3. Reciprocity

Reciprocity is an important part of the informing process and is connected to confidentiality and consent. It involves ensuring that potential participants are fully informed of what will happen to the information they provide (Flewitt, 2005). It was, therefore, important that the PIS form informed the participants how the research finding would be reported and that the consent form asked their permission to use non-identifiable quotations for publication. Participants were also asked if they would like to receive a leaflet summarising the research findings upon completion of the study. All the research participants who have ticked this consent form box will receive a summary of the findings along with a letter inviting them to feedback any thoughts they have about them[9].

Participants were also clearly informed as to what they may individually gain from taking part in the research (NHS, National Research Ethics Service, 2011). Linked closely to this is the ethical issue of ensuring participants are not exploited for the researcher's own personal gain. To safeguard against this, it is recommended that they are acknowledged for their contributions and reimbursed in various ways for their efforts (DiCicco-Bloom and Crabtree, 2006). This research was non-therapeutic, in that a child was unlikely to benefit therapeutically from taking part (Allmark, 2002). The young person's PIS form made this clear by stating:

> "I cannot promise that this study will help you, but it may help us learn more about how we can help young people like yourself".

I did decide that in keeping with social constructionist research, the young participants should receive a token of gratitude, in the form of a store voucher, which was a way of saying thank you for giving up their time to benefit others (Freeman and Mathison,

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[9] Developing a well written, informative leaflet will take time, and therefore this will be developed, as recommended by my thesis supervisors (October 2013), post thesis write up.

2009). The Social Care Institute of Excellence urges researchers to consider rewarding children for their participation in research and mentions the use of store vouchers (Wright et al, 2006, p.33). Medical research ethical guidelines, however, contradict this viewpoint, for example recommending that families do not receive payment for their participation in research because of the risk of coercion (MRC, 2004; NHS, National Research Ethics Service, 2011). Due to this debate I sought the opinion of the NHS Ethical Board who reviewed this study. They recommended that a store voucher be given post interview, but not mentioned prior to the interview.

3.7.4. *Contingency Planning in the Event of Participant Distress*

The likelihood that participants would come to any harm by undertaking this study was considered minimal; however, interviews can be intrusive, especially when exploring personal stories and there is a potential to cause upset (Claveirole, 2004). In addition vulnerable groups of young people were being interviewed. It was, therefore, imperative that contingency plans were made in the event that a participant became distressed, or harmful or illegal behaviour became evident during the study (Draucker et al 2009; McCosker et al, 2001). These contingency plans recognised not only the vulnerabilities of the young participant group, but also the vulnerabilities of their parents and school staff.

The contingency plans were mapped out at the research proposal stage in the form of flow charts. These detailed the strategic actions of the researcher and/or gatekeeper if a participant became distressed (see appendix 13, 14 and 15). A contingency plan was also mapped out in the form of a flow chart if during an interview it became apparent that a young person was at any risk of harm in any way (Cameron, 2005; Draucker et al, 2009) (see appendix 16). As a Nursing Professional, if needed, I could also draw upon my own professional code (NMC), which dictates a nurse's statutory safeguarding obligations.

As recommended by O'Reilly and Parker (2014), I ensured that all the research participants were happy and calm prior to concluding the interview. No issues arose whilst interviewing and no contingency plans were needed.

3.8. Quality Markers

At present there are no standard guidelines to assist the researcher in ensuring the quality of qualitative research (Meyrick, 2006; Reynolds, et al 2011). Furthermore, a wide variety of terminology is used to define quality, and this makes the process of ensuring it more complex (O'Reilly and Parker, 2014). The consensus of opinion, however, is that the quality of qualitative research should be assessed differently to that of quantitative research, and because of the data's subjectivity and diversity there should be no singular way of assessing it (Caelli et al, 2003; Guba and Lincoln, 2005; Meyrick, 2006). Qualitative researchers should endeavour to promote the trustworthiness and authenticity of their research by demonstrating clearly how the findings were derived identifying how they promoted the quality of the study (Spencer et al, 2003). Lincoln and Guba (1985) use the terminology "credibility, dependability, conformability and transferability" as quality marker descriptors for qualitative research. These markers are discussed below.

3.8.1. Credibility

Credibility refers to the ability of the researcher to demonstrate that the research study is designed in such a way that accurately describes the phenomena under investigation (Guba and Lincoln, 1994). One recommended way to do this is to gather data from multiple data sources in order that a fuller and richer picture of the problem is obtained (Dale Bloomber and Volpe, 2008). Obtaining more than one perspective on a problem is an approach known to promote research rigour (Corbin and Strauss, 2008; Roulston, 2010; Tracy, 2010).

Data for this study was obtained from multiple data sources, namely the young participants, their parents and school staff. Gathering multiple levels of data in this way exposed the phenomena rather than helping to validate or triangulate the finding. This is very often the case with qualitative enquiry and is described by Ellingson (2008), as crystallization. Tracey (2010) argues that crystallization is different to validation but of equal value.

The credibility of the research findings can also be promoted by using various collaborative modes of peer review (Meyrick, 2006; Whittemore et al, 2001). When

more than one researcher analyses the data, the findings are considered more reliable (Mays and Pope, 2000). The nature of a PhD study, however, indicates that the research activity is carried out alone, therefore other methods of peer review needed to be adopted, as this ensured that the findings were consistent with the data generated, and the participants' perspectives were being truly represented and not skewed by the researcher's own agenda (Reynolds et al, 2011; Tong et al, 2007). I carried out different peer reviewing strategies in the following order:

I. The thesis supervisors were initially involved in checking the data codes, categories and themes.

II. Codes and themes were then presented to a small group of expert practitioners from my own field of expertise (healthcare). The aim of this was that peers could check and validate the findings.

III. Codes and themes were then presented to a small group of educational academics. This was considered important in order to check and validate the findings from an educational perspective.

3.8.2. Dependability

Dependability refers to the extent that the research findings can be replicated by those carrying out a similar study (Guba and Lincoln, 1994). The qualitative researcher is required to detail meticulously the methodology and research methods used (Caelli et al 2003; Fossey et al, 2002). The researcher must also continually question the research process, from how the data was sourced to how accurately it may be interpreted (Dale Bloomber and Volpe, 2008). This recursive questioning process may lead to subtle changes in the research protocol, which notably is not an unusual occurrence when undertaking a qualitative enquiry (Sandelowski and Barroso, 2003). This is because the nature of a subjective enquiry is such that unforeseen problems and complexities can often reveal themselves further into the research process, making them difficult to anticipate. Nevertheless, it is vital that any changes are made clear (Baxter and Eyles, 1997; Meyrick, 2006). Table 10 provides a brief audit trail summarising the changes in the research protocol.

Table 10: Summary of Changes in the Research Process

Date	Change in Research Strategy	Rationale	LRD informed
22/7/11	Change in recruitment site from school and teacher gatekeepers to CAMHS and CAMHS gatekeepers.	See section 3.5.3	√
3/9/11	Post pilot - Refine interview cue sheets in order that all participant interviews are structured around the same four key questions.	See section 3.5.4	
13/9/11	Reflexive decision to allow families a choice of where they would prefer to be interviewed: at home or at their local CAMH service in a private room.	See section 3.5.5	√
14/08/12	Permission to expand recruitment sites from two to three services, the third one being an Early Intervention Psychosis Service.	See section 3.4.3	√
26/10/12	Changes in educational staff inclusion criteria - interview staff members despite them not being a qualified teacher.	See section 3.4.2	√
28/11/12	Due to heavy workload and to ensure timeline for completion of PhD, professional transcription support was obtained.	See section 3.5.7	
21/12/11	To withhold the family name of the young participant in order to safeguard internal confidentiality.	See section 3.7.1	
20/10/12	Thematic saturation was achieved earlier than originally estimated. Interviews stopped at 14 and 9 teacher interviews.	See section 3.4.1	
15/11/13	Advice was given at a thesis supervisors' meeting to disseminate findings to participants in leaflet format post thesis write up.	See section 3.7.3	
1/2/14	Introduce safeguards to prevent deductive disclosure at write up.	See section 3.7.1	

3.8.3. Conformability

Conformability aims to ensure that the findings are not prone to the biases and subjectivity of the researcher. This is because, at any time in the researching process, through personal assumptions or projections the researcher may unintentionally influence data collection (Malterud, 2001, Reynolds et al, 2011; Robson, 2011; Way,

2005). Boyatzis (1998, p.13) states projection means 'reading into' or 'attributing' something that is in your own character, emotion value or attitude onto somebody or something else and it is this that can threaten the plausibility of the data (Dale Bloomber and Volpe, 2008).

The key to promoting the trustworthiness of the data is to be as self-aware as possible; this requires honesty and sincerity with one's self, one's supervisors, peers and the thesis reader (Tracy, 2010). This entails detailing any subjective interpretations, beliefs, personal values and assumptions, so that they can be realised by one's self and put aside (Pope and Mays, 2006). I did this in a number of ways:

- A reflexive diary containing field notes was written throughout the research process.

- As recommended by Robson (2011), Bryman (2008) and Way (2005), I detailed my initial assumptions upon commencement of this study (See chapter 1 section 1.8). Assumptions, beliefs and interpretations will also be noted in the "Discussion" chapter (see section 6.8.1). Reflective memos are used in other parts of the thesis to support key points, as recommended by Meyrick, (2006) and Krefting (1991).

- As recommended by Tracy (2010) and Tong et al (2007), a CV is contained in appendix 17. This details my personal credentials, occupation, experience and research training and how my prior experience and training may have come to influence the researching process.

- Regular PhD supervisor and peer debriefing opportunities were scheduled throughout the researching process. These meetings became forums whereby assumptions, research methods and interpretations were questioned and challenged (Tracey 2010).

3.8.4. Transferability

Transferability is about the reader having the ability to determine if the findings can be transferred or applied to other settings or identical situations. This relies on the researcher providing the reader with rich descriptive data and being as transparent as possible about the adequacy of the sample, to answer the posed research question (Caelli et al, 2003). Transferability of the findings was also achieved by conducting

interviews with children from 10 different schools (see Table 6). Nine teachers were interviewed from eight schools. It can be argued that drawing participants from a range of schools across one county led to a broader view of what was happening in schools in general rather than just recruiting the sample from one or two schools.

A heavy emphasis was placed on including verbatim extracts when presenting the findings (Tong et al, 2007). This provided rich thick description to promote the authenticity of the research (Guba and Lincoln, 1994), therefore enabling the reader to make a more informed judgement as to transferability of the data (Whittemore et al, 2001).

It was important to convey that the data obtained from the sample adequately captured the information needed to answer the research question. Data saturation, although a gold star marker of sample size (Guest et al, 2006), is considered by some to be fundamentally impossible (Caelli et al, 2003, O'Reilly and Parker, 2013), because the nature of qualitative enquiry is that it explores uniqueness and diversity; consequently data can never be truly saturated, as there will always be something new to reveal (Wray et al, 2007). An emphasis, therefore, was placed on sample adequacy as a quality marker (as discussed in section 3.4.1). This ensured that the data captured was not dependent on the sample size, but also on the depth and breadth of information obtained (Bowen 2008). By collecting data from three participant groups (37 interviews in total) the aim was to promote the depth and breadth of data needed to answer the research question.

3.9. Summary

This qualitative study adopted a thematic design, which was underpinned by a social constructionist theoretical framework. At the heart of this study were the 14 mainstream school pupils, aged 14-16 years of age, who all had less visible mental health problems. The viewpoint of their parents and a named supporting educational staff was also obtained in order to obtain a richer insight into their lives. The young participants were recruited via CAMHS. Each participant took part in a semi-structured interview, and were asked questions pertaining to what they perceived to be helpful at school in supporting their needs, but also what they needed and why. This data was analysed using Thematic Analysis assisted by NVivo software.

CHAPTER 4: BELONGING VERSUS ALIENATION

4.0.   Introduction

The findings in this chapter, and chapter 5, reveal how children with intrinsic mental health problems may be better supported at school. The information presented has been ascertained by analysing more closely the young people's perspectives alongside that of their parents and supporting educational staff. The voice of the child was at the heart of this study; therefore, to convey this truthfully, the findings chapters contain extensive participant verbatim (Tracey, 2010; Tong et al, 2007).

The legend for the participant quotations is:

- YP = Young participant, P = Parent, ES = Educational Staff, I = Interviewer.
- An individual's name is replaced by ((child named)) or (((teacher named))) or (CAMHS clinician named).
- School and place names have been replaced by ((names school)) or ((names place)).
- "…" indicates a pause.

The focus of this chapter is on the data that indicates young people, with identified mental health problems, have basic school needs, which promote a feeling of belonging when at school. These needs were found to be prerequisite to offering any enhanced school support. School belonging is known to be a multifaceted construct (Osterman, 2000), which is primarily related to the emotional engagement a child has with their school, whereby they feel safe, secure and positively socially connected there (Libbey, 2004). The opposite of this is alienation, whereby the child feels socially isolated, unsafe and estranged at school. The three overarching themes discussed in this chapter all relate to the attributes of either belonging or alienation (see Figure 9):

Figure 9: Visual Thematic Map – Global Theme 1

Overarching Theme 1 Social Connection	Overarching Theme 2 Security	Overarching Theme 3 Safety Threats
•Peer Relationships •Teacher Relationships	•Mental Health Awareness •Disclosure •Confidentiality	•Bullying •Mental Health Discrimination

The main issue that arose from theme 1 (Social Connection[10]) was the fundamental need for children to have a sense of social connectedness to others when at school in order to promote their belonging. The importance of having positive relationships with peers and teachers is highlighted. Theme 2 (Security) centred on the active methods pivotal in promoting these relationships and preventing any threat of alienation. Linked to this were aspects related to mental health awareness, disclosure and confidentiality. Theme 3 (Safety Threats) centred on what these young people perceived to put their safety at jeopardy when at school, putting them at risk of alienation. Bullying and mental health discrimination are focused upon in this theme.

4.1.   Theme 1: Social Connection

The findings indicated that school interpersonal relationships played a crucial part in assuring pupils had a strong sense of belonging at school as it was these good social relations that made children with identified mental health problems feel content, happy and secure within their school environment. Such findings are consistent with seminal literature that relates to attachment which dictates a child's secure social connections plays an important part in promoting an individual's well-being (Bowlby, 1988). It is secure social connections with others which can positively influence an individual's self-concept, self-esteem, confidence and their reaction to social stress (Patton et al, 2000).

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[10] The multidisciplinary literature refers to a variety of definitions for school connectedness. This can cause confusion, i.e. school, engagement, attachment, bonding or involvement (Libbey, 2004). To promote clarity, this thesis uses the term connection as it represents the social link a child has to others when at school.

This overarching theme of social connection, therefore, focuses on the two principle relationships a child forms at school; their peer and teacher relationships.

4.1.1. Peer Relationships

This study's findings emphasised the importance of children with mental health problems having strong relationships with their peers, as this strengthened their sense of belonging in the school environment. The data did, however, reveal that these children face difficulties in forging peer relationships because of their mental health problems. It was, however, their school staff who the young participants perceived to be best positioned to support them when they were experiencing peer difficulties.

This stresses how school friendships make a difference between feeling happy, secure and connected at school or unhappy, insecure and alienated there. All of the young participants made frequent reference to the importance of school friendships. This was predictable because theoretical evidence informs us that adolescence is a time when children naturally move away from the primary influence of their life, their parents, to that of their peers. Peer relationships then become central to their identity formation (Brechwald and Prinstein, 2011). Identity is interpreted in this context as the development of a sense of who one is and what one believes (Davis, 2012; Kroger, 2007). YPk's statement below demonstrates the importance of school friendships and how they helped shape his identity:

> **Extract 1: YPk**
>
> **I:** *"What are the good things about school, tell me all the good things you like about school"?*
>
> **YPk:** *"Having friends there".*
>
> **YPk:** *"Like my main ones like help me out, my main two, three friends, they really help me out and they'd go places with me to help me build back up my life again".*

YPk really enjoyed school, due to good school friendships. His statement demonstrated the powerful influence of his strong peer bonds in that they improved his school experience, by ensuring he felt better protected and supported. This consequently helped to promote his well-being, self-esteem and self-concept, thus promoting a

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positive happy identity. Others spoke similarly about the value of their peer friendships especially when they were experiencing school difficulties, such as bullying (n=10). Their viewpoint is supported by research which recognises how positive peer school relations can promote a child's resilience (Davis, 2012; Bollmer et al, 2005), and protect a child from social harm (Hall-Lande et al, 2007; Rumberger, 1995) as the below statements illustrate:

> ### Extract 2: YPf
>
> **YPf**: *"If I have got stuff going on then I can talk to my friends".*
>
> ### Extract 3: YPj
>
> **YPj:** *"Yeah but I don't think that is really a relationship that most people have with a teacher, it's more something you have with a friend if you are feeling down. I would probably go to one of my friends rather than a teacher".*

Both participants drew attention to the importance of being able to confide their difficulties in friends, as they believed this helped them to cope at school, which then helped to promote their self-efficacy and resilience. Adolescent development theory gives an explanation as to why talking to one's friends and confiding in them is so important in that it suggests a crucial part of identity development is the need to converse with friends, exchange and disclose problems and give each other advice. It is through this exchange process a teenager learns what they share with others and what is unique about themselves (Davis, 2012). The majority of the educational staff also acknowledged the importance of teenage pupils having good relationships with their peers (n=6). They implied, however, that pupil relationships would often be complicated by natural adolescent peer pressures, as articulated by the educational staff below:

> ### Extract 4: ESe
>
> *"Peer pressure, and they can never take their foot off the gas they all agree that you cannot relax for a minute, because if you relax you might lose some of your street cred, or you might miss something that you should have known. You know that is a really big thing for them".*

"Not wanting to be seen as different, I think you know, this age isn't it when everybody needs to conform and they're insecure and wanting to be liked by everybody else".

Both statements highlight how children today often feel the need to follow cultural norms and expectations, with many adolescents possessing a 'herd mentality' in order to conform to contemporary youthful stereotypes. The problem, however, is that this mentality, whereby it is important to 'fit in', stifles acceptance of difference making children with marked differences feel left out and socially isolated. More damaging is then their ability to negatively appraise their differences leading to low self-worth and confidence. This is a phenomena that others studying different populations of schoolchildren with mental difficulties, have also highlighted. For example Humphrey and Lewis (2008) when exploring the school experiences of children with autistic spectrum, highlighted the children's need to 'fit in' and the damaging effect that negative perceptions of their difference can have on them. Similarly Hallberg et al, 2010, found children with ADHD, often felt a need to hide part of themselves to 'fit in'. The educational staff did not, however, make reference to any of these additional adolescent pressures that children with identified mental health difficulty may experience. This omission, therefore, implied that potentially they had limited knowledge of this, or they did not deem it worthy of discussion in the research context. Some young participants (n=6) did, however, provide insight into the additional adolescent pressures they faced. For instance one problem causing the female participants difficulty was an inability to confide in their friends; this was despite peer pressures to conform to the adolescent norm and be close to friends. YPz's and YPd's statements illustrate this:

Extract 6: YPd

"But I guess with the friends' thing, like now I know how to pick my friends better and I can say well obviously that person is not good enough to be a friend, and I have got a lot of trust issues. I won't hardly talk to anyone, if you ask my parents they will say I don't tend to socialise much. I usually stay in my room at weekends

and not come out much and that is because I don't want to socialise. I just can't do it".

Extract 7: YPz

"Um I don't necessarily cope particularly well with it, but I know that a lot of people they just sort of tend to share it with each other and sort of help each other through it".

These girls demonstrated they had insight into their peer relationship difficulties, in that YPd stated she had '*a lot of trust issues*' and found the sharing of personal issues with her peers difficult. She said she preferred her own company above the company of her peers. YPz knew her peers talked together, but despite knowing it made coping at school easier she stated she had difficulty doing this. This inability to share problems may have exacerbated her mental health problems, in that YPz was diagnosed with anorexia nervosa. A common trait of anorexia nervosa is to socially isolate one's self (Scholz and Asen, 2001), possibly because it can serve as a means of avoiding eating (Cockell et al, 2003), but also children with severe eating problems are known to have a susceptibility to negatively socially evaluating themselves (Rieger et al, 2010). Consequently, this often leads to isolation and loneliness, which then maintains and exacerbates the child's mental health problems (Rieger ibid). YPd linked her friendship problems to attachment difficulties derived from being traumatised in infancy. Attachment difficulties are also known to stifle a child's ability to form strong, trusting emotional bonds with others (Cairns, 2002). Arguably this detachment from their peers was perpetuating both girls' difficulties and hampering their resilience. Others (n=6) spoke less about their psychological difficulties complicating peer relations but more about society's attitude towards mental disorder and how this hampered the formation of strong peer bonds because it made them fearful of peer rejection as illustrated by YPu below:

Extract 8: YPu

"I would say I am quite a sociable person because I used to be really sociable as well, and the only problem is one of the people who I was really good friends with, she kinder, coz, she saw I was getting weirder but not in the way I was acting, just the things which were happening in my life and in my mind and stuff, and so

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she kinder started to, she became a bit frosty, so I thought well we will see whether it is because my front is so down that she has noticed something or whether it is just her being frosty in general, and when I got the front up again she was perfectly fine. So it was just like, it's kinder of effected friendships and it annoys me that".

YPu has described in detail how she needed to talk to a close friend about her personal thoughts and worries, but her disclosure resulted in her becoming very uncomfortable because her friends response was '*frosty*'. This reception resulted in her quickly realising that her problems were possibly not accepted by her friend. Consequently, she became fearful that her friendship was being threatened and, upon realising this, quickly diverted the conversation away from her psychological problems, by adopting a happy-go-lucky attitude. After this incident she reported that she chose not to confide in any of her school friends. Interestingly, YPu found school life difficult and was a participant who described her school relationships as superficial and tiring. It may be theorised, therefore, that her inability to be her true self at school was complicating her adolescence and her search for her true identity and, in turn, this was having a negative impact on her mental health. YPz, YPd and YPu's cases all reveal the susceptibility of this group of young people to having peer relationship difficulties because of their existing mental health problems. There is, therefore, a strong argument that these young people need assistance in developing healthy peer relations within their school environment.

A chief worry voiced by parents was that their child would not make friends at school (n = 9). Many held the perception that secondary school teachers could do more to support their child in forming stronger peer relationships. This viewpoint is represented by Pu below:

Extract 9: Pu

"Right we have a group of children here who are not mixing very well, we can take them to one side once a week and do an activity, do something with them, they can then create a nice group of friendships, they are not going to be left on their own".

Pu's daughter had frequent friendship problems. She believed that teachers could do more to help her daughter forge stronger peer relationships. Her statement described how targeted group work facilitated by teachers may help. Other young participants and their parents spoke about the value of their school helping them to forge stronger school friendships. For instance, one child spoke about the value of drama and how it had built up his confidence, enabling him to form stronger bonds with his peers. Another parent spoke about how a specialist intervention named Circle Time[11] had helped her daughter. The educational staff, however, spoke less frequently about nurturing peer activities and more about the importance of dealing with pupil conflict by mediation, as illustrated by ESw below:

> ***Extract 10: ESw***
>
> *"Well they come in, normally when I get this bit where they say, so and so said that, I'll say well actually I've listened to what you've said, I'd actually like you to go and find them for me and let's sit and have talk together. And then we normally just sit down and we talk, and then they'll say, and I'll say well, okay, that wasn't very nice".*

ESw conveys a warm supporting nature, demonstrating her intent on reducing the children's conflict by mediating and listening to the viewpoint of each child. Research has found when teachers offer this type of support, positive changes in student behaviour are seen, with fall outs and bullying being reduced (Cowie and Jennifer, 2007; Cowie, 2011). The challenge, however, is implementing this type of practice, because teachers need time to attend training and, financially, this can be costly. Instigating this type of intervention in a busy secondary school in reality is, therefore, difficult and may explain why only one of the young people spoke about being assisted by this type of intervention. Another school intervention that some young participants (n=4) and their parents (n=5) said helped in enabling them to form more secure peer relationships and feel more connected and less alone at school, was an informal peer buddying up system. This involved the school budding up the child with another pupil who also had lived

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[11] Circle Time is a school socio-emotional group intervention, which aims to ensure children feel heard and supported by their teachers and other pupils. The objective is to foster their emotional and social skills via group activity, such as turn taking, conflict resolution and listening skills (Cooper, 2012).

experience of mental health problems. The helpfulness of this is illustrated by YPa and Pg's statement below:

Extract 11: YPa

"My friend who is self-harming my friend brought it up with ((names teacher)) and they approached me to help as they try and set up support networks between pupils".

I: "Was that helpful?"

YPa: "Yes because I managed to talk to her and help her."

Extract 12: Pg

"Um what they did do was arrange for her to meet up with another student and have a little session with them with her whenever. She, I think, she sees her once a week this girl called ((names child)). Um ....they were obviously, they were aware she had similar problems and was an older pupil who had come through it".

The above excerpts demonstrate the power of this type of peer support, in that it enabled these children to confide in another person of their own age. The advantages were that they were assured by common difficulties and, therefore, less fearful of being judged. This ties in with an earlier point that it is important that all adolescent children can confide in their friends, as this helps them with their identity formation and improves their self-esteem and promotes their resilience (Kroger, 2007). Interestingly, YPa stated this '*budding*' helped to promote his self-esteem because he gained satisfaction in helping somebody else, yet it was clear this young person was extremely vulnerable himself. Despite this type of anecdotal support for interventions of this nature, there is still limited evidence supporting it (Appelhoff, 2013). Furthermore, a recent systematic review that evaluated the effectiveness of peer support for those with severe mental health problems stated that to date the benefits of peer intervention is inconclusive (Lloyd-Evans et al, 2014). A more complex literature does, however, indicate that best friend networks in adolescence can significantly increase risk-taking behaviours like self-harming (Giletta et al, 2013; You et al, 2013). This, therefore, suggests peer support strategies aiming to help those with intrinsic distress require

further exploration, as there is concern these types of interventions do more harm than good due to the iatrogenic effect.

In summary, strong peer relations are important in promoting school belonging as good social connection can strengthen the resilience of the child with identified mental health problems, consequently promoting their well-being. The problem, however, is that this population of young people are susceptible to peer difficulties, complicated by their mental health problems and this can make peers' relationships complex. What was valued was educational staff placing more emphasis on nurturing pupil peer relationships by intervening when necessary in a supportive way. This ensured these vulnerable children felt safe, secure and socially connected to school, safeguarding them from alienation or detachment from their education.

4.1.2. Teacher Relationships

A second issue that impacted on the child's sense of belonging when at school was that of the importance of the teacher/pupil relationship and the part this plays in promoting a sense of connectedness to school. The interpersonal qualities perceived to strengthen and threaten the pupil/teacher relationship are presented in this subtheme.

All the young participants emphasised the importance of having good relationships with their teachers. They frequently made reference to positive and negative issues pertaining to their relationship with teachers and the power these relations had on their well-being, by enhancing their happiness and contentment at school. This was not an unsurprising find, because evidence already exists that the general population of schoolchildren, (Osterman, 2000; Hallinan, 2008) and children with BESDs (Cooper and Jacob, 2011a) all benefit from having a close bond with a classroom teacher or another significant adult at school. This is because strong pupil/teacher relationships promote school belonging, which subsequently promote learning and emotional well-being (Patton et al, 2000).

All the young participants and their parents emphasised the importance of teachers possessing kind, supportive, warm interpersonal qualities as they expected cold interpersonal qualities to fuel mistrust and conflict. Educational research focusing on children with BESD also points out this correlation in that a warm, supportive teacher

has potential to increase social, emotional and academic belonging or connection with school (Hallinan, 2008; Roorda et al, 2011), and a cold hostile teacher approach is associated with alienation and detachment from school (Hamre and Pianta 2001; Beck and Malley, 2003; Spilt et al, 2011; McHugh et al, 2013; Pianta et al, 2012; Roorda et al, 2011). Figure 9 details the teacher qualities that were perceived by the young participants as helpful and unhelpful.

Figure 10: Negative and Positive Interpersonal Qualities of Teachers

Warmth and Support = Belonging
Active listening (n = 14)
Noticing distress and helping (n = 13)
Caring (n = 12)
Being discreet and being aware of privacy (n= 10)

Conflict and Mistrust = Alienation
Not noticing distress and not helping (n =13)
Not wanting to understand the childs viewpoint (n =10)
Not caring or being bothered (n = 10)
Not listening or communicating (n =9)
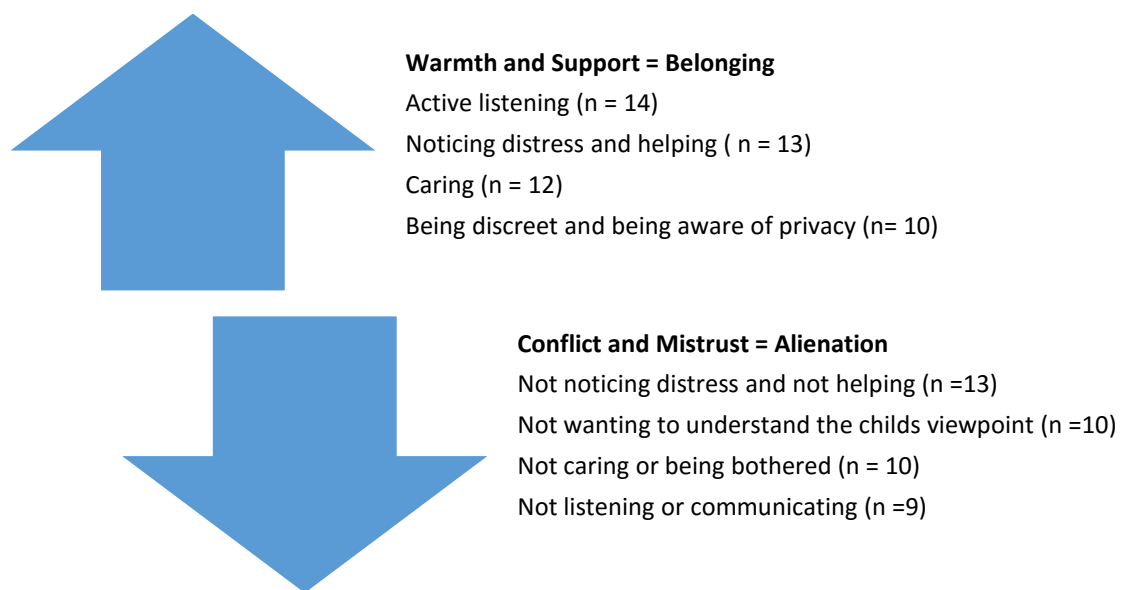
As Figure 10 above illustrates the most valued interpersonal attributes was an ability for teachers to listen and hear them. This viewpoint is represented by YPx and YPe below:

Extract 13: YPx

"Actually she is a love or hate kind of teacher, so if you don't get on with her then you are screwed, but if you do then you do, and she's really down to earth and isn't one of these teachers which just says 'you are going to be ok', she just listens".

Extract 14: YPe

I: "And tell me ((names child)) what is best with you when you get a little bit upset and angry. What is the best thing they can do? What are the techniques"?

YPe: "I don't know just they talk and listen".

I: "Talking and listening is a big thing isn't it really".

YPe: "That's what I have always wanted them to do but teachers are just stupid they don't really care".

Both YPx and YPe emphasised the importance of their teachers listening. YPx felt that, because her teacher was listening, this demonstrated she was interested in what she had to say and it was this that was reassuring. She linked this interest to the likelihood that her teacher would have a better understanding of her difficulties. YPe stated that the only teaching support she required was for teachers to listen. She related listening to care. She did not, however, feel all teachers listened and, therefore, felt many did not care. Listening is an attribute that other educational researchers say is fundamental in promoting the pupil/teacher relationship (Cooper, 2012). It has been pointed out, however, that teachers are often excellent at talking, but rarely trained in active listening (Roffey 2011, p.105). Yet when pupils are not listened to, they often feel unacknowledged and disrespected (Cooper and Jacob, 2011a). This can then lead to disaffection and alienation from school (Pomeroy, 1999). Other participants described incidents whereby they did not feel listened to as YPn's and Ypd's stories below demonstrate:

Extract 15: YPn

"Yes when the teacher asked me why I said 'I don't like that person', and they said to me that's not very nice, and I said I can't help it because they were horrible to me so I'm not going to like them am I, and when they refused to move me I almost flipped at them and I really wanted to chuck my book at them. I just got really angry but I just walked out the classroom".

Extract 16: YPd

"*I fear some of them are quite cocky and they need to know stuff about me, because there's an example where I was meant in registration time, to go to DT[12] to get my course work done and the head of the department said 'look you need to go and I said I can't go and I won't go in there', and they just said yes you are, you will go in there no matter what, and I said well I'm not going in there and I'm not going near him ((names another child)), and I had this long argument with her about it and she wouldn't listen and she wouldn't talk".*

Both excerpts demonstrate the consequences of pupils not having their side of the story listened to, in that both felt their problems and feelings were not being acknowledged. The outcome is that trust between teacher and pupil is eroded and conflict arose. Others spoke about how conflict with their teachers exacerbated their mental health problems (n=5). For instance, the mother of Pz, below, compared the impact a cold, harsh teacher had on her daughter's well-being with that of a more caring teacher.

Extract 17: Pz

I: What do you think helped changed things for ((names child))?

Pz: "A different form tutor, the last form tutor she had she had from year seven to the end of year ten, and she always found faults with ((names child)), it was ((names child)) done that and ((names child)) done that and the next thing she actually got a new form tutor in September and I cannot fault her".

Pz explained how her daughter's eating problems had been exacerbated by the uncaring, critical form tutor. This then led to her daughter alienating herself by truanting or taking frequent absence. Pz noted, however, that her social, emotional and academic engagement with school positively changed when her daughter was assigned a warmer more encouraging tutor. The power of a strong pupil/teacher relationship was demonstrated by Pz's daughter feeling able to re-engage with school life again. One of the main reasons for pupil/teacher relationship breakdown, from the young people's perspective (n=6), was the adult centric attitude possessed by their teachers. This is a

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[12] DT: Design and Technology lesson

dynamic occurring when an adult perspective is favoured over those of young people, with the adult having a tendency to view the child's problems from a biased, adult perspective, choosing not to listen to the child's perspective. This attitude is exemplified by the below statements:

Extract 18: YPj

YPj: *"I don't know, the thing is with teachers they don't really believe it if they hear it from a student. They have to hear it from a medical professional or like at least an adult or a parent. Because there is one thing about teachers they generally don't tend to believe children that kind of stuff".*

Extract 19: YPx

YPx: *"I think so, I think people have forgotten that actually we are kids and that we are people, sorry it really annoys me the fact that adults get stressed, but they forget we do or they think our stress is less because we are younger and it is so frustrating, because actually it is great if you have a job or house kind of stress, but you have no idea what I am stressed about so you can't judge that and say my stress is worse than yours because you don't know what I am stressed about".*

YPj's statement described how powerless she felt when trying to convey to her teachers her emotional difficulties and how she perceived her teachers to be more believing of another adult. YPx implied her teachers held an adult centric attitude because they did not believe children experienced stress. The adult centric attitude of these teachers led to both participants feeling unacknowledged, judged, not believed, not cared for and not respected. Eva Pomeroy (1999) carried out a study examining the perceptions of excluded children, and concluded similarly that adult centric attitudes have a very damaging impact on the teacher/pupil relationship and a child's engagement with school. Pomeroy suggested that to rectify this power imbalance there is a need for more adult-like interactions whereby both parties have a mutual respect for each other. Some (n=7) participants described this type of respectful interaction, whereby their teachers demonstrated this by listening, not judging and acknowledging their difficulties discreetly. This is illustrated by YPz below who was suffering silently with anorexia nervosa:

YPz: "Um, I've always been a person to keep my emotions to myself a lot of the time, but I know, um, at a point before I had some time out of school I was particularly upset and a teacher sort of, um, kept me back after the lesson and sort of asked me questions, and I think he sort of told my tutor and things like that, so".

I: "And did that help"?

YPz: "Um, I think so in a way because it sort of, um… meant that more people sort of knew what I was struggling with, rather than me just keeping it to myself, cos I wouldn't have told anyone else".

YPz's story described all the positive attributes identified in Figure 9. Her story demonstrated the power of this type of teacher interaction, because silence is a common trait for adolescent girls with anorexia nervosa to adopt, because they often wish to present themselves in a positive light and hide any evidence of negative emotions (Gustafsson et al, 2011). This teacher interaction did, however, appear to chip away at some very complex psychological barriers, like self-concealment and associated perfectionism, because this young person even stated it helped "*in a way*". This was supported by the narrative of another young participant (YPn), below, who described a similar caring interaction:

Extract 21: YPn

"There was one teacher once actually, and everyone had to leave and I was the last person in the room, and he asked me if I was ok, and I said 'yes fine', so I obviously lied to him, and he told me I didn't look well and maybe I should wear makeup to make my face look brighter, he wasn't trying to offend me but he was right".

I: "Did he try to cheer you up?"

YPn: "Yes because I looked like I was basically dead he thought make up might brighten my face a bit and make people look at me better".

I: "Yes and not notice that you were struggling".

YPn: "That's what he meant when he said it and I looked at him funny".

I: "That must have been nice that someone cared".

YPn: "Yes it was nice that he noticed but most teachers didn't notice or care".

Once again the pupil/teacher interaction depicted, was private and discreet. It occurred at a critical point when YPn was struggling in silence with her mental health problems. Despite the rather unusual nature of their conversation in that the teacher felt she would benefit from wearing makeup, the teacher demonstrated care because he had acknowledged and noticed her distress. YPn's statement did, however, reveal that many more teachers had a less caring attitude and often did not acknowledge her distress.

In summary, children with mental health difficulties feel more secure and attached to school when they are supported by warm, respectful, caring, members of the school staff. They also want teachers to discreetly acknowledge their verbal and non-verbal distress. The barrier to this type of assistance, however, is that educational staff do not always possess the right attitudes and warm interpersonal skills to help, namely the ability to listen empathetically, respond warmly and privately and seriously to the child's needs. This can then lead to disengagement from school and subsequent alienation. Positive school relations between pupils and teachers must be advocated when a child is experiencing mental health difficulties. These relationships need to be nurtured in order that the child engages positively with school. Sequentially this promotes learning, well-being and resilience, assisting children to recovery from their mental health problems.

4.2. Theme 2: Security

Security and the measures to promote it were found to play a pivotal part in promoting a child's social connectedness to school. Inversely, however, poor security measures often caused relationship difficulties and led to alienation and disengagement from school. The subthemes discussed in this overarching theme relate to the participants' most frequently referenced security aspects, namely mental health awareness, disclosure, and confidentiality.

4.2.1. Mental Health Awareness

The research findings revealed the importance of educational staff having some awareness of mental health issues as this promoted the emotional security of this population of schoolchildren. This is a finding supported by a growing literature that stresses the importance of school staff having a better awareness of mental health issues, so that they can better detect the emotional distress of pupils and, therefore, better support them (Weare, 2015). There is, however, more limited literature outlining the child's perspective on this matter, and the impact it has on them when school staff have little or no mental health knowledge. This theme analyses some of the complexities associated with ensuring school staff are more mental health aware.

The majority of the young participants (n=10) and their parents (n=9) held the perceptions that school staff did not have a good understanding of mental health issues. Four participants did, however, perceive their school staff to have some understanding of their issues. YPc's statement, below, represents the thoughts of the majority of the young participants who perceived their teachers to have little understanding and knowledge of mental health problems.

> *Extract 22: YPc*
>
> *YPc: "It just feels like they don't understand me… what I am going through and everything".*

YPc's statement conveyed a perception that because her teachers had little understanding of her unique needs her problems were not accepted. Notably, she was a participant who did not feel happy and secure at school, with some of her unhappiness stemming from her teachers failing to understand her problems related to her obsessional compulsive disorder (OCD). Other young people spoke more broadly about teachers not placing enough emphasis on mental health issues as demonstrated by the statements below:

Extract 23: YPw

"*Whilst a lot of the time things are not physical, you cannot see an open wound and you have not got a cast on or something, it does not mean it is not really affecting that person and I think they need to be more tuned in with that*".

Extract 24: YPa

"*Didn't ((names a Politician: Alistair Campbell)) didn't he have a big campaign about depression and he said it was amazing how society could recognise a man with a broken leg but not with a broken mind. That kinder thing is actually quite dramatic language but I think teachers should be required to know a bit more about it*".

Both statements highlight how society legitimises physical problems but are not as accepting of less visible emotional problems. YPw proposed it was easier for her teachers to be '*tuned in*' to physical difficulties but less so to emotional distress. YPw suggested her teachers were less '*tuned*' into mental health issues, because they possessed nonchalant or judgemental attitudes towards mental disorders. Other participants spoke more about some of the nonchalant attitudes their teachers had towards mental illness as demonstrated below by YPb and YPf, who was prompted to say this after watching film clip Vignette 1:

Extract 25: YPb

YPb: "*I mean, I just think teachers in general just kind of need more, I just think they need to be educated more on the kind of problems that young people have like self-harm and that kind of thing because literally teachers will look at you and they just kind of, some of them will just kind of look in disgust at you. They sit there and like yeah, and in a way I kind of I understand that because people don't understand like why it's done or anything, but at the same time it's kind of it's not really fair. So I guess they just need support to help support us really as young people*".

Extract 26: YPf

 YPf: "*Yeah like when I go in class like (refers to vignette character 1) was then some of the teachers would say get out your mood blar blar and stuff like that*".

YPf held the perception that some of her teachers were ignorant of her emotional problems. She conveyed this by repeating the colloquial statement that she believed her teachers to use *"get out of your mood"*. YPf's viewpoint was that this type of flippant statement was not helpful, as this told her they had little insight into her mental health problems because she knew she was not able to alter her mood instantly. YPb's story, on the other hand, demonstrated the power of non-verbal language, and how negative attitudes can pervade without words. For example she said *"some of them will kind of look in disgust"*. She attributed these looks to their lack of knowledge and awareness of self-harming behaviours. She believed it was her teacher's ignorance that led to their inertia and powerlessness. Other studies that have focused their investigations on the reactions of school staff to Non-Suicidal Self-Injury (NSSI) and concluded similarly to YPb that, despite a high proportion of teachers holding negative attitudes to this type of behaviour, when provided with knowledge about NSSI, teacher understanding and confidence improves and as a consequence so does the support pupils receive (Best, 2006; Heath et al, 2011; Jasper et al, 2012)

Many young participants (n=8) and their parents (n=7) held the viewpoint that teaching staff needed more formal training on mental disorders. It was a widely held perception that their teachers were presently ill-equipped to deal with the complexity of their problems. This point is represented by YPx, below:

> ### Extract 27: YPx
>
> **YPx**: *"Cos sometimes I think the positions I put them in, I kind of make them a bit out of their depth … but yeah I think the barrier for teachers is probably just, they probably just don't they don't really know enough".*

YPx's statement demonstrates how her teacher's lack of mental health knowledge personally impacted on her. She described how guilty she felt when burdening her teachers with her difficulties, as she knew they were powerless to help. She perceived this lack of awareness acted as an invisible '*barrier*', hindering her engagement with teachers, as their knowledge deficit made them less approachable. Other participants spoke about the potential benefits they could personally reap if their teachers had some formal mental health training, as represented by YPn below:

Extract 28: YPn

YPn: "I think if every teacher had an understanding and wasn't scared to talk to a student I think it would help".

YPn advocated teachers should be trained in mental health issues, as this would make it easier to approach teachers when experiencing emotional problems. YPn also proposed that teacher training had the potential to increase teacher confidence, making them feel less *'scared'* to assist a child with mental health problems. The outcome of this would be that the child would feel secure in sharing any problems. Others (n =4) spoke about how they could personally benefit from teachers possessing generic mental health knowledge, in that it meant they would be spared the awkwardness of trying to articulate difficult emotions and feelings, as illustrated by YPa and YPd below:

Extract 29: YPa

YPa: "I think if they had more awareness or more knowledge; one of the problems when I have to talk to them is that I feel I have to explain myself which at times can be quite agonising".

Extract 30: YPd

YPd: "I feel quite judged because they don't know what I have gone through and they don't know how I am feeling, I can tell them, but words really can't convey how I feel inside most of the time".

YPa used the word '*agonising*' to describe how he felt when trying to explain difficulties to teachers who had no comprehension of his problems. He felt if teachers had some mental health knowledge of depression, he would not have to explain the problems associated with his illness in so much detail. Consequently this would be less stressful. YPd felt she did not possess the emotional vocabulary to express her true emotions, so felt powerless to rectify any of her teacher's judgemental attitudes. She believed that if school staff possessed some training she would not feel judged. The educational staff also felt that having some knowledge of mental health problems would be helpful (n = 6). The chief barrier they voiced to receiving this type of training was, however, resource and time, as demonstrated by ESr and ESj below:

Extract 31: ESr

ESr: "Cos we have training days regularly but it tends to be things like fire extinguishers and Epi-pen training and that sort of thing".
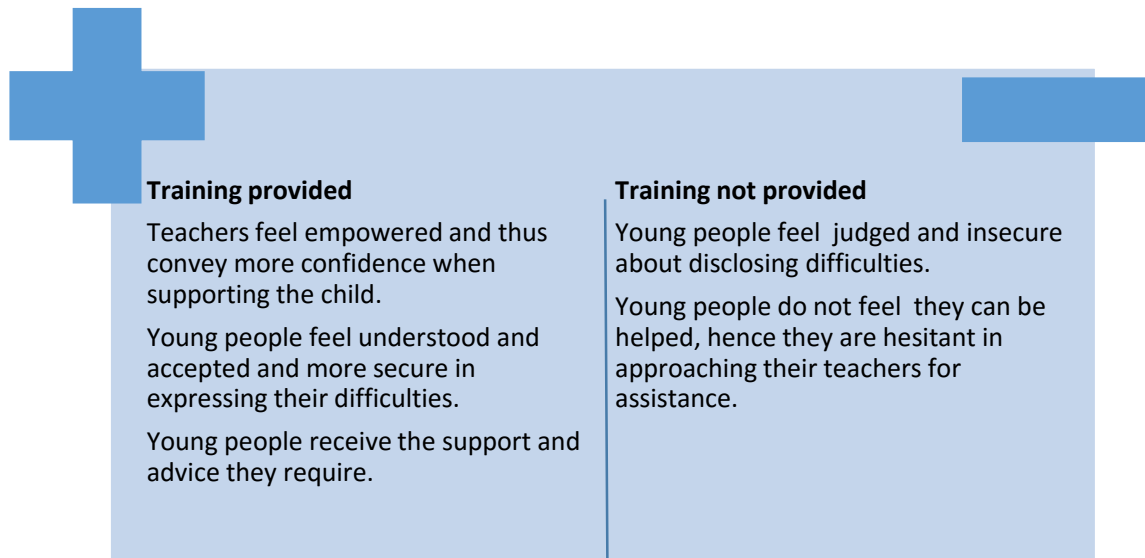
Extract 32: ESj

ESj: "I am going to some self-harm training in a couple of weeks so when we get offered things like that I will take them up, you just don't get offered things like that very often".

These statements draw attention to the lack of mental health training but also how other safety training takes priority, as illustrated by ESr where fire safety and physical first aid took precedence. Of interest is that, like ESj, other educational participants (n=3), who had attended training on matters related to mental health, all spoke about its value in promoting their confidence. This perspective supports the handful of studies evaluating the impact of very short formal mental health in-house school training like '*Mental Health First Aid'.* Teachers report more confidence post '*First Aid'* training and pupils report they receive more beneficial advice and feel more supported (Jorm et al, 2010).

In summary, when school staff lack awareness and knowledge of mental health issues, they are more prone to conveying negative attitudes towards mental health problems. This causes the young person to feel insecure about seeking assistance and subsequently this dynamic is a barrier to engagement, fuelling pupil distress, which then risks the child becoming more alienated from school. Figure 11 summarises the positives of training and the impact no training can have on pupils with mental health problems.

Figure 11: The Advantages, to the Pupil, of Mental Health Training Compared with No Training

Training provided

Teachers feel empowered and thus convey more confidence when supporting the child.

Young people feel understood and accepted and more secure in expressing their difficulties.

Young people receive the support and advice they require.

Training not provided

Young people feel judged and insecure about disclosing difficulties.

Young people do not feel they can be helped, hence they are hesitant in approaching their teachers for assistance.

4.2.2. Disclosure

Improving the knowledge and mental health awareness of school staff is just one factor that has the potential to make this group of children feel more secure at school, especially when seeking assistance with mental health difficulties. There was another important security issue that this study identified as needing to be addressed; this was disclosure. This subtheme discusses this in more detail and how if disclosure is handled well, a child's security can be promoted but conversely if handled poorly can lead to insecurity.

An abundance of research highlights the complexity associated with the disclosure of emotional problems. For instance, researchers exploring issues related to bullying disclosure point out that despite government campaigns advising children, when bullied, to take the right action and tell an adult (i.e Stop Bullying.Gov) older school pupils still find disclosing their problems difficult (Boulton and Underwood, 1993; Carroll-Lind and Kearney, 2004; Sawyer et al, 2011), with approximately only 21% of school bullying problems being disclosed (Sullivan et al, 2004). Additionally research exploring the factors preventing children with mental health difficulties seeking help, has also identified complex disclosure barriers, in that children have lots of worries about what

will happen following disclosure and it is this that can prevent children from seeking help (Bowers et al, 2013; MacLean et al, 2012; Kendel et al, 2014; Rigby, 2011).

This study identified three reasons why young people did not disclose emotional difficulties to their teachers. Firstly, they perceived the schools actions in addressing their disclosed emotional difficulties to be ineffective (n =9). Secondly, disclosing difficulties was perceived to cause them more problems or make matters '*worse*' because staff were likely to handle their problems insensitively (n= 6). Finally, school staff were perceived to be unbelieving (n= 5) or insensitive. Parents also discussed disclosure problems (n=10) conveying the same type of concerns. Notably, a study carried out by Oliver and Mano (2007) cited similar reasons for schoolchildren not disclosing their school difficulties. Oliver and Mano found that pupils feared their teacher's response would be ineffective, insensitive or excessive. Perceived ineffective, insensitive action is represented by YPw and YPn's statements, below:

> ### Extract 33: YPw
> *"A lot of times I kinder felt that I was kinder trapped under a bit of ice and I was screaming and nobody could hear what I was saying and I felt like I wasn't getting anywhere with anything".*

> ### Extract 34: YPn
> *"Yes that annoyed me so much in school like you go to the teacher or something and they would say it will resolve itself in a few days, and it gets worse, and you go back to them and they say it will resolve itself, and you go back again and again and again and eventually you think I am getting sick of this".*

YPw felt her voice was not being heard and used the analogy of being under a sheet of ice, which demonstrated that even if she shouted about her school difficulties and emotional problems, that in her case related to bullying, she would not be heard and not helped. YPn was a participant who described a situation whereby she perceived her school staff's reaction to her disclosure to be ineffective. YPn, in her statement, described the laissez-faire attitude of her teachers to her disclosure of school difficulties. This attitude was conveyed by their lack of effective action they took to help her, despite the fact she continually voiced her difficulties. Over time, because no action was taken

to help her, she became frustrated and finally felt defeated and helpless and had learnt not to disclose her problems. Both statements clearly convey frustration and anger about not being taken seriously but also how this led to insecurity and fear. In contrast to the laissez-faire attitude described by YPn and YPw, other young participants (n=6) and parents (n=10) described excessive and insensitive management of their disclosure. Their viewpoint is represented, below, by YPd and YPz:

Extract 35: YPd

"I went to my head teacher and said there seems to be a problem with this girl she seems to be getting annoyed with me for some reason and I can't understand why, and they said keep your head down, so I did but out of nowhere the girl came out and attacked me. I had a cut on my eye and a swollen eye and they didn't do anything about that".

Extract 36: YPz

"I don't think it's best to force support on them because sometimes that can just sort of make things worse".

YPd described an ineffective and insensitive response to the handling of a serious assault and implied her teachers were not taking her disclosure seriously. Her teacher's presumption that it was not a serious situation led to ineffective and insensitive school action in that impractical advice was given *"keep your head down"*. It is possible that if school staff members had responded more empathetically and sensitively, this may have prevented a more serious physical assault occurring. YPz's statement describes the fear young people possess of '*things getting worse,*' post-disclosure, because of excessive insensitive reaction by staff. Many considered this to be a chief barrier in disclosing school difficulties (n = 6). YPu's story, below, described how her situation was made worse following disclosure:

Extract 37: YPu

"She was like don't worry about it you can tell me people's names and you can say exactly how you're feeling because what happens in here is confidential. … I felt safe then to tell her these things and then I told her exactly what was going on and how I was feeling and all these people's names. …. right at the end of my

meeting with her that's when she told me … she would have to go and tell someone she would have to go and have meetings with the people in school … and she'd have to ring my parents and stuff and I didn't really realise that because she kind of lured me into a false sense of security because I felt safe that I could trust her…and now that's kind of affected me for the future".

YPu perceived her disclosure of peer difficulties to have been poorly handled by one staff member. This was because they approached the pupils who YPu had reported. This action led to the situation getting worse, in that she lost friends. Also as a result of this there was a rapid breakdown of trust between her and her teachers, because she perceived that she had been '*lured in*' to a *'false sense of security'* which understandably made her fearful of disclosing any difficulty again. It was likely that this staff member had all good intentions of resolving the conflict between these pupils, but did not consider the literature which proposes a chief reason for non-disclosure of peer difficulties at school is related to the unspoken adolescent code which is not to tell on your friends and not to confide in an adult (Mishna and Alaggia, 2005).

When the young participants and parents spoke about disclosure fears and problems, they were also asked if they would like to elaborate on what ideally they wanted the school to do in these incidents. Their responses mainly focused on bullying disclosure; however, their perceptions were insightful in that it revealed they approved of a tough behavioural policy like anti-bullying but they also voiced the need for a '*softly, softly'* approach, wanting staff to deal sensitively with any personal emotional disclosure and to understand the potential that a situation may be made worse by inappropriate action. A place for a soft and sensitive approach is clearly articulated by YPw and YPz below:

> ***Extract 38: YPw***
>
> ***"****She deals with situations like really practically like as a teacher she knows well if I do this that is going to happen with those kids and that is going to make it worse for that student so I won't do this, I will deal with it in a sensitive way so that it is dealt with properly. Whereas at the other school they kinder gave no regard to what their gung-ho actions were going to do to the student and if they were going to make it worse for the student".*

Extract 39: YPz

"Well, you can't really say there's no bullying cos obviously it happens but I think if you're willing to go to someone there's plenty of people who can sort it out and they're very sort of happy to adapt things to how you need it to feel supported".

YPw, when interviewed, described how she had moved from one school to another because of school bullying and, therefore, often compared her time at the old school with the new one. She hinted that the sensitive handling of disclosed information was key to her new school's success and the downfall of her old school in that her new head of year was considerate to the pupil's individual needs and took careful action to ensure pupils were not put in any further jeopardy. The staff at her old school, however, did not do this. YPz's excerpt demonstrated a perception that because her teachers possessed an ability to resolve disclosed school problems quickly and sensitively, by taking the pupil's viewpoint into consideration, this helped pupils feel secure. Her excerpt identifies three components to more effective handling of disclosure; firstly, teachers should be empathetic and secondly collaborative. Collaborative in this instance is ensuring the pupil has a say in what action the teacher should take. The third component being '*adaptive*', meaning teachers should adapt their action ensuring the child's solution to the problem is fully considered. The Educational Staff, who spoke about disclosure issues, did not, however, demonstrate collaboration or adaptation, as illustrated below:

Extract 40: ESj

"We have got one student who's … well she, she is possibly being bullied to some extent but she does bring things on herself she is very antagonising she likes to wind people up and students find that difficult to respond to, anyway... we always advise her to stay away from certain people and she should go into the toilets".

Extract 41: ESk

"We had a situation where her mother came in and she wasn't happy because her daughter was being picked on and her daughter had special needs and problems and we talked about it but in the end you know she didn't like the way I was doing things but the school said we had to carry on so we carried on and over the course of about 18 months this was when the girl left us and she went to another school".

In both of these situations the teacher, pupil and parent appeared to have different perspectives in that the teachers appeared to hold the perspective that the child and parent should be told what to do, rather than deciding collaboratively on a course of action. Notably, literature instructing teachers as to what to do about bullying, like the DfE (2015e), NSPCC (2010) and the Anti-Bullying Alliance (2014) recommends teachers should listen carefully to children and obtain the facts before taking action, but what this literature neglects to highlight is the importance of collaborating with the child or parent about what they think should be done about the disclosed problem.

In summary, disclosure is a sensitive issue that concerns the expression of complex emotional problems and it is especially difficult for the child already experiencing mental health problems. Any disclosure, therefore, has to be handled sensitively. This is because insensitive, ineffective or excessive management of the disclosure can cause additional distress, making the child feel insecure. Subsequently, this can reinforce the child's feelings of alienation from school. Therefore, alongside the behavioural and bullying protocols that are designed to promote the child's school safety and security, there is arguably room for a '*softly-softly*' approach which is thoughtful and empathetic and ideally should be carried out in collaboration with the pupil.

4.2.3. Confidentiality

An issue discussed in close conjunction with disclosure was confidentiality. This was an issue raised by many young participants (n=10) and their parents (n=8). All of whom stressed the importance of ensuring schools had safe working practices when it came to secure personal private information exchange. This subtheme, therefore, presents some of the participants' worries around confidentiality and then presents some of the

complexity associated with schools maintaining it.

Other researchers have highlighted how confidentiality is a chief barrier to young people seeking psychological assistance (Del Mauro and Williams, 2013; Gulliver et al, 2010). Of interest was Dines 1996 study, exploring why young people aged 13-17 years chose not to talk about the sensitive issue of sexual advice and not to seek help from an adult school staff member in a position of support. Dines found that a chief barrier preventing help seeking behaviour was school confidentiality. Mental health issues are also sensitive issues and, therefore, like Dines participants, the young participants also raised fears about school confidentiality, as demonstrated below:

> ***Extract 42: YPu***
>
> *"I'd always have that kind of vision of the teachers kind of in the staff room all talking about me and I wouldn't want that".*

> ***Extract 43: YPb***
>
> *I: "So you feel that if you were to talk to them and told them quite an important piece of information, important to you they would either ignore it or not deal with it appropriately?"*
> *YPb: "Yeah, either that or they'd kind of take it too far and they'd like end up like breaching my confidentiality I suppose, because I would have put my trust in them and told them something".*

Both of the above excerpts reveal the lack of trust these participants had in their teacher's professional responsibilities to keep sensitive personal information private. For instance YPu spoke about her vision of teachers '*gossiping*' in the staff room and YPb about her fears that school staff would '*breach confidentiality*' by divulging too much of her personal private information. Other young participants had similar insecurities about confidentiality breaches as described by YPd:

> ***Extract 44: YPd***
>
> *"And the fact that I felt invaded because I had to tell her my personal issues because obviously being a teacher I don't know if she kept that or told the school but I didn't want that going round and everyone knowing what happened*

between me and him and the fact I had someone force themselves on me I don't
want people to know that".

YPd was describing an incident whereby she had to disclose some distressing
information to a teacher about a sexual assault, but what compounded her distress were
her fears about what would happen to this sensitive information following disclosure
and would it remain confidential. Following this incident she was not only recovering
from the abuse but also ruminating about being subjected to school gossip. Parents also
expressed worries about the potential of their child becoming a victim of school gossip
or bullying if their child's personal mental health information was not kept confidential.
Two mothers' (Pg and Pk) statements, below, depict these parental concerns:

Extract 45: Pq
"I think the school could be supportive if they knew about it. I have the feeling it
will not always be totally confidential, I just don't know whether something will
be written somewhere and that person will have access to that file".

Extract 46: Pk
"There's a teacher that I said I don't really trust I can't provide names because
she started saying things in class without asking us or ((names child)) whether
she minded … cos I didn't know how much information she was letting out you
know".

These mothers' statements demonstrate again the lack of trust in the teacher's
professionalism in keeping private sensitive information confidential. Pq's statements
demonstrated this, in that, she knew exchanging information about her daughter's
mental health problems may possibly have benefits, but she did not trust the school to
keep this private information confidential. She feared confidentiality would be
breached, causing her child additional problems. Pk demonstrated similarly her lack of
trust in school staff keeping sensitive information confidential. She described a situation
whereby she perceived a teacher to be breaching confidentiality, because she believed
she was sharing too much personal information about her daughter with other staff
members and pupils. Consequently, she feared her daughter would be victimised for
having mental health problems.

The young participants and their parents revealed good reasons for their confidentiality concerns as the majority of the school staff also made frequent reference to worries about safe handling of information and confidentiality pertaining to mental health issues (n= 8). ESm and ESy, below, demonstrate this:

> ***Extract 47: ESm***
>
> *"It's hard it's hard to know which is the right course to go because if you don't say anything and something happened I would never be able to live with myself".*

> ***Extract 48: ESy***
>
> *"There are things that I have passed on then I have thought have I done the right thing because is it breaching that kind of trust?"*

The above excerpts demonstrated the teacher tensions around confidentiality concerns in that ESm says it is "*hard to know what the right course of action is*" and ESy mentioned how issues pertaining to confidentiality caused her stress, by saying "*have I done the right thing?*" Another educational participant, ESk, also reveals some complexity around the difficulty in deciding what should be shared with parents:

> ***Extract 49: ESk***
>
> *"I had a child once when I was here and she had cuts all on her arm and I didn't know what to do and I spoke to her but didn't actually know what the outcome was you know I was concerned because she had all these cuts and I didn't know whether her parents should be informed or you know what to do so you know I think training on that would be good".*

The above statements revealed ambiguity about what personal information should be shared with others and because of this ESy voiced a need for confidentiality training. Notably, when the educational participants spoke about confidentiality issues pertaining to mental health issues, they often mentioned this in conjunction with the schools safeguarding protocol, therefore, indicating school confidentiality policies are entwined within this protocol, which looks to protect children from maltreatment and prevent impairment of their health or development (DCSF, 2009b and DCSF, 2013). ESy's statement illustrates this point and gives insight into what the pupils are told when they

are looking to disclose a confidential problem to their teacher.

> ### Extract 50: ESy
>
> *"Look Mrs can I talk because I have got this problem and at which point if they are going to disclose anything then we are in not a difficult position but legally where we have to say you do realise anything that you are going to tell me cannot be kept confidential I do need to pass things on".*

The above statement made by a qualified teacher implies that teachers share all the child's personal information and not just the information relating to risk. This, therefore, suggests some teaching staff make the assumption that problems pertaining to mental health are safeguarding issues, which is sometimes the case but not always. YPx draws attention to her teacher's confusion around this matter:

> ### Extract 51: YPx
>
> *"I don't think teachers understand what's a danger to a child and sometimes you just need to talk and sort it out and what is genuinely a danger and a safeguarding danger and I think teachers are scared to delve into what's wrong with a student because of what could come up and I don't want to say fear of responsibility because that's not right but if you ignore a problem and hope it goes away I get that feeling a little bit".*

YPx's statement implies schools are presently running the risk of developing a detrimental risk adverse culture which hinders safe information exchange. She reported that the rigorous safeguarding protocol makes school staff fearful of talking to pupils just in case it triggers a safeguarding issue. It may be argued that the heavy emphasis on safeguarding protocol in our schools, along with a lack of protocol around other sensitive disclosure issues like mental health, has led to some confusion which needs to be resolved. At present it appears there is a lack of clarity and school policy directing staff on issues pertaining to mental health confidentiality and what can be shared with other professionals and parents. Other researchers have also drawn attention to the ambiguity and unclearness around the issue of confidentiality, especially information relating to risk-taking behaviours (Dines, 1996; Rae et al, 2009; Moyer and Sullivan, 2008). In effect at present, however, confidentiality concerns are an invisible barrier

hindering young people from seeking help with their emotional problems. Therefore, the question is, are teachers in need of another protocol more aligned to the disclosure of mental health distress? Yu Ke, (2008) raised the point that the concept of confidentiality originated in the healthcare arena and, therefore, healthcare professionals have clearer guidelines and protocols, whereas those working in other fields do not have this advantage and have less extensive guidelines. Therefore, it is understandable that ambiguity and confusion exists especially when it relates to complex ethical decision-making.

In summary, young people with mental health difficulties may feel more secure in today's stigmatising culture, if school staff conveyed a more professional attitude to confidentiality. School staff may be better placed to convey this professional attitude if they received clearer guidance on how to handle sensitive issues pertaining to mental health. This study's findings suggest, however, at present there is some confusion and tension around what is a safeguarding issue and what is empathetic support and also what to tell parents and what not to tell parents.

In order for children with identified mental health difficulties to feel secure at school more proactive action needs to be taken in promoting mental health awareness of school staff. Staff also need to tackle disclosure issues more sensitively and more guidance must be provided on issues pertaining to mental health confidentiality (see Figure 12, below). These methods may enhance the security of this particular vulnerable group of pupils and make them feel more connected to school and, therefore, promote belonging and ultimately prevent alienation.

Figure 12: Methods That Promote Security

Enhanced understanding of mental health confidentality issues

Sensitive, proactive handling of disclosure

A generic awareness of mental health Issues

Promotes Pupil Security and Belonging at School
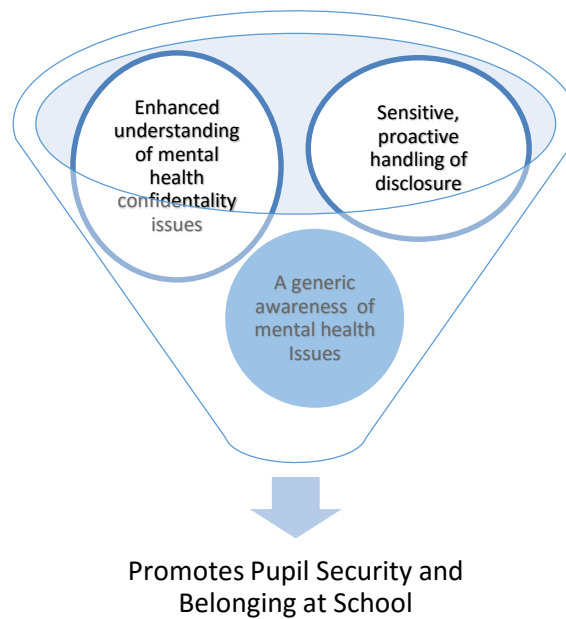
4.3.   Theme 3: Safety Threats

A major concern raised by the majority of the young participants (n=10) and their parents (n=11) was the importance of feeling safe and not feeling threatened physically or psychologically at school. The empirical literature supports this viewpoint, emphasising for every child to thrive, develop and learn at school, they must feel safe and secure at school (Twemlow et al, 2002; Dwyer et al, 2000). Presented in this overarching theme are the factors perceived to threaten school safety and the psychosocial impact the insecurity resulting from the lack of school safety has on the child. The findings demonstrate the importance of safeguarding children from any threat of psychosocial harm and detecting subtle signs of school distress so that assistance can be provided. Two issues that threatened a child's personal school safety were identified; bullying or the threat of it and being discriminated against for having a mental health problem. The core issues pertaining to these threats are presented in the following subthemes.

4.3.1. Bullying

This is an extensive subtheme because it was a topic that the majority of the young participants (n=11) and their parents (n=11) were concerned about. This subtheme firstly frames the context of the bullying endured by the young participants, indicating

why it was of such concern to them and their parents, therefore, revealing the psychosocial impact of the bullying and some subtle signs of bullying distress.

Interestingly, the participants who did not perceive bullying as a concerning issue, conveyed happy school experiences, whereby they felt well supported and secure at school (n=4). This was in contrast, however, to the participants who described school bullying problems, in that they perceived school as an unhappy, unsafe place, having a lot of weaknesses (n=10). They made frequent reference to bullying issues (ref = 168), as did their parents (ref = 155). Surprisingly, in contrast however, the educational staff made little reference to the topic (ref= 20). ESe's statement, below, typifies this viewpoint:

> ### Extract 52: ESe
>
> *"Yes definitely I think any bullying we are really hot on it but we don't have a massive bullying problem".*

This above excerpt demonstrates the teacher's admission that school bullying did exist, but their perception was that of a low level problem, that was handled quickly and effectively. This contrasted with the viewpoint of the young participants and their parents who described serious, complex, bullying problems. For example some had endured severe victimisation like sexual assault (n =2). Others experienced physical violence (n = 7)[13], rumour spreading and name calling (n =10), with some of the bullying extending out of school and being reported to the police because of its seriousness (n=4). Pn's account of her child's bullying experience epitomises many of the children's bullying problems and helps to demonstrate the enormity of their experiences:

> ### Extract 53: Pn
>
> *"We had problems with some lads and they took the bullying outside the school and for over two years we have things thrown at the windows and doors kicked and we couldn't go into Tesco because she would get called names and we had to have a police camera put in to catch them".*

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[13] All participants who divulged this form of harm at interview had already reported it to the authorities and their complaint was in the process of, or had already been investigated.

Pn's description of the bullying her daughter endured, demonstrated how the problems escalated out of control when it spilled outside of school, and how when this happened it became a more serious form of victimisation. Of note, research proposes that despite school bullying being on the decrease (Rigby and Smith, 2011), it has become a more complex problem, mainly because it is no longer just confined to school (Juvonen and Gross, 2008; Yerger and Gehret, 2011). This mother's experience demonstrated bullying is a safeguarding concern and therefore, places an emphasis on schools proactively tackling bullying problems as early as possible to prevent them escalating into bigger problems whereby there is an increased threat of serious harm (DfE14a; DfE, 2015d).

Five young participants and parents also raised cyberbullying[14] issues and how cyberbullying complicated their bullying problems. For instance, mother (Pb), below, described how her 14-year-old son's bullying was intensified by the perpetrators filming the abuse and posting it on the internet. Similarly mother (Po) described how her child became a victim of a serious assault precipitated by cyber gossip and mobile phone texting:

> ### Extract 54: Pb
> *"Basically some much older children who must have been either in GSCE year or sixth form, kind of taped him up to a chair like kind of, like something out of Reservoir Dogs and taped up his mouth and his eyes and like drew all over him and poured water all over him and kind of just subjected him to physical abuse and verbal abuse and he, they'd got other people who were watching and like filming it on their phones and all sorts of things like that".*

> ### Extract 55: Po
> *"((Names child)) had cuts to her eye and she was in a mess her face was all cut up and this girl had heard gossip about ((names child)) on the phone that ((names child)) was after her boyfriend but it wasn't her boyfriend really it was just someone she was texting and he lived miles away in ((names place)). And she had never met him and she had been told by someone that ((names child)) was*

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[14] Cyberbullying is a form of covert psychological bullying delivered via electronic media such as texts or the web.

meeting him or something and this girl just planned it all in the lesson and went out in the break and smashed ((names child)) face in, so that is all phone".

In both of the above cases, digital technology was escalating the participants' bullying experiences and exacerbating their distress. Notably, cyberbullying research says it is a damaging form of bullying because of its unique features, in that it can be carried out anonymously, operate covertly and can also be spread quickly and widely (Juvonen and Graham, 2014). Pb's and Po's stories revealed an additional danger, making it more damaging, in that the perpetrators of these participants bullying were having problems differentiating between a technological fantasy world and that of their school reality. Pb described how the bullying perpetrators were copying a scene from a fictional film and Po described how her daughter's perpetrator was obsessed by a virtual fantasy relationship. Notably, strong empirical evidence now exists linking some violent video games to a child's ability to empathise and have human understanding (Bavelier et al, 2011); however, there is a lack of evidence supporting the theory that bullying can be fuelled in a similar way. What the above participants' stories do illustrate, however, is the negative impact digital communication, such as social media, can have on the relationships of today's schoolchildren and the importance of tackling the cyberbullying problem. The difficulty, however, is that cyberbullying is no longer confined to school and therefore, more difficult for schools to manage (Rigby and Smith, 2011). Two teachers, ESk and ESr below, made reference to the complexity of dealing with today's cyberbullying problem:

Extract 56: ESk

"Well bullying is a difficult thing because it's hard for the school to get on top of it because you have mobile phones, the internet, Facebook you have all of these things going on outside school. Years ago when I was at school anything that went on once you left the gates at night you didn't see or weren't involved with anyone else and ok it might still be there the next day when you come in but it's not there 24 hours a day you aren't getting text messages sent at two in the morning or people on Facebook saying whatever they say or whatever they do. So I think nowadays it's much more difficult because a lot of the bullying goes on over the internet so it is hard to get on top of".

Extract 57: ESr

"Obviously there is bullying, we have occasions when we've got, particularly with the mobile phones and things, but again I'd like to think that we get on top of them as quickly as we can".

The above excerpts illustrate two differing viewpoints on the cyberbullying problem. ESk adopts the viewpoint it is '*impossible*' to get on top of, indicating an acceptance that it is a modern phenomenon, here to stay, and not within the school's power to deal with effectively. ESr opposes this viewpoint by saying she would '*like to think*' cyberbullying was being handled effectively. She did not, however, provide any strong evidence as to how the school dealt with this covert problem. These statements indicate that, at present, teachers are not receiving enough guidance on how to tackle cyberbullying. It was, however, noted in my field notes, when being shown around two separate schools, prior to conducting interviews with educational staff, I was informed their schools had banned the use of electronic devices during school hours. Both teachers fed back that they had noticed this had reduced problems and improved the educational culture of their school. Also of note is that the young participants linked to these teachers did not speak about bullying problems, therefore indicating a culmination of proactive methods like this can promote pupil security and help schools tackle safety threats. Teachers unions and Ofsted have called for bans on mobile phone use as mobiles not only distract pupils, but also an online survey in the US has linked more mobile phone use with cyberbullying (Openet, 2012).

Despite all the young participants and parents acknowledging the difficulties schools had in tackling bullying problems, they felt this provided more justification for schools to tackle bullying threats more proactively. They stressed the importance of schools adopting an anti-bullying policy and harsher punishments for the bullies (n=11). The reason the participants put so much emphasis on this proactive stance was they perceived bullying as putting a young person's mental health in jeopardy.

The next section of this subtheme will illustrate the psychosocial impact of school bullying on the young participants from the participants perspective. YPn, below,

provides some insight into the daily psychological and social trauma she endured when feeling threatened by school bullies:

> ***Extract 58: YPn***
>
> *"Like most of year 11 was terrible because the people that didn't like me I couldn't even look at them without feeling nervous and having the fear that they would start something with me".*
>
> **YPn:** *"it was like when I was in lesson I was safe and when I was out of lesson I wasn't".*
>
> **I:** *"So how did you cope when you were out of lesson?"*
>
> **YPn:** *"I went to film clubs and drama clubs and just tried to stay away from them as much as possible I guess".*

YPn's excerpt describes how the threat to her safety made her feel, think and behave, in that she described how the intrusive thoughts of danger caused her to feel fearful; this then brought on a state of hyper-vigilance and nervousness, which then led her to escape which is a natural inherent behaviour to adopt when threatened with danger. She did this by seeking out safe havens within the school. Part of this response was likely to have been fuelled by the physiological neuroendocrine reaction to stress known as the *'flight or fight response'.* YPw described a similar response to the threat of being bullied:

> ***Extract 59: YPw***
>
> *"It was horrible, that kinder brought on the start of loads of panic attacks just going to school it was just horrific on a daily basis because I did not know what was going to happen".*

YPw's *'fligh*t' and *'fight'* response was triggered, similarly to YPn; however, because she was unable to take *'flight'* or *'fight'*, her anxiety culminated into frequent panic attacks. Enduring this perpetual anxiety for a long period led some young people, like YPw and YPn, to also experience coexisting mood disturbance (n =5), which is often a secondary

problem of anxiety. The following participant statements illustrate the impact that perpetual anxiety can have on an individual's mood:

Extract 60: YPd

"It put my confidence down I did take attempts on my life thanks to the bullying but I am happier now that it has stopped".

Extract 61: YPw

"Absolutely I don't think I have ever felt lower and it was absolutely school".

Extract 62: P

"She was suicidal she was self-harming all as a result of what she experienced at that school".

YPd, above, illustrated how low mood made any problems feel overwhelming and insurmountable, hence diminishing confidence and self-worth. In both YPd's and YPw's cases these feelings led to rumination about suicide, as they perceived there to be no means of escape. These young people's experiences are supported by global research claiming bullying can cause young people to suffer significant psychological distress (Arseneault et al, 2010; Brunstein Klomek et al, 2007) and it can lead to youth suicide (Fritz, 2011). Evidence also exists indicating the longer the duration of the bullying the more severe the mental health problems (Hong and Espelage, 2012), with some studies linking early on-set of psychosis in adolescence to bullying (i.e.Van Dam et al, 2012; Wolke et al, 2013). YPn's case supports this link, in that she reported that she was bullied for most of her school life and experienced her first episode of psychosis in adolescence. Her thoughts and the thoughts of her mother are conveyed in their statements below:

Extract 63: YPn

"It was the reason my life has been the way it is I always blame that".

I: "The bullying?"

YPn: *"Even if it's nothing to do with bullying I will just blame it on the fact I was bullied"*.

Extract 64: P

"I think it triggers it off in the first place, I think the bullying issue is a major that they needed to deal with".

Both held the viewpoint the bullying was the root cause of YPn's mental health problems, perceiving her mental health problems had been precipitated by persistent school bullying. They were, however, unable to confirm this, stating "*even if it is nothing to do with it*" and "*I think".* Nevertheless this mother's statement alluded to the belief that if the bullying had been dealt with quickly and more effectively her daughter may not have experienced such severe mental health difficulties.

The next section of this subtheme describes how the young participants coped with long-term bullying. Some described intrinsic methods of coping. For example, some would cope by restricting their food (n=4). Of note is that the eating disorder charity BEAT, in a 2012 survey, found 65% of eating disorder cases were linked to bullying. Other young participants used Non-Suicidal Self-Injury (NSSI) or cutting behaviours (n=6). NSSI is a rising problem amongst adolescents (Heath et al, 2011) and is a method sometimes used to cope with the pressures of modern life (YoungMinds and Cello, 2012). Similar to eating restriction, NSSI can stifle anger. It is a maladaptive coping mechanism enabling the young person to cope with their distress. Notably, larger scale research has now also made the link between school bullying and NSSI (Fisher et al, 2012; Hay and Meldrum, 2010). YPc and YPd's statements, below, demonstrate the link between bullying and the need to self-injure:

Extract 65: YPc

"I was at my school when I was getting really cross and everything at um school I use to cut my wrists because I got so stressed and angry at my school because I was getting picked on, which was really bad, I regret doing that now".

Extract 66: YPd

"When I'm angry I need to step out the lesson because I get to a certain point where if I get really angry I feel like I need to cut".

Both YPc and YPd had endured school bullying for a long time and both were experiencing difficulty with pent-up emotions. Both described feeling anxious, stressed and angry. Notably, Non-Suicidal Self-Injury (NSSI) is known to occur most frequently in the context of worry, fear and isolation and is frequently used to regulate and deal with difficult pent-up emotions (Chapman et al, 2006; Heath et al, 2008; Nock and Prinstein, 2005). Others spoke about how difficult these pent-up emotions were to deal with and how they were sometimes prone to rages brought on by frustration with the bullies and the school's ineffectiveness. Sometimes they took matters into their own hands and reverted to uncharacteristic aggression, as illustrated by the participants below:

> ***Extract 67: YPd***
>
> *"But I must admit one of the times that one of the boys were bullying me I just lost it, he kept calling me a slut and I said say that once more and he did, the thing I said back to him I wasn't proud of it because it was quite violent what I said".*

> ***Extract 68: Px***
>
> *"She took a knife into school a little knife I was looking thinking where is that knife gone you know it has probably gone in the bin and it took someone else's son to say ((names child)) got in trouble today because she took a knife in her book bag because the school confiscated it but hadn't bothered to ring me".*

Both the above participants were describing how, when bullied, they moved from counter aggressive, nonchalant and helpless victims (Salmivalli, 2014) to provocative victims (Olweus, 1994; Barker et al, 2008). Research suggests that victimised aggressors or bully victims are said to be at higher risk of emotional problems like depression (Sourander et al 2007; Swearer and Hymel, 2015). Research also suggests the behaviour of bully victims also makes these children more susceptible to peer difficulty and loneliness at school (Glew et al, 2008; Juvoven et al, 2003). YPd described how she uncharacteristically threatened another child with their life if they did not stop bullying her. Px described how her placid child took a knife to school in a desperate attempt to fend off the bullies. Despite the seriousness of taking a knife into school this mother made a point of saying this stark change in her child's temperament went largely

unnoticed and unreported by school staff. Therefore, cases like this demonstrate the need for school staff to be more alert to temperamental changes in their pupil's behaviour and if a child displays out of character behaviour, question if this maybe is a subtle sign of bullying distress.

The remaining section of this subtheme discusses other subtle signs of bullying distress that a teacher, if aware, may detect. For instance, others spoke explicitly about how bullying impacted on their academic attainment:

> ***Extract 69: YPc***
>
> *"I lose my concentration a lot at school because I get picked on, people call me names like I turn round and I get fidgety it is quite hard but I kinder cope with it".*

> ***Extract 70: YPd***
>
> *"It did affect my grades a lot when I was getting bullied they dropped quite a lot".*

YPc was describing a chain reaction in her anxiety and hyper-vigilance and how this led to her fidgeting and losing concentration, subsequently leading to an inability to learn. YPd noted that her grades dropped when being bullied because her mental state deteriorated, leading to concentration and memory problems. Interestingly, some American studies have linked a school bullying climate with poorer pupil test performance (Bowen, 2011; Juvonen, 2014). Others described their disengagement from school by truanting or taking more frequent sick absence (n=8). The following statements gave insight into this avoidance tactic:

> ***Extract 71: YPd***
>
> *"I don't even feel safe coming to school I didn't feel safe getting on the school bus or anything and that's why I wanted to stay at home because I knew I was safe at home and if anything did happen I have my parents here".*

> ***Extract 72: YPf***
>
> *I: "What do you do to get yourself back to school?"*
>
> ***YPf****: "Um just think I can't hide for ever so I may as well go and face the music and when I do go back I realise it is not quite so bad until something else happens*

and then I will try and go through that process again and of not going in and then going in".

The above excerpts demonstrate how these young people were trying to cope with the situational stress of feeling threatened at school by '*taking flight'* or escaping and hiding at home, as this was perceived to be a safer and less anxiety provoking environment. Recent research examining truanting behaviour amongst the generic population of schoolchildren has linked bullying to truanting (Colechin, 2012; Beat Bullying and Truancy Report, 2006). Data, however, revealed that children with identified mental health difficulties were also more likely to take more authorised sick absence. This is illustrated by mothers Pa and Pz:

> ### Extract 73: Pa
>
> "*Because you could not get her to do a full week. Not a full week until you go back to about Christmas because of her panic attacks and her anxieties just because her fear of being in a lot of situations".*
>
> ### Extract 74: Pz
>
> "*Basically I told her she had to go to school because she has got exams she can't stay at home she has got to face the problems at school head on".*

School absence in the above cases was condoned by parents and, therefore, unlikely to be questioned by school staff. These mothers' statements illuminated the complexity of the situation; they felt in a difficult situation, in that returning their child to a stressful environment would cause a deterioration in their mental health. Other studies have also linked bullying with higher rates of absenteeism (Juvonen and Graham, 2014). One theory why anxious children have increased absence rates is because long-term anxiety increases their cortisol levels making them more prone to mental and physical illness (Gianluca et al, 2014; Knack et al, 2011). This shows regular sick absence, school refusal or truancy cannot always be tackled by placing an emphasis on punishing parents by legal enforcement or fixed penalty fines, especially when the root cause is possibly due to school distress.

Therefore, school distress needs to be more robustly assessed. CAMHS workers are well positioned to assess school distress; teachers can play a part in noticing subtle signs of school distress by noting changes in a pupil's academic performance, irregular attendance and fluctuations in their temperament. All these small signs could signal bullying distress. Therefore, this raises an argument for more vigilant multi-agency monitoring.

In summary, school bullying is an environmental stressor that needs proactive intervention to prevent it spilling outside of school, as the longer the duration of the bullying the more serious the mental health problems. To promote pupil security, school staff and healthcare practitioners need to play their part in assessing the subtle signs of school distress so that they can intervene as early as possible and as proactively as possible. Figure 13, below, depicts visually how the environmental stressor of bullying can give rise to a vicious, de-motivating cycle of negative thoughts, feelings, emotions and behaviours, if proactive intervention is not taken. This cycle is wholly supported by the bullying activity and, if left to continue, will lead to the child's mental state deteriorating and risk them alienating themselves from their education.

Figure 13: Bullying Victimisation - The Reaction Cycle

Thoughts
"Fear of imminent attack"
"No Escape"

Behaviours
Intrinsic - self harm
Extrinsic - anger
Alienating - truancy
or sickness

Environmental Stressor
Bullying

Physical Reaction
Anxiety or Panic
Memory and concentration impairment

Mood
Sadness
Frustration
Anger
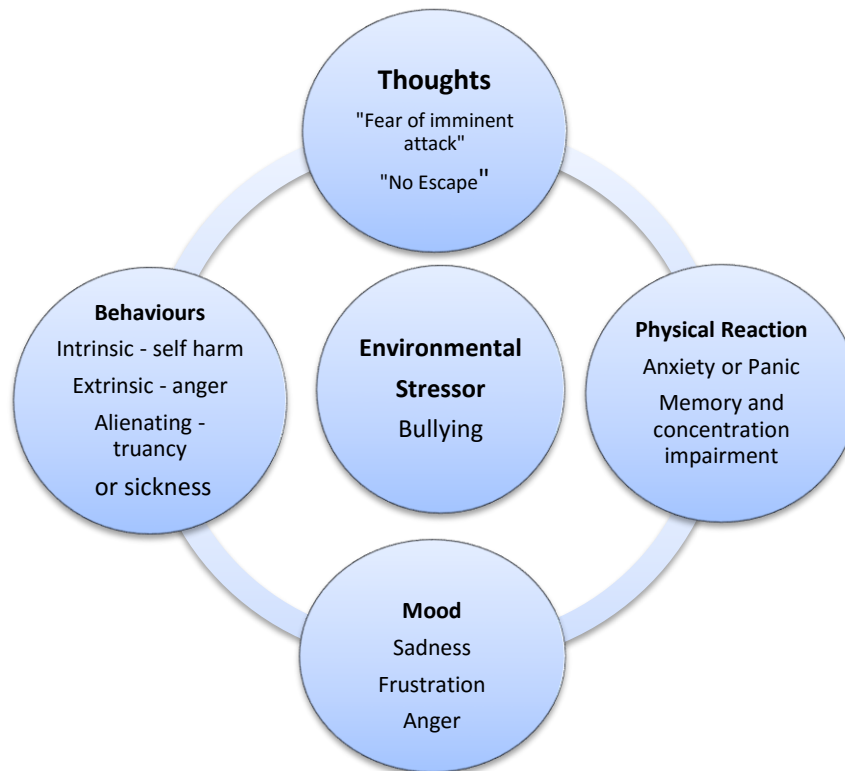
4.3.2. *Mental Health Discrimination*

This subtheme discusses how discrimination can threaten the psychological safety of young people with mental health difficulties too, as it is a form of victimisation that makes children feel psychologically threatened at school, as it can have tentative links with bullying. Discrimination in this context is defined as the unfair treatment of a person of a minority group, with this action being based on prejudice. Prejudice means an adverse judgement or opinion formed beforehand or without knowledge or examination of the facts.

It must be emphasised that the young people and their parents did not commonly use the words discrimination or prejudice when interviewed. They did, however, make frequent reference to '*not wanting to feel different'*. YPx's statement below exemplifies this viewpoint from the child's perspective and Pd's from the parent's perspective:

Extract 75: YPx

"No, I would not tell certain teachers at school even some of the teachers that teach me anything about me because I know they will treat me differently because I have seen it happen".

Extract 76: Pd

"With ((names child)) he doesn't like to be treated differently, he knows he has problems but people know he has problems but he doesn't want to be treated differently to how other people get treated. He hates being treated different. But sometimes people can't help but treat him different because of the problems he has got... it does annoy him".

These statements illustrated both the young persons and parents fear of prejudice and discrimination. They feared if a teacher was to learn about a pupil's mental illness they might treat them differently. Pd stressed the importance of staff treating a child with mental health difficulties no differently to any other pupil, implying that even good natured support could do more harm than good as standing out amidst the crowd threatened the child's security, making them more susceptible to bullying because of mental health stigma. (n=9). Stigma was a chief reason the young participants and parents chose not to tell their teachers about their mental health problems. Stigma happens when the negative attitudes held by others, or behaviours of others, result in inequitable and unfair treatment because a person has these difficulties (Pietrus, 2013). YPa and YPd, below, illustrated the fear of public stigmatisation. Public stigma is when society endorses stereotypes about mental illness (Gale, 2007):

Extract 77: YPa

I: "It sounds to me that you like to know that a teacher is there but choose not to tell a teacher about your problems in detail am I right?"

YPa: "Yer."

I: "Can I ask you why that might be ((names child))?"

YPa: "I think it is just in the past people have had loads of paranoia about mental health issues and I think I am worried about exposing that fully to the school".

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Extract 78: YPd

"Yes I wouldn't want to say … because I feel that goes on my records if I go for a job and they might bring that up and I don't want reminders of all that in my life like when I get into adulthood I want to settle down and start working and I don't want reminders because it will be hard and they may not want to hire me because they may think I am a nutter".

Both of the above excerpts demonstrate the young participant's awareness of society's negative portrayal of mental illness and the stigma associated with it. YPu and YPz, below, demonstrate another stigmatising phenomena known as self- stigmatisation:

Extract 79: YPu

"So I don't want to tell people because they will think you freak because they say no of course we don't but that is the problem with loads of mental health issues everyone thinks you freak and that's why no one wants to talk about it and that makes it worse and so that is the problem I think".

Extract 80: YPz

"I don't want the entire school talking about me because they think I'm a nut job because a teacher has said something or made some comment in class or said something too loudly and someone else has heard it".

In effect both YPu and YPz appear to be turning society's stigmatising attitudes against themselves, leading them to overtly stereotype themselves. This type of self-stigmatisation is known to result in a loss of self-esteem and self-efficacy (Corrigan and Watson, 2002; Hatman et al, 2013), and can exacerbate mental health problems (Rüsch et al 2005) and impact negatively on recovery (Wykes and Craig, 2013). Their excerpts also demonstrate, however, another form of stigma known as 'label avoidance'; this is where people avoid seeking help for the fear of being labelled with a stigmatising mental health problem (Gale 2007). In their cases they were speaking about their fear of being labelled by their teachers and peers as "*a freak*" or a "*nut job*" and, therefore, avoided seeking help. Notably, many studies examining mental health stigma conclude that living with the differing forms of stigma, public, self and labelled, is worse than the condition itself (Pietrus, 2014; Corrigan, 2014). Others spoke about the reality of being

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discriminated against for having mental health difficulties and how this made them feel and how it threatened their safety. For instance YPb described this incident:

Extract 81: YPb:

"They see you like walk out of a classroom or something, and they'll make some comment on something, like don't go and cut yourself or whatever".

I: "How does that make you feel?"

YPb: "You're walking out to get time out, and then someone says that to you as you're leaving, that just gets you even more upset … then you don't want to go back in there because there's all that in there, but then you're outside by yourself and all these bad thoughts are coming to you like maybe I should go and cut myself and everything".

YPb's story showed how distressed and unsafe her fellow pupils made her feel when making a derogatory comment about her cutting behaviour or NSSI. This excerpt demonstrates the close association discrimination can have with bullying, in that it conveys her experience of humiliation and intimidation. Studies exploring homophobic school attitudes, which is another form of prejudice and discrimination school pupils can endure, also points out that a chief hazard of discrimination is bullying (Fleming, 2012; Poteat et al, 2011: Whitney and Prinstein, 2011). Interestingly, a recent review carried out by Juvonen and Graham, (2014) has reported the need for more research aimed at exploring the connection between discrimination and the bullying of potentially stigmatised groups. YPc and her mother's take on another incident, gives further insight into the damaging effect that prejudice can have on a child. YPc was a 14-year-old female participant who suffered severe anxiety and associated OCD:

Extract 82: YPc

I: "What does the teacher do when you get anxious?"

YPc: "They just say to me like don't do this I get shouted at a lot at school because I have OCD I fidget and I get fussy and everything I can't really help it but like it's hard for me because I have OCD… which gets me down and upsets me as well so I find it hard at school… because in science classes when we have done an

experiment even if it is nothing to do with chemicals I still have to wash my hands and my teacher will get cross with me and she says oh fine you will not do another exam another experiment next time I am like… coz I was fussing I was worried about getting things on my hands and I made them sore".

Extract 83: P

"She has got it but you can't stop her doing this because she can't help it she needs to be guided not penalised for having something which is not her fault she feels like well we feel like she is being penalised because of this OCD… and not helped and isolated".

It is difficult to untangle the prejudice from the emotional victimisation when reading YPc's story. It was clear, however, that this interaction caused YPc to feel threatened because she became distressed and, therefore, was victimised. YPc's mother felt her daughter was '*penalised*' for having OCD, alluding to the fact that she perceived her daughter was being discriminated against because of the prejudicial attitude of her school teacher who was ignorant of OCD problems. Other YPs (n=8) described similar prejudicial attitudes of school staff towards their mental health problems, describing incidents whereby they had either intentionally or unintentionally been victimised due to teacher ignorance, which then led to them feeling unsafe, insecure and distressed at school. This links with findings presented in theme 2, subtheme 1, arguing that this form of ignorance is an attitude borne out of lack of knowledge and perhaps not discrimination.

The next section of this subtheme illuminates how the young participants coped with discrimination, prejudice and stigma. This was different to how they coped with bullying, in that they tried hard to prevent problems from arising by keeping quiet about their mental health problems (n=8). Some kept their problems a total secret (n =4); insight into their rationale is provided by YPf and YPu below:

Extract 84: YPf

"The teachers don't know that I come here".

I: "Is that your choice not to tell them?"

YPf: *"Ye."*

I: *"Can I ask you why?"*

YPf: *"Coz I don't feel they need to know about it because if I did tell them they might treat me a little bit differently coz I go here they might just check on me a lot more and I don't want that".*

Extract 85: YPu

"If I were to tell them about this it would kind of shatter it all and it would be like just completely different and I don't want them to look at me differently".

These excerpts again stressed the importance of these young people not wanting to feel different and, therefore, doing their utmost to conceal their mental health problems from schoolmates and teachers. Others, who have studied the perceptions of other groups of teenagers with mental disorders, have also mentioned the importance of these children striving for normality and fitting in. For example, Hallberg et al, (2010) when exploring the perceptions of teenagers with ADHD, noted how these children wanted to keep their problems hidden as they did not want to appear different to their peers. How children with intrinsic mental health problems kept their problems a secret was insightful in that they adopted a phenomenon of masking their difficulties especially when they were fearful about revealing their true self at school for the fear of mental health discrimination. This masking behaviour is illustrated by YPu and YPn below:

Extract 86: YPu

"Well sometimes I find having to keep up the front really hard, it has affected a lot of my friendships and I have had to work really hard to get the front back up again to get them back to normal so um and yeah and now coz my best friend lives in Spain and my other best friend does not even go to my school so it is a bit like ooh ((laughs-shrill voice depicting being scared or fearful)) so I have had to work really hard to keep the front up".

Extract 87: YPn

"Yes I am stronger and I don't just cry over nothing I tend to just put on a face to kind of deal with it".

Both of the excerpts above described the emotional threat of having the constant fear of people rejecting and stigmatising you if your mental health problems were to be known at school. YPu detailed her daily ritual of masking her true identity by being jolly and chatty in order to deter peer rejection. She described this behaviour as '*keeping up the front'*, but she also described how exhausting this daily act was. Therefore, this raises the question; could this energy be better expended tackling her mental health issues. YPn described a similar scenario but used a slightly different analogy describing it as '*putting on a face'*. Notably, YPn already endured school bullying so masking her difficulty ensured that her bullying problems were not exacerbated. Some parents also spoke about how their children chose not to expose their true distress at school and they described '*a front*' or '*mask*' as depicted by one mother Pu and one father Ps2:

Extract 88: Pu

"Because every time they say to me ((names child)) always has a smile on her face, but I say yes she has but she puts it on as front, but we don't think so, I say but I know my daughter more than you do and I know she smiles and underneath that she is really upset and she is not happy".

Extract 89: Ps2

"I guess it's quite tough isn't it? I mean if you looked at ((names child)) and spoke to her, you wouldn't necessarily know what she's going through because part of what she's going through there's like a mask almost isn't there? So she's not conveying her inner core beliefs or what she's feeling necessarily".

These parents' statements emphasised the ability of their children to fool others that they did not have any problems. Pu stated that even when she tried to explain this phenomenon to her daughter's school teachers they did not believe her. Ps2 demonstrated how much of a barrier this masking phenomenon was when trying to help her daughter emotionally. Other studies suggest a significant proportion of distressed adolescents hide or disguise their psychological difficulties, expending a lot of energy in

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keeping their problems a secret. This is complex phenomena that has been associated with a personality style characterised by 'self-concealment and a tendency to engage in perfectionistic self-presentation' (Flett and Hewitt, 2013 p.12) or presenting, when depressed, with a façade of being well despite emotional distress (Allan and Dixon, 2009). It may be argued that it is this type of concealment that makes recognising less visible school distress very difficult, especially to an untrained eye. Notably, the school staff participants stressed that one of the key barriers to helping children with emotional difficulties was that pupils themselves did not voice a need, as these excerpts from school staff, ESe and ESy, interviews illustrate:

> ***Extract 90: ESe***
>
> *"I just was thinking we have got at this given time two of three students who have recently been admitted to hospital and we are very mindful of those and just sort of thinking of examples of students who may be aren't quite far down the line I think if we identify them then we do support them but they aren't easily identified unless they want to be identified".*
>
> ***Extract 91: ESy***
>
> *"It is just those quiet ones that worry me that slip under the net because nobody picks up anything or they just don't tell you or there are no signs and there is nothing to see".*

ESe and ESy demonstrated the complexity of recognising intrinsic emotional distress as there were often no visible signs. ESe drew attention to the fact that it was only when schools were notified of pupils being admitted to hospital when schools learnt of any difficulty. This statement implies, therefore, that at present schoolchildren experiencing emotional distress do not always feel safe enough to tell schools' staff about their problems. This demonstrates the importance of promoting their security by adopting helpful methods outlined in theme 1 and security methods outlined in theme 1 and 2.

In summary, it is clear that mental health discrimination, unique to this group of young people, is a complex mental health issue that causes fear and distress. It is fuelled by different forms of stigma discrimination and prejudice which is compounded by society's lack of compassion in accepting mental health issues. To cope with this, when school

does not feel safe, the child will often remain silent about their difficulties and adopt alienating practices that mask or cover over their problems. It is, therefore, important that schools staff are 'tuned' into this type of distress as these children have a double jeopardy risk; firstly, living with a mental health problem and the stigmatisation and discrimination that comes with it, but also the risk of victimisation arising from the mental health problem themselves in the form of bullying or emotional victimisation.

In order for children with identified mental health difficulties to feel secure at school, their safety cannot be compromised by the harmful threat of bullying or mental health discrimination. Time and energy must, therefore, be invested in recognising the subtle signs of their distress and they must implement the security measures presented in theme 2, because without them, these young people find seeking help difficult and adopt complex alienating behaviours to cope with their problems.

CHAPTER 5: PROMOTING RESILIENCE VIA INDIVIDUALISED SUPPORT

5.0.   Introduction

This chapter builds on from Chapter 4 by reporting on the individualised supports that children with identified mental health difficulties preferred when their prerequisite needs of social connection, security and safety were assured. It is important to highlight, however, that the findings indicated that, to accept any enhanced individualised assistance, these young people needed some say and choice as to their preferred support. They favoured discreet supports, especially when related to their health condition, which they could access themselves when the time was right. This was because, ultimately, this population of young people shared the same goal of being able to cope resiliently and as independently as possible at school, despite their difficulties. There is, therefore, a need for school and CAMHS staff to have a better insight and understanding of these schoolchildren's individualised needs, so that their resilience and coping strategies can be better promoted. The individualised support this population of schoolchildren preferred is discussed in three overarching themes, as presented in Figure 14 below:

Figure 14: Visual Thematic Map – Global Theme 2

Overarching Theme 4 Information Sharing	Overarching Theme 5 Individualised Support	Overarching Theme 6 Coping Autonomously
• Choosing what is communicated • Preferences as to the methods of information exchange	• Preferred learning assistance • Preferred pastoral assistance	• Coping autonomously by building resilience • The importance of safe quiet space

Theme 4 relates to the information sharing. The core issues reported were the need to be involved in what information is exchanged, as well as considering how information is best communicated. Theme 5 centres on the young people's favoured individualised educational and pastoral supports. Theme 6 discusses the young people's ultimate goal and the need to cope as autonomously as possible whilst at school. All six of the overarching themes discussed in the two results chapters are connected, in that each layer of support strengthens the young person's well-being, learning and resilience. Together this support serves to provide the wraparound assistance the young person

needs to promote their recovery from mental health problems, thus enabling them to better focus on their learning. Figure 15 below depicts in pyramid form the interconnectedness of each layer of support. It may be noticed that this hierarchical relationship is akin to the seminal humanistic psychological theory proposed by Abraham Maslow in 1954 'The Hierarchy of Needs'. Similarly to Maslow's hierarchy, it is dictated that prerequisite to independent coping at one's full potential is the human need to feel physically safe and emotionally secure.

Figure 15: The Priority of Need

Coping autonomously

Having access to preferred learning and emotional support

Feeling secure about key information being shared with teachers

Physical and emotional security at school through feeling socially connected and having a sense of belonging
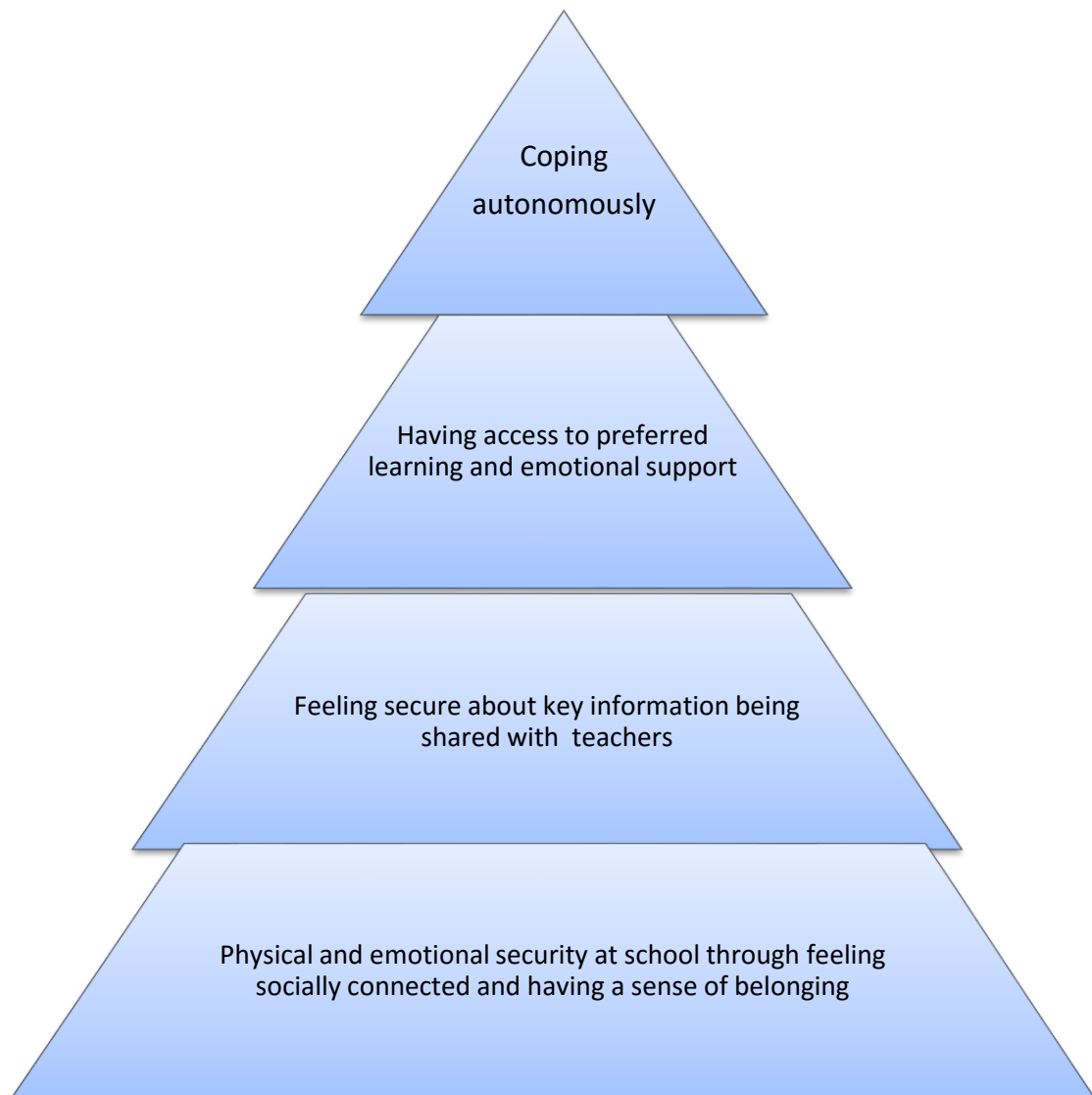
5.1. Theme 4: Information Sharing

The young participants (n= 9) and their parents (n=10) conveyed a need for schools to receive '*need to know*' information, as this was perceived to ensure that any individualised school assistance would be obtained. The participants indicated, however, that several complex factors complicated the exchanging of information pertaining to their mental health problems. Some of these have already been highlighted in Chapter 4, in relation to confidentiality, disclosure and mental health stigma, all of which made children and parents feel insecure about sharing personal information. There were also some more practical communication factors around information exchange hindering them from exchanging '*need to know*' personal information. This subtheme focuses on these issues. First, there is the problem of deliberating what personal information should and should not be shared with the school. Second, how CAMHS staff can best exchange information.

5.1.1. Choosing What Is Communicated

The majority of the young participants (n=11), despite their insecurities about exchanging information with the school, were aware that for their educational staff to attend to their unique individual needs, they required a good awareness of their emotional problems. The majority of their parents concurred with this viewpoint (n=13). Some young participants (n=9) spoke more explicitly about how, in an ideal world (whereby school staff had an understanding of mental health problems and confidentiality), this would benefit them personally. The perceived benefits of information exchange were articulated by YPa and YPb below:

> ### Excerpt 92: YPb
>
> I: *"Do you ever feel there's a need for CAMHS to liaise with your school?"*
>
> YPb: *"Obviously, cos my workers are professional, so they could probably give them some advice on how to deal with me at school, and that kind of thing".*
>
> ### Excerpt 93: YPa
>
> YPa: *"I do think it is really complex but I think if CAMHS told the school more exactly the things you are feeling, you would not have to do it which would make*

it less daunting, and I suppose they would be more aware that you are feeling those kind of emotions. So, more communication between them might help".

YPb's statement placed an emphasis on the need for school staff to have 'some' advice, as she believed this had the potential to secure additional resources for her, or grant her special classroom permissions when required. YPa, like many of the other young participants (n=6), also believed that if school staff knew a little more about his unique difficulties they would be more likely to detect his signs of distress. He then perceived that better teacher understanding would ensure he received more caring help. YPa hinted that this was important when distressed, because he found it difficult to articulate his emotions and explain his difficulties. The ability to manage and understand a child's or young person's emotions is a core skill possessed by all CAMHS practitioners (Roth et al, 2011). The problem that these young participants highlighted, however, was that despite CAMHS practitioners being skilled in understanding emotional expressions or behaviours, this knowledge or information was not being shared with schools. The majority of the parents (n=9) similarly perceived that their child's school experiences would be improved if school staff received some basic information relating to their child's emotional needs. In the extracts below, Ph, Pm1 and Pm2 give some insight into their viewpoint:

> ***Excerpt 94: Ph***
>
> **Ph:** *"With the Head of like his house, and he said to me, we really do need to get to grips with ((names child)) and this school thing, you know he's got to realise that he's got to come to school and I said I can assure you he does realise that he has to come to school, and I can assure you that it's not just school that is affected, and I said it's home, and I went through everything like with home; I said he can't go out, he can't walk round the block. And I don't think he realised, I think, he thought that it was just school, and I wouldn't say that he was trying it on trying to get out of school but I think that was his impression".*

Excerpt 95: Pm1 and Pm2

Pm1: *"I thought it was important because it gives somebody a quick understanding, of ah, that's why we have got to this point. If you don't have that explanation, it doesn't have to be that I have to talk about what has happened in his background, I don't particularly want to tell anybody, because it is none of their business but just the understanding of going to CAMHS for this".*

I: "So, just an understanding that this child is going to CAMHS because of …"

Pm1: *"Ye, exactly, I think that is the one thing that is missing the link between CAMHS and school, and school and CAMHS".*

I: "So, it is important not just to have that home link but also have that CAMHS…"

Pm1: *"A professional link really".*

Pm2: "A professional link really".

Pm1: *"Because we were very open with the school because ((names child)) is going to CAMHS because of this and this, we didn't tell every man and his dog, but we need to make you aware that this is going to affect him at some point, we don't know how it is going to come out, when it is going to start but it will as it has in the last six months, it has seriously affected ((names child)) behaviour at school, his behaviour at home, so it has sort of taken six months to get down the line of saying you really need to talk to CAMHS now, because you need to know because, we know what is going on, but you need to know what you need to do".*

Ph believed a brief explanation of her son's difficulties safeguarded him from being judged and stereotyped as deviant. Excerpt 95, whereby mother and father were interviewed together, also conveys this belief and demonstrates how, by exchanging key information about their son's severe anxiety problems, and how this caused him to disengage from school work, this had, in their opinion, prevented teachers from stereotyping their son as deviant. The child's mother believed the information they conveyed provided teachers with invaluable insight into his problems, ensuring he was better assisted at school. Pm and Pm2 also placed an emphasis on the importance of the

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school having some information by saying "*it doesn't have to be what has happened in his background, I don't particularly want to tell anybody because it is none of their business*". This statement demonstrated their wish to withhold the complexities of their son's problems to school staff, but provide just enough information to ensure staff better understood his difficulties. The educational participants also spoke about the value of parents passing on key information about a child's difficulties, as illustrated by ESs and ESr below:

> **Excerpt 96: ESs**
>
> **ESs**: *"I do think it is important to tell teachers. There are obviously some things you can't, because it is confidential, but even then you can tell them enough to make them feel that they know what they need to know, a need to know basis".*
>
> **Excerpt 97: ESr**
>
> **ESr**: *"Sometimes parents will give us information that is very useful to us".*
>
> **I**: *"Can you expand for me?"*
>
> **ESr**: *"I've got another one where mum has just told me details of what's going on at home, and so we've, and she's gradually letting me know more and more about the family background, which is helping because otherwise we're working in the dark and wondering what's actually happening".*

These teacher statements demonstrate the helpfulness of receiving key information, that ESs states "*just enough*" information is helpful and ESr emphasises that the information "*is very helpful to us*". The empirical literature especially emphasises the need for schools to forge good home/school links with parents of children with complex difficulties because it is acknowledged parents possess special knowledge about their child's unique needs, which, in turn, is invaluable to teachers (Mitchell and Sloper, 2002). In reality, however, it has to be acknowledged that parents are sometimes ambivalent when it comes to exchanging information about their child. The above excerpts demonstrate the educational staff's awareness of this. For example, ESs mentions how parents may struggle with confidentiality issues and ESs reveals how difficult it may be

for parents to reveal to school staff personal information of a private nature, especially pertaining to the sensitive topic of mental health.

Research has drawn attention to the reasons why parents of children with mental health problems have difficulty exchanging information with their child's school. For example, studies have stressed how parents experience stigma and self-stigma in relation to their child's mental health problems and that sometimes they burden themselves with blame and guilt and thus do not seek help (YoungMinds and Cello, 2012; Meltzer et al, 2011: Zisman-llani et al, 2013). Dealing with this and the stress of supporting a child with mental health problems can also make parents feel inadequate and socially rejected (Porter, 2008; Zisman-Ilani et al, 2013). Educational research has highlighted how parents themselves have a past school life, which if negative, can be reactivated into the present, thus leading to a transference reaction whereby past school memories can hinder present school engagement (Cooper and Jacob, 2011a). These findings indicated, however, that there was a further factor hindering parents from exchanging information about their child, namely their child's wish for their parents not to share private information about them. Many parents respected their child's wishes (n=9), but often found that this made them feel helpless on how best to support their child.

The young participants gave a number of reasons why they did not want their parents to share personal information with the school. For instance, some thought that their parents may unintentionally complicate school issues (n=3) or that their parents' knowledge of school difficulties may cause additional problems at home (n=3). Others spoke about how their parents' ill health and school worries might cause their parents additional worries (n=4). This reflects the evidence that one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves (Leinonen et al, 2003; UNOCINI, 2004). These findings, therefore, indicate the complexity associated with parents informing schools of their teenager's difficulties, especially when they do not wish their parents to be involved. Interestingly, the young participants referenced the issue of school involvement approximately only 8 times, whereas their parents referenced this approximately 362 and their teachers 57.

An abundance of policy and research advocates strong justification for good school/home links, and that parents and teachers especially want to strengthen school/home communication, yet these findings indicated that this population of young people did not share this viewpoint. Developmental theory suggests that it is normal for adolescents to demand greater autonomy (Kroger, 2007) and for parental involvement in their schooling to decline (Weare and Gray, 2003). Despite the numerous barriers hindering parent/school engagement, schools are continuously reminded of the benefits of such good parent liaison and collaboration (Millar and Wood 2011; Power et al, 2012). To date, however, there are few studies addressing parents' or teenage pupils' preferences about how their parents are best involved in their secondary schooling, as most research in this area has been primary school focused. Even less is known about the unique issues parents of children with mental health difficulties face, especially when disclosing mental health-related information about their child to school professionals (Kramer et al, 2006).

Young participants and their parents did, however, indicate one way of circumnavigating a lot of the above described complexities. They felt it appropriate for their CAMHS professional to pass on key '*need to know*' information on their behalf. This was because they believed a CAMHS worker would be able to explain more concisely their emotional difficulties. This viewpoint is demonstrated by the father (Pf) below, who described how his daughter, when supported by tier 3 CAMHS, had initially kept her concerns a secret from school staff; it was only following an admission to hospital because of an acute relapse in her mental state, that her school became aware of her problems. He explained how the tier 4 CAMHS in-reach schooling team had helped improve his daughter's school experiences by relaying key information.

> ### Excerpt 98: Pf
>
> *Pf: "To be aware that there is an issue, you know, when ((names child)) started back, there was a sort of you know it had to mentioned by in-reach; what do you want to say if a child comes to you and says where have you been what do you want to say if a teacher comes to you and says where have you been? In the past, you could say I have been ill, you could say I have had a mental health issue or you could say I don't want to tell you. The small bit of understanding that the*

teacher can take on board, they don't need to know what has happened to ((names child)), but they need to be aware that something has happened. I think that is probably the most you can ask so that a typical issue of where's your tie, where's your school jumper, we are having a push on you must wear them; maybe that could knock a patient's confidence back whereas if please don't have a go at a child, because they have not got their tie on, because this child has had an issue that's as much as they can be aware they can't push it any further than that, and provide support that they can they can just pull back".

Pf's statement described how an important part of his daughter's re-integration back into school after a long illness involved the CAMHS in-reach teacher discussing with his daughter and himself what personal information the teachers needed to know. Together they discussed what she would say and do in the event of being asked prying questions by other pupils or school staff. Pf believed that these collaborative conversations helped his daughter understand the importance of sharing information with the school and also enabled them to better decide what "*small bit of understanding*" the school needed to know. He believed that this exchange of information then ensured school staff provided more sensitive individualised support, which was especially important because one small comment could negatively impact upon his daughter's confidence, potentially causing her mental state to relapse.

Other young participants (n=3) reported similarly that this type of support provided by the in-reach schooling team was invaluable. This finding, therefore, indicates the value of this type of collaborative discussion between a CAMHS professional, parents and the young person as it ensures they have a better understanding of the pros and cons of sharing key information and schools receiving the information they need to support the child's individual needs at school. This collaborative approach also ensured that the young person has the ultimate say in what should be exchanged with the school. A consequence of this is that it promotes their security. It also ensures parents are not left in the unenviable situation of feeling they need to pass on key information. This suggests the outreach school teaching team approach, used when rehabilitating a young person back into school life following absence, could be used widely by CAMHS professionals. Notably, present school guidance (i.e.'*Supporting pupils at school with medical*

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conditions' (DfE, 2014c) details how to support children reintegrating back into school following illness but does not distinguish the needs of children with physical health problems from those with mental illness. This suggests that more specific guidance should be developed in relation to children with mental illness.

In summary, CAMHS professionals need to consign time to carefully negotiate with young people and their families what '*need to know information'* is best passed onto the school. A core part of this discussion is for the young person and parents to be informed as to the benefits of sharing key information. The young person should then have the choice as to what "need to know" information should be exchanged and ideally it should be the CAMHS professional who passes this information over to the school.

5.1.2. *Preferences as to the Methods of Information Sharing*

Having ascertained that young people would prefer their CAMHS professionals to share relevant information with their teachers, there is a clear suggestion to focus on the improvement of collaborative links between schools and CAMHS. This was because the majority of participants reported that the exchange of communication between schools and CAMHS was sporadic, with many young people (n=9) and their parents (n=8) believing that the two agencies had poor communication. The teachers, representing differing schools, had mixed opinions, with half believing CAMHS and schools had good collaborative links and the other half perceiving these links to be poor.

A wealth of literature highlights the challenges that professionals from differing agencies face when exchanging key information. Key enquiry reports have highlighted how poor inter-agency communication has in some cases led to tragedy (e.g. Brandon et al, 2008; Laming, 2003; Lundberg, 2013). The problem is that although it is widely recognised that good inter-agency collaboration is vital, communication is one of the most challenging aspects of supporting children with complex mental health needs (Salmon, 2004; Weist et al 2012). Some of the complexities have already been highlighted in section 1.7. This subtheme focuses, however, on one aspect of inter-agency communication, i.e. mechanisms through which to channel communication exchange. The statements below highlight the young participants' perception of CAMHS's school communication being largely intermittent in nature:

Excerpt 99: YPb

YPb: *"So, I think it is helpful, cos it's happened before, like communication has gone on if something's happened at school that CAMHS needs to know, or something happens at CAMHS that school needs to know, it's kind of, it has happened before, and it could probably happen more often".*

Excerpt 100: YPj

I: *"You have had that time where you have been with CAMHS; did CAMHS speak to your school?"*

YPj: *"Um, not particularly, when it came to in-reach education, that was when the link was, but other than that there wasn't really a link".*

YPb hinted that her school and CAMHS were more likely to converse only when the need arose, usually following a crisis. She perceived this to be inadequate and stated CAMHS and school should have more regular communication. This was a perspective reiterated by YPj who stated that her tier 3 CAMHS team had very little contact with her school. She did, however, highlight that, when supported by tier 4 CAMHS in-reach schooling team, the collaborative link between CAMHS and school noticeably improved. Once again this indicated that communication tends to happen more frequently when the child's problems have escalated, and thus communication is reactive rather than proactive. This perspective on communication was also held by the parents. This was because they often felt they needed to step in and act as the conduit between the two agencies, as represented by these parents below:

Excerpt 101: Pm1 and Pm2

Pm2: *"It is the understanding, you know, of schools that children will go through different aspects. I think they do understand that, but it is connections that need to be in place".*

I: *"You say the connections need to be in place, what are they?"*

Pm1: *"Yeah, I know, what you mean, yeah".*

Pm2: *"Yeah, exactly".*

Pm1: "Are they actually doing it?"

Pm2: "Yeah, as we, like what we were saying. It has taken us to say you talk to you and you talk to that person, and we will kinder make you meet in the middle sort of thing".

I: "So, if parents are not as articulate as you then…"

Pm1: "Like they knew he was going to therapy, but they never at one point said, 'do you think we need to contact CAMHS to find out what is going on'. They never made that, it was me that said on that Monday, perhaps you need to make a contact with them, so that they can discuss direct with you".

Excerpt 101 demonstrates how strongly these parents felt about a CAMHS professional being better positioned than themselves to explain to the school the likely negative impact that psychotherapy (because of having to revisit difficult past emotions) would have on their child's mood and behaviour. This excerpt demonstrates how they urged CAMHS and school to communicate, but how unsuccessful they were. They, therefore, were left to convey this vital information themselves. Other parents spoke similarly about how they had to act as the conduit, passing key information to schools from CAMHS, but found that on many occasions they were not taken seriously, as Px and Pu describe below:

Excerpt 102: Px

Px: "We have the diagnosis we can now say, right she has got a diagnosis and these are the things that need to be put in place for her; please make sure they are".

I: "And have they?"

Px: "No because they are still waiting for a letter from the consultant, they won't do it just because parents say so, it has to come from higher grounds and they have to have a letter from the consultant".

Excerpt 103: Pu

Pu: *"I mean, I had to write and say to the teacher that ((names child) needs a stress ball, but they took it off her".*

These parents were attempting to pass on suggestions, made by CAMHS professionals to school staff, but both felt ignored. The excerpts demonstrate that schools sometimes have problems with parents acting as the conduit between healthcare professionals and themselves. This was a dynamic that hindered good parent/school relations, as it made parents feel subordinate, which resulted in them having less confidence in school staff. Interestingly, a study carried out by Mukherjee et al, (2000) exploring the perceptions of parents with children with complex physical health needs, found similarly that school staff often had problems with parents conveying healthcare related information. Mukherjee and a colleague's data indicated this was because school staff feared parents would either withhold key information, deeming it not relevant to school, or they were suspicious of them 'twisting' what a health professional had said to get what they wanted from school staff. Findings from this study did indicate, however, that home/school communication was improved when parents had the opportunity to attend arranged tripartite meetings between themselves, school staff and external agencies. The helpfulness of these meetings is indicated by Ph below:

Excerpt 104: Ph

Ph: *"Obviously I went in to see them and they sort of like said, you know, this is what we would like to do if you agree, and obviously I said, yes, and every, I don't know, sort of like every three months we'd go in and we'd both have an update and they'd say what this, you know, ((names child)) has got this far we think now he could do this, this and this".*

I: *"Right".*

Ph: *"Stepping onto the next stage".*

I: *"So they asked your opinion?"*

Ph: *"Yeah, yeah they did".*

I: *"Yeah. And ((names child)), did he have a voice as well?"*

Ph: *"Yes, he did, yeah, he was in the room and…"*

I: *"Yeah".*

Ph: *"He could say yes or no or, you know, what his feelings were, how he felt about things".*

This excerpt demonstrates how much this parent valued this type of contact, believing this to be an opportunity that enabled her and her son to take an active part in deciding how he should be best supported at school. In effect her opinion was valued, the mother felt empowered. Other parents stated, however, that a key disadvantage of more formal meetings is that they often did not happen, because they relied on teachers and healthcare professionals surrendering time out of their busy schedules. Consequently, promised meetings sometimes did not happen or were cancelled. Other researchers highlight similar issues of time constraints (Mukherjee et al, 2000). This implies that more informal collaborative parental and inter-agency channels of communication are needed. Some of the young participants indicated that they had a preference for more informal exchanges of information such as written notes rather than meetings. YPc, below, indicated the need for a note and YPn highlighted some difficulties with this type of information exchange:

Excerpt 105: YPc

YPc: *"I think ((names CAMHS clinician)) could maybe write a letter to the school and say how serious I have got".*

Excerpt 106: YPn

YPn: "All the teachers had some information in a note about me but the only one who took it into consideration was my science teacher".

I: "Can you remember what the note said? Were you happy with what the note said?"

YPn: "It just said that I had anxiety issues and I had to have my own seat. I couldn't sit somewhere else, I have always had my own seat no matter where I am, it's just a thing with me, I have to have my own space and once a teacher

tried moving me and I said I am not moving there, but that was before they had the note and the next day they apologised to me and said they didn't realise".

I: "So, that one little piece of information about you liking your own seat was really valuable at school?"

YPn: "Yes".

YPc felt that CAMHS professionals could assist her at school by providing a letter summarising her emotional difficulties. Other studies exploring the perceptions of children with chronic physical needs have also reported that this type of written information exchange is valued by young people (Lightfoot et al, 1999). YPn did, however, demonstrate how in reality less formal channels of communication like a letter, written by her CAMHS professional, containing some key 'need to know' information was a good idea in principle, but because school staff had some scepticism about her mental health condition, this still did not ensure she received the individualised assistance she required. It was argued that the note was not taken seriously because of the teacher's lack of mental health awareness. This, therefore, links back to a previous theme (section 4.2.1) highlighting the need for teachers to have basic mental health knowledge. This can then ensure schools have a better understanding of the information being exchanged from another agency, thus allowing school staff to have a good understanding of why this information needs exchanging so ensuring it is not ignored.

To improve inter-agency communication, schools and CAMHS are being urged to carve more creative channels of communication, through, for example, email and texts (National CAMHS Support Service, 2011; Weare, 2015). It does appear that the participants concur that such methods of communication are a good idea, as they take less time and the young people voiced a preference for more informal methods of communication. Some educational staff also spoke about the need for more informal methods of collaboration with agencies like CAMHS, as they felt that meetings were time- consuming and not always necessary. Their viewpoints about collaboration are represented by ESe below:

Excerpt 107: ESe

I: "What do you think the school needs to better support these young people that we have identified? If we were to wave a magic wand?"

ESe: "I think at the point where we aren't sure where to go, we need some better type of network to help us to get advice and support. I mean, going back to CAMHS I feel a bit bewildered by that and this young lady, you know, she has come to me and told me she has very dark thoughts, she has thoughts about harming other people and she is frightened of herself; she is a very confused young lady and that is one sort of facet, and I think if we could access support not in six months' time, but really before it gets out of time if you could make a problem stay small by dealing with it as quickly as possible; everything just takes far too long".

ESe was describing a complex pupil case which identified the need for a trans-professional forum providing the opportunity to discuss, informally, complex cases with external agencies like CAMHS, perhaps via the telephone or email. ESe believed that at present referral pathways to CAMHS were poor. She believed that this form of CAMHS/school collaboration would, however, enable school staff to strengthen their ability to determine risk and to ensure that any pupil with mental health problems was provided with appropriate timely support. There have been various global projects, all of which have introduced more proactive linking strategies with school and partnering mental health agencies. Evaluations of these projects in the main conclude that the more collobrative links there are between a school and any healthcare agency, the greater the potential to raise the awareness of child mental health issues amongst school staff, and that promotes early detection and early intervention (National CAMHS Support Service, 2011; DH, 2015).

In summary, passing on 'need to know' information via formal inter-agency collaborative mechanisms, like meetings, is well received by all stakeholders; however, relying solely on these communication channels is time-consuming and not necessarily needed in every instance. Therefore, alternative and more cost-effective channels of communication need to be forged. This is because at present information is sometimes

being lost or not being taken seriously when exchanged. A parent acting as conduits between healthcare and schools is not adequate, therefore, CAMHS and schools need to bridge the communication divide, considering their busy workloads, via both informal and formal modes, embracing new technology when appropriate so that key information can be conveyed. Teachers should also be given the opportunity to develop mental health awareness, so maximising the information being exchanged.

CAMHS staff are considered well placed to facilitate the debate with young people and their parents as to the benefits of sharing information, discussing what should be shared with schools and whom it should be shared with. Schools and professional agencies like CAMHS must carve out more creative channels of communication as consultation via multi-disciplinary meetings can be costly, time-consuming and is not always necessary. New modes of communication must, however, be taken more seriously and become incorporated in organisational protocol and IT systems.

5.2. Individualised Assistance

The young participants gave a unique insight into what academic and pastoral assistance they preferred. All of their suggestions were feasible, sensible and arguably, relatively inexpensive and not time intensive. They were, however, learning and pastoral supports that required external agencies to provide educational staff with some 'need to know' information. When it came to receiving enhanced support from their school, two key messages were conveyed by the participants. They wanted to harness more of their teachers' specialist skills in order that they could be better assisted with their learning. Secondly, the pastoral assistance most valued had to be discreet, as it was perceived less stigmatising.

5.2.1. Preferred Learning Assistance

It is important to highlight that the young people who took part in this study varied in their academic ability. Four parents revealed that their child was considered to be academically gifted (n=4). Two parents stated that their child had a SEN statement (n=2)

and one child had SEN support without a statement[15]. The child's intellectual ability did not, however, make them experience less academic stress, because the majority of the young participants (n=13) reported that they worried about school work and exams. These findings parallel those of national surveys which state academic worries are one of the main childhood stressors (Beaumont, 2013; NSPCC, 2015). All the young participants described how these academic worries negatively impacted upon their mental health problems. Many of the participants also spoke about how their mental health problems negatively impacted on their learning ability and their academic attainment (n=8). For example, common cognitive deficits associated with emotional problems were described, such as concentration impairment or emotional dysregulation. These are illustrated by YPf, YPn and YPa below:

Excerpt 108: YPf

I: "How often do you feel low at school?"

YPf: "Three out of seven days".

I: "That must be difficult?"

YPf: "Yeah, I think about everything. Yeah, and like I stopped paying attention and then just thinking, and then trying to do the work again, and then doing it for a bit, and then thinking again".

Excerpt 109: YPd

YPd: "Because I didn't do much homework when I was depressed and my school work was at quite a poor standard for me".

Excerpt 110

YPa: "I think often the combination of the work and the fact that I have been diagnosed with depression, and this brings quite a lot of anxiety, and I often find that often gets on top of me, and quite a lot of nervousness about school

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[15] A statement of SEN outlines the child's needs and the support required to meet those needs. It can include specialist therapists, a specified number of 1:1 hours and specialist teaching required. This was replaced in September 2014 by the Education Health Care Plan EHC Plan.
https://www.gov.uk/children-with-special-educational-needs/support-before-september-2014.

translates into more anxieties, and often I do feel stressed and think things are too much".

YPf spoke about how easily distracted she was in class whilst being low in mood, and as a result she found concentrating difficult. YPd found when low in mood her attainment declined. Consequently, she blamed this on the lack of motivation and apathy associated with her depression. YPa conveyed how his depression frequently made him feel overwhelmed, which, in turn, caused him to ruminate about his academic work and subsequently perpetuated his mental health problems. The symptoms these participants described are listed in the Pappas and Frize (2010) Intellectual Disability: Mental Health First Aid Manual, p.32. This is a manual designed for frontline practitioners like teachers, so that they can better identify mental health problems amongst children with learning disabilities. Some highlight, however, that less advice is available to frontline professionals, detailing the signs of depression and anxiety amongst children who do not have a co-existing learning difficulty or who are considered gifted (Lamont, 2012; Mueller, 2009; Suldo et al, 2013).

According to the SEND code of practice[16], '*Special Educational Needs in England',* because their learning does not lag behind the majority of pupils of the same age, they do not qualify for additional learning support (DfE, 2015b). This is concerning because these findings suggest that many children in mainstream education, who experience mental health problems, are being overlooked for extra educational support because they are considered academically able. Mukherjee et al (2000) study similarly highlighted that children with chronic illness but no learning disability were often not receiving the academic assistance they required.

The majority of the young participants felt that if their teachers were given more information about how their cognitive and emotional difficulties impacted upon their ability to learn, they would be better able to provide them with the individualised learning assistance they required. This finding indicated, however, that at present school

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[16] SEND: Special educational needs and disability code of practice gives guidance to English schools, local authorities and health bodies, as to their statutory and legal obligations when supporting children with special educational needs, under part 3 of the Children and Families Act 2014 (DfE, 2015b).

staff are unlikely to understand the reasons why children with less visible mental health problems need additional academic assistance, especially when they are not classified as having learning needs. This is because, when the educational participants were asked what they thought young people with identified mental health problems needed at school, they neglected to say how the symptoms of depression, anxiety or eating disorders, can impact on the child's cognitions such as memory and concentration, and how this, in turn, can impact on attainment and learning or on their behaviour. Other researchers investigating teacher knowledge in this area have also concluded similarly that teachers do not have this basic mental health knowledge to link cognitive deficits to mental health symptoms (Taggart and McMullen, 2007). What some educational staff (n=5) indicated, however, was that they prioritised attainment over well-being. This is demonstrated by the below excerpts:

> ### Excerpt 111: Esr
> **ESr:** *"We here have a big thing about children achieving the absolute best that they possibly can; education is so important in life that we push our students as far as we possibly can in pretty much all cases".*
>
> ### Excerpt 112: ESj
> **ESj**: *"Primarily my job really is being a maths teacher and pastoral side almost comes second really, that is not always right but that is how it is, just that is the way a lot of teachers work".*

ESr states "*we like to push our students as much as possible in pretty much all cases*". This implied that attainment was a priority and the child's well-being was secondary. This teacher was aware that school success was paramount because it improved the pupil's life chances. ESj's statement also confirms that in today's contemporary schools, attainment is often prioritised over well-being and pastoral support. Many parents (n=6) also felt this was so. This is surprising because in recent years there has been an abundance of research emphasising how well-being and attainment are linked, as both are of equal importance (Bradley and Greene, 2013; Suhrcke and de Paz Nieves, 2011). This has resulted in clear recommendations to teachers to balance statutory health and attainment needs (Public Health England, 2014). The statement of YPa below highlights,

however, this balance is often not struck. Notably, the statement above (Excerpt 111) was made by his teacher:

> *Excerpt 113: YPa*
>
> *YPa: "This time round I am getting more and more worked up over exams recently to the point where I have some stupid thoughts and I could just kill myself and not have to do the exams, that's never a serious thought, it is just like it makes me feel quite hopeless sometimes".*
>
> *YPa: "If I want to make things a bit easier, I could… the same way the school could help by reducing the workload, but I don't know I sort of feel I think it is just part of the guilt belonging to depression, because I feel I would be taking advantage of them in some way or something".*

YPa's statements demonstrate how the negative thoughts, emotions and behaviours linked to his depression, guilt, shame and low self-worth were preventing him from seeking his teacher's assistance when feeling overwhelmed by his school work. It also highlighted how fragile his mental health was at exam time. He was aware he needed to reach his full academic potential, but not to the detriment of his mental health; yet, because of his mental health difficulties he was not able to voice his problems.

The young participants and their parents did suggest ways through which their teachers could ensure they maximised their academic potential yet be emotionally supported. One method of assistance many found helpful, whatever their intellectual capability, was the opportunity to talk over their academic stressors with their subject teachers (n=10). This was verified by their parents (n=12). YPx and Pk represent this viewpoint below:

> *Excerpt 114: YPx*
>
> *YPx: "But if you feel yourself getting stressed and you don't talk to someone, then it doesn't help, then you have time off school and get behind and teachers shout at you".*

Excerpt 115: Pk

Pk: "One of the teachers there was brilliant, and she really helped her. Cos she would really say like, she took a lot of the pressure off ((names child)) with her English work and that".

YPx's statement describes the negative consequences of not talking to a teacher about school stressors and academic pressure, in that it led her to alienate herself from school. Pk demonstrated the value of her daughter talking to her teachers about her academic worries, in that it acted as cathartic release enabling her to positively reappraise her problems and to cope better. There is plenty of information in the public domain emphasising the importance of young people talking over worries and academic stress (i.e. Child Line, Beat Exam Stress Leaflet; Child Line, Worried Need to Talk Leaflet; NHS Choices, Talking to Children). This is because talking is known to reduce the risk of avoidance behaviours, self-blame, rumination, higher levels of self-criticism and perceived incompetence, which can all exacerbate mental health problems (Garber, 2006). Other young participants (n=5) also highlighted the value of teachers giving them practical support, like discussing how their academic workload could be limited without jeopardising future opportunities. For instance, a bright child could take 8 GCSE's rather than 10, and reap as many benefits. Other young participants spoke about the value of practical revision and exam support (n=10), so did their parents (n=12):

Excerpt 116: YPf

I: "So, you have problems concentrating when you get stressed, and the teachers don't understand how difficult it is to concentrate on your revision".

YPf: *"Yeah, especially at home, as well like when I'm at home I lose concentration, and then I end up like don't revise a lot, and then but at school if they did have extra revision lessons at school, then I think that would be quite helpful".*

YPf felt that additional revision lessons would help her with her homework, because she found that her anxiety and depression often inhibited her learning and she could not concentrate in the home environment. Interestingly, researchers studying the perspectives of children with chronic physical illness have also identified that, because of their higher than average absenteeism rates, they value more academic support in

the form of revision assistance and catch up support (Lightfoot et al, 1999). The young participants (n=6) and their parents (n=6) highlighted how distressing exam time was and how much they valued practical or emotional support. Pg, below, spoke, about the lack of exam support and its impact on her daughter's mental health:

> ### Excerpt 117: Pg
>
> **Pg**: *"She sat her exams in the main hall with everyone else and struggled. She still got good grades but stressed her to hell, and it had a knock-on effect to her health, silly little things like that could be put into place so easily, they could get rid of some of the levels of stress that she has already got".*

Pg conveys a perception that the school may have done more to reduce her daughter's stress at exam time. This mother felt her daughter's mental health would have been safeguarded if some practical exam adjustments were made so as to ensure she was relieved of some of the stress she was experiencing. For example, by ensuring she could take her exams in a less hostile environment. In contrast, YPj explained how the support she received from the CAMHS in-reach teaching team really helped her to cope with exam-related stress.

Excerpt 118: YPj

> **I:** *"So, did in-reach help you with exam stress?"*
>
> **YPj:** *"Yeah, they told me how to structure it, how to keep a positive attitude with it, coz when you are stressed you have five exams, you stress about it, and you just keep thinking, oh my goodness I have five exams; and you keep thinking about it, and I don't have time to revise and that is going to make you worse; but if you just sit down and say, ok, I have got this exam on the first, and if I revise then, and I have got this one on the third I am going to revise then and this one on the seventh I am going to revise then, and this breaks it down and makes it easier to deal with".*

YPj's statement demonstrates how the in-reach schooling advice helped her prepare for her exams despite her depression. She was encouraged to adopt a *'bite size'* revision plan which discouraged her from feeling overwhelmed. This enabled her to feel more in

control and implies that there is value in the in-reach schooling team disseminating some of these practical helping strategies, in leaflet form, to other children attending CAMHS so that they may benefit from this advice too.

In summary, all young people with mental health problems, regardless of their academic ability, benefit from enhanced learning assistance from teachers who have some information about mental health problems. It is this knowledge which can positively impact the child's ability to learn and ensure a young person can be individually supported in a number of ways, from having the opportunity to talk about exam or academic stress, to helping gauge realistic academic targets considering their well-being or providing practical provision like catch up revision or exam adjustment. In this way children can benefit academically, but also most importantly be safeguarded emotionally. This finding indicated, nevertheless, that educational staff are frequently not privy to this information and as yet attainment is often considered over the child's well-being.

5.2.2. Preferred Pastoral Assistance

Having discussed the young participants' learning needs, this subtheme now focuses on what the young people, their parents and teachers perceived as realistic pastoral school support that enabled them to better concentrate on their learning. The majority of the young participants voiced a need to compartmentalise their emotional difficulties when at school in order to focus on their learning (n=12). They consequently tried hard to separate their school life from their CAMHS support:

> **Excerpt 119: YPg**
>
> **YPg**: *"No, I didn't want my problems to feel like they are at school as well. It is blatantly obvious that someone has just found out whatever problem and that something is going on, like a TA[17], in a calm voice how's everything ((child says name)). You know they are trying to be nice and everything, but it can get quite annoying, especially if you feel like you are being treated differently from*

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[17] TA: Teaching Assistant

someone else because of whatever problem you have. But, um, ye, I would like that to stay in the sessions, you know".

YPg, like some of the other young participants, felt strongly that the core role of his school teachers was to help him learn and that instead he should be assisted with his emotional difficulties by his CAMHS workers. The reason he reported for this, was he did not want his problems pervading his school life. Neither did he want to stand out amidst the crowd and appear different to other school pupils. By attempting to leave his problems at the school gate and concentrating on his learning, he was safeguarding himself from the discomfort of having differences that could potentially separate him from his friends. YPn and YPb, below, spoke similarly to YPg about the discomfort when speaking about their emotional difficulties at school:

> ***Excerpt 120: YPn***
>
> ***I:*** *"Would you talk to someone in school?"*
>
> ***YPn:*** *"Not really, because what would they do, like when I talk to ((names CAMHS practitioner)) I know she is part of a separate place and they have like a skill in talking to people or something, but at school they are just teachers".*
>
> ***I:*** *"So you wouldn't go to the counselling services or anything like that?"*
>
> ***YPn:*** *"No".*
>
> ***I:*** *"Could you tell me why?"*
>
> ***YPn:*** *"Because it is just awkward".*
>
> ***I:*** *"Why do you think that…?"*
>
> ***YPn:*** *"It's because you know them as a teacher and when I have people I know as like what they do like, I know my English teacher is my English teacher, so I wouldn't talk to her about other stuff; but somebody who has the job of speaking to people, they know what they are doing and saying".*

Excerpt 121: YPb

YPb: "I think it's called Service Six or something, and I think they come in like once a week or something, and you can go and like drop in and talk to them. But I just feel like anything on the school grounds, I don't know, even when I'm, even if I walk out of the nurse's office and someone sees me walk out the nurse's office, you get, you always get them asking, what are you in there for? So if I was to go and see the counsellor at school or the Service Six lady, then if someone saw me come out of there, then I'd immediately get questioned and, yeah. So, I guess I do just kind of, and it's, and I feel better. It's in a separate building".

The majority of the young participants (n=13) indicated similarly to YPn and YPb that they had a preference to speak to their CAMHS professional about their emotional difficulties away from school, rather than seek the support of a school counsellor, school nurse or teacher. The majority also stated quite adamantly they did not want to have any form of therapy or psychological support at school (n=12). This was because they felt their difficulties were too complicated for their school staff to understand and because of this, they would be more likely to judge them, thus causing them discomfort. Furthermore, as suggested by YPb, they also feared stigmatisation.

It was surprising to learn that the majority of the young participants did not want any form of more intense psychological support at school, as most directives on pupil mental health support suggest schools are appropriate settings because they are less stigmatising (DH, 2015). For instance, an abundance of literature, mainly derived from the USA and cited in the background chapter, indicates that schools are ideal for offering mental health support (Kutash et al, 2006; Weist et al, 2007). This is because they offer a more naturalistic and less stigmatising environment, therefore it has repeatedly been hypothesised that schoolchildren will find it easier to seek help there (Stephan et al, 2007; Nabours et al, 2000). Worryingly however, these findings dispute that school is a less stigmatising place. For instance, YPb demonstrated her fear of stigma by describing the discomfort she would have when other pupils asked her awkward questions about seeing a school nurse or even a drop-in professional. Other participants described situations whereby they had experienced awkwardness and embarrassment because their CAMHS therapy, indirectly or more directly, interfered with their ability to

compartmentalise school from CAMHS therapy as illustrated by YPa and YPn below:

Excerpt 122: YPa

YPa: *"It also feels like I have to really sneak away from school every single Wednesday. I have to go home really covertly, and it just feels like there could be some kind of better system, and schools factor in that mental health issues are quite common".*

Excerpt 123: YPn

YPn: *"Yes, that's why I told ((names her CAMHS worker)) not to tell the school originally, but when things started to get like weird and people would just annoy me, I got her involved".*

I: *"And do you think that helped in a way because things got so bad that you had to get somebody involved?"*

YPn: *"It was really awkward when a teacher would come into my class, because I forgot I had an appointment set and she would be like, ((says name)) you have to come with me, and everyone would look at me and think where is she going and when I came back everyone would ask me where I have been, and I had to make up excuses like I had to do extra revision".*

Both participants described the embarrassment of leaving school to attend CAMHS appointments and the lengths they went to not to divulge to their peers where they were going for fear of stigmatisation and victimisation. YPn, when reminded in class to attend an appointment, would become embarrassed and awkward, and would feel the need to lie. YPa would feel the need to be convergent and go undercover. This indicates that at present children do not always feel safe enough at school to have, attend or receive therapy sessions. This finding contradicts government recommendations which suggest that many young people would prefer to visit a school-based psychological service than visit their local CAMHS, as the school environment is less stigmatising (DfE, 2015a; DH, 2015). Studies evaluating the effectiveness of school counselling services in the UK have, however, highlighted a chief barrier to UK schools successfully delivering psychological service success is stigma (Baruch et al, 2001). This evidence suggests that

when implementing any form of therapy in a secondary school, which is not a universal intervention, that the child's school safety status must be carefully considered. This is because children with complex mental health needs often do not always feel confident enough to verbalise their needs or be accepting of individualised support, whether selective or indicated, because it risks making them feel different. They, therefore, need to be given a choice as to where and when to receive therapy.

As already highlighted in section 4.1.2, what children most wanted at school was discreet support from a key member of their teaching staff who knew them well (n=11) and who had a good awareness of their unique needs (n=13). Many parents concurred with this viewpoint (n=13). This form of teacher assistance is very different from the support offered by their CAMHS practitioner, in that it was more likely to focus on their school worries. The problem was that, despite voicing a wish for this form of discreet support from a specially named school staff member (a teacher having a key worker or mentor role), few of the young participants received this type of support. This was because they either did not feel safe enough at school to divulge their needs or their SEN needs were not considered serious enough by school staff to warrant more enhanced individual key worker support. The young participants who did, however, receive this form of support (one-to-one/key worker/mentor style support) from a special teacher were the young people subject to more intensive statutory support such as the Care Programme Approach (CPA)[18] or safeguarding protocol, whereby this was recommended as part of the care package. One-to-one teacher assistance then became integral to the care plan as demonstrated by these parents' statements below:

> *Excerpt 124: Pf2*
>
> *Pf: "Yes, they have pointed out which is the best teacher ((names the child)) feels most comfortable with; so if there was a panic she would go and find her".*

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[18] The Care Programme Approach (CPA) is a way of coordinating multi-agency care for someone diagnosed as having a severe mental disorder, from assessment, to managing and re-evaluating their holistic needs. This is conducted via multi-agency meetings and communication (DH, 2008).

Excerpt 125: Pz

Pz: "School have supported ((names child)) quite a lot since she started, because there have been like issues with social workers and all that from, like when she started, they helped her out because, they were on Child Protection things like that. Because they do support ((names child)) quite a lot".

Excerpt 126: P[19]

P: "Um, she's been doing the CPA because the lady that used to oversee ((names the child)) education, she was like the intermediate, you know, between her and school, she left to have a baby, so ((names teacher)) took over that role and comes in for the CPAs".

P: "Um, I mean, cos I think ((names the child)) got a mentor or two she can go to, you know, with teachers and stuff and said any time she wants to talk they can go and talk".

Excerpt 127: YPz

I: "What do you talk mainly about, when you go and see the deputy head teacher?"

YPz: "Um, I think it's mostly about well-being because, um, even if it is about work, it tends to be about whether anything's too stressful or anything like that, so that's what that is based on really, and that's sort of how it's adapted to sort of suit me I think".

The parents above (Pf and Pz) highlighted how their daughters benefited from a statutory or voluntary formalised protocol, in that it ensured she received the special discreet one-to-one support from a named teacher she wanted. Pz's daughter received one-to-one teacher support because she was subject to a child safeguarding procedure. Pf's daughter and YPz were subject to CPA which helped to ensure they received the school support they preferred which was to have access to a named teacher. YPj, below, describes similarly to YPz how at a CPA meeting the outreach schooling team asked for

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[19] Full participant pseudonym withheld to prevent deductive disclosure. The parent statement gives important contextual information so that YPz's statement (excerpt 127) can be better understood.

her to be assigned a named teacher whom she could emotionally connect to on a daily basis:

> **Excerpt 128: YPj**
>
> **YPj**: *"It is just knowing that, um, knowing that I don't have to do anything that I am not ready to do".*
>
> **I:** *"Ye".*
>
> **YPj**: *"Or, if I am not feeling great that people will understand that".*
>
> **YPj**: *"I think that is quite helpful, because you can if you want to, you can go and talk about things or ask them to change things".*

YPj indicates this type of intervention ensured that small school issues were resolved quickly before they escalated, thus reducing undue anxiety, and promoting her confidence and self-esteem when at school. She also highlighted the value of being able to speak to a named teacher who was aware of her difficulties and who she felt comfortable to approach. Most importantly, YPj's and YPz's excerpts demonstrate how comfortable these children were with this form of individualised assistance, in that they did not feel marginalised or segregated from other pupils, as this form of additional support was discreet and easily accessible. It is also apparent, from their statements, that their teachers possessed mentoring and coaching skills (a point already highlighted in the background chapter section 2.1.3). The young participants were aware that their teachers did not have the skill to support their emotional needs at a more advanced level, hence their wish to ring fence their school problems from more complex family and emotional issues which they preferred to discuss with their CAMHS therapist.

The findings, therefore, indicated that children often valued the educational coaching or mentoring of their teachers. It must be pointed out that the use of mentoring in education varies considerably in terms of approach and delivery. Mentoring programmes come in many adapted forms, from those that aim to support the academic attainment of youth who are at risk (Ross et al, 2010), to those addressing pupil attendance problems, or the more vulnerable pupils at transition from primary to high school (Komosa-Hawkins, 2012). Mentoring programmes can also help the gifted pupil

who is prone to anxiety and perfectionism (Benson, 2009). There is, however, limited literature focusing on teacher/pupil mentoring schemes adapted to support young people with complex emotional or other mental health problems. Yet the data collected indicates that a low key one-to-one mentoring or coaching teacher role focusing primarily on school issues and learning might benefit these young people. This is endorsed by the two parents below:

> **Excerpt 129: Pm1 and Pm2**
>
> **Pm2**: *"Throughout the five years he has been at ((names child's school)), she has stayed with him not as a one-on-one TA; but as a group TA but has always been there, hasn't she"?*
>
> **Pm1**: *"Yeah."*
>
> **Pm2**: *"She has been fantastic. She has like wrote homework in his planner, because he is like just that little bit behind everyone else with his concentration. She has helped him at lunch times out of her own times to catch up with any work he needs to do, particularly with his GCSEs. We just can't fault them at all to be honest ((laughs))".*
>
> **Pm1**: *"Yes, because the problem is trauma has affected his short term memory so trying to remember things, he just forgets, so she has been good with that".*

It is clear from the above excerpt that this Teaching Assistant (TA) knew this child well, for example his memory, concentration and organisational difficulties. Her special knowledge of these difficulties was acquired over time and allowed her to better guide the child and support him by implementing tailored strategies. Of note is that this child had a statement of SEN, therefore, a statutory assessment process dictated that any identified enhanced need be met, which in this child's instance was one-to-one support from a specially assigned member of the SEN team. What this finding indicated was that in the UK children most likely to receive coaching support or one-to-one intervention from a specialist teacher are those already prioritised for intensive statutory support, e.g. because of safeguarding concerns or having received a SEN statement which is now known as the Education Health Care Plan EHC Plan. Unfortunately only 2.1% of children

have a statement (DfE '*Statistical Release*', 2014d). The findings indicated young people subjected to review mechanisms like this and inter-agency support mechanisms like CPA and Child Protection protocols were more likely to receive personalised teacher support. This is possibly why other young participants did not receive it, despite their stated wishes and often evidenced need. Interestingly, the Common Assessment Framework (CAF) (see footnote 5), which is another shared planning process enabling schools and supporting agencies to assess a child's additional needs (Children's Workforce Development Council, 2009). This was not mentioned by any of the study's participants, which, therefore, suggests that the CAF/ Early Help Assessment[20] maybe being underutilised, especially when it comes to supporting children with mental health needs. This underutilisation was possibly because parents and indeed young people and their teachers did not appear to know that they had the right to request a CAF. The parents' statements, below, illustrate their frustration at not receiving more one-to-one teaching support from a named teacher:

> ### Excerpt 130: Pu
> **Pu:** "*Because that would keep a teacher in the job, because they can do one-to-ones with them when they need it… like ((child's name)) has had her one-to-one's stopped and she needs it*".

> ### Extract 131: Pg
> **Pq:** "*There should be one teacher which they can trust*".

These parents placed an emphasis on their child being able to approach one key member of staff whom they could trust. This was because they believed it was more difficult to personally engage with a child like theirs who was experiencing mental health problems (n=9) unless the child trusted the adult. Pq's statement conveyed the belief that her daughter's school experiences would be improved if she had at least one such teacher. Similarly, Pu suggested that her daughter needed "*one-to-one*" support. Pu described how her daughter had benefited from such support when making the transition from primary to secondary school, but then this support ceased, despite her remaining

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[20] The Early help Assessment replaced the CAF in June 2015. The new assessment is designed to help professionals from various agencies, such as teachers, health workers and GPs to make an accurate record of the needs of a child, young person or family.

vulnerable. The educational staff voiced one reason why her support may have ceased and this was not having enough time (n=6). This was acknowledged as a barrier to good pastoral support:

Excerpt 132: ESs

ESs*: "Um, talking to students or rather giving them an opportunity to talk because they don't always want too, giving them that sense of security so they feel that they have got permission to talk if they want to. But it can take time, it can take time".*

ESs points out that building up a trusting relationship with a child needs time, especially when encouraging them to verbalise their difficulties. Many of the educational participants said they did not have enough time in a busy secondary school, particularly when a child has long-term problems. This is why many secondary schools are buying in specialist pastoral counselling services devolving the teacher's pastoral responsibility to others with more specialist roles such as school counsellors or learning mentors. The problem is that learning and emotional well-being are intrinsically linked and these findings suggest that schoolchildren still value the pastoral support of a teacher as this can best help them address their learning worries.

In summary, the majority of children experiencing emotional problems have simple pastoral requirements. They are aware that teachers do not have the time or expertise to deal with their more complex emotional difficulties and prefer their CAMHS practitioner to support them. They value, however, their teacher's pastoral role and wish for support from a teacher or named staff member whom they know well or whom they trust. They want an opportunity to talk over their unique school concerns in order that tailored solutions to any school difficulties can be identified. This type of intervention is, however, more frequently offered to children subject to more intensive service protocol like CPA or Child Protection or those who have a SEN statement.

School staff, when they receive 'need to know' information, can better support children with mental health difficulties in two ways: a) subject teachers are better positioned to offer additional practical individualised learning assistance that considers cognitive and emotional difficulties, and b) one-to-one discreet pastoral assistance, from a special

teacher or a member of the teaching support team is valued when a child feels they need support with school worries. These forms of assistance dictate, however, a thorough awareness of the child's mental health problems, personal fears and idiosyncrasies, so that any school support can be better tailored to their needs. The problem is that this type of support is time-consuming and needs adequate resourcing, especially if one-to-one support is needed. This data does, however, indicate that schools often support well children categorised with SEN difficulties or who are subject to inter-agency review mechanisms, therefore educational staff and the agencies like CAMHS should generate similar strategies for a larger number of children without statutorily identified needs.

5.3.   Coping Autonomously

This final theme moves on from school pastoral support to how secondary schools and any external agencies can promote children's resilience at school. Ultimately, all the young participants voiced their aspiration to cope autonomously. Coping and resilience are discussed together because they are closely related (Ming-Hui and Nishikawa, 2012). This theme describes how young people cope by using their own coping strategies, alongside coping strategies introduced by their teachers and CAMHS professionals. The issue of safe and quiet space and how this can help the child to cope more resiliently at school is highlighted in the second subtheme.

5.3.1. *Coping Autonomously by Building Resilience*

All the young participants spoke about the ways they coped with their emotional difficulties at school. A commonly used strategy, already highlighted in section 4.1.1, was the need to talk to friends (n=5). A popular alternative coping strategy was, after school, to seek out parental support (n=8). This was not surprising because research indicates cohesive family relations with warm encouraging family involvement can protect a child from adversity and promote resilience (Coleman and Hagell, 2007; Walsh, 2006). The value these children place on family support is illustrated below by YPu and YPc:

Excerpt 133: YPu

YPu: *"I spent a few days panicking, and then I was like speaking to my dad about it because we talk a lot about that; and also because they are coming up, and I find it easier to kinder talk though my plan with someone and they can say, ye, that is good or that is bad. And he was like just, don't worry about her because your plan is fine, you have got three whole weeks and you have got it all sorted out; and I was like, ok, and then I felt slightly better".*

Excerpt 134: YPc

YPc: *"I get picked on, people call me names like I turn round and I get fidgety, it is quite hard but I kinder cope with it".*

I: "How do you cope with it, as it must be quite hard?"

YPc: "It is, yeah, I kind …of in a way I cope with it at home but in a way I don't cope with it at school, I just try get it out of my mind".

I: "Anything else?"

YPc: "It's my mum she listens to me very much, and she is my best friend, she is like always there for me. I love her so much and she is like, there's no other words that describe her, she is one in a million and she is always there for me. I will always love her and always will, she is the best person ever".

YPu was describing how she would seek reassurance from her father when she was worried about her academic targets, and how her conversations with him would alleviate her worries. YPc described how, when experiencing school bullying, she would speak to her mother at the end of day and it was this strong bond which enabled her to cope. Both statements demonstrate how confiding in their parents enabled these young people to resiliently manage their difficulties, by giving them an opportunity to problem solve. This demonstrates that, although the young participants did not want their parents sharing information about them with school staff or indeed attending meetings at the school about them, they did value their involvement in other ways and on their terms. Research suggests that affectionate bonds with parents promote resilience and it is these ties that encourage trust, autonomy and initiative (Hill et al, 2007).

Many parents, however, did not always find it easy to support their child, because they found it difficult to cope with their own worries about them. For example, many parents spoke about how they worried about their child getting ill again (n=9). Of note is that a recent survey by Action for Children (2015) found that the biggest concern parents had related to their child's mental health. They also worried about their child's future (n=7), which was largely linked to their concerns about their child's mental health. They did, however, voice that one of the chief difficulties they had when it came to supporting their child, was determining normal teenage angst from true emotional distress (n=11). Their viewpoint is represented by Ps2 below:

> **Excerpt 135: Ps2**
>
> **Ps2**: *"That's what we're stuck between, fifty percent teenager, fifty percent illness, and we're trying to carve up which bit's which and it's quite difficult to differentiate between the two sides sometimes, cos they're so blurred. You know, all of the mannerisms of uh, fed up, fed up with everything is teenage".*

Ps2's statement describes the difficulty he and his wife were having in distinguishing between normal adolescent behaviour and behaviour related to his daughter's emotional difficulties. Other parents also described how their relationship with their teenage child was often more conflictual and alienated than when the child was younger (n= 4) and they were not sure if this was because of their child's age or due to their child's mental health problems. This finding corresponds with a recent 2014 report by YoungMinds (Children, Young People and Family Engagement), which also suggested parents do not always feel very well informed about how to support their child when struggling with mental health or self-harming problems. It was, therefore, not surprising to learn that many parents valued the direction and guidance from CAMHS workers when they were having problems with their teenage children (n =8) as demonstrated by Px and Pf below:

> **Excerpt 136: Px**
>
> **Px:** *"But there was that stage, and I was thinking is this normal? And I must admit that is where CAMHS did help, because they did give me lots of information on adolescence and changing".*

Excerpt 137: Pf

Pf: *"Sometimes we run to CAMHS and say that was a problem, and they say, don't worry she is going to stay in bed today, and is nothing to do with mental health, it is just that she is 15".*

The statements, above, demonstrate how reassured these parents felt when they received parenting advice and support from CAMHS. This indicates that, for parents to strengthen their adolescent children's resilience, more time needs to be spent strengthening parent resilience. This is because for parents to better support their child they need to feel supported themselves. The findings also indicate that more work needs to be carried out exploring how parents of teenagers can be involved with their schooling in other ways than just meetings.

It must be noted, however, that not all young people have the privilege of supportive parents and family environments, and, therefore, their resilience needed to be promoted in alternative ways. Resilience also resides within the individual and the wider community. Many of the young participants talked about their ways of coping at school, as described by YPx and YPe, below:

Excerpt 138: YPx

YPx: *"I sing, that's my thing. I sing and when I am stressed its one song, and when I am really stressed I will hum it, and I can hear it in my head and put it on loop".*

I: *"And do you find yourself doing it sometimes at school?"*

YPx: *"Yes."*

Excerpt 139: YPe

I: *"What do you try and do if you are trying to hold everything in?"*

YPe: *"I go on the computer. I just put my headphones on because that calms me down".*

These methods of coping enabled them to suppress, endure or release stress, and/or divert any difficult thoughts. This subsequently allowed them to better manage their emotions when at school. Although all children had their own coping behaviours, many

like YPx and YPe used diversional activities. This is a popular coping response when dealing with difficult emotions (Stone and Neale, 1984). Other participants (n=10) described how they used psychological methods to cope at school, for example planning via self-talk, targets and goals for themselves. This is also known to be a common coping response to stress (Ming-Hui and Nishikawa, 2012). YPu, YPz and YPg's statements describe this type of coping strategy:

Excerpt 140: YPu

I: "It is quite interesting. It sounds as if you have lots of little ways of coping with your distress at school, silence, time-out".

YPu: "Yeah, and making plans ((laughs)). Yeah".

I: "You like to write things down?"

YPu: "I tend to make mental plans. I have got quite a good memory ((smiles)), so I just make a mental plan and then I will stick with it, and I kinder know what is happening, and I kinder reassure myself and say, this is what you do now and this is what you are going to do later, and they help me".

Excerpt 141: YPz

YPz: "I like to have everything sort of planned, so that I know what's going, what I'm going to do when, so that's, I like to be organised like that, and that sort of helps me to cope with it. And I like to be able to tick things off when I've done it".

Excerpt 142: YPg

YPg: "Like if it's like Friday I feel pretty good about stuff because, you know, I have something to look forward to at the weekend. That's what keeps me literally going".

I: "So something to look forward to?"

YPg: "Yeah, like I catch the bus after school. There is a shop near there so it is kind of my reward at the end of the day. I go to the shop and get a drink or something 'Mountain Dew'.

YPu's and YPz's statements demonstrate how their psychological coping strategies improved their ability to perform at school, therefore improving their self-efficacy. Coping and resilience is linked to self-efficacy (Rutter, 1985). YPg demonstrated self-efficacy by setting himself a goal and rewarded himself with a treat at the end of each school day and this helped him cope. Some young participants (n=8), however, described psychological and behavioural methods that did not allow them to cope with their situation at school, but acted more as subtle avoidance tactics allowing them to escape difficult emotions. These behaviours have been termed as safety-seeking behaviours (SSB) and are commonly adopted by those experiencing chronic anxiety (Hedtke et al, 2009). YPn and YPk provide some insight into their unique SSB behaviours:

> **Excerpt 143: YPn**
>
> **YPn:** *"I just said that I had anxiety issues and I had to have my own seat. I couldn't sit somewhere else. I have always had my own seat no matter where I am, it's just a thing with me, I have to have my own space".*
>
> **Excerpt 144: YPk**
>
> **YPk:** *"It's like a spray and it's meant to calm you down".*
>
> **I:** *"Oh, right, and does that help quite a bit?"*
>
> **YPk:** *"It does actually, it's nice just to have a little calm spray with you".*

There is a school of thought that SSB behaviours can play a role in the maintenance of an emotional problem because a stressful situation is avoided rather than coped with. The argument is that this can hinder longer-term cognitive change stifling resilience (Hedtke et al, 2009; Thwaites and Freeston 2005). It is apparent, however, from the above statements that these safety behaviours and the maladaptive behaviours, as previously discussed in section 4.3.1, like non-suicidal self-injurious behaviour (NSSI), school refusal and truancy, are presently serving a purpose in that they act as a scaffold, thus enabling these children to cope at school in the face of adversity. Resilience theory provides some insight into why some of these young participants may have been prone to adopt these types of behaviours, as resilience is more likely to be activated by acute distress but wanes when experiencing more long-lasting enduring chronic stressors (Colman and Haggell, 2007). This validates the need for school staff and professionals

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from external agencies like CAMHS to play an active part in promoting the child's school resilience, especially when they have been identified with mental health problems. Some young participants valued this type of help but, as yet, they were not being supported in this way:

Excerpt 145: YPx

I: *"Has anyone talked about coping strategies or introduced you to anything which helps you with your emotional difficulties at school?"*

YPx: *"No, not really, my friends like to take me to Costa to calm me down. I think it's the caffeine".*

YPx *"If you did go to a CAMHS service I think that would be helpful, but I think having an understanding of coping strategies would be so helpful for all students".*

Excerpt 146: YPx

YPx: *"If schools and teachers taught coping strategies and how to cope with stress and things like that, and started talking about it, then it wouldn't be so stigmatised and a taboo subject, and then teachers might feel more comfortable about it, and the students feel comfortable to talk about it".*

YPx wanted their CAMHS and school to equip her with enhanced coping strategies. She implied that all pupils would benefit from this type of support, indicating that universal intervention may tackle mental health stigma by encouraging people to talk openly about their emotions. Of interest is that, despite the western world placing an emphasis on specialist school therapeutic interventions as detailed in section 2.2, none of the young participants made reference to taking part in school-based universal, selective or indicative specialist programmes that focused on their emotional needs or mental health. Only two young participants made occasional reference to the PSHE Education curriculum and how this covered aspects related to mental health like bullying. This concurs with OFSTED (2010) which states that a weakness of the present PSHE curriculum and its delivery, is it does not focus on aspects related to mental health as much as it should do. YPx implies teachers are uncomfortable talking about emotions

and, therefore, lack the emotional literacy skills to successfully deliver this type of curriculum. Some young participants perceived their CAMHS workers to have these skills as highlighted by YPb below, who described how CBT and relaxation methods introduced by her CAMHS therapist helped her at school:

Excerpt 147: YPb

YPb: *"I kind of just, I think about like where I'd rather be, like if I'm sitting in a classroom, like behind my desk, I just think about where would I rather be right now. And like I might think I'd rather be on a roller coaster and then I'll just imagine myself and I kind of put myself, like remember when I have been on a roller coaster in the past when I've been happy, and I'll kind of think about that. Or I'll think I wish I was on holiday and then I'll kind of be thinking about like the beach, and ice cream and all that kind of thing and it's just, it's just anything to kind of either block everything else out or take yourself out of where you are".*

YPb was describing how she used imagery to help her cope with difficult thoughts and emotions at school. She imagined herself on a fun roller coaster. This 'guided fantasy' strategy and other similar CBT strategies other participants spoke about, all of which had been introduced by their CAMHS therapist, appeared to strengthen their school resilience, rather than resolve any school problems. A promising new model that could be adapted by CAMHS professionals to promote school resilience is Pedesky's and Mooneys (2012) Four Step Strengths based model. This CBT approach places an emphasis on identifying an individual's strengths. The aim is to help the individual to adopt behaviours and thoughts by strengthening their resilience, rather than helping them to resolve their problems. The young participants demonstrated that, despite their vulnerabilities, they also possess many strengths. Notably, some educational participants (n=4) highlighted the importance of promoting the child's strengths and ensuring they were always optimistic about the child's future.

In summary, children with mental health problems commonly cope, despite experiencing adversity, by adopting coping behaviours and positive attitudes. This data indicates that these children and their families are largely coping alone. There is, therefore, a requirement for school teachers and CAMHS professionals to strengthen both family and individual resilience, especially when they are enduring long-term

difficulties. This can be achieved through parenting advice and reassurance and by focusing on the young people's strengths rather than deficits. Low intensity CBT strategies delivered by CAMHS or other trained practitioners may also help especially when the child is experiencing school difficulties.

5.3.2. The Importance of Therapeutic Space

The data presented in this subtheme centres more specifically on the school physical environment and how it may be therapeutically enhanced. It may be argued that this rich data should have been expected, because ample evidence from the field of environmental psychology highlights how important the physical environment is in promoting an individual's psychosocial well-being (Smith and Watkins, 2010). It is also established that children with mental health problems often struggle to regulate their emotions (Giedd, 2008) and hence why several young participants (n=7) stressed the need for suitable environmental space in which they could better regulate their emotions when stressed or feeling vulnerable, as described by YPd, YPe and YPj below:

> *Excerpt 148: YPd*
>
> *YPd: "I don't want to hurt people, and I don't want to take it out on them and hit someone, and do something I regret and mess up my school life because I got angry over something. So I would much rather take the anger out on me, so I try and ask the teacher if I can step outside".*

> *Excerpt 149: YPe*
>
> *YPe: "Every time, every day I see them, I just see red and walk out for a bit and I go back in lesson and pretend nothing happens, and get on with my work".*

> *Excerpt 150: YPj*
>
> *YPj: "Um, sometimes when I am in classroom situations, it's... it's kinder noisy if you get what I mean but busy coz say there is twenty people in the class and they are all having their own conversations, it gets sort of kinder overwhelms me sometimes, coz there are so many people it is nice to sort of go outside and sit on my own".*

All of these participants described how they valued time out of their lessons in order that they could better regulate their intense emotions. YPd and YPe spoke about

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regulating their anger and frustration while YPj described how, when feeling overwhelmed and anxious, having an ability to escape the classroom helped. It is apparent that, by being allowed to step out of class, it gave a sense of control, by reducing the environmental stressors like noise or by reducing proximity to other children and staff. The problem, however, was not being given permission to leave the class, because many of the children were granted permission to do so by their teachers by mechanisms like the yellow time-out cards which some young participants spoke about (n=5). The problem was once they left the class there did not appear to be any suitable, clean, private, non-stigmatising space to escape to, and in which to calm their emotions. This is illustrated by the young participants below:

Excerpt 151: YPd

YPd: *"Yes, because it was literally like hell going to school, like I would break down every day at school, and I would have to go into the girls' toilets and cry".*

Excerpt 152: YPg

YPg: "It depends really. It depends like how I want to be like if I want to be completely alone, then I would probably go and sit in the toilet".

Excerpt 153: YPu

YPu: "Yeah, if you have a problem like with your health obviously, and like if you are like really really upset, they just send you to the nurse. It's like, I don't want the nurse, I like want a room by myself, but like they can't leave you in the room".

I: "Yeah…"

YPu: "I sit in the school toilets for an hour, just because I want some time by myself, and it is not really right that somebody should have to sit in a toilet just to have some time by themselves".

Toilet areas were a very popular retreat for girls (n=7). This was despite the participants considering them far from ideal and society's popularly held opinion that school toilets tend to be the most neglected facility in the school building (Burton, 2013). YPu's statements highlighted why the school toilet was used. This was because it had one distinct advantage over other areas in the school; it assured privacy. Other assigned

retreats that children were asked to go to when feeling upset did not have this advantage. For instance, YPu was sent to the school nurse office whereby she was not left alone despite her wish to sit in solitude. It appears that many young people wanted more control over their personal environment, especially when stressed. This control was perceived to be stifled by adults controlling their school environment. For example, the teacher has the power to decide if a child can leave the classroom and where they should go if they are upset. They can decide this without taking the child's motivation or experiences into account, and in the school setting it is the adult's requirements that often precede the child's. This is, perhaps, why these children retreated to the toilet, because it was perhaps the only environment in the school not always controlled by an adult. This indicates that schools should consider the need for children to have more suitable space other than toilet areas. Environmental psychological research concludes that the type of space most conducive to promoting mental health is bright, calm and open space. Tranquil gardens and a room with a view can successfully help people restore mental health (Smith and Watkins, 2010). Only two educational participants mentioned the importance of schoolchildren being able to access tranquil space (n=2), but what the majority of the educational participants did emphasise was the need for school pupils to have access to an adult when distressed. This viewpoint is represented by ESc below:

> ### Excerpt 154: ESc
> **ESc:** *"We don't have time-out cards here or toilet break cards. Teachers are aware that if a child is getting upset or rattled by something or showing signs of stress, that they might either say, 'do you want to step outside for a few minutes or do you want to see your tutor', and tutors are mostly in the same rooms all the time, so they know where to find them".*

ESc demonstrates the teachers' understanding of the necessity for children to access space and time away from the classroom when distressed. Her statement does, however, appear to blur the need for private space with the need for children to have access to supporting educational staff. The two needs, although of equal importance, should not be confused; private space is the wish to be alone and accessibility is about

ensuring children can obtain the support of a caring member of staff. What these young participants voiced was a need for both.

When interviewing some of the educational participants my field notes highlighted the modern purposefully designed school building, which were open and bright. Such environments can help to prevent bullying and reduce school violence (Culley et al, 2006) and promote learning (DfES, 2002; JISC, 2006). They did, however, also appear to lack any private tranquil space. For instance, some schools had no staff offices or staff rooms, so teachers did not even have access to private space. The traditional quiet library had disappeared, being replaced by a large open plan auditorium book space, whereby walls no longer totally shielded sound from other areas. Interestingly, one educational participant (ESe) did speak about the complexities of the modern day school providing private space, and how her school had tried to pilot this type of provision. They named the space "*the Sanctuary*":

> ### Excerpt 155: ESe
> **ESe:** *"We had a sanctuary. The sanctuary was really for I wasn't around when it was created, but it was for students who, for whatever reason, couldn't be in main stream lessons. So you may have got someone who is suffering from bereavement or a family who have split up or going through a period of crisis. Just a bit of TLC really, but it was then also used for students who have been timed out of lessons, then may have been an ADHD student or someone with anger problems. So it all became a little bit, it wasn't such a sanctuary for some of the more timid or more vulnerable students, so it was closed down".*

ESe described how the "*Sanctuary*" was originally supposed to be an area for all students to access when they wanted quiet contemplative time, although the space gradually lost its purpose. It was often frequented by those with behavioural difficulties who did not always have the need for quiet space but rather for acting out. ESe's statement described the challenges that schools face in ensuring that any designated private space does not become abused and stigmatised as the space for those who do not cope.

In summary, children who experience mental health difficulties require therapeutic space in which to privately regulate their emotions. Despite school staff recognising the

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benefits of this, young people indicated that safe, private, clean, open and non-stigmatising space in a busy secondary school is a rare commodity. In addition, the child's needs for private spaces are sometimes in danger of being confused with ensuring pupils have access to supportive staff. Children want to draw on their own strength as well as being empowered by others to develop psychological and practical strategies. As their resilience can wane, it is important that the school environment is more therapeutically supportive and that CAMHS and school staff offer discreet assistance to strengthen their resilience when needed.

CHAPTER 6: DISCUSSION

6.0.   Introduction

This final chapter critically discusses some of the complexities associated with better assisting children with identified intrinsic mental health problems in a busy secondary school environment. A summary of the research findings opens this chapter to contextualise the key issues raised in the thesis. These findings are considered against the existing evidence, alongside a critical discussion as to how they may extend, refine or conflict with current literature, hence giving some illustration of how new theory has been developed. How the findings might inform or impact operationally on education and health services, are discussed, with recommendations applicable to both schools and CAMHS made. The integrity of the data is then promoted by detailing the methodological limitations and the implications of this research. A reflexive section describing the researcher's own presence and influence on the research promotes the transparency of the data yet further. This thesis then ends with a conclusion.

6.1.   Summary of Findings

The findings from this research gave some indication as to how this population of young people could be better supported at school and how the young peoples' perspectives differed from the perceptions of the adults supporting them. Overwhelmingly, the young participants indicated that when at school they wanted to feel positively socially connected to their teachers and peers. Having a positive social connection to others made them feel safer, better supported and hence more emotionally secure at school. It was this sense of security that largely contributed to them being able to cope independently and resiliently when at school. The fundamental need for social connection and emotional security were, however, found to be aspects currently being overlooked by the academically driven culture of the busy secondary school.

In contrast to the young peoples' perceptions, their parents and supporting educational staff placed less emphasis on the young peoples' basic need of belonging. This was because they believed that the young people were vulnerable and, therefore, in need of protection via more specialised prescribed assistance. The problem the young participants highlighted with this, was not their opposition to receiving such support,

but rather a need to, firstly, feel physically and emotional safe at school in order to be accepting of this form of support. This was because specialist assistance in an unsafe school risked highlighting their unique differences making them feel open to victimisation and stigmatisation from their peers. The young people, therefore, placed more emphasis on the need for this type of support to be provided at a time that suited them, recognising their need to feel safe and to have their say as to what school assistance they preferred to have. This choice gave them a sense of autonomy which is important to children at this developmental age, but most importantly it also ensured their continued emotional security and comfort at school.

6.2.   Augmenting Belonging and Preventing Alienation

A core finding of this study was that young people, when experiencing mental health difficulties, fair better, both academically and emotionally, when they feel positively socially connected at school. Feeling connected to others promoted their sense of belonging, coping ability and resilience, which allowed them, when at school, to put their learning needs over and above their emotional difficulties. These findings are consistent with previous quantitative and qualitative educational research, which supports the belief that all schoolchildren need to possess a feeling that they belong at school, as this promotes happiness and learning (Chhuon and LeBaron Wallace, 2014; Hallinan, 2008; Osterman, 2000; Roorda et al, 2011; Wallace et al, 2012a). The findings also concur with the multidisciplinary research focusing on more vulnerable groups, such as children with behavioural problems, physical and mental illness and which also highlights the need for a sense of school connectedness to promote learning, confidence, self-esteem and resilience (Cooper, 2012; Lightfoot et al, 1999; Shochet et al, 2006).

In contrast to belonging, the study indicated that when a child did not feel socially connected at school this led to unhappiness, isolation and alienation, which consequently had a negative impact upon their learning and well-being. Previous research has similarly indicated that school unhappiness often hinders learning and can lead to alienating behaviours (Hallinan, 2008); for example, increased risk of school drop-out and academic failure (Morrison-Gutman and Vorhaus, 2012), as well as making

a young person more vulnerable to risk-taking and anti-social behaviours (Larusso et al, 2008; Oelsner et al, 2011).

6.2.1 *Good School Relationships Determine Belonging*

Crucially, what was found to promote this specific population of children's belonging was having positive school relationships with their teachers and peers. This was because, when the young participants reported positive caring school relationships, this resulted in them feeling happier and confident at school, thus allowing them to better focus on their education. An abundance of multidisciplinary studies considering differing populations concur with this viewpoint, that caring teacher/pupil relationships can promote learning by protecting children against poor school outcomes such as behavioural problems, exclusion, school drop-out and bullying (e.g. Hamre and Pianta; 2001; Rumberger, 1995; Yerger and Gehret, 2011). Research has also linked more caring teachers with better pupil self-esteem, self-worth and resilience (Mueller, 2009; Myers and Pianta, 2008; Larusso et al, 2008; Larusso and Selman, 2011). Seldom, however, does research focus primarily on children with intrinsic mental health problems. The few studies that have centred on this particular population of schoolchildren have highlighted the importance of these children having good teacher relationships, as these often play a pivotal role in actively, as well as unknowingly and inadvertently, promoting a child's recovery from mental health problems (Kenny, 2013; Knightsmith et al, 2014).

As well as having good relationships with their teachers these pupils also needed positive peer relationships, as these played a major part in promoting their school happiness. A large body of literature highlights the importance of schools promoting positive school peer relations in order that friendships can be harnessed to promote better behaviour (Cooper and Jacob, 2011b) and protect a young person's well-being and mental health (Bollmer et al, 2005; Thapa et al, 2013; Wallace et al, 2012; Wormington et al, 2014). Positive peer friendship can also have a favourable effect on a child's self-esteem (Millings et al, 2012) and academic success (Juvonen, 2014). Conversely, however, research also highlights the negative impact poor peer relationships can have on a child's well-being, ability to learn, behaviour and their long-term mental health (Wallace et al, 2012; Thapa et al, 2013; Wormington et al, 2014).

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The importance of nurturing pupil and teacher relationships, when a child is vulnerable to emotional distress, is supported by a large body of research which has focused on ensuring children prone to emotional difficulties are supported during stressful school transition phases such as moving from primary to secondary school. This research has found that schools investing time in supporting and strengthening pupil and teacher relationships has correlated with improvement in pupil confidence, self-esteem and well-being, which can prevent disengagement from education (DfE, 2015a, Evangelou et al, 2008; YoungMinds, 2014).

Figure 16, below, summarises the power of school belonging and how strong connections with caring teachers and peers can promote learning, attainment and achievement which in turn can promote self-esteem, resilience and mental health recovery.

Figure 16: The Protective Value of School Connection
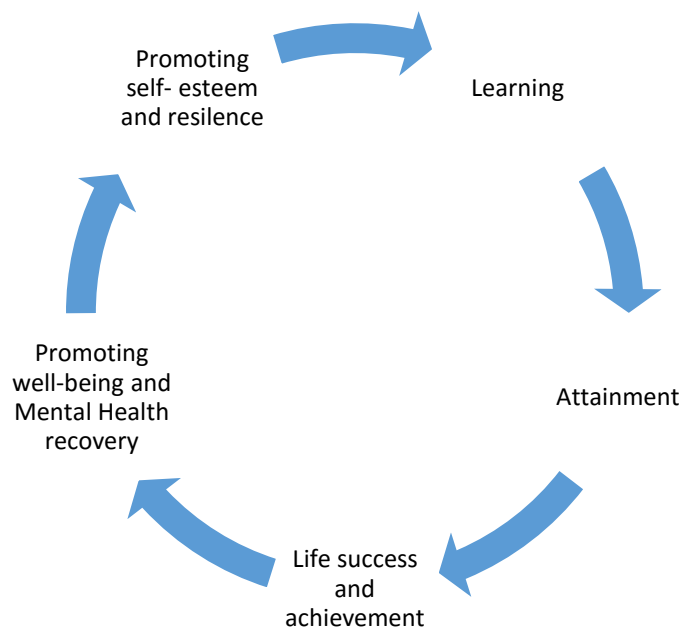
6.2.2. Alienation: A Complex Psychosocial Construct

Despite the power of connection this population of schoolchildren voiced unique complex psychosocial problems that often hindered positive connection to others whilst at school. Factors compromising their happiness were often complex phenomena associated with their mental health problems; some factors were external to the young person, whilst others related to inner turmoil i.e. a feeling of unrest and emotional

discomfort that was not outwardly obvious. This was more commonly linked to maladaptive cognitions and behaviours, which exacerbated the cycle of distress and alienation. It was evident that some of this complexity was not apparent to educational staff. The children's parents did, however, demonstrate insight into some of these issues, but in many cases felt helpless because their teenage child was often resistant to support. Of note is that helplessness is a common theme running through the empirical literature reporting on how parents feel when supporting their adolescent child who has mental health problems (Meltzer et al, 2011; Roles, 2005; Stapley et al, 2015).

When it came to external factors hindering connection to school and contributing to avoidant behaviours, the young people and their parents voiced that school bullying was a chief determinant of their emotional distress resulting in school unhappiness, difficulties in learning and subsequent alienation from school. Although it was not possible to clearly decipher if the bullying had precipitated the mental health problems, or indeed if the latter made them more susceptible to bullying, it was concluded that bullying was causing them to adopt alienating behaviours and, therefore, was a key determinant fuelling their mental health problems. As stated in section 2.3, empirical research has recognised that bullying often leads to alienating behaviours (DfE, 2014a) and mental health problems (Arseneault et al, 2010; Brunstein Klomek et al, 2007; Hamm et al, 2015; Hong and Espelage, 2012; Wolke et al, 2013). Interestingly, bullying is the only determinant of school distress recognised by the World Health Organisation (WHO) global well-being survey, which combined copious amounts of quantitative data (Currie et al, 2012). Even the epidemiologists conducting the study find it surprising that other determinants of school distress are not mentioned, for example, pressures to achieve, conflict with teachers or peers (Holstein, 2015). Data yielded by the young people and their parents did, however, suggest, that this particular population did have another determinant of school distress, in that they were also subject to mental health discrimination and stigma, which was also exacerbating their unhappiness and isolation.

A large body of literature, highlighted in section 2.2.2, has described how discrimination and stigma negatively impacts on young people and their recovery from illness (Corrigan et al, 2014; Gale, 2007; Jorm and Reavley, 2013), by preventing help-seeking behaviours which often leads to alienation and isolation (Bowers et al, 2013; Corrigan et al, 2014;

Golberstein et al, 2008: Perry et al, 2014). The negative impact of stigma on schooling was demonstrated by three quarters of the young participants who took part in this study in that they choose not to tell school staff that they were attending Child and Adolescent Mental Health Services (CAMHS), preferring instead to keep their mental health problems a secret. This was despite knowing that if they were open about their difficulties they would receive more school support and assistance to learn. It was apparent that the negative consequences of divulging this information appeared to outweigh the benefits of sharing information, in that they feared that if they were to divulge their difficulties they would be treated differently, stigmatised or discriminated against by their peers and teachers. Interestingly, educational staff spoke less about the implications of stigma suggesting that they were not fully aware that this was problematic for their pupils.

To rectify these external difficulties some children were prone to adopting maladaptive or avoidant behaviours. One avoidant behaviour was school refusal or truancy[21], or frequent parent condoned absenteeism, because parents were worried about their child's welfare at school. Of note is that this population of schoolchildren rarely adopted more obvious, outwardly expressed avoidant risk-taking behaviours. Instead they described other ways of coping, which often did not involve alienating themselves physically from school, but were psychological coping mechanisms that involved masking their problems. The literatures sometimes refer to this as "*disguised*" or "*smiling depression*" (Flett and Hewitt, 2013, p.5). Others spoke more about adopting more covert behaviours such as eating restriction or overeating. Some young participants also described covert non-suicidal self-injurious behaviour (NSSI) like the cutting of arms and covering cuts with shirt sleeves, which is a behaviour more frequently associated with intrinsic mental health presentations (Ross and Heath, 2002).

Exacerbating the young people's external school difficulties was the inner psychological turmoil they were experiencing, which was linked with their mental health problems. For example, negative cognitions such as their problems were insurmountable

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[21] School refusal is a psychosocial problem whereby the child has difficulty attending school because of severe emotional distress (Maynard et al, 2015). Truancy on the other hand is staying away from school when it is perceived there is no good reason for the absence. Truancy is more associated with children who display anti-social and risk-taking behaviours (Farrington, 1996; Maynard et al, 2015).

(Dummett and Williams, 2008; Williams, 2009) and self-stigmatising beliefs that they were mad or bad, all of which fuelled their wish to alienate themselves from school. Also compounding their school difficulties were emotional regulation problems associated with their symptoms of anxiety and depression, and the natural emotional regulation problems associated with biological and neurological changes in early or mid-adolescence (Casey et al, 2008). All these psychosocial difficulties would make this population of young people prone to physically or psychologically disconnecting from their peers and teachers.

The research data, therefore, suggests that this population can become trapped in a vicious cycle of school alienation and avoidance. The determinants of distress and factors commonly leading to alienation from school are not easily extrapolated as these are all intrinsically linked as conceptualised in Figure 17 below:

Figure 17: The Complexity of Social Connection
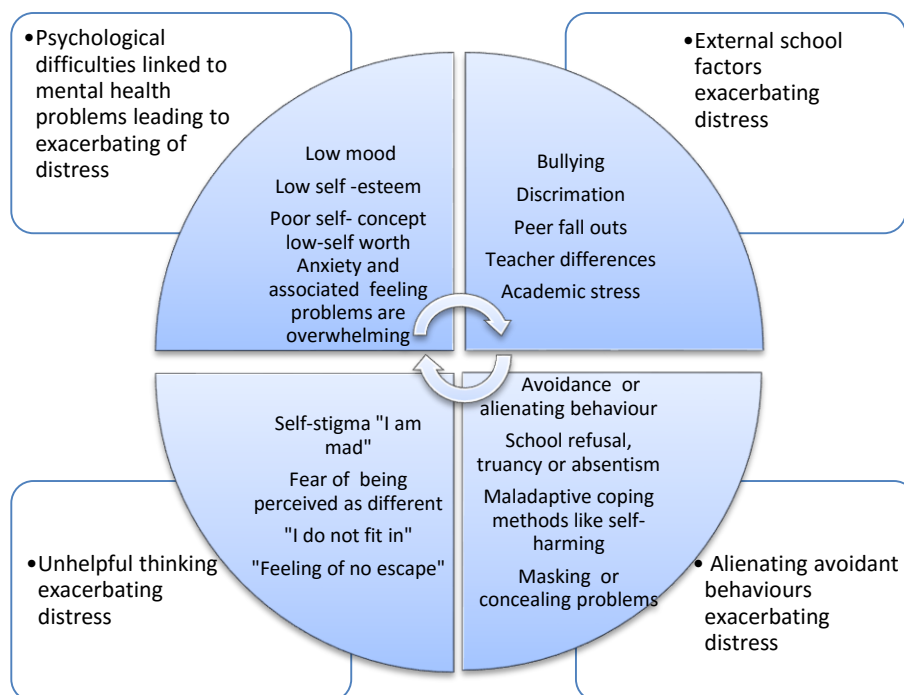
6.2.3. *Augmenting Belonging by Promoting a Safe and Caring School Environment*

It was evident the young people had the power to negotiate their difficulties if the school helped them to feel safe and secure. They reported that the most supportive schools were able to strike the right balance, whereby they felt able to achieve their full

potential academically, whilst feeling safe, happy and contented at school. They, therefore, recommended whole-school approaches at organisational, classroom and individual level to help support their learning, enhance their school relationships and promote their confidence and self-esteem. Some of these whole-school ingredients have already been outlined in section 2.3, and range from balanced leadership (DfE, 2014a; Harris, 2007) to clear guidance via school policies (Weare, 2015) and varied pastoral provisions (Charlton and David, 2012; Hornby and Atkinson, 2003).

The findings of this study suggested that no single school offered the same type of supportive provision, as their pastoral provision varied. For instance, some young participants and their parents indicated that their school had the right mix of whole-school ingredients (making them feel positively supported), whereas others suggested that their school was lacking key supportive components, which made them feel insecure. This lack of uniformity was probably because, unlike an academic curriculum, which is very much driven by statutory national directives, there is less national direction and guidance as to the right components needed to ensure a fit for purpose supportive whole-school provision that supports achievement alongside promoting pupil well-being (Thrapa et al, 2013; Weare and Nind, 2011). This is partly due to the public health directives placing an emphasis on schools having autonomy and flexibility to develop their own supportive provisions according to local need. For instance, the introduction of Social Emotional Aspects of Learning (SEAL) was not prescriptive (Humphrey et al, 2010), neither was TaMHS (see section, 2.4.2) (DCSF, 2008b; Wolpert et al, 2011), nor is the PSHE curriculum (DfE, 2015a). Even the safeguarding protocols encourage schools to adapt recommendations according to local need (Lefevre et al, 2013). So, as yet we remain unsure as to the right mix of whole-school ingredients needed to successfully promote pupil learning and resilience and to mitigate mental health problems. This national variation in pastoral provision makes it difficult to encapsulate what makes one school more supportive than another (Tucker and Calvert, 2009).

The findings from this study did, however, indicate more about the range of whole-school ingredients that these children valued, from strategic to individual level. At strategic level, the young participants wanted a well led school that felt friendly and safe and which promoted a feeling of wanting to attend. This was because a hostile school

environment led them to feel physically and emotional unsafe, which impacted negatively on their learning, as well as their well-being. Parents in particular emphasised the need for a school to feel safe because they worried about their child's vulnerability and risk of relapse. This concurs with the abundance of literature, some of which has already been highlighted in section 2.3, stressing that schools to be supportive must firstly be safe (Cowie and Jennifer, 2007; Cowie and Oztug, 2008; Jimerson, 2012; Nobal et al, 2011; O'Brennan et al, 2014).

Fundamentally, young participants and their parents believed that the important components dictating a safe environment mainly revolved around the school's ability to manage poor behaviour in a balanced, fair, consistent manner (DfE, 2014a; Libbey, 2004; OFSTED, 2012). It was apparent, however, that children's safety was not assured by consistent discipline alone, but also by the ethos[22] of care. Although an extreme example, the need to interlink safety and care in the institutional setting is clearly illustrated by the Mid-Staffordshire hospital case whereby a lack of a caring culture, driven by health targets and cost-cutting compromised patient safety at the most serious level (Francis, 2013). The findings from this research indicated that, similarly, schools are driven by academic targets and resource constraints; consequently, care could be a neglected aspect of school life.

Young participants and their parents indicated that care needed to pervade the school system from a micro level, via one-to-one warm school personal interaction with pupils and parents, whereby it was conveyed by staff demonstrating a wish to listen, acknowledge distress and help. Care was also needed on a macro organisational or strategic level, whereby caring values could be cascaded though school philosophy and policy. The macro caring attributes this study's participants identified were the need to be treated with respect within the large institutional setting, with their viewpoint being heard and considered. It was also important that they felt unconditionally accepted despite their differences. These values were particularly important to this group of

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[22] Ethos: "the more subjective values and principles underpinning policy and school practice" (Glover and Coleman, 2005, p.265).

children, because caring attributes reassured them that they were safe at school and any problems they were experiencing were empathetically addressed.

Getting large, academically driven, secondary schools to embrace caring values is not easy. This was highlighted by a number of SEAL programme evaluations (see section 2.2.1), which highlighted that, despite the intention of the SEAL programme being introduced as a whole-school approach to well-being, many secondary schools focused solely on the taught classroom component of it, paying little attention to changes in school ethos (Humphrey, 2013), thus the critical foundation for SEAL was lost, making it more difficult to shape a considerate environment (Durlak, 2011; Humphrey et al, 2010).

This is why the empirical literature pertaining to whole-school practices in relation to mental health places a heavy emphasis on the school provision having a committed team who model caring values (Craig, 2007; DfE, 2015a; Layard, 2007; Weare, 2015), thus influencing and cascading school policy accordingly (Grove, 2004; Hornby and Atkinson, 2003). A problem, however, is that both national and local school policies often primarily adopt a language of securitisation and exist to protect children, staff and ultimately the organisation from harm, rather than promoting the humanistic need of feeling cared for and respected. An example has already been given in section 2.1.1 when outlining how schools in the main, when dealing with anti-social disciplinary problems, follow hard-line exclusionary protocols to protect the institution. This is despite recommendations that it is preferable to prevent exclusion by trying to understand the pupil's difficulties from their own and their parents' perspective, and adopt more caring evidenced-based approaches to combat the problem behaviour (DfE, 2014a; Stamou et al, 2014; Office of the Children's Commissioner School Exclusions Inquiry, 2012).

Exclusionary disciplinary practices were rarely mentioned in the interviews. This was likely because this type of practice more frequently impacted on children displaying extrinsic behavioural and emotional difficulties. Children and their parents did, however, mention their school's anti-bullying policy, and how this was in need of overhauling in order to adopt a more balanced, cautious and caring approach alongside that of zero tolerance. The young participants felt that a humanistic child-centred approach to bullying was needed, as this would ensure that more young people who were worried

and fearful about disclosing bullying difficulties felt able to divulge their problems, because at present their schools in the main dealt with bullying problems as a safeguarding concern and, therefore, often took a more hard-line forceful approach (DfE, 2014a; DfE, 2015d: OFSTED, 2012). Educational staff held a contrasting viewpoint in that they felt they were successfully tackling bullying by taking a hard-line proactive stance and, therefore, did not believe bullying to be a particular problem for this population. The child's and parents' perception, however, was that there was a need for a more balanced 'softly-softly' approach alongside existing hard-line measures. This would ensure that bullying incidents, when reported, did not have the potential to make school problems worse, instead they would ensure that all bullying problems were taken seriously and that teachers dealt with any disclosure empathetically.

Others focusing on why children remain silent about bullying problems highlight similar reasons (NSPCC, 2010; Oliver and Mano, 2007; Rigby, 2011). It, therefore, makes sense that the child's perspective on this matter should be considered when developing policy. Notably recent recommendations to multi-agency staff with safeguarding responsibilities state clearly, when concerned about a child's welfare, that adults should see and speak to the child and ensure the child's view is taken into account (Lefevre et al, 2013; Martin et al, 2010). These recommendations are shifting the emphasis from adult-focused interventions towards more child-centred interventions. The problem is that the Children's Act 2004 places an emphasis on local authorities to give due regard to a child's wishes when determining what action to take to protect a child under section 47 of the Children Act 2004. Many feel, however, that society as a whole is still placing too little emphasis on listening to children's wishes whether it be about threats to their safety or their learning needs (Casey, 2015; Davies, 2005; Gray and Watt, 2013; Lock, 2013). This was a fact supported by the young participants. The literature indicates, however, in the real world there is a lot of complexity associated with the act of adults listening to children (Learning and Teaching Scotland, 2006; Kirby et al, 2003). For example, professionals can misinterpret listening to children and giving them their say as meaning, giving them their way, thus resulting in a reluctance to obtain the child's viewpoint. Time is also considered to be a key barrier to truly listening to children because to interpret what a child is saying the adult is required to immerse themselves

in their world (Learning and Teaching Scotland ibid). Despite this complexity it is recommended every school should aim to promote a more balanced caring school ethos by ensuring the child has their say and has some autonomy in deciding what they feel they need, rather than adults assuming their compliance and providing top-down prescriptive involvement only (DfE, 2014b; Weare 2010 and 2015). This will require many schools to adopt a different culture whereby they shift from a historical emphasis of not listening to children's viewpoints to one of listening. This will require schools to go through a process of organisational change which will inevitably lead to resistance and conflict between old ways of working to new ways, all of which will require time to be negotiated (Kirby et al, 2003).

6.2.4. Enhancing Emotional Security: A Joint Responsibility

The young participants felt their schools would feel safer and a caring whole-school ethos strengthened if the school placed more emphasis on their duty to safeguard their personal privacy, as this was perceived to better protect their emotional well-being and safeguard them from harm. This was very important because these children's mental health problems would often cause them to experience uncertainty, anxiety and self-doubt, with mental health stigma exacerbating these feelings. For example, participants highlighted how their schools needed to take more care when it came to consensual inter-professional information exchange, and issues pertaining to confidentiality and disclosure. The findings did, however, indicate that these aspects were presently being largely overlooked by the school system.

Despite all the psychosocial complexity revolving around their mental health difficulties resulting in reluctance to share information about their mental problems with the school, the majority of young participants and their parents ideally wanted to exchange some personal information, as they perceived this to be assured that they received the school assistance they required. They also highlighted practical difficulties with personal information exchange, for example the need for more help in deciding what information needed exchanging with their school and help in communicating these needs. Their concerns, therefore, mainly related to how the private information was handled rather than the well documented complexity associated with inter-agency communication, which has already been outlined in section 1.7.

A key barrier to disclosure, highlighted by the majority of young participants, was mistrust of staff in handling private matters. This is supported by the findings of other researchers exploring the viewpoints of secondary schoolchildren and their help-seeking behaviours and disclosing difficulties. For example, Kidger et al, (2009), Del Mauro and Williams (2013), MacLean et al, (2013) and Dines (1996) all focused their research on the general population of secondary school pupils, and all found the children voiced a need for more confidential school support. Knightsmith et al's (2014) study on secondary school pupils with eating disorders found that children often did not seek help because of privacy concerns and the risk of stigmatisation.

The young participants also spoke about another aspect of communication exchange that made them uneasy; which was not knowing what personal information their parents were exchanging with their school and conversely what information their school was disclosing to their parents. This was a particular concern to some children because this could potentially make matters worse at school or at home. This is a concern echoed by other young participants who have taken part in previous research (e.g. Bowers et al, 2013; Kendel et al, 2014; Oliver and Mano, 2007). Notably, the parents also expressed concern about information they were sharing directly with the school and whether it was remaining confidential. This made them feel they were caught in a 'double bind predicament', whereby they felt they needed to exchange information, whilst worrying as to whether this information would be handled appropriately. Such feelings were exacerbated if they were going behind their child's back. Notably, this type of communication dilemma and the wish to protect their child from further harm has been highlighted by other researchers reporting on the perceptions of parents of children with mental health problems (Ahmann, 2013; Meltzer et al, 2011).

The school staff felt that information from parents was helpful in enabling them to better support children with mental health problems. They did, however, divulge some of the challenges in dealing with parents' high anxiety, particularly parents who were angry or indeed unwell themselves. Parents on the other hand voiced frustration with teachers for not sharing key information with them. These ambiguities are particularly important to address in order to implement the policy and literature that advocates for

schools to be more proactively involved with parents, especially in relation to vulnerable groups (DfE, 2015a; DfE, 2014c; DfE, 2015b; Christenson and Sheridan, 2001).

The educational staff highlighted confusion as to what information should be exchanged with parents and when to pass key information to CAMHS, hence breaching the child's confidentiality. This is a difficult issue to tackle, as school staff are not legally allowed to maintain confidentiality if a child's welfare is at risk plus a minor under the age of 16 cannot easily be referred for treatment without parental consent. The data yielded by this study does, however, indicate that serious thought needs to be given to how school staff can distinguish mental health from a safeguarding issue. Baginsky (2007) reported the difficulties school staff face when making sense of worrying teenage behaviours such as depression or self-harming, when there is no clear disclosure or evidence of an abusive event. This leaves the school to make a complex decision as to how to handle or share the information. A recent example of the difficulties teachers face when handling disclosure and confidentiality was the case of Yale Howarth. Following a fellow pupil disclosing to a teacher that he possibly had non-consensual sex with her, the school staff applied child protection procedures to deal with the situation. As a result, the pupil experienced serious anxiety and committed suicide. The boy's parents felt that the disclosure was handled insensitively and called for a serious case review. Others have highlighted the problems teachers have in handling confidentiality and disclosures of older children because of lack of school guidance (Rigby, 2011).

The young participants had a simple viewpoint as to how they could feel more secure about their teachers receiving personal information about their mental health, in that they believed the key was providing the school with consensual 'need to know' information only. 'Consensual' meaning they should decide what information should be exchanged and give their consent for it to be exchanged. This then reassured them emotionally in that they knew exactly what was being shared and why. They expressed a need for help from their CAMHS workers to decide collaboratively what information to share. They also stated they felt it was safer for their CAMHS worker to pass on this information rather than relaying it themselves, or having their parents convey it. This finding has implications for multi-agency communication exchange as it suggests CAMHS and secondary schools need firmer communication links, with communication

directives and systems put in place so that schools receive key 'need to know' information from CAMHS about a child's special health needs, especially devised forms or email templates.

When it came to the mechanisms of exchanging information, the participants voiced some differences in opinions. Parents wanted more face-to-face meetings with inter-agency staff, as this ensured key information about their child was not missed. Educational staff voiced that a key disadvantage of meetings was that they were time-consuming. The young people, in contrast, did not value inter-agency meetings as much as their parents but instead sought more simplistic methods of information exchange such as letters or emails. Lightfoot et al's (1999) study, examining the viewpoint of children with physical illness, found that children with enduring physical illness also spoke positively about informal methods of information exchange i.e. leaflets or letters from their healthcare professional to their school. A possible rationale for young people indicating a preference for more discreet methods of communication may be because a school meeting may lead to their peers asking awkward questions, thus making them feel unsafe. It was, therefore, evident that the young people's emotional security needed sustaining, hence a continuous process of ensuring they were involved in key decisions related to the exchange of information pertaining. Active involvement consequently made children feel emotionally secure.

An important key finding was that all young participants stated that they did not want to receive any form of therapy or CAMHS input at school. This was because they feared that this type of support would jeopardise their physical and emotional security, as it risked them being perceived by their peers as different, thus potentially putting them at risk of victimisation. Their opinion was in direct opposition to current government recommendations to schools about mental health, which emphasise the need for specialist therapy provision to be offered in school (e.g. DfE, 2015a; DH, 2009, DCSF/DH, 2008; DH, 2015). This is because school is perceived to be a less stigmatising environment (DH, 2015). These findings, however, suggest that often larger secondary schools may not be perceived as sufficiently safe for this model. Interestingly, however, the most recent government report recommends schools to be the place in which children receive specialist mental health support. '*Future in Mind*' (2015) contradicts

itself in that, on page 35, it states that many of the children they consulted with in order to write the report's recommendations also stated '*their school was not an environment in which they felt safe to be open about their mental health concerns'.* This, therefore, suggests before CAMHS make strategic moves to change their service models to ensure schools take a more active role in therapeutic mental health intervention, like the new London CAMHS, THRIVE Model (Wolpert et al, 2014), more consultation with children is needed. There is not only an economical argument for this, ensuring money is well spent, but also an ethical argument in that this study's young participants suggested that there is a need for them to have a choice and a right to receive specialist therapeutic support where they want, whether through CAMHS or their school. The young participants felt this was important because it not only maintained a boundary between their school life and CAMHS, but also ensured their emotional security.

The young participants and some parents and school staff also drew attention to the lack of private, non-stigmatising school space in today's large modern secondary school, and how this hindered their emotional security. Many of today's modern schools are designed with their large open spaces for safety and teaching (DfES, 2002). There is, however, often no suitable space for pupils to have some private time to calm down and relax or to meet with somebody confidentially without disruption. This is despite evidenced practice being introduced into schools like CBT relaxation methods (Hilt-Panahon et al, 2007) or mindfulness (Burke, 210; Haydicky et al, 2012; Huppert and Johnson, 2010; Van De Weijer-Bergsma et al, 2012), all of which require quiet space to help young people better regulate distressing emotions. The problem is, despite the clinical evidence supporting the need for suitable space to regulate emotion, in this time of budget constraint with funding for school buildings being reduced, such aesthetic improvements are unlikely to be prioritised when re-evaluating school building design (Dudek, 2015).

6.2.5. *Prioritising Staff Development in the Area of Mental Health*

It was perceived by the young people and their parents that, for their large, busy secondary schools to successfully promote a more caring whole-school ethos, whereby their emotional security was better protected, the first step should be, for their schools to prioritise mental health training for school staff, especially their teachers. This was

because, if teachers more clearly understood, the symptoms of mental illness as much as physical illness symptoms, young people and their parents would perceive their difficulties to be better accepted by school staff and subsequently they would feel less inhibited in discussing their mental health concerns.

The educational staff concurred, in that they also felt they would be better equipped and more confident to deal with this population of schoolchildren's special needs if they had some training in mental health. An abundance of other studies echo the need for teachers to have further training in this area (e.g. Finney, 2009; Graham et al, 2011; Hornby and Atkinson 2003; Kidger et al, 2010; MacLean et al, 2013; Rothì et al, 2005). Only a small proportion of the educational participants (notably all had a specialist role supporting children with BESD) indicated that they would have the confidence to deal with pupils' mental health needs. Educationalists without BESD experience indicated that, if a pupil was presented with mental health problems, they would refer them straightaway to other specialist support rather than have any direct involvement themselves. Kidgers (2010) study made reference to this also by highlighting an emerging school culture, whereby it was common practice in many schools for a small group of staff to make it their business to support children with BESD, but school staff outside this group were reluctant to support these children, as they perceived this type of support to be a specialist domain. This suggests school support for children with BESD is fragmented and inconsistent.

The young participants and their parents in this study did, however, highlight a number of advantages of all school staff being knowledgeable about mental health problems, which are summarised in Table 11 below:

Table 11: Advantages of Staff Having Mental Health Knowledge

1	Better positioned to detect distress and intervene more appropriately
2	Better able to interpersonally engage with pupils experiencing mental health difficulties
3	Better able to manage mental health difficulties in the classroom
4	Better positioned to understand the importance of offering additional learning assistance to pupils experiencing mental health difficulties
5	Better positioned to promote pupil resilience, by conveying psychological strategies, thus enabling pupils to cope more independently
6	Less likely to directly or indirectly subject a pupil to stigmatisation

Considering these needs, it may be determined that mental health training for school staff should not only focus on knowledge acquisition, but also on improving the interpersonal skills of teachers, as well as tackling attitudes and any misconceptions about mental ill health. Some believe that teachers can benefit from developing their practice in these ways, in that teacher/pupil engagement will be improved, thus leading to an easier resolution of adverse behaviours (Roffey, 2011). Better pupil/teacher engagement will also promote the teachers' safeguarding role, because pupils are more likely to divulge worries to a teacher they have a good relationship with (Lefevre et al, 2013). In addition, it will better equip teachers to identify underlying mental health problems, thus ensuring that fewer pupils are wrongly labelled as 'troublemakers' and more are fast-tracked to supportive services (DfE, 2015a).

The young participants and parents in this study also felt that better mental health awareness and knowledge would enable them to be better supported with their learning. This was because all the young participants recognised that, regardless of their academic ability, their mental health impacted on their ability to learn. Yet none of the educational staff, who participated in this study, perceived these children to be especially needy of additional learning support because of their intrinsic mental health problems, neither did they demonstrate a knowledge of how their intrinsic mental health problems may impact upon their learning.

The young participants reported, however, how their anxiety and low mood often impeded their concentration and, when preoccupied, their memory recall could be

poor. This is supported by Salovey and Mayer (1990) who state that when a person's mood is low, this can affect their ability to register and retain information. The young participants also experienced anxiety due to feeling overwhelmed or through continuous rumination about academic pressures, which would sometimes hinder them from filtering out competing stimuli, as similiarly experienced by children with ADHD. Consequently, they struggle in prioritising homework tasks or managing their time (Green and Twill, *in* Waller, 2013). All these issues risked compounding the symptoms of depression or anxiety, thus making some children more susceptible to maladaptive coping behaviours like self-harm or eating restrictions. This is why many young participants voiced a need for their teachers to understand more about the importance of ensuring they had access to revision support and the importance of exam adjustments.

Government policy recognises the knowledge gap teachers have in supporting children with both learning disability and mental health difficulties (DfE, 2015b). It is less acknowledged, however, that children with solely mental health problems have learning needs too. This is despite research which recognises that intrinsic mental health problems have a serious impact on educational functioning (Schoenfeld and Janney, 2008). Notably, those who write about the emotional needs of gifted children, concur that even they need special support to safeguard their learning (Lamont et al, 2012; Mueller, 2009; Peterson et al, 2009). Unfortunately, as Rothi et al, (2008a) points out, schools tend to only involve themselves in children's mental health when problems are seen as direct barriers to learning. This study's findings corresponds with Hallinan (2008, p.281) that schools must "*consider and balance a young person's cognitive and psychological processes together*".

The young participants also spoke about the value of their school staff, CAMHS and in-reach teachers giving them advice and strategies that they could use independently to help them cope with school stressors. For example, they appreciated being taught low intensity CBT deep breathing, diversional strategies, or positive thinking strategies that could be utilised independently and autonomously at school when experiencing difficulties. What they also found helpful was being able to talk to a teacher about academic concerns and exam stress as the simple act of catharsis was beneficial.

Teachers introducing them to learning strategies that combated academic stress, like bite-size learning and revision tasks were also valued. A problem the children voiced, however, was that this type of knowledge was not common to many school staff thus these helpful tips were rarely being exchanged. Government recommendations are presently encouraging schools to use their Personal Social Health Economic (PSHE) curriculums to address the topics most relevant to their pupils (DfE, 2013; DfE, 2015a; Public Health England, 2014; House of Commons Health Committee, 2014), with the literature highlighting the importance of PSHE curriculums placing an emphasis on promoting the child's self-efficacy and encouraging their autonomous action rather than focusing on their vulnerabilities (Craig, 2007; Kitano and Lewis, 2005). The young participants indicated that the universal PSHE curriculum would be the ideal means of transferring information about how to better cope with school and academic, like exam pressures, bullying and cyberbullying. This, therefore, suggests the PSHE curriculum needs to address these areas more extensively and CAMHS and CY IAPT practitioners, with skills in CBT and mindfulness, have a part to play in developing suitable evidenced based PSHE activities.

In summary, for schools to adopt a caring ethos it may initially be helpful to map policy and approaches against four strategic domains: ensuring connection; instilling a safe, supportive and caring ethos; promoting a more mental health aware school and providing emotional security. Data from this study suggested that when these four aspects are equally considered, they can promote pupil well-being, recovery and resilience, and ultimately learning. Figure 18, below, illustrates how the four aspects are linked and how together they can serve as the nurturing scaffold that can potentially strengthen the supportive whole-school environment. It is important each domain receives the same attention as they are all intrinsically linked. For example, without a feeling of emotional security, the young person will feel unable to trust and connect with others, and without connection they will not feel ready to share information.

Figure 18: The Whole-School Scaffold Promoting Belonging and Resilience
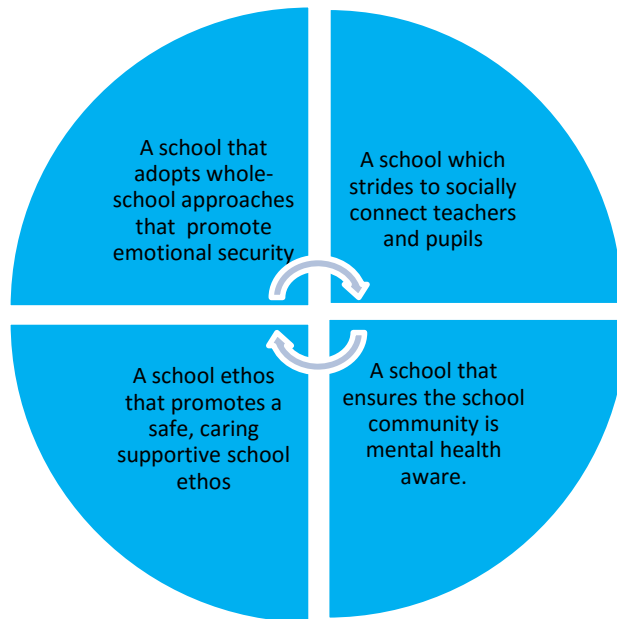
6.3   Service and Operational Issues; Managing the Disparate Perspective

The sections above demonstrated that, although young participants, parents and educational staff had some converging perceptions, they also voiced differing perceptions and priorities (As illustrated in Figure 19, below, in Venn diagram format).

Figure 19: The Disparate Participants' Perspectives
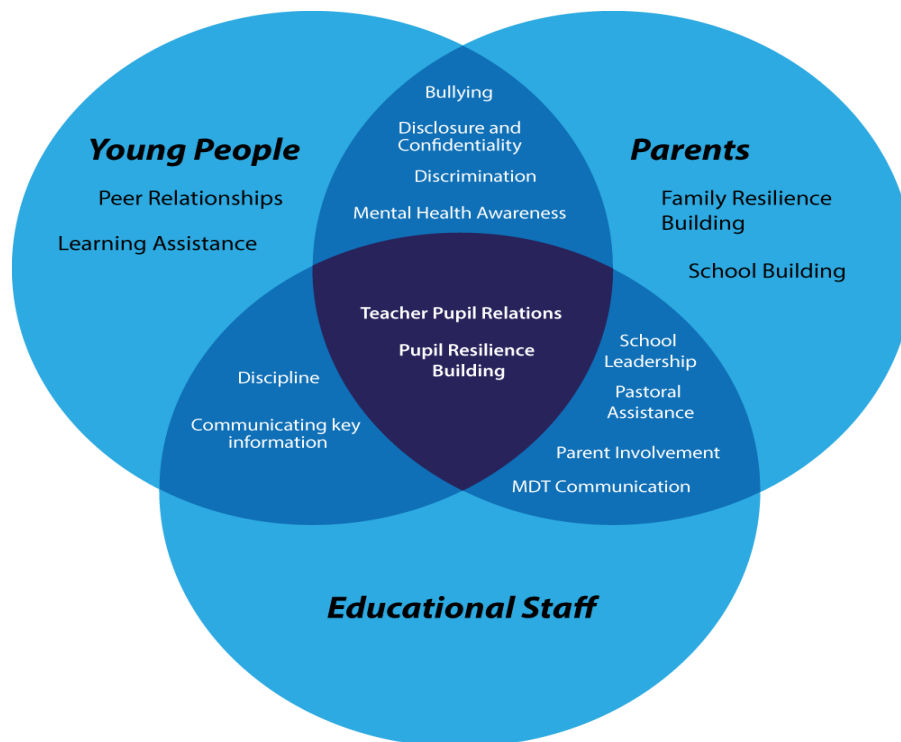
A good example of their differing perspectives is how the young participants expressed a critical need to feel physically and emotionally safe and socially connected at school, as a prerequisite to accepting specialist supports like school counselling. This 'bottom up' philosophy was in direct contrast to their parents and educational staff, who perceived the children to be vulnerable so placed more priority on a 'top-down' paternalistic approach thus prescribing the children specialist supports. This indicates that in order for school assistance to be 'fit for purpose' such differing perceptions need to be equally considered. There is a risk that adults may tend to oversubscribe to helping services, because of parental and professional anxiety, which is common in today's risk-averse culture. This can, however, fuel overprotectiveness which can inadvertently act as a barrier to the child's integration into normal school life and the promotion of their own resilience. The following three sub-sections discuss the operational and service implications of balancing and managing the disparate perspectives.

6.3.1. Promoting Connection by Listening to the Needs of the Young *People*

Secondary schools have a variety of methods for socially connecting schoolchildren. The psychosocial complexities that children with mental health problems have, alongside

the business of a large and academically driven secondary school, means that standard 'connecting methods' have some limitations. These children did, however, indicate that the key to connectedness was being better understood via open communication, whereby their opinions, choices and wishes are considered. It is this type of engagement that helps to ensure they feel safe at school, so that they are more likely to accept assistance rather than feeling this is being imposed on them.

All of the children stated that they felt better connected at school and safer when they had one key teacher who they knew well, and who they felt they could approach if they faced difficulties. The key to building a strong bond with a teacher was the tutorial system, as this enabled pupils and teachers to get to know each other on a more personal level over time. This was why many of the young participants valued the 'vertical' or 'horizontal' tutorial systems, in that they remained in the same tutor group from year 11 to year 13, thus receiving consistent support. Their parents also found this reassuring, because they felt a teacher who knew their child well was better placed to watch over them and assist them if necessary. Increased watchfulness is particularly important when a young person has multiple periods of depression or anxiety, as this allows for more effective early identification (DH2008a; DH, 2015). A report written by Lefevre et al, (2013), investigating good child protection practices in secondary schools, highlighted the need for school staff to have daily formal and informal contact with pupils so as to get to know their pupils well. Also emphasised was the need for the school to protect this time so it does not risk being dominated by other competing pressures (Lefevre ibid).

The educational staff who participated in this study did, however, suggest that their pastoral duties were slowly being eroded and becoming secondary to their teaching responsibility. This viewpoint was further supported by the young participants and parents in that, when asked to name a supportive teacher, several of them named an unqualified staff member (teaching assistant, learning mentor, family co-ordinator or counsellor) whom they did not see in their daily tutorial group. It was, therefore, apparent that, despite the value young people placed on teachers' pastoral responsibilities, this pastoral role was becoming more and more fragmented not only by a prescriptive overloaded National Curriculum, but also by the devolution of the pastoral

role to a new school workforce. One teacher union has argued that this new school workforce is in the main less qualified (ASCL, 2004), with others further highlighting the most problematic pupils are being supported both in the classroom and pastorally by less qualified staff (Edmond and Price, 2009; Tucker and Calvert, 2009). It is of concern that this trend will compartmentalise pastoral support further, moving it away from a teacher's responsibility. Notably, this trend is likely to continue as schools become more financially independent, for instance free school status now allows schools the freedom to employ lower-cost unqualified teaching staff (DfE, 2010; Vaughan, 2014). This can result in schools buying into cheaper pastoral provision rather than training pastorally qualified existing teaching staff, thus eroding the pastoral support of the teacher, which data yielded by this study indicates is what the children themselves value.

As well as having a solid teacher relationship at school, the young people very much emphasised the need to feel secure with their peers and valued the role that school staff had in both encouraging and nurturing positive peer relations. They especially stressed the need for teachers to help them resolve any peer conflict by adopting a caring mediating approach. This is an unconditional caring approach described by Cowie and Jennifer that invites all those involved in the conflict to collectively problem-solve the issue (Cowie and Jennifer, 2007). The problem is that, despite restorative methods being well evidenced in supporting older children and reducing behavioural problems (Bitel, 2005; Tfofi and Farrington, 2011), the findings from this study indicated that in reality few secondary school teachers are likely to have sufficient knowledge of how to safely facilitate relationships in this way.

Some young participants spoke about the value of nurturing their social interaction and promoting friendships via whole-school or classroom activities. The problem, however, was that this type of practice was rare in the busy and more academically driven environment of the secondary school class, perhaps because it is more frequently associated with supporting younger children in the primary school setting (Colley, 2009), who arguably have differing developmental and personal needs. Attempts have been made to adapt primary school programmes like nurture groups or circle of time[23] for

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[23] These activities aim to replicate the home environment by providing a safe, welcoming and caring base for learning. Time is set aside each week in which teachers and young people sit in a circle and take part

adolescents. These are designed to target children struggling in their mainstream education by involving them in activities that help them feel better engaged with their peers, and in doing so make them feel like a valued member of the school, thus building their self-esteem. The empirical evidence indicates that these interventions can make a difference to a pupil's behaviour and social skills, and promote a sense of community with children who might otherwise be at risk of disengaging from their schooling (Cooper and Tiknaz, 2007; Garner and Thomas, 2011; Kourmoulaki, 2012).

The young people who took part in this study did, however, voice some concern about group school programmes targeting identified children with specialist needs. This was because any specialist targeted therapeutic supports risked them being singled out from their peers as being different. As outlined in section 2.2.3 evidence, mainly originating from Australia, suggests that any form of targeted group activities with older children with intrinsic mental health difficulties should proceed with caution, as children of this age prefer universal support (Shochet and Ham, 2004; Rapee et al, 2006). This is because, when receiving such specialist targeted support, they report feeling exposed as different and subsequently worry about stigmatisation or victimisation. In the UK, however, it is considered that targeted intervention has better outcomes when supporting vulnerable children (Humphrey, 2013; Weare and Nind, 2011). The 'Pyramid Club'[24] is an example of a recent UK targeted programme for children with intrinsic difficulties like anxiety and shyness. Yet, despite the reported benefits of such specialist groups, what is being overlooked is the child's preference as to the support they receive and their need to feel safe in the school environment before accessing formalised provision. Craig (2007), a critic of more formalised pupil emotional supports such as SEAL, reminds us of the child's status in school by stating: '*Young people at school are a captive audience; they will be given little choice in whether they participate*' (Craig, 2007, p.11).

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in activities. Many of these relate to discussions about peer relationships, democratic principles, justice, individual freedom, and difficult problems.

[24] The Pyramid Club is primarily for children who find friendship difficult because of problems like anxiety and shyness. It aims to help children build friendships, confidence and coping strategies thus preventing more serious mental health problems. The aims are to get children involved in intensive fun activities, all of which aim to nurture peer relationships and build their confidence in a safe and quiet environment (ContinYou, 2012*).*

The form of support the young participants did prefer and value was one-to-one peer support. Some young participants and their parents had been buddied up with peers who were also suffering from mental health problems. They spoke about the helpfulness of teachers 'buddying' them up in this way, so they had some emotional support. Despite there being a sound empirical base amidst the educational literature supporting this type of one-to-one school intervention to promote learning (Cooper and Jacob, 2011b; DfE, 2015a; Weare, 2015) and friendships in the school context (Beattie and Holden, 1994; Davis and Florian, 2004), there is not enough evidence indicating that this type of support can help children with mental health problems. Indeed, a recent review of evidence by the Mentoring and Befriending Foundation (2010) highlighted that more research needs to be carried out in this area.

Appelhoff (2013) recommends that, in the absence of supportive evidence, schools refrain from peer-helping programmes in case these cause more harm (Appelhoff, 2013, p.138). Also, research investigating the impact of peer support[25] on adults with severe mental disorders suggests that it remains inconclusive as to the benefits that peer support may have on well-being (Lloyd-Evans et al, 2014). This suggests that caution needs to be taken when involving young people with mental health difficulties in peer support activities. This study indicates though that school staff are not aware of these concerns. This is likely because they are more aware of the abundance of literature highlighting the benefits of buddying and peer mentoring, from promoting learning (Baker et al, 2004; Cooper and Jacob, 2011a: Falk and Wehby, 2000) and tackling bullying (Cowie, 2011; The Mentoring and Befriending Foundation, 2010) to aiding children with transitions (Evangelou et al, 2008) and hence are less likely to be aware of the complexities associated with mental health problems such as the literature which suggests that children may be at risk of dangerous copycat self-harming behaviour or copying suicidal ideation (Giletta et al, 2013; You et al, 2013; WHO, 2006). Nevertheless, data from this study suggests that teenagers value this type of support, partly because they feel able to express themselves naturally with another person who understands their situation, rather than masking their problems. The DH (2015) report '*Future in*

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[25] Peer support is an umbrella term that encompasses many forms of assistance, from service users educating other service users to intensive one-to-one support (Lloyd-Evans et al, 2014).

Mind' also identified that young people want access to more peer support, whilst stressing the importance of safeguarding children when connecting them in this way. This suggests that novel approaches to peer connection need more in depth evidencing.

6.3.2. *The Further Benefits of an Emotionally Intelligent Workforce*

A core finding of this research was the need for all school staff to have more knowledge of mental health problems, as this would benefit these pupils in a number of ways (see Table 11). This raises several implications as, although whole-school training in the main was welcomed by the educational staff, some barriers were also voiced. One barrier was the actual time required to undertake training, whilst a second was the belief that not all staff would see the training as important. This type of attitude appeared to pervade in the secondary school environment, despite policy recommending that teachers adopt a more active role in preventing and promoting pupil mental health and that engagement with all schoolchildren is a fundamental part of a teachers daily role (House of Commons Health Committee, 2014; Johnson et al, 2011).

Some propose the introduction of statutory training in the teacher training curriculum to ensure that teachers are better equipped to detect mental health problems and to better support pupil well-being (Bostock et al, 2011; House of Commons Health Committee, 2014; Johnson et al, 2011). For instance, in the recent Carter review of initial teacher training (ITT) it was recommended that, in future, new teachers should be provided with a basic understanding of child and adolescent development, including the emotional and social domains, as well as mental health (Carter, 2015). This may go some way to improving teacher knowledge, but may prove challenging for all the teaching fraternity to embrace such training. There is, therefore, an argument for training to be targeted to specific daily requirements of the teachers rather than being mandatory.

Statistical data compiled by teacher unions provides some insight into some of the challenges teachers face on a daily basis, in that they are under a lot of pressure to meet national targets through an increase in their workloads. Furthermore, teachers are under pressure because of having to teach more children with behavioural difficulties in larger classes (DFe, 2010; NASUWT, 2010; NUT, 2013). It, therefore, makes sense that training should be designed to not only fill a mental health knowledge gap (benefiting

the young people), but also should aim to improve the mental health literacy of teachers, so that they can better manage their own mental health and that of others.

An abundance of evidence indicates that teacher interpersonal skills promote teacher/pupil engagement, reduce children's behavioural problems (Roffey, 2011) and improve their attainment (Cohen, 2006; Jennings and Greenberg, 2009), which all contribute to preventing teacher burnout (Chang, 2009; Jennings and Greenberg, 2009). Many support the opinion that training focusing on the acquisition of knowledge and interpersonal skills will enable teachers to better engage with children experiencing difficulties, as well as safeguard their own well-being (House of Commons Health Committee, 2014; Johnson et al, 2011; Spilt et al, 2011). This is why these authors place an emphasis on teachers developing their emotional intelligence (EI). Salovey and Mayer, the originators of the term EI, define this as: *"Having the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions"* (Salovey and Mayer, 1990, p.187).

At present the mental health training packages being utilised are varied. Some recommend training that looks to impart more specialist information on differing mental health presentations, e.g. eating disorders (i.e. Knightsmith et al, 2014) and developmental difficulties like ADHD (i.e. Wheeler et al, 2008). More recently, as mentioned in section 2.4.4, E-learning packages have also been developed for frontline children's works in order to promote mental health knowledge. The Mental Health First Aid course, which is a conventionally delivered teaching package, is one of the more extensively trailed mental health training packages presently available (Jorm et al, 2010). The strengths of this package are that it is short thus acknowledging the concerns teachers have about limited time to attend training. A recent systematic review suggested that Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes and behaviours towards mental illness (Hadlaczky et al, 2014). The limitation of the brief training initiatives is that it may not balance the unique needs of the teacher, which are to acquire mental health knowledge, develop interpersonal skills, whilst also maintaining classroom safety and comfort via assertive discipline.

A less evidenced programme that aims to empower teachers with the right balance of knowledge, interpersonal and disciplinary skills is The Solihull programme[26]. This introduces teaching staff to a combination of neurosciences and psychoanalytical theories, so that they can better understand children's emotional difficulties and better manage difficult behaviours in the classroom. Preliminary studies evaluating the effectiveness of this approach with younger children look promising because teachers report that they feel empowered with the right balance of disciplinary and interpersonal skills. The programme does have some disadvantages in that the training is time-intensive (Hassett, 2014; Simons and Jackson 2009), but is more evidenced in health visiting practice rather than school settings, especially secondary schools (Fairtlough, 2014).

The SEAL programme also included a component which centred on expanding the repertoire of teachers' social and emotional skills. SEAL evaluations, however, do not focus on this particular aspect in depth and findings are inconclusive. For example, Hallam (2009) reported that training linked to SEAL had changed teachers' reactions to classroom behaviour in a positive way by increasing their confidence in behaviour management and dealing with incidents in a more thoughtful and caring way. Others have reported less positive outcomes, in that some teachers have suggested SEAL training places them under more pressure to embrace new concepts and new ways of working, which was sometimes considered stressful (Craig, 2007).

Overall, it could be deduced at this present time that there is no suitable training package for secondary school teachers which would balance teacher and pupil needs. The lack of suitable 'off the peg' school training is possibly why a scoping study found that many schools were not buying into any form of mental health training (Vostanis et al, 2013). This suggests that more emphasis should be placed on developing fit for purpose and practice mental health teacher training programmes.

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[26] The Solihull approach was a manualised parent programme developed for health visitors to help them promote the emotional well-being and mental health of infants, children, adolescents and their families. More recently it has been adapted to help teachers to better support pupils' behaviour in the classroom (Hassett, 2014; Simons and Jackson, 2009).

6.3.3. *Wraparound Assistance from the School and CAMHS*

Children with more complex mental health difficulties do not only require a school that possesses a safe and more caring ethos, whereby they feel positively socially connected and supported there by emotionally literate school staff; they also, at times, require tailored assistance (DCSF/DH, 2008; DH, 2015; DfE, 2015a; DfE, 2014c; Suldo et al, 2013; Weare, 2015). Realistically such children require additional input from external agencies, some of which may already be involved with the family, thus there is a need to share information. Being privy to key information does, however, require schools and CAMHS to forge strong collaborative links in order that they can work together to offer more effective integrated interventions. The study data did, however, indicate that inter-agency working practices needed improvement. This is consistent with the work of others highlighting the complexities of inter-agency working and the many barriers hindering it (e.g. Oliver et al, 2010; Salmon, 2004).

The findings did, however, indicate the more complex the child's problems the better the inter-agency working was. Yet when the child's problems were less serious communication between schools and CAMHS was less evident. This was largely due to the lack of trust the young people and their parents had in school staff maintaining confidentiality and having the professionalism to discreetly aid them with their mental health difficulties. This led to them remaining silent about their difficulties thus CAMHS school communication often did not exist. CAMHS practitioners did not appear to question their silence. Yet what the data indicated was that when children did divulge difficulties to their schools (often due to necessity because of a hospital admission leading to long absence), their worries were often unfounded. It is thus important to break this barrier of silence driven by mistrust and insecurity via good collaboration and ensuring every child feels supported at school.

An abundance of evidence suggests there is a strong association between poor mental health and poorer educational outcome and that schooling has the potential to promote a child's well-being by improving their life chances (Bonell et al, 2014; Morrison-Gutman and Vorhaus, 2012; Langford et al, 2014). This suggests that every child vulnerable to mental health difficulty should, therefore, receive the support they require at school. It is not only important that schools enhance a child's emotional well-being at school but

also services like CAMHS must work more closely and regularly with schools to ensure a child is happy at school (Carr-Greig and Manocha, 2011). It was evident, however, from this research that neither schools nor CAMHS place enough focus on ascertaining if a child is happy at school and that they feel they belong there. The reasons for this might be linked to schools in the main being primarily attainment driven and it may be hypothesised that due to capacity constraints, CAMHS remain largely family-focused and work less proactively on school issues.

Detecting the subtle signs of distress or alienation is, however, the first step that allows school problems to be better managed. Although a heavy emphasis is presently being placed on school staff in detecting mental health problems, there may be less attention by external agencies to make it their business to recognise whether a child has school problems (Carr-gregg and Manocha, 2011; Oliver and Mano, 2007). The data yielded by this research indicates that it is infeasible for a child to report school problems because of the shame and fear these children possess of victimisation and stigmatisation (Carr-gregg ibid; Vessey et al, 2014). It is, therefore, important that school staff and CAMHS professionals tune into the subtle, observable signs, that indicate whether a child may be feeling alienated, so that discreet support can be provided by school and CAMHS staff. Hong and Espelage's (2012) review of the bullying literature, highlights the need for more attention to be placed on adopting multiple methodologies to detect school mental health problems like bullying. The empirical literature concurs with this study's findings that there are some subtle signs that can indicate school distress. School and CAMHS staff are, therefore, well positioned to recognise this by adopting multiple methodologies i.e. teacher observation, CAMHS' practitioners making a concerted effort to explore school issues at appointments, the use of routine school data, or closer inspection of psychometric testing. For example, the Strengths and Difficulties Questionnaire (SDQ)[27] in part measures peer relationships. The subtle signs of distress and just some examples of how this study's findings are supported by other researchers are summarised in Table 12 below. It is when school and CAMHS combine their

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[27] The SDQ Questionnaire is a brief self-report mental health questionnaire to help clinicians, researchers and other professionals' judge whether a child may be suffering from a mental health problem (Goodman et al, 2000).

assessment information that there is potential to better identify a child in need, particularly if difficulties are highlighted in more than one domain.

Table 12: Signs of School Difficulties

Subtle signs of school difficulties	Signs school staff may better detect	Signs CAMHS staff may better detect	Examples of the evidence supporting these signs are possible signs of distress
School refusal, truancy or regular absenteeism due to frequent minor illness, or psychosomatic complaints, and/or being sent home frequently for minor ailments	√		(Colechin, 2012; Juvonen et al, 2011: Peterson et al, 2009; Little et al *in* Waller, 2013; Maynard, 2015. Morrison-Gutman and Vorhaus, 2012)
Falls in grades or changes in the standard of work submitted	√		(Bowen, 2011; Juvonen et al, 2010; Morrison-Gutman and Vorhaus, 2012; Schwartz et al, 2005)
Observations of bullying or peer fall-outs and/or visible signs of isolation from peers. Or reports of bullying, peer problems or a feeling of loneliness at school	√	√	(Currie et al, 2012; Glew, 2008; Graham and Bellmore, 2007; Hong, and Espelage, 2012; Wormington et al, 2014)
Being detached from school staff or reporting an inability to approach school staff about school difficulties	√	√	(Hamre and Pianta, 2006; Pianta et al, 2012; Roorda et al, 2011; Wentzel et al, 2002)
Displaying, or reports of behaviour out of character, for instance behaviour that reverts from passive bully victim to aggressor	√	√	(Glew, 2008; Salmivalli; 2014)

The next aim is to quickly tackle a child's problems, preferably through proactive multi-agency action. Early intervention is especially important in preventing problems from becoming entrenched and impairing (Hong and Espelage, 2012; Weist et al, 2007; Van Dam et al, 2012; Wolke et al, 2013). For example, if teachers identify severe difficulties they should escalate concerns to the external services, so that the child and their parents are offered additional assistance. The literature stresses the importance of this especially when a child is a victim of peer victimisation (Graham and Bellmore, 2007). CAMHS, on the other hand, may work proactively with the child and parents in deciding

what information needs to be shared with school and the benefits of this, thus adopting a very similar model to tier 4 in-reach schooling team. When school issues are identified in such a systematic way, more formalised care or inter-agency support can then be put in place such as the Common Assessment Framework (CAF) or the Care Programme Approach (CPA) (DH, 2008; Easton et al, 2011).

It was noted, however, that none of the participants mentioned attending Common Assessment Frameworks (CAF) meetings. This was despite CAF being particularly recommended to secondary schools as a bridge to specialist services (Wolpert et al, 2011; Worrall-Davies and Cottrell, 2009; Oliver et al, 2010). Cost is considered to be a chief barrier to utilising CAF proactively, although, interestingly, recent research has challenged this perception, as it was found that the CAF's emphasis on early intervention can significantly reduce the future costs (Easton et al, 2011). Other barriers this research highlighted were school staff not having the time to attend meetings and an attitude pervading that children who struggle emotionally, but who do not have learning difficulties, should not be prioritised for more formalised support.

Only a small proportion of children in this study received more formalised tailored inter-agency support via CPA (see footnote 18), usually after inpatient admission to tier 4 services. This sub-group indicated that being subjected to CPA appeared to benefit all parties; the school, CAMHS and the family, in a number of ways. For example, CPA gave all parties an opportunity to collaborate and agree on the ideal, realistic, wraparound assistance to support an individual child. The young people were more proactively involved in their own care planning, as the formalised protocol ensured that they were consulted and allowed to have their say as to their preferred type of support. Parents were allowed to be more involved in their child's schooling as this reassured them their child was getting the assistance they required and prevented them from having to act as the conduit with the school. Mapp (2003) highlights how formalised meetings can create an environment whereby parents feel that their opinion is valued and their contribution is validated. This can increase, in turn, the parents' well-being and efficacy in helping their child (Cohen, 2005; Hoover-Dempsey et al, 2001). School staff appeared to have a better understanding of the child's needs, appreciate the advice they received and were thus more proactive. In contrast, children being cared for by tier 3 services

were less likely to receive this form of structured support. This is despite it being well known that mental health problems affect all aspects of a young person's life and no one service alone will be able to meet the child's needs (NHS England, 2014, p.10) and despite DH recommendations that more children who experience severe mental health problems should be supported through a CPA protocol (DH, 2008b; DH, 2015).

What this study data also suggested was that collaboration between CAMHS and schools would be improved by each service developing a better understanding of each other's roles. For instance, how a teacher can realistically support a child with more complex difficulties and how a CAMHS practitioner may better support the child's schooling. What was evident from this research was that the children themselves were clear as to how each professional could help them. Role ambiguity is highlighted by many as a barrier to effective multi-agency working (Lliffe, 2008; Oliver et al, 2010). The children did not, however, perceive this to be problematic, as they were able to identify their teacher's strengths and distinguish these from their CAMHS professional's competencies. For instance, they perceived CAMHS professionals to be better positioned to help strengthen their resilience with low intensity CBT strategies that they could potentially utilise at school. They also felt their CAMHS practitioners had a role in supporting their parents. In contrast they perceived their teachers to be more skilled in helping with their learning and in providing more practical advice on specific school worries. The data generated by this research suggested that in-reach schooling teams have useful practical advice that could be more widely disseminated to aid all teachers. Figure 20, below, summarises the wraparound support that young participants and their parents envisaged their CAMHS and teachers could realistically provide. Table 13 ends this discussion by mapping the interventions, school supports and methods highlighted in this thesis against the young participants' voiced needs. It demonstrates that multi-component school support is required to meet all the children's voiced needs, and that there are plenty of specialist and conventional school supports that are presently available to schools which have the potential to benefit the child with identified mental health difficulties. Table 13 also illustrates some of the gaps in whole school provision, all of which need address in order that secondary schools and CAMHS can better support

the wellbeing and education of the child with identified mental health difficulties. The areas that require further address are outlined in sections 6.4 to 6.6 of this chapter.

Figure 20: Wraparound Assistance from Schools and CAMHS; as Conceptualised by Young People and their Parents.

School individualised support

- Offer children with severe emotional difficulties one-to-one educational staff support ensuring, therefore, the child can talk over school worries when needed.
- If academic stress is evident, offer catch up learning support (revision and learning tips). Consider exam adjustment if the child is experiencing emotional difficulties.
- Ensure suitable safe private quiet space can be accessed when needed.
- Promote the child's well-being at school by understanding the importance of promoting the pupil's own coping strategies and working to their own strengths.

CAMHS individual support

- Decide in collaboration with the child and ideally parents what *'need to know'* information should be shared with the school and discuss why this is best shared.
- Forge more formal (via CPA and CAF) or informal information channels with the school so 'need to know' information is exchanged and an individualised care plan decided.
- Introduce the child to low intensity CBT strategies that they may use to promote their resilience at school.
- Promote the child's resilience by supporting parent resilience. (Give support and information to parents about how they may support their teenage child at school).
- Offer more intensive emotional support when the child is experiencing school distress giving them the opportunity to talk about school difficulties if needed.

Table 13 – Mapping the voiced needs of children against current available supports and interventions

	THE SCHOOL INTERVENTION AND SPECIALIST SCHOOL AND CAMHS INTERVENTIONS HIGHLIGHTED IN THIS THESIS																			
KEY FINDINGS AND DISCUSSION POINTS	(SEAL & PATHS) Programmes	BESTS	Consistent tutor form support	CBT programmes for anxiety (i.e. FRIENDS)	Specialist CBT programmes for depression (i.e. RAP and PENN)	Mind Ed E learning resource	School counselling	Teacher mentorship support	Peer helping programmes	Mental Health First Aid	The Solihull Approach	Universal Anti-stigma programmes (i.e. Time to Change)	Restorative Justice /peer mediation methods	CAF/CPA or Early Help MDT Models	Nurture groups and friendship groups (i.e. The Pyramid Club)	PMT programmes	One stop shops (OSS) in schools	Mindfulness/relaxation methods	CYP (IAPT)	PSHEE activity related to mental health
Enables pupils to better socially connect with their peers.	√		√						√		√	√	√		√					√
Enables positive teacher/pupil engagement by promoting teacher EQ.	√		√					√			√	√	√		√					
Promotes teacher mental health awareness thus improving teacher/pupil engagement.	√	√				√		√		√	√	√	√	√						√
Enables school staff to promote the emotional security of pupils by handling disclosure more sensitively.		√					√	√				√	√	√					√	

Enables school staff to promote the emotional security of pupils by maintaining confidentiality.		√								√		√		
Enables sensitive handling of classroom behaviour issues and bullying problems alongside zero tolerance methods.	√	√				√			√			√		√
Enables schools to ensure pupils do not experience mental health discrimination or stigma from teachers					√					√	√		√	
Enables the child to have more of a say in shaping their school ethos, pastoral care and individualised assistance.	√						√					√		
Ensures the child has a say in what personal information should be exchanged between CAMHS and school.		√										√		
Ensures teachers have the knowledge as to how they can better support the learning of pupils experiencing emotional difficulties or academic distress.		√				√		√	√			√		

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Ensures children are provided with the support and coping skills they need to more resiliently cope at school and in life in general, i.e low intensity CBT strategies.	√	√	√	√	√		√	√	√	√	√	√	√	√	√	√	√		√	√
Ensures teachers and CAMHS workers can better detect a young person's less visible mental health distress; i.e signs of alienation; school absence, drop in grades, signs of bullying, disengagement from teachers or other pupils, or out of character behaviour.			√			√		√			√	√		√						
Ensures the child has the opportunity to speak about school difficulties.		√	√	√			√	√	√				√		√			√	√	
Ensures the child has the environmental space to regulate their own emotions																				
Ensures parent resilience is promoted so parents can better support their child's wellbeing and learning.		√											√			√			√	

6.4.   Recommendations

There is still some way to go to ensuring our large, academically driven secondary schools provide the support children with mental health problems need. Action is required at national and local level by schools and CAMHS. The first steps can be broadly categorised and clustered into three recommendations, all of which aim to either strengthen the school assistance children with mental health difficulties receive, or explore more about the barriers that presently hinder them from receiving the supportive provision they require. The three broad recommendations are outlined in Table 14, below, followed by more detailed discussion:

Table 14: Broad Research Recommendations

1	Promote a safer and more emotionally secure whole-school ethos
2	Promote positive social connection within and outside of the school
3	Promote the school experience by being more child-centred

To Promote a Safer and More Emotionally Secure Whole-School Ethos

As previous studies have supported (i.e. Cowie and Oztug, 2008; Goldweber et al, 2013), when school is experienced as a safe and affirming place, children thrive academically and emotionally there. The findings indicated, however, that a heavier emphasis should be placed on whole-school supports that promote secondary school pupils' physical and emotional security. This is because young people experiencing mental health difficulties do not always feel safe enough to focus on their learning, to seek support or be accepting of the support offered to them. This study suggested that there are still considerable gaps in whole-school provision which should be addressed, as highlighted below:

A. Despite bullying problems being on the decrease (Ttofi and Farrington 2011), this research indicated this may not be the case for children with intrinsic mental health problems. Nationally there should be further research to establish if vulnerable children are more susceptible to cyber and school bullying and how they can be better protected at school (Graham and Bellmore, 2007; Idsoe et al, 2012).

School is a safer and more secure place when a young person is able to talk openly with teachers about their mental health problems, whereby they do not fear discrimination or stigmatisation. The first step in fighting such broad-reaching stigma is for schools to ensure that school staff receive appropriate training to promote better mental health knowledge, interpersonal skills and attitudes. Unfortunately, there is limited suitable training available to cover this gap. At a national level, future research should explore how this type of knowledge can be transferred to the school setting, ensuring it is fit for purpose and practice.

B. Linked to promoting these children's sense of emotional security, further research can contribute to the establishment of school protocols related to disclosure and confidentiality. The long-term goal is to work towards practical inter-agency directives which clarify the difficult boundaries between safeguarding and mental health and thus provide the most appropriate intervention. Clearer advice will aid school staff by resolving their apprehension and will strengthen their alliance with pupils.

C. Schools can inadvertently cause distress, yet often children do not feel safe enough to share their concerns with other agencies. It is, therefore, important that schools and CAMHS more proactively detect subtle signs at school and, if identified, tackle it together. This study suggested that a sense of alienation may signal the presence of unhappiness, whilst more factors than just bullying can lead to school distress, i.e. mental health discrimination, stigma, teacher and peer conflict, or academic stress. Future research should explore the impact of other school stressors, so more can be learnt about how to detect problems as well as how to intervene. For instance, these findings might suggest that schools should adopt a nurturing approach alongside zero tolerance guidelines to ensure that more vulnerable children experiencing bullying feel able to break their silence.

To Promote Positive Social Connection Within and Outside of the School

Positive social connection is an aspect that schools need to focus upon, as pupils feel safer and happier when their school relationships are positive. Previous research suggests that there is a need to help vulnerable children develop their social and personal skills by nurturing connection and friendships, as this promotes confidence and self-esteem (Evangelou et al, 2008; Gunslicks et al, 2010; Milling et al, 2012; Shochet et

al, 2006). This can also prevent incidents of bullying, especially among vulnerable groups (O'Brennan et al, 2014; Hong and Espelage 2012). Schools may adopt the European and Australian philosophy of instigating whole-school provision to better connect those inside and outside the school. The recommendations from this study are outlined below:

A. Children with mental health problems acknowledge that their mental health problems make them susceptible to peer friction and fall-outs. They hence want school staff to watch over them, and when peer conflict arises for those school staff to have the interpersonal skills to intervene effectively with mediating skills and restorative justice methods being favoured. These forms of support, despite being reasonably well evidenced in the secondary school setting, are not universally applied, therefore the barriers to their implementation need exploring. Furthermore, novel ways of connecting older children with mental health difficulties should be created and piloted, with more focus on aged appropriate school-based interventions.

B. Pupil/teacher connection was valued by this population of schoolchildren. This concurs with an abundance of research which identifies this as a crucial factor. Children voiced, however, a wish for discreet school support from a teacher who knows them well and who can assist them with their school worries. This highlights the need for schools to protect teachers' pastoral role, which notably is emphasised in the DfE (2015a) guidance to schools on mental health well-being. This will ensure that the present trend of buying in additional specialist pastoral services does not devolve totally the teacher's pastoral role to non-teaching staff. Consequently, it is timely for research to more clearly delineate the teacher's one-to-one pastoral role from that of the school counsellor.

C. Children of secondary school age naturally want their parents to be less openly involved in their schooling. Parents of children with mental health problems, however, voice the need for strong school links, as they value reassurance and support that can be generated at home. Plenty of Government policy also recommends schools engage proactively with parents (DfE, 2015a, DfE, 2014a, DfE, 2014c; DfE 2015d). There are, nevertheless, a number of barriers hindering conventional joint parent-school involvement, none more so than the teenager themselves. They often do not want their parents closely involved in their school affairs, but they prefer them to offer their

support in the sanctuary of their own home. Research on parent/school collaboration should consider the young person's perceptions alongside those of the adults involved in their care so that a balance can be struck and barriers overcome.

D. CAMHS and schools need to carve out more connective communication channels, thus allowing for more cross-pollination and dissemination of good practice. For instance, Educational Psychologists, SEN teachers, CAMHS professionals and in-reach schooling teams all have valuable information to share. This will ensure that more children can reach their full academic potential, but not to the detriment of their well-being. More emphasis must, therefore, be placed on providing further informal opportunities for professionals to share and transfer knowledge, i.e. via leaflets, supervision or trans-professional unified training. This concurs with others who have found this type of practice improves multidisciplinary team working (Cameron et al, 2012; Hulme and Cracknell *in* Campbell and Groundwater-Smith, 2010; Oliver et al, 2010).

E. CAMHS and schools should more proactively use the multi-agency support mechanisms proven to better connect families, school staff and professionals like the non-statutory CAF process (Oliver ibid), and CPA process (DH, 2008). Audit and research should identify the reasons for CAF's underutilisation by secondary schools and CPA's underutilisation in tier 3 CAMHS services. It is important to investigate this as a matter of urgency, because at present schools appear to be responding more proactively to mandatory legislation like child protection or CPA, implemented by tier 4 CAMHS services for those with severe mental health problems who have had an inpatient stay. It is also important that the child's view of this type of support, as well as their active role in it, should be explored alongside that of the professionals.

To Promote the School Experience by being more Child-Centred

Secondary schools and their well-being provision are often adult-centred and adult-driven. They should thus adopt more child-centred systems in order to improve the overall school experiences of all their pupils. As stated previously, the children's perspective should be central to good practice (Munro, 2011). There are not only strong ethical grounds for ensuring that secondary schoolchildren are free to express what they believe, are listened to, and have the right to be involved in key decisions about their

lives, as per the 1989 United Nations Convention on the Rights of the Child (Articles 12 and 13). There is also strong economic justification, as funding spent on supportive provision is less likely to be wasted on assistance that children do not value and do not engage with. Rudduck and Flutter (2003) suggested that schools must embrace strategies that listen to and consult with school pupils in order to promote their learning, as this allows teachers to gain a deeper understanding of the pupils' learning processes and the special assistance they require. The recommendations arising from this study have some similarities and are outlined below:

A. Action is needed at a national strategic level to ensure that children have an opportunity to be consulted on how they are pastorally assisted in schools. Parental consultation is also recommended (i.e. OFSTEDs, '*Personal, social, health and economic education in schools report*' 2010; Sawyer et al, 2011: Woolfson et al, 2008). It is, therefore, important to ensure their involvement is not just a political and managerial task which is '*tokenistic*' (Learning and Teaching Scotland, 2006, p.21). Good practice should instead ensure that both young people and parents have their opportunity to comment on their choice as the type of support they receive and a say in what they feel helps them. Professionals, therefore, need to recognise the diversity of childhood by adopting more collaborative dialogue by working with children and families to creatively and flexibly develop suitable fit for purpose supportive programmes or strategies that enable the individual child to play a central part in coming up with solutions to their own life issues. For instance, this research found that young people had a preference for universal over targeted supports, as the latter made them feel signalled out, thus reinforcing their fear of victimisation. The long-term goal would be to involve children in the development of these programmes, rather than solely relying on adult input, and in doing this we will move away from one approach fits all, by ensuring children and their families have their say.

B. In the healthcare setting Government guidelines dictate that children and parents are offered a choice of interventions appropriate to their needs (NHS England 2014, p.15). Schools and CAMHS must place more emphasis on ensuring that children have personal choice as to what school pastoral support they prefer. In this context, any specialist assistance offered to children with identified mental health difficulties should be in

concordance with their wishes, and that it is offered at the right time and in the right place, whereby the child feels comfortable and secure. More formal mechanisms of consulting with children should be incorporated at various stages of care planning. This study identified that ideally CAMHS should have a mechanism to consult and collaborate with children and their families about what 'need to know' information should be exchanged with their school. This discussion can promote security, as the young person has a better understanding of how this exchange of information may help them, whilst being reassured that they had control as to what should be exchanged and what should not.

C. Education and health are synergistic. Yet educational policy in England increasingly encourages schools to focus on attainment, whilst placing less importance on well-being. This is despite a growing literature highlighting the need to balance both aspects in a child's life, and how a caring whole-school ethos can help achieve this balance (Bradley and Greene 2013; Public Health England, 2014). There is, therefore, a need to move away from monitoring school performance on attainment only, by mandating school inspectors to report more specifically on child well-being and how the whole-school ethos promotes pupil safety and connection. Consideration should consequently be given at a national level as to how such subjectivity can be measured. School staff, parents and children should actively drive this consultation.

6.5.   Limitations of the Study

This qualitative study was designed to better access a population of young people who often remain silent about their difficulties (Reddy and Newman, 2009b; Weist et al, 2007). Primarily it aimed to obtain a broad view of their unique problems; therefore, many aspects of school life were explored. This exploration was essential, because a lot of the literature pertaining to school mental health centres on niche topics such as bullying or the promotion of emotional well-being. Thus only systematic reviews have united the fragmented literature and have revealed more about the young person's holistic needs. The drawback of obtaining a broader insight into these children's worlds was that no one aspect was studied in depth. This has, however, highlighted some other areas that require more detailed exploration. This study thus acts as an aid to the

researcher as to what the young people themselves feel are worthy avenues for further research.

A norm when undertaking a qualitative research is that the research sample is small (Fossey, 2002, Holliday, 2002). This may, however, be perceived as a study limitation as only 14 pupils were interviewed across ten schools, which may or may not reflect the educational experiences of the population of pupils with intrinsic mental health difficulties. The intended goal of the study, however, was not generalisation, but rather transferability (Lincoln and Guba, 1885), meaning the aim was to present thick data description, which aims to allow the reader to determine whether or not the data yielded can be transferable to other contexts. Nevertheless, there are commonalities between these findings and other studies (e.g. Kidger et al, 2010; Millings et al, 2012; O'Brennan et al, 2014; Oliver and Mano, 2007; Shochet et al, 2006).

The recruitment procedures were set out not to exclude any participant on the grounds of gender, race or ethnicity. A relatively homogeneous group of individuals experiencing intrinsic mental health problems (depression, anxiety, and eating problems) were recruited. There was, however, a high degree of internal diversity within this sample, both with respect to the variation in their diagnosis (e.g. eating, bipolar affective, depression, anxiety disorder), as well as to their academic ability - from gifted pupils to those with learning difficulties - and their socioeconomic status. Also, although not intentionally, the female over the male perspective was obtained, and the data reflected the Caucasian British perception as there was no representation from any ethnic minority group. To an extent, however, the children recruited did mirror the diversity of the population of children experiencing these types of problems in mainstream schools and the sample did in part mirror society as a whole whereby more girls present with intrinsic distress than boys (MacLean, 2013; West and Sweeting, 2003). Similarly, previous studies have found that mothers are the most active parents in relation to their children's education (Okpala et al 2001; Williams et al, 2002) and that ethnic minority groups can be hard to reach thus do not access CAMHS (Mapp, 2003). What this study has managed to do, however, is to obtain a better understanding of white British children's views, which enables further research to focus on other cultural groups, thus it extrapolates different issues for children experiencing a range of mental health

problems, gender, racial and ethnic characteristics. What is missing amidst the findings, however, is the perspective of the CAMHS practitioner. The need for this was highlighted by the participants speaking frequently about CAMHS in conjunction with their schools experiences. Ideally, if this research was to be carried out again, CAMHS professionals would have also been included.

In analysing the data, as is often the nature of a PhD study, a sole coder was used, which in itself is a constraint; however, a number of peer review measures were introduced to compensate for this (section 3.8.1). A reflexivity journal was maintained, which was a further quality marker that aimed to safeguard against the participant voice being filtered by the researcher's own adult interpretations (Jootun et al, 2009).

6.5.1. Methodological Implications for Future Research

This qualitative research has purposefully explored the broader issues impacting on children's school experiences and, as is the norm with this type of research, more lines of enquiry and research questions have been identified than clear answers (Bryman, 2008). This section of the thesis, therefore, outlines how the adopted research design has highlighted suggestions and implications for future research. This section broadly categorises these implications into two broad issues. The first issue considers the methodological approach, its theoretical framework and its analytical methods, but also how future research may begin to build on some of the limitations of the design by adopting other complementary research approaches to build a more holistic perspective on these children's needs. The second issue was that of the sample and the central focus on the child. The avenues for further child-centred research are highlighted, with some discussion of how child friendly participatory methods maybe useful:

6.5.2. The Methodology, Its Theoretical Framework and Analytical Methods

Adopting a broadly based mainstream qualitative approach, using a social constructionist lens and analysing the data with a thematic framework, has shown to be successful in exploring multiple life perspectives, thus allowing for a better understanding of children's wider school experiences in their social context. Also, because the research focused on a relatively unexplored area, an array of social issues and problems were uncovered, all of which have implications for further research, as outlined below.

It is important to establish if the findings of this small-scale research can be translated to the wider population, therefore testing theoretical ideas and concepts generated by this study and its research question. The difficulty, however is that this study has illuminated many sensitive issues, e.g. mental health stigma/discrimination, traumatic bullying experiences, friendship difficulties and maladaptive coping strategies. Ideally such topics need to be explored with human sensitivity, as without this the participant is unlikely to divulge their experiences (Freeman and Mathison, 2009). Although a larger-scale qualitative study adopting interviewing methods may be considered complex due to the time-intensive and costly approach, nonetheless some important findings are likely to emerge. A conventional quantitative survey could combat some of the pragmatic challenges of a larger qualitative study and could be designed in a way that considers such sensitivities. Common survey methods adopted when tackling sensitive topics is to rephrase questions such that the participants have to answer the question from the perspective of another person (Mathers et al, 2007). This suggests a questionnaire revolving around the vignettes similar to those used in this study may be useful, as it was evident that the young participants revealed their true feelings on sensitive issues when responding from the perspective of a similar but other person. The guarantee of anonymity is also very important when addressing sensitive topics, as participants are more likely to answer questions more truthfully (Cohen et al, 2007). This is why online surveys may be the most suitable method, as a wealth of research indicates that self-administered computer-based interviews increase responses to sensitive personal questions and yield more genuine answers, mainly because clients feel that their anonymity is better protected (Bryman, 2008).

We need to acknowledge the rapid pace of change in our society; politically, economically and culturally, it is important to revisit the child's social world at frequent intervals (Coyl, 2009; Duckett et al, 2008). This is because the problems of this generation, in a time of austerity, are unlikely to be exactly the same as future generations. Utilising the same research design in future years has the potential to illuminate how aspects like political reforms, knowledge, migration and economic changes have impacted on society's changing attitudes and the impact that these may have on children.

There are other areas that this research illuminated which need more inductive exploration. For example, children spoke about how they masked their mental health difficulties due to complex psychological processes like shame, fear and humiliation. These mechanisms can hinder help-seeking behaviours (Flett and Hewitt, 2013) and are, therefore, worthy of further investigation using qualitative approaches like phenomenology, which have the potential to reveal in more detail the complexity of human behaviours, not just from a social but also from a phenomenological perspective, so that such phenomena can be better understood and lessons learnt. Other lines of inductive enquiry may employ observation or discourse analysis. For example, an alternative further research avenue relates to the importance of social connection and how this may be strengthened by studying teacher or peer interaction.

6.6. The Sample and the Study's Focus on the Child

One of the main study challenges was ensuring the young people remained at the heart of this research. Some participatory methods were used in the early stages of the design (see section 3.5), which helped to ensure that young people's opinions and recommendations shaped a more child-focused study. The gold star quality standard of participatory research would have been to involve children at every stage of the research process (Hart, 1992; Heath et al, 2009). Ethical concerns may, however, have arisen if children had been asked to generate the data, as the young participants did divulge that they often worried about their peers' perceptions of their mental illness, therefore an adult researcher was more appropriate. The research did, however, identify further research directions exploring less sensitive issues whereby child-focused participatory research may be utilised; these being:

It was evident from carrying out this study that the supportive provision being offered to children is at present predominantly being driven by adult need and not necessarily by the children themselves. Therefore, supported by Calvert's (2009) view that pastoral care is being shaped by the dominant discourses of the day, there is a need for more child-focused and child-driven research. Especially, as plenty of literature states that the voices of young people must be heard when shaping their education (Bergmark, 2008; Carroll-Lind and Kearney, 2004; Frost and Holden, 2008; McCluskey, 2008; Simons, 2014; Weist and Rowling, 2002) and health and social services (Aubrey and Dahl, 2005;

Plaistow et al, 2014; O'Reilly et al, 2013a; The Care Inquiry, 2013; Willmott, 2010). The same should apply to shaping mental health support in schools. This research suggests that children of this age are very articulate, wise and have some creative, practical and relatively inexpensive ideas to promote their school mental health.

Obtaining the child's perspective alongside that of their parents and a supportive member of the school staff gave a valuable insight into how the child's school lives were being shaped by those around them and how they negotiated, managed, resisted and coped with this disparity. One must be mindful, however, that each perspective is unique and important and therefore the goal is to obtain a better understanding of attitudinal disparities in order to identify common understanding, goals and outcomes. This is because the support given to young people may be strengthened by focusing on the points of agreement, rather than on structural disconnections. For this reason more child-focused studies should therefore adopt a similar multi-user model.

One of the most challenging aspects of conducting this study was having access to children. Due to its sensitive nature, the most ethical method of recruiting children was via a CAMHS gatekeeper (Heath et al, 2007). The problem, however, with this recruitment method is that it is known to be time-consuming and potentially causes institutional inconvenience (Heath ibid). Furthermore, the adults who act as the children's gatekeepers, via their inferred paternalistic or over protective attitudes, can hinder the children taking part in research (Masson, 2004). This was evident when carrying out this study. Recognising the importance of considering the voice of the child, there is a need, therefore, to explore more about how these gatekeeping barriers can be overcome and how researching recruitment strategies can be strengthened in order to ensure all children have the opportunity to participate in research, but that the most vulnerable are still protected.

Table 15, below, considers this study's recommendations and the research implications outlined in sections 6.4 to 6.6. The table outlines the next steps with regard to the dissemination of this study's findings and avenues for futher exploration.

Table 15: Key Dissemination Messages and Further Avenues for Exploration

Broad Research Recommendations	What the finding suggest need to be improved in order to better support secondary school children with identified mental health difficulties.	Key messages for dissemination	Recommended further research
To promote positive social connection.	The need to promote pupil peer connection, i.e. the use of peer 'buddying', restorative justice methods and creative classroom and whole school activities.	• Teachers, who watch over a child, detect their distress and help in discreet ways are valued. • Teachers who, in subtle ways, help promote peer friendships are valued. • Restorative justice methods are felt to be helpful when friendship or bullying problems are evident.	• The peer 'buddying' of children with emotional difficulties needs further exploration. Research should investigate the strengths of such approaches as well as the iatrogenic effects. • A closer analysis of how this population of school children interact with their peers has the potential to reveal more about their friendship difficulties and bullying problems.
	The need to safeguard the pastoral role of the teacher ensuring this role is not totally devolved to none educational staff.	• Children experiencing emotional difficulties value the support of a teacher who they know well. They like 'vertical' or 'horizontal' tutorial systems because these models allow them to get to know one school teacher well. • When experiencing emotional difficulties this population of school children value the support of a teacher mentor. As this ensures they can be better assisted with any school difficulties.	• Research is required to clearly define the teacher's one-to one role from that of the school counsellor. Exploring the perspectives of school teachers, counsellors and pupils may more clearly delineate the differing roles and ensure the teacher's pastoral role is not devolved totally to others. • Study is needed to ascertain if one-to-one teacher mentor support is beneficial to pupils experiencing severe mental health difficulties. • A closer analysis of teacher/pupil discourse may potentially reveal how teacher pupil inter-personal connection can be strengthened.

To promote a more emotionally secure whole-school ethos	The need to develop a suitable teacher mental health awareness training package. This should meet the special requirements of pupils and teachers as highlighted in sections 6.2.5 and 6.3.2.	• Pupils and teachers benefit emotionally from having a better awareness of mental health problems. In that pupils feel better supported with their difficulties and learning and teachers feel more empowered and confident. • More joint health/training and education learning opportunities are needed, therefore allowing for more cross-pollination and dissemination of good practice.	• Educational packages that aim to promote secondary school teacher's mental health awareness require further evaluation, i.e. SEAL, The Solihull Approach and Mental Health First Aid. The strengths and weaknesses of such packages need to be identified and a suitably fit for purpose teacher training package developed.
	The need to strengthen disclosure and confidentiality school protocol.	• Confidentiality and the handling of mental health disclosure is an area that requires address. This is because pupils and parents do not have faith in present school protocols. School teachers also suggest clearer guidance is needed.	• More in-depth research is needed examining the teacher's perceptions of maintaining confidentiality and the handling of mental health disclosure. This may reveal more about the complexities that surround these protocols and how they can be confused with safeguarding concerns.
	The need for teachers and CAMHS workers to be more tuned into the subtle signs of school distress so early intervention is more possible.	• Schools and CAMHS must be better tuned into the subtle signs of school alienation and school distress, as highlighted in section 6.3.3.	• Inductive qualitative research i.e. a phenomenological enquiry has the potential to illuminate why and how pupils experiencing intrinsic distress mask their unhappiness. This type of enquiry may reveal more about the subtle signs of distress so detection is made more possible.

	The need for secondary school pupils to have access to suitable, none stigmatising space in which to regulate their own emotions.	• Children who struggle regulating difficult emotions are using inappropriate space, like toilets, in which to take control of difficult emotion. This needs address.	• Participatory methods involving children may be deployed to investigate how schools can ensure pupils have access to safe, none stigmatising space. The pupil's perspectives may then be shared with school leaders in order to ascertain the potential for piloting such recommendations.
To promote the school experience by being more child-centred.	The need to improve information exchange between CAMHS and schools, by ensuring children have more say in what personal information may be communicated.	• Children with intrinsic difficulties benefit from CAMHS sharing key information with the school about their difficulties. Children do not, however, always feel safe enough to share this information, and often do not know what to share and how it should be shared. CAMHS workers therefore need to take a lead role in supporting children and their parents in transferring information.	• It is important to obtain a more in-depth understanding of the children's, educational staff, parents and CAMHS workers perspective on the matter of information exchange with schools. A possible communication tool may then be devised and piloted. • At present CAF and CPA are underutilised despite their reported effectiveness. The reasons for this need further exploration. • Plans to pilot named points of contact in each school and CAMHS may have the potential to improve pupil and parent confidence in exchanging sensitive personal information with their school, however, this should be analysed by ascertaining the pupil and parents perspectives on whether these roles increase confidence in information exchange.
	The need for children to have a say as the type of school support they wish to receive.	• Schools do not always feel safe enough to receive additional mental health support. The stigma of mental illness compounds this problem. Schools and CAMHS must	• It is important to establish if the findings of this small-scale research can be translated to the wider population. A survey can now be developed from this study's findings so that more children experiencing emotional

		therefore place an emphasis on ensuring children have a say as to what type of school support they prefer, and when and where they wish to receive it.	difficulties have an opportunity to comment on their preferred school support and a say in what they feel is helpful.
		• When CAMHS and Schools develop joint care pathways for children experiencing mental health problems it is also important that their care is tailored according to the voiced need of the child.	
	The need to review how secondary schools can strengthen home school links and parental school involvement.	• Children have differing ideas to their parents and teachers as to how their parents can support their schooling. The perspectives of the children themselves, therefore, should be considered in order to strengthen home school links.	• Further research is needed to explore in more depth parents' and teenage pupils' perspectives on how their parents' are best involved in their schooling.
	The need for pupils to have their say in shaping the schools: ethos, pastoral care agenda and how their wellbeing can be better balanced with attainment.	• At present a schools supportive provision is driven by adult need. Children often hold differing views to the adults supporting them; therefore, children should play a more active part in shaping their education at both local and national level.	• This study's findings have the potential to shape a more supportive school ethos. It will, therefore, be useful to use participatory research methods with a group of young people to explore how this study's key messages can be disseminated in a youth friendly way to local schools.

6.7. Reflexivity

To convey to the reader the part I have played in constructing this research knowledge, my thoughts, emotions, feelings and behaviour are detailed in this section (Braun and Clarke, 2013; O'Reilly et al, 2013b). Please note my personal drivers for undertaking the study were detailed in an earlier reflexive section (1.8).

Attention to reflexivity is an important quality marker when undertaking qualitative research (Jootun, 2009), especially when carrying out research with children using a social constructionist framework (Freeman and Mathison, 2009). As reflexivity involves the continual promotion of self-awareness (Finlay, 2002), Johari's (1955) self-awareness model (see appendix 18) was considered to be a useful tool in scrutinising myself through the research process. This model suggests that we have four identity aspects, which should be addressed if we wish to promote our self-awareness. The next two sections identify and discuss these aspects and demonstrate how the Johari model helped me to identify, check and change my personal characteristics as and when necessary when carrying out this research.

6.7.1. My Public and My Hidden Self

Two aspects of one's identity the Johari model refers to are the public self (aspect of myself I am happy to share with others) and my hidden self (sensitive aspects I prefer not to share) (Luft, 1969). Enviably both aspects have come to influence this design and the research knowledge it constructed. I was aware that my public self would inevitably impact upon my research. Some argue that you have no control of how others perceive you (Heath et al, 2009). I would agree with this to a point, in that I could not alter the fact I was an older female researcher; however, it was during the pilot interviews that I became aware that, although I could not eradicate totally the perceptions others had of me, I could change my public demeanour by focusing on the '*quality of the research encounter by actively listening*' as recommended by Heath et al, 2009, p.48. The richness of my data suggests that I successfully did this with the children and their parents, as they were willing to share some very sensitive information. Perhaps this was partly due to them being aware that I was linked to CAMHS, and they perceived me as having an interest in their mental health. The fact they knew they were unlikely to see me again

may have also been an influencing factor (Cohen, et al, 2007). The asymmetry I introduced into the recruitment and interviewing process, whereby I followed recommendations to introduce myself as the least expert (see section 3.5.4), may have also helped to ensure that the power dynamic did not hinder the participants from expressing their true perceptions.

I did, however, introduce myself differently to the educational staff as they needed to know that I was a competent professional before taking part. Educational staff did however, make statements like *"am I right in saying?", or "you may know something I don't know",* thus suggesting that they saw me as an expert and as such a power dynamic was introduced. This was despite my reassurance that there were no right or wrong answers to my questions; instead, I was only interested in their perceptions. This perhaps led to me thinking that they may well have felt tested, so may not have felt totally comfortable in expressing their true perceptions.

Later in my research I became aware that my hidden self was also influencing my research. My journal entry below details this discovery:

Journal extract: 28/11/12 (Post interview)

"Didn't think interviewing teachers would raise any difficult issues. One teacher made me feel very uncomfortable today - she criticised blended families by saying:

Teacher: "There are difficult family circumstances in lots of children's cases where parents, you know, where there is antagonism between parents and stepparents and the stepchildren and they are living in houses with strangers, where the stepbrothers and sisters they have got are the partner of their mum or dad's children, and they are not related to the children and yet they are expected to live with them and I think sometimes it is just really hard for the kids".

This statement made me angry and guilty. I remember thinking that I felt uncomfortable. So, no wonder, I said:

Me: "Obviously that is about complex social issues, divorce, blended families extra".

I cut the conversation dead!!! Mind you, a lot of literature agrees with her opinion that societal changes in the family unit (divorce and blended families) can complicate

children's lives, thus leading to more childhood psychological difficulties. A UNICEF report indicates that family breakdown is the main barrier to child well-being in the UK!! Maybe I should have explored her comment more".

This journal entry pointed out my error of not exploring the participant's perspective. This led me to question how often I may have previously adopted this self-preservation tactic. Were there other times during the research process whereby I had done the same thing? Conversely, did my hidden self encourage me to explore aspects that I wanted to hear more about? Or did I read more into aspects that I was interested in because they were connected to me, thus effectively skewing the data? Following this process, I was more mindful of my own hidden standpoints, beliefs and values, when not only interviewing participants, but also when analysing data and writing it up. I tried hard to be more in-tune with my emotions and challenge them when needed. I did this by noting in my reflexive journal which incidents or happenings or statements caused fluctuations in my feelings. For example, I noted irritation, frustration, guilt, as well as fascination and intrigue. The journal excerpt gives an illustration of my self-checking techniques and how I tried to overcome my shortcomings by being more mindful.

***Journal extract: 15/9/12** (Early write up)*
"Feeling very frustrated today and yesterday, and likely to continue to tomorrow! I don't think I will ever get the structure of this background chapter right and make sense of the literature. My fear is I am bound to have missed some important literature because I have not come across it. I wish I had done a study that was narrower in its focus. I do hope that the interview participants don't swamp me with so many things to think about too. No, I mustn't think like that; even if they do mention lots of things I have to consider them".

6.7.2. My Blind and Unknown Self
The other two aspects of one's identity the Johari model refers to are known as the blind self (what is known by others but is unknown to one's self) and the unconscious self (these are latent parts of myself; feelings and experiences unknown to me and others) (Luft, 1969). These are aspects of my personality that can only be discovered through rigorous attention to reflexivity. This is especially important, because, as Corbin and

Strauss point out, '*a lot of what transpires in qualitative research takes place unconsciously*' (Corbin and Strauss, 2008, p.31).

When it came to my blind self, the most challenging aspect I faced when conducting this research was ensuring that I did not filter the child's voice by my adult interpretation, as this is known to hinder the researcher's ability to truly represent a young person's perspective (James et al, 1998; Spyrou, 2011). It was early on in the research process that I became aware of just how challenging it would be to align myself to the child's thinking. The journal entry below details the moment I became more mindful of the complexity I would have in tackling my blind spots:

Journal extract: 30/9/11 (early field work)

"I witnessed a funny incident today, when waiting to see a SEN teacher at a prospective participating school. I eavesdropped into a conversation between two boys, aged around 14 years. They were undertaking a school monitoring duty in greeting late arrivals and, whilst waiting, were filling out some homework sheets. The conversation went like this:

Child 1 "This question says, what do you need to be a good listener?"

Child 2 "I don't know, I am doing my Maths work sheet first".

Child 1 ((The boy says loudly)) "I know….

Child 2 "What"?

Child 1 "ears". ((Said seriously))

Child 2 "yeah" ((Does not laugh, just silence))

Neither boy laughed, it was serious school work. It struck me that their world was very different from mine. My lecturer role revolves around framing communication in complicated academic terms! These boys had a much simpler philosophy. How could I align myself to their thinking? Could I? As a mother it is very different; you accept rather than try to understand. My role as a researcher, however, is to portray the child's viewpoint as truthfully as possible, therefore I must try to understand. Not sure that will be easy".

Through this reflexivity I realised my ignorance. Claveirole (2004) points out that it is important to have knowledge of the child's world, language and differences, as a lack of knowledge runs the risk of ethnocentrism, or evaluating adolescent experiences through adult eyes, and this can compromise the quality of the data. Very little literature gives the researcher guidance as to how to protect themselves from falling into this trap (Greig et al, 2007). It was, therefore, important to learn more about the teenage world. Ethnographers recommend carrying out memory work reflecting on experiences of your own growing up (Heath et al, 2009). I, however, felt that my childhood was too long ago for this, so I rather focused on bridging the divide by learning through more diligent observation of my own teenage children (aged 14-17) and their friends. This type of mindful activity enabled me to gain more insight into a teenager's socially constructed world. I also ensured that I adopted participatory research methods at the design stage, for example, involving a youth drama group in developing the vignettes and the consultancy group in shaping the interview schedule. Both processes allowed me to solicit direct feedback from teenagers, thus ensuring that my adult views were not dominant. The best example of how my unknown self came to influence my research was how I frequently naturally allied myself towards the parental viewpoint. If I reflect back, it was the parent interviews that I most enjoyed, as it was their viewpoint I understood. Surprisingly, I was oblivious to this until I came to write up my findings. My awakening was logged in my reflexive journal:

Journal extract: 14/2/13 *(Mid-write up)*

"I have written a whole section on parental involvement and I now realise this is not the young people's priority. Can't believe I have not realised this. Only when I counted up the number of references made by children about parental involvement, and then compared those to the references their parents made, did I realise the children hardly mentioned it at all. Must re-listen to all the MP3s again".

Possibly it was my insider status of being a parent to two children who at times had also experienced school difficulties that made it easier for me to interpret the parents' stories. For example, my eldest son at the age of 13, had to move schools because he was unhappy, not wishing to get out of bed in the morning. My youngest son, I believe, when undertaking 'A' levels, went through a period whereby he lacked self-worth and

self-esteem. I was, therefore, grateful when a young Maths teacher noticed and made attempts to boost his confidence. Thus I knew what it was like to be a parent worrying about a child's school experiences. In the past, I had been one of these parents. Insider status is known to have its benefits (Demeetriou, 2011). Nevertheless, I was also aware that it often hampered me from seeing the perspective of other participants whom I was less aligned to, as noted in a latter journal entry below:

Journal Extract: 5/12/14 (write up – feedback)

Doing it again favouring parental perspective over young persons. Michelle (PhD supervisor) pointed it out today with her comments on my draft findings chapter. She said "Why use parent's quotes when you have just said it was the majority of the young people who believed this"? Not sure how I am going to rectify this, as subconsciously I keep doing it!

Acting on the constructive feedback from my peers, colleagues and supervisors in addition to being reflexive, this enabled me to challenge and rectify some of my presence throughout the research process in that I was able to scrutinise, capture, check and change some of my actions, thoughts and feelings in order to ensure that it was the child's voice that remained central to this research.

6.8. Conclusion

This research knowledge has added to the field of school mental health by providing an additional insight into the school world of young people with intrinsic mental health problems and how they prioritise their own school needs. The data has highlighted how disparate their perspectives can sometimes be from their parents and supporting school staff and gives some indication of how to better balance their needs with that of the needs of the adults supporting them.

The findings indicated that a complex web of psychosocial factors associated with their mental health problems hindered their school experiences. For example, stigmatising attitudes towards mental illness, susceptibility to bullying, peer and teacher fall-outs, academic stress; coupled with these are the natural pressures of adolescence which often made their school lives feel unsafe and difficult. It was during these periods of

unhappiness that these children would often be prone to remain silent about their difficulties and adopt complex alienating behaviours in order to cope.

To negotiate these complexities, children of this developmental age placed an emphasis on basic ecological whole-school supports that ensured their safety, emotional security and social connection to peers and teachers. This was because, when these aspects were assured, this promoted their belonging and happiness, and boosted their esteem enabling them to more independently and resiliently cope at school. They, therefore, voiced a preference not to have school support that jeopardised the all-important feeling of 'fitting in' at school as they held the perception that targeted support may highlight their differences putting them at risk of feeling vulnerable, open to stigmatisation and victimisation. In contrast to this, was the perceptions of their parents and their supportive school staff who felt these children to be vulnerable and in more need of enhanced specialist assistance. The children, though, felt they needed a firm bedrock of safety, security and good school relationships before being accepting of enhanced assistance.

Presently, however, our busy secondary schools need to do more to make their schools feel safe and caring. The research evidence points to schools adopting a whole-school ethos that must balance attainment with well-being. Amidst its multi-pronged whole-school approaches it is important staff training around mental health is prioritised, as this was perceived to make school feel a more caring place and allow teachers to better balance a child's well-being with their ability to attain academically. These children also voiced the need for better school guidance on the handling of mental health confidentiality and disclosure as it was perceived this would better ensure their emotional security. A stronger emphasis was also needed on ensuring children had good social connection to their teachers and peers, thus more novel ways of addressing peer problems and safeguarding the pastoral role of the teacher were felt to be important.

It was also emphasised that any form of school distress was harmful so it is imperative that schools and CAMHS place more emphasis on detecting and managing school difficulties. For schools and CAMHS to be able to do this, however, they needed to introduce more protocol and systems that ensured the children and their families were actively consulted with and given choice as to what information should be exchanged

with the school and their preferential school supports. There is not only a strong economic argument for this; to ensure money is not wasted on supportive provision that children do not value, but also consultation on a more interpersonal individual level, it was perceived by the children themselves to promote their emotional security, comfort and happiness at school. This, in turn, had the potential to develop their self-efficacy, promote their resilience, ultimately leading to mental health recovery and better learning which in synergy has the potential to promote a child's future life chances and safeguard their long-term well-being which ultimately every child has the right to.

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APPENDICES

Appendix 1: Diagnostic Terms Briefly Outlined

Condition	Brief Explanation
Anorexia Nervosa	A serious eating disorder whereby the young person is persistently preoccupied with their weight, shape and image. They therefore restrict their diet or use methods like excessive exercise, vomiting or laxatives to lose weight. These young people refuse to maintain a body weight above or at a minimal normal weigh for age and height.
Attention Deficit Hyperactivity Disorder (ADHD)	The key features of ADHD are inattentiveness, hyperactivity and impulsiveness.
Anxiety Disorder	An anxiety disorder is characterised by ongoing chronic apprehension and nervousness that is detrimentally affecting the quality of a young person's life.
Bipolar	A severe mental illness whereby the person has mood swings which fluctuate markedly from feeling very happy to feeling very low.
Bulimia Nervosa	A persist preoccupation with eating accompanied with a morbid dread of fatness. The young person often has irresistible craving for food which leads them to succumbing to episodes of overeating. To counter affect fattening effects the young person adopts purging behaviours such as vomiting or, use of laxatives.
Conduct disorder	Conduct disorders are characterised by a repetitive and persistent pattern of dissocial, aggressive or defiant behaviour.
Depression	Depressed or irritable mood, whereby common symptoms are loss of interest and enjoyment in everyday activities, poor concentration, reduced self-esteem and confidence, ideas of guilt and unworthiness, bleak pessimistic views of the future and ideas or acts of self-harm or suicide. Often the young person's experiences reduced energy leading to fatigue and diminished activity. Disturbances in sleep patterns and appetite are also common symptoms.
Obsessional Compulsive Disorder (OCD)	OCD is a condition typically characterised by distressing anxiety provoking obsessional thoughts or impulses, alongside these are the compulsive rituals which reduce the anxiety associated with the obsessions, but which are often in themselves debilitating.
Post-Traumatic Stress (PTSD)	This occurs in many young people following a traumatic event whereby the young person has perceived the event to be potentially life threatening for themselves or others. When experiencing PTSD the young person often has recurrent intrusive memories of the trauma which then leads to intense anxiety.
Psychosis	A symptom of serious mental illness whereby thought and emotions are so impaired that contact with external reality is lost.
Self-harm	Self-harming is a symptom of distress whereby the young person chooses to inflict pain on themselves in order to relive stress or pressure. Self-harm is a way of coping with problems, or to try to gain control of issues worrying them or in some cases away of punishing themselves.

Appendix 2: Interview Guide

Key Questions	Young People Interview (Examples of prompt questions)	Parent Interview (Examples of prompt questions)	Educational Staff Interview (Examples of prompt questions)
Problem free talk	**This centred on what children enjoyed in their lives including schools and club activities.**	**Problem free talk used if necessary.**	**This centred on their teaching role, their career history and teaching interests.**
What did participants perceive the schools <u>strengths</u> to be? Or in simpler terms what did they feel was <u>helpful</u> about school?	• What do your teachers do that helps you? • What do you feel the school does well or right? And why? • What's good about lessons? • What do you like most at school? And why? • What makes you happy at school? And why? • Does the school help you with any of your emotional problems? How?	• How does the school help your child? • What do they do which is helpful? And why? • How do they help you to support your child? • What school strategies help?	• What does the school do well when it comes to supporting children with emotional difficulty or MH problems? Could you expand? • How does the school help? • How do you help as an individual? • You have been named as a supporting teacher why do you think this was so? Please expand? • What do you perceive as your positive personal qualities when it comes to supporting these children?

What did participants perceive their schools <u>weaknesses</u> to be? Or in simpler terms what did they feel was <u>not helpful</u> at school?	• What do you not like about school? Lessons? Teachers? • What do you find unhelpful at school or does not help you?	• What do you think is unhelpful at school? • What does the school do that does not help your child? • What do the school or teachers do that is unhelpful? Can you describe any experiences?	• What do you perceive the school does do that helps these pupils and why?
What was difficult about school? In the case of the parents and teachers, what <u>difficulties</u> did they perceive the young person had at school?	• What is difficult at school? Or what was difficult at school? • Do you find school difficult because of your emotional difficulties? Can you expand for me? *The vignette(s) may be used to explore more about coping with emotional difficulties at school. • What do you think about x's situation?	• What difficulties do you perceive your child has at school? Considering their emotional problems? • Do you they have any problems with the school when it comes to speaking to them about your child's difficulties? • How do you think your child deals with some of their difficulties whilst at school?	• What type of difficulties do you perceive any child with emotional difficulties or mental health problems as having? • How does the school and how do you help with these difficulties? • Do you always notice these pupils' difficulties? Expand..

Considering some of these difficulties, what did the young participants feel <u>needed</u> from school and why? In the case of parents, considering their child's perceived difficulties what did they think their child needed from school and why? In the case of teachers what needs did they think children with identified mental health problems had whilst at school?	• How do you think the school can help you with your difficulties? • Does the school do anything at present to help you? • How could teachers do more? • How could the school do more? • How do you cope with your difficulties at school? • What helps? And what is unhelpful? • Could other people do more to help like? CAMHS? *The vignette(s) may be used to ask the child more about how they perceived the child's difficulties in the film clip and why and how their needs maybe met?	• What did you feel your child needs at school and why? • Does the school do any of this now? Why do you think they could do more? • Could other people like CAMHS do more to help? And how?	• What do you think these pupils need and why? • Does this happen at present? Can you give any examples? • Can others do more to help these pupils? Who and how? • What do you think you need to better support the needs of these pupils? And why?
Considering these needs what did the participants feel <u>constrained</u>? Or in simpler terms what got in the way of ensuring these perceived needs were met?	• What is getting in the way of the school doing things differently do you think? • Could the school do more? And how?	• Do you think the school could do more to help and why do you think they were not doing this at present? • What was getting in the way?	• What is getting in the way of these children's needs being met? Can you expand? • What is getting in the way of your needs being met to better support this population of pupils? Can you expand?

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Appendix 3: An Extract Illustrating How A Vignette Was Used During Interview

Interviewer

I am just going to show you a short video. I just want your comments really. They are very short film clip ((*Clip1 shown of Darren being low*)).

Interviewer

What do you make of that situation?

Young person

Well at our school we have kinder of been trained to say sorry I am late they probably would have been fine with it like it would have been ok sit down and that would have been it and that would have been the end of it because I don't arrive late but sometimes I will sit there really weirdly and they don't do anything, the only ones which have actually stopped and asked are the really motherly ones, the really nice teachers are like ((*puts actor voice on again*)) are you ok you don't seem yourself at all. Not many people have noticed like a lot of the time the male teachers don't notice and yeah even if they did they would probably just think it is teenage ((*? Word*)) and just kinder of leave it.

Interviewer

So what would be the best response to you?

Young person

Well this is a really hard one because it feels like if someone says are you ok it kinder makes me think ops I have let too much out and then also I think ah someone actually cares and then I also don't want to talk about it so I am like yeah yeah yeah I am fine I am fine, so it is annoying but it is also kinder of nice but really annoying at times.

Interviewer

So the best response is for somebody to notice you are not yourself today?

Young person

But not in front of the whole class, one time this teacher just walked in and he looked over to me and said are you alright are you feeling a bit sad today and the whole class just turned around to look at me and I was like yeah yeah just put the smile on my face I am fine, I am fine. He was like oh, ok and everyone was still staring at me and I was like just grinning away and it was like really annoying.

Appendix 4: An Excerpt from One Transcript

Interviewer

Do CAMHS help you with school?

Young person

Yeah we talk about school loads its really annoying ... um because also obviously um... like what is going on and sometimes if effects my school work and um so I get really annoyed with myself and when I am doing badly coz the teachers don't know. They will be like why is she doing so badly ... always asking me why I am sad it's like I don't want to draw attention to it.

Interviewer

Do you think if you didn't have this secret and that school were aware of your difficulties that would make a difference at school?

Young person

Um... because I can't condition every teachers reaction that's my problem so I don't know how they would react some of them might be really patronising and stuff and some of them might be ah come here and talk to me, because like when I had my big breakdown quite a few teachers were told that I wouldn't be in lessons and they told them she has had a breakdown and she needs to go home and they were like **(*uses a small voice*)** do you want to talk to me. I am like ok do you know I am having this because I don't want to talk to anybody especially not you because you don't know what goes on in that staff room **(*laughs*)**. So I just you know... and what freaks me out because I wanted to do Six **(* ? Word*)** for A/S and the teachers were like your name cropped up in the meeting today and if it crops up in a meeting like that and if I were to tell them it would crop up even more **(*voices rises up in explanation*)** and just for expressing emotion they would probably be like **(*uses a low voice like a teacher*)** I am really concerned kinder thing and it would be just really annoying and they would probably send me to the nurse all the time.

Appendix 5: Confirmation of Ethical Opinion

NHS

National Research Ethics Service

NRES Committee East Midlands - Northampton

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone: 0115 8839435
Facsimile: 0115 9123300

09 June 2011

Ms Tania E Morris
The University of Northampton
Yelvertoft
108 School of Health
Park Campus
Boughton Green Road
Northampton NN2 7AL

Dear Ms Morris

Study title: **A qualitative study exploring how young people with mental health difficulties can be better supported in mainstream education**

REC reference: 11/EM/0153

Thank you for your letter of 06 June 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Protocol	1	01 April 2011
REC application		15 April 2011
Response to Request for Further Information		06 June 2011
Summary/Synopsis	FLowchart Recruitment of Sample 2	02 June 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

> Notifying substantial amendments
> Adding new sites and investigators
> Progress and safety reports
> Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/EM/0153	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

PP.)Rle4

Mr Ken Willis
Chair

Email: jennifer.lea@nottspct.nhs.uk

Enclosures:	"After ethical review – guidance for researchers"
Copy to:	*Dr Michelle J O'Reilly, University of Leicester*
	Ms L Sayers, NIHR Mental Health Research Network (Heart of England Hub)

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Appendix 6: Study Approval Letter

Northamptonshire Healthcare **NHS**
NHS Foundation Trust

Associate Medical Director: Dr Sean Scanlon
Head of Quality Support: Ruth Clarke

Research and Development

Sudborough House,
St. Mary's Hospital,
London Road,
Kettering,
Northamptonshire,
NN15 7PW

R&D Manager: Lauren Sayers

Tanya Morris,
The University of Northampton,
Yelvertoft,
108 School of Health,
Park Campus,
Boughton Green Road,
Northampton.
NN2 7AL.

Direct Dial: (01536) 494756
Fax No: (01536) 494216

22.07.2011

Dear Tanya,

Ref: R.125.11
Title: A Qualitative Study Exploring How Young People With Mental health Difficulties Can Be
            Better Supported in Mainstream Education.
Project Status: Approved
End Date: 31.07.2013

I am pleased to confirm that with effect from the date of this letter, the above study now has Trust Research & Development permission to commence at Northamptonshire Healthcare NHS Foundation Trust.

All documents received by this office have been reviewed and form part of the approval. The documents received and approved are in accordance with approval from the National Research Ethics Committee. Please be aware that any changes to these documents after approval may constitute an amendment. The process of approval for amendments should be followed. Failure to do so may invalidate the approval of the study at this trust.

We are aware that undertaking research in the NHS comes with a range of regulatory responsibilities. Attached to this letter is a reminder of your responsibilities during the course of the research. Please ensure that you and the research team are familiar with and understand the roles and responsibilities both collectively and individually.

You are required to submit an annual progress report to the R&D Office and to the Research Ethics Committee.

The R&D Office is keen to support research, researchers and to facilitate approval. If you have any questions regarding this, or other research you wish to undertake in the Trust, please contact this office.

We wish you every success with your research.

Yours sincerely

Lauren Sayers
Research and Development Manager   Encs: Researcher Information Sheet

Documentation Requirements for a Site File: In accordance with ICH-GCP

The study PI / CI is responsible for creating a site file before the start of the project and also for maintaining the file during the entire course of the project lifetime. All study relevant documentation should be placed in the project site file, both to aid the management of the project and to ensure that the documents are readily available for review by auditors (FDA, MHRA). This can be supported by Quality Support if required.

To be in place/generated before clinical Phase Commences	To be in place/generated during Clinical Conduct of Trial	To be in place/generated after completion of termination of Trial
Investigator Brochure	Investigator Brochure updates	Investigational medicinal product(s) accountability at site
Signed Protocol & Amendments, also case report form	Revisions to protocol / amendments and case report forms	Documentation of investigation product destruction
Information given to trial subjects and Informed Consent Form	Ethics Committee approval for updates / amendments / revisions	Completed subject identification list
Any other written information	Regulatory authorities / approvals / notification for amendments and other documents	Audit Certificate
Advertise for subject recruitment	CV for new investigator(s) and / or study personnel	Final Trial close-out monitoring report
Financial aspect of the trial	Updates to normal value(s) / ranges(s) for medical / laboratory / technical procedure(s) / tests(s) included in Protocol	Treatment allocation and decoding documentation
Insurance / Indemnity Statement	Updates of medical / laboratory / technical procedures / tests	Final report by investigator to Ethics Committees and / or regulatory authorities, where applicable.
Signed agreement between involved parties	Documentation of investigational medicinal product(s) and trial related materials	Clinical Study Report
Dated, documented favourable opinion of Ethics Committee	Certificate(s) of analysis for new batches of investigational products	
Ethics committee composition & constitution/working practices	Monitoring visit reports	
Regulatory Authority approval/ authorisation e.g MHRA	Relevant communications other than site visits	

Laboratory Normal Ranges	Source documents	
Medical / Laboratory/ Technical procedures / tests	Signed, dated and completed case report forms	
Sample of label(s) attached to investigational medicinal product	Documentation of case report form corrections	
Instructions for handling investigational products	Notification by originated investigator to sponsor of SAE and related reports	
Shipping records for investigational medicinal products and trial related materials	Notification by sponsor and / or investigator, where applicable, to regulatory authority(ies) and Ethics Committees of SAE's	
Certificate(s) of analysis of investigational products	Notification by sponsor to investigators of safety information	
Decoded procedures for blinded trials	Interim / annual report to ethics committee / regulatory authority	
Master Randomisation List	Subject Screening Log	
Pre-Trial Monitoring Report	Subject ID Log	
Trial Initiation Monitoring Report	Medicinal Investigational product(s) accountability	
	Signature sheet	
	Record of retained body fluid / tissue samples (if any)	

Researcher Information Sheet

Your Research study has been granted R&D approval by **Northamptonshire Healthcare NHS Foundation Trust.** All those involved in research with human participants, their organs, tissue or data must be aware of and implement the law, and the basic principles relating to ethics, science, information, health and safety, and finance set out in the Research Governance Framework. Doctors and Consultants must also comply with the GMC guidance 'Good Practice in Research'.

This sheet has been sent to you as CI/PI, however please copy and distribute to others working on the study with you – co-investigators, collaborators, nurses, CRAs etc.

As a Researcher these are YOUR responsibilities

- To ensure your research is conducted in line with relevant legislation and guidance, this includes, but is not limited to, the DH Research Governance Framework, 'The Medicines for Human Use (Clinical Trials) Regulations 2004' (SI 2004/1031), Human Tissue Act, Mental Capacity Act, and subsequent amendments.

- Report adverse events – SAEs, SARs, SUSARs to the Sponsor, The R&D Department, Research Ethics Committee, and MHRA as required. Additionally, report any suspected research fraud or misconduct to the R&D Department and notify any serious breaches of protocol or GCP to the Sponsor, R&D Department as soon as they are identified.

- With respect to the use and supply of Investigational Medicinal Products (IMP), it is imperative to obtain advice from the Pharmacy department. Advice given by NHT Pharmacy R&D Clinical Trials Pharmacists in relation to IMPs must always be followed.

- Follow the agreed protocol as approved by relevant Research Ethics Committee (REC) and ensure any proposed changes or amendments to the protocol are submitted for approval to the REC and the R&D Department.

- Prepare and maintain a site file for each study, full details of site file content can be found attached, additionally for NHT sponsored studies, support in the compilation and storage of site files can be accessed through Quality Support.

- Ensure you are aware of, and follow, appropriate guidelines for Data Protection, The Caldecott Principles and health and safety, including relevant Trust policies.

- Anonymise patient data where possible and hold it in accordance with the Data Protection Act. Consent must be sought before using the information for any purpose other than that stated when it was obtained.

- Continually update yourself and your team with ICH-GCP Training; evidence of this should be available within each study site file. A refresher course is required bi-annually.

- Ensure all data and documentation associated with the study is available for audit at the request of the appropriate auditing authority.

- Discuss any Intellectual Property (IP) issues with the R&D Department.

- Involve consumers in the research where possible and appropriate.

- Disseminate results as widely as possible, both locally and nationally, and always ensure all participants are kept up-to-date on the progress of the research and given feedback at the end of the study.

CONTACT THE RESEARCH & DEVELOPMENT OFFICE

Research and Development
Sudborough House,
St. Mary's Hospital,
London Road,
Kettering,
Northamptonshire.
NN15 7PW.

Direct Dial: (01536) 494173
Fax No: (01536) 494216

Appendix 7: Information Sheet for Young People

Northamptonshire Healthcare NHS

NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICE

CHILD & ADOLESCENT MENTAL HEALTH SERVICE
Clarendon House
8-12 Station Road
Kettering
Northamptonshire
NN15 7HH

Tel: 01536 313850
Fax: 01536 313852

Exploring Your School Experiences

INFORMATION SHEET FOR YOUNG PEOPLE
AGED 14-16 YEARS
This is an information sheet for you. Please read it and keep it

Hello, my name is Tania, I am a researcher who would like to invite young people like yourself to help me with my research study. However before you decide whether to take part in this research it is important that you understand why this research is being done and what it will involve you doing. Please take time to read the following information and please feel free to discuss it with your parents or friends.

What is this research study about?
I wish to ask young people like yourself, what you require from school in order to feel better supported with your education and why. This is because I am very aware that years 10 and 11 at school are very busy and they can be extremely stressful due to things like exam pressures choosing course options and thinking about a future career. In addition to this, experiencing emotional difficulties, such as anxiety or low mood, anger or agitation, can make school life and learning even more difficult. This research is about learning how young people like you can be better supported with their learning.

Why have I asked you to take part in this study?
I am looking for young people in Years 10, 11 or 12 at school who are presently attending CAMHS.

What does taking part in the study involve?
If you are happy to take part in the study then all I would require is to talk with you for no more than 40 minutes. During this time I will ask your views on your school life and experience and we will look at some film clips of typical day to day school problems. I would hope that we could talk about some of the problems shown in the film clips.

1

To save me having to scribble lots of notes I would like to record our conversation on a MP3 player. This recording will be confidential and will be destroyed once my study is finished.

I would also like to talk to one of your teachers that you feel has supported you at school. The teacher will know you have named them as a supporting teacher, but I will not share any further information that you or your parents tell me with your teacher. However if you do not wish to name a teacher this is not a problem, you do not have to.

Following the interview with you I will interview your parents, asking them similar questions. I will not share with them anything you have said.

Do you have to take part?
I would like you to help me with my study, but you do not have to take part if you do not want to. If you want to stop helping me at any time, or there are any questions that you don't want to answer, that is fine. This will not affect you in any way at all.

Will taking part help you?
I cannot promise that the study will help you, but it might help us learn more about how we can help young people like yourself.

Will the information I give remain confidential (secret)?
Any personal information I collect from you will remain confidential, the only time I need to break this rule is if you say anybody is being hurt in any way. In this situation I would need to speak to a member of the CAMHS team.

Has anyone checked that this study is OK to do?
Before seeing you I will have firstly asked the CAMHS team, who are presently supporting you and your parents, if they are happy for you to be invited to take part in the study. Also before any research is allowed to happen it has to be checked by a group of people called an Ethics Committee. They make sure the research is ok to do. This study has been checked by NRES Committee East Midlands - Northampton.

Do you want to know anything else?
If you would like any more information about this study, please feel free to contact me on:

Tania Hart
Yelvertoft, Park Campus. Boughton Green Road. Northampton. NN2 7AL
Telephone: 07840712048
Email: tania.morris@northampton.ac.uk

I wish to say thank for reading this information sheet.

Appendix 8: Information Sheet for Parents

Version 2 – Exploring Young People's School Experiences   3rd June 2011

Northamptonshire Healthcare **NHS**
NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICE

CHILD & ADOLESCENT MENTAL HEALTH SERVICE
Clarendon House
8-12 Station Road
Kettering
Northamptonshire
NN15 7HH

Tel: 01536 313850
Fax: 01536 313852

Exploring Young Peoples School Experiences

INFORMATION SHEET FOR PARENTS

My name is Tania Hart. I am a researcher who would like to invite you and your teenage child to take part in my study. Before you and your child decide whether to take part, it is important that you understand why this study is being carried out and what it will involve.

Please take time to read this information sheet and also the young people's information sheet. Feel free to discuss the information contained on these sheets with friends or colleagues and do not hesitate to contact me if there is anything that is not clear or if you need any further information.

Part 1 – About the Study

What is this research study about?
This study is being carried out as part of my PhD study at the University of Leicester. The focus of my study is on young people, in mainstream education, aged 14 to 16 years of age, who are attending Child Adolescent Mental Health Services (CAMHS). I want to focus on their school experiences, as arguably, Years 10, 11 and 12 are some of the most stressful years of a child's schooling, due to factors such as taking exams and thinking about future education and careers. The purpose of my study is to explore how young people like your son or daughter can be better supported with their schooling. I also wish to explore how parents like yourself and teachers supporting your child, feel about how young people can be better supported in education.

Why you and your child have been asked to take part in this research study?
Your child is aged 14 -16 years of age, in mainstream education and presently attending CAMHS, it is this group of young people and their parent(s) that this research is especially interested in.

1

What does this research study involve?
If you and your child agree to take part in this study, and return the parent and young person consent forms to the researcher using the stamped address envelope, the researcher will then telephone you to arrange a suitable time and date for you and your child to be interviewed. I will interview child and parent(s), separately. If your child thinks that a particular teacher at their school has been helpful or supportive I would like to invite them to take part in this study also.

If you decide to take part in this study you will be interviewed by me. This interview will take no longer than 40 minutes. You will be asked broad questions related to how you view your child's whole school experiences.

The interview will not be overheard or interrupted because I will arrange for it to be carried out in a suitable quiet room at the CAMHS service you visit. It is important for you and your child to know that no information you tell me will be shared with any other teacher, parent or child.

The interview will be recorded and then transcribed onto paper. This recording will only be listened to by me and my university supervisors. At the end of this study the audiotape material will be destroyed.

Do you have to take part in this study?
It is entirely up to you and your child whether you take part in this study. If you do not wish to take part then it is not a problem. If you do decide to take part in the study you can withdraw from the study at anytime. Whatever your decision this will not affect either the standard of care or the services you and your family receive now or in the future.

What are the possible benefits of taking part?
This study may not directly help your family, but it might help the specialist CAMHS team and teachers learn more about how young people like your son or daughter can be better supported at school.

What are disadvantages and risks of me taking part?
This study has been designed to ensure that the possible disadvantages and risks to you and your child are minimal. There will be no disruption to your treatment at CAMHS and I will arrange interview times that suit you and your child.

What happens if something goes wrong?
If you have any concerns about any aspect of this study, you can speak to the researcher, Tania Morris (see contact below), or if you wish to speak to somebody else to raise a concern about this study please contact: Mr Harper (Consultant Clinical Psychologist, Specialist CAMHS. Tel: 01604 656060. Northamptonshire Family Services. 1st Floor Newland House, Newlands, Cliftonville, Northampton. NN1 5BE

If the information in part 1 has interested you and you are able to consider taking part, please continue to read the additional information in Part 2 before making a decision.

Part 2 – Additional Information

Will information given by myself be kept confidential or secret?
I will follow strict ethical and legal practices and all information given to me by you and your child will be handled in the strictest confidence. The only time when I would be required to break confidentiality would be if you disclosed information that suggested there was an immediate risk to you or someone else. In such circumstances I would discuss this with someone who could help, for example a senior member of the CAMHS team. I will only do so this with your full knowledge.

Paper documents resulting from this study will be kept in a secure locked location and all electronic files will be password protected.

What will happen to the information I give when this study is complete?
The results of this study will be presented in my PhD thesis, journal articles and through presentations. I may wish to anonymously quote some of your, or your child's, words in a written publication and if I did wish to do this I would ensure that these quotes would not identify you or your child in any way.

Who has reviewed the study and made sure it is ok?
The supervisory team at the University of Leicester: (Professor Panos Vostanis and Dr M O'Reilly) have reviewed this study. To protect you and child's rights and safety this research study has been reviewed by The NRES Committee East Midlands - Northampton Ethics. This committee ensures that research is carried out in a safe way.

What happens next?
If you wish to participate please sign the consent form. If after reading the young people's participation information sheet your child is also happy to take part in this study and they to have signed the consent form, please post the parent and young people's consent forms back to me in the stamped address envelope provided. I will then contact you via the telephone to arrange a suitable time for interviews.

Do you want to know anything else?
If you would like any more information about this study please feel free to contact me:

Tania Hart
Yelvertoft, Park Campus. Boughton Green Road. Northampton. NN2 7AL
Telephone: 07840712048 or 01604892389
Email: tania.morris@northampton.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 9: Consent Form for Young People

Northamptonshire Healthcare NHS

NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICE

CHILD & ADOLESCENT MENTAL HEALTH SERVICE
Clarendon House
8-12 Station Road
Kettering
Northamptonshire
NN15 7HH

Tel: 01536 313850
Fax: 01536 313852

Consent Form
For young people participating in the study of:
Exploring Young Peoples School Experiences

Details of this study are in the participant information sheet

Please initial the box

I have read and understand the information sheet (Exploring School Experiences) and have had time to consider this information, ask questions and have had them answered.

I can confirm I understand all the information given to me about keeping my personal information confidential or secret.

I understand I can stop taking part in this study at anytime, and this will not affect me or my family in any way at all.

I agree that when discussing experiences I will try not to name anybody.

I agree to my discussion with the researcher being audio taped, typed and stored safely and when Tania writes up her work, she has my permission to use some of the words I use in my interview, as long as I can not be identified in any way as having said these words.

I am happy to name a supporting teacher, who the researcher can contact, in order that the teacher may be invited to take part in this study also.

I understand that the information I give to the researcher (Tania), will also be looked at by her supervisors and her NHS colleagues from CAMHS.

When this research is complete, I would like to receive a leaflet that details what this study found out, from young people, parents and teachers.

Printed name of participant... Date...............

Participant's signature... Date...............

Printed name of researcher... Date.............

Researcher's signature.. Date.............

Thank you very much for agreeing to take part in this study.

Appendix 10: Consent Form for Parents

Northamptonshire Healthcare NHS

NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICE

CHILD & ADOLESCENT MENTAL HEALTH SERVICE
Clarendon House
8-12 Station Road
Kettering
Northamptonshire
NN15 7HH

Tel: 01536 313850
Fax: 01536 313852

Consent Form
For parents participating in the study of:
Exploring Young Peoples School Experiences

Details of this study can be found in that attached participant information sheet

Please initial box

I confirm that I have read and understood the participant information sheet (Exploring Young Peoples School Experiences (Version 2 - dated 3rd June 11). I have had the opportunity to consider the information, ask questions and have had these answered.

I understand   the information given on the information sheet relating to confidentiality (this part on the information sheet is entitled: Will my taking part in this study be kept confidential).

I understand I or my child can withdraw participation in this study at anytime, with no explanation required, and that this will have no affect on current or future services that my family receive.

I agree that when discussing experiences I will try to avoid using individual's names.

I give consent to take part in this study and give the researcher permission to approach my child to invite them to participate in this research also.

I consent to my discussion being audio taped, typed and stored safely electronically and none identifiable quotations potentially being used by the research in subsequent publications.

I give consent to allow my child, if they consent to participating in this study, to name a supporting teacher who they are happy for the researcher to contact, in order that the teacher may be invited to participate in this study also.

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I understand that relevant sections of the data collected during this study may also be looked at by the researchers' supervisors from The University of Leicester and supporting NHS colleagues from CAMHS.

I would like to receive a copy of the summary of the research findings

I am happy for the researcher to contact me on the following telephone number, at this preferred time.

Tel Number...

Preferred time of contact...

Printed name of participant.. Date..............

Participant's signature.. Date..............

Printed name of researcher... Date.............

Researcher's signature.. Date.............

Thank you very much for agreeing to take part in this study

Appendix 11: Information Sheet for Teachers

Northamptonshire Healthcare **NHS**
NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICE

CHILD & ADOLESCENT MENTAL HEALTH SERVICE
Clarendon House
8-12 Station Road
Kettering
Northamptonshire
NN15 7HH

Tel: 01536 313850
Fax: 01536 313852

Exploring Young Peoples School Experiences

INFORMATION SHEET FOR TEACHERS AND SCHOOL STAFF

I am writing to you to invite you to take part in a research study. Before you decide whether you wish to take part in this study you may wish to learn more about why the research is being carried out and what it will involve. Please take time to read the following information carefully and discuss it with your line manager or school principal. If there is anything that you are not clear about or you require further information please contact me, via email, or by telephone: details provided at the end of this information sheet.

Part 1 – About the Study

What is this research study about?
This study is being carried out as part of my PhD study at the University of Leicester. The focus of my study is on young people in mainstream education, aged 14 to 16 years of age, who are attending Child Adolescent Mental Health Services (CAMHS). I want to focus on their school experiences; as arguably, Years 10, 11 and 12 are some of the most stressful years of a child's schooling, due to factors such as taking exams, thinking about future education or career options. The purpose of my study is to explore how young people can be better supported with their schooling. I also wish to explore how parents and teachers supporting the child, feel about how young people can be better supported in education.

My research considers the increasing pressure for mental health practitioners to become more involved in supporting the schools emotional wellbeing agenda and the drive in the mental health field towards learning from schools as a mechanism to better support school aged children presenting with mental health difficulties.

Why have I been asked to take part in this research study?
Your name was given to me by a young person who I have already interviewed for my study. He or she has named you as a supporting /helping teacher. I have also interviewed the young person's parents. I have permission from the young person and their parents to make contact with you in order that I can also invite you to participate in this study. I would like to learn your perspective on how you feel pupils can be best supported with their learning/education. I have

permission from the young person and their parents to give you their name; however I am unable to share any other information with you that they have shared with me.

What does this research study involve?
Taking part in this study will involve you giving up to 40 minutes of your time to take part in a face to face interview. You will be asked to share your views, experiences and needs in relation to the one-to-one, classroom support you give to children identified with mental health difficulties. If you agree to take part, I will arrange a convenient date, time and meeting place to interview you at your school. Each interview will take no longer than 40 minutes.

The interview will be recorded and then transcribed onto paper. This recording will only be listened to by me and my university supervisors. At the end of this study the audiotape material will be destroyed.

Do you have to take part in this study?
It is entirely up to you whether you take part in this study. If you do not wish to take part then it is not a problem. Please inform your school principal ensuring they are happy for you to take part. If you do decide to take part in the study you can still withdraw at anytime. Whatever your decision this will not affect you in any way.

What are the possible benefits of taking part?
Although there are no direct personal benefits from taking part in this study, the information you provide has potential to inform others tasked with addressing the educational need of those with mental health difficulties. The findings of this research will be disseminated via conferences and journal articles.

What are the disadvantages and risks of me taking part?
The study has been designed to ensure that the possible disadvantages and risks to you from taking part in this study are minimal. The study has been designed to give minimal inconvenience in relation to your time. As previously stated it will involve approximately 40 minutes of your time and this will be arranged at a time that suits you.

What happens if something goes wrong?
If you have any concerns about any aspect of this study, you can speak to the researcher Tania Morris (see contact below) or if you wish to speak to somebody else to raise a concern about this study please contact: Mr Harper (Consultant Clinical Psychologist, Specialist CAMHS. Tel: 01604 656060. Northamptonshire Family Services. 1st Floor Newland House, Newlands, Cliftonville, Northampton. NN1 5BE

If the information in part 1 has interested you and you are able to consider   taking part, please continue to read the additional information in Part 2 before making a decision.

Part 2 – Additional Information

Will information given by myself be kept confidential or secret?
I will follow strict ethical and legal practices, in that all information given to me by you will be handled in confidence.   I will protect confidential information according to my own professional code of conduct; the Nursing Midwifery Council in that:

"All measure will be taken to safeguard against breaches of confidentiality by protecting information form improper disclosure at all times" (NMC 2004 Clause 5:3). The only time

Northamptonshire Healthcare **NHS**
NHS Foundation Trust

when I would be required to break confidentiality would be if you disclosed information that suggested there was an immediate risk to someone. In such circumstances I would have to discuss this with someone in authority who could help. I will only do so with your full knowledge. All information you share with me will be handled in confidence and stored securely. Information that you disclose to me that could be used to identify you (i.e. name, address, telephone number) will be stored safely and separately from the research data. Access will only be available to members of the supporting team at the University of Leicester. When the audiotape is transcribed onto paper any names, places and so forth will be coded. Audiotape and paper documents containing your personal details will be destroyed at the end of the research study.

What will happen to the information I give when this study is complete?
The results of this study will be presented in my PhD thesis, journal articles and through presentations. I may wish to anonymously quote some of your words in a written publication and if I did wish to do this I would ensure that these quotes would not identify you in any way.

Who has reviewed the study and made sure it is ok?
The supervisory team at the University of Leicester: (Professor Panos Vostanis, Dr M O'Reilly) have reviewed this study. This research study has been reviewed by The NRES Committee East Midlands – Northampton, ethics committee. This committee ensures that research is carried out in a safe way.

What happens next?
If you wish to participate please sign the consent form. When I learn you are happy to participate in the study I will arrange an interview date and time.

Do you want to know anything else?
If you would like any more information about this study, please feel free to contact me:

Tania Hart
Yelvertoft, Park Campus. Boughton Green Road. Northampton. NN2 7AL
Telephone: 07840712048 or 01604892389
Email: tania.morris@northampton.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 12: Consent Form for Teachers

Northamptonshire Healthcare **NHS**
NHS Foundation Trust

CHILD & ADOLESCENT MENTAL HEALTH SERVICE

CHILD & ADOLESCENT MENTAL HEALTH SERVICE
Clarendon House
8-12 Station Road
Kettering
Northamptonshire
NN15 7HH

Tel: 01536 313850
Fax: 01536 313852

Consent Form
For teachers and school staff participating in the study of:
Exploring Young Peoples School Experiences

Details of this study are in the participant information sheet

Please initial box

I confirm that I have read and understood the participant information sheet (Exploring Young Peoples School Experiences – Version 2 dated 3/6/11). I have had the opportunity to consider the information, ask questions and have had these answered.

I understand   the information given on the information sheet relating to confidentiality (this part on the information sheet is entitled: Will my taking part in this study be kept confidential).

I understand I can withdraw my participation in this study at anytime, with no explanation required, and that this will have no affect on me whatsoever.

I agree that when discussing experiences I will try to avoid using individual's names.

I consent to my discussion being recorded, typed and stored safely electronically and none identifiable quotations potentially being used by the research in subsequent publications.

I have informed the principal of the school of my participation in the study.

I understand that relevant sections of the data collected during this study may also be looked at by the researchers' supervisors from The University of Leicester and supporting NHS colleagues from CAMHS.

I would like to receive a copy of the summary of the research findings

I agree to take part in this study

Printed name of participant.. Date...............

Participant's signature... Date..............

Printed name of researcher.. Date..............

Researcher's signature.. Date..............

Thank you very much for agreeing to take part in this study

Appendix 13: When a Young Person Becomes Distressed – Researcher Course of Action

When a young person becomes distressed – researcher course of action

If a young person appears to be distressed prior to interview (possibly post CAMHS therapy session) the researcher will suggest to the young person the interview is rearranged. If the young person wishes to continue the interview – the interview will go ahead.

↓

A consenting young person participant becomes distressed during interview

↓

Researcher stops interview

↓

Researcher if concerned about the safety of the young person will refer to safeguarding flow chart

↓

If researcher does not have safeguarding concerns firstly the researcher will provide the young person with some reassurance and a little time then gives the young person the choice to go on with the interview or stop the interview.

↓ (left)   ↓ (right)

Young person chooses to stop interview and withdraws

Young person chooses to go on with interview

↓

Interview stops and all data collected from interview is shredded and not used as young person has withdrawn consent

↓

Researcher offers a listening ear (as a trained mental health practitioner with specialist child and adolescent practitioner experience) for remaining scheduled time of the interview

Researcher signposts young person to helping clinician at CAMHS

Before the interview recommences the researcher asks the young person if they would like 10 minutes following the interview whereby the researcher can give the young person further support. Or if they prefer they can be referred to a CAMHS clinician. If the young person does not express the wish to have this support their wishes are respected and the interview re commences

↓

Young person becomes distressed again – action is taken to stop the interview in the young person's best interests, researcher evaluates decision regarding safeguarding

Appendix 14: When a Parent Becomes Distressed – Researcher Course of Action

When a parent becomes distressed – researcher course of action

Parent is distressed prior to interview (perhaps due to previous therapy session) – Researcher asks the parents if they would like to rearrange the interview– if ok to be interviewed researcher interviews parents

Parent wishes to rearrange another time, parents are contacted at another time to rearrange

A consenting parent participant becomes distressed during interview

Researcher stops interview

Researcher if concerned about a safeguarding issue will refer to safeguarding flow chart

If researcher does not have safeguarding concerns firstly the researcher will provide the parent with some reassurance and a little time which gives them the choice to go on with the interview or stop the interview.

Parent participant chooses to stop interview and withdraws

Parent chooses to go on with interview

Interview stops and all data collected from interview is shredded and not used – the child of that parent will also not be interviewed.

Before the interview recommences the researcher asks the parent if they would like 10 minutes following the interview whereby the researcher can give the parent further information regarding helping services. (This maybe signing posting to their GP, or to ask their permission to approach the families supporting CAMHS team for help.

Researcher offers a listening ear (as a trained mental health practitioner with specialist child and adolescent practitioner experience) for remaining scheduled time of the interview.
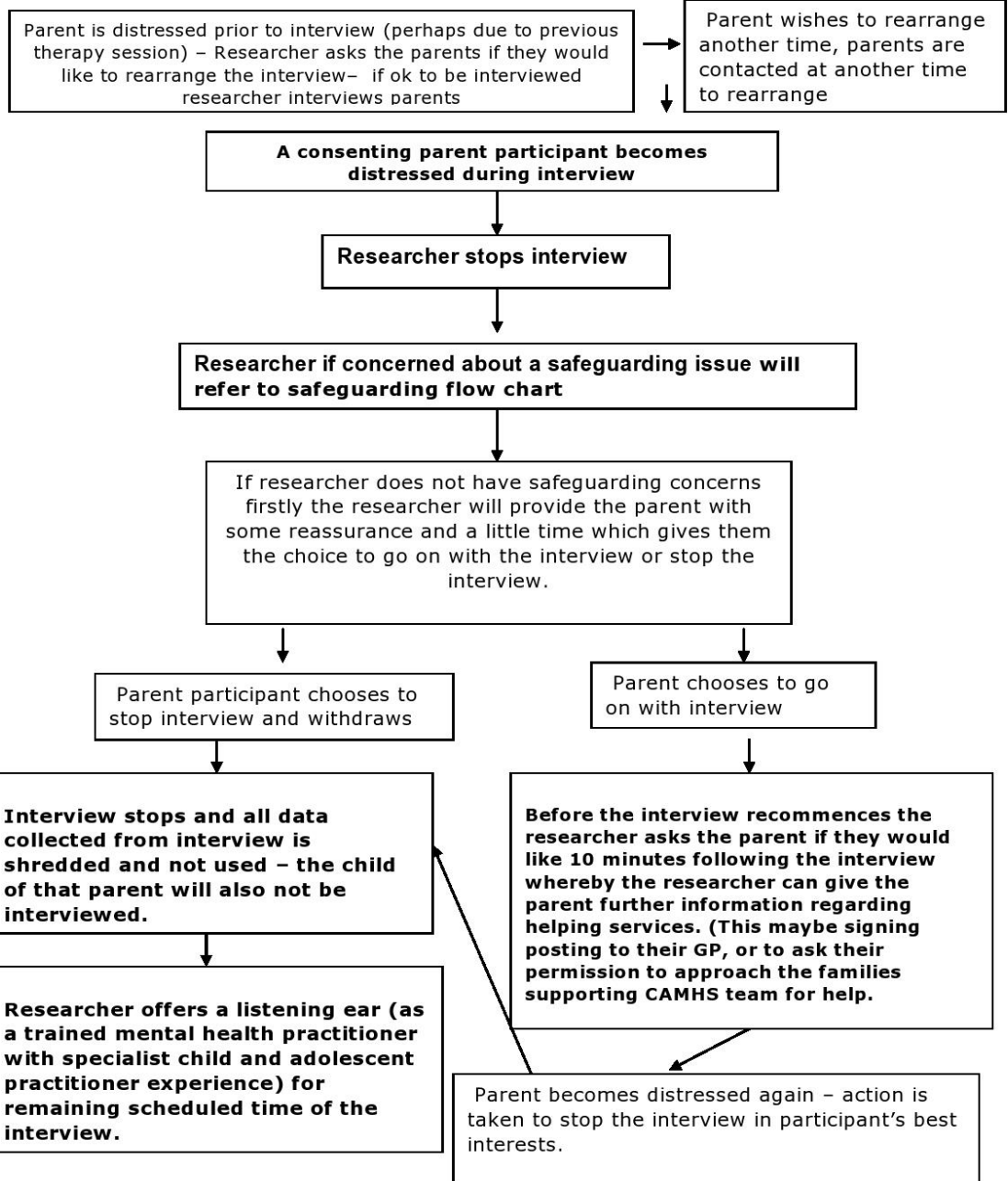
Parent becomes distressed again – action is taken to stop the interview in participant's best interests.

Appendix 15: When a Teacher Becomes Distressed – Researcher Course of Action

When a teacher becomes distressed – researcher course of action

A consenting adult research participant becomes distressed during interview

↓

Researcher stops interview

↓

Researcher firstly provides the participant with some reassurance and a little time then gives the participant the choice to go on with the interview or stop the interview.

| Participant chooses to stop interview | Participant chooses to go on with interview |

Interview stops and all data collected from interview is shredded and not used as participant has withdrawn consent

↓

Researcher offers a listening ear (as a trained mental health practitioner) for remaining scheduled time of the interview

Researcher signposts teacher to helping services before time together ends (see table attached)

Before the interview recommences the researcher asks the teacher if they would like 10 minutes following the interview whereby the researcher can give the teacher further information regarding helping services. If the teacher does not express the wish to have this information their wishes are respected and the interview re commences

Participant becomes distressed again

Supporting Agencies

Self Help – web sites

http://www.teachersupport.info/

http://www.teachersindistress.com/index.htm

http://www.bullyonline.org/

National Union of Teachers

www.teachers.org.uk
Both a professional association and a trade union. Membership is open only to fully qualified teachers and brings with it a wide range of benefits and services. Website features advice on tackling stress.

Recommended Self Help Books
Stress-busting for Teachers by Chris Kyriacou (Nelson Thornes, 2000)
This book discusses the causes of stress, warning signs to look out for and how to cope.

Stress Free Teaching by Russell Joseph (Kogan Page, 2000)
This guide aims to provide practical solutions to educators dealing with stress in their job.

Local services that offer psychological support
If you are worried it is always best to speak to your GP however in Northamptonshire you may wish to check out the following site and ask your GP if he/she can refer you in order that you can be assessed for further support:
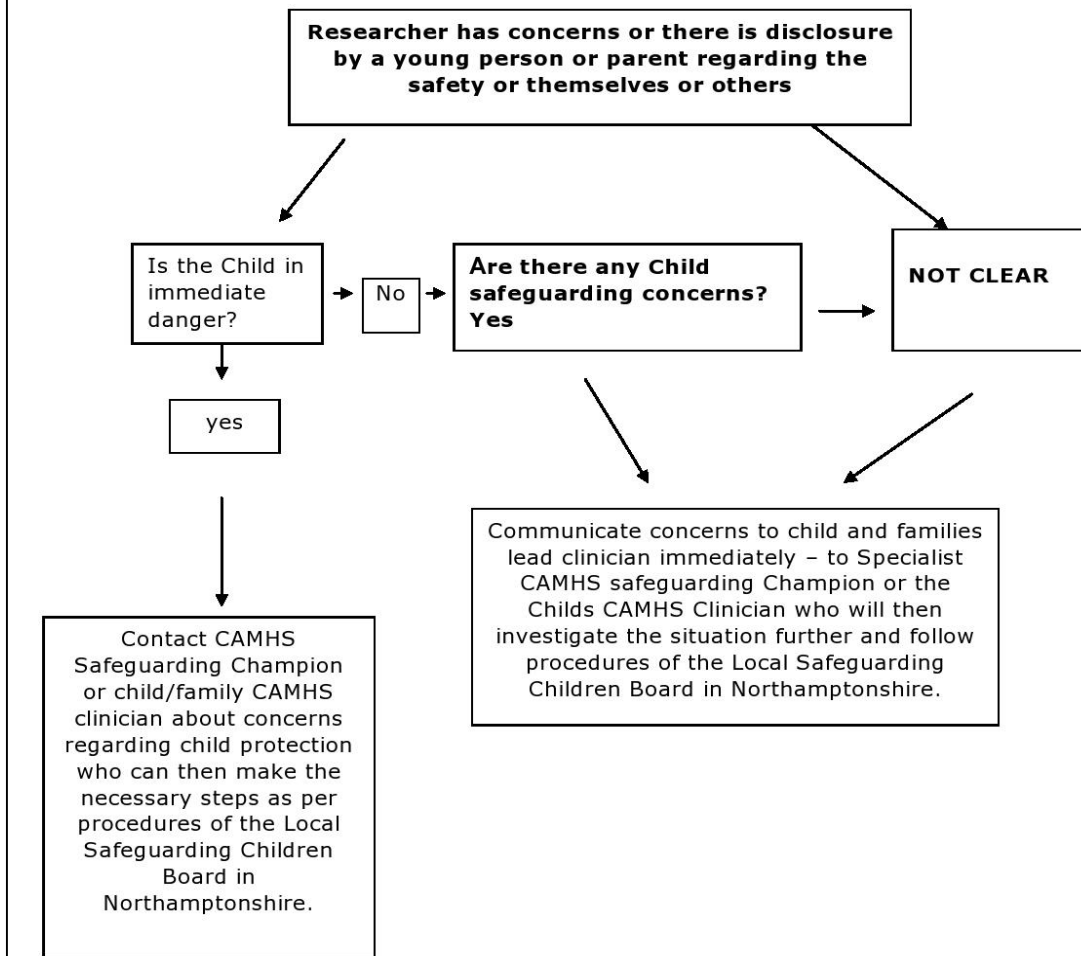
Changing Minds Northamptonshire Teaching Primary Care Trust

http://www.changingmindscentre.co.uk/

Appendix 16: Young People Safeguarding Flowchart

Exploring Young peoples' School Experiences – Version 1 – 15/4/11 - Safeguarding Children/young people protocol and referral pathway.

YOUNG PEOPLE SAFEGUARDING REFERRAL FLOWCHART

Researcher has concerns or there is disclosure by a young person or parent regarding the safety or themselves or others

Is the Child in immediate danger?

No

Are there any Child safeguarding concerns? Yes

NOT CLEAR

yes

Contact CAMHS Safeguarding Champion or child/family CAMHS clinician about concerns regarding child protection who can then make the necessary steps as per procedures of the Local Safeguarding Children Board in Northamptonshire.

Communicate concerns to child and families lead clinician immediately – to Specialist CAMHS safeguarding Champion or the Childs CAMHS Clinician who will then investigate the situation further and follow procedures of the Local Safeguarding Children Board in Northamptonshire.

CURRICULUM VITAE

Name:
Tania E Hart – Nee: Morris
Present appointment:
Senior Lecturer - University of Northampton
Part time PhD student enrolled at the Leicester University
Address:
Yelvertoft 108 - School of Health, Park Campus
Broughton Green Rd, Northamptonshire NN2 7AL

Telephone number:	Email address:
01604 - 892389	tania.hart@northampton.ac.uk

Qualifications and Awards	
MSc (Social Research Methods)	2002
BSc (Hons) Mental Health (1st class Honours)	1999
Certificate in Education	1995
RMN Registered Mental Nurse	1988
Northampton University Teacher Fellowship	2007
Currently undertaking a part time PhD study at Leicester University (Successful APG Transfer Oct 2010).	

Professional registration:
NMC Nursing Midwifery Council - Pin No   1794E
Previous and other appointments:
Senior Lecturer (Mental Health Nursing) – School of Health - Northampton University 01/09/03 – until present
Honorary clinical contract - CAMHS Northamptonshire – from 2009 -2011- One day per week I held a patient case load.
Clinical Nurse Specialist Children's Eating Disorders – Child and Adolescent Services – Huntercombe Hospital, Stafford - 01/09/01 – 31/08/03
Full Time Post Graduate Student   (MSc Research Methods) Staffordshire University 30/11/00 – 30/08/01
Specialist Nurse - Eating Disorders – (young people) - Staffordshire Health Authority 15/07/97 – 30/11/00
Specialist Nurse – Community Outreach (children and young people) – Southampton 01/04/92 - 29/11/00

Research experience:
- I have experience of obtaining ethical approval for research, for example dissertation project (Leicester LREC - 1999) and COREC for larger research project (Birmingham 2006).   - In previous working role as a Clinical Nurse Specialist, I was actively involved in larger scale clinical research supporting the research team. I became practised in gathering data in the field, collating both quantitative (questionnaire) and qualitative research data (focus groups and in-depth interviews), in order to measure treatment outcomes.   - In 2006 I managed a qualitative research project investigating new working roles and the integration of the Primary Care Graduate Mental Health Worker and Support Time Recovery Worker into the workforce. Subsequently I presented the data at the 9th Annual Conference of the UK Federation of Primary Care Research Organisations Health. Liverpool.   - In 2008 I undertook a qualitative action research project, generating data via focus groups to investigate the development of emotional intelligence in the 1st yr of the nurse training. My work in this area has been awarded a Northampton University Teaching Fellowship, with data findings presented at an international conference (Enhancing Practice 8 -Oct 08 - Veldhoven, Netherlands)

Research training:
- I undertook a full time Post Graduate Masters course in Social Research Methods in 2002. The Masters modules related to Quantitative Statistical Data, Qualitative Social Research Methods, Feminist Research Methods and Contemporary Social Research.   - I have undertaken specialist training in order to gather clinical data in the field of Eating Disorders and have used examination tools like the (EDE) – Adult EDE (Oxford 2003) and child EAT (Great Ormond Street 2003). These scoring/outcome scales were utilised for a larger scale random controlled research study. Whilst conducting the structured interviews with children my interview practice was continually appraised and evaluated.   - In Oct 09, I commenced PhD study at Leicester University and undertook workshops in, conducting interviews (Oct 10) and NVivo software (5 days of workshops). In addition to this I have attended two monthly research meeting at the Greenwood Institute of Child Mental Health. These have covered aspects of child and young people's research design. I have also attended a two monthly Language Interpretation Research Group whilst studying at the university.

Key Publications related to child mental health

Child and Adolescent Mental Health – Book Chapters

Smith, S & Morris, T. (2013) Chapter 13. Child Health in **An Introduction to Early Childhood a multi disciplinary approach 3rd edition** Ed.Tim Waller. Sage. London

Morris, T & Hayos, H (2012) Chapter 13. Emotional Wellbeing and Literacy In Thompson, M and Hooper, C. (2012) **2nd Edition of Child and Adolescent Mental Health: Theory and Practice.** Hodder and Arnold. London.

Smith S & Morris T (2005) **Child Health** *in* **An Introduction to Early Childhood a multi disciplinary approach** Ed. Tim Waller. Sage. London

Child and Adolescent Presentations

Morris, T. (May 2007) **Child and Adolescent Primary Mental Health Workers: An Overview A training and education conference.** The primary Care Graduate Worker: can this role be well utilised by CAMHS and more specifically by the PCMHW in order to enhance delivery? The Tavistock and Portman NHS Foundation. London, UK.

Morris, T & Turner, W. (Sept 2009) **2nd ENSEC conference**. Embedding knowledge and understanding of emotional and mental health in a teaching curriculum, Turkey.

Morris, T. (July 2011) **3rd ENSEC conference** Just how do you explore true teenage emotions and overcome the 'sticky' ethical issues? One research method proving to be very successful is film clip vignettes. Manchester University, UK.

Hart, T. (Febuary 2015) **4th European Conference on Child and Adolescent Mental Health in Educational Settings**. Valuing their voices and giving them their say: A qualitative exploration of how we can better assist the schooling of children with identified mental health difficulties. University of Lausanna, Switzerland.

Signature:	**Date:**

Appendix 18: Johari Window
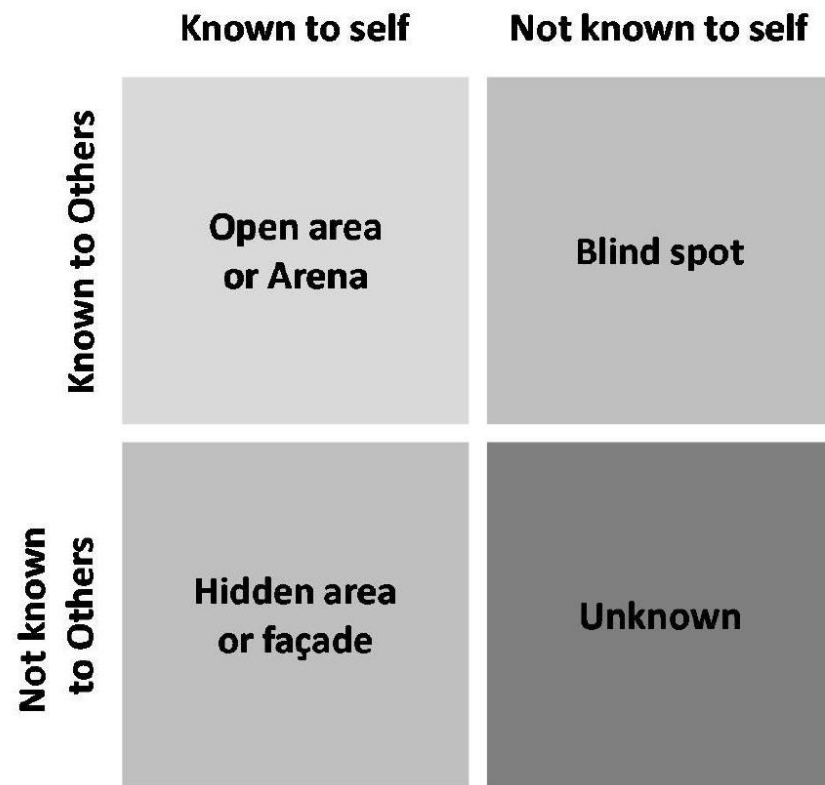
The Johari Window Model

From: Luft. J. (1969) Of Human Interaction: The Johari Model. Mayfield Publishing Company.