VOLUME ONE:

“IT’S PART OF MY JOB, BUT IT’S NOT MY JOB”: EXPLORING THE ROLE OF SENIOR MENTAL HEALTH LEADS (SMHLs) AND THEIR PERCEPTIONS OF MENTAL HEALTH WITHIN MAINSTREAM SECONDARY SCHOOLS

by

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Abstract

The role schools play in supporting students' mental health, particularly for adolescents, has been continually increasing and diversifying over the past two decades. However, whilst settings continue to adapt to roles and responsibilities related to government policy and guidance, limited consideration has been given to staff perceptions of their own roles relating to supporting students' mental health, and how staff construe 'mental health'. This current study chose to focus on the views of staff who have taken on a particular role recently introduced to schools: Senior Mental Health Leads (SMHLs). These are staff who have a particular responsibility towards promoting and developing mental health supports within their settings. Within this study, five SMHLs completed semi-structured interviews, including a diamond ranking activity, and an externalising objects activity. Thematic analysis generated themes related to the role of a SMHL (including how SMHLs perceive their role identity, pastoral responsibilities, strategic role elements, and learning and development); barriers and facilitators to this role; and their perceptions of specific SMHL training. SMHLs also discussed their perceptions of 'mental health', highlighting the nuanced and personal nature of mental health, as well as the variety of conceptualisations held. The complexity of the SMHL role is presented, alongside a call for further support from government agencies, school leadership members, and relevant professionals, such as educational psychologists. This includes consideration of a team to support mental health delivery and strategy within school settings, and further ways to implement meaningful training opportunities and staff supervision.

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Abbreviations

BESD: Behavioural, Emotional, and Social Difficulties

CAMHS: Child and Adolescent Mental Health Services

CR: Critical Realism

DfE: Department for Education

DfES: Department for Education and Skills

DofH: Department of Health

DofHSC: Department of Health and Social Care

DSL: Designated Safeguarding Lead

EHWB: Emotional Health and Wellbeing

ELSA: Emotional Literacy Support Assistant

GT: Grounded Theory

IPA: Interpretative Phenomenological Analysis

LA: Local Authority

MHST: Mental health Support Team

NHS: National Health Service

OCD: Obsessive-Compulsive Disorder

PHE: Public Health England

PSHE: Personal, Social, Health Education

RTA: Reflexive Thematic Analysis

SEMH: Social, Emotional, Mental Health

SENCo: Special Educational Needs Coordinator

SLT: Senior Leadership Teams

TA: Teaching Assistant

SMHL: Senior Mental Health Lead

UK: United Kingdom

WHO: World Health Organization

Chapter One: Introduction and Context

1. Introduction

This study is presented as Volume One of a two-volume thesis, submitted as part of the course requirements for the Applied Educational and Psychology Doctorate (App Ed and Child Psy D).

The purpose of this introductory chapter is to outline the overarching background behind this chosen research topic. This will involve considering the changing social landscape in relation to discourses of mental health; personal experiences; various conceptualisations of mental health as a construct; the relationship between adolescence and mental health; legislation and guidance within the United Kingdom (UK); and the emergence of the designated SMHL.

1.1 Social Landscape

A key contributing factor to my interest in pursuing this area of research stems from being an adolescent during an intense period of social campaigning to increase public awareness and understanding of mental health. Following on from the introduction of initiatives such as Mental Health Awareness week in the early 2000s, from 2007 to 2021 the 'Time to Change' campaign (including various celebrity voices) sought to promote conversations around the number of individuals experiencing mental health difficulties (Mental Health Foundation, 2023a; Mind, 2023a). The development of public awareness campaigns has continued across the past decade, especially strengthened by experiences during the Covid-19 pandemic, including prolonged social isolation (Mind, 2021).

Although these campaigns have been important in bringing the topic of mental health into the general public consciousness for further discussion, their long-term impact has not been conclusively determined. For example, whilst studies have described awareness campaigns as having had a positive impact on reducing mental health prejudices, other

research has illustrated ongoing stigmatisation and trivialisation of certain mental health disorders (such as psychosis, and obsessive-compulsive disorder (OCD)) (Evans-Lacko et al., 2014; Foulkes, 2021; Mind, 2023a; Robinson et al., 2019).

Despite this emphasis on promoting mental health discussions, greater awareness has not yet translated into an increased number of individuals being able to access support, especially considering additional disruption during the Covid-19 pandemic (World Health Organization (WHO), 2022a). This is despite a significant increase in referrals to Child and Adolescent Mental Health Services (CAMHS) in previous years (Crenna Jennings & Hutchinson, 2018). Research indicates that approximately one in four children and young people (aged 5 to 19 years old) with a diagnosed mental health disorder had not received either informal care or access to formal support services (Sadler et al., 2018). Similarly, Frith (2017) identified that approximately a quarter of young people referred to CAMHS were not able to access support. Additionally, of young people who were determined eligible for support, 20.7% were reported to wait for more than six months.

Furthermore, whilst increasing mental health awareness should be considered as a positive social force, there are concerns that the ambiguity in what 'mental health' relates to (even between professionals), has contributed to elements of the "human condition" (for example, sadness and test anxiety) being misappropriately labelled as mental health difficulties akin to 'conditions' (Foulkes, 2021, pp. 12). Therefore, whilst mental health awareness campaigns have been instrumental in promoting knowledge, for example statistics regarding prevalence of mental health disorders, there is still a lack of consensus as to how individuals within society view mental health (Foulkes, 2021).

1.2 Mental Health Definitions and Discourses

Before undertaking research considering 'mental health', it is important to first review what is understood about the concept itself. This is a challenging feat, as what is considered as 'mental health' is continually evolving, especially through tensions between notions of

mental health disorder(s) (often the focus of mental health awareness campaigns), and conceptualisations of wellbeing, relating to an individual's quality of life, either objectively (i.e., household income), or subjectively, such as happiness and contentment (Moore et al., 2018). The tension between these elements can be seen in various proposed mental health definitions. The WHO's description of mental health, for example, appears to furthest align with a joined concept of mental health and wellbeing: "a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community" (WHO, 2022b).

Other definitions of mental health, however, appear to be more closely aligned with the idea of mental health being associated to disorders/illnesses. Mind, for example, in their definitions of mental health and mental health problems appear to present poor mental health as associated with illness:

Mental health is on a spectrum – we can be ill and struggling and well and functioning […] good mental health means being generally able to think, feel and react in the ways that you need and want to live your life. But if you go through a period of poor mental health […] this can feel just as bad a physical illness or even worse (Mind, 2023b, para. 6; Mind 2023c, para. 2).

A lack of clarity and consensus on a unified definition of mental health creates particular challenges, as this may mean campaigns and support options may not be aligned to the same goal, either intentionally or indirectly. Whilst some mental health awareness campaigns, for example, focus on decreasing symptoms of mental health disorders, others are focused on promoting wellbeing (Manwell et al., 2015).

The following sections outline the main prevailing discourses which present themselves within narratives surrounding mental health.

1.2.1 Medical Discourses.

The term ‘mental health’ is often presented as synonymous with ‘mental health disorder(s)’, for example as classified in the Diagnostic and Statistical Manual 5th edition (DSM-5) (American Psychological Association, 2015). Within this conceptualisation, what is considered as best mental health is characterised primarily as an “absence of mental diseases” (Manwell et al., 2015, pp. 1). This way of constructing mental health holds with a reductionist view that mental health difficulties are contributed to by discrete, underlying biological structures (for example, chemical imbalances), and naturalism, whereby biological structures causally contribute to such disorders (Patil & Giordano, 2010). Although definitions of mental health have been extended to include other elements, including wellbeing, there remains a query within the field of psychology as to whether mental health remains a euphemism for mental health disorders, with critique emphasising that this way of considering mental health presents difficulties as pervasive, chronic, and restricting (Georgaca, 2013; Thyer, 2015).

1.2.2 Biopsychosocial Model.

Moving from a purely medical conceptualisation, the biopsychosocial model (proposed by Engel in the 1970s) represents a key shift in expanding the definition of mental health. This model promotes the notion that mental health difficulties develop, and are supported, by complex interactions between three areas: biological, such as the nervous system (subpersonal), as well as the psychological and social, including various relationship (suprapersonal) elements (Gask, 2018; Porter, 2020). A key assumption of the biopsychosocial model is that no one area in isolation is sufficient to contribute to mental health concerns, illness, or disorder. Within research into depression, for instance, studies explore factors across these areas within the biopsychosocial model, for example the impact of neuronal networks (biological) (Nixon et al. 2014), emotional reactivity (psychological) (Bylsma et al., 2008), and social conditions, such as experiencing discrimination (social) (Stirling et al.,

2015). Therefore, the biopsychosocial model was pivotal in moving forwards perceptions that mental health represented purely biological contributions, towards recognising the importance of additional elements, which remain supported in current conceptualisations of mental health (Tripathi et al., 2019).

However, as research into the area of mental health has continued to develop, criticism of the biopsychosocial model has been presented, describing it as “over-privileging the biological" […] rather than relationships, community, and culture” (Norwich et al., 2022, pp. 808). This apparent privilege may reflect a continued emphasis on biological processes being held by professionals within mental health research, as other authors have noted that the prioritisation of areas within the model is due to the values and assumptions held by clinicians (Gask, 2018). Furthermore, it has also been questioned whether the lack of balance defined within this model means that any one of these areas (biological, psychological, and social) can be over or under-emphasised, and that the biopsychosocial model does not allow for consideration of subjective individual factors, such as faith or spirituality (Benning, 2015).

1.2.3 Positive Mental Health and Wellbeing Narratives.

As previously illustrated within the WHO definition of mental health, a shift is occurring to integrate the concepts of mental health and wellbeing; “this *mental health as wellbeing concept” (*Norwich et al., 2022, pp. 807).

The study of ‘wellbeing’, capturing positive human feelings and experience, has been increasingly explored, especially with the development of the field of positive psychology (Cooke et al., 2016). Wellbeing has been examined through a variety of different lenses and conceptualisations, including subjective-wellbeing and life satisfaction; reaching a sense of mastery or achievement; and quality of life (including physical health and social relationships) (Cooke et al., 2016).

Models of wellbeing have been proposed which begin to combine these various domains and move towards a positive mental health narrative. Keyes, for example, proposed

that “flourishing” in regard to wellbeing related to three core components of emotional, psychological, and social wellbeing; holding a “high level of subjective well-being with an optimal level of psychological and social functioning” (Westerhof & Keyes, 2010, pp. 111-112).The opposite pole is considered as “languishing”, and individuals positioned between these as experiencing “moderate” well-being (Westerhof & Keyes, 2010, pp. 112).

Seligman (2011) builds upon areas of wellbeing within the PERMA model, which includes the dimensions of: positive emotions, supportive relationships, engagement, developing meaning, and accomplishment. The influence of wellbeing upon the conceptualisation of mental health has been highlighted by the move to considering ‘good’ or ‘positive’ mental health, including factors such as: enhanced cognitive skills (for example, organising information), academic or work-related achievement, the development of emotional regulation skills, established relationships with friends and family, and developed social skills (Fusar-Poli et al., 2020).

The movement to integrate the concepts of mental health and wellbeing has also been seen in educational definitions, for example the term ‘emotional health and wellbeing’ in the National Healthy Schools Programme (Kidger et al., 2009). Within this conceptualisation, “optimal” mental health (with linked positive impacts) is considered the opposite of “mental unwellness” or “struggling” (Norwich et al., 2022, pp. 808; Seaton et al., 2021, pp. 38).

However, this definition has been described as insufficient as it does not capture the nuanced and multi-faceted nature of the human experience, for example ‘positive’ emotions during periods of poorer mental health, or the sadness, frustration and anger which can occur in daily life whilst one is not experiencing mental health difficulties (Seaton et al., 2021).

Other definitions have instead sought to capture the brevity of emotional experiences as well as the notion of positive mental health; describing “internal equilibrium” (Galderisi et al., 2015, pp. 232) or “positive functionality” (Bhugra et al., 2013), where an individual is able

to “recognise, express, and modulate one’s own emotions […] empathise with others [and] cope with adverse live events and function in social roles” (Galderisi et al., 2015, pp. 232).

1.2.4 Mental Health as a Dual Model or Continuum.

As the complex nature of mental health and its relationship to wellbeing has been grappled with, this polarising approach to considering ‘positive’ and ‘negative’ mental health and wellbeing has been broadened into multi-dimensional conceptualisations. These approaches appear to describe ‘positive’ mental health and wellbeing synonymously, and this construct is described as fluctuating between an “optimal state of wellbeing to debilitating states of great suffering and emotional pain” (WHO, 2022a, pp.13). This idea can also be expressed as mental health and wellbeing ranging from “languishing” to “flourishing” (Norwich et al., 2022, pp. 809). The idea of “mental illness” or mental health disorders are considered as a separate, but related, dimensions.

One such example of this conceptualisation is the two continua model proposed by Keyes. This model holds that “mental health and illness belong to two separate but correlated dimensions in the population” (Keyes, 2013, pp. 181). This means that an individual may have a diagnosable mental health disorder, whilst experiencing positive mental health in their daily life; ‘flourishing’ (see positive mental health and well-being narratives). Additionally, an individual who does not meet criteria for a mental health disorder, may still be experiencing or struggling with poor mental health (Westerhof & Keyes, 2010).

1.2.5 Social Constructivism.

Whilst various conceptualisations of mental health have been developed, the medicalised narrative is often still presented within the mainstream media (for example, emphasis on the within-person description of specific disorders). This is proposed by those from a social constructivist stance as showcasing the dominant, scientific interests within psychiatry and psychology, as opposed to focusing on what ‘mental health’ truly means, and how it is experienced by individuals within society (Georgaca, 2013).

Social constructivism posits that human experience occurs as a result of interactions between a person and their social world; presenting mental health as a "social and psychological phenomena"; not unique or distinct to the individual mind or experience (Cottone, 2007; Georgaca, 2013, pp. 55). This connection between mental health and social conditions has been described by Ahsan (2022, para. 4); *"if a plant were wilting, we wouldn't diagnose it with "wilting-plant-syndrome" – we would change its conditions*". Therefore, in order to support individuals experiencing mental health difficulties, care must be taken to review the environmental supports and external environments. Ahsan further describes that young people who experience poor mental health and wellbeing are impacted not by an internal 'within' condition, but instead by their social climate, such as poverty, peer pressure, exam-driven schooling, bullying, and exacerbated by interactions within social media platforms.

Therefore, as opposed to a within-person narrative, in this discourse what is considered as reflecting mental health is developed from discussion between an individual and those in their community of support, such as colleagues, teachers, and professionals (Doucet et al., 2010). Within this way of thinking, there are multiple 'truths' of what mental health may mean determined through this discourse; termed "complexity of the perspectives" (Doucet et al., 2010, pp. 302). This approach aligns further with considering mental health as 'wellbeing'; relating to the forces in an individual's social world which promote or restrict their wellbeing.

An example of mental health conceptualisations being built through communication can be seen in focus groups conducted by the Office for National Statistics (2020). In this research, children describe that to them the notion of wellbeing relates to feeling safe, having supportive relationships, feeling able to be themselves, being in a positive school environment, feeling secure in family finances, and being listened to (Office for National Statistics, 2020).

1.2.6 Impact of Differing Mental Health Discourses.

How individuals and societies conceptualise mental health has a significant impact upon the support individuals receive and experience. The medicalised discourse surrounding mental health, for example, contributed to the development of the tiered mental health system in the National Health Service (NHS), whereby specialist support is often reserved for those with complex mental health needs/disorders (Norwich et al., 2022). Similarly, this medicalised discourse has in part shaped the type of supports sought for and provided to children and young people. Prescriptions for antidepressants amongst 3 to 17 year olds, for example, were seen to double between 2006 and 2015, with 61% of first-time prescriptions in 2015 being given to adolescent females (aged 15 to 17) (Saringson et al., 2017). The framing of mental health around medicalised diagnostic language can also be seen to impact the way young people describe mental health. Spencer et al. (2022a) for example, found 14 to 17 year olds described depression and anxiety when discussing mental health, and outlined that "saying something is wrong with your mental health, that's quite serious", although also acknowledging that "if you have mental health in general, it doesn't have to be a bad thing" (Spencer et al., 2022a, pp. 365).

1.3 Adolescence

The overarching aim of this research is to consider the experiences and perceptions of SMHLs working within mainstream secondary schools (settings where pupils are aged between 11 and 16 years old). Therefore, it is fundamental to consider from the outset of this study the importance of adolescent mental health in particular, and the supports for young people.

Adolescence has been continually demonstrated to be a key life stage in relation to the development of mental health difficulties, with estimates of up to half of adult mental health disorders having presented before 14 years old (Kim-Cohen et al., 2003; Norwich et al., 2022). What constitutes 'adolescence' has been widely debated, but in order to "correspond more

closely to adolescent growth and popular understanding", the age range within this developmental area has been presented as between 10 and 24 years old (Sawyer et al., 2018, pp.1).

Previous research has indicated that between 14.0 and 16.9% of 10 to 19 year olds appear to meet criteria for a mental health disorder, with further research suggesting that this figure is continuing to rise (Garside et al., 2021; Sadler et al., 2018; WHO, 2021). Globally, it is estimated that 4.6% and 2.8% of 15 to 19 year olds experience the symptoms of anxiety and depression respectively. Adolescence is also reported as an age group linked to the onset of other mental health difficulties, such as eating disorders and psychosis (WHO, 2021).

Mental health difficulties have been noted (for example, using large scale data sets) to rise during the transition from primary to secondary school in the UK (Jerrim, 2022). This rise appears to occur earlier for adolescent girls (in Year 8), compared to adolescent boys (Year 11 onwards). Strikingly, this trend for adolescent females continues into later adolescence, with girls aged 17 to 19 years old found to be at an increased risk for experiencing certain mental health difficulties (for example, 22.4% meeting criteria for an emotional disorder), and with studies indicating 52.7% of these adolescent girls report having engaged in a form of self-harm (Sadler et al., 2018). Similarly, young people (14 to 19 years old) who identified as "lesbian, gay, bisexual, or with another sexual identity", were more likely to meet criteria for a mental health disorder compared to their peers who identified as heterosexual (Sadler et al., 2018, pp. 16). Other demographic factors that have been associated with increased rates of mental health disorders in young people include experiencing financial difficulties in the home, parental experiences of mental health difficulties, exclusion from school, lack of social support, and poor physical health (Sadler et al., 2018).

In regard to wellbeing, there is less consensus in the literature as to how this has impacted adolescents over recent years, with some studies suggesting that overall subjective wellbeing has been improving for young people, whilst others propound that it is decreasing (Bradshaw & Keung, 2011; Aldridge & Change, 2018). However, research appears to indicate

that mid-adolescence is a particular age where a decrease in subjective wellbeing is reported (14 to 15 years old) (The Children's Society, 2022). Children and young people experiencing an emotional disorder have also been noted as having below average wellbeing (Sadler et al., 2018).

Adolescence is a particular period of risk relating to poorer mental health, due to a variety of factors. During adolescence, young people are experiencing biological changes, for example neurologically and hormonally, which appear to make them increasingly more susceptible to feelings of social pressure and isolation, as well as displays of risky behaviours, including using substances which are implicated in decreased mental health and wellbeing (Blakemore, 2018; Jerrim, 2022). Additionally, there are known environmental factors which impact upon young people during adolescence in school, such as stress and pressures relating to academic attainment, and social pressures relating to evaluation from peers (Jerrim, 2022; Seaton, 2021). These environmental scenarios are especially important to consider in relation to the impact of the Covid-19 pandemic, for example the impact that increased social isolation and school closures may have had on depression and anxiety symptoms of adolescents, although research is still investigating these potential links (Nearchou et al., 2020; Widnall et al., 2022).

Understanding individuals' experiences of mental health difficulties across childhood and adolescence is important due to the repercussions this can have on "adverse psychological outcomes" in a young person's later life, as well as upon academic achievement and employment (Jerrim, 2022; Vostanis et al., 2013, pp. 151). Young people with mental health disorders are at an increased risk of experiencing discrimination, stigma, and physical illness (WHO, 2021). This risk of stigmatisation may also prevent adolescents from seeking support (Velasco et al., 2020). Furthermore, adolescents report feeling as though they are expected to have a wealth of knowledge relating to mental health, despite feeling that they have not been supported to develop this understanding (Spencer et al., 2022a).

Additionally, as well as the long-term impacts for these young people, there is also an increased economic cost associated with mental health conditions beginning in adolescence (Knapp & Wong, 2020). However, it should also be considered that adolescence offers a unique period to focus on intervention to develop mental health understanding. For example, due to both internal physiological changes and the influential impact of the environment during adolescence, this period is described as a life stage where individuals may be also increasingly susceptible to "learn the foundations of optimal mental health" (Seaton, 2021 pp. 39).

1.4 Legislation, Guidance, and Best Practice

In light of the increased understanding of the importance of supporting young peoples' mental health, many agencies have called for various sectors, such as health and education, to work collaboratively alongside each other to support mental health. This call has also been mirrored in legislation and guidance from the government, as social awareness and interest in supporting mental health has developed.

Themes explored within this section focus on characteristics presented across policy and guidance primarily since the introduction of the SEND Code of Practice (Department of Education (DfE) and Department of Health (DofH), 2015). It should be recognised that other guidance pre-dating this document impacted subsequent publications, for example the Nationally Health Schools Initiative (Department of Health and Social Care, (DofHSC), 1999), Every Child Matters (Her Majesty's Treasury, 2003), and Social and Emotional Aspects of Learning (Department for Education and Skills (DfES), 2005; DfES, 2006).

1.4.1 Construction of Social, Emotional and Mental Health.

How mental health is presented and described within education guidance has been continually evolving. The current construction, presented in the SEND Code of Practice (DfE & DofH, 2015) significantly impacted the way that mental health is considered within educational settings. Within this code, outlining legal precedent and guidance within special

educational need provision, ‘social, emotional, and mental health’ (SEMH) was recognised as a distinct area of educational need, replacing the previous area of ‘social, emotional, and behavioural difficulties’ (Hickinbotham & Soni, 2021). Alongside the acknowledgement of mental health needs, the code outlined the responsibilities of professionals and schools to have a rudimentary understanding of mental health. This conceptualisation of SEMH re-iterated the medical discourses described within the previous section, for example with reference to “anxiety disorders”, “attention-deficit hyperactivity disorder”, and “attachment disorder” (Norwich et al., 2022, pp. 811). Additionally, emphasis is placed on providing practical and tangible provision options to children and young people experiencing mental health difficulties, for example Disability Support Allowance (DSA), and transition support to higher education.

1.4.2 Broadening the Scope of Education.

Policy and guidance documents have further promoted the broadening of schools’ role in relation to mental health. This aligns with a prevailing view within education and psychology to “move away from the rationalist to a more holistic view of education” (Vostanis et al., 2013, pp. 151).

Across initiatives such as Targeted Mental Health in Schools (TaMHS; DfE, 2011, pp.7), Closing the Gap guidance (Social Care, Local Government and Care Partnership Directorate, 2014), the Future in Mind taskforce (DofH & NHS England, 2015), and Promoting Children and Young People’s Mental Health and Wellbeing guidance (Public Health England (PHE) & DfE, 2021), there have been continued calls to develop schools roles to systemically support children and young people in their settings. This is primarily proposed through the adoption of a whole school approach to mental health (DfE, 2011; PHE & DfE, 2021), but also specific mechanisms to promote systemic culture change to develop resilience and wellbeing for young people, such as staff training (DofHSC, 2022), developing social and emotional mental health curriculums (DfE, 2011), and bespoke intervention options for schools being considered “in response to local need” (DfE, 2011, pp.7).

It should be noted that whilst several iterations of policy and guidance have promoted the use of the whole school approach, research findings indicate that there is limited information within these documents as to what a whole school approach should include (Spencer et al., 2022b). This lack of clarity may further impact on inequality across school settings, as the type of support schools provide in response to this guidance may differ based on prioritisation of mental health, as well as other features such as finances and identified needs (Patalay et al., 2017). Garside et al. (2021), however, found that 70% of senior school staff responding to a questionnaire felt their school had a whole school approach to mental health, which indicates that it is a feature of guidance which is being adopted by schools in a form. The features described within the PHE (2021) framework also appear to support the development of areas both staff and children felt would support young peoples' mental health, including: a positive school climate where open and honest conversations can occur, safe spaces within school, and positive relationships with staff (Jessiman et al., 2022).

Due to the inequality experienced across society in accessing mental health services, schools are also being positioned within policy and guidance as sites for both universal and targeted support (relating to the Tiers 1-4 framework) (DofH & DfE, 2017). Whilst this is explored in detail within the Transforming Children and Young People's Mental Health green paper (DoH & DfE, 2017), emphasis on schools developing this role has been placed since the introduction of the TaMHS initiative in 2008, where it was noted schools were offering various types of interventions, such as individual and group therapy (Wolpert et al., 2017).

1.4.3 Communication Across Agencies.

Related documents have also promoted schools' role in communicating and working alongside other external agencies, such as CAMHS (DfE, 2011; DofHSC, 2022). This primarily relates to schools described functions in the early identification of mental health needs and in facilitating onward referrals (Social Care & Local Government and Care Partnership Directorate, 2014; DofH & DfE, 2017). Interestingly, there are conflicting messages found in relation to best practice across guidance and research. Within Mental Health and Behaviour

in Schools non-statutory guidance (DfE, 2018), for example, teachers are positioned as primarily responsible for identification and onward referral. It is explicitly stated that “school staff cannot act as mental health experts” (DfE, 2018, pp. 5), but rather as individuals who engage in onward referral via collaborative multi-agency working, offer education to students, and balance promoting whole-school conditions for wellbeing with expectations for behaviour. However, as described within research, mental health support in schools is often primarily facilitated by teaching staff in secondary school settings (Vostanis et al., 2013; Wolpert et al., 2013).

1.4.4 Leadership.

As well as considering roles for teachers and schools’ generally, guidance has also presented a specific emphasis on the importance of leadership within mental health. Within the Future in Mind taskforce, it was proposed that a specific individual in school should be identified to co-ordinate mental health support. This individual, as discussed in later research, was, and in some cases remains, the Special Educational Needs Coordinator (SENCo) (Boddsion & Curran, 2022).

However, leadership is also considered as an underpinning value within the eight principles outlined by PHE guidance (PHE & DfE, 2021, pp. 9); “leadership and management that supports and champions efforts to promote emotional wellbeing”. This leadership responsibility in relation to mental health is described as both relating to a collective responsibility for all staff, but also specifically for the endorsement and support of Senior Leadership Teams (SLT) and governors for whole school approaches and initiatives. This policy document also relates to adopting a strategic lead for mental health, whose responsibilities include ensuring the implementation and monitoring of the whole school approach, and that mental health is woven into school improvement plans. This role was named the Senior Mental Health Lead (SMHL) in the 2017 green paper (DofH & DfE, 2017).

1.5 Designated Senior Mental Health Lead

The importance of leadership, as previously discussed within policy and guidance, became a key focus within the 'Transforming Mental Health' green paper (DofH & DfE, 2017). Here it was outlined that every mainstream state funded school should be incentivised to have a SMHL (DofH & DfE 2017, pp. 20). Whilst not yet a compulsory role, implementation of a SMHL was incentivised via a grant of £1,200 provided to contribute towards training and the implementation of whole school approaches (DfE, 2023).

Whilst the SMHL role is still in its infancy, research has begun to explore the adoption of this role across settings. Analysis of findings from the Mental Health Literacy and Capacity Survey for Educators (MHLCSE), for example, has illustrated that of 206 schools, approximately 71% reported that they had a SMHL (Mansfield et al., 2021). There were more mental health leads in secondary schools (N=59, 78.7%) than primary schools (N=87, 66.4%).

SMHLs are described as holding primary oversight for many of the responsibilities discussed in relation to previous guidance and legislation. The SMHL, for example, would be responsible for the organisation and delivery of the strategic whole school approach to mental health (PHE & DfE, 2021). Due to the strategic input of the SMHL, guidance suggests these individuals are part of the school SLT (DfE, 2023). This, however, is described as not essential if individuals have the support of their schools' SLT (PHE & DfE, 2021). Research has indicated that the SMHL role is often taken by SENCos in primary settings, and other senior leadership members in secondary provisions (Ellins et al., 2023). In order to retain mental health knowledge, existing staff with responsibility for mental health are also eligible candidates to act as a SMHL (DfE, 2023).

1.6 Summary

In summary, the ongoing discussion and awareness of the importance of mental health at a societal level has impacted upon support and education in a multitude of ways, including increased strain to services. Whilst mental health appears through guidance to continue to be

described using medical or biological discourses, there is also further consideration of factors such as wellbeing, the spectrum of emotional and lived experiences, and the separation of 'illness' from concepts such as 'suffering'. Adolescence has been noted as a key life phase where intervention to support mental health is vital, due to knowledge regarding onset of mental health difficulties within this developmental period, and the impact upon adolescents later academic, work, and personal lives. Focusing on the progression from adolescence into adulthood also reflects a personal interest of mine within this research area, due to my own, family, and friends' mental health experiences across adolescence and into early adulthood.

Therefore, understanding how school staff in secondary settings can support young people's mental health is a fundamental area of importance. This has been discussed within policy, guidance, and research, with roles identified as to whole school approach development, early identification, intervention, and providing educative support. However, this responsibility for staff has been described as differing from providing therapeutic support, with this instead being positioned as offered by external professionals (as described within the 2017 green paper; DofH & DfE, 2017).

One key member of staff identified as having oversight of the many facets of mental health support within schools is the SMHL. As such, it is imperative to understand the experiences of these staff members, with regards to how they conceptualise mental health, what they feel their role and the roles of schools are in supporting young people's mental health, and what barriers or facilitators impact upon their perceived role. This will be the focus of this current research. The following chapter will review literature related to the roles of school staff, including SMHLs, as well as how staff conceptualise mental health.

Chapter Two: Literature Review

2. Aim

The purpose of the following chapter is to present and analyse relevant literature related to this study's research area. The research included focuses on how school staff perceive their roles relationship to supporting and promoting mental health, and their understanding of 'mental health' as a concept. This research considered the perspectives of various individuals, including teachers, pastoral leads, teaching assistants (TAs), Heads of Year, senior leadership, and SMHLs.

Whilst this was a narrative literature review, further information is provided for additional clarity into the search process. A systematised search was conducted using the following databases: Scopus, Psych Info, Web of Science, and Google Scholar. Search terms included various iterations of terms such as: school, secondary, high school, mental health, wellbeing, school staff, pastoral, teacher, perceptions, views, and construct Hand searches of the literature were also conducted. Research within this narrative review was considered from 2008 onwards, aligning with the TaMHS project; a specific national initiative to develop schools' ability to respond to mental health need within local communities (see legislation, guidance, and best practice section in Chapter 1). Research consulted for this review was considered internationally (due to a reduced number of studies within the UK context, and the heterogeneity of the school staff samples within studies). Broad inclusion criteria included: school staff members working within mainstream educational settings for adolescents (for example, secondary school provision); studies being written in English, staff included being members of the school community (and not external or agency professionals). Studies were excluded if: staff did not work in mainstream educational settings with adolescents. A table of key studies, referenced throughout this literature review, which includes the country and role of staff, is presented in Appendix 1.

2.1 Role Tensions

Before presenting themes relating to school staff supporting mental health, it must be noted that there does not appear to be a consensus as to how staff who support adolescents feel in relation to their role within this domain.

Whilst research and legislation has begun to position school staff as key agents who can support young people due to their unique positioning within students' lives, this is not a view which is universally shared by individuals in teaching roles (Byrne et al., 2015; Vostanis et al., 2013).

Some members of school staff report that their roles within education are linked to supporting young peoples' mental health and wellbeing (Kidger et al., 2009; Rothì et al., 2008). Kidger et al. (2009) conducted interviews with 14 members of secondary staff, across eight schools in England, (including Heads of Year, a SENCo, and TAs), on the topic of "emotional health and wellbeing" (EHWB) (Kidger et al., 2009, pp.1). Staff interviewed described that promoting young peoples' EHWB was inseparable from other aspects of the teaching role, being so closely linked to adolescents' development and behaviours. However, staff interviewed also expressed that some colleagues appeared to be "reluctant to take an interest" in supporting mental health (Kidger et al., 2009, pp. 7). It is important to note that Kidger et al. (2009) conducted individual and paired interviews. Therefore, this may have had an impact upon the views shared by school staff, for example by feeling they needed to conform to the views shared by others.

The notion of teachers refuting their role in mental health support has been corroborated within further research, where staff present different levels of willingness to discuss mental health with young people (Jessiman et al., 2022; Graham et al., 2011); one staff member in Graham et al. (2011, pp. 8) stated that they were "teachers not mental health workers". Dimitropoulos et al. (2022) conducted interviews with 48 teachers across two settings in Canada and found a "small minority" felt that they should not intervene or identify

young people experiencing mental health difficulties, and that this was not an area they were trained to deliver within their roles (Dimitropoulos et al., 2022, pp. 408).

Additionally, whilst some teachers and staff do believe that mental health support falls within their role (Cefai & Askell-Williams, 2017), they can still report feelings of uncertainty within this area; “I’m there to be like a caregiver, but to a certain degree” (Shelemy et al., 2019a, pp. 7). Additionally, teachers can present as describing one aspect of their role as being more influential than another. Shelemy et al. (2019a), during face-to-face interviews with seven secondary school teachers, found that teachers described their key focus was one of an academic instructor, with an element of behavioural challenge, although they also valued building trust with young people to allow them to share.

Teachers’ uncertainty in relation to their role supporting mental health may be linked to several factors. In several international studies, school staff reported that they did not feel sufficiently trained in identifying, promoting, or preventing mental health difficulties (Ibeziako et al., 2009; Kamel et al., 2020; Mbwayo et al., 2020; Rothì et al., 2008; Shelemy et al., 2019b). However, this concern may be in the process of being addressed as mental health training is reported to be increasing across settings, with Mansfield et al. (2021) highlighting that just under half (approx. 45%) of their included schools in England reported that staff were offered mental health literacy training (with a higher percentage in secondary provisions compared to primary settings). However, this training may be limited to certain staff members, as in their study of schools in England, Garside et al. (2021) reported 95% of schools had teachers trained in mental health first aid, but that this ranged from one member of staff to over 80 depending on setting.

Furthermore, staff in education settings are experiencing an increase in workload, creating further pressure on the “balancing act” between elements of their role (Graham et al., 2011; Shelemy et al., 2019a, pp. 7). Staff have reported that increase in demands on their time has impacted upon their capacity (Shelemy et al., 2019a). Similarly, emphasis on academic performance indicators has added additional strain to workload, leaving staff

reporting feeling overwhelmed and lacking in confidence within the area of mental health (Jessiman et al., 2022; Kidger et al., 2009).

Increasing workload pressures has also been noted to impact staff with pastoral responsibilities. Guidance teachers in Scottish secondary schools (who hold responsibilities for providing educative and individual student support for all young people in secondary settings; Mcgeough et al., 2021) have reported that they have limited capacity to support young people in a way that they felt aligned with their role requirements, with teaching impacting upon the time they had available to support young people (Stoll & McLeod, 2020). Similarly, Harvest (2018) highlighted that pastoral leads' views of their multiple roles, such as being teachers, counsellors, and social workers, reduced both the time available to provide support to young people, and their feelings of capacity and competence.

Therefore, this tension in perceived role may highlight true differences in views of staff role in relation to mental health. However, it may also give insight into how staff perceive their role at this current time. Corcoran and Finney (2015), for example, interviewed staff working across primary and secondary schools regarding applying psychology within education across the North of England. Participants described mental health support as an "ideal" as opposed to the lived reality (Corcoran & Finney, 2015, pp. 106). In either case, it must be considered that school staff consistently report differences and tensions between how individuals perceive their responsibilities within mental health support.

2.2 Elements of Role

2.2.1 Relationships.

School staff report across studies that developing relationships with students was important to their role in supporting young people's mental health (Jessiman et al., 2022). The act of forming a relationship was identified by school staff as being a method which even in isolation was powerful (Kidger et al., 2009); "relationships are the key to everything" (Cefai & Askeel-Williams, 2017, pp. 110). Forming meaningful, caring, and supportive relationships

with young people (Graham et al., 2011) was seen as important to develop trust (Dimitropoulos et al., 2022) and social capital (Harvest, 2018) to encourage young people to disclose how they are feeling.

Teachers reported that methods which supported them to develop these relationships were curiosity, empathy (Dimitropoulos et al., 2022), trust, approachability (Cefai & Askell-Williams, 2017; Neill et al., 2021), sympathy, caring, (Shelemy et al., 2019a) and offering praise and encouragement (Ibeziako et al., 2009). Additionally, teachers identified that creating relationships with young people supported them to model effective coping strategies (Dimitropoulos et al., 2022; Graham et al., 2011). Building relationships was also identified as impacting on other elements which support teachers' roles in relation to mental health, such as developing a supportive school environment (Jessiman et al., 2022) and relationships with parents (Dimitropoulos et al., 2022).

It is important to note that not all school staff felt that relationships were part of their role, with some identifying that supportive relationships with students were unique to the role of pastoral staff (Jessiman et al., 2022). Interestingly, Flint (2017) conducted research with four members of pastoral staff and found, in their experiences, that part of their pastoral role specifically involves fulfilling a duty of care to support *staff* members, as well as students. This related to support both in school as well as wider elements of colleagues' lives. Shelemy et al. (2019b) additionally indicated that teachers would seek out containment from pastoral staff regarding their concerns for specific young people. However, it is important to consider that within this study teaching staff were identified to participate in focus groups by the pastoral lead within the school, and so may have a closer working relationship with these members of staff than their fellow colleagues. Yet, building relationships with staff members has also been identified in wider research. Teachers in Harvest (2018)'s study described reciprocal, non-judgemental relationships between all staff colleagues as being helpful to support young people's mental health by promoting staff resilience and providing containment.

However, even roles whereby staff may be explicitly expected to develop relationships with young people were identified to be impacted by contextual barriers (such as time demands, and pressures from other aspects of the role) (Shelemy et al., 2019b; Stoll & McLeod, 2020). Stoll and McLeod (2020) conducted interviews with six pupil support staff and found that although their role required them to have supporting conversations with young people, these were often informal or unplanned, with staff feeling unable to follow up afterwards. Additionally, whilst staff in Shelemy et al. (2019b, pp. 7) reported using their interpersonal skills, including common sense and instinct within conversations with pupils, this could often lead to staff questioning their input, feeling concerned that they had not done the "right thing".

Developing relationships was also seen by staff as being related to identification, as having a bond with young people ensured one could notice any behavioural changes, positioning staff as able to check in with young people quickly (Cefai & Askell-Williams, 2017).

2.2.2 Identification.

Another role within supporting mental health was identification and monitoring. This related to ensuring that the ever changing needs of young people were identified quickly (Beames et al., 2022).

School staff reported various ways in which they approached identifying mental health difficulties for young people. These included face to face methods, such as check-ins with young people (Cefai & Askell-Williams, 2017; Jessiman et al., 2022), observations, and mentoring sessions (Cefai & Askell-Williams, 2017), as well as indirect methods, for example using attendance data (Jessiman et al., 2022), note taking, and programme checklists (Cefai & Askell-Williams, 2017). Staff also described across studies both informally (Dimitropolous et al., 2022) and formally sharing concerns with their colleagues to identify support options and next steps (Dimitropolous et al., 2022; Jessiman et al., 2022).

For staff acting in roles with aligned pastoral responsibilities, identification of mental health needs was an increasingly formalised aspect of their role. Guidance staff within Stoll and McLeod (2020), for example, reported attending weekly meetings to identify and discuss select young people deemed at risk, and to consider external referrals. This formalised space, however, cannot be considered as a part of all pastoral staff's role. Within Harvest (2018), pastoral staff reported wanting to have access to a reflective space where they could discuss their concerns as a team, to provide additional supervision, as well as containment.

It is important to consider that for some teachers, initial relationships and identification were presented as the extent to which they would intervene to support individual young people's mental health. In Shelemy et al. (2019b) 49 teachers from secondary schools in the UK reported they felt their role was immediate support as a "holding position until the right people can come along" (Shelemy et al., 2019b, pp. 7). Teachers highlighted that they would then hand over responsibility to identified pastoral leads. Similarly, Monducci et al. (2018) in a survey of 500 teachers across London boroughs and Italy identified that approximately 40-50% of teachers in both Italy and England would inform other colleagues if they felt a student was experiencing psychosis. For English respondents, these may include a Head of Year (12%), a pastoral staff member (7%), or a learning mentor (6%). However, Iachini et al. (2015) highlighted that school principals for middle, high, and technical education settings in one school district in America, felt that it was the role of the teacher to both recognise and respond appropriately to students' mental health needs.

Staff across studies reported a number of concerns in relation to identification as part of their roles within school. Research identified that across teaching and senior staff members, it was reported that staff felt they needed clearer training to effectively carry out this aspect of their role (Kidger et al., 2009; Rothì et al., 2008; Shelemy et al., 2019b). However, in other studies considered within this review, staff training needs appeared to align more with knowledge, as opposed to purely identification (Cefai & Askell-Williams, 2017; Jessiman et al., 2022; Shelemy et al., 2019b). Additionally, research by Vostanis et al. (2013) surveyed

over 700 staff members (primarily Deputy Heads and Headteachers) from primary and secondary schools in the UK and identified that 71.2% felt support was provided reactively to young people experiencing mental health difficulties, as opposed to preventatively, which may indicate that identification is occurring only for young people already experiencing significant distress. This aligns with Stoll and McLeod (2020, pp. 9), where guidance staff identified that meetings discussing young people were framed around “high tariff” young people.

2.2.3 Whole School Approach.

In contrast to the reactive narrative within identification of existing mental health difficulties, staff also discussed their role in relation to supporting the whole school approach to mental health (Kidger et al., 2009). Garside et al. (2021) conducted questionnaires with 36 members of senior staff members across 23 schools in England. Across respondents, 76% identified that they felt their school adopted a whole school approach to mental health. This was an increase compared to 66% of secondary schools reported in Sharpe et al. (2016). Vostanis et al. (2013), using a similar methodology and sample to Garside et al. (2021), found that 64% of predominantly senior staff members felt their school’s focus on mental health was across all young people, rather than aimed at specific individuals.

Across studies, staff members identified many different facets of a whole school approach that they felt supported young people generally (Jessiman et al., 2022) as well as specific vulnerable groups, such as refugees (Podar et al., 2022). Adopting a whole school approach was presented by teaching staff as relating to the creation of a “safe, supportive climate”, ensuring a focus on prevention, supporting young peoples’ feelings of emotional and physical safety, and enhancing young peoples’ voices (Beames et al., 2022; Cefai & Askell-Williams, 2017; Podar et al., 2022, pp. 3). Graham et al. (2011) conducted surveys with over 500 teachers in Australian primary and secondary schools. In this study, teachers reported that whole school approaches guide young people to develop a sense of school belonging, promote a positive school environment, and to experience mastery. Similarly, research has found that whole school approaches support a shared vision of mental health, and assists

young peoples' skill development, for example in those related to emotion regulation (Cefai & Askell-Williams, 2017). It is important to consider that schools recruited within Cefai and Askell-Williams (2017) were actively considering working on developing mental health supports as an ongoing focus, and that this may have contributed to certain positive responses regarding mental health support from staff.

Staff identified that elements which supported their role in relation to adopting a whole school approach included: utilising an open-door method, such as during breaktimes (Littlecott et al., 2018; Jessiman et al., 2022); physical spaces where young people can find support, such as a nurse's station (Littlecott et al., 2018); restorative approaches towards behaviour (Jessiman et al, 2022); increasing diversity amongst school staff to support young people to feel represented; and the development of a shared language around young people's needs (Harvest, 2018).

However, again within this area a tension was identified amongst school staff's perceptions. Stoll and McLeod (2020) found that guidance staff were in favour of the adoption of a whole school approach to enable staff to work collaboratively to support young people. However, these staff similarly viewed that they had experienced resistance from working with other teachers who felt this overstepped their role. Additionally, teachers have also reported feeling that their school's mental health policies were not effective (Andrews et al., 2014; Rothì et al., 2008).

2.2.4 Curriculum.

Staff further reported that they deliver mental health information within personal, social, and health education (PSHE) (Beames et al., 2022; Kidger et al., 2009; Neill et al., 2021). Graham et al. (2011) identified that teachers reported that mental health education was important or extremely important within school (45% and 44% respectively). Similarly, Garside et al. (2021) highlighted that 81% of senior staff felt that the PSHE curriculum is impactful in supporting mental health.

Staff reported that they disseminate advice, guidance, and certain interventions to young people through the PSHE curriculum and assemblies (Jessiman et al., 2022). However, staff were concerned as to the level of information they felt able to share, due to their own knowledge level, for example due to a lack of accessible information for teachers (Andrews et al., 2014; Beames et al., 2022; Jessiman et al., 2022). A lack of in-depth information gained by students from such activities, including assemblies, is also supported by shared views of young people (Spencer et al., 2022a).

Additionally, staff report that mental health information should be incorporated into the wider curriculum (Kidger et al., 2009). Within Cefai and Askell-Williams (2017) staff reported that their role should include collaborative time to develop both the general wellbeing curriculum, as well as to consider how to further include mental health within wider curriculum spaces. This development was reported to promote young peoples' skills relating to resilience, problem solving, emotional literacy (Cefai & Askell-Williams, 2017), emotional expression, physical health management, and understanding of racial topics (Graham et al., 2011). Mental health concepts integrated in this way, delivered through creative and physical activities, are noted as a means through which schools support students' mental health (Vostanis et al., 2013).

2.2.5 Intervention.

There was far less consensus between teachers as to their role in delivering interventions to young people. Teachers within studies across Nigeria, Australia, USA, China, and England described that they can support young peoples' mental health through offering counselling, mentoring, and specific interventions (Graham et al., 2011; Ibeziako et al., 2009; Monducci et al., 2018; Salinger et al., 2019). Townes et al. (2023) also conducted a scoping review examining Tier 2 interventions across primary and secondary schools across several countries (including the USA, UK, Australia, and Canada). Their review outlined that teachers held great responsibility in delivering Tier 2 interventions, such as small group mental health

interventions, however, it was suggested that teachers often do not receive appropriate training in relation to this role.

This view that counselling or similar interventions are not part of school staff roles is also prevalent elsewhere. Within Monducci et al. (2018), only 36% of Italian teachers felt that it would be appropriate for them to offer initial support to a student experiencing psychosis compared to approximately 60% of English teachers. Counselling was presented by teachers within Canada (Dimitropoulos et al., 2022) as outside of teaching practice, due to a lack of capacity and training. Similarly, teachers within England articulated in Shelemy et al. (2019b), that they felt they had a “duty of care, not duty of cure” (pp. 8). Even in relation to staff with pastoral roles, guidance teachers in Stoll and McLeod (2020) reported the distinction between their role, and counselling; “we have to be careful, we say ‘we do not offer counselling but use counselling skills’” (Stoll & McLeod, 2020, pp. 7).

2.2.6 Referrals and Signposting.

Teachers reported that signposting to, and sharing additional resources with, young people is another element of their role (Beames et al., 2022; Dimitropoulos et al., 2022; Shelemy et al., 2019a). Staff highlighted that this was possible through curriculum content, assemblies, and other similar activities (Jessiman et al., 2022). Teachers’ abilities to perform this role was reported to be impacted by their access to audio and print resources (Kamel et al., 2020), training (Kamel et al., 2020; Dimitropoulos et al., 2022), and knowing which external supports can be accessed by young people (Jessiman et al., 2022).

Making onward referrals to other professionals and external agencies was also highlighted as part of teachers’ roles for vulnerable groups. Podar et al. (2022) found external referrals were a key part of German teachers’ role in supporting refugees’ mental health, for example by supporting parents with application processes, and navigating language barriers (Podar et al., 2022). In addition to teachers, pastoral staff were also specifically identified as being advocates for young people and families to external agencies (Flint, 2017).

Challenges related to teachers' onward referrals were highlighted, including specific contextual factors for agencies in the UK (including waiting lists for CAMHS) (Shelemy et al., 2019a), and the bureaucracy associated with referral to services (Flint, 2017). Additionally, previous research has highlighted that staff felt they lacked appropriate information on who to make onward referrals to (Rothì et al., 2008).

2.2.7 External Supports: Parents and Agencies.

School staff identified aspects of their role related to supporting parents to consider young peoples' mental health (Beames et al., 2022; Flint, 2017). Developing relationships with parents was seen as important and prevalent, with Garside et al. (2021) finding that 86% of senior staff members reported they worked alongside parents. However, staff also reported that collaborating with parents included challenges, such as considering parents' own mental health needs, parents' stigma regarding mental health, and a potential lack of engagement (Flint., 2017).

Staff perceived their role as extending to referrals with external agencies, but appeared to believe that their support for young people ended when it was deemed a *professional* was required to be involved. This notion of specialist individuals working with individual young people is increasingly prevalent in secondary schools compared to primaries (Vostanis et al., 2013). Garside et al. (2021) highlighted that external agency involvement is widespread in secondary environments in the UK, with 90% of schools reporting support from external therapeutic services, and 57% support from voluntary agencies. Sharpe et al. (2016) highlighted the support received in over 300 schools in England from educational psychologists (EPs) (81%), counsellors (62%), and clinical psychologists (20%), with specialist and external agency support being more likely to be acquired within secondary schools compared to primary settings. This is also described internationally, with teachers in Canada expressing that their role runs alongside externals, such as social workers, and family liaison officers (Andrews et al., 2014; Dimitropolus et al., 2022). However, in their study of over 2000 teachers in Saudi Arabia Kamel et al. (2020) reported greater engagement was felt to

be required from supports in the community (over 80% of respondents), that a school psychologist must be in place (over 80%), and that there should be a hotline for additional support (approx. 79%).

Therefore, teachers and other school staff appear to report their desire for external professionals to provide support for these young people, as opposed to themselves (Iachini et al., 2015; Ibeziako et al., 2009; Stoll & McLeod, 2020). Guidance staff similarly identified that their role, despite having a pastoral focus, has limits compared to the impact of an external professional. Staff in Stoll and McLeod (2020) described welcoming support from an external counsellor, who would add to their potential offer for young people. Pastoral staffs' relationships with external professionals appear to revert to a role relating to referral (Flint, 2017; Harvest et al., 2018).

However, despite teachers feeling that the support from external professionals was outside of education staff roles, some young people do not appear to have access to such supports, especially vulnerable groups such as refugees (Podar et al., 2022). Specifically in relation to the UK, previous research has highlighted that 61% of school staff saw NHS CAMHS, and 38% of other child mental health services, as having profound barriers for mental health support, and identified they felt they did not communicate effectively with CAMHS (Sharpe et al., 2016; Shelemy et al., 2019b). Additionally, whilst studies have suggested teachers want more specific "expert advice", for example on managing mental health within the classroom, and identifying supporting resources (Rothì et al., 2008, pp. 1223), pastoral leads working in the UK were seen as fluctuating between framing external professionals as overworked and painting them as dismissive (Flint et al., 2017).

2.3 Unique Roles: Pastoral, Strategic, Senior Mental Health Lead

As previously touched upon throughout this chapter, roles of staff within education relating to mental health begin to differ with level of pastoral responsibility (Flint, 2017; Boddison & Curran, 2022). An increase in workload for education staff appears to have contributed to a

perception that pastoral staff have a unique and specific role to play in student support, due to their limited teaching responsibilities (Garside et al., 2021; Jessiman et al., 2022; Littlecott et al., 2018). Rice O'Toole and Soan (2022), using online survey and interviews, found that secondary school teachers felt that pastoral leads had a unique ability to consider all aspects of a child's development and wellbeing, whereas teachers could not take on such roles due to the demands of their workload. Approachable pastoral staff have also been described as beneficial to teachers in relation to supporting mental health (Shelemy et al., 2019b).

Pastoral leads further report that their role in supporting mental health was wider than they had initially assumed. The four pastoral leads interviewed by Flint (2017) noted that they had additional responsibility for staff mental health as well as young people, and a duty of care to protect staff from being impacted by information related to young people's mental health experiences. Similarly, pastoral leads noted that they had a distinct role in advocating for young people with staff to promote understanding of their mental health. Additionally, a pastoral lead indicated surprise that they had a substantive role in the management of colleagues.

However, roles also appear impacted by strategic responsibility. Boddison & Curran (2022) found via a survey of over 1000 SENCos that post pandemic the key focus within their role was broadening and developing their school's universal mental health offer, and developing relationships with parents to widen external support. However, alongside these strategic developments, staff still appear to value senior leadership teams' visibility and individual relationships with young people, seeing this as beneficial to young people' mental health (Jessiman et al., 2022). Senior leadership members appear to be identified as those who may take on additional responsibility for mental health, although how this occurs differs within settings. Across four case study schools in South Wales, for example, Littlecott et al. (2018) found that mental health responsibility may be held by one senior member of staff (such as an assistant head), small teams (for example, a deputy head, the school nurse, and a wellbeing lead), or as whole teams of pastoral/wellbeing staff.

Additionally, research has begun to explore the specific role of SMHLs. Mansfield et al. (2021) found that across 284 primary and secondary schools, SMHLs were reported to be engaged in: whole school mental health co-ordination (62%), collaborating with external services/agencies (46%), supporting staff training (45%), providing individual student support (44%), and teaching young people about mental health (35%). Interestingly, these roles appear to be those shared by all education staff, as discussed within this chapter, but with a greater emphasis on strategic support for these individuals, for example through staff training.

The role of a SMHL has been specifically explored in relation to those acting in primary school settings. Tonks (2022) conducted interviews with four SMHLs and one individual who identified as a wellbeing lead but had responded to the research advert as considering themselves to be acting as a SMHL. SMHLs reported feeling committed to, and proud of, their role, and presented it as fluctuating between being "hands on" (direct pupil support) and "behind the scenes" (developing strategic impact, for example policy development, PSHE curriculum creation, and acting on steering groups) (Tonks, 2022, pp. 107). SMHLs identified that the role should be filled by someone who is "best suited", for example who has skills in reflection and emotional attunement (Tonks, 2022, pp. 128). This appears to align with previous staff perceptions that to support the mental health of others, staff were required to develop skills around curiosity and empathy (Dimitropoulos et al., 2022), and to model related skills (Cefai & Askell-Williams, 2017; Dimitropoulos et al., 2022; Graham et al., 2011).

As with previous staff research, in Tonks (2022) SMHLs placed emphasis on the development of a whole school approach to mental health, supporting staff to feel mental health was a part of every colleague's role, and creating strategies to reduce mental health stigma. The role of SMHL appeared to overlap with others held by the participants, including assistant leadership, SENCo, safeguarding lead, and designated LAC teacher. SMHLs felt that being in a leadership role was important to ensure impact and change as part of their role, which they reported was increasingly vital with the impact of the Covid-19 pandemic on both child and staff mental health. This strategic oversight also appeared to relate to managing,

employing, and working alongside external professionals and agencies, such as CAMHS, play therapists, and Mental Health Support Teams (MHSTs).

As previously identified for pastoral leads (Flint, 2017), SMHLs felt that supporting staff wellbeing was a vital part of their role. Furthermore, developing a community mental health focus was also reported to be part of a SMHLs role, with a bidirectional relationship identified between supporting parents' mental health, and parents working collaboratively alongside young people with school in relation to mental health. SMHLs reported seeking and requiring formal and informal additional training to support their role, for example in trauma, attachment, and mental health.

2.4 Conceptualising Mental Health

2.4.1 Concerns about Competence.

Research has highlighted that school staff share an interest in mental health, and many consider mental health and wellbeing of central importance to young peoples' academic and personal development (Kidger et al., 2009). Over 90% of teachers surveyed within Andrews et al. (2014)'s study in Canada affirmed the notion that mental health and wellbeing is known to impact drop-out rates and learning for students in secondary school. Similarly, principals in middle schools, high schools, and technical education settings up to Grade 12 in one school district in the USA reported 80.9% felt mental health and behavioural needs represented a significant need (Iachini et al., 2015). However, within the literature staff report extensively a feeling of concern that they do not have a sufficient comprehension of mental health, for example relating to knowledge of mental health difficulties or identification (Byrne et al., 2015; Dimitropoulos et al., 2022; Rothì et al., 2008; Soneson et al., 2022; Yamaguchi et al., 2021). Only 36% of teachers in Andrews et al. (2014) reported feeling confident in understanding what mental health is. Teachers described that they can offer "superficial support"; feeling that they often had to resort to "common sense", and so were not able to give conversations in this area "justice" (Shelemy et al., 2019a; pp. 11; Kidger et al., 2009, pp. 9). This concern or doubt

is also shared by pastoral leads. Flint (2017) found that pastoral leads reported discomfort in being considered as experts, due to experiencing doubt in their level of knowledge, which in turn leads to feelings of being de-skilled and experiencing self-doubt.

2.4.2 Understanding of and Impacts on Mental Health.

Alongside these concerns of competence, in research school staff have outlined their understanding of mental health. It is important to consider that in relation to the current research proposed within this volume, many of the studies included in this section of the review are from countries with their own particular cultural contexts (including Japan, Kenya, and Saudi Arabia). Therefore, the findings from these studies may not be immediately transferable to the UK context, for example due to the vast heterogeneity across school structures and experiences of schooling across the included countries.

Teachers reported ambiguity in understanding what was meant by the term ‘mental health’ (Rothì et al., 2008), reporting previously difficulties in considering the overlaps and differences between terms such as behavioural, emotional, and social difficulties (BESD) and mental health (Rothì et al., 2008), as well as the complex nature of the term ‘mental health’ (Neill et al., 2021). Despite describing a known increase in mental health difficulties for adolescence, pastoral leads in Flint (2017) reported “shock” at the types of mental health needs experienced by young people in their care, for example their experiences of anxiety (Flint, 2017, pp. 90). However, other research has suggested that teachers may under-estimate the mental health needs of their students. Within Kamel et al. (2020), teachers estimated approximately 1.8 students per class may experience mental health difficulties (lower than the global average). Teachers in this study who displayed increased awareness of mental health were seen to identify students more effectively, and as making more further onward referrals.

Similarly, in relation to mental health disorders, Yamaguchi et al. (2021) surveyed over 600 high school teachers in Japan and found approximately 51% recognised the symptoms

of depression, 35% schizophrenia, and 78% panic disorder in vignettes. In relation to general knowledge of mental health (as assessed through a true/false questionnaire in response to items related to mental health disorders), the authors found on average a correct response rate of approximately 58%. Using the "Knowledge, Barriers and Perceived Readiness Survey" for mental health, Mulla and Bawazir (2020, pp. 650) found 74% of teachers scored below the 75th percentile (indicating a "poor knowledge" of mental health, pp. 654)

Anxiety was reported as a particular area in which teachers felt they supported young people, and as such where students experienced mental health problems, as well with areas such as bereavement, bullying, and low mood (Stoll & McLeod, 2020). Research also suggested that guidance teachers saw students seeking support in different areas as they grew older, for example older students may seek support for anxiety and low mood, and younger students for bereavement and bullying (Stoll & McLeod, 2020).

In relation to recognising mental health difficulties in young people, teachers report they may see young people appearing to find it difficult to follow rules, presenting as inattentive or withdrawn, struggling to form relationships or integrate socially, or showing a dip in their academic performance (Ibeziako et al, 2009; Rothì et al., 2008). Research has also considered young peoples' experiences of mental health internationally. Mbwayo et al. (2020) for example, conducted focus groups with teachers in three primary and secondary school settings in Kenya. They described supporting students with behaviours which presented as internalizing and externalizing in nature, as well as seeing mental health as presented through "bizarre" behaviours, hallucinations, threatening behaviours, and linked to drug use (Mbwayo et al., 2020, pp. 155). This can be seen as similar to findings by Rothì et al. (2008), where teachers were described as identifying mental health problems through a normative lens, such as how different students' behaviour presented differently to their peers. However, within the Mbwayo et al. (2020) study, teachers also reported learning difficulties as a mental health difficulty. This was also reported in research in Nigeria (Ibeziako et al., 2009).

2.4.3 Medical Discourses.

Research has further highlighted that school staff can describe mental health as framed by medicalised discourses, for example referring to professionals “fixing” young people, genetics, or the need for young people to attend hospital (Mbwayo et al., 2020; Ibeziako et al., 2009; Shelemy et al., 2019a; Yamaguchi et al., 2021).

Teachers likened mental health to physical illness, for example 70% of teachers in a Saudi Arabian study felt mental health was like an “organic disease” (Kamel et al., 2020, pp.4). Similarly, a quarter of teachers from England and Italy in Monducci et al. (2018) highlighted schizophrenia or psychosis were related to “brain disorder” (Monducci et al., 2018, pp. 459). Secondary school teachers specifically within English schools are also more likely than primary school teachers to consider medication as an option for mental health support (Vostanis et al., 2013) (although it could be posited the age of students may be an additional factor in this decision; Hopkins et al., 2015).

However, it is important to consider that teachers in these studies are responding to definitions of mental health which appear to be framed, at least initially, from medicalised narratives. In Kamel et al. (2020) mental health was described as “psychological, social, emotional, or behavioural problems that interfere with students’ *ability to function*” *(*emphasis added) (Kamel et al., 2020, pp. 2). Furthermore, Yamaguchi et al. (2021) framed mental health as specifically related to mental illness in their questionnaires. Similarly, in Soares et al. (2014), approximately 42% of teachers in Brazil agreed with a set statement that mental health was related to the “ability to be free of disorders”, yet only approximately. 6% of teachers felt mental health problems reflected the same concept as mental illness. This indicates that there may be other narratives that teachers feel relate to mental health (Soares et al., 2014, pp. 942).

2.4.4 Contextual Factors.

Additional factors were identified as being impactful upon young people's mental health by school staff. These included academic pressures, for example pressure exerted by staff due to being influenced to maintain academic progress indicators (Harvest, 2018; Jessiman et al., 2022; Neill et al., 2021; Nyguen et al., 2013), the school's physical environment (for example, the physical shape of the building), staff retention, and diversity of staff members (Jessiman et al., 2022). Wilson (2022) similarly identified that societal and specific school norms related to masculinity could also impact mental health of boys in Australia.

Additionally, teachers have identified that students may be impacted by relational and community factors (Graham et al., 2011; Ibeziako et al., 2009). Graham et al. (2011) noted young peoples' mental health may be impacted by various factors including: divorce, poverty, bereavement, difficult relationships with parents and siblings, friendship difficulties, suicide of a peer, community trauma, and violence. The most impactful factors upon mental health were identified by teachers as bullying, peer rejection, and non-effective behaviour management. Shelemy et al. (2019a) similarly found that teachers reported that students experiencing mental health difficulties experienced "unstable lives at home" and within friendship groups (Shelemy et al., 2019a, pp. 9).

2.5 Summary and rationale for the present research

As identified within this literature review, research has considered the role that school staff, namely teachers, play within supporting students' mental health. Such roles included: developing relationships with students, identification of mental health needs, participating in a whole school approach, developing curriculum, delivering intervention, referrals to external agencies, and communicating with external agencies and individuals. As staff gained increasing pastoral and/or senior responsibility, it appeared that they placed greater emphasis upon supporting their colleagues' wellbeing and development. Current research supports the

notion that acting as a SMHL within primary settings is a unique strategic role, which differs in its responsibility and perception to other leadership responsibilities (Tonks, 2022). Therefore, it is important to extend knowledge of how SMHLs working in educational settings for adolescents perceive their role, particularly in light of evidence suggesting the prevalence and impact of mental health difficulties during the adolescent years (Jerrim, 2022; Sadler et al., 2018.; WHO, 2021). Considering SMHLs' role in supporting adolescents is also imperative, as previous research has highlighted differences in mental health provision across age groups, for example primary and secondary settings (Garside et al., 2021). Additionally, it is important to consider how SMHLs believe others perceive their role, for example to assess if senior leadership responsibility is required in provisions for adolescents. This would contradict education guidance regarding the role of a SMHL, where individuals are not formally required to be senior leadership members to fulfil this role (DfE, 2023; DoH & DfE, 2017).

Furthermore, this research will also develop the understanding of education staff perceptions of mental health. Whilst previous research has explored staff perceptions relating to mental health, this has been in the context of considering set definitions of mental health, often related to medicalised discourses, across a wide variety of cultural contexts (Ibeziako et al., 2009; Kamel et al., 2020; Yamaguchi et al., 2021). Therefore, further exploration is needed to allow school staff to present their own constructions and perceptions of this construct, without external influence. Additionally, as presented in previous literature, how mental health is construed appears to be tightly woven into the necessary actions within roles, and as such should be considered within this new leadership role (Graham et al., 2011; Kidger et al., 2009; Shelemy et al., 2019b). The aim of this research will be to allow exploration of individual perspectives of SMHLs within England, as well as to consider themes which may be shared across those within this role.

Therefore, the overarching research questions aligned to this research are:

- How do SMHLs in secondary settings perceive the role of a SMHL?
- How do SMHLs in secondary settings construe 'mental health'?

Chapter Three: Methodology

3. Overview

The purpose of this chapter is to outline areas related to the methodology employed within this study. It will firstly consider the philosophical positioning of the study (including ontology and epistemology), and ethical considerations. This chapter will also present information as to the recruitment and demographics of participants, the interview methods employed, and the data analysis method (including discussion of reflexivity and research quality).

3.1 Philosophical Position

Critical realism (CR) is the underpinning philosophy which guides this research. Rather than having one unified definition, CR is considered as stemming from the works of various authors, including the writing of Bhaskhar (Archer et al., 2016; Bhaskhar, 1979; 2008). Within the following sections, consideration will be given to how CR impacts the ontology, epistemology, and methodology of this current study.

3.1.1 Ontology.

Ontology refers to the nature of social phenomenon under study within social science research (Thomas, 2017a); namely *what* one is considering to study, and the nature of its existence (Cohen et al., 2018). Ontological perspectives are often presented in research as being positioned as poles or as a spectrum, ranging from realist perspectives (the idea objects exist independently from the perspectives and thoughts of others) to relativism (the notion that truth is unique to individuals, and only specific to unique cultural contexts) (Cohen et al., 2018).

Critical realism holds a realist ontology. This is the idea that “there is a real world that exists independently of our beliefs and constructions”; objects can be considered as existing in reality, independent of our knowledge of them (Maxwell, 2012, pp. vii). Bhaskar posited a transcendental argument for reality: that reality can be considered as three layers: the

empirical (what individuals can experience through their senses), the *actual* (events which occur, which may either be known by or not known by individuals), and the *real* (causal mechanisms underlying events) (Bergin et al., 2008; Hood, 2016). Within critical realist understanding, however, it is also acknowledged that concepts such as mental states attribute to part of reality (Maxwell et al., 2012).

3.1.2 Epistemology.

As opposed to *what* social phenomenon can be considered to be, epistemology considers *how* one can learn about them (Thomas, 2017a). This is again broadly presented as a pole, between empiricism (knowledge being gained through observation of the world) and interpretivism (knowing being generated through collaborative exploration with others, for example through conversation) (Cohen et al., 2018; Montuschi, 2014). Whilst holding a realist ontology, CR adopts a constructivist/interpretivist epistemology (Maxwell, 2012). This presents a dichotomy between ontology and epistemology in CR; whilst there is an objective reality, it is "conceptually mediated" (Danermark et al., 2001, pp. 41). What we can learn about the reality of social concepts, our knowledge, is continually filtered through our own experiences (i.e. changes in the empirical level), as well as the experiences of other individuals who are often the focus of our social study (Danermark et al., 2001). Therefore, rather than having a firm focus purely on ontology, CR takes the stance that what can be known about the nature of a social phenomenon is limited by how it can be explored; the "ontological gap" (Danermark et al., 2001, pp. 22). Furthermore, what one determines about a social phenomenon is influenced by our use of tools, with one of the most important being language (Danermark et al., 2001). This perspective therefore holds that there is not purely one correct interpretation of reality (although reality itself is fixed) instead considering that context and individuals themselves can influence and mediate outcomes, and so must be acknowledged within research (Braun & Clarke, 2021a).

3.1.3 Rationale for Critical Realism.

The perspective of CR, namely the ontological gap, aligns with my personal world view relating to the nature of social phenomenon. This perspective allows the construct of mental health, therefore, to exist within the actual and real levels of reality, and independent from the knowledge that can be generated by individuals trying to learn about it. However, it is understood that what can be learned about this truth or knowledge is filtered through our own experiences, and those of others around us. Whilst this also aligns with an interpretivist epistemology, holding a CR position avoids “the inward collapse of relativism” (Danermark et al., 2001, pp. 17), where the view could be concluded that there is no objective truth or causal mechanisms.

3.2 Ethics

This research project received ethical approval from the University of Birmingham Humanities and Social Sciences committee (ERN_22-0209). Throughout this study, care was taken to adhere to the guidance within the BPS Code of Human Research Ethics (Oates et al., 2021). SMHLs were reminded of their right to withdraw from individual questions or the entire interview process, as well as reminded of their right to withdraw their data for up to fourteen days post the conclusion of their interview.

3.3 Participants

Eleven SMHLs directly expressed interest (via email) in taking part in this study. Inclusion criterion for participants included:

- Acting as a designated SMHL.
- Working in an education setting that supports adolescents (namely a secondary school, sixth form, or college provision).
- Working in a mainstream, state funded provision setting within the West Midlands.
- Having worked in their setting for over one year.

Of the 11 SMHLs who expressed interest, nine met the inclusion criterion set within this study. One individual who expressed interest was from a specialist setting, and one individual worked within a primary school setting. Of these nine eligible participants, five went on to consent to take part in an interview. The four SMHLs who did not participate reported that time demands prevented them from taking part in an interview. Interviewed SMHLs were in roles across four local authorities (LAs). It is important to note that two of the SMHLs worked for the same multi-academy trust (in two different LAs). All SMHLs worked within secondary school settings. All SMHLs have been given pseudonyms for confidentiality. SMHLs demographic information is presented in Table 1.

3.4 Recruitment

A variety of methods were used to recruit SMHLs. Emails were sent to each SENCo attached to secondary and Post-16 provisions within the researcher's placement LA; individual EPs within this LA spoke to their link secondary settings; emails were sent to SMHLs for secondary and Post-16's for the supervising researchers LA; and individuals were contacted who were known to colleagues and friends of the researcher in wider LAs. The researcher followed up all expressions of interest with emails and/or phone calls.

After a SMHL expressed interest in this study, the researcher sent via email an information leaflet and consent form for the SMHLs to read and review (Appendix 2). The researcher ensured interviews were booked at least one week post sending this information, to allow SMHLs time to consider the information, and to formulate any questions they wished to ask the researcher or the supervising researcher. Four interviews were conducted via video conferencing software (Zoom and Microsoft Teams), and one interview took place face to face in the individual SMHLs secondary school provision (as per the request of SMHLs).

Table 1.

Demographic information relating to SMHLs

SMHL	Gender	Time in Current Setting	Time as SMHL	Current Additional Roles	Previous Roles
Adam.	Male.	23 years.	Not reported.	Safeguarding Lead for secondary school. Leadership member for safeguarding and inclusion within the school trust.	Behaviour Specialist in secondary school. Leadership for residential provision for young people with social, emotional, and mental health needs.
Becky.	Female.	6 years.	3 years.	Pastoral Lead. Safeguarding Lead.	Psychiatric Nurse (children and families). Primary Teacher.
Cassie.	Female.	5 years.	Not reported.	Vice Principal.	Secondary Teacher. Designated Safeguarding Lead.
Delilah.	Female.	10 years.	1 year.	Head of Year. Wellbeing Coordinator.	Cover Teacher. Secondary Teacher.
Eloise.	Female.	2 years.	Not reported.	Assistant Principal. Designated Safeguarding Lead. Secondary Teacher.	Secondary Teacher.

3.5 Procedure

After providing informed consent, SMHLs were invited to take part in an interview (further information is provided in the semi-structured interview section). This interview was proposed to take approximately one hour and be conducted by the researcher. SMHLs interviews were scheduled via email and telephone. SMHLs were provided the option to participate in an interview either face to face or via video conferencing software (including Microsoft Teams and Zoom). SMHLs within this interview were asked open-ended questions within five areas: introduction (one question), role (four questions), training (two questions), mental health (one question), and barriers and facilitators (two questions). SMHLs also completed two activities as part of this interview (see data collection section). SMHLs were asked follow-up questions, and additional prompts, as required. The order of the delivered activities and questions is presented in the interview schedule within Appendix 3.

3.6 Data collection

Participants were asked to complete a semi-structured interview, including a diamond rank activity and externalising objects activity. Each will be discussed in turn below.

3.6.1 Semi-structured interview.

Interviews are a commonly used qualitative method within psychology research (Robson & McCartan, 2016). Interviews can be conducted with individuals, or larger groups (referred to as focus groups). In the case of this research, a focus group approach was not selected due to concerns regarding social desirability bias, with SMHLs potential to want to appear as if their role was akin to practice guidance, and similar to their colleagues in other settings. Similarly, there could have been a threat of a perceived authority figure in the group (for example, a SMHL with a greater amount of experience in a leadership role, who staff deferred to and agreed with in an overarching consensus as opposed to discussing their unique roles within their settings) (Bergen & Labonté, 2020).

Various types of interviews can be utilised to best suit differing types of research questions and depth. Structured (or fully structured) interviews, for example, are akin to questionnaire measures, seeking to only gain research related to a finite set of questions (Robson & McCartan, 2016). Alternatively, unstructured (or depth interviews) are utilised to let a participant talk freely related to an area of interest. Semi-structured interviews retain flexibility for the researcher (to following prompts), but also follow up on responses from participants. They are suggested as a method for projects where the researcher is also the main interviewer (Robson & McCartan, 2016). Furthermore, due to the dual nature of this research exploring both role and constructs of mental health, semi-structured interviews would allow for a balance of responses across these areas.

Interviews within this study were divided into questions considering the role of SMHLs, and how they construed mental health. Areas included: how SMHLs and others perceived the role; their experiences of training; their construction of mental health; and what barriers and facilitators they identified in relation to their role. A copy of this interview schedule can be found in Appendix 3. Interview questions, including activity statements (see diamond rank activity section), were initially devised by the researcher, for example by reviewing guidance documents (such as the mental health green paper, DoH & DfE, 2017), job adverts for SMHLs, and using knowledge of mental health intervention supports i.e., delivered by local authority EPS'. Interview questions were also guided by the findings from the literature review, for example asking about staff perceptions of the SMHL role was guided by consideration that staff members can perceive pastoral roles as being uniquely positioned to support both students and staff (Jessiman et al., 2022). The questions were collaboratively reviewed with the supervising researcher (an Associate Professor and Senior Educational Psychologist, whose role involves supporting SMHLs), a secondary teacher, and two trainee educational psychologists (TEPs). The interview involved a mixture of open-ended questions, as well as two activities: a diamond rank activity, and an externalising object activity. Interviews were conducted via video conferencing software and in person, with items for the specific diamond

rank activity either displayed via sharing the researcher's screen or as individual paper statements.

3.6.2 Diamond Rank Activity.

The diamond rank activity is a well evidenced tool, used within education and research (Clark, 2012; Rockett & Percival, 2002). The aim of completing a diamond rank activity is to allow individuals to explicitly name, discuss, and consider how they "organise knowledge" (Clark, 2012, pp. 223). Diamond rank activities are valued for facilitating discussion in research and making knowledge and understanding about and between concepts explicit (Clark et al., 2013). Within this current research, it was considered that utilising this activity type would allow SMHLs to begin reflecting on various purported aspects of the role, and how they may place value or importance on elements. This reflection process is highlighted to be of key importance within this approach (Clark, 2012).

A diamond rank activity involves asking individuals to organise a set of nine statements or images, often representing an array of perspectives or ideas, into a set order ranging from most to least based on a certain feature in relation to a prompt or question. Depending on the question posed, the selection process may involve ordering items in relation to features such as importance, significance, or interest (Clark, 2012). One item is ranked as most linked to the prompt, and one the least. Two items are ranked as next most linked or as next least linked, leaving three items remaining in the middle. Within this current study, this activity was used to facilitate discussion as part of the interview, as opposed to generating separate analysis.

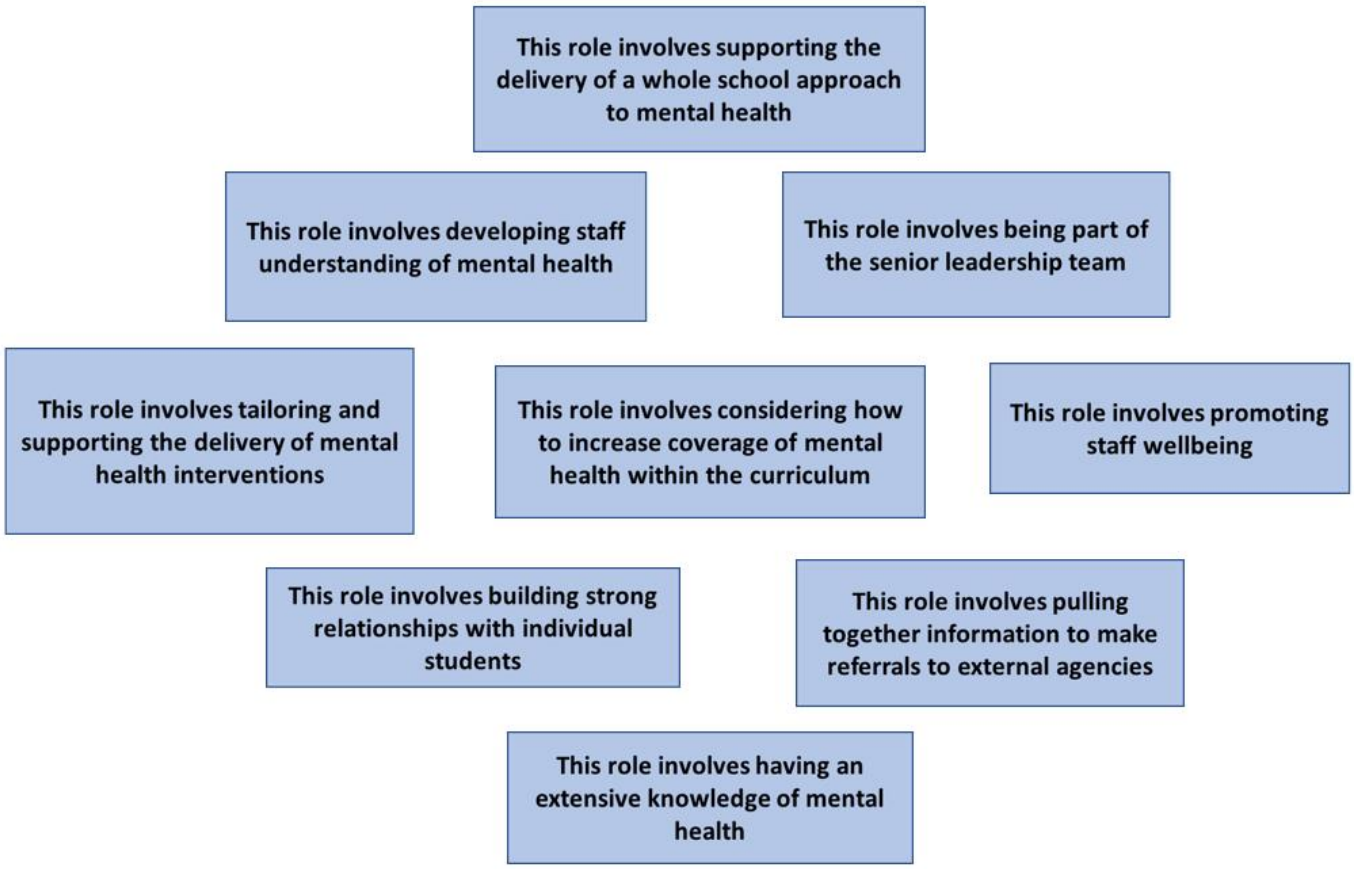
However, a potential limitation considered was that SMHLs may have viewed the statements within the diamond rank activity as definitive descriptors of their role, and not feel able to contribute their own ideas or aspects which they may have viewed as being more unique to their setting. Care was taken to minimise this risk by outlining to SMHLs that the statements were to help begin conversations, and that there may be other aspects of their role SMHLs would like to highlight or discuss.

SMHLs were asked to rank the items provided in regard to their importance in relation to the role of a SMHL.

An exemplar of the product for this ranking activity within this interview is included here for reference, as completed by *Adam*.

Figure 1.

Diamond ranking activity completed by Adam, during interview.



3.6.3 Externalising Objects Activity.

The externalising objects framework utilised in this study was adapted from previous doctoral research exploring mental health (Sangar, 2018). Within this current study, this activity was included again to facilitate discussion, and to provide an alternative questioning

approach to encourage SMHLs to reflect on the concept of mental health. Responses to this activity were analysed within the overall data analysis approach.

Externalising methods, stemming from narrative approaches, involve asking an individual to consider a construct as occurring outside of themselves (White, 2007). Within this study, SMHLs were asked to consider if 'mental health' was beside them, what would it be like in regard to both its physical and any other notable characteristics. This was intended to personify and create a near image (closely related to one's own perspective) of what mental health is for each SMHL (Carey & Russell, 2002). This externalising activity was used within this study to provide SMHLs with another lens through which to discuss a complex and nuanced topic (White, 2007). Similarly, this activity was intended to allow SMHLs to reflect on what mental health meant to them personally, whilst also encouraging through greater separation from the construct, the individual space to consider the impacts of wider social discourses on their construction (Carey & Russell, 2002).

The decision was taken to engage in a purely conversational discussion, as opposed to any additional activities (such as drawing or creating extended stories; Legowski & Brownlee, 2001), within the externalising objects activity, with this verbal information captured and explored within the subsequent data analysis (see relevant section). This could be considered to have impacted upon the richness of data gathered, for example if a SMHL had found it easier to convey their ideas in an alternative format. However, it was considered that adults may find this type of activity too far removed from their typical conversations with other adults, and this may actually have reduced engagement.

3.7 Data Analysis

Remote interviews were recorded via Zoom and Microsoft Teams, with both audio and visual information, whereas the face-to-face interview was recorded using a Dictaphone by the researcher. The researcher then transcribed using the audio from these recordings. Interviews ranged between 23 and 57 minutes, with an average of 40 minutes.

Before selecting reflexive thematic analysis (RTA), I also considered the use of interpretative phenomenological analysis (IPA) and grounded theory (GT). IPA involves in-depth examination of individuals experience, looking firstly within each unique case for meaning and themes, before considering links across cases. Focus of analysis is on unique individual experience, as well as the use of language, and role of metaphor in highlighting experience (Braun & Clarke, 2021b). This approach was not subsequently used as the focus of this research required a significant focus on shared experiences across SMHLs within the wider educational context, in order to align with the philosophical perspective informing this study, but also due to a desire to inform how SMHLs roles may be best supported through future actions (Braun & Clarke, 2021b).

As with IPA, GT as an overarching analytic method represents various analytic strategies. In the current study, I had considered utilising GT with theoretical sampling, to interview first one SMHL and then recruit subsequent individuals in the same process to further the building ideas within the analysis. Progressing from open coding (for example, line by line coding), through various levels, the aim would be to generate an overarching category which encapsulates all aspects of the developed GT, with related categories as required. From this, an overarching theory would be produced (Braun & Clarke, 2021b). I decided not to utilise this approach due to the dual nature of the research questions (role and concept), which required in depth discussion of each area, as opposed to unifying into an overarching theory. Additionally, the focus of this research was not on a specific social process, which is often recommended for GT (Braun & Clarke, 2021b).

To promote the methodological integrity of this research it was important to select an approach which was able to be aligned with the critical realist ontological stance and research questions identified within this study (Levitt et al., 2017). RTA focuses on considering and exploring individuals' sense making about their experiences whilst also allowing patterns and themes to be drawn across interviews (Braun & Clarke, 2021b). There also remains an understanding in RTA that the researchers' perspectives cannot be dismissed from the

analysis, as their “research values, skills, experience and training” all impact upon the data garnered (Braun & Clarke, 2020, pp. 39; Braun & Clarke, 2021b). Furthermore, RTA aligns with qualitative research values which perceive knowledge as having been shaped by and as situated within certain contexts (Braun & Clarke, 2021b; Clarke & Braun, 2013).

As described by Byrne (2022), a mixture of both deductive and inductive analytic approaches were used within this current analysis. Deductive analysis elements were included to scaffold the inductive coding, meaning inductive analysis occurred within the broad areas of the interview: role, training, mental health, and barriers/facilitators. This ensured that “open-coding contributed to producing themes that were meaningful to the research questions” (Byrne, 2022, pp. 1398).

The stages of RTA engaged in during this analysis are outlined in the table below. However, it should be noted that these stages are flexible, and therefore several iterations occurred within stages (for example, within developing and reviewing themes) (Braun & Clarke, 2021a).

Table 2.

Six stages of RTA (adapted from Braun and Clarke, 2021a, pp. 35, and Braun and Clarke, 2021b).

Phase	Notes
Familiarisation and notes	Interviews were transcribed verbatim by the researcher from audio files. To ensure familiarisation, transcripts were read through in entirety twice following transcription. On the second read through, notes were taken of initial thoughts and ideas. Examples of notes include: • Normalising mental health conversations. • SMHL role not known to students. • Systems around children need to support parents.
Systematic coding	Initial codes were created using NVivo 12 software. Examples include: • Wellbeing captures positivity. • Being the face of wellbeing. • Flexible external agency support.
Generating initial themes	The researcher generated initial themes by clustering codes into overarching groups, within the four areas of the interview identified: role, training, mental health, and barriers/facilitators. Codes which did not appear to fit into themes were retained.
Developing themes and reviewing	Themes were iteratively reviewed, to ensure themes captured overarching concepts, and that there was no overlap between themes. Sub-themes were developed which were associated with individual themes.
Further refining themes, creating definitions, and naming	The names of themes were reviewed to make sure they felt reflective of the content, as well as engaging. Themes further reviewed and refined during supervision with the supervising researcher. SMHLs were invited to participate in a virtual session to review the generated themes. No SMHLs responded to this invitation.
Writing up	The findings from this analysis were incorporated into thematic maps and written up within this thesis.

3.7.1 Reflexivity.

Reflexivity is an important consideration throughout the entirety of the research process. It relates to consciously, critically, appraising one's thoughts, beliefs, and judgements about how who we are, and how this may guide our actions or impact the broader research process (Jamieson et al., 2023). Throughout this current study, I have used reflexivity to guide my actions, and have included in this section specific examples.

When considering exploring the views of SMHLs, I spent time reflecting on whether by speaking to adults likely in a position of leadership, I was not allowing space for the voices of children and young people themselves to be heard. However, in collaboration with the supervising researcher, we considered that the lack of research conducted with SMHLs (in a new and developing role), made it vital that their voices were also heard within research.

Additionally, I considered whether I was the right individual to undertake this research. For example, educational psychologists (EPs) are often associated with mental health support in secondary schools, and as such this may impact SMHLs responses. However, I reflected that my service was not involved in SMHL support directly, and I would not have an established relationship with SMHLs in other authorities. Yet, as part of my role, I did have a relationship with several senior leadership members, SENCos, and teachers, and as such I felt I would be able to understand their experiences. This, I felt would reduce feelings of me 'othering' the SMHLs (Jamieson et al., 2023).

During the recruitment process, I was also put in contact with, through a third party, the SMHL for the secondary school that I had attended as a young person; this SMHL then participated in the study. Additionally, during another interview, I became aware that the individual I was interviewing had been a secondary teacher at the secondary school I had attended as a student. At the end of the interview, I confirmed with the SMHL that we had been in the school at the same time, and they felt happy to retain their data within the study. During both of these interviews, I had to be aware of my own experiences at the school (for

example, I had perceived a lack of mental health support for students when I was at school) and ensure that I retained this awareness of my own perspective during the data analysis phase also, to avoid my own experience not allowing space for the consideration of perspectives of the SMHLs themselves.

3.7.2 Research Quality.

Throughout this study, steps were taken to promote the quality of the generated research. As previously discussed, care was taken to consider which analytic method would closely align with the ontological and epistemological positioning of this research (Braun & Clarke, 2021b). Due to the CR frame of this research, it would be inappropriate to consider factors such as reliability, validity, and replication, which stem from ideas within a positivist orientation (Willing, 2013).

The decision was made to utilise criteria associated to reviewing psychological research which align with the philosophical positioning of this research. Therefore, Yardley's (2000) criteria for considering the trustworthiness of qualitative research were utilised. These are presented in Table 3.

Table 3.

Criteria considering the research quality of qualitative research (Yardley, 2000)

Criterion	Addressed within this study	Potential limitations
Sensitivity to context	Consideration was given to relevant legislation and guidance, which are important for understanding the context in which this research was conducted. A thorough literature review was conducted to ensure that the current studies research questions were able to extend upon existing research. All SMHLs interviews were transcribed verbatim, and inductive analysis occurred within a deductive analysis frame, to ensure a sensitive exploration of SMHLs views and ideas. Ethical considerations were presented, including a consideration of my relationship as a trainee educational psychologist to SMHLs (considering status, and role relationships).	Existing research included relied upon international research (especially in relation to understanding of mental health). This may not represent the context in which this research was conducted. Possible research may not have been included within the literature review, potentially due to the research terms, and difficulty accessing grey literature.
Commitment and rigour	Interview questions were reviewed with the supervising researcher, who has experience in supporting SMHLs, by a secondary school teacher, and by trainee educational psychologists. Reflexivity was considered throughout the research process (see reflexivity section). After consideration, RTA was selected as an appropriate analytic technique (see discussion within research analysis section). Supervision was used to consider the interpretation of themes.	Interview questions were not reviewed by a SMHL, due to difficulties related to recruitment (further considered within the discussion section). Although SMHLs were offered the opportunity to reflect upon the themes generated, SMHLs did not respond to an invitation to do so. Due to time constraints, a second opportunity was not offered. This could mean the themes are influenced more by the experience of myself as the researcher, than those of the SMHLs themselves.
Transparency and coherence	Clarity in methods included within the methodology section. Clarity in	Full transparency (including all theme iterative stages)

	the analytic method used is provided in Table 2. Initial notes (from familiarisation) and screen shots of initial codes for SMHL role coding (from NVivo files) are included in Appendices 4 and 5, to demonstrate the nature of initial coding (with the largest area of codes as an exemplar). Themes were presented in the results section with sufficient detail, and illustrative quotes. Discussion clearly considered links to research, as well as the researchers own reflections (considering bias).	were not possible to capture (due to the iterative nature of these changes).
Impact and importance	The impact and importance of this research is considered within the rationale of this research and Chapter 1; for example the importance of understanding students mental health and the experiences of school staff. The importance of this research within educational psychology is further considered within the discussion section.	

Chapter Four: Results

4. Findings

4.1 Themes

As described within the data analysis section, within this chapter the themes generated are presented in relation to relevant interview sections. Themes are presented within thematic maps, with overarching themes and related sub-themes. Three of the theme areas (SMHL role, training, and barriers and facilitators) relate to the research question “how do SMHLs who work in secondary schools perceive the role of a SMHL?”. The final theme area (mental health constructs), relates to the research question “how do SMHLs construe ‘mental health’?”.

4.1.1 Senior Mental Health Lead Role.

The following themes are related to areas within the role of a SMHL including: role identity, pastoral and supportive, strategic, and learning and development. Both of the themes role identity and strategic contained 4 sub-themes, with both pastoral and supportive, and learning and development containing 3 sub-themes. A thematic map is presented in Figure 2.

Figure 2.

Thematic map displaying themes and sub-themes generated in relation to areas of SMHL role

4.1.1.1. Role identity.

This overarching theme related to SMHLs describing ways in which their SMHL role identity was viewed (by themselves and by others).

4.1.1.1.1 Balancing multiple busy roles.

Balancing multiple busy roles captured the notion that being a SMHL involves balancing many responsibilities (within the SMHL role and across roles within school). Eloise, for example, highlighted the difficulties of having multiple roles and responsibilities within the school setting:

"*Time can be difficult sometimes, so I still teach, so I'm a senior mental health lead, I'm a DSL, I, I still teach eleven hours a week and I do duties and things like that so, but sometimes obviously it's about managing isn't it*".

Other comments related to the challenge experienced in combining the SMHL role with additional responsibilities, for example due to the lack of financial incentive to solely

hold the responsibility of SMHL, which in turn creates additional pressure upon staff. Adam for example commented:

"Because the level of responsibility to the additional small incremental pay is […] too scary people don't want it, so we wrap it up as a position, a senior position within the school".

However, Becky noted that she felt able to manage the balancing act of responsibilities:

"*I'm quite good at knowing what I can take on and what I can't".*

4.1.1.1.2 Face of wellbeing.

The sub-theme **face of wellbeing** highlighted comments made that a SMHL was seen as the visible advocate for mental health support within the school, by both staff and students. Cassie, for example, highlighted in relation to students:

"I have [laughs] you know I have that reputation in school when I walk in it's oh […] whose upset now".

Becky similarly notes that staff also view the SMHL as the face of wellbeing support:

"As soon as mental health comes into a conversation or crops up […] then I get alerted. Now for some people that's [Becky'll] sort it out, and for other people that's […] can you offer some advice".

4.1.1.1.3 Promoting change through leadership.

SMHLs described mixed views relating to whether being part of senior leadership was important to their role identity and promoting change.

One view, as encapsulated in this quote by Adam, highlights the status afforded to SMHLs who are part of senior leadership, and the impact this has on staff engagement with mental health initiatives:

"Because of my roles as safeguarding lead […] you automatically tend to have that level of respect given to you, because of your title and status […] if I was a, I hate using this but a norm-, just a senior teacher in the school with that, would that be the same".

Delilah, however, did not agree that senior leadership was a key part of the SMHL role:

"Cause I don't think it needs to be essential, I feel like there could be a me that's not a Head of Year".

4.1.1.1.4 Part of a team.

SMHLs described that they did not work in isolation, and instead saw their role as being a member or part of a wider team. SMHLs noted teams which supported their work included a *"mental health support team"* (of over 20 school staff who work with young people; Becky), *"peer mentoring"* teams (of sixth form students; Becky), and *"committees*", for example to lead on assemblies and signposting (Eloise). Delilah for example noted that she is part of a wider wellbeing team within school:

"She [senior leader] oversees wellbeing, but it doesn't mean she needs to do all the work, like it could be work in a team and I work alongside her […] so having her to sound things off on and work as a team".

Eloise similarly emphasised her role as involving being part of a wider team:

"But as you can imagine when you work as a team, there are some in my team who children go to instead do you know what I mean so it's not just on me".

4.1.1.2 Pastoral and supportive.

This theme captured information shared by SMHLs about the pastoral and supportive elements of their role.

4.1.1.2.1 Previous experience in supportive roles.

SMHLs shared that their **previous experience in supportive roles** had contributed to their appointment as SMHL. This included roles such as psychiatric nursing, running an alternative provision focused on supporting children's mental health, and pastoral roles within schools. Becky for example noted:

"So as soon as everybody found out about my experience and expertise, I suppose I was asked to take on additional responsibilities in school when I originally came around wellbeing […] and then under the banner of senior mental health lead".

4.1.1.2.2 Relationships and support to students and families.

SMHLs highlighted that their role involved developing relationships and offering support to both students and families. Cassie, for example, commented on her role involving direct support for children in her school:

"*So sometimes I'm at the coal face so I will be working with children directly, making things like toolboxes if they're self-harming*".

In regard to providing support to families, this was discussed both in relation to working directly with families to support young people, and in providing opportunities for family engagement (such as family fun days and parent workshops). Cassie for example commented:

"And [I] will be that bridge with parents, so sometimes my role is sitting down and explaining that their son or daughter wants to be known by a different name or pronoun".

Whereas focusing on wider parent engagement (primarily through workshops and signposting), Eloise reported:

"I know we're a school […] but ultimately it's the parents who need the support, and it's the parents who need the knowledge, because they're the ones who are living with these children […] it's actually about educating parents or showing parents how to get support […] I see that as a big part of my role".

4.1.1.2.3 Safeguarding overarches mental health.

SMHLs commented on their responsibilities in relation to safeguarding, for example through their additional role as a DSL. SMHLs also discussed how the area of safeguarding has responsibility (both explicitly and implicitly) for mental health support. Adam, for example, reported:

"I need to know that safeguarding runs through everything we do, so even when it comes down to the mental health lead, I will still always have safeguarding as my main focus within that […] we do an awful lot of training, and by training, I mean wider safeguarding, we have done sessions on the importance of mental health".

4.1.1.3 Strategic.

This theme considered the strategic responsibilities described by SMHLs. This considered wider level strategy (for example, for culture and whole school planning), and day to day responsibility for managing systems and processes delivered within school.

4.1.1.3.1 Establishing a supportive culture.

Developing a supportive culture related to developing an overarching ethos of support within school, as part of a unified, whole school approach. This was achieved through creating a facilitative environment (for example, displaying information around the school, and using open door policies), embedding ideas in the curriculum, and staff training. Adam for example, commented:

"We need a very fluid, flexible, and real approach […] our kids need to see it, touch it, smell it and know it's real so we have to keep, have to keep revisiting, revisiting, and in lots of different ways".

However, it is important to highlight that this culture development from SMHLs was framed around student support primarily, as opposed to staff. This was not because SMHLs felt staff wellbeing was unimportant, but due to either staff wellbeing being provided in an alternative format, or due to the pressures of delivering student support. Cassie, for example highlighted the disconnect between the creation of this culture for students as opposed to staff, as she highlighted that although she hosts a weekly staff gathering to support staff wellbeing, staff wellbeing does not fall within SMHL responsibilities:

"For me it's the children's needs, staff we just have to manage".

4.1.1.3.2 Audit and planning.

SMHLs noted their role in relation to co-ordinating whole school audits and planning. This included meeting with governors to plan, completing wellbeing audits, and writing mental health strategy. Eloise also noted another aspect of audit and planning related to reviewing the curriculum:

"Making sure that I meet with the PSHE co-ordinator every half term to look at what's been delivered […] for example there was some self-harm sessions that were delivered that seem to have triggered children a little bit, and I'm looking at that, how it was delivered".

4.1.1.3.3 Internal support systems.

SMHLs described their responsibility for co-ordinating and managing internal support systems, for example by triaging young people for direction to the most appropriate support within school. Delilah, for example commented on the responsibility of managing a newly introduced internal triage system:

"They know I have to like hold the waitlist […] And now being able to actually assess need, what's really good is I'll sit down with [wellbeing co-ordinator] and do her timetable, I'll sit down with [mental health advisors] and I'm sort of managing all the people that are within those teams".

SMHLs appeared to position themselves as gatekeepers in relation to this role, although the responsibility was shared with others. For example, Delilah also expressed:

"They see me as the person [laugh] very much to grab and go "oh I need to refer to and so" […] and I'll be like pop it on the form […] and they're always saying to me please it's really urgent can you just pop this person on so and so's caseload."

4.1.1.3.4 Engaging with external professionals and agencies.

SMHLs were also described as needing to engage with external professionals and agencies, to co-ordinate existing support. Cassie for example, commented:

"So we then employed a mentor to do some positive steps with the children […] she's brought in a trainee counsellor for me […] [counsellor] and I meet every Tuesday morning"

Similarly, staff reported it being the role of SMHLs to engage agencies in conversations to increase support available for students. Adam for example, reported:

"This year's task has been to go where nobody's been before and try and engage CAMHS in conversations and do really risky, darey things like that".

4.1.1.4 Learning and development.

SMHLs commented on areas of learning and development which they hold important in their role; for students, staff, and for themselves.

4.1.1.4.1 Co-ordinating mental health education.

SMHLs reported that their role involved developing a universal offer of mental health education (including school delivery and signposting), as well as student engagement

opportunities. This included engagement in assemblies, peer mentoring sessions, and the PSHE curriculum more widely. Adam, for example highlighted the variety of ways this engagement occurs:

"So anything from assemblies, snap shots, things out in form, mind to be kind, time to talk".

Eloise also highlighted a shared view about making this education relevant and up to date:

"*Sometimes it's about the up to date, so you know, so like this Andrew Tate […] and all the misogyny well that's obviously having an effect on wellbeing and mental health as well [….] so again it's adding, adding things in as well when that needs to be promoted or you know being educated really".*

4.1.1.4.2 Staff training and knowledge.

SMHLs discussed the importance of their role in relation to developing staff training and supporting staff knowledge. Becky, for example illustrated:

"Just making sure that people are able to be equipped to be able to go and tackle some of those things themselves, and have the confidence to do that, so I do a lot of coaching and working alongside people".

Eloise also similarly highlighted:

"Yes because [staff are] the ones who need to know how to support and guide […] I think you know I have to put that, make sure that training happens for staff, so that staff are aware to spot and report cause […] they're the ones who are working with the children".

4.1.1.4.3 About understanding and learning, not knowledge.

Finally, SMHLs highlighted that the SMHL role was about understanding children's needs, being empathetic, and having a commitment to learning more, as opposed to needing to enter this role with an extensive level of knowledge. Adam, for example commented:

"I'm not there to treat them am I, I'm not trying to be a psychiatrist and say, or a psychologist […] I need to be able to identify it […] I just need to know that you'll be looked after and we'll, we are here for you and you know you're not alone".

Delilah also highlighted:

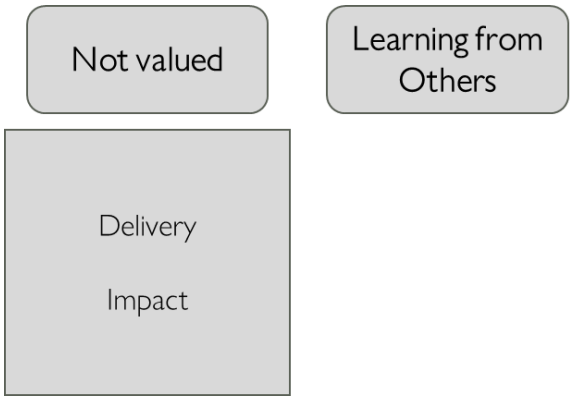
"I think that to have an extensive understanding I think that is important, but again something you can grow within the role, so like I've opted to attend like a foetal alcohol course, and any opportunities where I'm like oh I could understand a bit more […] it doesn't stop me being able to do that job".

4.1.2 SMHL Training.

The following themes related to experiences gained in attending official training courses (for which government funding was provided), aimed at learning more about the SMHL role. Experiences of training vastly differed, for example between a series of shorter sessions delivered virtually across approximately two weeks, and a six-month course offered by a university. The thematic map is presented in Figure 3.

Figure 3.

Thematic map displaying themes and sub-themes generated in relation to the area of training



4.1.2.1 Not valued.

When describing training experiences, SMHLs highlighted predominantly negative experiences. These related to issues identified with the delivery of the training, and a lack of impact subsequently upon the school environment.

4.1.2.1.1 Delivery.

SMHLs reported concerns related to the delivery of SMHL training. Factors included the content of the training, and delivery by providers. Becky, for example, reported generally in relation to the training:

"I don't think anybody's got this right and I've spoken to a lot of people who've done a variety of these courses, the DfE have a fantastic habit of just throwing […] money at stuff, and not quite getting that right […] when I started look at what people would provide for the nine hundred quid it was going to cost, it was rubbish, you know absolutely dreadful".

The virtual delivery of some training sessions, and the size of cohorts, was also highlighted, for example by Cassie:

"It was huge, it was all virtual which I don't always find I particularly enjoy […] and there were many, many schools on there".

However, it should be noted that another SMHL (Delilah) was positive about the virtual delivery of training:

"*The training was virtual online, and that was really good".*

4.1.2.1.2 Impact.

SMHLs also reported that they felt there was a limited impact of the training on their own practice and settings. Cassie, for example, reported:

"I don't want to appear critical of the courses that were offered by the providers around mental health, but they didn't really tell me anything I didn't already know, and they didn't give me that support I was hoping they would".

Becky, in relation to the wider school impact, reported:

"Is there any value to us as a school, yes a little bit, and it's given me you know, I was able to present things back to our SLT and governors, are we changing any of our practices, hmm not as a result of that, no".

4.1.2.2 Learning from others.

A positive element, and a further desired element of training, reported by SMHLs was the opportunity to learn from others. This was noted as having occurred in the training sessions themselves, and also in other places, such as in SENCo supervision groups. Delilah, for example commented the benefit to:

"Get ideas off other people […] the networking of other schools was really, really good".

Eloise similarly commented about a SENCo meeting:

"We found that useful because it was listening to other schools, about what they do […] it was quite interesting how they do it and I think that's probably what I'd like to see more of is probably about tying it all together".

Becky highlighted how her training experiences had supported her to learn from others through reviewing research:

"There was a lot of Canadian elements to it in terms of their practices […] I really enjoyed that because actually some of it was quite innovative, and I hadn't heard of it".

4.1.3 Barriers and Facilitators.

During the interview, SMHLs also reflected upon barriers and facilitators they had encountered in their SMHL role. Both themes related to barriers and facilitators contained four sub-themes. A thematic map is presented in Figure 4.

4.1.3.1 Barriers.

Figure 4.

Thematic map displaying themes and sub-themes generated in relation to the area of barriers and facilitators.

4.1.3.1.1 Inability to access support.

SMHLs discussed they were unable to access additional support for students, either due to a lack of capacity, financial pressures, or an inability to engage with certain services. Eloise, for example, highlighted:

"*Schools ain't got that money […] we're expected to do all these things now, but we're not given any resources to do it […] but when it's […], when it's actual you know clinical depression I think they need to have specialists".*

4.1.3.1.2 Part of my role, not my role.

HLs also reported the challenges faced by the SMHL role itself containing a variety of responsibilities. This wealth of responsibilities led SMHLs to consider that the role could be considered as a full-time position, despite the SMHL role often being held by staff with a number of additional responsibilities within school. Adam highlighted, for example:

"The bit that worries me […] would be do I really have the time to commit to it as much as I want, no, no I don't […] I could see it being a full-time job […] when it's part of my job, it's part of my job, but it's not my job".

4.1.3.1.3 Societal impacts.

SMHLs reported impacts upon students' mental health that were beyond the school environment, instead influenced by communities and wider society. These included: the current cost of living crisis, deprivation within communities, domestic violence, Covid-19 experiences, and cultural differences in families' responses to mental health. SMHLs highlighted that these experiences exacerbated the mental health difficulties experienced by young people and could be outside of the SMHL's ability to influence.

"*We're crashing and burning into a lot of deprivation in terms of the cost-of-living crisis again, which again is going to impact, a lot of the children are caring for parents in the family*

who have got mental health issues themselves that are going undiagnosed, untreated, that are then impacting on them as well, so it's on a second and third generation that we're not getting to".

4.1.3.1.4 Staff understanding and capacity.

SMHLs reflected on a barrier to their role being other colleagues not feeling skilled enough or having a limited capacity to engage in mental health training or practices. Cassie, for example highlighted:

"I don't know how other teachers would have managed it, you haven't got the time, and plus it's having the headspace […] I think you have as a teacher, you're spinning plates".

4.1.3.2 Facilitators.

SMHLs highlighted a number of factors which promoted their ability to engage in their role as a SMHL.

4.1.3.2.1 External agency support.

External agency support was identified as a feature which supported SMHLs to support their students. Delilah, for example, noted:

"Yeah the connections with all the different external agencies […] I think we're quite lucky that we have enough trained people who come into school".

SMHLs identified that there was a variety of options available which had been developed to support student mental health (proactively, as opposed to reactively in the face of a crisis), including opportunities for SMHL training and development. Adam, for example reported:

"You've got the newsletters […] the reminders about training […] there's loads that you can access".

Adam also highlighted that he felt there were agencies *"listening"* and that there were "*other doors opening*" in regard to increasing external agency support.

4.1.3.2.2 Utilising existing resources.

SMHLs identified existing resources within their settings which supported the delivery of aspects of their role. This included: budget, existing links with external agencies, developed PSHE curriculum, relationships between staff and families, founding ethos of supporting mental health in the school, senior leadership knowledge of LA through previous roles, and non-teaching staff. Delilah, for example, commenting on the existing PSHE curriculum illustrated:

"Cause it would have been one of the changes I made, but these were [an internal triage system] the changes I implemented cause that was already in place, so I suppose it's not that it's not a priority, I just felt like it was ticking along".

4.1.3.2.3 Covid increasing profile.

SMHLs discussed that whilst the Covid-19 pandemic had caused other difficulties, it was in one way a facilitator in relation to their role at school, as it had increased the profile and importance mental health was afforded. Eloise, for example, reported:

"Because of Covid obviously a lot more's been done and spoken about mental health […] the big positive from it was how [mental health] became a forefront again do you know what I mean in terms of people trying to push and lots more was talked about".

4.1.3.2.4 Caring and understanding colleagues.

Finally, SMHLs identified that a facilitating factor for their role was the caring and understanding nature of their colleagues across all levels within school. This related to caring towards their own role as SMHLs, as well as their care and compassion towards student's experiences of mental health. Becky's comment appears to encapsulate this theme:

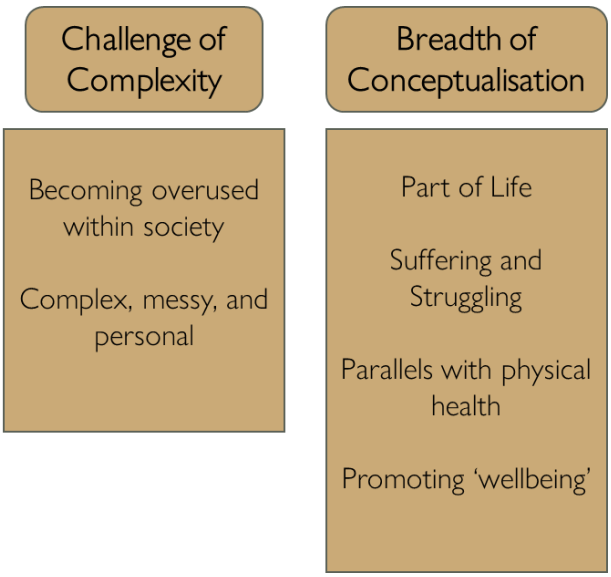
"People being naturally enthusiastic about finding out more, researching, supporting in different ways, offering their support, volunteering".

4.1.4 Mental Health Constructs.

In relation to the second research question, SMHLs were also asked multiple questions related to how they construe the concept of 'mental health'. In regard to this area, two themes were generated. Firstly, the theme 'challenge of complexity' described the difficulties of conceptualising mental health and contained two sub-themes. Secondly, 'breadth of conceptualisation' contains four generated sub-themes, each focused on a way of conceptualising mental health portrayed within SMHLs responses. A thematic map is presented in Figure 5.

Figure 5.

Thematic map displaying themes and sub-themes generated in relation to the areas of mental health and conceptualisation.



4.1.4.1 Challenge of Complexity.

SMHLs reflected that understanding the nature of mental health was a challenging feat, due largely to the lack of consistency of terminology, the misuse of the concept within society, and the personal nature of the mental health experience.

4.1.4.1.1 Becoming overused within society.

SMHLs reflected that the term 'mental health' has become overused within societal discussion, to the point where normal human experience is labelled as experiencing mental health difficulties, and the experience of those who do have challenges related to mental health are minimised or not "heard" (Delilah). Adam, for example, highlighted:

"It's probably not politically correct to say, I worry that it gets very much overused, it's become a bit like bullying, if a child says to another child shut up then the parent comes in and says my child's bullied […] it's a bit like this you can have low mental health that lasts for no more than they were sad that night at home and the parent's bringing them in saying they've got poor mental health, because it's so spoke about".

4.1.4.1.2 Complex, messy and personal.

SMHLs described 'mental health' as being complicated entity, with no clear definition. Adam, indeed, described mental health as being invisible:

"It doesn't have any shape or form […] so you can never, you can never try and, put in place, what that equates to".

Mental health was described as an entirely personalised and specific concept to each individual, increasing its complexity. Becky for example commented:

"*I think you know each and every one of us would be describing mental health using a personal, you know sort of representation, so it would be ever changing, being completely specific to each person".*

This personalised and complex entity discussion also aligns with narratives around confusion and tangled webs described by SMHLs. Cassie and Delilah both used narratives around a tangled-up complexity, or "*big jumbled up mess"* (Delilah), for example Cassie compared mental health to:

"That Mr Man who walks around and he looks like a ball of wool, and you've got to untangle him all".

4.1.4.2 Breadth of Conceptualisation.

The following overarching theme encapsulates the breadth of mental health conceptualisations illustrated by SMHLs. Whilst these categories can be considered as exclusive to each other, they are not discordant (and as such, multiple conceptualisations could be held at one time).

4.1.4.2.1 Part of life.

SMHLs described 'mental health' as being a normal part of everyday life. Mental health was described to be fluctuating (from positive to negative) consistently, and just *"how we all think and how we all function and it can affect our emotions obviously"* (Eloise). Delilah, for example, described mental health as:

"I think we need to do more to educate people that mental health is a norm-, everybody has mental health".

Eloise similarly highlights the changeability of mental health as part of *"normal"* experience:

"I think it's important that we're teaching young people that actually this is nothing to be embarrassed or ashamed about, it's normal, it's normal, […] we have periods where our mental health is good, and sometimes its not".

4.1.4.2.2 Suffering and struggling.

However, as well as the concept of mental health being a part of life, SMHLs also highlighted that 'mental health' to them was represented by suffering and struggling; *"I could be on the floor mentally and thinking this is horrific"* (Adam). In this conceptualisation, mental health was presented as something which could be frightening, such as the *"silent assassin"* image presented by Adam. Cassie reported, for example, when describing mental health visually:

"It would be a really bright colour because it's so clearly obvious that many of our children are unhappy and suffering […] it looks like self-harm".

Eloise presented it as being positive that she had not had to experience mental health challenges:

"I've been fortunate really not to have suffered with proper mental health issues does that make sense, so I probably don't know, I know lots of friends and family who have struggled […] I've been very lucky touch wood".

4.1.4.2.3 Parallels with physical health.

SMHLs presented parallels of mental health with physical health. This related in part to how our biology contributes to mental health. Delilah, for example illustrated:

"We need to keep our mental our brain health and I'd love for society to sort of see it in that way, and then understand that it would become-, be as I said if we have a headache we take ibuprofen, you have different levels of illnesses like physical illnesses […] we've also got that with our mental health as well, but everybody has a brain health that's why it's called mental health".

However, physical health and biological language was also used to stress the importance of mental health being part of overall 'health'. Becky, for example, commented:

"It [taking time off for mental health] won't be frowned upon, and it'll be look at you know as it, as it would be if you had flu or a chest in-, or a chesty cough or whatever it might be".

4.1.4.2.4 Promoting 'wellbeing'.

Finally, SMHLs discussed the view that rather than considering 'mental health' generally, instead a focus should be placed on only the notion of *"good mental health"* (Adam), *"wellbeing"* or "*emotional health*" (Becky). A focus was placed on considering how to promote wellbeing and trying to consider positives. Eloise for example highlighted:

"We try and use the phrase wellbeing more than mental health, we've stopped […] we've sort of stepped away a little bit from mental health and really talk about positive wellbeing".

Adam, similarly, noted:

"See we're talking about mental health, and […] the thing that we try to deliver here is to talk about health […] what would make good mental health, instead of pointing out the bad".

4.2 *Externalising Objects Activity*

Whilst the analysis for this study primarily focuses on thematic analysis, the described imagery from the externalising objects activity is included in the table below for additional information.

Table 4.

Externalising objects activity descriptions by SMHL

SMHL	Quotes
Adam.	"So, for me it's exactly as it is now, I can't see it, I can't smell it […] I can't touch it, so to visualise it that's my visualising of it […] it's almost like the silent assassin […] if I described to you this big black fog that came screaming in great because when it comes I'm running, cause I know it's coming, so I can't visualise it because to me it's unseen, unknown […] doesn't have any shape or form and it doesn't have any vision or sight, it tends to be that you only see that when there's an actual erm problem occurred through it, so, so, by the time its then affected you […] I will be what you see"
Becky.	"I can answer that to an extent, but, it depends on how you're viewing mentally health really […] so for many people that answer would be a dark shadow, or a dark cloud, or whatever it might be, and of course that's right isn't it, if you're in that place of feeling […] because I think it's actually very specific to somebody and their mental health […] so I can't, I'm not going to answer for that"
Cassie.	"It's so many different things […] it's such an absolute erm tangle [...] you know that Mr Man who walks around and he looks like a ball of wool […] and you've got to untangle him all […] so for me it would look like a big jumbled up mess because it's really hard to find, to work out, it would be a really bright colour because it's so clearly obvious so many of our children are unhappy, and suffering […] so a big jumbled up mess".
Delilah.	It's a bit of a personal opinion […] I would say it shows us somebody screaming and shouting but that's not the truth and, I think we need to do more to educate people that mental health is a norm-everybody has mental health" […] it's a ball of confusion […] a big sort of big ball of confusion […] it might look like somebody screaming and shouting […] but it could be silent as well […] that's what other people see"
Eloise.	**"**That's quite a hard one innit, I mean it depends on what you mean […] so I don't know if I could answer that very well […] I just think it's very different for different people […] some people you can see they can give physical symptoms […] I think mental health it can be a disattachment […] they are present in the room but not […] their minds somewhere else […] some present very differently and emotional and crying […] but I find sometimes where the kids are, I worry about most are the ones that just seem that they're […] here in person but their minds elsewhere"

Chapter Five: Discussion

5. Purpose

The aim of this chapter is to present an overview of the findings from this study, as well as to consider their associations with government guidance and previous research. Strengths and limitations of the study will be explored, alongside links to school setting and EP practice, alongside opportunities for future research.

5.1 SMHL Role Perceptions

The first aim of this study was to consider how SMHLs perceive their role within secondary settings. SMHLs over the course of these interviews highlighted multiple ways in which they perceived their role, including practical responsibilities, their role identity, and their relationships with students, families, and their colleagues.

A number of themes and sub-themes raised by SMHLs, as may be expected, align with the SMHL role requirements put forward by the DfE (2023). These included: establishing a supportive culture and approach, developing policies, managing internal support systems, engaging with external professionals, co-ordinating mental health education, and delivering staff-training. The overlap between themes and role requirements primarily related to the strategic functions of the SMHL role. This strategic responsibility has also been reported, however, to be generally increasing across other pastoral roles (Stoll & McLeod, 2020). Similarly, the responsibility of co-ordinating and delivering mental health opportunities has also been raised by senior leadership members within previous research (Garside et al., 2021), as well as the expectation of developing an overall culture and ethos to support mental health, for example through open door policies and environmental changes (Garside et al., 2021, Littlecott et al., 2018; Jessiman et al., 2022)

Additionally, as in previous research, SMHLs within this current study reported the importance of working alongside parents (Dimitropoulos et al., 2022; Flint, 2017). Similar elements, for example, were raised by SMHLs relating to advocating for students with their parents (Beames et al., 2022), and supporting parents to develop a greater understanding of mental health (Flint, 2017). Parental discussion with children related to mental health, and involvement (for example, attending school events) has also been noted within literature as supportive for adolescents' mental health (Panchal et al., 2021; Wang & Sheikh-Khalil, 2014). SMHLs also reported similar barriers to previous research associated to working with parents, such as cultural stigma towards mental health (Flint, 2017). However, SMHLs within this study also shared further contextual factors which impact their ability to support students, related to community and societal level factors, such as the ongoing cost of living crisis and experiences of deprivation. This finding aligns with previous understanding of the impact of poverty on children's mental health, and the emotional toll on young people of worrying about families' financial situations (Dauvermann, 2023).

SMHLs also appeared to share the perception that external, specialist individuals and agencies provide essential support, which cannot be delivered within their role. Although SMHLs did report having some involvement in working with students directly, emphasis was also placed upon liaising with external professionals to provide this support. This aligns with previous research indicating teachers and pastoral staff felt student support was part of the role of outside professionals (Dimitropoulos et al., 2022; Shelemy et al., 2019b; Stoll & McLeod, 2020).

However, SMHLs did report their role involved building some relationships with, and delivering direct support to, students. This is interesting as this is not considered as a responsibility within the role specifications of a SMHL (DfE, 2023). Direct support may be something that SMHLs are engaging with in response to the limited capacity of support systems, both within and outside school (as highlighted within the barriers theme). The idea that SMHLs are directly engaging in student support could show the impact they feel

individualised support has, which therefore must be implemented above other responsibilities they hold. Alternatively, the desire to engage in student support may instead reflect a passion or motivation to engage in student support due to the satisfaction gained in working with students directly.

Furthermore, as in previous studies, SMHLs note they are being positioned by others as the 'face of wellbeing' within their settings; with staff and students viewing them as the main avenue to the delivery of support in their setting (Jessiman et al., 2022; Littlecott et al., 2018). This may also explain why staff engage in student support, although it is outside of their role, as they are being presented as 'the' individual to approach related to wellbeing. Therefore, although this role was devised as one of strategic responsibility, due to their positioning as the 'face' within school SMHLs may be being pushed into an increasingly support led role.

This view of increased pastoral responsibility appears to align with the view of staff in Rice O'Toole and Soan (2022) that leadership members with pastoral responsibilities are best placed to take on student support. This is interesting, however, as staff in their study felt pastoral staff were able to do this because of a lack of other responsibilities, such as teaching. This was not the case for SMHLs within the current study, for example Eloise noted "*I still teach eleven hours a week and I do duties and things like that".* This appears to highlight that whilst SMHLs are being positioned as definitive holders of responsibility by staff, this not being reflected in their role responsibilities. Indeed, SMHLs note that despite balancing multiple roles alongside their SMHL responsibilities (for example, leadership positions), this role would constitute enough to fulfil a full-time position. One role, however, that SMHLs highlighted did support the delivery of the SMHL position was being part of a safeguarding team. SMHLs described how mental health support within their school often fell within the remit of safeguarding, and therefore SMHLs who shared safeguarding responsibilities, or worked as part of the safeguarding team, feel holding this additional role supports their ability to engage in the SMHL role.

Contrary to previous research, SMHLs interestingly highlighted that they did not have a responsibility in their role towards staff wellbeing, although they deemed it important. Previously, other pastoral staff and primary SMHLs had emphasised the importance of staff wellbeing support within their role (Flint, 2017; Tonks, 2022). The emphasis being placed upon student support is intriguing, as research has indicated that secondary school staff experience one of the highest sick leave rates across professions and are at an increased risk of experiencing burnout (García-Carmona et al., 2019). This discrepancy between views of primary and secondary setting SMHLs may be due to the increased number of staff in a secondary provision exacerbating support challenges from a logistical standpoint.

Moreover, whilst literature has noted that staff generally feel underprepared to deliver, and as lacking knowledge within, mental health support (Byrne et al., 2015; Soneson et al., 2022), SMHLs within this study saw knowledge as something that was not essential to the SMHL role. Instead, SMHLs described how knowledge would be generated throughout learning opportunities within the role. It could be considered that this is due to the strategic emphasis in SMHL roles, whereas teaching staff for example may be experiencing feelings of pressure or responsibility to have more frequent conversations with students. However, as discussed in this study, SMHLs also reported delivering student support, which appears to link to the notion that SMHLs have a previously developed confidence and understanding of mental health, for example through their previous pastoral experiences, which contributed to their selection for the role.

Whilst SMHLs report they will have opportunities to learn within the role, SMHLs noted that specific SMHL training they had received had not impacted their practice. This again alludes to the notion that SMHLs may have a developed confidence and understanding in supporting mental health, which exceeded content within the training, for example related to specific mental health disorders experienced by students (DfE, 2021). This could explain the lack of impact reported by SMHLs, as well as any disappointment in the content delivered. Additionally, SMHLs noted a reduced capacity to engage in training activities within this role.

This may also explain why specific training courses were perceived as not effective (due to limited capacity for engagement), but also highlights a paradox where staff report they can engage in learning opportunities within the role to extend knowledge, but acknowledge that they do not have capacity to do so.

In further contrast to previous research, SMHLs presented mixed views as to whether leadership was necessary to the SMHL role. Whilst sharing similar roles to the SMHLs interviewed by Tonks (2022), only some of the interviewed SMHLs within this current study shared the perspective that leadership is important to create change within the school system. This appears to align with the perspective shared by the DfE (2023), that SMHLs were not required to hold leadership positions, but to instead be responsible for this area within school. Furthermore, there is often an increased level of devolved leadership responsibility in secondary schools (such as Head of Subject, or Head of Year) which may lessen the individual leadership status/power of individuals, meaning holding leadership is viewed as a less impactful or necessary trait to the delivery of change. However, as noted by SMHLs, effecting change still requires investment from school staff, and supportive and engaged colleagues across school systems.

Interestingly, SMHLs highlighted that the Covid-19 pandemic, had acted as a facilitator in regard to their role, as it had increased the importance and profile of mental health understanding. Existing resources within schools, such as teachers' relationships with families, were also noted to support delivery of the role.

5.2 Mental Health Constructs

SMHLs presented a breadth of conceptualisations relating to how they perceive mental health. These ranged across themes including: mental health being part of the normal human experience; mental health representing suffering and struggling; mental health being paralleled with or akin to physical health; and the idea that 'mental health' should be passed

over for the conceptualisation of ‘wellbeing’. SMHLs additionally reported that mental health was a complex, messy, and highly personal concept, which is overused within society.

The conceptualisation of mental health as akin to or related to physical health, aligns with previous findings related to the medical discourse (as described in Chapter 1). Delilah’s reflection on *“brain health”,* for example, echoed similar terms used within previous studies (such as Kamel et al., 2020, and Shelemy et al., 2019a), and mirrors the shift to medicalised and biological language used within adolescent mental health guidance and policy (Callaghan et al., 2016). This is interesting as within the current study SMHLs were given no steering statements or narratives related to mental health and were instead asked to reflect purely on their own experiences (through the externalising activity and the use of an open-ended question). This further supports the notion that this conceptualisation of mental health being associated or linked with physical health is becoming a dominant or prevalent perspective within society.

Concepts shared by SMHLs appeared to also align with the positive wellbeing narrative, as introduced in Chapter 1. Within this conceptualisation, mental health is presented as reflecting a spectrum between optimal wellbeing and struggling or suffering with mental health and wellbeing. This is also presented as flourishing and languishing (Norwich et al., 2022; Seaton et al., 2021; Westerhof & Keyes, 2010). SMHLs in this study appeared to highlight that experiencing mental health difficulties reflected something which could be frightening, or which would extensively negatively impact your mood, emotional state, and experience of life (aligning with the idea of suffering or languishing). This is interesting when considered alongside the finding that SMHLs feel safeguarding overarches mental health in their role. Whilst safeguarding in part relates to “promoting the welfare of children”, emphasis is heavily placed on the responsibility to “protect [children] from harm” (NSPCC, 2023, pp.1). By positioning mental health within safeguarding, this appears to also substantiate the idea that mental health is considered as something to shelter or guard young people from experiencing.

However, SMHLs also described mental health as being re-conceptualised as ‘wellbeing’ and highlighted that the construct of ‘mental health’ can also relate to feelings of positive wellbeing. This aligns with ways in which wellbeing is being considered as synonymous with positive mental health, and how wellbeing factors are becoming increasingly important to mental health construct development, such as the elements of the PERMA model proposed by Seligman (2011).

Some SMHLs, however, such as Eloise appeared to stress that although ‘wellbeing’ appears to be related to the concept of positive life experiences, the phrase ‘mental health’ itself appears to be more often associated with difficulties and illness; *“we’ve sort of stepped away a little bit from mental health”.* This appears to support the notions proposed within the two continua model by Keyes, whereby mental health and wellbeing is a separate dimension from mental illness (Westerhof & Keyes, 2010). However, Eloise appears to be describing the former dimension as purely related to her consideration of wellbeing and not of mental health.

The confusion around the relationship between these two constructs (mental health and wellbeing) is an ongoing debate within psychology. de Cates et al. (2015, pp. 195), for example, discusses the impact that considering mental wellbeing as an independent construct from mental health may have upon our understanding of mental distress (for example, pulling focus from this topic, and “diverting resources away from evidence-based treatments”). This is interesting as SMHLs also described that mental health is becoming increasingly overused within society. This may further emphasise that although wellbeing was described within the topic of ‘mental health’, SMHLs perceive that experiencing extended difficulties or struggling are most reflective of *“proper”* (Eloise) mental health.

However, SMHLs also appeared to highlight that experiencing mental health was ‘part of life’, and that mental health would naturally continue to fluctuate, for example across a day. This appears to align with views shared within broader societal narratives, for example by mental health awareness charities. The Mental Health Foundation, for example, use the analogy of the seasons changing, and the weather within seasons, to consider how mental

health “strongly affects our daily lives” including “ups and downs” (Mental Health Foundation, 2023b, pp.1). Yet, even within this example presented by the Mental Health Foundation, other themes illustrated by SMHLs are present, such as “darker days” which “dip and drag you down a darker road” (struggling and suffering), and also include links to the importance and relevance of physical health (Mental Health Foundation, 2023b, pp. 1).

The interweaving of these different facets of mental health further supports the notion discussed by SMHLs that experiencing mental health is highly individual and complex. As previously discussed, mental health can be considered to vary across: a pole of wellbeing to suffering, different periods of time, contexts, and is contributed to by an individual’s health. The variety of factors included within mental health may explain why SMHLs find it difficult to present one unified notion of mental health, as well as the different focuses potentially held by SMHLs, parents, and the young person themselves.

5.3 Role Experience and Constructions of Mental Health

As discussed in Chapter 2, mental health constructions can be perceived as linking to actions or outcomes for young people (Graham et al., 2011; Kidger et al., 2009; Shelemy et al., 2019b). These may be bidirectional, for example constructions influencing practices, or vice versa. Within this study, there are links which can be tentatively inferred between mental health constructions of SMHLs and their role responsibilities.

SMHLs appear to note they, at least partly, position their roles as strategic managers of *“caseload[s]”* (Delilah). SMHLs also reported students were primarily supported by external or specialist staff/professionals, such as counsellors, wellbeing co-ordinators, or CAMHS. This idea of co-ordinating mental health support through a tiered model, linked to health care, can be seen to link to the medicalised discourse of mental health (Norwich et al., 2022).

Furthermore, the notion of safeguarding as an overarching presence in SMHLs roles and mental health support, may also contribute to the perception of suffering and struggling. As

previously noted, safeguarding's relationship to risk and harm, links to the idea that mental health is a challenge, a negative experience, and something which should be avoided.

A shift to considering a positive mental health or wellbeing narrative, may also influence the support offered by SMHLs. For example, SMHLs who promote or hold this conceptualisation may be more likely to emphasise whole school support strategies focusing on feelings of mastery, emotional regulation, and supportive relationships between students, related to the domains within these 'positive' mental health areas (Fusar-Poli et al., 2020; Seligman, 2011)

The wide variation of SMHL role responsibilities may contribute to the breadth of conceptualisations of mental health identified (or vice versa). SMHLs' role in supporting families, whole school assemblies, and broader signposting, for example, may feed into the conceptualisation of mental health being 'part of life' (as these activities are shared universally with all students). Furthermore, the idea of social factors acting as a barrier to supporting students (such as due to the cost-of-living crisis), highlights the idea that mental health fluctuates alongside temporal life experiences. The 'suffering and struggling' conceptualisation, however, could lead SMHLs to incorporate increased responsibility for, or delivery of, direct student support, as a way to decrease the negative experiences they feel students are subject to. This maelstrom of perspectives may contribute towards the lack of clarity between 'mental health' and 'wellbeing' (as appears to be captured within the 'promoting wellbeing' theme).

5.4 Strengths and Limitations

Whilst a final sample of five SMHLs was appropriate (given the exploratory nature of this research project, and wide variety in samples sizes utilised within this approach (Clarke et al., 2015)), it should be noted that recruiting SMHLs into this study was challenging. Despite extensive recruitment efforts, including advertising the project in training sessions attended by SMHLs, only nine eligible SMHLs expressed interest in this study, and of these only five

participated within this research. Those who did not take part noted the demanding time and capacity pressures of their role meant that they could not participate. This demand was also commented upon by those who did participate, for example after having to re-arrange our interview several times, Delilah within her interview noted *"well you've seen I try and book a meeting, and I get pulled in ten different directions".*

Therefore, it is important to consider in future any alternative methods which could be utilised to support SMHLs to share their views. Questionnaires could be developed, for example, based on the findings of this initial research, which could be shared with SMHLs and followed up by focus groups (with independent researcher/educational psychologists attached to official SMHL training courses). However, this extensive pressure upon SMHLs should be noted as an important finding in its own right, and both role amendments and wellbeing support further considered for SMHLs within their settings.

Additionally, due to time pressures upon myself as the researcher, and the SMHLs themselves, interviews were often arranged virtually during the school day. Whilst this was preferred by SMHLs, as discussed, lack of capacity was a recurring theme. This means that interviews were often fitted into busy days for SMHLs, potentially after having seen particular young people, or having meetings related to mental health. Whilst this may have primed them for our discussion, it may have also meant that SMHLs were entering interviews with a reduced reflective capacity, or after having had a particularly difficult experience in school. Therefore, in future research it may be beneficial to arrange interviews during the longer summer holidays, to allow SMHLs time to reflect upon a previous year in the role, and key ideas they would like to share. However, care was taken within this study to give SMHLs time prior to the interview, to allow them to consider any particular thoughts they would like to share (such as booking the interview for at least a week after the booking was made, in order to give them time to reflect on the topic).

It should also be considered that (likely due to time demands), SMHLs did not respond to invitations to participate in a follow up session to review generated themes (as described in

Chapter 3). This was despite all individuals expressing interest in this during consent gathering. The lack of SMHL involvement in reviewing themes therefore could be argued to have impacted the robustness of generated themes and sub-themes. However, Thomas (2017b, pp. 37) proposed that member checks (for example, participants being sent research findings or transcripts) do "not enhance the credibility or trustworthiness of qualitative research". Thomas does identify, however, that for research aimed at representing community views, member checks can support feedback from participants, for example in relation to approving the use of data (such as specific or personal quotes) (Thomas, 2017b, pp. 38). Further strategies were included within this research to ensure the quality of the analysis (as described in Chapter 3), including promoting sensitivity and rigour. The interview schedule was continually developed through supervisory processes, and with external input. Reflexive practice, such as considering my relationship as a trainee with various SMHLs, throughout this study also promoted the quality of the analysis.

For SMHLs, the flow of the interview appeared to be interrupted by the externalising activity. SMHLs commented that this was a difficult question, or that they would find it challenging to put their thoughts into a visual idea. Whilst the interview questions were reviewed, for example by the supervising researcher, due to the difficulties in recruitment it was not possible to conduct a review of the questions with SMHLs, which may have highlighted that a change was required to this question. However, despite SMHLs reporting on the difficulty of this question, valuable information was still gained through this additional style of questioning, which gave further insights within the thematic analysis, for example the perception of mental health as associated with suffering and struggling. Therefore, whilst it was considered that adults may be less engaged in the activity if additional mediums were included, consideration should be given to ways in which SMHLs may be primed to consider various styles of questioning. This could occur within the information sheet and beginning of the interview, for example informing SMHLs that different types of questions and activities may

be involved. Potential scaffolds could also be provided, such as neutral images to support SMHLs with this activity, including prompting images, colours, and textures.

Alternatively, the diamond rank activity appeared to be a useful activity for SMHLs, and allowed individuals, as predicted, to consider how they organised the factors of their job, and the relative importance or influence of activities (Clark, 2012). During the interview, SMHLs fluidly moved or asked the statements to be moved around and appeared to use the statements to consider their views on activities as the interview unfolded. However, only one SMHL identified an element of their role that was not explicitly included in a statement during the activity (working with parents), and this may have indicated that SMHLs felt unable to contribute novel ideas during this activity. However, as shown by the variety of role elements included within the thematic analysis, SMHLs did feel comfortable bringing up a variety of responsibilities across the interview itself, for example related to parent support.

The aim of this research was to be as broad as possible in allowing SMHLs to consider their own perceptions of mental health. However, it could be considered that by the structure of the interview (from role to conceptualisations) SMHLs were primed to consider purely their view of mental health in relation to school settings. Whilst this may indeed increase the specificity of the conceptualisation to this research, it is important to ensure that future research explicitly supports SMHLs and other school staff to consider mental health across all system levels: including at home, their work life, and within wider society.

5.5 Implications for Practice

This study has indicated several areas which may impact upon school settings, the SMHL role, and within EP practice. I feel it is fundamental to highlight, however, that during this section references to changes made in schools require wider societal support, for example financial support from LAs, or broader governmental led support. To suggest that schools, or individuals, should shoulder the responsibility of such change would invalidate many of the experiences and barriers shared by SMHLs within this research.

A key finding from this research is the breadth and complexity of the current SMHL role. SMHLs described the pressures they experienced in balancing aspects of this role, including managing other pastoral and teaching responsibilities, alongside support for families. SMHLs feel they are being positioned as not only co-ordinators of wellbeing support, but indeed central pillars of support for staff and students. This is beyond the scope of the role proposed by the DfE (DfE, 2023). It is vital that relevant government agencies, such as the DfE, are made aware of the tensions experienced by SMHLs in balancing aspects of this role and provide support to either change the expectations placed upon SMHLs, or further tangible resources to support the implementation of mental health support in schools.

In the interim, consideration should be given by school leadership, such as Head Teachers, into how individual SMHLs can be supported. This could include moving to develop teams responsible for mental health and wellbeing within school, with activities divided and shared. One example included within this study by a SMHL was the use of committees of staff and students to take on various elements of roles currently identified as belonging to a SMHL. Sharing roles and responsibility may also help to promote a supportive culture, as well as to reduce SMHLs being positioned as 'the face of wellbeing'. However, this must be balanced alongside staff capacity, as this is a noted barrier for staff engaging in mental health support initiatives.

This research also highlighted implications regarding staff wellbeing support in secondary settings. As illustrated by SMHLs, staff wellbeing is not being awarded the same emphasis within the SMHL role as creating a culture of mental health promotion for students, despite the belief that staff mental health and wellbeing is important. This finding illustrates the importance of senior leadership in secondary settings considering methods to ensure the mental health and wellbeing of staff can be prioritised. This could include a specific individual who considers staff wellbeing, who works alongside a broader team who support mental health within school, to reduce the burden of workload described by SMHLs. Secondary settings may also benefit from working alongside EPs to systemically consider wellbeing initiatives for staff. Research

has highlighted for example acceptance and commitment therapy principles can be integrated into settings to support staff wellbeing (Gillard et al., 2018). EPs can also support staff wellbeing through integrating supervision structures into school settings (Dunsmuir et al., 2015).

As highlighted in this research, family support should also be a priority for community organisations, school settings, and LAs. SMHLs report supporting parents (for example, through co-ordinating family fun days and parent workshops), was a key part of their role, and a way they could support the mental health of students. Engagement with families therefore should be considered as a priority for senior leadership teams, and this could be supported through engagement with community initiatives and systemic work with LA services, such as EPs. However, it should be noted that external agency support was reported as difficult to access by SMHLs, and there is a noted lack of communication between voluntary and statutory community groups, increasing the complexity of co-ordinating additional support (Public Services Committee, 2021). Therefore, schools require support from charitable organisations and LAs to build relationships with such supports to ensure schools and families can access support.

Support for families is, however, developing, for example through the introduction of Family Hubs (currently proposed for areas with high levels of deprivation for families of children aged between 0 and 19) (DfE & DofHSC, 2022; Public Services Committee, 2021). These types of hubs represent additional community supports schools can engage with to co-ordinate support for families within mental health.

Additionally, within this study SMHLs expressed a preference to engage and learn from others within training and development related to mental health. This highlights an avenue for EPs to develop opportunities for connection across mental health leads, for example similar supervisory groups as used with Emotional Literacy Support Assistants (ELSA) (ELSA Network, 2017). Whilst this type of approach is currently beginning to be utilised by services across the country for SMHLs, this study highlights the perceived importance of such

opportunities for SMHLs, as well as an approach which should be considered within training opportunities to ensure these feel purposeful and impactful. However, SMHLs also highlight the difficulty they experience in finding time and headspace to engage in training opportunities. Therefore, there must be discussion and agreed actions between the DfE, school leadership members, SMHLs, and relevant facilitators (such as EPs) as to how this training involvement can be managed, for example with release time, rolling training opportunities, and a problem-solving forums, such as termly steering group meetings within local authorities.

Furthermore, EPs must consider ways in which the profession can advocate for greater support for families experiencing financial difficulties, as highlighted by participants discussing impact of the cost-of-living crisis upon adolescents' mental health. One example of this, for example, is the group Psychologists for Social Change, previously Psychologists Against Austerity, who lobby for greater understanding of the impact of "social, political, and material contexts" upon communities (Psychologists for Social Change, 2023, pp.1). In 2014, this group created a briefing paper "The Psychological Impact of Austerity", which highlighted the clear links between public services decreasing and mental health difficulties (Psychologists Against Austerity, 2015).

5.6 Future Research

This research has provided initial exploration into understanding the roles of SMHLs in secondary settings, as well as how they construe mental health.

Subsequent research could use the findings from this study to create a further in-depth, nuanced consideration of SMHLs roles and mental health, for example using a Q-sort method (Brown, 1996). This research could increase understanding of the subtle differences in job role priorities, such as how SMHL roles may be prioritised compared to other additional responsibilities, as well as within the SMHL role itself. Similarly, this type of approach could build upon the conceptualisations of mental health described within this study, to consider how

various aspects of these (for example, between suffering and wellbeing) are considered by SMHLs.

It is also important to consider that a SMHL works within an overarching school system, and as such the effectiveness of their role is impacted by relationships and interactions with other elements of this system. Due to the currently emerging status of SMHL roles, and schools evaluating how to structure pastoral and mental health provision within schools in response, action research may provide a valuable method to further understand implementation across a school setting (for example, including perspectives of adolescents and school staff), whilst also providing benefit for settings in supporting the development of such structures.

Additionally, findings and propositions from this initial exploratory study should be investigated in subsequent research. SMHLs reported they feel as though they are the 'face of wellbeing', for example, may be supported by the creation of a mental health team within schools. Whether this would feel supportive to SMHLs, and how this organisational shift could be managed, could be explored through the use of soft systems methodology (Mingers & Taylor, 1992).

Finally, future research should consider the unique factors impacting the SMHL role in specialist settings and alternative provisions. Specialist settings, for example, within the Children and Young People's Mental Health Trailblazer programme reported that programmes intended to support children's mental health were not sufficiently adapted to support their students (Ellins et al., 2023). Additionally, this initial research by Ellins et al. (2023) identified that educators felt students with increasingly complex needs do not feel adequately supported by external agencies, for example with students remaining on long waiting lists. It may therefore be the case that certain barriers identified by secondary provision SMHLs in this study (such as difficulty accessing external services) are exacerbated within specialist settings. Yet it is also likely that these settings will face their own unique strengths and difficulties regarding implementing mental health support, and the SMHL role specifically.

5.7 Conclusion

In conclusion, this exploratory study has highlighted the views of SMHLs within their daily role, and their constructions of mental health. SMHLs have expressed the strengths and issues they experience within their role, which appear unique to mainstream secondary school settings. The areas of concern raised must now begin to be addressed, and as highlighted in the implications section this is something which can begin to occur immediately through minor changes to practice. The complexity of the SMHL role must receive consideration from relevant governing bodies, regarding the potential need for further support, as well as current consideration of ways the role could be supported through developing a team of individuals who support mental health delivery and strategy within school, and enhanced training opportunities.

The constructions of mental health presented within this research are a call, to both research bodies and applied psychologists, to continue to strive towards a cohesive narrative surrounding 'mental health' and 'wellbeing', as well as ensuring the perspectives of individuals are always explored when moving towards systemic development within school systems. Finally, this research should be considered as a springboard into action by school settings, EPs, and governmental structures, to address the inequalities experienced by vulnerable adolescents, to ensure that whole school approaches can be as effective as possible, in supporting the mental health of all children and young people.

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Appendices

Appendix 1

Key texts included within literature review.

Study	Roles	Country
Cefai & Askell-Williams (2017)	School leaders, teachers	Australia
Dimitropoulos et al. (2022)	Teachers	Canada
Flint (2017)	Pastoral leads	England
Garside et al. (2021)	Senior staff members	England
Graham et al. (2011)	Teachers	Australia
Harvest (2018)	'Pastoral staff' including teachers, teaching assistants, school leaders	England
Ibeziako et al. (2009)	Teachers	Nigeria
Jessiman et al. (2022)	Senior staff members, teachers, support staff	England
Kamel et al. (2020)	Teachers	Saudi Arabia
Kidger et al. (2009)	Head key stage/year, PSHE coordinator. TA. assistant principal. learning mentor. learning support manager. SENCo	England
Monducci et al. (2018)	Teachers	Italy, England
Rothì et al. (2009)	Head teachers, deputy/assistant head teachers. teachers. SENCo. head of year family liaison. pastoral support	England
Shelemy et al. (2019a)	Teachers	England
Shelemy et al. (2019b)	Teachers	England
Stoll & McLeod (2020)	Guidance teachers	Scotland
Tonks (2022)	SMHLs. pastoral lead	England
Vostanis et al (2013)	School staff, reported as often head teacher or deputy head	England

Appendix 2

UNIVERSITY OF BIRMINGHAM

Information

Exploring Senior Mental Health Leads (SMHLs) role and perceptions of mental health within mainstream secondary schools

Description of the proposed study

This interview is designed to explore the views of designated senior mental health leads (SMHLs), who work within mainstream secondary schools in the West Midlands.

This interview may cover:

- The role of a SMHL in mainstream secondary schools
- Views around mental health
- Support options for children and young people
- Strategic school factors
- Facilitators and barriers to the role of a SMHL

Invitation to participate

You have been invited to participate in this interview as you are:

- A designated senior mental health lead (SMHL)
- Working in a mainstream secondary school in the West Midlands
- Have been working in your school for over one year

Participation in this interview is entirely voluntary, and you have no obligation to take part.

In this study, you will be asked to take part in an interview with the researcher (Catherine Stanford). This will involve discussing topics related to your role and mental health. You may also be invited to take part in various discussion activities. Depending on geographical location, Covid-19 risk assessments, and your personal preference, interviews will either take place in person or on virtually. Interviews will be recorded either using audio-recording (if interviews are conducted face to face), or video recordings (if interviews are conducted remotely e.g., Microsoft Teams).

This interview is estimated to last approximately 1 hour. There are no expected negative impacts of participating in this research. However, if the researcher has any immediate or substantive concerns regarding your safety or wellbeing, or that of a young person you work with, the researcher will relay this to your school's designated safeguarding lead.

After the completion of this interview, you will be invited to attend a follow up collaborative feedback session. Please see more information about this in the section below.

If you would like any additional information, or to discuss this research prior to participating please email:

Catherine Stanford

(see contact information section)

Collaborative Feedback Session

When all interviews are completed, you will be invited to participate in a collaborative feedback session, alongside other participants. In this session, preliminary analysis of findings from these interviews will be shared, and you will have the opportunity to provide your thoughts and perspective on interpretations made. This session will be conducted either face to face or virtually (to be confirmed, for example depending on Covid-19 risk assessments).

If you would **NOT** like to be contacted about participating in this session, please ensure you indicate this on the consent form.

Reward and reimbursement

There will be no provided incentive to participate in this research.

Confidentiality and anonymity

You have the right to withdraw from this research at any point until 2 weeks (14 days) after the conclusion of your interview (not including the date of your interview). At this point, it will not be possible to withdraw your interview data.

If you request for your data to be withdrawn, this will include the removal of: any audio/video recordings of your interview, the transcript of your interview, and your name and contact information (if retained for further feedback regarding the collaborative feedback session, or for you to receive study feedback).

Your interview will either be audio-recorded (if face to face) or video recorded (Microsoft Teams) depending on the format of your interview. These recordings will be kept only until your interview has been transcribed word for word by the researcher (Catherine Stanford), with all identifiable information removed. These recordings will then be destroyed.

Your data will be stored **confidentially**. This means it will be possible for the researcher (Catherine Stanford) to link your personal information to your interview Your personal information is linked to your interview data as this makes it possible to identify your responses if you wish to withdraw within the 2-week period, as well as to further understand demographic characteristics of this research. However, at no point will anyone other than the researcher team be able to identify you from your data, as *all reported findings will be anonymised.*

Your personal information will either be retained until: 2 weeks post the interview study completion, the collaborative feedback session (post completion of all interviews), or the until the submission of this thesis into University of Birmingham eTheses Repository (estimated September 2023). This will depend on your preferences as indicated in the consent form for this interview.

Results of this study

The findings from this research may be shared in multiple ways:

- As part of Catherine Stanford's university thesis, as part of the Applied Child and Educational Psychology Doctorate, at the University of Birmingham.
- In academic journals.
- In dissemination events, such as with school leaders and charitable organisations.
- With local authority commissioners.

Please also be advised that anonymised data collected in this research will be stored by the researchers and the University of Birmingham for a minimum of 10 years.

Contact details

Catherine Stanford (Trainee Educational Psychologist)

Dr James Birchwood (Academic Supervisor)

Consent

To consent to being involved in this project, you would need to feel comfortable consenting to all of the following.

I confirm I have read and understand the participant information sheet entitled: **Exploring Senior Mental Health Leads (SMHLs) role and perceptions of mental health within mainstream secondary schools** ☐

I have had the opportunity to ask any questions I wished to, and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw my interview data from this study at any point until 14 days after the interview has been conducted (not including the date of my interview). ☐

I understand transcripts of these interviews will be analysed by Trainee Educational Psychologist, Catherine Stanford. ☐

I understand anonymised transcripts may be kept indefinitely, by the researcher team, and the University of Birmingham, in accordance with GDPR and Data Protection, and for a minimum of 10 years ☐

I understand that this anonymised data could be used in different ways, and shared through different means, such as: ☐

- As part of Catherine Stanford's university thesis, as part of the Applied Child and Educational Psychology Doctorate, at the University of Birmingham.
- In academic journals.
- In dissemination events, such as with school leaders and charitable organisations.
- With local authority commissioners.

I understand verbatim quotes may be included in the write up of interview findings. I understand that I will not be personally identifiable from these quotes. ☐

I consent to participate in the collaborative feedback session. I understand this will involve the retention of contact information I have provided e.g., postal address and/or email. ☐

I understand that participation in the collaborative feedback session will involve respecting the privacy and anonymity of other attendees. Outside this session, I will not reveal the identities of the others, ☐

report specific comments, or make links to those who made them during the discussion

I understand that I will not be able to withdraw my interview data after participating in the collaborative feedback session, if this falls after the 14 day period specified. ☐

I would like to be contacted with further information about the results of this study. This would include a summary of key findings, and a full copy of Catherine Stanford's thesis post its submission to the Birmingham etheses repository. I understand this will involve the retention of contact information I have provided e.g., postal address and/or email. ☐

Signed _____ Date _____

Name (Print) _____

If you have any questions, please contact:

Catherine Stanford

Trainee Educational Psychologist

If you have any concerns or any further questions, please contact:

Dr James Birchwood

Academic Supervisor

Appendix 3

Interview Schedule

Please note that this interview schedule is designed to provide a framework for discussion which may be covered. Individual questions and activities may fluctuate depending on initial discussions with each SMHLs.

"Thank you so much for taking the time to participate in this interview. Before we begin, I would just like to remind you:

- Your participation in this research is entirely voluntary
- You have the right to withdraw at any time during this interview
- You have the right to withdraw your data for up to 14 days post the completion of this interview (not including today)
- You can stop this interview for a break at any time"

Issue/topic	Possible questions	Possible follow-up questions	Probes
Introductions	Rapport building focus: How long have you worked here at [x] school? So, you said in your email…		Can you tell me a little bit more about that?
Role of SMHL	How did you become your schools SMHL?	So, it sounds like you [put yourself forward/were volunteered for the role/were selected because…] is that right?	Non-verbal prompts
	What do you feel your role is as a SMHL?		Can you give me some examples of that? Would you be ok to tell me a bit more about that?
	What do you think other people see your role as at school?	Is this the same or very different to your view? Does this differ across members of staff?	
	What do you think the students at your school think your role is?	Is this different to yourself/staff/others?	Can you give me an example of that?

<table>
<tr><td>Potential Activity: Role</td><td colspan="3">Diamond Rank Activity

Various statement cards are present and also some blank cards are present so the SMHL can add their own thoughts and statements:
Aim of the activity is to rank various statements in order of importance e.g., 1 most important, 2 second most important, 3 middling, 2 lesser, and 1 final statement which is least helpful or descriptive. These statements describe considered roles of a SMHL:

- “This role involves supporting the delivery of a whole school approach to mental health”
- “This role involves developing staff understanding of mental health”
- “This role involves being part of the senior leadership team”
- “This role involves tailoring and supporting the delivery of mental health interventions”
- “This role involves having an extensive knowledge of mental health”
- “This role involves considering how to increase coverage of mental health within the curriculum”
- “This role involves promoting staff wellbeing”
- “This role involves building strong relationships with individual students”
- “This role involves pulling together information to make referrals to external agencies”

What are your relationships like with external agencies for supporting mental health?</td></tr>
<tr><td rowspan="2">Training</td><td>Have you been on a specific SMHL training course?</td><td>What was this like?
What did this involve?
What was the main thing you took away from this training course?
Who was this course provided by?</td><td></td></tr>
<tr><td>What further training, if any, might you want as a SMHL?</td><td></td><td></td></tr>
<tr><td>Potential Activity</td><td colspan="3">Externalising activity – describing mental health outside of the person (links to narrative therapy) e.g.,

“If mental health was [here – points next to the person]
- What might it look like?
- Sound like?
- Smell like?
- How big would it be?
- Be like?
Etc.</td></tr>
<tr><td>Mental Health</td><td>What does the term ‘mental health’ mean to you?</td><td></td><td></td></tr>
</table>

Barriers and Facilitators	What barriers do you think you have currently to acting as a SMHL in your school?		Can you tell me a bit more about that? Can you give me an example of a time that happened?
	What facilitates your ability to act as a SMHL in your school?		

Appendix 4

Familiarisation (Initial Ideas) – Adam

- Experienced member of staff
- Challenges in deprived areas
- Safeguarding lead as additional role
    - Safeguarding as overarching, main role
- Step in for roles
- SMHL links to safeguarding
- Experience for the role
- Unattractive position
- Part of a larger role
- Loss of role information with loss of staff
- Sharing role knowledge
- Practices unique to setting
- Real world not policy
- Steps to create an ethos
- Normalising mental health conversations
- Management role
- Vulnerability in review
- Continually looking forward
- Beyond token gestures
- Engaging external agencies
- Training for staff
- Lockdown taught us about importance of mental health
- Keeping in touch with every learner
- Auditing children's experiences on return to school
- Changing strategies depending on children's concerns
- Utilising technology
- Staff understanding importance of mental health
- Staff not always in position to recognise signs of mental health
- Staff associate role with safeguarding
- 'Status' allows greater respect from staff
- Taking staff on a journey
- Children not recognise role title, but the people
- Staff supporting children should extended beyond SMHL
- Being Senior Leadership helps get things done
- Don't need an "extensive" knowledge
- Building relationships with students beyond SMHL role
- Referral making beyond SMHL role
- Not a psychologist
- SMHL role involves building a system
- Supporting staff learning
- Personal interests versus role demands
- Silent assassin
- Unknown of mental health
- Discuss mental health as 'health'

- Promoting students areas of strength
- Promoting what makes good mental health
- Trying not to frighten people discussing mental health
- Individual differences
- Mental health and physical health
- Mental health continually fluctuating
- Importance of considering protective and risk factors
- Can't compare and contrast with others
- 'Overused' term of mental health
- Raising awareness leads to flooding
- Creating a filtering mechanism for referrals
- Supportive school leadership for SMHL
- Lack of time to role
- Support of staff
- Changes to recognition across time
- Overwhelmed CAMHS
- Supporting external agencies in local authority
- Lonely walk as lead
- Fears around knowing what to do
- Hoping making good decisions
- Fears around cost of living
- External influences on mental health
- Family support a key part of mental health support
- Lack of knowledge on how to support self-harm
- Lack of strategies to support with self-harm
- Passion for the area

Familiarisation (Initial Ideas) – Becky

- Pastoral lead background
- Safeguarding background
- Previous experience working in mental health
- Experience for the role
- Auditing current progress
- Working on related concepts in school
- Covid pandemic leading to role creation
- Covid pandemic highlighting importance of mental health
- SMHL a leadership role
- Providing training and CPD
- Developing system of supporting adults
- Developing staff knowledge base
- Developing understanding of trends
- Establishing recording and reporting systems
- Take on more intense therapeutic cases
- Working with local authority teams
- Developing dissemination resources
- Perception SMHL is the focal point for SMHL support

- SMHL advisory role
- Students understand purpose, not role definition
- Upskilling students knowledge
- Chatting with students to develop understanding
- Staff wellbeing being outside role
- Whole school approach how support started
- Developing student comfort and confidence
- Prevent it remaining a ‘taboo’ subject
- Staff wellbeing weaker than student wellbeing
- Limited contact with senior leadership team
- Senior leadership more interested in academics opposed to wellbeing
- Understanding of mental health integral
- Watering down of role with staff leaving
- Student relationships build foundations of trust
- Creation of processes
- Peer mentoring to support students
- Needed a more in-depth mental health course
- Training content outdated
- Lack of co-ordination across training
- Cross-country research interesting
- No time to engage in training
- Role being brought under other senior positions
- As positive as it is negative (mental health)
- Specific, personal representations
- Breaking down scary content
- Rebranding as wellbeing or emotional health
- Core importance of mental health
- Reducing stigma
- Lack of interest or motivation from others

Familiarisation (Initial Ideas) – Cassie

- Over 20 years in teaching
- Experience as safeguarding lead
- Experience as senior leadership
- Volunteered for position of SMHL
- About bringing in support
- Management of budget
- Limited budget to support
- Direct work with children
- Need for external agencies to bolster available support
- Creating referral processes
- Triage mechanisms in role
- Liaising with counsellors
- Recognition of lack of supervision
- Staff wellbeing under another umberella
- Pushing upwards to SMHL

- Deprivation and parenting impacts
- Staff concerns around doing the right thing
- Lack of teacher training on mental health for staff
- Students identify SMHL as key supporting adult
- Working with parents and families
- ‘Face of wellbeing’
- Introducing wellbeing strategies for students
- Difficulties of virtual training
- Difficulties mixing primary and secondary discussions
- Wanted to talk through experiences in training
- Limited capacity to engage in training
- Spinning plates, reduced headspace
- Mr man made of wool
- Complexity of mental health concepts
- Defensiveness of experiences
- Characteristics becoming ‘embedded’
- Desire for instant support
- Teacher knowledge tangentially related
- Clear young people are suffering
- Young people not able to articulate feelings
- Covid highlighted importance of mental health
- Mental health akin to physical health
- Pressure to ‘fix’
- Help children to gain clarity and access
- Mental health represents many factors
- Lack of time
- Lack of budget
- High threshold of local authority safeguarding
- Pressures formed by covid
- Lack of staff knowledge, not motivation
- Teachers understand importance of mental health
- Looking beyond labels
- Belief in young people

Familiarisation (Initial Ideas) – Delilah

- Pastoral experience
- Experience within teaching
- Part of new role opportunity
- Role integrating pockets of work
- Operational role
- Reassuring staff of referral processes
- Observing trends
- SMHL seen as gatekeeper
- Staff sense of urgency to refer on for support
- Slowing down reactive support options
- Tiered referral system (pastoral above)

- Staff over-responsive to referrals
- Unpicking levels of need as SMHL
- SMHL not a known role to students
- Role about creating clearer system for support access
- Plethora of support options from external agencies
- Expanding engagement options and what's available (e.g., music)
- Manging support timetable
- Experience supports the role, not leadership position
- Working as part of a team
- Other role demands impact ability to engage in role/training
- Too much to take on student and staff wellbeing
- Knowledge can grow within the role
- Ongoing interest in trauma informed school? Mentioned previously in Intv 1
- Adaptability of role (changing focuses)
- Insightful to learn about other schools
- Difficulties with follow up due to time commitments
- Skewed view as society of mental health
    - Shouting and screaming
- Mental health like physical health
- Overused term to describe
- Missed group of the quietly struggling
- Big ball of confusion
- Changing presentations (noise)
- Complexity of mental health
- Mental health something we all have
- Difference between mental health and disorders
- Senior leadership support benefits
- Follow on courses/support
- Time
- Funding
- Intervention as opposed to crisis reaction

Familiarisation (Initial Ideas) – Eloise

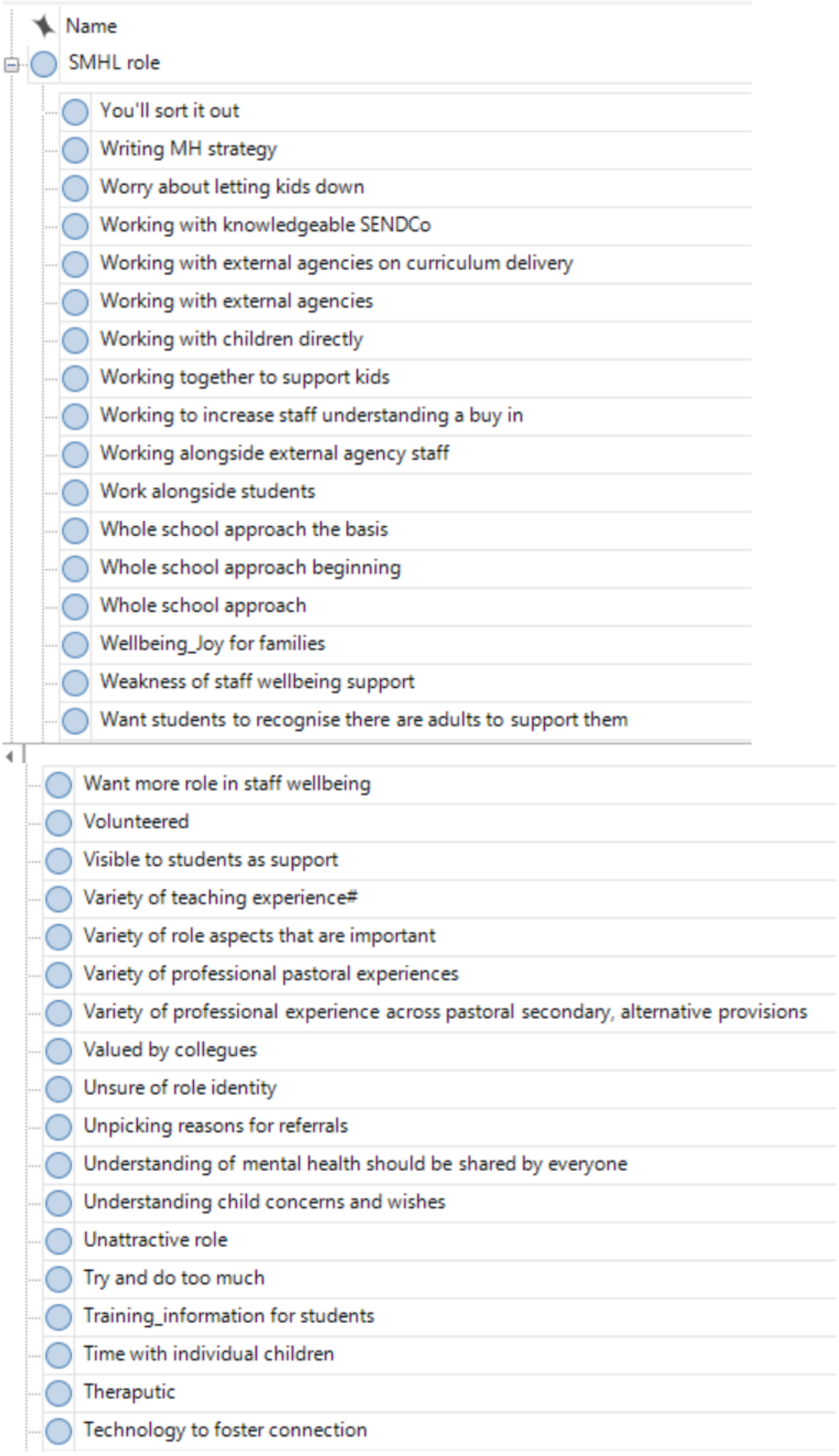
- Previous safeguarding experience
- Extensive teaching experience
- Overlap between safeguarding and mental health lead role
- Happy to take on role
- Assumption role is part of safeguarding
- Signposting students to support
- Promoting positive mental health
- Delivering assemblies
- Supporting parents
- Overseeing counselling systems
- Managing budget
- Difficulties referring to external agencies
- Lack of involvement in staff wellbeing
- Rephrasing to wellbeing as opposed to mental health

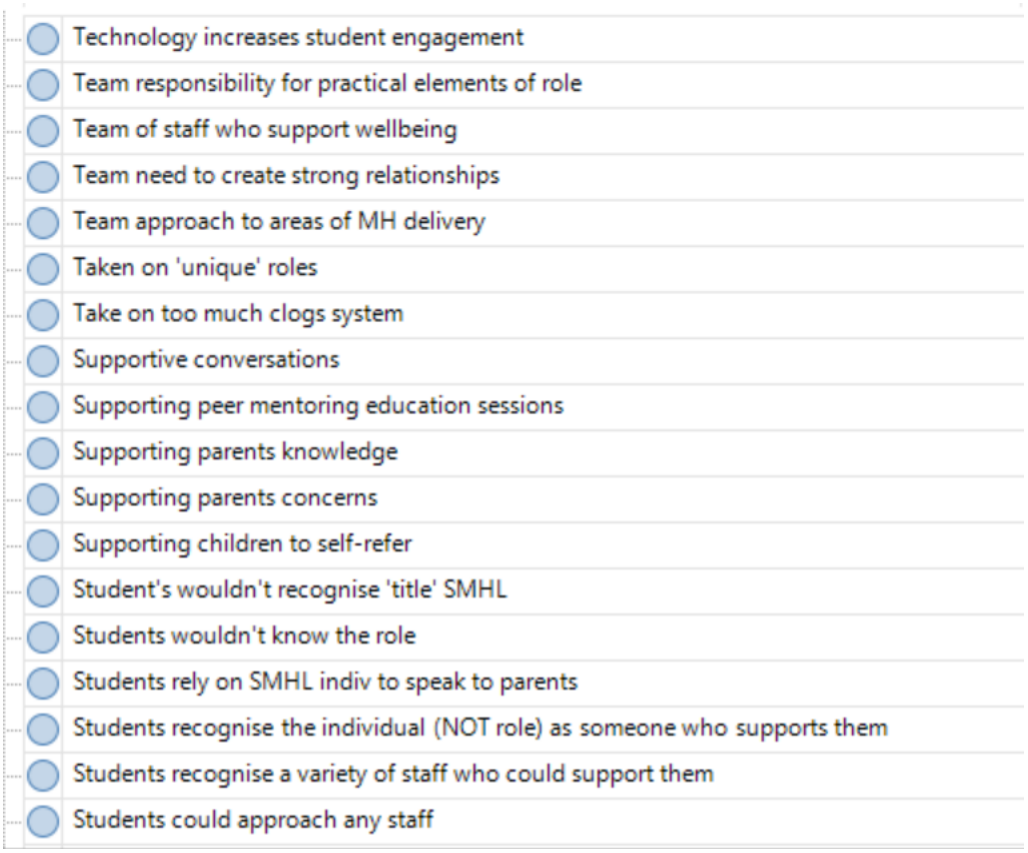
- Developing staff support strategies
    - Mentors
- Supporting students to support each other
- Team of staff who can support
- Promote SMHL less than others
- Seen as a key support in eyes of students
- Family relationships developed over Covid
- Creating supportive environment
- Young staff get it
- Value in staff training
- Seen as outward member of safeguarding/wellbeing
- Perception to be a senior leader
- Importance of getting the area to lead others
- Not a counsellor
- Lack of focus on staff wellbeing
- Referrals can be done by others
- Can't be on person
- Reviewing curriculum content
- Developing knowledge of mental health continually
- Developing training for parents
- Covid highlighted mental health importance
- Teens need boundaries
- Mental health a big topic
- Systems around children, need to support parents
- Useful to learn from others in the role
    - EPs developing supervision groups?
- Developing adaptive support options
- Clarity on role training expectations
- Different across individuals
- Variety of presenting behaviours/symptoms
- Duality: crying, screaming and quiet, reserved
- Acknowledgement of lack of lived experience
- No quick solution
- Mental health comes before academic support
- Seen as important as physical health
- CAMHS barriers
- Budget facilitators – gain external support
- Need trained professional support
- Impact of Covid
- Importance of family support

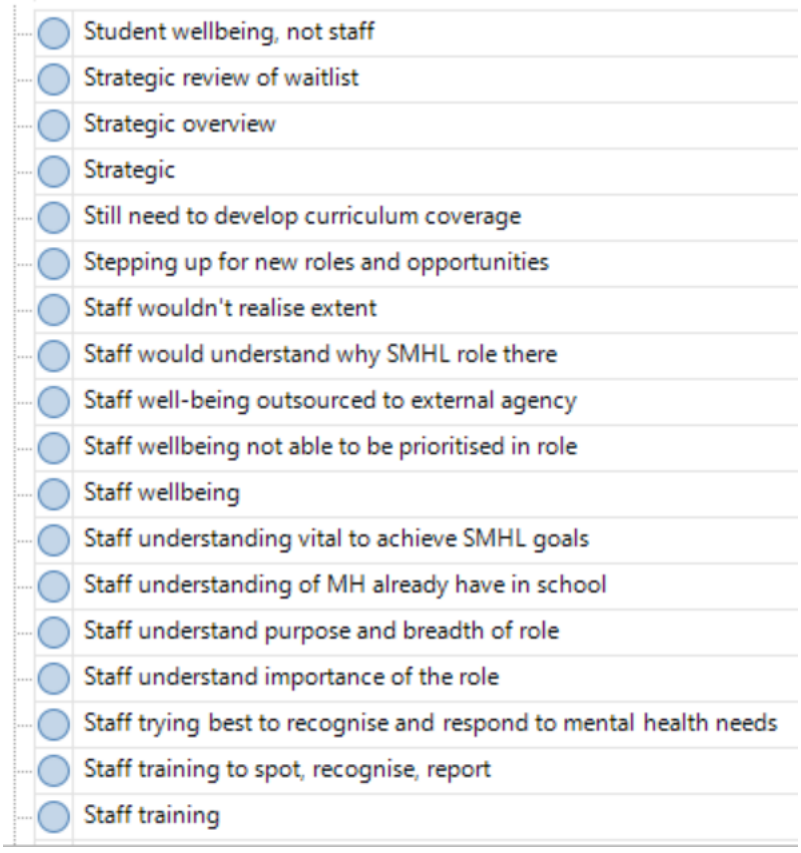
Appendix 5

Initial codes: systematic coding

SMHL Role

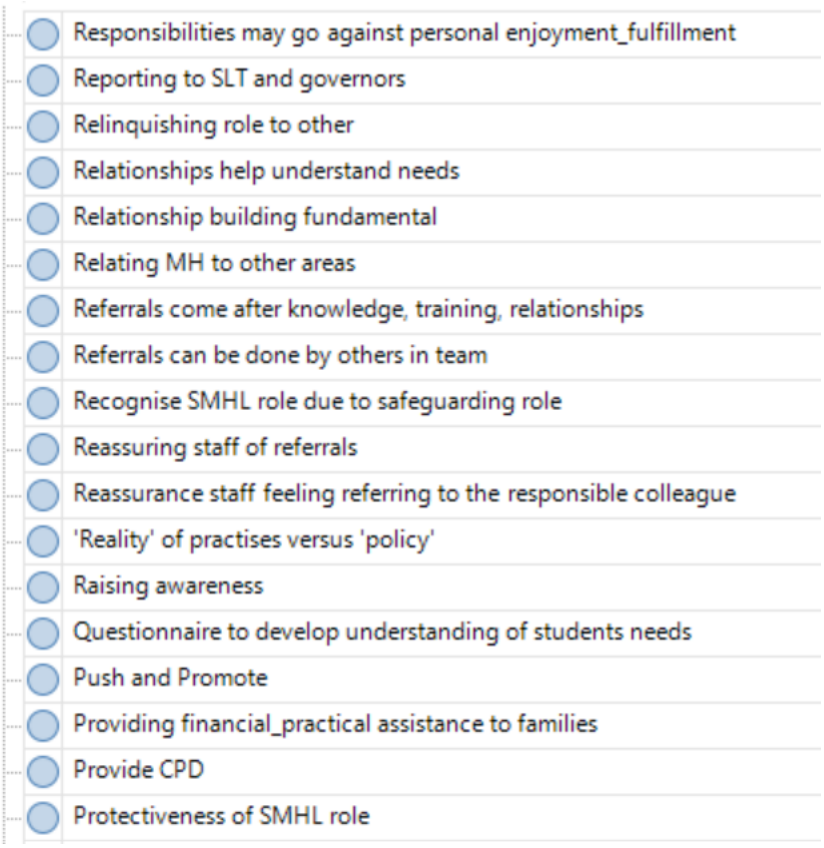


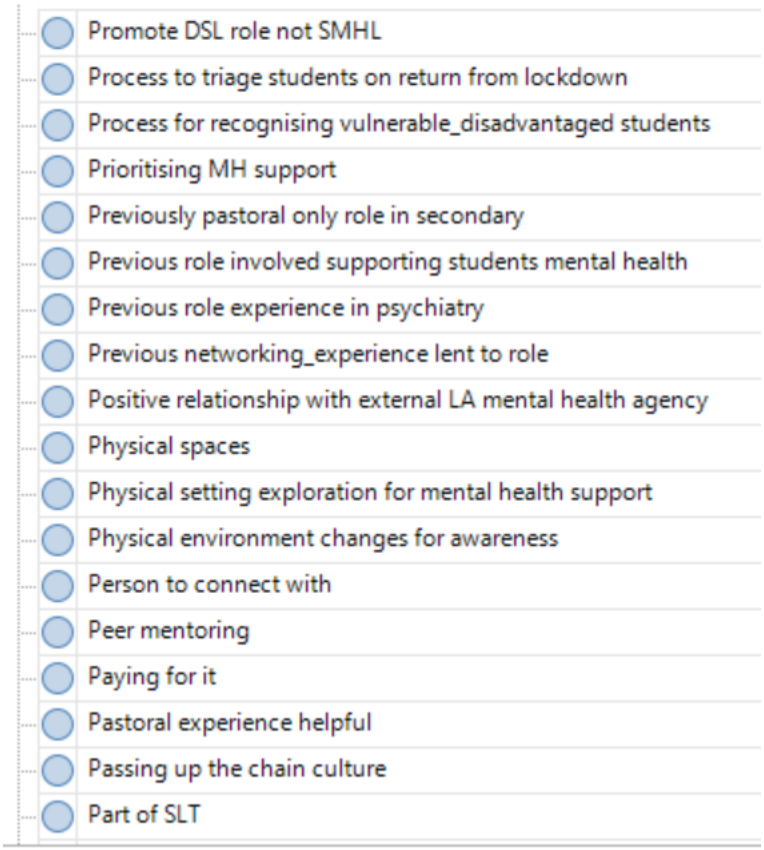

Technology increases student engagement
Team responsibility for practical elements of role
Team of staff who support wellbeing
Team need to create strong relationships
Team approach to areas of MH delivery
Taken on 'unique' roles
Take on too much clogs system
Supportive conversations
Supporting peer mentoring education sessions
Supporting parents knowledge
Supporting parents concerns
Supporting children to self-refer
Student's wouldn't recognise 'title' SMHL
Students wouldn't know the role
Students rely on SMHL indiv to speak to parents
Students recognise the individual (NOT role) as someone who supports them
Students recognise a variety of staff who could support them
Students could approach any staff


Student wellbeing, not staff
Strategic review of waitlist
Strategic overview
Strategic
Still need to develop curriculum coverage
Stepping up for new roles and opportunities
Staff wouldn't realise extent
Staff would understand why SMHL role there
Staff well-being outsourced to external agency
Staff wellbeing not able to be prioritised in role
Staff wellbeing
Staff understanding vital to achieve SMHL goals
Staff understanding of MH already have in school
Staff understand purpose and breadth of role
Staff understand importance of the role
Staff trying best to recognise and respond to mental health needs
Staff training to spot, recognise, report
Staff training

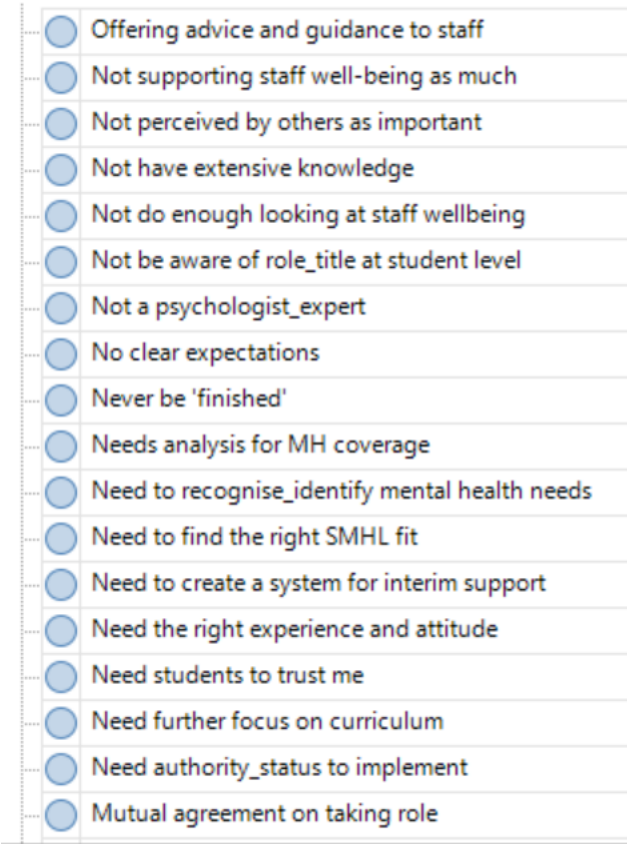
- Staff see as person to go to with concerns
- Staff reffering to SMHL supports their emotional response
- Staff referring to SMHL as answer
- Staff less likely to approach SMHL around their wellbeing
- Staff learning and developing
- Staff give SMHL respect due to leadership status
- Staff CPD for those with increased support responsibilities
- Staff approach me because DSL
- Staff approach because don't feel confident
- Splitting role across collegues
- Specialist roles held in school
- Someone people can talk to
- Sole responsibility for developing staff understanding
- SMHL supports staff learning and development
- SMHL seen as gatekeeper to support services
- SMHL roles and responsibilities unique to setting
- SMHL role not making onward referrals
- SMHL role includes a lot

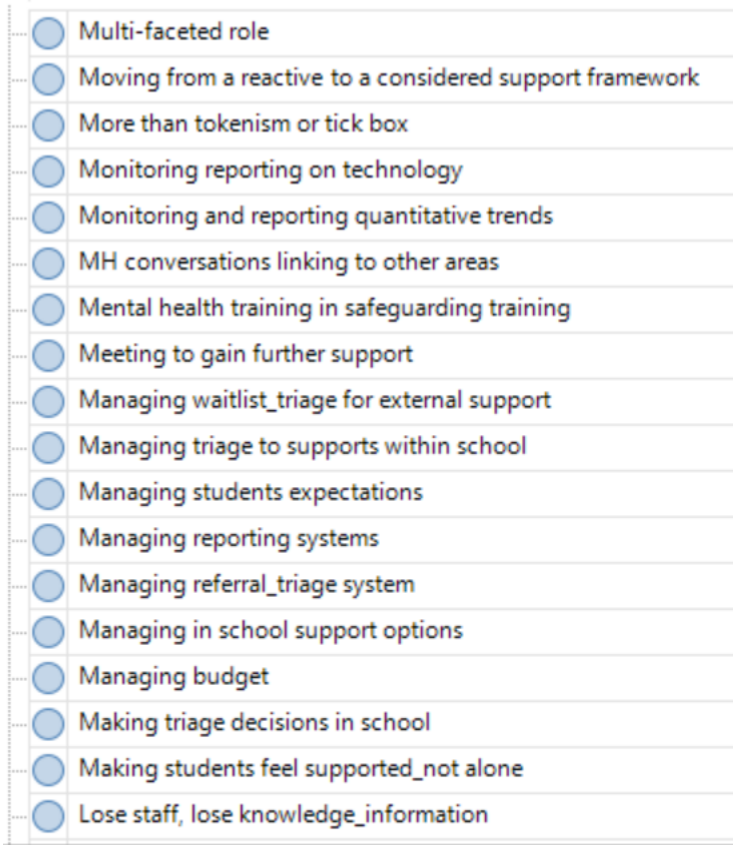
- SMHL role for planning_overview
- SMHL role fits with safeguarding
- SMHL role changing hands
- SMHL only role in school
- SMHL not involve building individual relationships with students
- SMHL individual not sought out by students
- SMHL doesn't have to be a lot
- SMHL creating overarching mental health support structure
- SMHL as a co-ordinator_manager
- Slow process of handing over role
- Singposting children
- Signposting to other services
- Signposting families
- Signposting
- Sharing initial MH support conversations in team
- Shared responsibility
- Setting facilitated family relationships
- Seeking out further support
- Seeking out events to include MH in school day
- Seeking creative support for young people
- See SMHL as part of a team response
- See SMHL as individual who is someone to approach
- Safeguarding understanding is the same as mental health understanding
- Safeguarding role guides OVER and above SMHL
- Safeguarding overarches mental health
- Safeguarding experience
- Role varies
- Role to listen and understand


Responsibilities may go against personal enjoyment_fulfillment
Reporting to SLT and governors
Relinquishing role to other
Relationships help understand needs
Relationship building fundamental
Relating MH to other areas
Referrals come after knowledge, training, relationships
Referrals can be done by others in team
Recognise SMHL role due to safeguarding role
Reassuring staff of referrals
Reassurance staff feeling referring to the responsible colleague
'Reality' of practises versus 'policy'
Raising awareness
Questionnaire to develop understanding of students needs
Push and Promote
Providing financial_practical assistance to families
Provide CPD
Protectiveness of SMHL role


Promote DSL role not SMHL
Process to triage students on return from lockdown
Process for recognising vulnerable_disadvantaged students
Prioritising MH support
Previously pastoral only role in secondary
Previous role involved supporting students mental health
Previous role experience in psychiatry
Previous networking_experience lent to role
Positive relationship with external LA mental health agency
Physical spaces
Physical setting exploration for mental health support
Physical environment changes for awareness
Person to connect with
Peer mentoring
Paying for it
Pastoral experience helpful
Passing up the chain culture
Part of SLT

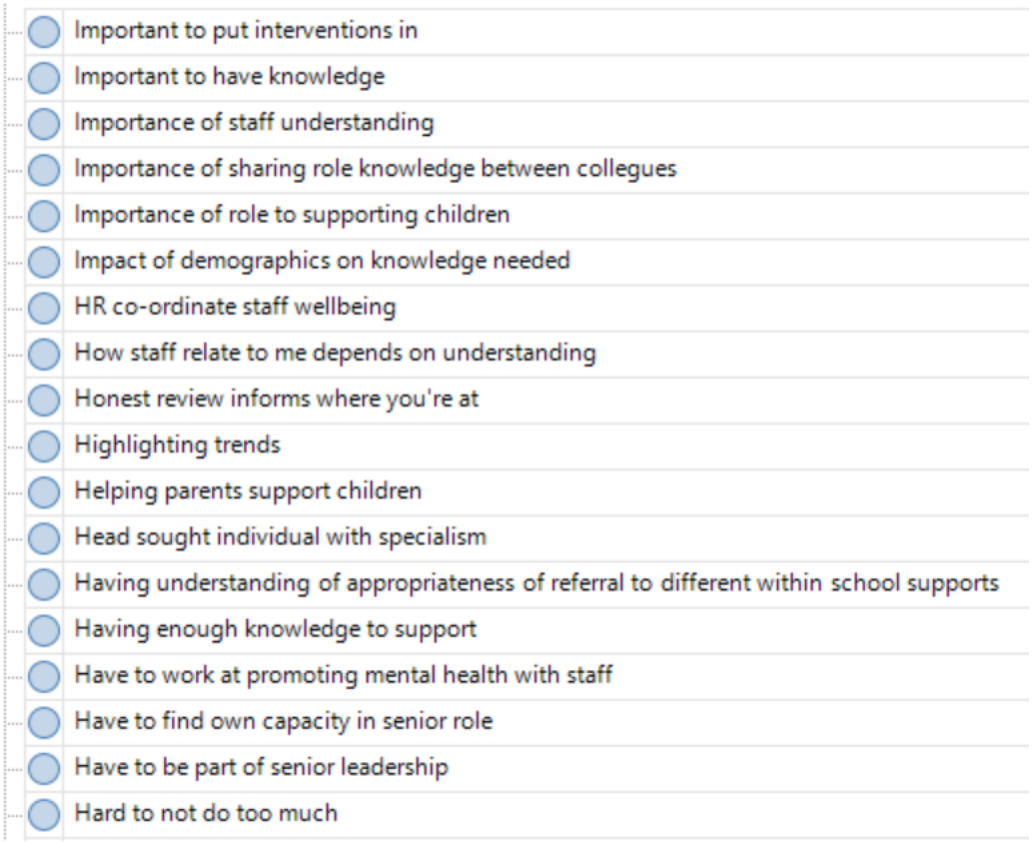

Parents finding parenting challenging
Parent support needed
Overview of students accessing support
Overarching resopnsibility of senior leader
Over twenty years in setting_teaching
Over 20 years in trust_teaching
Over 10 yeras in setting
Ovearching processes
Other pastoral roles e.g., children in care
Originated from DSL involvement
Organising training for staff champions
Organising family support_cost of living
Organising check in support
Opportunity for technology to support curriculum
Opportunities for student engagement
Operational
Open door policy
Only understood_discussed SMHL role on pastoral level


Offering advice and guidance to staff
Not supporting staff well-being as much
Not perceived by others as important
Not have extensive knowledge
Not do enough looking at staff wellbeing
Not be aware of role_title at student level
Not a psychologist_expert
No clear expectations
Never be 'finished'
Needs analysis for MH coverage
Need to recognise_identify mental health needs
Need to find the right SMHL fit
Need to create a system for interim support
Need the right experience and attitude
Need students to trust me
Need further focus on curriculum
Need authority_status to implement
Mutual agreement on taking role

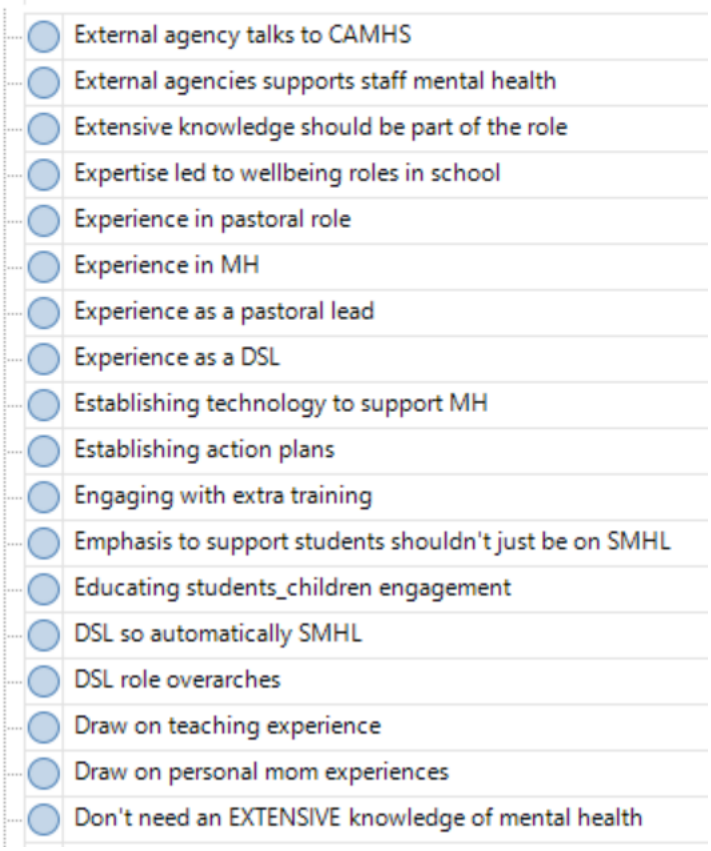

Multi-faceted role
Moving from a reactive to a considered support framework
More than tokenism or tick box
Monitoring reporting on technology
Monitoring and reporting quantitative trends
MH conversations linking to other areas
Mental health training in safeguarding training
Meeting to gain further support
Managing waitlist_triage for external support
Managing triage to supports within school
Managing students expectations
Managing reporting systems
Managing referral_triage system
Managing in school support options
Managing budget
Making triage decisions in school
Making students feel supported_not alone
Lose staff, lose knowledge_information


Lockdown helped promote learning and change practice
Listening to views of staff on cases
Linking students to support staff
Linking families to support agencies
Limited staff wellbeing support in school
Likening to safeguarding
Liaising with local authority services
Liaising with governor for mental health
Liaise with agencies led by needs
Learning within the role
Learning through pandemic
Leading to have biggest impact
Leadership role larger than SMHL part
Leadership role
Leader not isolated responsibility
Knowledge_passion of supporting_doing right thing
Knowledge not seen as integral to role
Knowledge not how role will be decided


Knowledge for role learned_adaptable
Knowledge developing in role
Keeping content up to date
Keep changing to keep students engaged
Invevitability of losing individual in the role
Introducing student used strategies
Introduce_manage referral processes
Informal staff wellbeing support
Influencing personal development sessions
Influencing broad curriculum
Individual_SMHL approached by students for support
Individual to sort it out
Individual child support
Increasing staff knowledge and confidence
Increasing coverage of MH in curriculum as in other areas
Increasing capacity by sourcing external support
Increased knowledge due to previous roles
Increase staff awareness

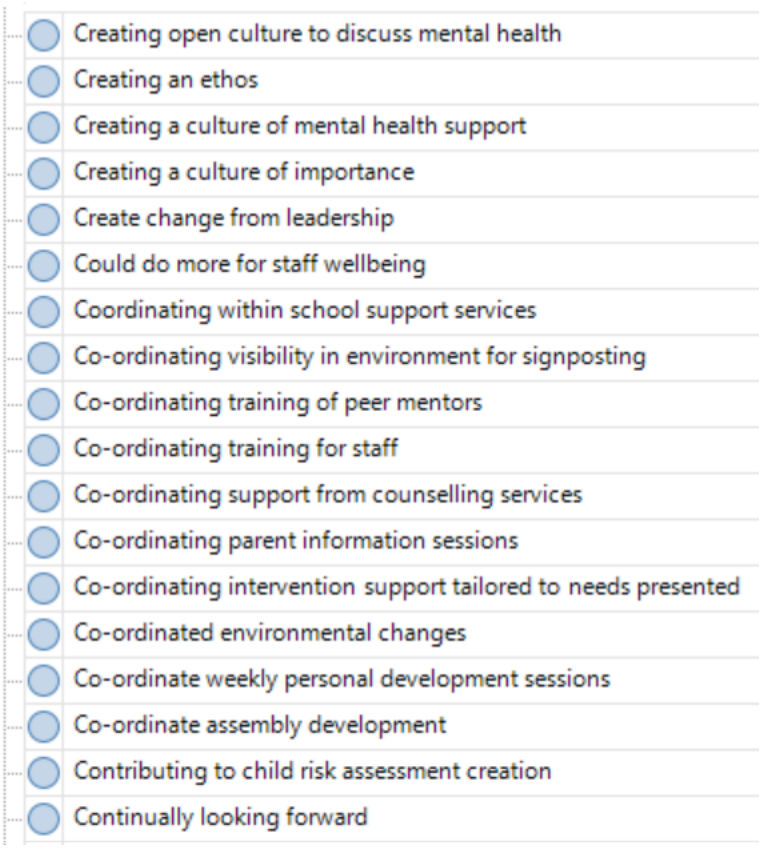

Important to put interventions in
Important to have knowledge
Importance of staff understanding
Importance of sharing role knowledge between collegues
Importance of role to supporting children
Impact of demographics on knowledge needed
HR co-ordinate staff wellbeing
How staff relate to me depends on understanding
Honest review informs where you're at
Highlighting trends
Helping parents support children
Head sought individual with specialism
Having understanding of appropriateness of referral to different within school supports
Having enough knowledge to support
Have to work at promoting mental health with staff
Have to find own capacity in senior role
Have to be part of senior leadership
Hard to not do too much


Group role as part of senior leadership position
Got role because of knowledge
Good at reactive support
Getting role establishment right
Getting as much support as possible
Gathering referral information
Gatekeeper for next level support
Formalised role before training
Following MH system_mechanisms
Focus on children, can't be staff
Focus for staff concerns
Focus as school on mental health training
Felt there would be a greater need post Covid
Feel don't have enough knowledge
Feedback from students about mental health experiences
Facilitating sharing of knowledge from external agencies
Facilitating audit_review
Face of wellbeing

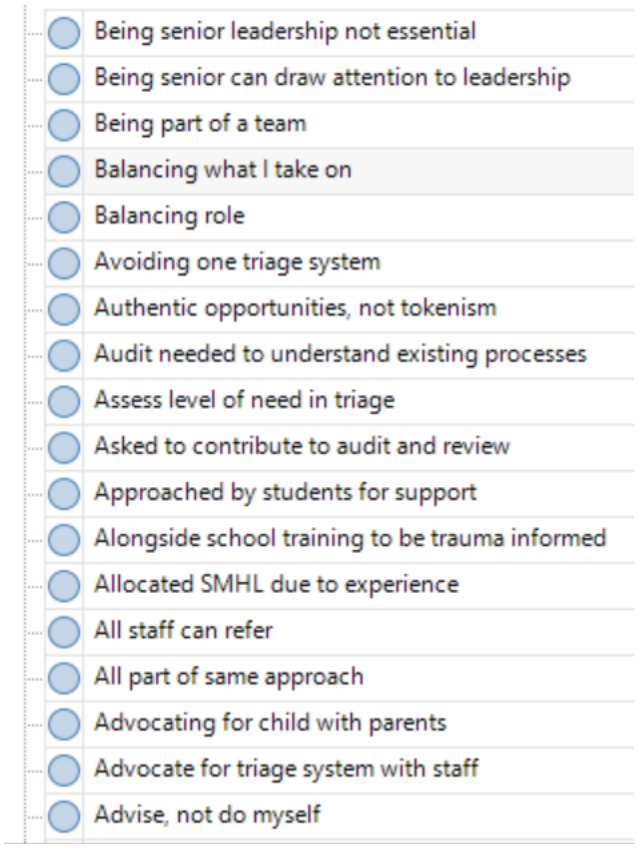

External agency talks to CAMHS
External agencies supports staff mental health
Extensive knowledge should be part of the role
Expertise led to wellbeing roles in school
Experience in pastoral role
Experience in MH
Experience as a pastoral lead
Experience as a DSL
Establishing technology to support MH
Establishing action plans
Engaging with extra training
Emphasis to support students shouldn't just be on SMHL
Educating students_children engagement
DSL so automatically SMHL
DSL role overarches
Draw on teaching experience
Draw on personal mom experiences
Don't need an EXTENSIVE knowledge of mental health

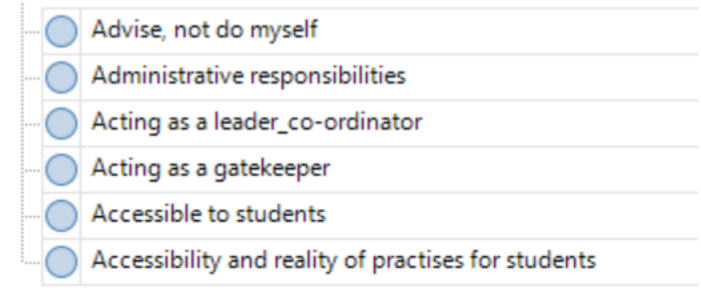

'Doing' parts and 'planning' parts of role
Disseminating MH strategy
Disseminating information about school support
Discussing role with leadership and governors
Direct work with young people_intensive
Difficulties of working within deprived areas
Difficulties of low aspiration area
Difficulties of engaging with CAMHS
Difficulties of area_deprivation
Difficulties finding SMHL replacement
Developing trauma informed ethos
Developing tiers of support
Developing students comfort in discussing mental health
Developing staff understanding of MH strategies
Developing staff understanding important
Developing MH staff team
Developing curriculum ongoing process
Developing counselling access offer for staff


Developing a whole school approach
Developing a supportive ethos and environment
Developed team of staff members supporting MH
Develop knowledge within the role
Desire to make a difference
Desire to establish supervision
Delivering elements of wellbeing week
Delivering assemblies
Defensiveness of existing practices
Cycle of retraining
Curriculum already established within school
Current involvement in safeguarding roles
Culture to create comfort and openness for students
Culture shifts take time
Creative cohesive system of support
Creating unified response
Creating understanding environment
Creating teams of staff young people can see for support


Creating open culture to discuss mental health
Creating an ethos
Creating a culture of mental health support
Creating a culture of importance
Create change from leadership
Could do more for staff wellbeing
Coordinating within school support services
Co-ordinating visibility in environment for signposting
Co-ordinating training of peer mentors
Co-ordinating training for staff
Co-ordinating support from counselling services
Co-ordinating parent information sessions
Co-ordinating intervention support tailored to needs presented
Co-ordinated environmental changes
Co-ordinate weekly personal development sessions
Co-ordinate assembly development
Contributing to child risk assessment creation
Continually looking forward


Considering_organising additional different support options
Come to me_staff_because I'm DSL
Collaborative triage
Children approach me as an individual
Children also approach other team members
Changing, learning, and adapting support
Changing relationship to the role
Changing and adaptable previous roles
Changes depending on what's been implemented in other spaces
Challenging conversations with families
Can't use role to enforce mental health agenda
Can't always think about child's mental health_not perfect
Building relationships with parents
Building capacity in system
Bringing staff together for connection
Bringing staff on journey with you
Biding for support
Being with child to unravel support needs


Being senior leadership not essential
Being senior can draw attention to leadership
Being part of a team
Balancing what I take on
Balancing role
Avoiding one triage system
Authentic opportunities, not tokenism
Audit needed to understand existing processes
Assess level of need in triage
Asked to contribute to audit and review
Approached by students for support
Alongside school training to be trauma informed
Allocated SMHL due to experience
All staff can refer
All part of same approach
Advocating for child with parents
Advocate for triage system with staff
Advise, not do myself


Advise, not do myself
Administrative responsibilities
Acting as a leader_co-ordinator
Acting as a gatekeeper
Accessible to students
Accessibility and reality of practises for students