Volume Two:

Professional Practice Reports

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CHAPTER ONE

Introduction to Volume Two: Professional Practice reports

1. Introduction

This volume comprises four professional practice reports which describe extended pieces of professional casework or small-scale research projects, undertaken over two years, between September 2010 and June 2012. The work was conducted during a supervised work placement in an Educational Psychology Service, and formed part of the professional training route for Educational Psychology, whereby trainee Educational Psychologists (TEPs) are employed by a Local Authority in the second and third years of the three-year doctorate in Applied Educational and Child Psychology. Professional practice reports therefore describe genuine examples of Educational Psychology practice requested by service users, conducted within a Local Authority context.

2. Service Context

The Educational Psychology Service (EPS) described operates within a Local Authority in an East Midlands county. The service is relatively large in size, with four geographical teams, and currently employs around thirty Educational Psychologists in total, equating to 19 full time equivalent posts. The service operates within a consultation model of service delivery, with work negotiated where possible between Educational Psychologists and stakeholders. The county in which the EPS is based is a large county with a population of around 680,000, and has both areas of deprivation and more affluent, rural villages. The county's population is predominantly white British (90.2%) with a lower than average number from an ethnic minority (NHS, 2008).

As described above, these reports describe work undertaken by a Trainee Educational Psychologist who was employed by a Local Authority within the Educational Psychology Service (EPS). The service formed part of the county's Children and Young People's Service until August 2011, when a number of services were restructured to form a larger Adult and Children's Service (ACS). The ACS also included other specialised services for children, families and schools, such as the Specific Language and Learning Difficulties team, the Autism Support Team, the Behaviour and Curriculum Inclusion team and the Pre-school/Early Years and Portage team. However, in April 2012 the ACS was again restructured and these additional teams ceased to exist, to be replaced by a unitary 'Education Entitlement Service' with some of the professionals from each of the prior teams. Many other posts were deleted. The Educational Psychology Service also became a partly commissioned service in September 2011 in order to maintain the existing level of staffing and breadth of work. This means that certain 'core' priorities are funded by the Local Authority, including statutory assessments of pupils' special educational needs, work with pupils Looked after by the Local Authority and work with pupils who are at imminent risk of exclusion. Any other work must be commissioned and paid for by schools. This impacted on the delivery of extended casework and research projects, meaning that the work described in the professional practice reports was mostly commissioned and therefore had to meet the requirements of stakeholders in terms of intensity, duration and cost of involvement.

3. Chapter Two - Professional Practice Report One: Evaluation of a Specialist Provision for Pupils with Social, Emotional and Behavioural Difficulties: How well does the school meet its pupils' mental health needs?

This report is an evaluation of a specialist provision for secondary pupils with social, emotional and behavioural difficulties. Specifically, the research aims to evaluate how the provision meets the mental health needs of its pupils, rather than just the academic and educational requirements that are typically reviewed in SEBD setting evaluations. This evaluation uses a focus group methodology

to gather the views of school staff on how they meet their pupils' mental health needs, as well as a scale to measure the sense of membership or 'belonging' felt by pupils in this setting. The evaluation is discussed as a process and in terms of outcomes for the role of the Educational Psychologists supporting the school and future planning of support.

4. **Chapter Three - Professional Practice Report Two: Reducing and Managing School Stress in Key Stage Four Pupils: a cognitive-behavioural approach.**

This report describes the planning, delivery and evaluation of a therapeutic group intervention aimed at reducing perceived stress in adolescents. The work was requested by a secondary school Special Educational Needs Co-ordinator (SENCo), in response to reports from year tutors that some pupils were feeling anxious and stressed around exam time and appeared unable to manage or reduce the stress they experienced. The school asked their link Trainee Educational Psychologist to plan and deliver an intervention, which could teach some coping and relaxation skills as well as help pupils to understand their own reactions to stress. The work was also evaluated to demonstrate whether the intervention had an impact on pupils and led them to report reduced stress levels and increased use of coping strategies.

5. **Chapter Four - Professional Practice Report Three: Applying the Research and Development in Organisations Framework (RADIO): Engaging Under-Represented Families through a Sure Start Children's Centre.**

This piece of research and development work focuses around a small Children's Centre in an East Midlands Local Authority developing services for the most 'hard to reach' families. The centre requested support with researching possible barriers to engagement for socially excluded families and with developing client-focused services. This was a collaborative project between staff working within the Children's Centre and the Local Authority Educational Psychology Service. Focus groups and semi-structured questionnaires were planned and carried out jointly, in the local community

with targeted parents, and results were considered alongside themes from the literature to plan future services. The report describes the process of collaborative research, along with the difficulties encountered whilst planning research with 'hard to reach' families.

6. **Chapter Five - Professional Practice Report Four: A School Development Project to Support the Emotional Wellbeing and Reduce Occupational Stress of School Staff through the Delivery of 'Resilience for Life' – a CBT based Adult Resilience Programme.**

The final report describes the conception and delivery of a programme for school staff to increase resilience and reduce anxiety and stress. The newly appointed Head Teacher of a primary school which had been placed in 'special measures' by Ofsted requested support from the Educational Psychology Service (EPS) to build the emotional wellbeing and resilience of school staff. This report describes the delivery of a five-session resilience programme, developed by the authors of FRIENDS for life, a well-known programme for school-aged children, to build resilience and reduce anxiety in adults during times of transition or stress. The delivery of this programme is discussed, along with evaluation of its impact using quantitative and qualitative measures. Implications for future programmes, school development work and the EP role are discussed.

7. Implications of Professional Practice reports

The four professional practice reports were chosen from a range of potential projects and cases to be representative of the diverse nature of Educational Psychology involvement within the county. The reports highlight the broad range of settings in which work is carried out, stakeholders with whom work is negotiated, groups for whom work is considered beneficial and theories and approaches used. Each report represents a distinct contribution to research and knowledge and builds upon the current evidence base for Educational Psychology Practice. The first report evaluates a distinct area of special school provision, and focuses on the school's provision for meeting emotional and mental health needs of pupils, rather than the academic or vocational outcomes that

are frequently evaluated. The second report describes the pilot delivery of a therapeutic group intervention which was designed by the author in response to a need for a stress-management programme for school pupils, which has limited coverage in present literature. Professional practice report three investigates barriers to engagement, a widely-researched area, but focuses on the needs of a specific community which were previously not known. Finally, report four evaluates a new intervention which has no published data on impact or efficacy, in order to contribute to the evidence base for a new resilience course for school staff; an approach which is absent from Educational Psychology research to date.

The reports have provided valuable opportunities to deliver more in-depth, extended pieces of work with schools and settings, and allow a far greater application of prior research, theory and literature than might usually be possible in such a demanding service. They have also encouraged the development of a wide range of research skills, more rigorous research methodologies and a critical appraisal of available methods and tools, which has in turn impacted on the research practice of the service as a whole. The work undertaken has built on the skills, knowledge and practice developed during Educational Psychology training and extended the range of topic domains in which an in-depth understanding is gained. The opportunity to research topics in some detail, extend pieces of work or develop new materials for these reports has led to a greater knowledge in a number of areas related to Educational Psychology work and has developed the author's professional practice in these areas. It has also highlighted the importance of continuing this level of evidence-based practice wherever possible to ensure a current knowledge base and sound theoretical underpinning of casework.

CHAPTER TWO

Evaluation of a Specialist Provision for Pupils with Social, Emotional and Behavioural Difficulties: How well does the school meet its pupils' mental health needs?

1. Social, Emotional and Behavioural Difficulties

The term 'social, emotional and behavioural difficulties', or SEBD, is a relatively new classification of Special Educational Need (McLeod and Munn, 2004; Hunter-Carsch et al., 2006). Previously, documents such as the Underwood Report (DES, 1955) referred to 'maladjusted children', meaning those being disturbed or disturbed by normal situations. The term 'emotional and behavioural difficulties', or EBD, was in use by 1994, for example the document 'Pupils with Problems' (DfE, 1994) described EBD as being more than sporadic difficult behaviour but less severe than mental illness, linking difficulties with mental health, including withdrawn, depressive, aggressive or self-injurious tendencies. The development of the term SEBD acknowledges the crucial role of social factors in children's difficulties (Cooper, 2001). Cooper describes SEBD as "characterised by their effect of being socially disruptive or disruptive to the development course of the individual" (2001, p. 18). Cooper (2006) suggests that although SEBD are most apparent when children display disruptive behaviour in school, the term also encompasses crime, substance abuse, phobic, suicidal and withdrawn behaviour. Patterson et al. (1992) propose a social learning model of SEBD, whereby experience in childhood of social disadvantage, poor parenting, parental violence, parental or peer rejection or low self-esteem can lead to adult anti-social behaviour. Although this terminology appears to reflect the complex nature of children's difficulties, rather than emphasising purely behavioural needs, definitions of SEBD are also broad and subjective (McLeod and Munn, 2004; Pirrie et al., 2006), with no clear model to explain or address SEBD.

Social models of SEBD consider the role of families, schools and communities in children's development, for example modelling of aggression from parents, violence in the community or hostility amongst peers (Clough et al., 2005), rather than just behaviours presented by the child, and are reflected in the classification 'SEBD'. However, social models may not take account of all the biological, psychological or developmental factors contributing to SEBD. Interactionist and systemic models are possibly the most dynamic and can take account of multiple factors in SEBD (Cooper, 1996; McLeod and Munn, 2004), for instance the interaction between biological risk factors, social disadvantage, early psychological development and school environment. This way of thinking considers the impacts of a child's environment on social and emotional development, and acknowledges the importance of provision for children with SEBD.

2. Context of Specialist Provision for Pupils with SEBD

Following the Warnock Report (Warnock, 1978) and the 1981 Education Act, integration of 'maladjusted' children became more important (Hurt, 1988; Laslett, 1998). Maladjusted children were redefined as having Special Educational Needs and more emphasis was placed on educating within mainstream classes. Although special schools for children with SEBD could therefore be viewed as precluding integration or inclusion, some pupils require specialist provision which meets their needs. Separate provision for SEBD has at times been criticised for stigmatising its pupils, however many, including parents of these pupils, defend special schools due to concerns that mainstream education cannot provide the specialist support needed (McLeod, 2006).

Since the 1980s, arguments have focused not just on whether specialist provision should exist or not but more specifically on whether it can provide quality education and support to pupils, with criticisms of some specialist provision, particularly Pupil Referral Units, that curriculum is too narrow and poorly delivered (Her Majesty's Inspectorate of Education, 2003) and that these institutions

impact on self-esteem (Cullen, 2000; Watts, 2000). With these criticisms in mind, it seems essential that specialist provision, if it is to continue, becomes accountable for what it delivers to pupils and for how it meets their educational, social and emotional needs.

3. Evaluating SEBD Provision

Various inspections and research projects have addressed the question of what constitutes effective provision for pupils with SEBD (Cole, Visser and Upton, 1998; Hamill and Boyd, 2000; Cooper, 2001; Howarth and Fisher, 2005). However, many of these have focused primarily on the educational outcomes of pupils or on how well schools manage pupil behaviour. This is perhaps understandable, considering the often poor academic attainment and long term outcomes of pupils with SEBD (DfEE, 1997; Farrell et al., 1999) as well as the poor standard of education observed in many special schools (DfE, 1997). However, these findings are over ten years old; therefore more up to date evaluations of pupil progress are needed.

Cole et al. (1998) previously gave a comprehensive review of SEBD provision; however the main measures or outcomes considered by Cole et al. were academic attainments and the number of pupils returning to mainstream education. A more recent Ofsted evaluation of SEN provision (Ofsted, 2010) similarly inspected schools according to attainment first and foremost, before progress in other areas, including exclusion and attendance figures, participation in other activities, relationships with peers and monitoring and evaluation. This assumes that the primary objective of special schools is to ensure pupils make academic progress, much like mainstream schools, and that care and personal development are, in essence, there to complement learning. This view can be challenged; for example a Head Teacher of a special school is quoted in Cooper (2001):

> "*I think now we have to consider whether the educational model pays sufficient attention to all the emotional needs of the child. On balance I would prefer that our pupils grew up*

adjusted rather than qualified. In the end, that is a higher order of attainment - to enable them to integrate into life after school and their future relationships." (p. 6)

Cole et al. (1998) conducted a national evaluation of 156 schools for SEBD pupils using a detailed questionnaire. Encouragingly, the survey looked for factors that help to manage pupils and address their needs, for example personal and social education, creative arts, good staff-pupil relationships, sessions with counsellors and affective support. This meant that schools could respond from their own experience and give a picture of what interventions actually meet pupils' needs; however, questionnaires of this sort rely on accurate reporting by head teachers, whereas responses can in reality be subjective or not representative of the opinions of all staff. Additionally, any ratings (for example, rating sessions with counsellors as 'quite important') would be based on perceptions of outcomes rather than thoroughly evaluated interventions. The 'outcomes' section of the questionnaire disappointingly measured only academic achievement and return rates to mainstream, not long-term pupil outcomes or progress with social, emotional or behavioural targets. Although these outcomes are difficult to measure, positive social, emotional or behavioural outcomes could demonstrate that SEBD schools are providing specialist support.

Cole and Visser (1998) explore the idea that whilst EBD provision should be evaluated in similar terms as mainstream schools, further impacts should be considered, with less emphasis placed on educational attainment. They suggest that the National Curriculum may be of secondary importance compared to resolving emotional and social difficulties, and that these SEBD would need to be addressed before pupils can attain their full potential. Focusing on educational outcomes may even devalue the personal, emotional and social outcomes from good provision. More recent accounts of SEBD provision should be considered, though, as Cole et al.'s research (1998) may not reflect the current state of provision or any progress made in the past decade.

Fredrickson et al. (2007) suggest that the assessment of social or emotional outcomes has been overshadowed by emphasis on academic outcomes for pupils. They report that Local Authorities and schools have agreed on the importance of a number of outcomes in different domains, such as social, affective and life chance outcomes, in addition to academic progress, but that there is little idea of how to measure these. Fredrickson et al.'s study attempts to measure the outcomes of inclusion in terms of social acceptance, social behaviour and pupils' sense of belonging within the school setting. They use quantitative measures, including the 'Social Inclusion Survey' (Fredrickson and Graham, 1999), the 'Guess Who' measures (Fredrickson and Graham, 1999) and the 'Belonging Scale' (adapted from Goodenow, 1993), to provide tangible figures for comparing special and mainstream schools on meeting pupils' needs. Whilst in this case the research was comparing schools on the outcomes of inclusion, these measures could also be used in specific schools to measure progress in pupils' feelings of social acceptance, social behaviour and belonging, by giving pre and post intervention measures. Fredrickson et al. (2007) discuss the concept of inclusion linked to community and belonging, following Warnock's recommendation that: "the concept of inclusion must embrace the feeling of belonging, since such a feeling appears to be necessary both for successful learning and for more general wellbeing" (Warnock, 2005, P. 15). Here, Fredrickson et al. appear to be moving away from the established evaluations of academic performance, considering instead how provision meets the emotional needs of pupils, allowing them to feel secure, accepted and part of the school community.

4. Mental Health in Schools

Promoting pupils' mental health represents a differing perspective to addressing social, emotional and behavioural difficulties. Whilst SEBD could be seen as a deficit view, labelling difficulties children experience, promoting mental health could constitute more positive support of children's psychological, emotional and social development. Although pupils with SEBD are at increased risk of having some mental health needs (Hackett et al., 2010), addressing these could mean promoting

personal resources, such as agency, autonomy and optimism (Weare, 2002) for dealing with challenges, which in turn could result in reduced SEBD.

The 2009 DCSF document 'Improving the Psychological Wellbeing and Mental Health of Children and Young People' (DCSF, 2009) sets out the requirements for childcare provision and schools to support children's personal, social and emotional development, to promote psychological wellbeing and mental health, and for specific, targeted and therapeutic support to be available for those identified as at particular risk of experiencing mental health problems. This could include settings (e.g. Pupil Referral Units and SEBD settings), with mental health practitioners delivering evidence-based, therapeutic interventions to those identified as at risk. Although the document raises the profile of mental health needs for at risk pupils, including those with additional SEBD, it does not give a clear idea of how the mental health of pupils should be measured or monitored. Definitions of mental health given are likewise imprecise and difficult to measure (e.g. DfES, 2001):

For children who are **mentally healthy**, they have the ability to:

- develop psychologically, emotionally, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and Learn;
- develop a sense of right and wrong; and
- resolve (face) problems and setbacks and learn from them.

Meeting 'mental health needs' would suggest that one or more of the above are absent or developing incompletely, as can be the case with SEBD, and that provision should aim to help pupils develop in this way.

Assessing mental health has been attempted by a number of research projects to evaluate the success of interventions, but many measure within-child traits like strengths and difficulties, general functioning or self-esteem (Wells, Barlow and Stuart-Brown, 2003; Jacobs, 2007). Fredrickson et al.'s (2007) study turned this around, and focused on the social aspects of mental health that are promoted by inclusive schools. This approach looks at the school factors that nurture mental health, including pupils who are socially accepted, whole-school behaviour which is socially positive and a school ethos engendering belonging.

5. Belonging as a Primary Mental Health Need

Maslow's (1970) hierarchy of needs sets out the fundamental needs of human beings to achieve psychological wellbeing. It suggests that the most basic needs, such as eating, drinking and sleeping, feeling safe and secure, and affiliation with others, need to be met before higher order needs including self-esteem and self-fulfilment can be met. SEBD can be viewed as unmet needs within the hierarchy (Cooper, 2006); for example disordered home environments might result in poor diet or sleep patterns, while violence in the home and community could prevent feelings of safety, and lack of belonging to a stable family unit or peer group could cause feelings of rejection or anxiety. Most schools would strive to meet physiological and safety needs, by providing meals, health education and a safe environment, and may try to promote self-esteem and fulfilment, but Malsow's hierarchy shows the additional importance of feeling affiliation with a group or setting.

In more recent psychiatric practice, social ties, connectedness and a sense of belonging are seen as key to maintaining mental health (Hagerty et al., 1992; Kawachi and Berkman, 2001); however these studies have centred on communities, friendships and shared values. Ideas of 'belonging' have moved into the school context, where sense of belonging in the classroom can be viewed as a protective factor against mental health difficulties (Goodenow, 1993; Osterman, 2000; Anderman, 2002). Baumeister and Leary (1995) discuss the importance of belonging in terms of experiencing social value, positive relationships and concern for others' wellbeing. They demonstrate that *lack* of

belonging can lead to negative outcomes, including stress, psychopathology and health problems, but do not investigate the positive outcomes of affiliation. Others have linked a sense of school belonging to motivation and school engagement, which ultimately increases attendance, achievement and social development (e.g. Finn, 1989). Unfortunately though, these studies are out dated and focus on American populations, reducing their validity in the UK. They purely describe correlation between reported sense of belonging and concurrent psychological outcomes, and do not demonstrate how improving the school ethos of belonging can alter outcomes. It is not, therefore, clear whether 'belonging' can be manipulated to improve outcomes for pupils, or whether it is one aspect of a wider positive school environment which nurtures development.

A large-scale, longitudinal study in the US (Anderman, 2002) looked at psychological outcomes for adolescents across schools, by comparing sense of school belonging against outcomes including depression, social rejection, school problems and achievement. Anderman reports that previous research shows a perceived sense of belonging to one's school leads to improved academic, psychological and social outcomes for adolescents; however findings from the study are contradictory. Individually-reported sense of belonging appeared to be inversely related to depression, rejection and school problems; however aggregate belonging, that is, where high numbers of the school population feel belonging, was linked with greater school problems and bullying for some. Such longitudinal studies are problematic, as psychological states, including affiliation, tend to fluctuate across schools, areas and over time. Additionally, the school factors found to be linked to belonging were ones that cannot easily be changed, such as school size, urbanicity and year group structure.

Another longitudinal study of school belonging attempted to find factors that contribute to affiliation, in order to enhance school connectedness (McNeely et al., 2002). These included teachers being empathic, fair and encouraging, and student participation, whilst harsh behaviour policies and frequent exclusions resulted in lower perceived belonging. These more recent studies indicate that

belonging continues to be associated with positive psychological outcomes. Most of these studies use similar measures of school belonging: a scale with statements such as 'I feel like I am part of this school' with a three or five point Likert scale to indicate agreement. Although this relies on pupil self-reports, which could be subject to interpretation of the terminology and feelings on the day, it also provides some numerical indication so that group means can be compared.

Goodenow (1993) developed a scale of this sort to measure the psychological sense of belonging. Using the scale in US schools, Goodenow found that a perceived sense of belonging or membership was strongly positively correlated with motivation, and weakly associated with achievement and effort. The study did not, however, correlate belonging with any psychological outcomes such as school dropout, exclusions or mental health. Further research here could address whether belonging is a likely indicator or predictor of psychological wellbeing. Additionally, Goodenow hypothesises that establishing belonging, or perceived position within a setting, may be a primary task for adolescents and take priority over other tasks, akin to group formation theories of forming, storming, norming and performing (Tuckman, 1965). This could have implications for SEBD settings, and suggest that whilst pupils do not feel affiliation for their setting or are unclear on their position within it, they cannot focus on other tasks or development. These ideas are only hypotheses and have not been researched by Goodenow; however they could have strong relevance for SEBD settings. A lack of affiliation within a school for pupils with SEBD could prevent formation of supportive relationships and lead to further disengagement and challenging behaviour.

6. Promoting Whole-School Mental Health

Wells et al. (2003) review approaches to promoting mental health, finding that the most successful were whole-school, adopted continuously for over a year and promoted positive mental health for all pupils including changing the school climate, rather than brief preventative interventions.

Patton et al., (2000), describe the Gatehouse project in Australia, aimed at promoting mental health in secondary schools. They echo the importance of whole-school climate and ethos in mental health promotion, through healthy attachments with peers and teachers, and a sense of security and trust, mirroring ideas in research on belonging. Key to this systemic approach are the adults working in school, who are required to form these positive relationships and maintain a climate of security and trust. The authors do not appear to address the potential impacts of negative staff or adults who are not willing to engage in such project work though. In order to attempt systemic mental health work in schools, staff engagement is key. Schools are potentially a protective environment but rely on adults being willing to establish meaningful relationships and participate in interventions (Doll et al., 1998). Wyn et al. (2000) found that mental health promotion in 24 Australian secondary schools relied on teachers being comfortable and confident in teaching for mental health, as well as a supportive school environment and specific, targeted interventions for the minority who require them. Although the research suggests that teachers are central in promoting mental health, it is not clear which factors contribute to this, whether existing skill-level or motivation is necessary or whether training and support can induce this.

According to Weare (2002), supporting factors in promoting mental health in schools include a whole-school approach, systemic work on school climate and environment, and cohesive relationships. Weare (2002) acknowledges teachers' need for training, time and support to understand mental health issues and become aware of how to address them. It is staff who may be responsible for implementing any whole-school changes or interventions, therefore it is desirable to recognise the views of staff and their perceptions of the school environment, as well as any suggestions for how to support pupils' mental wellbeing, so that staff will engage in interventions and feel able to support pupils.

7. Context and Aims of this Study

Oak Tree School (a pseudonym) is a specialist SEBD provision for pupils aged 12 to 16. It takes pupils who have either been excluded or would be excluded from mainstream schools. Generally, pupils here require a statement of Special Educational Needs, and many have been educated in a Pupil Referral Unit pending statutory assessment. According to senior staff, many pupils have experienced disordered and traumatic home lives, for example periods in care or domestic violence. Additionally, if pupils have experienced rejection from at least one previous school they may find it difficult to feel affiliation with future school settings and peer groups.

During initial planning meetings with school management at Oak Tree School within my role as a link trainee Educational Psychologist (EP), the need for support meeting pupils' mental health needs was discussed, both at an individual and whole school level. The Educational Psychology Service (EPS) suggested looking at the whole-school environment, to identify supports and barriers to mental health. Additionally, school management felt that all staff should have the opportunity to contribute their views and ideas on what could be done to develop mental health provision, recognising their contributory role in this (Doll et al., 1998; Patton et al., 2000; Weare, 2002).

After consultation with the key stakeholders (School Head, Special Educational Needs Co-ordinator (SENCo), Assistant Head, Senior EP and Link Trainee EP), we agreed on two research questions for the evaluation:

1. **How far do pupils feel a sense of affiliation with the setting?**

   This was developed from research on belonging/affiliation as a foundation for psychological wellbeing (e.g. Maslow, 1970; Goodenow, 1993; Anderman, 2002)

2. **How do staff believe that the school is able to meet pupils' mental health needs?**

This was hoped to uncover the views of staff and address *their* needs in supporting vulnerable pupils (Doll et al., 1998; Weare, 2002).

8. Methodology

In order to measure 'belonging' as a pupil perception it was agreed that Goodenow's Psychological Sense of School Membership Scale (1993) would be the most appropriate measure. This consists of 18 items such as 'The teachers here respect me', with a five point Likert scale (where 1=not at all true and 5=completely true). Belonging was agreed as a valuable measure as it is whole-school focused and results could generate some intervention work. There was a discussion about the validity of such a quantitative measure in assessing a subjective, changeable construct. The Goodenow measure was chosen as it is a widely used and readily available tool, and its development was also discussed to alleviate concerns about its validity and reliability. The measure was originally developed in the US in 1993. 28 items were initially pooled from themes in research literature and administered to three different samples of adolescents, along with other measures, to gage validity. Items that reduced internal consistency were then removed to give an 18 item scale. The sample tested gave a mean score of 3.86 and then 3.84 one year apart, suggesting strong test-retest reliability. The Goodenow scale revealed positive correlations with school attainment/outcomes, motivation, school engagement and lack of psychopathology (Baumeister and Leary, 1995; Finn, 1989; Goodenow, 1993; Anderman, 2002) which are relevant to both the SEBD population and in promoting mental health.

The BPS (2009) highlights the importance of informed consent for human participants. This was attempted by writing to pupils' parents or guardians to explain the purpose and content of the research and request notification of any wish to opt out. It is possible that some parents may not have fully read or understood the letter and therefore that full 'informed' consent was not

guaranteed; however this was the only realistic means of communicating with all families. Pupils were also allowed to cease participation at any time and had full explanation and debriefing. Risk of harm to participants was considered low, as the short scale contained ideas and language that had been discussed with pupils already in class.

The Psychological Sense of School Membership Scale (PSSM) was administered by class teachers in school during a Friday morning. Most teachers opted to administer it in a group setting (in a class of between 4 and 8 pupils); however some individuals were absent and completed the scale the following week with one to one support. Since this could mean that these pupils felt more influence/pressure from the adult present, I asked for pupils to be seated a distance from the adult so that responses were private. The class teacher explained that the PSSM was a short survey to find out more about the school, that names on the sheet were optional and that response sheets would be taken by myself and analysed, then destroyed. Confidentiality was not assured as teachers would be able to see response sheets.

Teachers opted to read all 18 statements aloud and allow pupils to circle their response, to accommodate the literacy difficulties of some pupils. Responses were then collated to give an overall mean and class means, to look for class differences, for mean item responses and give a baseline measure before any intervention. This may appear to assume a positivist epistemology, assuming that belonging is a concrete, 'discoverable' reality; however this was only one part of a broader evaluation. Focus groups for school staff were less structured, taking a less positivist approach, allowing the individual constructions of staff to be included.

Focus groups were thought to be a valuable research method by both EPs and school staff. Use of a questionnaire was considered; however discussion was considered more likely to engage staff and allow detailed views to emerge. Semi-structured interviews would have been a useful method, as they can give rich, in-depth data and allow participants to give honest views with feeling pressure of consensus (Kvale, 1996; Seidman, 2006). Interviews may give more valid responses as subjects are

less likely to lie or conform to group views; however group discussion also allows verification of responses. Unfortunately, interviews are time consuming and would require multiple visits. Focus groups were chosen as they give a sense of whole-staff perceptions and more widely held beliefs, and allow ideas to develop with prompts from others and the researcher (Wilkinson, 2004).

During focus group discussions the researcher usually acts as a facilitator (Robson, 2000). It is important that the facilitator allows the group members to feel at ease, able to contribute openly and give genuine opinions without conforming to group consensus. Some members of a group can be more dominant and others far less confident in speaking; therefore a facilitator should attempt to even out any power imbalance and encourage all members to speak (Barbour, 2007). A skilled facilitator is sensitive to any comments which could develop into new lines of enquiry or have analytic promise, but equally should be perceptive of potentially difficult situations such as members arguing or talking over one another (Barbour, 2007). Brief ground rules established early on, including allowing others to finish and not dominating, could help the flow of discussion.

Lastly, there are ethical considerations for focus groups such as this: staff had research purposes and processes explained and were asked for (verbal) consent prior to the discussion. Also, staff were advised they could cease participation at any point (BPS, 2009). Secondly, participants might reveal personal or sensitive information, for example a teacher might admit to feeling incompetent in dealing with anxious pupils, or recount a story about a situation with a specific pupil. It is therefore important to establish confidentiality, purpose and data use at the outset.

In this focus group, I explained that information was to be used for the purpose of evaluation, to be seen by myself and the Senior EP in the authority and the SENCo and Head of the school, but that no names would be printed, only anonymous comments included in my report. I also asked members not to use pupil or staff names or give identifying personal information, and not to repeat the content outside of the session.

Robson (2000) suggests preparing around 6 topic areas which are phrased as questions. It is important to match the questions carefully to the desired research aims and questions, and to ensure that discussion develops but does not deviate too far from these. The suggestion of Robson (2000) was also considered, to start with general, open questions then move towards more specific ones. Questions were developed with the Head and senior EP, to address staff perceptions of how school supports pupil mental health and what could be developed. Final questions and prompts can be found in Appendix 1.

The focus group was held after school with staff members who volunteered to participate. 10 staff took part: 7 Subject Teachers, 2 Teaching Assistants and the school's SENCo. Questions were asked to the group, with prompts where answers did not develop fully, but responses that deviated from the question were allowed to develop in order to gather valuable information.

9. Results

Each Psychological Sense of School Membership (PSSM) scale was scored individually to give a mean score between 1 and 5, where a score of 3 or more indicates feelings of belonging and a score below 3 indicates a pupil at risk of social exclusion and lowered commitment to education (Goodenow, 1993). Percentages of pupils within school with scores below 3 were then calculated, as suggested by Goodenow, as rates above 25% might indicate poorer quality social relationships within a school.

Table 1. Mean Scores for Individual Pupils on the PSSM

	Class 'A' (Years 8 / 9)	Class 'B' (Years 8 / 9)	Class 'C' (Years 10 / 11)	Class 'D' (Years 10 / 11)
	4.0	2.9	4.3	3.7
	2.5	4.1	4.4	3.8
	3.1	3.8	3.5	3.1
	3.0	3.8	4.5	4.1
	3.6	3.7	3.3	3.7
		3.9	3.3	2.6
			4.3	
Mean Score for Class:	3.24	3.7	3.9	3.5

The results above show that all classes had mean scores above 3, suggesting no class-specific concerns. Additionally, the whole-school mean score was **3.59**, showing a good overall sense of school membership, which indicates good quality social relationships (Goodenow, 1993). Out of 24 pupils, 3 pupils indicated they did not feel a strong sense of belonging, which might put these pupils at increased risk of social exclusion or disengagement from education. This equates to **12.5%**, which is well below the threshold of 25% that Goodenow used to suggest poor quality relationships in school.

Analysis of individual scale items (Appendix 2) revealed trends in ratings given. Looking at individual scale items, the highest rated items were 'People here notice when I'm good at something' (mean 4.5), 'There is at least one teacher or other adult here I can talk to if I have a problem' (mean 4.6) and 'People here know I can do good work' (mean 4.8). This suggests that pupils generally experience positive relationships with staff and emotional support when needed, and that staff recognise their achievements, perhaps by praising work.

The lowest mean ratings were ‘Other children in this school take my opinions seriously’ (3), ‘I can really be myself at this school’ (3.2) and ‘Other pupils here like me the way I am (3.1). This might imply poorer social relations between pupils, either perceived or actual negativity towards other pupils and more frequent experience of criticism or contempt.

Content analysis of staff focus group responses was used to look for recurring themes or responses. Whilst ethnographic analysis could be used to look more in-depth at segments of data (Wilkinson, 2004), a content analysis better suited to the research aims as general views were wanted from all staff, and one specific theme was not of more importance. The responses were examined for any apparent themes or trends, then these were systematically identified across the data set and grouped together by themes. Themes abstracted from quotes from staff are shown below (table 2), along with any links to themes identified within previous research. Although Morgan (1997) suggests that a count can be useful in content analysis to show how many mentions of each theme were made, I wanted to give all responses equal weight rather than emphasising frequently mentioned themes.

Table 2. Content Analysis of Focus Group Responses

	Theme	**Illustrative Quotes**	**Link to Literature**
	Concepts of mental health	"being happy and enjoying life" "able to succeed" "motivation" "positive relationships with peers and adults and relatives" "expressing emotions"	DfES (2001)
	Pupil mental health needs	"a lack of social skills, emotional literacy, empathy…" "they struggle to communicate effectively" "trust, self-esteem, feeling safe" "they have no boundaries or consistency outside of school"	DfES (2001) Weare (2002)
Current strengths that help promote mental health for pupils	Staff Approaches	"so many positive relationships with pupils and genuine regard" "always supporting them even after a bad incident" "constant praise" "we've had lots of training in ADHD and dyslexia already, I think we are confident in dealing with pupils day to day"	Weare (2002) Patton et al. (2000)
	Whole-school systems	"clear behaviour management" "incentives and rewards" "the school is a really nurturing environment for them" "nutritious school dinners help" "multi agency support"	Wells et al. (2003)
	Whole-school interventions	"SEAL throughout the school" "circle time and PSHE"	
	Individual, targeted support (only discussed after prompt)	"personalised learning like for X" "I've done one to one social skills with X" "school counsellor" "art enrichment"	
Future develop-ments needed to improve mental health	Staff training/development	"we could do with training, strategies to support ODD in the classroom" "training on how to use language effectively to avoid conflict"	Wells et al. (2003) Weare (2002)
	Whole-school development	"we are most anxious about the merge with X and the new building. It would be great to have support with the transition for staff and pupils"	

	Individual, targeted support	"maybe anger management groups or group projects" "definitely one to one therapy for some, but there is not enough time or space at the moment"	

10. Discussion and Outcomes

This research sought to investigate how well a specialist SEBD secondary provision supported pupils' mental health. Specifically, it asked whether pupils felt belonging and affiliation with their school, and how well staff believed they could meet pupils' mental health needs.

PSSM scores indicated a strong sense of membership for most pupils with particularly positive perceived relationships with staff, but lower perceived regard from fellow pupils.

Staff focus group discussions revealed several themes which staff appeared to agree on. High frequency of comments around current strengths, particularly in staff approaches and whole school systems, suggested that staff feel the school supports pupils' needs well, but there were fewer examples of individual targeted interventions, and these had to be asked for (prompted) specifically. Comments about developments required focused around training for staff, therapeutic interventions for specific pupils and EPS support with forthcoming changes.

The discussion on areas of support was particularly rich and focused on impending changes within the school. The school planned to merge with a primary SEBD provision and move into a new building next year. The staff all anticipated that this would be a huge challenge, and discussed EP support with the transition for both pupils and themselves, for example, work on transition to prepare pupils, support for staff to build new skills and relationships, and change management throughout the process. This was a valuable discussion which opened up opportunities for EPs and school staff to work at an organisational level, to support the transition. Data of this nature would

be far less likely to emerge in a structured questionnaire or interview situation, highlighting the value of the method chosen.

A final discussion of these results with staff suggested that the school environment was conducive to pupils' sense of belonging. Staff and pupils felt this to be primarily due to the relationships that staff foster with pupils, the clear boundaries and the consistent positive regard given. There were agreed wide-ranging mental health needs for pupils, but staff agreed that school could still positively impact on this.

During the discussion of results it was agreed that the school had a good 'whole-school' mental health provision for all pupils, including SEAL (Social and Emotional Aspects of Learning) and circle time, but that there was less targeted provision for individuals. Since the PSSM indicated strong school membership there was not felt to be a need for specific intervention in this area, only for maintenance of current good practice. Given these outcomes, using the PSSM might not appear to be an efficient use of time; however it may not otherwise have been apparent that the school was meeting these needs. Additionally, given the positive results, staff members agreed to share their good practice with other SEBD schools in the county.

Possible lower perceived social support between pupils was discussed and agreed as a focus for future EP involvement, where work to improve pupil relationships could be considered. The lack of attention to this in literature reviewed was apparent, but further reading around building positive pupil relationships will inform any future work.

The concept of belonging has been assumed throughout the research to be a reliable and valid one; however one could challenge this concept on the grounds that perceived belonging is a subjective, changeable and socially constructed concept. Firstly, belonging has been called a personal perceived 'acceptance' within relationships or environments (Anant, 1967; Hagerty et al., 1992) which might be subject to recent experiences or mood. Secondly, affiliation is constructed amongst humans

according to a need for social connectedness (Hagerty et al., 1992). It could be said that measuring 'belonging' is neither reliable nor meaningful; however, the concept can be meaningfully discussed where there is a shared meaning. For the purpose of this research, belonging can be understood and examined through the use of the PSSM scale, but results which are meaningful within this specific setting cannot be generalised to other settings.

The research also assumed that belonging is a valid aspect of mental health, as suggested by Maslow (1970); however Maslow's ideas lack a current evidence base. Other studies find links between perceived belonging and positive psychological outcomes (Finn, 1989; Maslow, 1993; Anderman, 2002) but such evidence cannot infer that belonging is a valid indicator or predictor of mental health, only a correlate of it.

The methodology had some limitations, due in part to the school context. Administration of the PSSM in class was felt to be an efficient means of data collection; however, the reading and explaining of items by the teacher might have influenced pupil responses. I could perhaps have administered the scale myself without school staff present, had time allowed.

The validity and reliability of the PSSM scale can itself be questioned. Pupils may not take items seriously or fully understand statements so valid, true responses are not guaranteed. Perceived belonging is a somewhat subjective and fluctuating characteristic, so arguably should not be measured with a static scale. It is possible that scores would vary on differing days; however Goodenow (1993) found strong test-retest reliability in his much larger sample. Other threats to reliability include any bias that could be imposed by teachers explaining scale use and the interpretation, which hinges around a specific threshold that could apply differentially in different schools. Additionally, pupils might feel pressure to be positive about the school since it is administered by teachers. It would be difficult to overcome this without personally assessing each pupil individually, which would take more time.

The focus group was felt by staff to be valuable and genuinely raised issues that could be developed. My concerns were that the SENCo, a line manager within the school, was present in the group which might put pressure on staff to be positive about the school as a setting; however I also felt that she had valuable opinions to include. All members of staff did contribute, as I was clear about addressing questions to everyone and making eye contact with those who had not contributed to invite them to respond. I was also very aware that staff were invested in the outcomes of research and likely to be biased about their own skills and abilities. Staff responded, as expected, with mainly positive comments about their competence and experience in handling pupils. It would, though, be difficult to do a truly neutral evaluation of a school's mental health provision, as neither staff nor pupils are neutral, and mental health provision is also more difficult to inspect than teaching or exam grades are. This mirrors findings in the literature, where evaluation of SEBD settings rarely focuses on mental health outcomes (Cole et al., 1998; HMSO, 1990), and also where government documents are not clear on how to assess settings on mental health provision (DCSF, 2009).

The research as a whole has limited reliability since the evaluation focused on one setting with a specialised intake of pupils. Findings could not therefore be generalised to other settings. The role of school management in constructing research questions and design means the evaluation is more focused on intrinsic interests than theoretically determined hypotheses. This reflects the 'trade-off' between being an objective/independent researcher and a link Psychologist, who is required to meet the needs of a school, not just to carry out theoretically driven research.

This evaluation concludes that Oak Tree School positively supports pupils' mental health needs such as affiliation, and that staff contribute to a number of support systems including affirmative relationships, positive school climate and provision of basic skills such as SEAL. However, findings suggest that individual, specialised support and group interventions are required developments. The results imply that staff approaches are primarily responsible for the positive climate; however this cannot be asserted without further research. Implications could be that staff motivation and training

could impact positively on pupils' mental health. Whilst these findings cannot be generalised to other settings, they may have implications for future work in other schools. Aspects of mental health such as affiliation could be investigated further in a variety of settings to look for trends in school types or populations of pupils, or develop interventions to improve school membership.

This evaluation, along with previous studies reviewed, highlights both the importance of trying to evaluate schools' provision for pupils with mental health needs, but also the difficulties in doing so. More work is needed to show how the outcomes of specialist and mainstream schools' mental health interventions can be measured. Additionally, school inspections could begin to include monitoring of non-academic outcomes for pupils, such as pupils who develop psychologically, socially and emotionally. Although this is clearly difficult to measure objectively, the increased emphasis by inspectors would most likely lead to schools attempting to demonstrate their valuable impacts on pupils' mental health.

6,698 words

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Appendix 1

Focus Group Questions

1. What do you think constitutes mentally healthy pupils?
    a. Prompt: what is mental health, what qualities should healthy children possess?
2. What are some of the mental health **needs** of pupils here? What are they lacking?
    a. What are barriers to health and wellbeing?
3. What does the school do to support these needs? What are current strengths?
    a. What is in place now? E.g. policies, approaches, interventions, strategies.
    b. Prompt areas not raised, e.g. behaviour policy, therapeutic interventions.
    c. Recap answers. Is there anything else?
4. What more could the school be doing to support pupils' mental health?
    a. Suggestions: e.g. groups, resources, one to one, links with parents,
5. How confident do you, as staff, feel about supporting individuals you see day to day?
    a. Are there times you need additional resources/support? Examples?
6. How confident are you about noticing needs, communicating with pupils, providing support and delivering interventions?
7. What could EPs do to support you in this? What would you like to help you promote mental health?
    a. e.g. training, supervision, joint delivery of interventions, resources, one to one,
8. What changes and developments would you like to see in the next 12 months?
    a. What are your best hopes for next year? Where do you see the school?

Appendix 2

Table 3. Mean Scores for Individual Items on the PSSM

Item Number and Statement	Mean Pupil Rating (between 1 and 5)
1. I feel like a real part of my school	4
2. People here notice when I'm good at something	4.5
3. It is hard for people like me to be accepted here	1.8* (3.2)
4. Other children in this school take my opinions seriously	3
5. Most teachers at my school are interested in me	4.4
6. Sometimes I feel as if I don't belong here	1.4* (3.6)
7. There is at least one teacher or other adult in this school I can talk to if I have a problem	4.6
8. People at this school are friendly to me	3.5
9. Teachers here are not interested in people like me	1* (5)
10. I am included in lots of activities in my school	4.4
11. I am treated with as much respect as other pupils	3.9
12. I feel very different from most other pupils here	1.5* (3.5)
13. I can really be myself at this school	3.2
14. The teachers here respect me	4
15. People here know I can do good work	4.8
16. I wish I were in a different school	1.4* (3.6)
17. I feel proud of belonging to my school	3.6
18. Other pupils here like me the way I am	3.1

*Items 3, 6, 9, 12 and 16 are negatively phrased, so reverse scored for analysis (shown in brackets)

CHAPTER THREE

Reducing and Managing School Stress in Key Stage Four Pupils: a cognitive-behavioural approach.

1. Introduction

This report describes the planning, delivery and evaluation of a therapeutic group intervention aimed at reducing perceived stress in adolescents. The work was requested by a secondary school Special Educational Needs Co-ordinator (SENCo), in response to reports from year tutors that some pupils were feeling anxious and stressed around exam time and appeared unable to manage or reduce the stress they experienced. The school asked their link Trainee Educational Psychologist to plan and deliver an intervention, which could teach some coping and relaxation skills as well as help pupils to understand their own reactions to stress. The work was also evaluated to demonstrate whether the intervention had an impact on pupils and led them to report reduced stress levels and increased use of coping strategies.

2. What is Stress Versus Anxiety?

Hans Selye (1956; 1980) wrote about a biological concept - 'stress' - meaning a bodily response to demand or threat, followed usually by the body's adaptation to it. However, his definition overlooked much of the individual emotional and psychological experience of stress. Stress has been understood more frequently in terms of perceived excessive demand, particularly where there are felt to be insufficient resources or control over these (Cox, 1978; Lazarus and Folkman, 1984), which takes some account of individual differences; however this definition focuses on causes or processes rather than what is actually experienced. Stress is sometimes said to be a non-specific concept which encompasses anxiety, tension, trauma and emotional disturbance (Elliott and Eisdorfer, 1982;

Lazarus and Folkman, 1984) or an 'organising concept' for a variety of variables and processes (Lazarus and Folkman, 1984), yet this still does not make explicit what stress means. Perhaps this difficulty in defining stress is because it can encompass a variety of states, including emotional, physiological, and cognitive arousal (Rosenhan, et al., 2000; Cooper and Dewe, 2004).

The terms 'stress' and 'anxiety' are frequently used synonymously in the research literature (Parsons, Capps and Wicks, 1985; Wells, 1992; Hinton et al., 1991; Pretzer and Beck, 2007), yet there exist attempts to differentiate the terms. Parsons et al. (1985) describe anxiety as one of the forms in which stress can be endured, and state that, although the terms are sometimes interchangeable, anxiety is employed in clinical terms as pathological, whereas stress can be mild or severe, normal or pathological. Lovibond and Lovibond (1995) compared measures of depression, anxiety and stress in non-clinical populations, concluding that there is a natural continuum between stress and anxiety, with no clear division, but that anxiety might be more severe, enduring and fear-related. Whilst stress and anxiety continue to be written about coincidentally, the term stress will be used here to indicate a persisting reaction, being psychological, physiological or both, to common stressors in a non-clinical adolescent sample.

3. Stress and anxiety in adolescents

Adolescence, the period between childhood and adulthood (Wolman, 1998), can be a time of increased stress (Arnett, 1999; Rudolph & Hammen, 1999); however suggestions that this is universal, inevitable and biologically based have been refuted (Steinberg & Levine, 1997; Arnett, 1999). Rather, adolescent stress has been linked to an increasing number of contextual and cultural stressors, including complex peer-group relationships (Bowker et al., 2000), family environment and conflict with parents, (Colten and Gore, 1991; Seiffge-Krenke & Shulman, 1993; Chandra and Batada,

2006) as well as to developmental changes such as the separation-individuation from caregivers (Mahler, Pine and Bergman, 2000), or the struggle towards autonomy.

School can impose a variety of stressors on adolescents, who strive to manage coursework and exams, time pressures, conflicts with teachers and anxieties about future education or work placements (Schultz & Heuchert, 1988, DeAnda et al., 2000, Murberg & Bru, 2004). It seems inevitable that some young people will perceive these demands as unmanageable for them, causing stress.

4. Effects of Stress on Adolescents

Both short and long-term effects of stress have been observed in children and adults. Immediate negative emotional and physical reactions, including increased heart rate, muscle tension and inability to relax (Spielberger et al., 1978; Garmezy et al., 1984; Taylor, 2006) clearly impact on quality of life, but may also lead to longer term outcomes. Adolescents under persistent stress can show greater levels of hostility, anger and aggression (Aseltine, Gore and Gordon, 2000) and more persistent emotional and behavioural disturbances (Grant et al., 2004; Phillips et al., 2005). Long-term reactions to stress could therefore undermine self-esteem and academic achievement (Wachelka and Katz, 1999; Lindhal et al., 2005), hence, it is critical to minimise the effects of stress on adolescents.

5. Models and theories of stress

Stress has been described as an imbalance between demands placed on a person and their resources or capacity to cope with them (Phillips, 1978; Remsberg and Saunders, 1984; Schultz and

Heuchert, 1988). This simplistic view, however, does not acknowledge the individual differences in perceptions, causes or effects of stress.

There are several different ways of understanding stress that can inform approaches to managing it. The arousal model first described by Yerkes and Dodson (1908) sees stress as simply an extreme form of arousal. As arousal increases, performance can initially improve to an optimal point, showing that some stress is both normal and even beneficial, but past this optimal level, increased stress impairs performance unless managed. Management of stress, according to this model, would simply involve limiting the stressors one is faced with to an optimal level, for example, limiting workload so that it is stimulating and challenging but not overwhelming. This model helpfully presents stress as a continuum, from under-arousal to excess stress, but it unifies individual responses and processes. It does not explain why some individuals can be persistently stressed while others under similar demands appear not to be.

The transactional model of stress (Cox and Mackay, 1976) describes the complex nature of stress and stressors as a 'transaction' between an individual and their environment. Crucially, Cox and Mackay acknowledge the effects of individual perceptions, describing stress as perceived demand which outweighs perceived ability to cope. They also recognise that these perceptions are influenced by a number of factors, including personality, previous experiences and context. Lazarus and Folkman (1984) further developed this model, suggesting that stress is caused by a person's subjective cognitive appraisals of a situation, meaning that there are no objective 'stressors', only perceptions of stress or inability to cope. The importance of this model is twofold; not only does the model help to explain individual differences, due to individual appraisal of events, but it also provides a framework for managing and reducing stress, by altering perceptions and providing coping strategies. Lazarus and Folkman (1984) differentiated between emotion-focused coping, or attempts to reduce the emotional impact of stress, such as social support, alcohol or drug use, and problem-focused coping, or attempts to deal with stressors, such as time-management or problem-

solving. One possible method of problem-focused coping could be cognitive reappraisal, or changing perceptions of both stressors and resources, to reduce stress experienced; however, the model does not provide a deeper analysis of where perceptions arise from or how to reappraise events.

Cognitive models similarly highlight the importance of appraisal or perception in stressful experiences, but with explanations of these processes. Beck (1995) views stress and anxiety within a cognitive framework, with irrational or maladaptive thinking patterns such as 'I must get everything right' or 'I can't do this' at the heart of disproportionate stress reactions. Beck outlines principles for cognitive conceptualisations of stress, including analysing dysfunctional thoughts, cognitive distortions and core beliefs, and considering better interpersonal and lifestyle strategies for coping with stress.

Beck (1995) describes a number of studies where Cognitive Therapy or Cognitive-Behavioural Therapy reduces generalised anxiety (e.g. Blowers, et al., 1987; Durham and Turvey, 1987) however, these studies focused on clinical adult populations with diagnosed anxiety disorders, rather than non-clinical stress in adolescents, with no clear distinction between stress and anxiety, or pathological versus non-clinical symptoms. There is a need for further research using cognitive approaches for the treatment or prevention of stress; to establish whether such an approach is adaptable to school settings or adolescents under school stress.

6. Stress Management Interventions for Children and Adults

Carson and Kuipers (1998) summarise the wealth of research into stress management in the workplace. They distinguish between individual preventative approaches, such as problem solving or assertiveness training, individual combative strategies, such as coping skills or relaxation sessions, and workplace interventions such as organisational restructuring, supervisory support and environment modification. The most successful approaches reportedly target individuals, and often

include enhancing coping resources, reducing arousal and changing appraisals of stressful situations (Dollard and Weinfield, 1996). However, this conclusion may be misleading as individual approaches are both more common and better evaluated than workplace 'systems' interventions (Carson and Kuipers, 1998). Additionally, there is a risk of 'blaming' the individual for their disproportionate stress reactions rather than addressing organisational and environmental factors contributing to stress, therefore an organisational awareness of stress could be complementary to any individual or group interventions. Whilst this research focused on adults, and there is significantly less stress-management research based in schools, principles of occupational stress could be applicable to schools, as coping strategies, relaxation and re-appraisal techniques are all approaches that could be implemented with children and adolescents, and organisational changes could equally support young people with managing stress.

Meichenbaum (1988) outlined an approach known as Stress Inoculation Training (SIT), based on cognitive-emotional theories, where anxiety consists of heightened physiological arousal and negative thoughts and images. SIT follows three phases, psycho-educational 'stress-awareness' training, 'skill acquisition and rehearsal', and 'application and transfer' of skills into daily life. The intervention was progressive for its time, exploring maladaptive cognitive structures and teaching self-monitoring, so that clients could become aware of their negative, anxious inner dialogue. Although SIT was not developed for adolescents or children, it has been used in a variety of contexts, including with college students for test anxiety (Meichenbaum, 1972), indicating that the theoretically-based SIT can be applied with varying age groups and presentations. However, SIT is a clinically-based treatment programme, designed with a therapist-client relationship in mind. It takes time, motivation and rapport to be effective, meaning it may be less appropriate in brief, teacher-pupil group formats. Despite the age and context of SIT's development, it is still reportedly effective when adapted for use with adolescents in schools (Hampel et al., 2003).

7. Coping

Coping strategies represent intentional responses to stress which could include both adaptive and maladaptive efforts, such as exercise, problem solving or alcohol abuse (Lazarus and Folkman, 1984). Folkman and Lazarus (1986) suggest that reduced negative outcomes, such as fewer depressive symptoms, are linked to a greater range of coping approaches and use of the most adaptive strategies; however this is amongst adults, experiencing qualitatively different stressors to adolescents in school. De Anda et al. (2000) examine the coping strategies employed amongst 333 Los Angeles' High School Students. They distinguish between adaptive strategies (cognitive reappraisal, emotional release, relaxation) and maladaptive strategies (behavioural excess, alcohol/drugs, withdrawal). Encouragingly, adaptive coping strategies were reportedly used more than maladaptive strategies by all, with distraction used most frequently and substance abuse used least frequently; however, overall, coping strategies were used infrequently, with the most popular strategies only used moderately (scoring midway on a scale). Significant gender differences were observed, with males reporting substance abuse and females reporting help-seeking and affective release more than their counterparts. This research concludes that adolescents under-use coping strategies and that the range used is limited, with distraction (avoidance or change in activity) used more than other methods. The authors suggest that interventions should enhance pupils' coping repertoires by teaching clinically-proven relaxation methods, increasing the variety of strategies available beyond distraction and validating those strategies used less by males, such as help-seeking and affective release. Relevance of this research is limited by its culturally distinct sample of Los Angeles students, who may have very different coping strategies and stressors to UK school pupils, although this is not discussed. As an example, a number of students rated 'earthquakes' as a stressor, which is unlikely to affect UK pupils. The cultural specificity of stress and coping is inadequately addressed in the research, as different age groups, regions or school types may experience radically different stress responses. The findings are also contradicted in other research, where adolescents in Germany are reported to use more maladaptive than adaptive coping

strategies, with both age and gender affects in responses (Hampel and Petermann, 2005). Such discrepancies in findings could indicate either marked differences in cultural norms, or that samples used are not truly representative. Even more likely, the methodology employed may result in different outcomes, as the measures used to assess stress, and consequent factor analysis, can favour certain responses. Both studies note gender differences in coping, as well as some ethnicity differences, suggesting that coping strategies are highly individual and could vary between age groups and schools. This could have implications for intervention, meaning teaching of coping responses should be broad, with none suggested as 'best', so that pupils can explore strategies most relevant to their situation.

8. Arousal Reduction Techniques

Clinical trials demonstrate some effectiveness of relaxation training in reducing autonomic nervous system arousal, or such physiological stress reactions as muscular tension, increased heart rate and dizziness, by applying techniques including progressive muscle relaxation, meditation, biofeedback and mental imagery with children and adolescents (Smith and Womack, 1987; Lee and Olness, 1996; Lohaus et al., 2001). Progressive muscle relaxation involves systematic tensing and relaxing of muscles throughout the body whilst in a relaxed state, so can be learnt and applied outside of clinics. Meditation and guided imagery involve picturing calming images or places and can be used in any situation, but could be less effective without a trained clinician to 'guide' the imagery. Biofeedback is a means of controlling autonomic arousal by being aware of how heart rate or skin conductivity fluctuates with stress, and could be used in conjunction with other forms of relaxation, but requires specialist equipment (e.g. electrodes attached to skin), therefore is not appropriate for most adolescents to use outside of clinics. Using these techniques during weekly sessions results in lower autonomic arousal, which is inferred to indicate lowered stress (Smith and Womack, 1987), however only physiological responses are measured, not perceived stress or long term benefits. Additionally,

techniques are applied during sessions with highly trained clinical professionals and arousal is measured concurrently, therefore it is not clear whether techniques are applied between and long after sessions to reduce stress long-term. A more recent review found a lack of evidence for the effectiveness of relaxation training alone, with progressive muscle relaxation and cue-controlled relaxation yielding no significant effects for school children with test anxiety in two controlled studies (Parslow et al., 2008). However, stress-management programmes incorporating relaxation alongside coping or reappraisal techniques have shown reduced levels of perceived stress (Hampel et al., 2008; Yahav and Cohen, 2008), suggesting that relaxation techniques could afford additional coping strategies to adolescents if presented in conjunction with cognitive-behavioural approaches.

9. Cognitive-Behavioural Approaches

Cognitive-behavioural approaches aim to reduce psychological distress, including anxiety and stress, by addressing cognitive processes such as appraisals of stressful events (Stallard, 2002). Such approaches are theoretically driven, and assume that by altering thought processes, a change in feelings and behaviour is possible. Cognitive-behavioural therapy has been found effective in the treatment of generalised anxiety (Silverman et al., 1999) and post-traumatic stress (Smith et al., 1999), but fewer studies apply similar techniques to adolescents under less severe, school-related stress. Cognitive stress management approaches have been used alongside additional methods with asthma sufferers (Hampel et al., 2003) and in non-clinical samples (De Anda et al., 1998), but these had small samples (46 and 36 respectively) and were not with UK school children, therefore it is difficult to estimate the potential effectiveness of cognitive-behavioural stress management techniques.

Yahav and Cohen (2008) evaluated a cognitive-behavioural intervention to help school-students cope with daily stressors. They conducted an eight week randomised controlled trial with 255

participants aged 14 – 16, teaching stress awareness, coping strategies, relaxation and cognitive approaches to reappraising situations and coping with stress. For example, participants learned to identify typical cognitive responses to common stressors then restructure them into more adaptive thoughts. The authors concluded that stress decreased in intervention groups, as pre and post intervention measures revealed significant reductions in state anxiety (temporary tension or worry); however the link between this measure and perceived stress is unclear, reducing the validity of these approaches to stress specifically. The population sampled was a large city in Northern Israel, selected from one Arab and one Jewish school, meaning the sample would not be representative of all adolescents. These students have additional unique sources of stress, with political conflict and terror attacks, as well as cultural stressors such as mandatory military service, meaning that stress interventions there may not be applicable to UK school children. Yahav and Cohen (2008) also successfully used a biofeedback technique, recording electrodermal activity of participants to show how physiological responses are affected by relaxation techniques, but this requires a computerised program which would not be widely available in schools.

Hampel et al. (2008) ran preventative 'Anti-Stress Training' (AST) for 138 adolescents aged 10-14, with 182 in a control group. The intervention consisted of a 6 week cognitive-behavioural programme for pupils, with coaching sessions for teachers and information given to parents. The AST programme was based on the psychological model of stress proposed by Lazarus and Folkman (1984) and Meichenbaum's SIT (1988) and included techniques such as cognitive restructuring, problem-solving and transfer to daily life. Perceived stress was measured before and after using seven items (e.g. too much homework) with a five point Likert scale. A coping questionnaire was also given to assess the use of nine possible coping strategies. A significant reduction in perceived stress was noted in experimental groups, with increased stress in control groups. Experimental groups also showed improved coping. Importantly, a follow-up assessment three months after training showed persistent improvements. The authors concluded that AST strengthens protective factors in adolescents, but also that teacher and parent participation contributed to the efficacy and

application of the intervention. Although the study used students from two Austrian schools, which may not represent UK pupils, the large sample and longitudinal follow-up strengthen the reliability of findings. Measures used were not rigorously developed, but designed by the authors, with limited numbers of items offered, which reduces validity of results. However, the results suggest that stress management training can reduce perceived stress in adolescents, particularly when combined with parent information and teacher awareness of environmental stressors. This also mirrors government recommendations around promoting emotional wellbeing in schools, which suggests that explicit teaching of behaviours and skills is most effective in reducing mental health problems, including anxiety (Weare and Gray, 2003).

10. Development of a Stress-Management Intervention

A large East Midlands secondary school requested support from the Educational Psychology Service (EPS) in supporting Key Stage Four pupils (14-16 year olds) experiencing school related stress. Previously, the school had offered suggestions to pupils including relaxation with music, exercise and establishing sleep patterns, however there were still high levels of stress reported by pupils to Form Teachers, during pastoral or review meetings. Therefore a pilot 'stress management' intervention was planned.

One potential difficulty in this work was the possible conflicting role of the Trainee Educational Psychologist (TEP) as a professional linked to the school, versus a researcher attempting to evaluate an intervention. It is typical for schools to select pupils they are concerned about for EPS involvement, however in research it might be preferable to identify participants randomly, using a set of criteria or through prior assessment. Typically, a researcher would also not evaluate their own work in case of bias, however as a TEP it is usual to evaluate the impact of any case or group work undertaken, to demonstrate impact. Therefore, this work was not conceived as a piece of rigorous

research, rather as an account of Educational Psychology group work. It was hypothesised that teaching pupils to manage and reappraise stress would lower perceived stress and consequent physical arousal, in line with previous findings (Hampel et al., 2003; Yahav and Cohen, 2008). In order to demonstrate this, it was necessary to measure perceived stress and arousal before and after the intervention.

11. Measuring Stress, Arousal and Coping in Adolescents

Measurement of stress in previous studies has often confused stress and anxiety, for example where stress management interventions use anxiety scales to demonstrate reductions in stress (Hinton et al., 1991; Kessler et al., 2000; Yahav and Cohen, 2008). Whilst Lovibond and Lovibond (1995) suggest some overlap between anxiety and stress assessments, use of anxiety scales alone will impact on validity of results for stress management programmes, as they are not matched to programme aims. It is essential that any measurements reflect the intended outcomes of interventions, for example coping measures or inventories would be useful where teaching of coping strategies occurs.

The 'Holmes-Rahe Social Readjustment Rating Scale' (Holmes and Rahe, 1967) has been used and adapted to score stress in adults and children (e.g. Dise-Lewis, 1988; Powell, 2000), however the scale is simply a multiplication of stressful life events experienced with values assigned for how stressful events are. This follows a simplistic model of stress (c.f. Yerkes and Dodson, 1908), assuming that individuals perceive the same events as stressful. Another means of measuring stress is to record physiological symptoms associated with stress, for example the Beck Anxiety Inventory measures symptoms such as numbness, tingling or heart racing, but measuring only symptoms ignores the psychological experience of stress and could miss those who do not notice physical effects.

There exist a number of standardised 'stress' scales which have been designed to be reliable and valid, including the Stress Arousal Checklist (Mackay et al., 1978), Adolescent Stress and Coping Measure (Bradley et al., 1990) and the Perceived Stress Scale (Cohen et al., 1983). Such scales are more rigorously developed, for example by repeat testing on large samples for validity and reliability, and more relevant to stress management than simple stress inventories or checklists, but they also assume a positivist epistemology: that stress is a clearly defined, discoverable concept that can be measured, whereas literature reveals stress to be difficult to define and highly personal (Lazarus and Folkman, 1984; Rosenhan, et al., 2000). Despite this difficulty, without clear measures the efficacy of stress-management interventions cannot be demonstrated, therefore a measure which yields quantitative data but acknowledges individual perceptions, such as the Perceived Stress Scale, or a numeric scaling of perceived stress, is a methodological compromise.

The Perceived Stress Scale (PSS) was developed by Cohen et al. (1983) to measure, as objectively as possible, the degree to which events are appraised as stressful, rather than purely the number of stressful events experienced or the symptoms experienced. This idea follows Lazarus' (1966) theory of appraisal and stress, and aims to take into account the perceptions and experiences of stress, including the degree of coping, control and confidence felt. The scale was designed and tested with adults over eighteen years of age. Although this reduces the scale's validity when used with adolescents, the scale was originally tested with a sample of 332 college students; with a mean age of 19 years (Cohen et al., 1983) meaning that the original sample was only four years older than the group of pupils completing this intervention. The scale was tested again with 2,387 participants, and found to have adequate validity, with positive correlation between PSS scores and depressive symptoms, social anxiety, life-event scores and use of health services (Cohen and Williamson, 1988). Internal reliability is cited as 0.78, and predictive validity is described as good, as the PSS predicted health-related outcomes, such as giving up smoking, better than life-event scores (Cohen and Williamson, 1988). Test-retest reliability is not likely to be high as the scale addresses the past month, therefore changes would be expected over time, but this also means that the PSS can be

repeated after one month. The PSS is described as “the only empirically established index of general stress appraisal” (Cohen et al., 1983; p. 385). It is not a diagnostic instrument as it has no thresholds or cut-offs, but can be used to compare populations or the same group over time, and therefore would be a valuable tool to indicate any changes before and after the intervention in perceived stress. Despite the PSS being an adult, not an adolescent scale, the items appear to be appropriate for adolescents as they are easily understood and general enough to apply to school pupils (see appendix 1), however the scale may not be appropriate with younger pupils or those with limited literacy levels. The PSS is particularly valid for this intervention as the cognitive-behavioural approaches adopted aim to reduce perceptions or thoughts of stressful events as unmanageable or overwhelming, and increase feelings of self-efficacy and coping.

Another measure relevant to the intervention content would be a measure of coping, or more specifically of types of coping strategies used. Part of the intervention aims to provide pupils with a range of constructive coping strategies to try and practice. In order to measure the effectiveness of this, a measure of coping strategies will be used, adapted from Powell (2000). This consists of a list of possible coping strategies, for example “request help and support from others” and “have realistic expectations about myself, accepting my limitations” with a score from 0 (never) to 5 (frequent) to indicate how frequently these were applied in the last 2 months (see appendix 2). The checklist can be scored to give numerical values for 7 types of coping: assertiveness, social support, self-organisation, rationality/re-appraisal, leisure, self-care and maladaptive coping. This kind of measure, whilst less rigorously developed (not tested for reliability or validity) and therefore not a good ‘stand-alone’ instrument, could be used to give an idea of what coping strategies were used before the start of the intervention compared to after it. Any differences could indicate that a greater range positive coping strategies were used, that fewer maladaptive strategies were used, that some strategies were used more frequently or that specific strategies were tried that had not been previously. The checklist does not give an overall ‘score’ to measure a general coping level, but

does give data about the types of coping employed, in the form of figures for frequency of using specific strategies.

Use of these quantitative measures might appear to be a highly positivist epistemology considering the subjective nature of stress as a concept. If stress is a socially constructed phenomenon and a personal construct, it could be argued that it cannot adequately be measured using quantitative scales, however the PSS and the Coping checklist both allow for the personal constructions of stress and coping, as they ask for pupil self-reports of 'perceived' stress and personal coping styles adopted. Therefore, whilst the research accepts the subjective nature of stress, the measures are considered to capture this in a way that also allows comparisons of figurative data.

12. Methodology

Key Stage Four pupils, aged 14 – 16, were selected by school staff to participate in a six-week stress management programme designed to increase stress awareness, reduce perceived stress levels and teach a range of coping strategies including relaxation techniques.

Participants were not selected at random, but referred by form teachers who were concerned about stress levels of these pupils. Although some clinical interventions might use a diagnostic tool or specific criteria to select participants, it is usual in Educational Psychology casework for schools to 'refer' pupils who they are concerned about, therefore no further criteria were used, other than pupil and parent consent (see appendix 3). It is possible that relying on teacher 'referrals' leads to a skewed sample or engineered group dynamics, and could also prevent equality of opportunity for all pupils to benefit from stress management, and therefore alternative selection procedures could be considered in future interventions. 15 pupils were selected and divided into two year groups, as each year had a different timetable, preventing pupils from participating at the same time. Seven pupils from year 11 participated in the stress management intervention initially, whilst eight year 10

pupils acted as a comparison group, before completing the intervention the following term. All participants were invited to a preliminary group meeting to explain the aims and content of sessions, to attain informed consent (appendix 3), and to administer pre-intervention assessments (the PSS, Cohen et al., 1983, and the 'Ways of Coping' checklist, Powell, 2000). All 15 chose to sign consent forms and participate in the group. Parental consent was also obtained, verbally, by phone, following an explanation of the intervention content and aims from tutors.

All sessions were facilitated by two adults; a Trainee Educational Psychologist linked to the school and a Teaching Assistant from the school. Suggestions from Weare and Gray (2003) for developing emotional wellbeing were followed, including use of cooperative group work with rules and facilitation of relationships, teaching of skills in participatory and empowering ways, and support to apply and generalise skills to real life. During the first meeting group rules were suggested by all pupils and agreed on, which included 'to listen when others are talking', 'to respect the views and thoughts of others', 'to join in and take it seriously' and 'to keep personal information we hear to ourselves'. Since some of the pupils did not know each other well, some 'ice breaker' starter activities were used to build rapport and confidence within the group (see appendix 4 for session plans). Session one included discussion of stress, its effects and causes. Pupils were encouraged to participate by using group discussion, writing ideas on sticky notes then adding to a board, filling in quizzes and diagrams, and sharing ideas with partners. In later sessions, the Cognitive Behavioural approach was introduced by teaching the model and then using example situations to elicit thoughts, feelings and behaviours. Coping strategies were then discussed, first in an open forum for pupils to share ideas, before suggestions were grouped into 'helpful' and 'unhelpful' strategies by pupils. New coping strategies were introduced and discussed, including the importance of social support, balanced diet and exercise, planning and time management, problem solving, and relaxation techniques. In sessions 5, 6 and in follow up, all pupils and facilitators participated in relaxation exercises (progressive muscle relaxation, slow breathing and guided imagery) towards the

end of the sessions. Pupils were encouraged to use coping techniques, reappraisal, problem solving and relaxation between sessions and feed back on what was helpful, to generalise new skills.

A follow-up session was arranged two weeks after session 6, for pupils to recap key points form the programme, share any coping strategies used and to join in repeat relaxation exercises to reinforce previous learning. The PSS and 'ways of coping' questionnaires were administered to all Year 11 pupils again, and were administered to the Year 10 comparison group later that day. If any pupils had disclosed information that concerned the facilitators or indicated possible harm, such as using recreational drugs or alcohol as a coping strategy, this information would have been passed on to the school's designated safeguarding officer, however there was no such disclosures. This was explained to pupils in session one and is standard procedure for school staff and visiting professionals.

Finally, pupils were given leaflets, a factsheet and details of helplines by the school so that the support was not removed entirely. The Teaching Assistant also agreed to offer support after the group to any pupils feeling upset or stressed, in the form of a lunchtime drop-in centre based in Learning Support, for which the TEP was also available. Other ethical considerations included the provision of a designated member of pastoral staff to speak to if needed (learning mentor) and opportunities to remain after each session if advice or support was wanted. In order to avoid the intervention focusing solely on pupils, and ignoring the contextual factors in adolescent stress, the school was asked to distribute information sheets to all staff on 'how to reduce stress in young people', information that the school already had in the staffroom but did not provide copies of.

13. Results

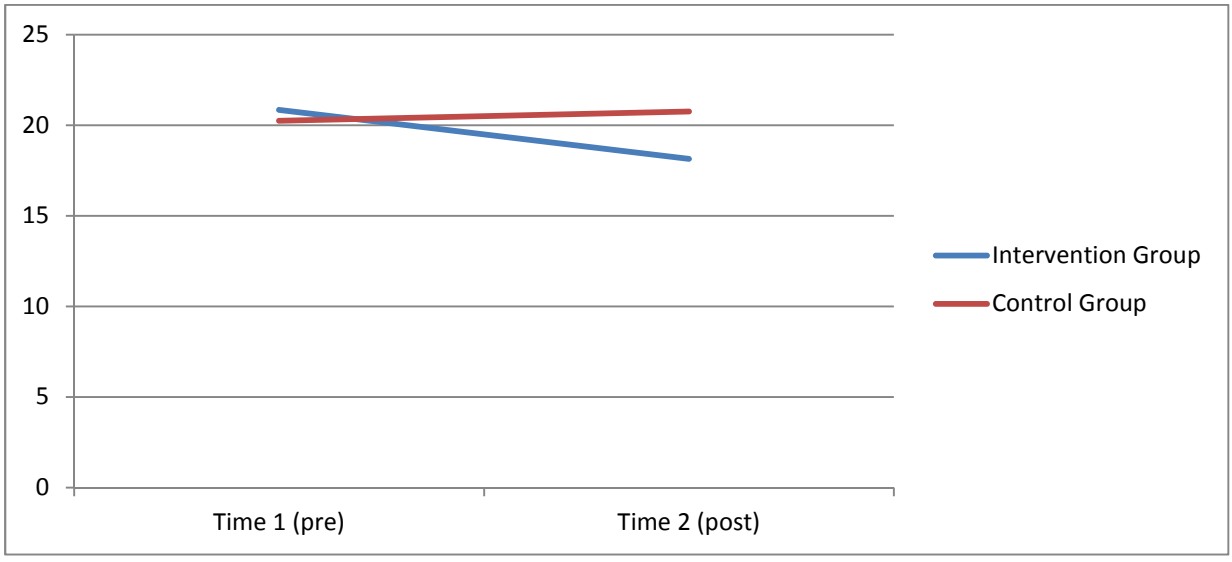
The Perceived Stress Scale was completed by 15 pupils (7 intervention, 8 non-intervention) 7 weeks apart. The PSS contains 10 items which can each be given a score between 0 (never) and 4 (very

often), giving an overall 'perceived stress' score between 0 and 40 (positively stated items are reverse-scored). Mean scores for each group, at time one and time two, are shown below.

Table 1. Mean PSS Scores Before and After Stress-Management Group

	Mean score at Time 1	Mean Score at Time 2
Intervention Group	20.85	18.14
Comparison Group	20.25	20.75

Figure 1. Mean PSS Scores Before and After Stress-Management Group



The 'Ways of Coping' checklist was also completed by 15 pupils (7 intervention, 8 non-intervention), 7 weeks apart. The questionnaire contains 28 items, divided into 7 types or styles of coping strategy, but ordered randomly. Each item can be given a score between 0 (never) and 5 (frequent), then scores for each subgroup are combined to give a value between 0 and 20 for each coping style. High scores would indicate frequent use of this kind of coping strategy, however overall means are not

calculated as one subgroup is 'maladaptive', in which a high score is not desirable. Mean total scores for each coping style are shown below, for each group, at time one and time two.

Table 2. Mean total scores for coping styles over time in intervention and comparison groups.

	Intervention Group		Comparison Group	
Coping Style	**Time 1**	**Time 2**	**Time 1**	**Time 2**
Assertiveness	4.71	6	3.85	3.71
Social Support	11	12.36	10.62	11.64
Self-organisation	7	13.21	8.14	8
Rationality/Appraisal	5.57	12	6.71	6.85
Hobbies/Leisure	10.85	11.85	9.36	10
Self-care	7.14	11.14	7	7.14
Maladaptive	10.14	4.57	8.14	8

Each coping style was looked at separately for group differences over time, as shown below.

Figure 2. Mean total scores, for intervention vs. comparison groups, for **frequency of coping style**

Figure 2.1: Assertiveness

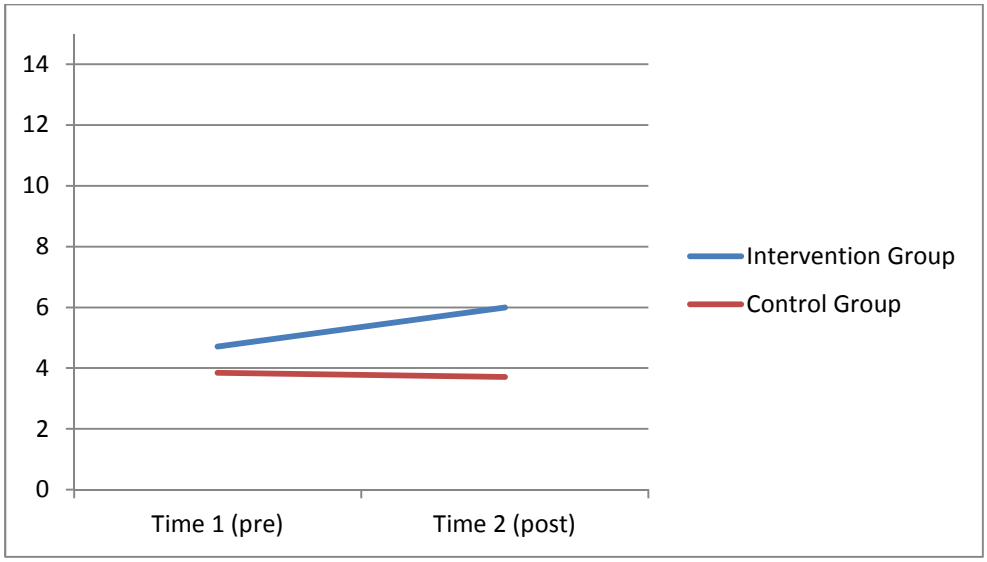


Figure 2.2: Social Support

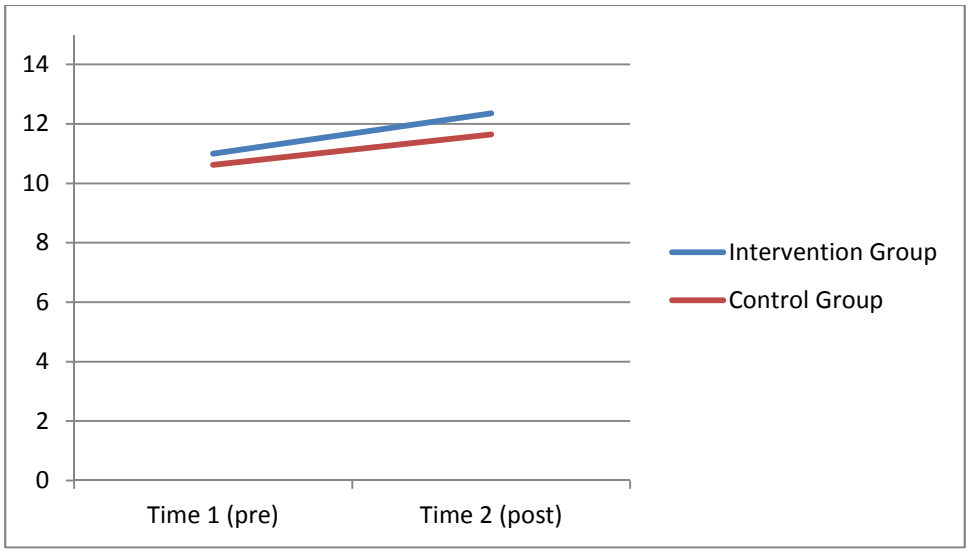


Figure 2.3: Self-organisation

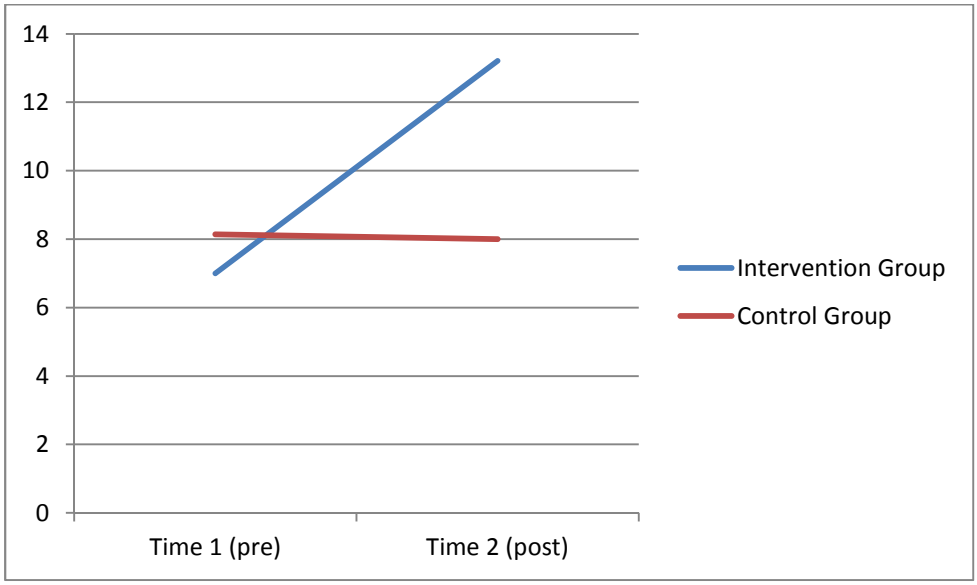


Figure 2.4: Rationality/Appraisal

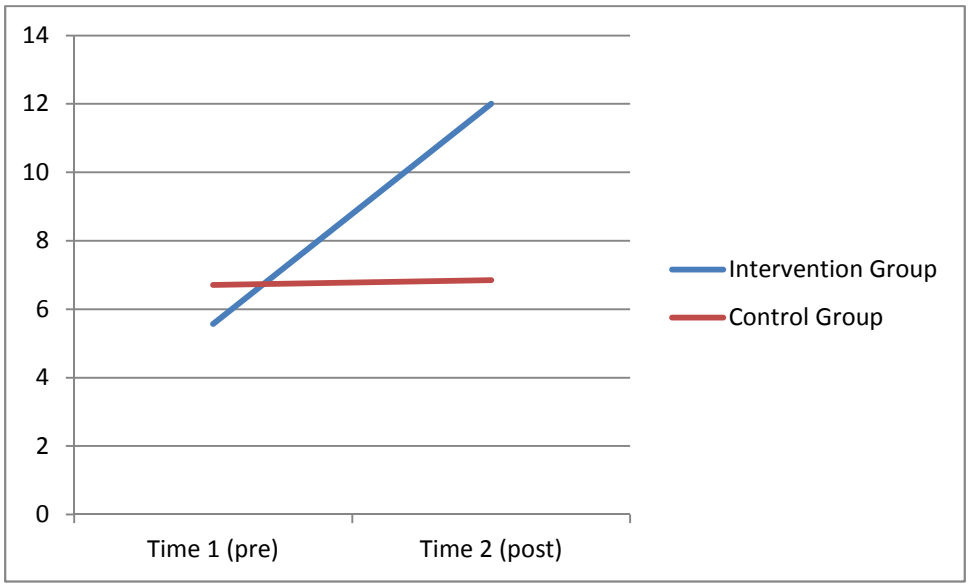


Figure 2.5: Hobbies/Leisure

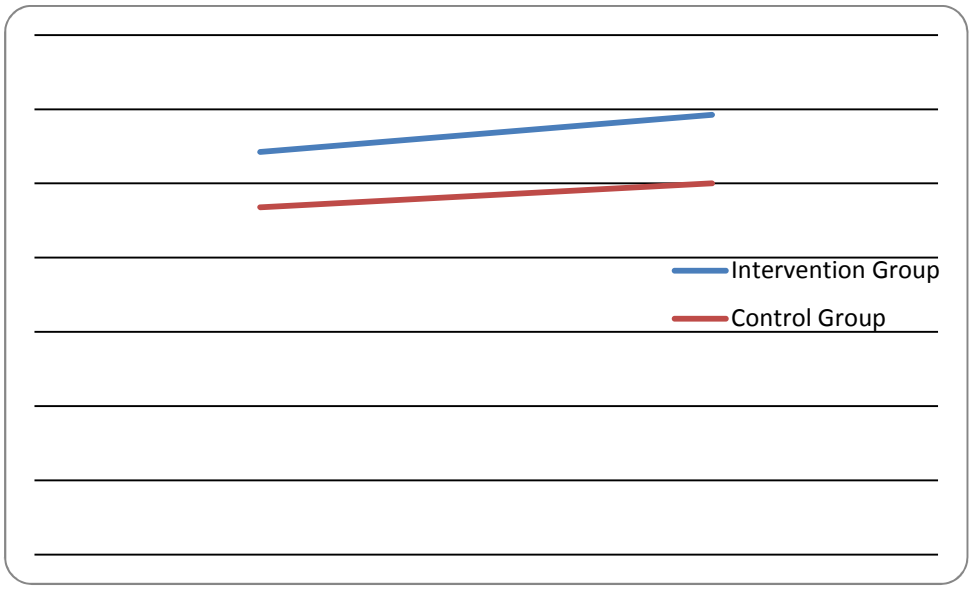


Figure 2.6: Self-Care

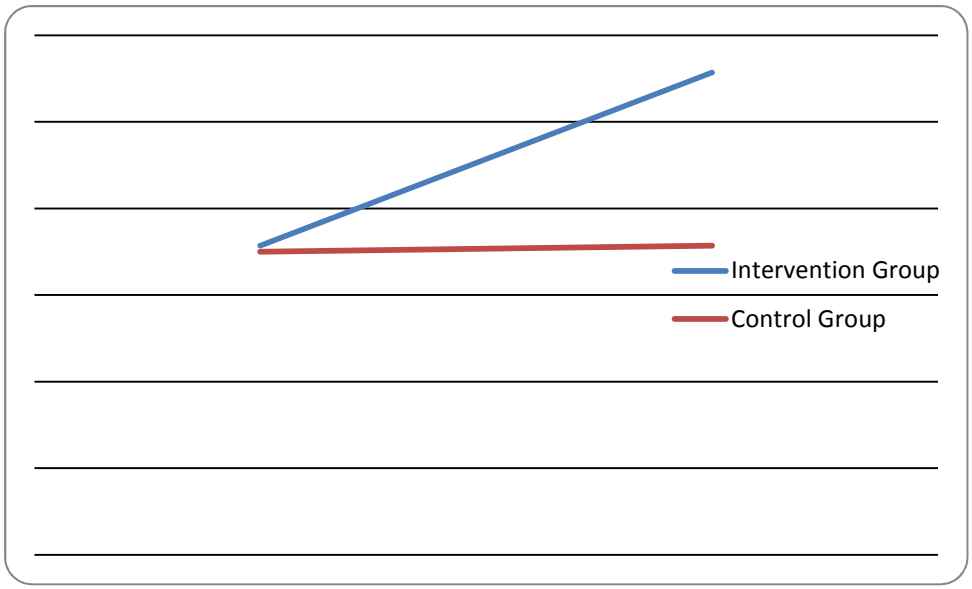
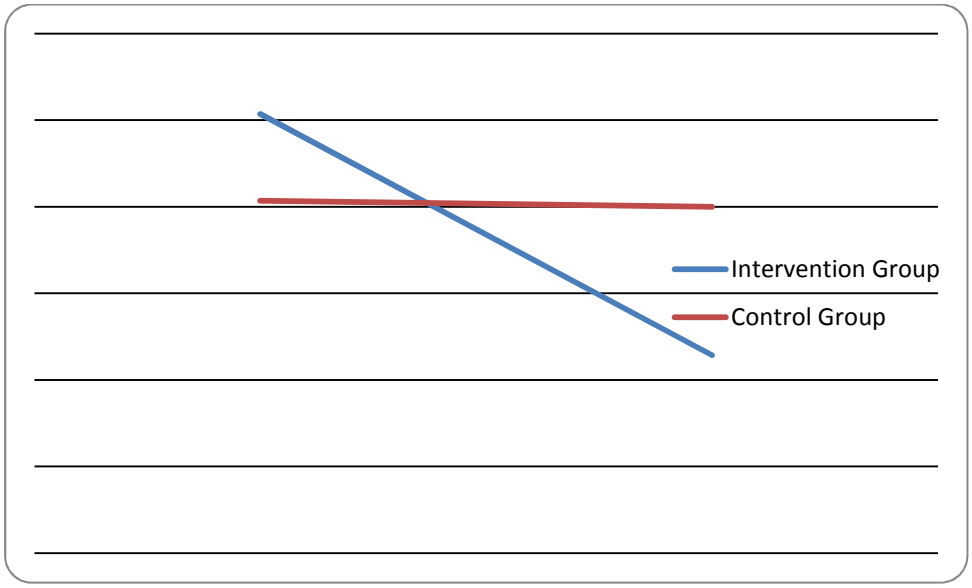


Figure 2.7: Maladaptive



The tables and figures here indicate that there were some differences between the intervention and comparison groups' pre and post measures in levels of perceived stress, and in many of the coping styles, however it is important to note that statistical significance levels cannot be obtained for the data as the sample size is too small. Therefore no definite conclusions can be made that the intervention group had significantly lower perceived stress at time two, but apparent differences, shown in the graphs, can none-the-less be commented on.

Figure 1 demonstrates that the intervention group did report lower perceived stress following the intervention than before it; however the difference is relatively small. Table 2 gives figures for the mean total scores calculated for each coping style. The data indicates that some coping styles were used more frequently after the intervention by the participants, whereas some other styles showed little change in use. There was a slight increase in use of assertiveness strategies, social support strategies and hobbies/leisure by participating pupils. There was a clear increase in frequency for the intervention group for self-organisation, rationality/appraisal, and for self-care strategies. Finally, the checklist also included some maladaptive coping strategies, interspersed throughout the other

items, which included avoidance – 'put things off', withdrawal - 'bottle things up', and increasing intake of food, alcohol, cigarettes or drugs. There was a large decrease in the use of maladaptive strategies for intervention pupils, compared to slight decrease for comparison pupils. Finally, the coping checklist had spaces at the end for pupils to add any other coping styles. Following the intervention four pupils added further items, which were 'deep breathing' (rated 4), 'muscle tensing' (2), 'relaxing alone in a quiet room' (3), and 'thinking differently about a problem' (4), whilst non-intervention pupils did not add any.

These results suggest that the stress-management intervention allows pupils to avoid some maladaptive coping strategies, and instead try a range of positive coping strategies. Overall, this appears to contribute to a decreased sense of perceived stress for pupils who participated in the intervention.

14. Discussion

This research hypothesised that a stress-management intervention that involves teaching of new coping styles, psycho-education on stress and a cognitive-behavioural approach to encourage reappraisal of stressful situations, would reduce the perceived stress reported by adolescents and increase the range and frequency of positive coping strategies used, as found by Dollard and Weinfield (1996). Results indicate that the intervention reduced the perceived stress of adolescents aged 15 and 16, whilst a comparison group of 14 and 15 year olds reported increased stress. Unfortunately it cannot be said that these results are statistically significant, as the intervention group size of 7 is too small for statistical analysis. The 'Ways of coping' checklist suggests that pupils do learn to use some new coping strategies, as suggested by Lazarus and Folkman (1986) and that fewer maladaptive strategies are used following the programme. The non-intervention group offers

some basic comparison, as pupils in this group are at the same school and of similar age, and suggests that the decrease in stress is due to participation in the intervention rather than other factors, such as time of year.

Such an interpretation must be made with caution, however, as the comparison group is not a 'scientific' control group, due to pupils being in a different year group (one year younger) and experiencing slightly different school pressures, with fewer exams and no pressure of choosing further education or employment imminent. The controls were also not age and gender-matched or allocated randomly, as year groups had to participate at different times due to the restraints of school timetables and staffing, and there is some evidence for age and gender effects in reported coping styles (Hampel and Petermann, 2005). Despite this, the comparison group does provide some useful data, as pupils in year 10 might be expected to be less stressed than year 11 pupils, as they have fewer pressures, yet their perceived stress levels actually increased, while intervention pupils reported a decrease. This is supportive of the intervention's beneficial impact on pupils.

The timing of the intervention, particularly in respect of pre and post assessments, could be influential in results, for example, it could be possible that pupils are less stressed typically at the end of a term or after a holiday. Any such effects are very hard to control here, but the pre-reports were taken on a Wednesday afternoon immediately after the Easter holidays, whilst post-reports were taken at the same time of day, on a Wednesday, immediately following a half term break, and therefore timings were well-matched. It could be argued that pupils were more stressed at time 2 as they were closer to exams or equally that they were less stressed as they had finished some already. In any school intervention it is difficult to factor in mediating effects, which is why the comparison group gives some indication of effects of other variables. However, in any repeat research, it would be important to use a randomised controlled trial, with far greater numbers than this study, to demonstrate statistically significant reductions in stress levels.

The ‘Ways of coping’ checklist (Powell, 2000) was a very useful tool in this research and gave rich information on the types of coping strategies used by pupils and how these could be influenced by school-based intervention. The tool is not standardised or tested on adolescents, however it was highly relevant to the intervention’s content, and therefore its use could be justified as long as figures are interpreted with caution and not used to diagnose or classify pupils. The Perceived Stress Scale (Cohen et al., 1983) was also designed for an adult population and therefore reliability and validity cannot be assumed with an adolescent sample, however it is used here only as a tool to compare reported perceived stress over time, not as a one-off assessment. Other scales which have been designed for adolescents include the Adolescent Coping Scale (Frydenberg and Lewis, 1993) which only gives 18 items, without subgroups, therefore would yield less detailed data for comparison. In a small school-based research study these tools were considered adequate to indicate how successful the intervention was, even though results would not be sufficient to draw generalisable conclusions from.

The coping checklist provided interesting comparisons for frequency of use of various strategies, particularly when compared to the course content. For example, some coping strategies appeared to be used more frequently following the intervention, in particular ‘self-organisation’, ‘rationality’ and ‘self-care’. These mirror coping mechanisms explored in the course, for example the course discussed time management, avoiding procrastination, planning steps to success, prioritising and goal setting, which could be considered as ‘self-organisation’ strategies. The course also spent a considerable amount of time on cognitive-behavioural strategies, including thinking through problems, avoiding negative appraisals, having realistic expectations and positive self-talk, which may have contributed to the increase in ‘rationality’ or appraisal techniques. Some time was spent discussing the importance of diet, exercise and relaxation, and these are referred to in the checklist as ‘self-care’, which also increased. Other styles increased much less despite being featured in the course, for example social support, which could be because it already had a high frequency rating pre-intervention. It is also possible that social support depends to a larger extent on the

environment of a pupil (i.e. whether there are supportive peers and family) and is not influenced by explicit teaching. 'Hobbies and leisure' and 'assertiveness' styles increased very little, but these were not discussed extensively during the course. Some of the items listed as 'assertiveness' were not considered to be relevant to adolescents at school, for example 'delegate work' and 'say no to extra work'. Finally, maladaptive coping reduced considerably, which is encouraging, since this was discussed during the course. Pupils gave examples of 'unhelpful' coping, including avoiding work, not talking to anyone, arguing and drinking alcohol, then explored how to avoid these, which appeared to prompt a decrease in frequency following the course. Folkman and Lazarus (1986) suggest that using a range of adaptive coping approaches leads to reduced negative outcomes, such as fewer depressive symptoms, suggesting that stress-management work could also reduce negative outcomes and behaviour in adolescents, such as depression, substance misuse or social difficulties.

The results shown are of limited application to other settings, due to the small sample size of each group and the lack of a scientific control. The results are specific to the seven pupils who completed the intervention and can only be looked at in the context of this school, therefore cannot be generalised to other schools or other age groups. However, the results are useful for the school and the Educational Psychology Service (EPS), to give some supporting evidence for using the intervention and show positive outcomes for the work with these pupils. Results were shared informally with the school SENCo as evidence for the success of this work and consequently the intervention was requested for the following year. Repeat evaluated trials of the intervention with greater numbers would be required before it could be said to demonstrate significant impact and be used more widely, however this may occur in the future so that the EPS can offer the intervention to other schools.

Qualitative methods were not used in this research as the school and EPS sought numerical data to indicate how successful the programme was. Time was also limited and conducting interviews or focus groups would have required pupils to miss another lesson which was not justified.

Additionally, quantitative data should be less open to researcher bias than thematic analysis of interview data. Qualitative comments would have been useful, to give some indication of pupils' views on the course content and impacts, however pupils could have felt pressured to give positive feedback since one facilitator works in the school and the other is linked to the school. During the final session, when pupils discussed aspects of the course that were useful and had been tried at home, many pupils reported having used the breathing techniques and muscle relaxation at home, and one or two pupils reported that they had a better understanding of how their thinking could make them feel more stressed and how to think more positively. Since comments were made to the facilitators they cannot be assumed to be reliable, however, so do not form part of the research data.

Positive immediate outcomes of this intervention were found, but long term impact cannot be assumed without further retesting pupils. Unfortunately, these pupils were about to leave school so retesting was not possible. If the intervention was trialled with younger pupils, it would be beneficial to look at the longevity of reduced stress levels, perhaps after 3-6 months. The impact of persistent stress has significant long term risks, including increased anger, hostility and aggression (Aseltine, Gore and Gordon, 2000) and more persistent emotional and behavioural disturbances (Grant et al., 2004; Phillips et al., 2005). Therefore, reducing stress experienced by adolescents could prevent later problems (Wachelka and Katz, 1999). Further research over a longer period could address the longer-term benefits of this intervention and look into whether it improves exam performance and consequently GCSE grades. Evidence of this type would make stress-management interventions highly appealing to schools.

It is difficult to argue that stress is a concrete, measurable entity as might be suggested by this research, however this intervention does not intend to reduce stressful events, physiological reactions or actual experiences, only to equip pupils with tools to perceive stress differently and cope when it arises. The use of self-report tools such as the PSS and Ways of Coping inventory

acknowledge the personal nature of stress and allow pupils to quantify their subjective perceptions of stress, rather than attempting to measure objective behaviours or environmental stressors.

In conclusion, stress-management interventions such as this one appear to reduce adolescents' perceived level of stress and increase adaptive coping. Early intervention, with pupils who display non-clinical levels of stress could prevent later problems such as depression, anxiety, anti-social behaviour and under-achievement. Well-evaluated, evidence-based programmes should be developed and promoted within schools as part of an emotional-wellbeing curriculum, and could also represent a valuable role for Educational Psychologists, in designing, delivering and evaluating interventions.

6,497 words

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Appendix 1

Appendix 2

Appendix 3

Consent and Information Form

Dear Student,

You are invited to join the Year 11 Stress-Management Group. It will run this term, every week, from **Wednesday 27th April** to **Wednesday 25th May** during tutor time (1.40pm). There will be a follow up session after half term, on **Wednesday 8th June**.

The group will be a fun and informal way to explore what stress is, what makes us stressed and what effects it can have, so that you can look out for stressful things and signs of stress. We then look at how to change our ways of thinking about stressful things and how to feel more confident and able to cope. Lastly, we will think about lots of different coping strategies and try out some relaxation techniques and ideas that you can use at home or at school.

You are invited to join in with use because we think it might be helpful before your exams, but **you don't have to!** If you would like to come along, please sign below to agree that you would like to

- come to **every session**,
- follow the **group rules** agreed in week one, and
- complete some **questionnaires** before and after the programme (today and at the follow up)

Your questionnaires will be used by me only, to see how successful the course is, and will not be shown to anyone in school.

I would like to come to the Y11 stress management course

Signed: _____ Date: _____ Form: _____

For Head of Year: Parent consent obtained verbally ☐ yes ☐ no

Please return the signed forms with parental consent to J. Wright by 26th April.

Appendix 4

Stress Management Intervention – Session Plans

SESSIONS 1 & 2: Stress Awareness

1. Introductions: each person says their name and favourite colour
2. Group aims: discuss purpose and outline of sessions, ask for what each hopes to get out of it
3. Group rules: all contribute group rules, to be written on sheet on wall. Ensure confidentiality is brought up.
4. Ice breaker: Each person takes a sentence starter card from a bag and completes it (e.g. " I remember feeling really excited when…"
5. Questionnaires: all complete a perceived stress scale, coping checklist and YP Core
6. What is Stress? – Brainstorm answers to add to board, concentrate answers on what ***is*** stress not what causes stress.
    a. Question: 'do all people react the same to the same situations?' if not, what determines our responses?
7. Education/discussion: definitions of stress: e.g. perceptions of resources/coping vs. load, chemical reactions in the body, disequilibrium
8. Question: 'why is stress a problem?' then 'Is stress ever a good thing?'
9. Education/discussion: short and long term effects of stress, stress facts
10. How does stress make us feel? Large outline of body – each adds labels for feelings/effects.
11. What kinds of things make us stressed? Each person has block of sticky notes to record things that make us stressed, then each comes to place some on board, if happy to do so.
12. Discussion of similarities and differences, bigger and smaller stressors. Divide sticky notes into two columns: 'things we could change' & 'things we couldn't really change'
13. Stress bucket diagram: each adds their stressors and three targets for change.
14. Introduce stress diary

SESSIONS 3 & 4: Problem Solving and Coping

1. Self Esteem activity: sentence starters – each completes (e.g. “I have always been good at..”)
2. Positive self-talk: sheet with negative thoughts – substitute for positives. Each give one example of a negative thought we could change to positive
3. Problem solving: CALMER planning sheet – identify problem, set goal, visualise preferred future, note first 3 steps to goal. Reminder of stressors we could change.
4. Coping strategies: each writes one thing we do if we feel stressed on a sticky note. Add to board in 2 columns: constructive and destructive strategies.
5. Self-talk: practice inner dialogue, each give an example of something to rehearse before an exam.
6. Problem solving and planning – discuss use of planning sheets or three step plan.
7. Social support/Relationships: crutch analogy: each thinks of one person to be their ‘crutch’. Quality time, love, listening, help, relaxation. Remembering to say thank you.
8. Distraction: music, TV, games, exercise, phone call, any others?
9. Relaxation: breathing techniques, music, muscle tensing, guided imagery – discuss pros/cons
10. Breathing: all try the 7:11 breathing technique and discuss
11. Relaxation: muscle relaxation
12. Guided imagery: special place exercise.

SESSIONS 5 & 6: Changing Thought Patterns

1. Introduction to thoughts, feelings and behaviour triangle (diagram on board)
2. T, F, or D sheet to understand thoughts, feelings and what you do.
3. Each complete table with examples of how thoughts might affect feelings and behaviour
4. The magic circle: complete sheet for something enjoyed
5. The magic circle: complete difficult situation
6. Automatic thoughts – examples of what might go through our heads for different situations, divide into positive and negative
7. Thinking errors: all-or-nothing thinking, magnifying the negative, the mind reader, setting yourself up to fail.
8. Thinking errors quiz
9. Balanced thinking: is there any evidence for thoughts? what would X say? Am I making thinking errors?
10. Complete table for example characters, then add one example for your own.
11. Introduce thoughts diary to track stress, stressors and thoughts and feelings
12. Relaxation exercise: breathing, muscle relaxation or imagery.
13. Give out stress management booklets and exam stress guide.
14. Evaluation: each completes perceived stress scale, coping checklist and YP Core.
15. Discussion about maintenance and drop in sessions at lunchtime.

CHAPTER FOUR

Applying the Research and Development in Organisations Framework (RADIO):

Engaging Under-Represented Families through a Sure Start Children's Centre

1. Abstract

This report describes a collaborative research and development project between a Sure Start Children's Centre and the Educational Psychology Service. The joint planning, implementation and implications of the research, aiming to investigate barriers for engagement of under-represented families and increase attendance for these at the Children's Centre, are reported. Data collection methods, including focus groups and questionnaires targeting at 'hard to reach' parents, are critiqued and their limitations in practice are discussed further. Finally, the outcomes of research, implication for planning services and future work, and links to relevant literature in the area are summarised.

2. Introduction

This piece of research and development work focuses around a small Children's Centre in an East Midlands Local Authority developing services for the most 'hard to reach' families. The centre requested support with understanding possible barriers to engagement for socially excluded families and with developing client-focused services. This was an area for development for this centre, as identified by previous Ofsted inspections, and required research with targeted families in order to increase engagement. The centre's management team agreed to commission their link Trainee Educational Psychologist (TEP), part of the Local Authority's Educational Psychology Service (EPS), in order to help plan and conduct research to investigate these barriers and plan future services. The

TEP role here was to share literature in the field of hard to reach families and service engagement, to help plan and conduct research and analyse data, and to oversee the planning of future activities to meet the needs of families. This was a collaborative project between staff working within the Children's Centre and the Local Authority EPS. The project used the Research and Development in Organisations (RADIO) approach (Timmins et al., 2003) as a framework with which to plan the research activities alongside centre managers and to evaluate future actions resulting from the research.

3. Sure Start Children's Centres

In 1998 the Labour Government announced £452 million funding in England for new Sure Start centres: local programmes targeting children under five and their families, aiming to reduce social exclusion and improve life chances of younger children (Glass, 1999). The centres were intended to bring together local services and agencies for children and families, including, at a minimum, a range of 'core services': outreach services and home visiting, support for parents, learning and childcare, healthcare and advice, and support for those with special needs or disabilities (Glass, 1999). Phase one of the plan focused on centres in the most disadvantaged areas, with phases two and three involving roll out of centres in other areas, so that all children under five and their families should have access to a Sure Start programme (DCSF, 2008).

A National Evaluation of Sure Start (NESS, 2005) found that Sure Start local programmes were not having the desired impact on children's development and attainment, and another research project (Sylva et al., 2004) highlighted the benefits of integrated Children's Centres with childcare provision for children's development. The two initiatives were merged to form Sure Start Children's Centres in 2005 (Belsky et al., 2007), combining family support and advice with childcare and early learning opportunities (DCSF, 2007).

4. Impacts of Sure Start Children's Centres

Evaluations of Children's Centres to date show mixed outcomes, perhaps due to the lack of time for longitudinal research (House of Commons, 2010). Barlow et al. (2007) reviewed parenting and family support in 150 Sure Start programmes, and found that whilst a wide range of family support programmes were being implemented, with examples of good practice observed in some areas, programmes had minimal impact. The authors concluded that penetration was on the whole low, and therefore unlikely to effect changes in child outcomes. A research brief by the Department for Education (2010) investigated child and family functioning in 150 Sure Start (SS) areas compared to families in similarly deprived areas without a Sure Start Children's Centre. Some positive impacts of Children's Centres were found including reduced body mass index (BMI) and better health for children, parents providing more stimulating environments and less harsh discipline. However, parents in SS areas also reported more depressive symptoms and poorer attendance for school appointments and meetings. Crucially, no differences were found between children in SS and non-SS areas on seven measures of cognitive and social development from the Foundation Stage profile, and four measures of social-emotional development from parent reports, which suggests that Children's Centres may not have had a positive impact on early child development to date. Much criticism of Sure Start Children's Centres focuses on the variation and inconsistency in activities delivered and the lack of targeted support for the most hard to reach, needy groups (National Audit Office, 2009).

5. Defining 'Hard to Reach' and Excluded Groups

The terms 'hard to reach', 'hard to engage', 'socially excluded', 'marginalised' and 'under-represented' have been used in both government policy and literature to refer to groups or sections of the community who are not supported by particular services, or who are difficult to involve in

activities (Social Exclusion Unit, 2004, Boag-Monroe and Evangelou, 2010). However, it is difficult to find a clear definition or criteria for these terms. A number of studies suggest that what constitutes hard to reach will vary from place to place, dependent on context, location, what the service is and who it serves (Doherty et al., 2004; Coe et al., 2008; Cortis et al., 2009) however, recurrent themes in literature seem to suggest that certain families are less likely to engage in public services (Cortis et al., 2009; Boag-Munroe and Evangelou, 2010). These include:

- Minority groups and those with other languages and cultures;
- Fathers;
- Lone parents;
- Teenage parents and parents under 25;
- Homeless families;
- Families with a parent or child experiencing mental or physical ill-health, or disability;
- Workless households;
- Mobile and travelling households; and
- Families with a parent misusing substances.

Doherty et al. (2004) suggest three categories or models for viewing such families, which could be helpful in considering reasons for lack of engagement or how to approach these:

1. Under-represented: these are groups who are not primary service users due to their social, economic or minority status. This model highlights the social factors at work in accessing services.
2. Invisible/overlooked: these are groups who are not addressed or catered for by services, or who may 'slip through the net'. This model highlights the limitations of services in meeting needs.

3. Service-resistant: these are groups who choose not to engage because they are wary, afraid or simply do not want support. This model emphasises individual responsibility for accessing services, but risks stigmatising families as irresponsible.

Doherty et al. (2004) suggest that the categories overlap and in reality there may be elements of all three models which contribute to some families not accessing services.

6. Problems with Categorising 'Hard to Reach' Families

There are some difficulties with the terms 'hard to reach' or 'hard to engage', and in particular with their use and assumptions. Cortis et al. (2009) suggest that many professionals take Doherty et al.'s third model of disengagement and view families as personally responsible for not wishing to engage, focusing on individuals rather than groups or services. This may stigmatise certain groups and become a barrier to engagement in itself, and detracts from the responsibility of services to remove barriers. It could also be said that terms such as 'hard to reach' are constructed and understood by professionals, rather than families, and so give little insight into reasons for disengagement. It is unlikely that families would view themselves as 'hard to reach', and much more likely that they would view services as unnecessary, interfering, irrelevant or hard to access. Some suggest that it is the services that are hard to reach, not families (Crozier and Davies, 2007), and that professionals need to shift their focus to think about what makes services difficult to access for some families (Landy and Menna, 2006).

The Social Exclusion Taskforce (2007) lists challenges of engagement under two headings, to encompass the 'views of some families on services' and the 'views of services on some families', suggesting that there are multiple and complex factors preventing engagement, lying within families and within services; however the difficulties in changing family demographics are also recognised. It

could therefore be preferable to consider these groups as under-represented groups, rather than hard to reach, and look into how services can engage families.

7. Barriers to Engagement

Boag-Munroe and Evangelou (2010) review the literature on barriers to parent and family engagement in services, dividing these into three broad categories:

(a) 'Organisational barriers', which make the system hard to engage with, for example professional jargon,

(b) 'Hard to reach families', where barriers may prevent families from accessing services, for example lack of transport, and

(c) 'Hard to engage families', where barriers lie within families who do not wish to engage, for example due to reservations about services.

Some studies focus more on one category than others, but this comprehensive review of literature suggests that there are genuine barriers in each of these areas.

Crozier and Davies (2007) focus primarily on the organisational barriers that 'exclude' families, claiming that schools and services are themselves hard to reach for many families of other cultures. They talk of a white, middle-class imposition of values which dictates how parents should engage, and alienates parents who wish to engage in other ways. Crozier and Davies interviewed 591 parents and children from 157 households, 89 of which were of Pakistani heritage and 68 of Bangladeshi heritage. These groups represented 4.4% and 0.41% of the local community, respectively. The authors started with the research question 'why are the schools hard to reach?' - a fairly narrow research question which could pre-empt negative and skewed responses. The authors found that many parents interviewed did not see a need to visit the school or attend parent meetings, because they felt they would hear of any problems through the school or community. Few parents felt they

should play a direct role in education, feeling that their role was instead to provide a supportive home and enforce Islamic and family values. Many left their children to make school-related decisions and inform them of progress or problems. Children were found to be complicit in their parents' exclusion from schools, for example by not informing them of parent meetings, not passing on letters or asking for involvement, for reasons including embarrassment about culture and perception of parents as not understanding the school. The research highlights some important issues relating to organisational understanding of families' culture and values, and suggests that schools are not aware of parent needs or perspectives, do little to inform parents of the school system and do not communicate sufficiently with some groups. However, the research is skewed in its approach and considers only organisational barriers to parent engagement. It focuses on only Bangladeshi and Pakistani families, ignoring other families who are under-involved, and therefore results would only be relevant to this specific geographical area. In other areas, where underrepresented families include white or black minority groups, the data may not be applicable, however the conclusions of this research may still apply. The research advocates that professionals should do more to elicit the views of underrepresented families and respond to their needs, but does not suggest how this should be done.

More relevant to the current study, Avis et al. (2007) conducted interviews with 60 parents to discover the factors that both promote and hinder participation in Sure Start programmes. Parents revealed that they attended Sure Start to make social contact, to get information about activities in the community and to build job-related skills. Parents added that they would be most likely to attend following an invitation, either by post, letter or home visit. Parents who did not attend Sure Start gave reasons such as lack of confidence, distrust of professionals, and anxiety about not knowing other families using the service. There were also a number of organisational barriers mentioned, including inappropriate venues or timings of events, lack of communication, cleanliness of centres, stigma of using services and lack of understanding of Sure Start's role and function. The research indicates that there are multiple barriers for some families, but that many are things

Children's Centres could address if they were aware of the problems. Unfortunately, the research contained only a small sample and all were parents that had registered with Sure Start at some point and indicated consent to participate in evaluation and research, which may not be representative of local 'hard to reach' families. The sample did not include any parents who had never participated in Sure Start and so may exclude those with specific reasons for not engaging or miss significant barriers. Despite this, the research highlights some important organisational and family barriers to accessing Children's Centres, as well as some factors encouraging engagement which could be used to promote services to other families.

Coe et al. (2008) recruited ten parents in Sure Start areas to each interview three other non-participating parents, aiming to discover what barriers might prevent parents from using Sure Start programmes. Barriers identified were grouped into three categories: lack of information, accessibility and social isolation. Accessibility was a recurrent theme in parent interviews. For example, some parents cited having to walk and catch a bus to reach a centre as off-putting, whilst others missed most activities due to working full-time.

Other reasons fell into the social isolation category, for example some parents felt inhibited by not knowing who might be there, and others felt there were language or cultural barriers where other parents were of different ethnicities. Lastly, although most parents interviewed had heard of Sure Start, many were misinformed about the nature or purpose of programmes, feeling that Sure Start was only for low-income or single parents, or that it was purely a childcare provision. This research has limited validity in other areas due to the small geographical area surveyed and small number of participants. Using parent interviewers, with limited experience and training, could detract from the reliability of data if questions are not standardised or coding is inconsistent, although they also offer a valuable 'way-in' to access hard to reach sections of the community. The outcomes are mirrored in other research on barriers to accessing services (Milbourne, 2002; Simpson, 2002; Landy and Menna, 2006) which suggests that although barriers to engagement will depend on locality, population and

service providers, there are some recurrent themes summarised below. Some of the main recurring themes in literature on hard to reach groups are summarised here.

Table 1. Summary of barriers to engagement found in literature

Theme	Examples	Reference/Research
Communication limitations	• Language not spoken by centre • Culture not understood • Literacy levels not catered for • No access to phones or internet • Services use too much jargon • Information not available • Service not listening/responsive	• Milbourne (2002) • Tunstill et al. (2005) • NESS (2005) • Avis et al. (2007) • Landy and Menna (2006) • Garbers et al. (2006) • Crozier and Davies (2007)
Setting or service barriers	• Lack of visibility of service • Inappropriate activities • Timing of activities • Waiting lists • Unwelcoming/unclean setting • Inappropriate venue • Location of venue • Stigma of service • High staff turnover	• Avis et al. (2007) • Glennie et al. (2005) • Coe et al. (2008) • NESS (2005) • Landy and Menna (2006) • Avis et al. (2007); NESS (2005); Doherty et al. (2003) • Doherty et al. (2003) • Devaney (2008)

Isolating 'within-family' barriers	• Single parent family • Minority groups • Young parents • Fathers • Lack of transport/access • Rural isolation/distance • Low/no income • No/poor accommodation • Unstable relationships or chaotic domestic situation • Lack of time/resources • Weak literacy skills	• Brackertz (2007) • Crozier and Davies (2007) • Garbers et al. (2006) • Tunstill et al. (2005) • Doherty et al. (2003) • Coe et al. (2008) • Avis et al. (2007) • Brackertz (2007) • NESS (2005); Statham (2004); Brocklehurst et al. (2004) • Boag-Monroe and Evangelou (2010); Milbourne (2002);
'Within-family' reluctance	• Prisoners' families • High-crime contexts • Refugees/asylum seekers • Drug/alcohol/substance use • Travellers or 'underground' families (not registered) • Families with reservations/ distrust about services	• Garbers et al. (2006) • Milbourne (2002) • Katz et al. (2007) • NESS (2005); Coe et al. (2008) • Landy and Menna (2006); Garbers et al. (2006) • Statham (2004); Landy and Menna (2006); NESS (2005)

8. Actively Engaging Hard to Reach Groups

Much of the research into barriers to engagement also outlines implications of barriers found and suggestions for overcoming these and engaging families. A summary of suggestions for engaging families considered 'hard to reach' is outlined below.

Table 2. Summary of proposed means of engaging families from literature

Barrier Type	Key to engagement	Reference/research
Cultural, language or literacy barriers	• Relationship building • Consultation with groups • Responsiveness to needs • Awareness of cultural messages conveyed in words, dress, etiquette and routines • Innovative means of contact using technology and word of mouth	• Milbourne (2002); Statham (2004); Glennie et al (2005); NESS (2005); • Landy and Menna (2006); NESS (2005); Statham (2004) • Avis et al. (2007); Landy and Menna (2006),
Overuse of jargon, services not approachable or trustworthy	• Use of parent ambassadors to relate to newcomers • Shared, simplified language used by all services • Adopting a respectful, non-stigmatising approach	• Avis et al. (2007) • Milbourne (2002); Avis et al. (2007); Devaney (2008) • Statham (2004)
Lack of visibility of service, accessibility of service or accurate messages	• Use of new media tools, e.g. social networking, text, web • Outreach workers or	• Avis et al. (2007) • NESS (2005), Garbers et al.

	befrienders • Leaflets in well-used locations, e.g. GP surgery	(2006) • NESS (2005)
Services or activities inappropriate, irrelevant, ill-timed or inaccessible	• Consultation in the community with key groups/planning services with users • Listen to needs of families • Open days/drop in sessions • Flexible timings, planned around client needs	• Avis et al. (2007); Glennie et al. (2005); Landy and Menna (2006) • Korfmacher (2008) • Glennie et al. (2005) • Coe et al. (2008)
Services and venues unwelcoming, off-putting, inappropriate or unclean	• Outreach work to ease anxiety/brief home visits • Avoiding 'officialdom' • Purpose-built buildings • Friendly, relaxed staff • Staffed reception areas • Consideration of cleanliness, décor, colour, furnishings and layout	• Landy and Menna (2006) • Landy and Menna (2006) • NESS (2005) • NESS (2005) • Chand and Thorburn (2005) • Avis et al. (2007); Ball and Niven (2005); Boag-Monroe (2010)
Isolation of families, e.g. lack of transport, funds, childcare, etc.	• Offers of transport • Childcare provided • Low-cost/free services • Outreach/parent ambassadors	• Statham (2004); Crowley, (2005); Brackertz (2007); NESS (2005) • Coe et al (2008)

	• Frequent communication	
Underrepresentation of groups, e.g. fathers	• Encourage views of fathers as involved caregivers • Flexible timings, outside of working hours • Dedicated fathers' worker • Activities aimed at men • Male staff employed in venue • Activities avoiding sitting and talking, e.g. football, BBQ,	• Ghate, Shaw and Hazel (2000) • Crowley (2005); Tunstill et al. (2005); NESS (2005);

A key suggestion for Children's Centres from the literature is to plan activities and services around the needs of users, listening to views and being responsive to what families want, rather than trying to engage families in existing services that may be inappropriate, poorly timed or inaccessible. Avis et al. (2006) advise services to consult in the community with under-represented groups to establish what barriers could prevent engagement and what could be done to tailor services to their needs. This idea is echoed by the Performance Management Sure Start Children's Centres SEF Standards Matrix (Together for Children, 2009), which expects services to plan activities around the needs of hard to reach families (see appendix 1).

This research and development work therefore enables the Children's Centre, with the support of other agencies (Educational Psychology Service) to develop services around the needs of hard to reach groups in the community.

9. Research and Development in Organisations (RADIO)

The RADIO framework was used in this research to plan work alongside stakeholders from the Children's Centre. A summary of the RADIO model can be found in Appendix 2, along with a short critique of the model's development, which was shared with stakeholders during an initial meeting.

10. Summary of Research Project and Outcomes

Clarifying Concerns

Stage 1 – Awareness of Need: The first phase of RADIO is the means by which a need for research arises. The Children's Centre manager and Family Support Worker met with me (their link Trainee Educational Psychologist) to discuss key areas for development, as identified by centre managers and Ofsted inspectors. The manager described the local community as predominantly middle-class homeowners, with a few 'pockets' of deprivation which were not thought to access the centre or its outreach activities. A recent Ofsted inspection had rated the centre 'good' but highlighted the need for engagement with more 'hard to reach' families and planning of services around these under-represented groups. It was therefore suggested that some research into barriers of engagement for hard to reach groups and how centres could better engage families could be carried out, with the aim of giving the centre more rich, detailed information with which to plan activities.

Stage 2 – Invitation to Act: During this early phase it is necessary to be clear about each professional's role and present an outline of what the RADIO model can offer organisations. Expectations and realistic outcomes were discussed. These included TEP (Trainee Educational Psychologist) support with designing research methods, collecting and analysing data, and planning future actions, whilst the centre was expected to actually carry out the actions and review or evaluate these. The centre managers agreed to be collaborators, jointly involved in data collection, and were very happy to go ahead with the project.

Stage 3 – Clarifying Organisational and Cultural Issues: RADIO takes into account the likelihood that organisational culture may influence the research and development process (Schein, 1990). It is important to be aware of any contextual background information, tensions or strengths that impact positively or negatively on the research. Ignoring any barriers to change or vital resources could jeopardise the success of the project. General cultural issues within the organisation included the background, such as the relatively short time the centre has been open, the staffing concerns, including imminent loss of two jobs and movement of managers between centres, and the recent Ofsted inspection, were discussed in the previous meeting. Some potential barriers to research and development included the lack of time and funding for the centre, the movement of staff due to job cuts and turnover, and the small number of staff, which at that point included one manager, one family support worker, one deputy manager and two outreach workers (amounting to 3.5FTE). Supportive factors that could aid the research process included the dedication and commitment of staff, the desire for the centre to work with other agencies and involve the local community, and the emphasis from recent Ofsted inspectors to develop services.

Stage 4 – Identifying Stakeholders: It is essential to consider who has an interest in the research and who to involve, at what level, before planning research, so that interested parties can contribute to the process. Whilst all users of the Children's Centre, including parents, children, other services, staff and the wider community could be said to have an interest at some level, it was decided that the Children's Centre Manager, Family Support Worker and Deputy Manager would be the key stakeholders involved in the research process, as they would be invested in change and committed to planning future centre developments.

Stage 5 - Agreeing the Focus of Concern: Although the focus of this research had been discussed early on, it was still important to specify an area of interest and agree potential research questions. We agreed that hard to reach parents were the focus group for data gathering, and this group had already been defined by the centre in previous planning. They were said to include:

- Lone parents;
- Workless households;
- Fathers;
- Parents of children with disabilities;
- Families in temporary accommodation;
- Young parents and
- Minority ethnic groups.

The focus of research was to answer two main questions:

1. What are the barriers to engagement for 'hard to reach' groups? i.e., why have families not used the centre in the past, what prevents them from accessing it, what could put them off?

   It is important to ask this question, even though many barriers have already been identified by literature, as research suggests that engagement in services is highly individual to local areas and services and can vary depending on the community and who is 'hard to reach' (Doherty et al., 2004; Coe et al., 2008; Cortis et al., 2009).

2. What could be done to engage this group more? i.e., what could encourage families to use the centre, what could help them access, what would they be interested in attending?

   This is the central research question which will enable the centre to plan activities around services. Being responsive and listening to the needs of local families is essential in engaging underrepresented groups, according to literature in the field (Avis et al., 2007; Glennie et al., 2005; Landy and Menna, 2006; Coe at el., 2008).

The stakeholders also felt that if contact with the hard to reach groups could be made, then it would be interesting to ask what was known of the centre and what families thought the centre offered, to

ascertain perceptions of the centre that could contribute to reluctance to engage. Finally, in order to plan client-focused activities, as suggested by the SEF standards matrix (Together for Children, 2009), parents should be asked what time is most suitable to access services, what venue would be preferred, and what services or activities they would like to use.

11. Research Methods Mode

Stage 6 – Negotiating the Framework for Information Gathering: Stakeholders and researchers collaboratively plan data collection methods, timeframes and analysis appropriate to the research questions and intended participants at this stage. Participants to be targeted included parents in the 'hard to reach' categories mentioned earlier, with children under five years as these families can use the Children's Centre. In order to reach this group, the easiest way was agreed to be via the local schools and nurseries. Parents with a child under five who attended the local infant schools and nurseries were thought to be accessible as they were registered and would attend the school daily.

Initial discussion focused on the need for qualitative methods in order to give rich, detailed information which did not pre-suppose answers from families. Literature suggests that qualitative approaches complement the process of developing new services and provide information for fine-tuning services that have been in place for short periods of time (Henderson et al., 2002). Qualitative research can also uncover people's experiences of services from their own point of view, and can help researchers understand the feelings and thought processes involved that quantitative methods could not (Strauss & Corbin 1998). Whilst the previous survey commissioned by the centre had given numbers of parents responding to each theme, this research was hoped to give more detailed information, not confined by closed questions or tick boxes.

For this reason focus groups were considered to be a good forum for parents to give qualitative answers which could be developed by prompts during the process to gather the most information possible. Focus groups have a number of advantages relevant to the research aims:

- Focus groups can empower participants and raise consciousness of issues in a social context. Responses develop as ideas are shared between subjects, meaning more developed answers than a survey, questionnaire or single interview might yield (Johnson, 1996)
- Group methods are an efficient use of time and resources (Robson, 2002).
- Robson (2002) also states that group dynamics can be beneficial as extreme opinions can be checked and more consistent opinions will be concurred with, providing 'natural quality controls'.
- Focus groups are accessible to those who might not usually respond, say little, or have low literacy levels (Kitzinger, 1995), which is particularly relevant here.
- All those present can contribute their experiences of what happens, rather than simply hearing from dominant characters or the most articulate, or from those who are motivated to return questionnaires (Vaughn et al., 1996).

However, focus groups also require a time commitment from participants and coordination to ensure all can attend at the same time, which could be difficult for busy parents or those who do not usually choose to commit time in this way. There are some drawbacks to focus groups which need to be carefully considered:

- If parents who have young children are expected to commit time to a focus group, discussions must be time-limited and structured, with fewer than ten questions asked in no more than an hour (Robson, 2002) as parents have limited time.

- Focus groups require participants to travel to a venue, so it should be convenient and accessible, such as meeting at the local school, for example, immediately after dropping children at school in the morning or before collecting them in the afternoon.
- The process needs to be facilitated so that less articulate, shy or less interested participants can share their views and so that conflicts or power struggles do not arise. For this reason one of the facilitators should be experienced in conducting focus groups.
- It is advisable to start with simple, specific questions to encourage participation, and then move on to open-ended questions (Vaughn et al., 1996). For this reason, "have you ever used the Children's Centre" would be an ideal opening question.
- Hard to reach parents may be wary of attending a 'focus group' or may be reluctant to speak if questions seem judgemental or aggressive, therefore the discussion will be called a 'coffee morning', with coffee and cakes to encourage participation, and questions will be carefully phrased to avoid asking parents outright why they do not access the centre.

Focus group questions were designed with these factors in mind, and can be found in Appendix 3. Groups were arranged for a Tuesday morning at 9am so that parents could attend after taking children to reception/nursery classes. Parents were recruited by initially sending a letter home from school explaining that a researcher would telephone some parents to invite them to a voluntary coffee morning with Children's Centre staff (see Appendix 4). Parents in the hard to reach categories, with under 5s, were identified by the schools and telephoned a week later to invite them to the coffee morning to discuss what the Children's Centre could offer local parents. 12 parents from one setting and 18 from another setting were telephoned, and four parents from each setting agreed to attend.

Stage 7 – Gathering Information: The groups were held on consecutive Tuesdays in the local schools. I intended to ask the main focus group questions, whilst the Family Support Worker prompted or developed answers of interest and gave out information about the centre. Unfortunately no parents attended either of the groups, and most did not leave a message as to why. Two parents told the school that they could not make the morning and one parent's child was absent from school. Other parents simply did not show up and it was not clear whether the parents did not want to attend or whether they had forgotten. One school's Head explained that he had also arranged events in the past that parents had not attended and explained that engagement in school events was typically low.

Following this we returned to stage 6 to re-negotiate information gathering, to consider alternative ways of eliciting parents' views.

Stage 6 – Negotiating the Framework for Information Gathering: This stage can be revisited as necessary until sufficient information is collected, so the centre managers and I met to rethink data collection methods. This time we also met with the school Heads as they were thought to have relevant knowledge on the parents at each school. We discussed sending questionnaires to parents' homes since parents were reluctant to attend focus groups and interviews would most likely pose the same problems. The focus group questions we had planned could easily be made into a short, simple questionnaire and sent to all parents of under-fives, or to targeted parents in the hard to reach groups. The advantages of questionnaires were considered:

- Questionnaires can quickly and easily be used to gather standardised data from a large number of people, without requiring lots of money or resources (Fink, 2003).

- Surveys are flexible and can contain a large number of detailed questions or a few short questions (Mertens, 2010). They can be highly structured, with closed or multiple choice answers, or unstructured with open, qualitative responses.
- Questionnaires delivered remotely (e.g. via post) can allow anonymity if addresses are detached, encouraging openness, whereas the researcher will know who has responded in a focus group. Additionally, centre staff would not be present so parents may feel more able to answer critically about the centre.
- They can be more reliable and less biased than interviews and focus groups, but only if questions are carefully worded to avoid influencing responses (Robson, 2002), for example in focus groups parents might simply echo the views of other parents rather than think of their own genuine reasons.

However, there are also considerable difficulties with questionnaires in this context:

- A researcher will not generally be present when participants fill out surveys to clarify or develop questions, so participants could interpret questions differently (Fink, 2003). To minimise this effect, the wording must be clear and the questions unambiguous.
- Ideas cannot be developed in a questionnaire, so all required data must be obtained from within the questions.
- According to Robson (2002), surveys can be affected by the characteristics of the respondents and possibly even their motives, for example parents who already use the centre and would like particular activities might be more motivated to respond than non-users who are not interested in using it.
- With questionnaires the response rate can be low, particularly if it is long, complex or requires posting back. This can be minimised by keeping questionnaires short and simple, avoiding asking for personal data, anonymising responses, facilitating returns (e.g. with

stamped return envelopes or collecting replies) and adding incentives such as prizes (Gillham, 2007).

- Questionnaires may exclude those with low literacy levels, English as an additional language or difficulties returning responses.

For these reasons, questions were deliberately few, short and very simply worded. Parents were given the option of posting responses back in stamped addressed envelopes (provided), or leaving with the school when collecting children. Following Strauss and Corbin's (1998) suggestions of using qualitative methods to elicit people's experiences, feelings and thought processes, questions were open ended to allow parents to give any responses they thought of, rather than pre-supposing themes or possible answers. Although this requires more writing than tick-box or multiple choice questions and could be off-putting, it was hoped to yield the detailed information wanted by the centre. The questionnaire can be found in Appendix 4.

Stage 7 – Gathering Information: Fifty questionnaires were sent to local parents of under-fives, sent out by the schools. Targeting only 'hard to reach' groups was felt to be unethical by the TEP and school Heads, therefore all parents of children under five were given questionnaires, but the last question asked parents to tick which group they belonged to in order to later analyse 'hard to reach' responses. Whilst all data was passed to the Children's Centre for their interest and planning, only hard to reach responses were analysed here, in accordance with original aims and research questions. Response rate for hard to reach groups was predicted to be low, and unsurprisingly there were 22 responses in total, 8 of which fell into our original target group. Whilst a low number, this still matched the number who agreed to the original focus groups, so data was analysed for themes in responses and for specific detailed responses.

12. Ethical Considerations

Previous Sure Start evaluation has targeted only parents who have given prior consent to take part in evaluation and monitoring (Avis et al., 2007), however this project aimed to target parents who had never registered with Sure Start. Accessing this group posed some ethical problems, as the Data Protection Act (1998) prevents schools from giving contact details to researchers without consent. To avoid this, we decided to send letters home to explain the research and ask for parents to participate. Parents who did not wish to participate were invited to contact the school to prevent a subsequent phone call, or decline the invitation during the phone call. Whilst this is less ethical, as parents do not give express consent prior to being telephoned, the population was felt to be too difficult to contact otherwise. Once questionnaires were sent out, schools were able to send these home as part of school correspondence, and parents signed the bottom of the questionnaire to 'opt in' and give consent to information being used for research purposes (see Appendix 5), following guidelines in Conducting Ethical Research (Stuart and Barnes, 2005). Questionnaire responses were sent back anonymously (with no identifying details) and analysed as such. Data was stored securely, in locked filing systems, at the Local Authority Children's Services office.

13. Results

Table 3. Summary of parent responses to questionnaire by theme, example and link to literature

Question	**Response theme/code and frequency**	**Example Responses**	**Link to literature**
Do you know of the XX Sure Start Children's Centre on	No (n=6)	"don't know where it is" "not aware of it"	Avis et al. (2007)

XX Road?	Yes (n=2)	"I've heard about it"	
Have you used the Children's Centre at XX in the last 12 months?	No (n=5) Yes (n=1)		
What do you think the centre might offer and who is it for?	No knowledge (n=4) Parent/baby groups (n=1)	"don't know" "not really sure" "stay and play, and other parent/baby groups I think"	
What could stop you from using the centre or put you off?	Lack of time (N=2) Lack of transport (n=1) Lack of childcare (n=1) Unfamiliarity (n=2)	"I just don't get time between school and working" "Don't really have time to go" "I don't drive so it's difficult to get anywhere with the push chair" "I have my baby and my sister's baby in the week" "Not knowing anyone" "Just don't know what is	Boag-Monroe and Evangelou (2010); Milbourne (2002); Doherty et al. (2003) Brackertz (2007) Landy and Menna (2006)

		available or what it's about"	
	Irrelevance/need (n=1)	"Don't really need anything at the moment, but might use it another time if I did"	Glennie et al. (2005)
What could make you want to use the centre or encourage you to visit?	More information (n=3)	"If I knew there was something on I wanted to go to" "children's activities in the holidays, I don't know if they already do that"	Landy and Menna (2006); Avis et al. (2007); NESS (2005)
	Childcare (n=1)	"Crèche or day care"	Crowley (2005); Brackertz (2007)
	Familiarity (n=1)	"If I knew someone going there or who worked there"	Landy and Menna (2006); NESS (2005)
	Need/relevance (n=3)	"something on I wanted to go to" "If I needed something to do in the week or holidays" "Something the kids would enjoy"	Landy and Menna (2006); Avis et al (2007); Korfmacher (2008)
What activities, events, training,	None (n=1)	"Can't think of anything "	

advice or help might you like to use?	Child-centred (n=2)	"a fun activity for the kids" "maybe games, football or sports for my son"	
	Work-related (n=1)	"if there was training like a qualification or computers"	
	Parenting (n=2)	"parents groups for parents to learn more about behaviour and routines" "advice on parenting"	
What time of day and day of the week would be best?	Weekend (n=4)	" Sunday afternoon" "Weekends or evenings" "Weekends in the morning"	Crowley (2005); Tunstill et al. (2005); NESS (2005)
	Holidays (n=2)	"Summer holidays" "Through the holidays"	
	Any (n=2)	"Any day" "No preference"	
Where would you prefer to meet to use the centre or try activities?	Any (n=2)	"Don't mind" "Anywhere in XX"	
	Current (n=2)	"Where it is now is OK" "X Road centre"	

	School (n=1)	"Parent groups at the school would be best"	
Do you fall into any of these groups?	Out of work (n=1) Lone parent (n=5) Parent of a child with a disability (n=1) Father (n=1)		
Any further comments or suggestions?	Information (n=2)	"I would be interested in getting more information about the centre" "If there is a list of what's on I would like to find out more"	Landy and Menna (2006); Avis et al. (2007); NESS (2005)

14. Conclusions

Questionnaire responses were compared with findings in the literature and divided into themes where responses echoed those found by previous studies. Due to low response rates, this research sample is very small and themes have small numbers of supporting responses; however themes from the analysis of questionnaire responses revealed some patterns that mirrored findings in

literature. In particular, there appeared to be a lack of visibility, or awareness of the Children's Centre and lack of knowledge around what it offers, as previously found by Avis et al. (2007). Only one of the 'hard to reach' group sampled had heard about the centre, and had heard that it runs 'stay and play' groups for parents to take young babies and socialise whilst playing. Other parents did not know where the centre was, who it was for or what it offered. Some parents expressed a wish for activities that the centre already offers, e.g. holiday activities for children and families, parenting groups and help with work qualifications, but evidently parents did not know this was offered. Two parents requested more information about the centre and timetables of activities, which are already sent to local schools monthly and displayed on notice boards outside. This suggests that there is a lack of awareness about the centre and that current means of communication, such as putting events on school noticeboards, are not effective in reaching all groups.

In terms of barriers to engagement, parents listed lack of time, lack of transport and lack of childcare as possible barriers, as previously found in literature (Boag-Monroe and Evangelou, 2010); Milbourne, 2002; Doherty et al. , 2003; Brackertz, 2007). One parent cited difficulties as she looked after her own and another baby in the week, which could be viewed as lack of time and childcare, however this may also present a lack of knowledge about the centre as it is designed for parents to take babies and toddlers to activities etc. for support during the day. Two parents also mentioned a lack of familiarity with the centre and parents using it, which might make them feel nervous of visiting, and one parent felt that there was nothing there s/he needed, which could imply that the activities currently offered are irrelevant, or might mean that the parent sees the service as one for needy families.

Possible incentives to use the centre included crèche or day care facilities (which are not currently offered), knowing someone there, and activities that were particularly interesting or relevant. A lack of knowledge about what is offered was also listed, as parents did not know what might be available

to them. Parents expressed some interest in parenting groups, for example advice around establishing routines and boundaries with children, and behaviour management. This type of parenting group has been offered previously by the centre, but advertising may not have been sufficient to reach all local parents who could benefit. One parent requested training that could support employment, for example computer skills, which has not previously been considered by the centre but could be implemented.

Stage 8 – Processing Information with Stakeholders: The results from questionnaires, patterns in themes, and implications for the centre's planning were discussed with stakeholders during a team planning session, where previous literature was summarised by the TEP, as well as data gathered, for ideas to engage parents. The discussion is summarised below:

Table 4. Summary of research results with possible implications for development

Issue Identified	Suggestions in Literature	Agreed Action Planning
Lack of visibility/ knowledge of service	• Increased advertising or communication (NESS, 2005) • Outreach workers (NESS, 2005) • 'Befrienders' to recruit local parents (Garbers et al., 2006) • Leaflets in well-used locations (NESS, 2005) • Consultation with local parents (Avis et al., 2007; Landy and Menna, 2006) • Listening to needs of local families (Korfmacher, 2008)	• Increased communication with local schools and nurseries around what's on • Leaflets left in GP surgeries, offered by health visitors and in childcare settings • Outreach workers to continue publicising centre • Consultation and research such as this to continue • Activities planned around feedback

	• Open days/ drop in sessions (Glennie et al., 2005) • Flexible timings/activities for working parents (Coe et al., 2008)	• Open days planed for following term • Flexible sessions planned for holidays, Saturdays and evenings
Lack of childcare, time and transport	• Providing childcare, offers of transport, low-cost/free services and outreach work (Statham, 2004; Crowley, 2005; Brackertz, 2007; NESS, 2005)	• Arrangement of crèche facilities during some key activities, e.g. parents courses • Activities to continue to be offered free of charge • Outreach work to continue
Lack of familiarity	• Befrienders (Garbers et al., 2006) • Parent ambassadors (Coe et at., 2008) • Staff friendly, relaxed and non-judgemental (NESS, 2005) • Reception areas welcoming (Chand and Thorburn, 2005)	• Consideration of existing users to act as parent ambassadors and 'recruit' other parents • Staff already considered welcoming and friendly • Lack of current reception area discussed, consideration of friendly 'welcome' area at entrance
Appropriate and needed activities	• Listening to needs of users (Korfmacher, 2008)	• Future activities to be planned from parent feedback such as this

	• Activities planned around under-represented groups (Crowley, 2005; NESS, 2005)	• Parenting group to be planned for next term • Evaluation of activities to consider needs of parents

Stage 9 – Agreeing Areas for Action: This short summary of discussion outlines the areas where this research was beneficial in highlighting potential barriers to engagement for local families, and where the centre immediately planned actions to resolve issues. The lack of awareness of the service was surprising to centre staff, and a number of actions for overcoming this were planned for the forthcoming year. The stakeholders found this outcome particularly useful and felt that it would directly influence practice. The lack of familiarity for new users had been considered previously but this process, particularly the presentation of literature in the area, gave the centre possible actions for addressing this. Overall, the project also helped the centre to meet its obligations to seek out and consider the views of local parents and plan future sessions around the needs of local, underrepresented parents.

Stages 10 – 12 – Planning, Implementing and Evaluating Actions: It was agreed that the centre would be responsible for planning their exact actions based on these areas for development, and that implementing action plans and evaluating these could be carried out by the centre without direct Educational Psychology Support. The centre felt able to do this, but agreed to contact their link TEP if they needed support to evaluate any changes made.

15. Discussion

This piece of research and development work was described by the centre managers as highly beneficial to the Children's Centre and enabled them to consider the needs of local parents and plan

to involve families that may not have previously accessed these services. It met the centre's aims for researching local views and planning around the needs of families, and was felt to be an improvement on previous attempts to do this. The data obtained was used in the centre's planning, however it was limited in quantity and in depth, due to methodological difficulties and the size of the sample responding.

The target sample of 'hard to reach' families was predictably difficult to engage as suggested by literature (NESS, 2005; Coe et al., 2008) and led to the failure of the planned focus groups. Despite attempts to make the focus groups as unobtrusive and as convenient as possible, the targeted parents were not keen to attend and this methodological approach was therefore unsuitable. The consequent planning of questionnaires was felt to be the only viable method, but was not initially favoured as it may not give the detailed information that a focus group could. As expected, despite the open-ended questions and request for detail, the responses were in general short and lacked the detail and depth hoped-for. Limitations of the approach also meant that responses could not be clarified or developed, as in a focus group, so that some responses were of limited use. For example, one parent listed "not going" as a barrier to using the centre, but the meaning of this was not understood and could not be coded.

The sample of parents was also a limiting factor in this research, both in terms of size and make-up. Despite sending out fifty questionnaires, the response rate was low for hard to reach parents (16%), however it is possible that there are few families in these groups to begin with, and that 16% is fairly representative. Response rates could have been improved by using incentives such as prize draws; however the centre did not have a budget for this. There may have been a response bias, where those choosing to respond are not representative of all hard to reach families, but motivated to respond by an interest in the centre or desire to voice opinions. This is difficult to avoid with questionnaires and can only be taken into account when planning. Additionally, other methods, such as focus groups and face-to face surveys would most likely present the same problem.

The target group of underrepresented families was anticipated to be a difficult population to engage in research, due to the 'hard to reach' nature of families who typically do not access support services, and therefore methodology has to flexible to engage as many as possible. Whilst the sample many not be large or representative in traditional research terms, any data from the groups is beneficial to services as can be used in planning. Targeting this group specifically can have ethical difficulties, as families may feel stigmatised if they know they are being targeted, and using personal information to target parents is prevented by the Data Protection Act (1998). For these reasons, it was felt to be preferable to question all parents of under-fives, then analyse data according to parental status, moreover, parents volunteered this information so could withhold personal information if uncomfortable. On reflection, however, an optional tick-box for 'prefer not to answer' would have been more ethical, for parents who felt uncomfortable giving personal details on the questionnaire.

Access to this group is notoriously difficult, due to their under engagement in services, however using local schools and nurseries was a good 'way in', as all families must be enrolled in education unless educated at home. Whilst using local schools meant the youngest children could be missed, it also allowed a cross section of families to be targeted. In order to access families with children under three, other services could be used as a 'way-in', for example, GP surgeries or health visitors. Health visitors could potentially ask parents to fill in questionnaires, however this could also be unethical if parents are vulnerable and feel unable to refuse, due to their reliance on such professionals.

The generalisability of this research is low, but was not intended to be applicable to other geographical areas, as families' needs can vary across areas and be highly localised. The implications of the research can only be applied to the immediate local area from which participants were drawn, as demographics of other areas, even the adjacent town, are quite different. This area has predominantly white, middle class residents, with only a few pockets of deprivation and few ethnic minorities or cultural variations. Other areas, perhaps with minority ethnic groups, or other

languages spoken, could have vastly different barriers to engagement. Additionally, the results of this project could be difficult to reproduce and have low reliability, as responses could be different with different parents or at different times of year. For example, the references to summer holiday activities are likely to be influenced by the timing of questionnaires (July), as parents are thinking of forthcoming holidays. Encouragingly, responses mirrored findings in literature and other research studies, suggesting that results have some reliability, but without repeat research the extent of this is unclear. Reliability is limited here by the small sample (8 participants); however a large sample of such a specific group of parents in this small area would be difficult or impossible.

In conclusion, whilst the research undertaken has some methodological limitations, it has considerable use and benefit to the Children's Centre engaged in this development work. For the centre, the project enabled them to collaboratively research the views of a sample of local parents and plan activities around the data obtained, which should improve the quality of service provided and be recognised positively by Ofsted. The centre also gained expertise and experience in small-scale research and development work, and should have increased their capacity to direct their own development work in future. The RADIO model was beneficial in guiding the research process, aiding collaborative work and providing a framework for planning future development, as well as being flexible enough to allow revisiting of previous phases and changes in method. It was therefore felt to be a valuable and efficient use of Educational Psychology Service time and an appropriate means of directing involvement.

6,572 words

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Appendix 1

The Performance Management Sure Start Children's Centres SEF Standards Matrix (Together for Children, 2009) sets out standards for Children's Centres to meet in terms of engaging and planning around families. The matrix indicates standards expected for each of the performance grades in the DCSF Guidance for Children's Centre Self Evaluation. An 'excellent' classification on inspection requires that:

- "Activities are planned collaboratively with other services to identify and respond to the needs of the reach area population, especially children and families marginalised or "hard to reach". There is an on-going analysis of the quality and effectiveness of services." (p. 7)

- "The centre has a well-developed approach to identifying the needs of "hard to reach" and excluded families." (p. 45)

- The centre has "developed priority actions and activities which are focused on overcoming barriers to engagement with isolated and non-engaged needy families of 0-5 year olds in the reach area" (p. 45)

- The centre "uses innovative and original approaches to engage with "hard to reach" communities" (p. 45)

- "Hard to reach" parents in the local community with young children under 5, are significantly involved in designing and developing service provision including the "re-engineering" of traditional service provision" (p. 45)

- "Service provision is designed to overcome barriers to access and with an emphasis on equality of access needs" (p. 46)

Appendix 2

RADIO Model

Research And Development In Organisations

1. Awareness of Need
   - Support requested through planning meeting
2. Invitation to Act
   - Contact made and available support accepted
3. Clarifying organisational/cultural issues
   - Exploration of supportive or impeding factors
4. Identifying Stakeholders
   - Concerned users identified, e.g. head, staff, governors, pupils
5. Agreeing Focus of Concern
   - Potential area(s) of action agreed/negotiated
6. Negotiating Information Gathering Framework
   - Methods and timescale of data collection agreed
7. Gathering Information
   - Data collection carried out
8. Processing Information with Stakeholders
   - Results shared and discussed with all concerned
9. Agreeing Areas for Action
   - Collaboratively agree future action or development needed
10. Action Planning
    - Plan timescales, content and those responsible for action
11. Implementing Action
    - Action carried out over time, with or without service support
12. Evaluating Action
    - Action outcomes considered with or without service support

Background to the RADIO Model

The RADIO approach was developed by Timmins, Shepherd and Kelly (2003) to help Trainee Educational Psychologists (TEPs) negotiate school development work, however the approach can equally be used by other professionals or qualified Psychologists. RADIO allows TEPs to share the process of research and development with stakeholders (those involved in or affected by the work) as work is commenced, and to continue to review the process throughout. The approach could be viewed within a collaborative action research and an organisational development framework (Timmins et al., 2003) as stakeholders from within the organisation are actively involved in the research, rather than passive recipients of research data. It could also be said to take a social constructionist view, by considering the views of stakeholders, different constructions of the problem and 'insider' knowledge as central in the research. The model is highly appropriate in this research project as it provides a clear, staged process that can be conceptualised by both researchers and centre staff, but is also flexible enough to allow phases to be revisited, and to support research methods most appropriate to the research question, either quantitative or qualitative. The approach is informed by Myers et al. (1989), which emphasises the importance of information that comes from the organisation, for example the centre articulating its needs and co-developing the research questions, contributing to data collection and planning and reviewing future action.

Appendix 3 – Letter to parents

Dear Parent,

We are writing on behalf of X X Children's Centre and X X Infant and Nursery School. We are interested in hearing from parents with **children under five years old**, to gather the views of local parents on what the Children's Centre could offer to support families with young children.

We would like to telephone a selection of parents with children under five and explain further how parents could help us to develop the services offered by the Children's Centre. You may be invited to a coffee morning at school to discuss what we could offer. If you receive a telephone call during the next two weeks from the school's Educational Psychologist, who is conducting this research, you are entirely free to give your views or to choose not to participate. The purpose of our questions and what might be involved will be explained fully. If you do not wish to be telephoned or to participate, you can inform the school at any time or explain this when called.

I hope that you feel able to help us to plan the best possible services for families. If you would like any more information or have any questions, you can contact the school's Educational Psychologist on the number below, or contact X X School or X X Children's Centre.

Many thanks in advance for your help,

XXXX

Trainee Educational Psychologist,

For more information: call

XXXX

Children's Centre Lead,

For more information: call

X X Children's Centre – Parents' Information

- Who knows of X X Children's Centre? Who knows where it is?

- Quick guesses: what might you get from the Children's Centre? Who is it for?

FSW: Info about centre – we would like to have a conversation about what you might like, what you may not like and what could be offered

1. What might put you off using the centre or stop you going?
    - E.g. location, people, timings, perceptions, what's on

2. What might encourage you to use the centre or make it easier/possible for you to use it?
    - E.g. weekend events, bring a friend, invitations, outreach

3. What activities, groups, advice or training might you want us to offer?
    - E.g. safety, first aid, healthy eating, behaviour management, CV writing, back to work, qualifications,

4. Previously parents have mentioned they would like training – is there any training that might interest you?

5. What could we do to enable you to join us?

6. What times and days of the week are best?

7. Which venues might be convenient?

8. How should we encourage parents to join us? Invitation? Leaflets in school? Post? Libraries? Word of mouth? Posters? Text/Call?

CLOSE: List of activities run in CC – please tick if it is something you might want to do, and leave a name and contact number if you would like us to call.

If you can think of any other activities not on the list that would be good please add them or leave a post it note

Appendix 5

Dear Parent,

We would like to ask you a **few short questions** about the local Children's Centre, which you may or may not be aware of. This is to find out how we can improve the centre and offer services that local families like yours would like.

Please take a few minutes to answer the 8 questions below, giving **as much detail as you can**, and return the completed questionnaire to **school reception** or **post back in the envelope provided**.

Your help is voluntary, if you do not wish to complete this form you do not have to, but any help is very much appreciated. Your answers will help us to improve the centre and all data is anonymous – **no names or contact details are needed**. Thank you.

Q1. Have you heard of the X X Sure Start Children's Centre on X Road before?

Q2. Have you used the Sure Start Children's Centre on X Road in the last 12 months?

Q3. What do you think (or know) the centre offers or does? Who do you think it is for?

Q4. What could stop you visiting and using the centre? What could put you off or make it difficult?

Q5. What would make you want to use the centre or encourage you to visit it?

Q6. What sessions, activities, events, training, advice or help might you like to use if it was offered? (If unsure, you can use the list overleaf for ideas of what is offered)

Q7. **Where** would you most like to meet to use the centre or try new activities? (e.g. current venue, library, school, social club, or others)

Q8. What **time of day** or **day of the week** (or time of year) would be best for you to use the centre?

Finally, please tick any of the following boxes if they apply to you:

- ☐ Lone/single parent
- ☐ Currently out of work (other than maternity leave)
- ☐ Young parent (under 25)
- ☐ Parent of a child with a disability
- ☐ Parent with a disability
- ☐ Minority Ethnic Group
- ☐ Father
- ☐ Homeless or in temporary accommodation

Any other comments or suggestions for us:

Please sign to agree to us using this information to improve our service: _____

Many thanks for completing this questionnaire. Please return to the school reception or by post in the freepost envelope. If you would like any more information about this research or the centre please contact XX (Family Support Worker) on XXXXX XXXXXX

Here is a list of current and previous activities, if you would like more information please contact the Children's Centre directly or add contact details to this form next to any activity and return with your questionnaire. If you have any other ideas – add them at the bottom!

Activity	What it is	
Stay & Play	A play session in the centre for all.	
Family Support	Family support worker can provide specialist, one to one support to families experiencing difficulties. Referral through health visitor.	
Baby Days		
Baby Massage	A 4 week course for you to learn various massage techniques and the benefits to both you and your baby.	
Being a Mum	Post-natal group. An opportunity to speak with a NCT trained leader to discuss your new responsibility of being a Mum.	
Baby Time	For Mums-to-be and those with babies up to 12 months. Includes breastfeeding support, a rhyme time and opportunity to talk with other Mums.	
Outdoor Play	A fun, safe environment in the outdoor area at the centre for children to play.	
Rhyme time	An opportunity for you to learn rhymes with your child and meet other parents.	
Antenatal courses	6 week course for expectant parents to attend to gain knowledge and support leading up to the birth. Everything you need to know and more.	
Healthy Start	The centre is part of the Healthy Start Vitamin Scheme and can provide these to families supported by the programme.	
Tea & Toast	A joint session with Newton Road providing a drop in with play at the	

	Cricket Club, in Rushden.	
Dads and Tots	An opportunity for Dads to attend a session at the weekend with their child. 1st Saturday of every month.	
10% Challenge	NHS led a chance to lose weight safely and healthily through this 12 week course.	
Community Police Drop In	Opportunity for centre users to meet their local community police team and discuss any concerns they may have within their neighbourhood.	
Fun on Fridays	Fun sessions held at the Bede house every Friday (not running through summer holidays). Including crafts, activity sessions and Play Rangers on rotation.	

CHAPTER FIVE

A School Development Project to Support the Emotional Wellbeing and Reduce Occupational Stress of School Staff through the Delivery of 'Resilience for Life' – a CBT based Adult Resilience Programme

1. Abstract

The newly appointed Head Teacher of a primary school which had been placed in 'special measures' by Ofsted (Education Act, 2005) requested support from the Educational Psychology Service (EPS) to build the emotional wellbeing and resilience of school staff. Literature in the area of resilience and teacher stress is reviewed, revealing a lack of research on explicitly enhancing the emotional wellbeing of teachers and school staff. This report describes the delivery of a 5 session resilience programme, developed by the authors of FRIENDS for life, a well-known programme for school-aged children, to build resilience and reduce anxiety in adults during times of transition or stress. The delivery of this programme is discussed, along with evaluation of its impact using quantitative and qualitative measures. Implications for future programmes, school development work and the EP role are discussed.

2. Introduction: School Improvement Work and Organisational Context

Hopkins (2001) identifies school improvement as work that aims to enhance student outcomes and strengthen the school's capacity to develop and change. Central to this approach is the aim to build capacity within the school staff and structure, so that schools can actively learn from change and continue the process independently. Burden (1978) highlighted the importance of viewing school development work within the wider school context, including barriers, constraints and tensions within the organisation, in order to ensure change is embedded. This suggests that school

development work requires an awareness of the organisational context and management of contradictory or oppositional practices (Miles, 1986; Reynalds et al., 2000; Timmins et al., 2003).

Two planning meetings were held with the school's Head Teacher and two link Educational Psychologists (EPs) to discuss the school development work that could be offered by the EPS to this school. The school was a large primary school in an urban area of high deprivation. The school had been placed in 'special measures' by Ofsted inspectors following a report which graded the school as 'unsatisfactory' in all areas, due to poor pupil results, some inadequate teaching and monitoring and unsatisfactory leadership (see appendix 9 for a summary of Ofsted's report). The Head Teacher had resigned shortly after this and a new, more experienced Head Teacher was appointed to manage and improve the school and its staff. During the first planning meeting the new Head Teacher outlined several areas of tension within the organisation. Firstly, the previous Head Teacher was described as 'bullying' by members of staff and was felt by some to create anxiety and fear in staff by applying disciplinary measures for minor issues. Secondly, the school's poor performance and consequent negative Ofsted inspection had lowered the morale of staff even further, and some individuals had reportedly been 'blamed' for the inspection outcomes. Additionally, the new Head Teacher described some staff as having a negative attitude towards the children and families living within the catchment area, with possible low self-efficacy as teachers, claiming that they could never engage the children, that poor results were simply due to the families living in the area and that teaching some of these children was impossible. The Head also reported that several members of staff were currently or had been on leave with stress and that this could impact on other staff, where negative discourse became the norm in staff rooms. She asked for support in raising the morale of school staff, helping them think more positively about the pupils and to learn strategies to manage stress and cope with some of their daily occupational challenges.

In this organisation, it was important to be aware of the school's tensions and difficulties, and discuss them openly to prevent those becoming barriers to any development work. At the same

time, part of the work with staff could include the identification of strengths and resources within the organisation that could support development, as suggested by Timmins et al. (2003). The school's link EPs and Head Teacher agreed to plan school development work aimed specifically at supporting school staff and building their resilience and wellbeing.

3. Whole-School Emotional Wellbeing

There has been an increasing emphasis in school development work on school leadership, supporting teachers and whole staff development (Dembo and Gibson, 1985; Ross, 1995; Bubb and Earley, 2009; Wahlstrom and York-Barr, 2011). Dembo and Gibson (1985) highlight teacher self-efficacy as central to school improvement, suggesting that teachers' sense of efficacy, or their perception of being able to effect change and make a difference to pupils, is significantly correlated with student performance and results. They found in observations that teachers high in self-efficacy spent more time on whole-class instruction, less time managing behaviour and more frequently led pupils to find answers before giving answers, than low self - efficacy teachers. Dembo and Gibson's data relied on correlational evidence and cannot conclude that self-efficacy leads to better teaching or student outcomes, as the behaviours observed could be the result of a number of factors, such as class size, pupil motivation or teacher experience. The findings do suggest, however, that psychological wellbeing of teachers, including self-efficacy beliefs, can be a factor in school improvement and pupil outcomes. Whilst Dembo and Gibson suggest that experience and school leadership can be factors in enhancing teachers' self-efficacy, a significant factor is also reported as the individual differences of teachers, including their thought patterns, motivation, ability to overcome challenges and temperament. Similarly, Ross (1995) reviews research on teacher efficacy, concluding that teachers who set themselves and their pupils challenging goals, take responsibility for pupil outcomes and overcome obstacles or persist in the face of adversity are the most effective. He suggests that efforts to improve schools should include a focus on increasing teacher efficacy, but

does not suggest how this can be done. The research here suggests that school improvement work should focus on developing teacher self-efficacy, which may be linked to experience, individual differences, responsibility and overcoming challenges, however there is less emphasis on how schools can enhance the self-efficacy of staff or how staff should be supported in their roles.

More recently, some school improvement research has focused on developing whole school mental health and emotional wellbeing, which includes a focus on the school environment, ethos, school staff and pupils (Wyn et al., 2000; Weare, 2002; Stewart et al., 2004). Supporting the emotional wellbeing of school staff may be critical to improving the outcomes for pupils, as school staff are the primary contact for children in schools, and need to be supported themselves in order to be committed and invested in pupil wellbeing (Doll et al., 1998; Patton et al., 2000; Weare, 2002; Wells et al., 2003). Similarly, Parsons et al. (1996) recommend consideration of the role of school staff in school development work, and call for the active promotion of the health and wellbeing of school staff in order to improve outcomes for pupils.

The 'Health Promoting Schools' project in Australia has taken such an approach, building the resilience and wellbeing of pupils by developing the whole-school environment and mental health, including that of staff and parents, finding that schools with supportive environments, positive adult and peer social networks, connectedness or attachments to adults and a sense of autonomy, yielded higher pupil ratings of psychological resilience (Stewart et al., 2004). Another large-scale project, 'MindMatters' (Wyn et al., 2000), takes a whole-school approach to promoting mental health, including staff training on pupils' mental health, resources and professional development, suggesting that teachers with lower levels of stress and higher levels of wellbeing may be more effective in their teaching; however these programmes do not specifically devote time to building the resilience or wellbeing of teachers and school staff, so that they are more able to support pupils. There is much research into the stress and anxiety experienced by teachers (Coates, 1976; Sinclair, 1987; Kyriacou,

2001), but relatively little attempt to design interventions around school staff as a professional group.

4. Stress, Anxiety and Burnout Amongst School Staff

Stress has been described as an imbalance between demands placed on a person and their resources or capacity to cope with them (Phillips, 1978; Remsberg and Saunders, 1984; Schultz and Heuchert, 1988). More advanced models also acknowledge the role of perceptions or individual thought patterns and coping styles (Cox and Mackay, 1976; Lazarus and Folkman 1984; Folkman and Lazarus, 1986), and attempt to explain why some individuals find events more stressful than others.

Whilst most adults experience stress at some time, the exposure to persistent high levels of stress over an extended period of time can have negative short and long term consequences. Immediate negative emotional and physical reactions, including increased heart rate, muscle tension and inability to relax (Spielberger et al., 1978; Taylor, 2006) clearly impact on quality of life, but may also lead to longer term outcomes. Individuals under persistent stress can show greater levels of hostility, anger and aggression (Aseltine, Gore and Gordon, 2000), breakdown in relationships with family and colleagues, and increased incidence of illness and missing work (Sheffield et al., 1994; Tennant, 2001), hence, it is critical to minimise the effects of stress on teachers.

The incidence of stress and 'burnout' amongst education professionals, particularly teachers, has been well documented (Kyriacou, 1987; 2001; Borg, 1990; Abel and Sewell, 1999; Troman and Woods, 2001). Kyriacou (1987, 2001) defines teacher stress as a negative feeling or emotional state related to work as a teacher, which can threaten wellbeing. Extreme stress can result in burnout, including feelings of exhaustion, isolation and powerlessness, which have been linked to illness, absence and early exit from the profession (Ewing and Smith, 2003; Howard and Johnson, 2004). There are thought to be a range of negative impacts of occupational stress on school staff themselves, on their performance and consequently on pupils in their care. Pierce and Molloy (1990)

questioned secondary school teachers on their levels of occupational stress, psychological and biographical variables, and resultant health, coping strategies, job performance and confidence. Regression analyses (correlation of variables) revealed that those teachers reporting highest levels of stress and burnout also reported poorer physical health, higher incidence of absenteeism, lower self-confidence, and greater use of maladaptive coping strategies. Higher burnout also related to lower resilience or 'hardiness', lower levels of social support and decreased career commitment and motivation. In contrast, reduced stress was associated with greater career commitment, motivation, job satisfaction and pupil performance. Whilst regression analyses cannot prove that reducing stress results in better teaching or improved outcomes for pupils, the research suggests that school staff stress does have a negative impact on pupils and that reducing stress or increasing coping strategies could lead to improvements in teacher performance. Moreover, whilst some research has linked school stress with external factors, such as number of years teaching experience, role ambiguity and leadership style (Capel, 1987; Borg, 1990), Pierce and Molloy (1990) found that psychological variables such as personality, resilience ('hardiness') and locus of control (how far teachers feel in control and responsible for outcomes) were more significant predictors of stress than biographical variables. This links closely with some of the research on teacher self-efficacy, which suggests that teachers who feel they have some control and impact on pupil outcomes are more effective teachers, and this correlates with pupil performance (Dembo and Gibson, 1985).

A number of studies examine the possible of causes of stress and burnout in school staff and link these with possible 'risk factors'. Pratt (1978), for example, found links between primary school teachers' reported stress levels and age and characteristics of their pupils, and concluded that there were five main areas contributing to teacher stress: a general inability to cope with teaching problems, non-co-operative children (challenging behaviour), poor staff relationships, concern for children's learning and age of children (stress increased with pupil age in primary classrooms). Other studies find quite different risk factors, however, including lack of teacher experience, ineffective

leadership style and vulnerable personality (Capel, 1987; Pierce and Molloy, 1990). The discrepancy in research findings impacts on their reliability, but could be due to methodology used, where teachers are administered questionnaires asking for specific details such as experience, children's age, or perceptions of role. In this way, the researcher pre-empts the possible causes of stress and includes these in the questionnaire, which could omit other variables. Additionally, a regression analysis with small numbers of participants and large numbers of variables can potentially find small effects without sufficient numbers (Gorard, 2005). These analyses focused predominantly on negative or deficit variables associated with high levels of school staff stress, and many studies single out poorly defined, individual deficits, such as 'inability to cope with teaching problems' (Pratt, 1978)rather than wider systemic issues such as staff autonomy, peer relationships, leadership or workload. This places the 'blame' for teacher stress on the individuals, and misses the common factors which are responsible for high burnout rates in the profession (Griffith et al., 1999). Alternatively, if education is a particularly stressful environment or career path, this research could have focused more on those professionals who showed low levels of stress and burnout, and how they managed, or coped better with occupational stress.

5. Resilience and Wellbeing in School Staff

More recently, research has begun to focus on the positive skills and characteristics of resilient teachers, and how resilience can be enhanced in teachers to reduce or prevent occupational stress (Bobek, 2002; Howard and Johnson, 2004; Gu and Day, 2007; Johnson et al., 2010). Bobek (2002) describes teacher resilience as the ability to adapt to a variety of situations and increase competency in the face of adversity, and asserts that it is critical to classroom success, for pupils and teachers, and the retention of professionals. Bobek suggests that resilience is a multi-dimensional concept that develops over time as individuals are faced with new situations, and even suggests that adversity can be a 'catalyst' for creating or enhancing resilience. She states that resilience is

enhanced when teachers assess adverse situations, recognise options for coping and arrive at solutions. Other suggested resources for coping include problem-solving skills, prior experiences, supportive colleagues and positive family experiences, and these can buffer against negative effects of stress (Bobek, 2002). Crucially, Bobek implies that resilience develops and is learnt, rather than simply being an individual personality trait, and lists skills that can be explicitly taught, such as problem-solving skills, as well as conditions that can be enhanced in schools, such as colleague support and experience. Bobek does not, however, reflect on how schools could enhance the resilience of their staff or whether any aspect of resilience is most important.

Howard and Johnson (2004) develop Bobek's theories to look at what is 'going right' for teachers who manage well in challenging roles, focusing on protective factors, rather than risk factors. In traditional resilience models, which have often been related to children and adolescents (e.g. Masten and Reed, 2005), protective factors include having key relationships, connection to others, problem-solving skills, a sense of agency or effectiveness, clear goals and a sense of achievement or competence (Howard and Johnson, 2004). This research used semi-structured interviews with teachers in challenging schools in South Australia to investigate how resilient teachers cope, and whether protective factors are the same for teachers as those found for children. They found that certain factors were strong themes for 'resilient' teachers, including a sense of agency or locus of control (feeling responsible/efficacious), having a support group or network of friends and family, and feeling a sense of achievement or competence. The research suggests that teacher resilience is therefore similar to child/adolescent resilience, however the interview questions may have pre-empted certain responses, as previous research has done, by asking questions such as 'what makes you proud?' in order to ascertain professional competence. In addition, the research sample relied on the selection of 'resilient' teachers by their school principle, without clear screening measures, reducing validity; therefore the teachers interviewed may not be representative of resilient teachers elsewhere, particularly in other countries like the UK.

Gu and Day (2007) used an extended, four year project involving 300 teachers to explore the factors which promote resilience in teachers. They suggest that resilience is not reliant on specific skills or qualities, but is determined by an interaction between the individual and their environment over time, and so varies from teacher to teacher. The research suggests that resilience is a more complex concept than suggested by Howard and Johnson (2004) and may not involve a pattern of skills or circumstances but be unique to individuals in different situations; however this does not explain why other studies find common protective factors amongst teachers who cope effectively with challenging roles. The authors do not give an indication of whether resilience can be enhanced and how schools might endeavour to support their staff to become more resilient.

Johnson et al. (2010) also conducted semi-structured interviews with school teachers and used narrative enquiry to search for conditions that support teacher resilience. They identified five groups or domains of conditions which support resilience; these are (a) relationships, (b) school culture, (c) teacher identity, (d) teachers' work and (e) system policies and practices. As found by Gu and Day (2007) though, factors varied between individuals and there were no clear-cut, specific elements within each group but rather a range of qualities that were found to be supportive, suggesting a:

> "Dynamic and complex interplay among individual, relational and contextual conditions that operate over time to promote teacher resilience." (p. 7)

Within the domain 'relationships', for example, there were no specific types of relationships that supported resilience, such as marriage or colleague support, but qualities of relationships, including those based on mutual trust, care and respect, and those which fostered a sense of belonging or connectedness, as found previously by Stewart et al. (2004) and Howard and Johnson (2004). The research focused less on individual qualities that enhance resilience, such as problem-solving skills, however this may be a result of the interview questions once again, although these are not given by the authors. Interestingly, the authors have drafted a plan suggesting how resilience can be supported and developed by schools (Appendix 1), which includes general approaches for managers

and staff, such as “give explicit affirmation”, as well as advising schools to promote the emotional wellbeing of staff, for example “develop a high level of emotional intelligence”, “nurture one’s well-being and work-life balance” and “make provision for the emotional and tiring nature of teachers’ work” (see Appendix 1) . This suggests that schools should actively support, develop and enhance the resilience of their staff, although no specific guidance is given on how this could be done.

Discrepancies between research findings around resilience may arise due to methodological difficulties and a lack of clarity in the concept of resilience (Kinard, 1998). Different studies use different definitions, which can impact on the measures used to assess resilience and lead researchers to look for specific factors or qualities that are considered ‘protective’ factors. Resilience is a contested term, with no consensus on definition, its stability over time, how to measure it or its criteria, which contributes to methodological difficulties in research into resilience in children, according to Kinard (1998). There is little research or literature to date on how to develop staff resilience, and nothing specifically on programmes that could be developed for this purpose. Whilst there is little research into school staff resilience interventions, there is a wealth of research detailing programmes for children and adolescents, and some emerging research on programmes for adults or employees more generally.

6. Adult Resilience Interventions

Pilot interventions in Australia have recently developed resilience programmes for adults aimed at reducing occupational stress and promoting mental health (Millear et al., 2008; Liossis et al., 2009). The PAR (Promoting Adult Resilience) programme has been evaluated with two cohorts of professionals in office-based environments. The programme teaches Cognitive Behavioural Therapy principles, interpersonal and social skills and coping strategies to adults in 11 weekly sessions within the workplace. The intervention draws on a similar adolescent programme called RAP (Resourceful

Adolescent Programme) which has been used successfully in schools (Sochet et al., 2001). Pilot interventions have shown some positive impacts immediately after the programme and at 6 month follow up, including reduced scores of anxiety and depression and increased coping self-efficacy (how one manages difficult situations). Illness and absence rates also fell over the 9 month research trial and participants gave positive feedback on using the skills in real-life situations (Millear et al., 2008). However, there was no significant difference in scores of social skills, life satisfaction, work satisfaction, psychological wellbeing or work-life balance. The authors hypothesise that the programme influences specific work-related coping skills rather than broader work-life balance; however the lack of effect on psychological wellbeing and work satisfaction is disappointing. The study did not use a comparison group in the evaluation, and therefore the positive results observed (reduction in anxiety/depression and increased coping) could be simply an effect of the supportive group meetings (intervention effect), and given the participants feedback that the group format was the most enjoyable aspect (Millear et al., 2008), this is quite possible. Whilst this intervention could, in principle, be applied to professionals in a school context the lack of impact on work satisfaction would reduce the value of this particular programme, as current research links job satisfaction or sense of achievement with teacher resilience (Bobek, 2002; Gu and Day, 2007; Johnson et al., 2010).

A similar project has begun in Australia by the creators of the school-based anxiety-prevention programme 'FRIENDS for life', Pathways™. FRIENDS for life is a strengths-based resilience programme written by a clinical psychologist, and is based on principles of Cognitive Behavioural Therapy, coping skills and problem-solving frameworks (Barrett et al., 2006). Evaluations of the FRIENDS programme with school-aged children have shown positive post-course and follow up impacts including reduced anxiety and depression scores, reduced emotional and conduct problems, increased social self-esteem and increased use of problem solving strategies (Stallard et al., 2005; Barrett et al., 2006; Stallard, 2010; Stopa et al., 2010). The programme is widely used in a number of countries including the UK (Stopa et al., 2010), however it has recently been adapted for use with adults. Pathways have trialled this adult resilience programme, called 'Resilience for Life' in Australia

but have yet to publish research on its impact. In order to evaluate its impact with adults in other countries, Pathways™ trained Educational Psychologists within one Local Authority in the UK to deliver the programme and evaluate its efficacy.

This research uses the 'Resilience for Life' Programme, developed by Pathways™, with adults who are members of staff in a challenging primary school in the UK. The programme aims to build strengths and enhance resilience in staff, so that they are able to cope effectively with the challenges of working in a school in special measures, located in a disadvantaged area, with a changing management. The programme is similar to the children's FRIENDS programme but has been adapted for use with adults by changing language, examples and activities. It is a positive, skills-based programme with 9 modules, that can be delivered flexibly over 9 one-hour sessions or 4 half days (or a combination). For information on the programme and a summary of sessions see appendix 2.

7. Methodology

The 'Resilience for Life' programme aims to enhance adult resilience and coping skills in order to reduce or prevent incidences of negative affect such as anxiety and stress (see appendix 2). In order to evaluate the effects of the 'Resilience for Life' programme on participants and add to the evidence base for this intervention, Pathways™ requested the use of three quantitative tools to evaluate impact, used before and after the course, then again at 3 month follow up. This standard procedure has been used for the trials in Australia and would ensure that a body of evidence, with a large sample of data, could be analysed together. The three quantitative measures recommended were the DASS21 (Depression Anxiety Stress Scales – Short Version) (Lovibond and Lovibond, 1993), the Resilience Scale (Wagnild and Young, 1993) and the Teaching Satisfaction Scale (Ho and Au, 2006). The three quantitative tools were chosen to give a balance between deficit focused measures

(anxiety/depression) and more strengths-based (resilience) measures, and are short enough that adults can complete all within a few minutes. The Teaching Satisfaction Scale was recommended only where participants are teachers, and measures the job satisfaction and career commitment referred to in literature on teacher resilience (Bobek, 2002; Gu and Day, 2007; Johnson et al., 2010). The measures and their development will be discussed here.

The original DASS is a 42 item questionnaire, with items divided between three scales, the depression scale, the anxiety scale and the stress scale (Antony et al., 1998). Items were initially derived from clinical consensus on stress symptomology, then refined using a factor analysis technique. No external, pre-existing diagnostic criteria were used in formulation, as opposed to some other scales which use DSM diagnostic criteria (Lovibond and Lovibond, 1995). Items were added and deleted over successive test trial samples until the stress factor emerged. Anxiety and depression factors were distinguished but not deleted due to the overlap between stress, anxiety and depression. Whilst the testing was initially completed with clinical samples, the final major testing took place with non-clinical samples to give a measure of general affective syndromes (Lovibond and Lovibond, 1995). The 42 item scale was reduced to a 21 item scale for non-diagnostic and research use with larger samples (Henry and Crawford, 2005), and will be used in this research. The DASS-21 was tested for validity with a large, non-clinical UK sample, revealing internal consistencies of 0.88 for the depression scale, 0.82 for the anxiety scale, 0.9 for the stress scale and 0.93 for the total scale (Henry and Crawford, 2005). It is positively correlated (0.69) with negative items of the Positive and Negative Affect Scale (PANAS, Watson, Clark, & Tellegen, 1988), inversely correlated with the positive items (-0.48) and highly correlated with the DASS-42 (Henry and Crawford, 2005). The scale was deemed appropriate for use in this research as it is a brief questionnaire, with adequate reliability and validity, developed with non-clinical UK samples and relevant for non-diagnostic purposes. It was used to give an indication of levels of negative affect and stress, in order to compare pre and post-intervention means for the entire participant sample. Its limitations include the initial development with psychiatric populations and the conflation of

three possibly distinct concepts (Henry and Crawford, 2005), however testing with large, non-clinical samples and the validity data suggest that it is a valid tool for research purposes.

The Resilience Scale (Wagnild and Young, 1993) was originally developed using statements from adults who had adapted successfully following adverse life events and a thorough review of literature on resilience. 50 statements were tested and reduced to 25 to match characteristics in literature. The scale has been tested with a range of samples to reveal internal consistency of between 0.73 and 0.91, and correlation with measures of depression (inverse relationship), morale and life satisfaction (Wagnild, 2009), however the measure was initially developed in Australia with a non-representative sample, of 24 older female adults (over 53), then subsequently tested with a number of highly specific samples, including carers of spouses with Alzheimer's, first-time mothers returning to work, students and residents in social housing (Wagnild and Young, 2003). The scale has not been developed with a UK sample and may therefore have limited validity with younger adults in this country and more general samples. Since then the scale has been used in a range of research studies with differing samples, and so is thought to be applicable to a diverse population (Wagnild, 2009). The tool provided a positive, strengths-based measure for participants in the 'Resilience for Life' programme to compare changes in resilience over time.

Lastly, the Teaching Satisfaction Scale (Ho and Au, 2006) was used with this sample to compare role satisfaction and teacher stress before and after the programme. The scale was adapted from the life Satisfaction Scale (LSS; Diener, Emmons, Larsen, & Griffin, 1985) simply by altering wording to reflect the teaching profession specifically, as research suggests a relationship between job satisfaction and life satisfaction (Ho and Au, 2006). The scale was tested with 202 teachers, both male and female, from primary and secondary schools within Hong Kong. The sample may not therefore be representative of UK teachers due to differences in language, culture, schools or roles. Internal consistency of the Teaching Satisfaction Scale reached 0.77, test-retest reliability reached 0.76,

whilst convergent validity (correlation with other measures) was 0.5 for the Brayfield-Rothe Job Satisfaction Scale and 0.47 for the Warr's Job Satisfaction Scale. The scale was also found to be inversely correlated with psychological distress (-0.31), teaching stress (-0.16) and positively linked to self-esteem (0.22). Given the high convergent validity of the instrument with other measures and the use of the Life Satisfaction Scale and other job satisfaction measures in the UK the tool is thought to be applicable to UK teachers in all schools of both genders (Ho and Au, 2006) and so was deemed appropriate in this research to indicate changes in job satisfaction over time. The evaluation pack given to participants, including all three measures, can be found in appendix 4.

Whilst the programmes authors (Pathways™) requested only this quantitative data for their evidence-base, the Educational Psychology Service also required qualitative data from participants in order to help the service adapt and use the programme with future schools, as the programme had not yet been trialled with school staff, so that any aspects of the programme that were not relevant to school staff, or should be altered for future schools could be identified. The Educational Psychologists delivering the programme designed a short questionnaire for participants to complete immediately following the last session. Developing a questionnaire was felt to be a time and cost effective method of data collection, which could gather qualitative information from a large number of participants concurrently (Gillham, 2000). A questionnaire was chosen over interviews or focus groups as not only are questionnaires more time and cost efficient than interviews or group discussions, but they allow standardisation of data by asking all participants the same questions in the same way, which is particularly important in pre-test post-test designs (Robson, 2011). Additionally the interviews or focus groups would have been conducted by the programme facilitators which could have prevented valid responses. Anonymous questionnaires are not conducted face to face like interviews or observations so may ease participant anxiety, encourage disclosure of feedback and reduce researcher bias (Gillham, 2000), however the questions cannot be clarified or explained so need to be easy to understand and interpret. Since participants would also

be asked to complete the quantitative measures, the questionnaire was kept extremely short to avoid intrusive and time consuming data collection. Unfortunately, this meant that qualitative data was limited in breadth and depth by the briefness of questions, however taken in conjunction with quantitative measures these were felt to give some idea of participants' views. Just three questions were asked, in order to discover how relevant they felt the course was to their professional roles, what could be changed in future and what was most useful. In case participants had forgotten some programme content the session outlines were printed as reminders. The questionnaire used can be found in appendix 5.

8. Participants

The participants in this research were all members of staff at a Primary school in the East Midlands. All staff who have direct/daily contact with pupils were invited to attend by their Head Teacher, but attendance was voluntary as some sessions were held after school hours. Those participating were a mixture of teachers, teaching assistants, higher level teaching assistants and learning mentors. 30 staff members participated in total (8 males, 22 females) although some missed one or two sessions. A list of attendees was not made so there was no record of attendance. The staff were of mixed ages and professional and educational backgrounds, but personal data on age, qualifications or background was not gathered as this was considered too intrusive for some staff.

9. Method

All members of staff were sent letters regarding the 'Resilience for Life' programme asking for consent to participate in research (see Appendix 3) 4 weeks prior to the first session. The programme had been explained to staff previously by the Head in a staff meeting and a summary attachment was emailed to staff (appendix 2). Included with the consent letter was an evaluation

pack (appendix 4) sent from Pathways. Participants were asked to complete the pack anonymously and return to the school secretary in a sealed envelope. The Head also reminded staff by email.

Participants then attended 5 sessions for the 'Resilience for Life' programme, consisting of one half day (3.5 hours) and four twilight sessions (1.5 hours each) which were spread across four months, between January and April. The sessions were delivered by an Educational Psychologist and a Trainee Educational Psychologist and participants sat in groups of 5. The sessions were informal and interactive, including individual and paired activities, group discussion, role play, and games. Although attendance was not recorded there was a low attrition rate and similar numbers (between 25 and 30) attended each session.

At the end of the last session participants were given certificates of attendance and asked to complete the brief questionnaire. The week after the last session, evaluation packs were sent to the school, as before, and returned anonymously to the secretary. Whilst there will be a six month follow up where the evaluation pack is given again, this has not been completed at the time of writing and cannot be included in research.

10. Ethical Issues

The delivery and evaluation of this programme raised a number of ethical concerns regarding the safety, trust and emotional wellbeing of staff. Firstly, participation was voluntary and with informed consent, at the insistence of the facilitators, in accordance with BPS and HPC principles (HPC, 2008; BPS, 2009) as it was considered that some staff may find such a programme uncomfortable or distressing. Given the organisational issues and tensions, including possible bullying and staff anxiety, it was made clear that staff were able to withdraw or leave at any time, did not have to disclose anything and did not have to participate in any activity if they preferred not to. The programme content had the potential to raise difficult issues or cause distress to participants, for example if they had recently endured a stressful life experience or were feeing anxious or depressed,

as well as the stress caused by organisational difficulties. Not only were warnings given before each session that content could arouse difficult feelings, but anyone feeling uncomfortable or vulnerable was offered support from Educational Psychologists following the sessions, helpline numbers of a mental health charity and advised to leave or take a break if necessary. Finally, the administration of the DASS-21 had ethical implications in case individual participants were suffering from depression or anxiety and scored highly on the scale. The researchers considered identifying individual scores above a certain threshold and recommending referral to health professionals, however this was eventually decided against. It was decided that the EPs were using the tool only in a research and intervention capacity, and that it was not within their roles to diagnose or identify individuals who may have clinical levels of negative affect. Secondly, participants had not consented to be identified individually or referred on, therefore it was unethical to do so, but as a precaution all staff were given contact details for the EPs, for a mental health charity and also advised to contact their GP if issues in the measures caused concern or they wished to discuss them further.

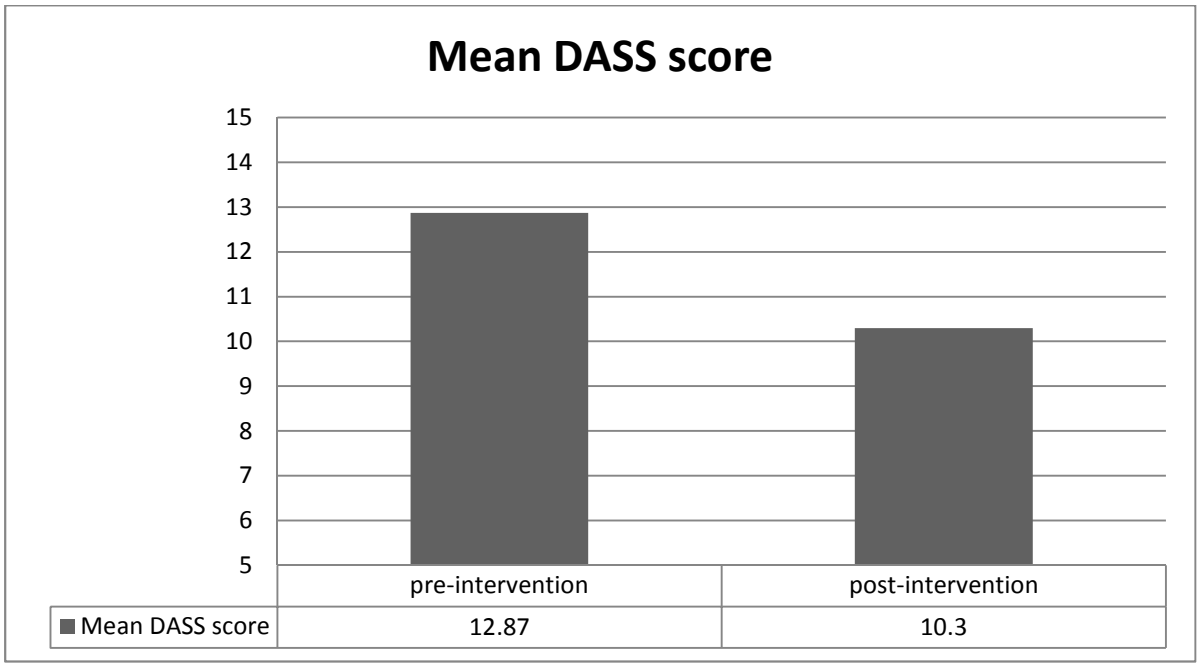
11. Results: Quantitative Measures

Item scores on the DASS-21 were summed to give a total score out of a maximum 63. DASS-21 scores from pre and post intervention were scored as two groups (i.e. all scores taken together at each time) to compare means for before and after the programme. The scores were entered into SPSS (version 16) data analysis package to give descriptive statistics and also compare means for significance, using a paired samples t-test (for two groups of scores from the same sample).

Table 1. DASS-21 descriptive statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Pre-intervention	30	9.00	18.00	12.87	2.47
Post intervention	30	7.00	14.00	10.30	1.97
Valid N	30				

Figure 1 Mean scores for pre and post intervention on DASS-21



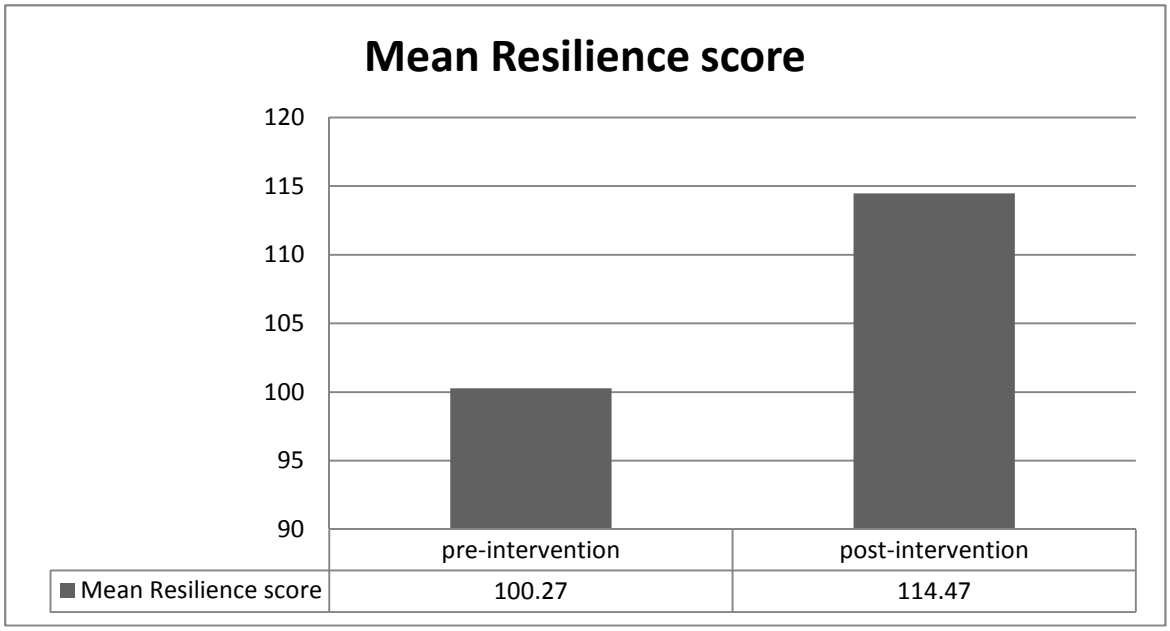
A paired t-test revealed a significant decrease in DASS scores following the intervention (t=11.771, df=29, p<0.05). Individual results and SPSS output tables can be found in appendix 6.

Similarly, the Resilience Scale was scored to give totals (out of a maximum 175) for each participant, and means for pre-intervention and post-intervention were compared using a paired samples t-test.

Table 2. Resilience Scale descriptive statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Pre-intervention	30	67.00	135.00	100.27	16.46
Post intervention	30	85.00	146.00	114.47	15.93
Valid N	30				

Figure 2. Mean scores for pre and post intervention on Resilience Scale



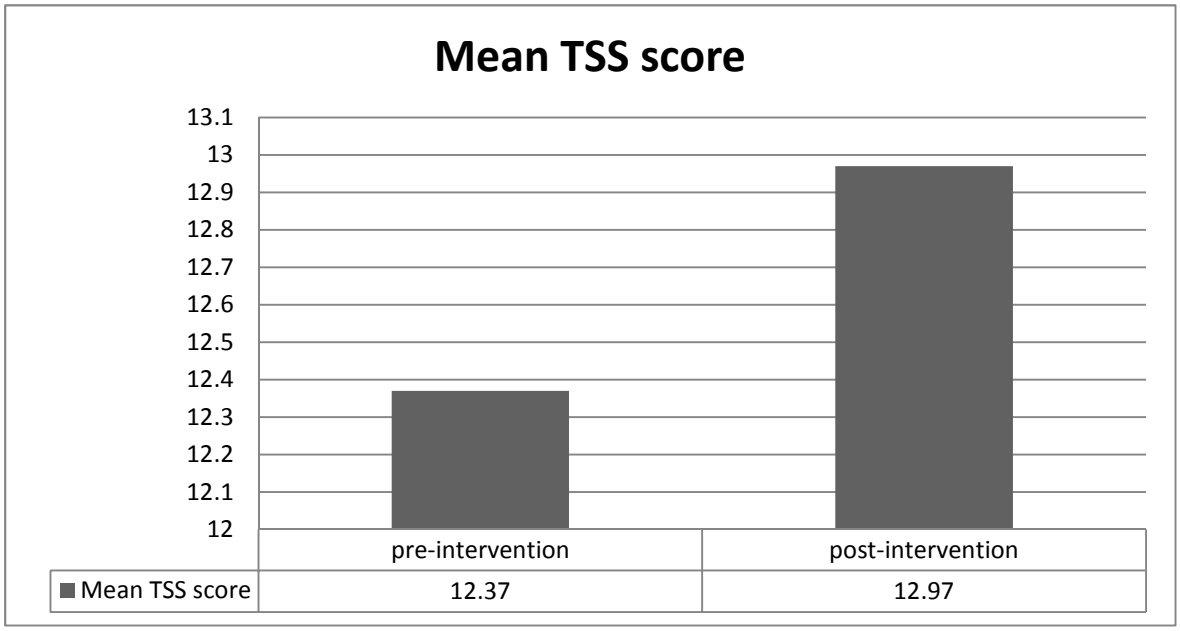
A paired t-test revealed a significant increase in Resilience Scale scores following the intervention ($t=-8.036$, $df=29$, $p<0.05$). Individual results and SPSS output tables can be found in appendix 7.

Lastly, the Teaching Satisfaction Scales were scored to give total TSS scores out of 25, and means were compared as above, using a paired t-test.

Table 3. Teaching Satisfaction Scale descriptive statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Pre-intervention	30	7.00	21.00	12.37	3.56
Post intervention	30	8.00	22.00	12.97	3.82
Valid N	30				

Figure 3. Mean scores for pre and post intervention on Teaching Satisfaction Scale



A paired t-test revealed no significant difference between pre-intervention and post-intervention scores for Teaching Satisfaction (t=-2.902, df=29, p>0.05). Individual results and SPSS output tables can be found in appendix 8.

12. Results: Qualitative Measures

The brief questionnaires were completed by participants at the end of the last session. As some participants were absent for the session and some may have chosen not to complete it there were 21 responses (rather than 30 for quantitative measures). Thematic analysis was used to find themes or patterns in the data, as responses were varied. Thematic analysis is a process by which gradually more latent themes emerge through repeated reading, note-making, coding, re-coding and organising of themes (Cassell and Symon, 2004). Questionnaires were read repeatedly, then sections deemed to be relevant were highlighted, before themes were identified as patterns to be searched for in the data. The responses were read and analysed by the Educational Psychologist and Trainee educational Psychologist delivering the course, separately at first, then together to give the final

codes and themes, consistent with the methodology recommended by Braun and Clarke (2006). Final themes in relation to outcomes following the course are shown below.

Table 4. Themes regarding course outcomes

Theme	**Description**	**Illustrative Quotes from Questionnaires**
Cognitive and perceptual changes	Changes in thinking patterns, including positive thoughts and challenge of negative perceptions	" I found myself seeing things from the pupil's view" "using thought challengers" "telling myself it's not personal, avoiding that trap of jumping to conclusions" "trying to change the automatic pre-conceptions I have about work"
Use of coping strategies	Reference to application of relaxation techniques, coping strategies or self-regulation in daily routine	"Now I join in with the pupils when we do relax kids, and get the TA to as well" "Even though I always used relaxation after work, I'm more aware of it now and probably use it even more" "I am trying to use portable techniques at work like the athletes breathing"
Skill acquisition	Use of new skills and tools, e.g. problem solving	"I used a coping step plan, just in my head, recently for planning a class project" " learning new skills" "Some of the tools have been more useful than others, but I have tried mindfulness once or twice"

Reinforcement of existing skills and knowledge	Increased awareness of prior knowledge or use of skills	"I realised we already have a lot of these skills and know about CBT from other courses" "made me think about applying the strategies we use with children to ourselves" "reinforced the importance of looking after ourselves first, so we can meet the needs of children" "Reminded me of how important those support networks are and made me think about other people's reliance on me"
Course Content	Information, examples or content given during the course were enjoyable	"the sessions were really enjoyable" "loved the example of the oxygen mask" "The mindful washing up example"
Course Style	The way information was presented or offered was enjoyable	"I enjoyed the style of it most – the chance to discuss things with groups or partners, practice techniques and have a laugh!" "really informal and enjoyable sessions"
Changes to format	Participants may have preferred alternative formats, timings or arrangements	"I think sessions work better in the day – I was more tired by the twilight sessions" "The longer session was better for me as we had a chance to relax and feel comfortable"
Changes to style of	Participants may have	"There was a lot of discussion in groups,

course	preferred less verbal input or less group work	which is OK but meant that the same people talked a lot or dominated" "Maybe some more variation in presentations, like video clips or visual style would have been good"

13. Conclusions and Discussion

This pilot programme for adults aimed to increase resilience and coping skills in order to reduce negative affect such as anxiety and stress in primary school teachers. The quantitative measures were scored for all participants and pre-course and post-course means were compared to indicate what impact the programme had, if any, on participants.

The DASS-21 means revealed a significant decrease in scores following the programme, which suggests that participants' levels of anxiety, depression and stress decreased after completing the course. Since concepts of depression, anxiety and stress overlap and are not entirely distinct in the DASS it is not possible to establish which aspects decreased most. Instead, negative affect in general can be said to have decreased after the programme.

The Resilience Scale mean scores for before and after the programme were also compared and revealed a significant increase following the course. This suggests that participants' reported resilience increased after completing the course. The measure includes items such as 'I feel that I can handle many things at a time', 'When I'm in a difficult situation I can usually find my way out of it' and 'I usually manage one way or another'. Statements such as these relate to coping and so give an indication of increased coping as well as resilience.

Thirdly, the Teacher Satisfaction Scale was used to assess changes in job satisfaction and perceptions of teaching. Whilst the post-course mean was higher than the pre-course mean, there was no statistically significant difference here, suggesting that the difference was too small, or the variance too high, for the result to be reliable.

These results suggest that the 'Resilience for Life' programme increases participants' resilience and coping, and decreases negative affect including stress and anxiety. It does not have a significant effect on job satisfaction in this research but further research could potentially demonstrate a greater effect. Reducing stress and anxiety may lead to increases in teacher self-efficacy, motivation and commitment, more effective teaching and improved pupil performance (Pierce and Molly, 1990; Wyn et al., 2000). Additionally, increased resilience may buffer against the negative effects of stress (Bobek, 2002) and may be linked to increased teacher self-efficacy (Dembo and gibson, 1985) and improved teacher and pupil performance (Pierce and Molloy, 1990; Ross, 1995).

The qualitative data from the brief questionnaire was used to indicate how far the programme was useful and relevant to school staff and what could be changed in future, since this was a pilot programme in the county. The themes described in Table 4, along with example quotations from the questionnaires, show that participants gave predominantly positive feedback on the course. Many aspects from the programme were described as relevant and useful for teachers and school staff and were reportedly used in day to day work and home life. Specifically, participants reported cognitive and perceptual changes, for example viewing situations more positively or avoiding negative automatic thoughts, increased use of coping strategies, for example relaxation and breathing exercises, skill acquisition such as problem-solving skills and mindfulness techniques, and a number of participants reported reinforcement of existing skills and knowledge such as CBT techniques or increased awareness of their value in their own lives. This relates to previous research and literature in the field of youth resilience which suggests that problem solving skills, coping strategies and cognitive styles may be linked to increased resilience (Masten and Reed, 2005). When asked what

was most useful or enjoyable, most participants said that the course format and course style was particularly enjoyable, for example the informal style of sessions, the examples given and the mix of presentation and discussion with activities. Lastly, when asked what could be altered, omitted, added or improved, many participants did not suggest any changes, but one suggested that there was too much group discussion which resulted in dominance of some participants over others, and two participants suggested that the timing of sessions (after school from 3.45-5.15pm for twilight sessions) was not ideal as staff were tired. The data generally suggests that the programme was useful and relevant for staff and that many aspects were beneficial, including the strategies and techniques given and the style of sessions.

Suggestions for changes to future courses can be considered before the programme is used in other schools, for example if staff are tired after school then alternative times should be advised, however if not possible then staff may need a short break or a stimulating activity to open each session. Secondly, future course facilitators should be aware that group work can be difficult where staff are already familiar with each other and some tensions may exist. Group discussion could be minimised, in favour of paired discussion or whole group talk, however some participants reportedly enjoyed it. Facilitators may wish to mix groups up each session, to walk around and join in discussion, or to choose groups randomly, in order to manage group dynamics in future.

The first evaluation in the county of this trial programme is generally positive and suggests that the programme may have a positive impact on participants and may even reduce incidence of work-related stress and burnout. Whilst it did not have a significant impact on job satisfaction, this was not one of the original aims of the course and this research suggests that job satisfaction may not be easily altered by a staff intervention. Teaching satisfaction may be a consequence of, or affected by school-level systems such as workload, leadership, career progression and school ethos, as suggested by some previous research (Capel, 1987; Borg, 1990; Pierce and Molloy, 1990). Additionally, the measure was designed specifically for teachers, whereas more than half of the

sample were not teachers but non-teaching support staff, which means that the tool had limited validity for these participants. A measure for non-teaching school staff does not currently exist, but using a more general job-satisfaction scale may have been more appropriate, or development of a measure for all school staff may be needed in future.

14. Limitations

This research was not a randomised, controlled trial or even an experimental design, but an evaluation conducted in the natural environment, therefore there are some limitations. Participants were not randomly allocated but were an opportunity sample of staff in a primary school that had requested this programme. Results cannot, therefore, be generalised to the wider population of teachers as this sample may not be representative. No personal data was asked for in this research, such as age, gender, qualifications, experience or mental health background history, as this was considered too intrusive and may have caused unnecessary anxiety. This meant that effects of other factors, such as age or experience, could not be looked at here but may exist. There was no comparison group available to act as a control group, as all of the staff participated in the intervention. Whilst another school could have been recruited as a comparison group, it would have been difficult to match the schools on type, size or geographical area, and external differences (e.g. staff ages, experience or backgrounds) could not easily be controlled. Since there was no comparison group, and other variables common to staff, such as school events, staff meetings or training, could not be controlled for, it is impossible to state with certainty that the intervention was responsible for the changes in participants. Repeat evaluations, with comparison groups wherever possible, would be needed to establish whether the programme causes an increase in resilience scores and a decrease in DASS scores for other participants in other schools.

This research only provides evidence for one pilot of a new programme, and clearly on-going research is required before any concrete conclusions about the course's efficacy can be made. Future research is needed to repeat this programme with other groups and evaluate its impact.

Ideally, the intervention could be run with a range of school staff, including secondary as well as primary, in mainstream and special schools and in schools of varying sizes and locations to establish if the programme is equally relevant and valuable to a range of staff. Additionally, the programme may be delivered and evaluated with adults from the general population (not school staff), as intended by Pathways™. In this research, results could not be analysed for effects of age, experience, education or health, as this data was not collected, but in future research this may be useful. For example, the results for teaching and non-teaching staff could be compared, effects of experience or training could be analysed, or additional measures such as locus of control questionnaires could be used to link resilience with other traits.

15. Programme Delivery and The Educational Psychologist's Role

The Local Authority in which this trial was based had only trained Educational Psychologists (EPs) in the programme and so currently only they can deliver and facilitate the course. Prior to and during the delivery this seemed to be appropriate, as EPs usually have existing knowledge of Cognitive Behavioural Theory and experience in delivering sessions to groups of children and training staff. The facilitators frequently drew on previous experience, for example delivering interventions to adolescents, and were asked a number of questions around thought patterns, coping skills, social skills and stress, which the facilitators were well-placed to answer. Additionally, the programme delivery may require a high level of skill in facilitating large groups, managing discussions and responding to emotionally sensitive comments and questions, which are skills that EPs should have(HPC, 2008; BPS, 2009). EPs are also in a position to inform schools about the programme and suggest or recommend where it may be useful, due to their links to schools, knowledge of organisational issues and culture and familiarity with school staff. In some instances this may be an advantage after the programme is finished, where staff require follow up advice or training, additional support, or referral to other agencies. Where EPs are familiar to staff and have good

relationships with schools, their presence may also reduce anxiety or discomfort compared to an outsider. Therefore future interventions using the 'Resilience for Life' programme with school staff will continue to be delivered and evaluated by Educational Psychologists, although without further research it is not possible to say whether other professionals are equally able to facilitate the course.

This evaluation has indicated the potential value of resilience programmes or emotional wellbeing interventions used with school staff, and highlights the importance of supporting adults who have challenging and demanding roles working closely with school pupils. It also provides some initial evidence for the positive impact of 'Resilience for Life' and suggests that the programme may continue to be used with school staff and further evaluated. The report has also highlighted a relative lack of research into the resilience and emotional wellbeing of school staff, and on how schools can support their staff and reduce anxiety and stress. Further research in this area would be valuable to provide evidence for how school improvement can enhance pupil outcomes via support for staff.

8,699 words

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Appendix 1

Draft Profile of Conditions Supporting Early Career Teacher (ECT) Resilience

(Johnson, Down, Le Cornu, Peters, Sullivan, Pearce, & Hunter, 2010)

Relationships

Relationships refer to the social networks, human connections and belongingness experienced by ECTs. In relational schools there is a continual focusing on the complex emotional needs of ECT's in the form of social exchanges that bring with them respect, trust, care, and integrity. ECT resilience benefits significantly when these values are evident.

To enhance ECT resilience, it is important to:

Promote a sense of belonging, acceptance, and wellbeing

- Foster relationships based on mutual trust, respect, care and integrity
- Give support to manage personal and professional challenges and conflicts
- Encourage help-seeking
- Create opportunities to be involved in professional, social and community networks
- Value support from family, friends and peers

Foster pedagogical and professional growth

- Value the personal strengths, assets and resources of teachers
- Provide explicit, constructive and timely feedback
- Give explicit affirmation

Promote collective ownership and responsibility

- Cultivate a generosity of spirit
- De-institutionalise relationships
- Employ a capabilities approach

School Culture

School culture refers to the values, beliefs, norms, assumptions, behaviours and relationships that characterise the daily rituals of school life. ECT resilience appears to flourish in those schools that actively promote collaborative relationships, professional learning communities, educative forms of leadership and dialogic decision-making.

To enhance ECT resilience, it is important to:

Promote a sense of belongingness and social connectedness

- Value and practice affirmation
- Encourage diverse perspectives and practices
- Foster trust and goodwill
- Minimise isolation

Develop educative, democratic and empowering processes

- Promote distributive leadership
- Take collective responsibility for teacher well-being and physical safety
- Work through problems respectfully
- Include all school personnel regardless of employment status
- Establish an ethical commitment to social justice

Provide formal and informal transition/induction processes

- Appoint mentors/coaches/buddies
- Provide on-going induction
- Apply equitable processes regardless of length and nature of appointment
- Promote understanding and appreciation of the different roles in the school

Develop a professional learning community

- Promote opportunities for risk taking and innovation
- Provide environments and resources that optimise teaching and learning
- Provide opportunities for collaborative learning
- Take collective responsibility for student behaviour, learning and well being

Teacher Identity

Successfully negotiating teacher identity is pivotal to becoming a resilient teacher. During this process teacher identity is actively constituted, through experience, in a range of personal, professional and structural discourses. Resilience is more likely when ECTs successfully integrate these discourses in ways that sustain both a coherent sense of personal identity and emerging teacher identity over time.

To enhance ECT resilience, it is important to:

Understand the discursive nature of personal and professional identities

- Recognise that teachers' identities are socially and culturally produced in context
- Be aware of the interconnectedness of personal and professional identities
- Understand the evolving nature of personal-professional identities
- Understand that emotions are an integral part of discursive practices

Be reflexive

- Accommodate new and different ways of thinking
- Challenge and develop beliefs, assumptions, values and practices
- Negotiate the contradictions, dilemmas and tensions of teaching
- Employ proactive coping strategies

Enable the development of a strong sense of agency, efficacy and self-worth

- Commit to the ethical and moral purposes of teaching
- Develop a high level of emotional intelligence
- Maintain a sense of hope and optimism
- Have space for identity work
- Nurture one's well-being and work-life balance

Teachers' Work

Teachers' work refers to the complex array of practices, knowledge, relationships and ethical considerations that comprise the role of the teacher. It acknowledges the ways in which teachers' work is being reshaped in the context of a broader set of economic, political and cultural conditions. ECT resilience is more likely when the focus is on understanding the complex, intense and unpredictable nature of teachers' work rather than on individual deficits and victim blaming.

To enhance ECT resilience, it is important to:

Acknowledge the complex, intense and unpredictable nature of teachers' work

- Attend to the physical, intellectual, relational and emotional dimensions of teachers' work
- Make provision for the emotional and tiring nature of teachers' work
- Negotiate multiple relationships in complex settings

Develop teachers' curriculum and pedagogical knowledge and strategies

- Provide opportunities for collaborative planning, teaching, assessment and reporting
- Allocate space and structures for teachers' intellectual work
- Focus on student diversity and difference
- Promote creative, innovative and intellectual work

Provide support to create engaging learning environments

- Take collective responsibility for management of student behaviour
- Develop practical skills and strategies to manage the physical classroom environment
- Share and demonstrate context specific strategies
- Model and promote autonomous and collaborative decision making

Ensure access to appropriate ongoing support, resources and learning opportunities

- Provide equitable and timely access to needs-based PD
- Support the development of pedagogical beliefs, values and practices
- Provide adequate release time

Policies & practices

Systems' policies and practices refer to the officially mandated statements, guidelines, values and prescriptions that both enable and constrain ECT well being. ECT resilience is enhanced when systems' policies and practices show a strong commitment to the principles and values of social justice, teacher agency and voice, community engagement, and respect for local knowledge and practice.

To enhance ECT resilience, it is important to:

Provide relevant, rigorous and responsive pre-service preparation for the profession

- Foster stakeholders' collective ownership for preparation
- Encourage diversity of pre-service professional experiences

Create innovative partnerships and initiatives that assist smooth transitions to the workforce

- Support professional development suitable to school context
- Acknowledge value of previous professional experiences in similar or same school
- Provide additional resources to complex settings

Implement transparent, fair and responsive employment processes

- Notify appointment in a timely manner
- Provide the potential for continuity of employment
- Appoint to roles and schools suitable to expertise
- Ensure access to timely and appropriate ongoing support, resources and learning opportunities
- Provide induction and ongoing processes for learning
- Provide additional release time to all ECTs
- Provide school leaders with professional learning to support ECTs

Appendix 3

Information/consent letter

Dear Participant,

Your school has been invited to take part in a pilot evaluation of a new Adult Resiliency programme called Resiliency for Life. The course provides a positive approach to increasing all of our skills in coping with the ups and downs of day-to-day life, developing our emotional resilience and thinking in a helpful way. The sessions will be presented by Unity Harding, Educational Psychologist, and Suzanne Richer, Trainee Educational Psychologist. The course consists of nine 'modules', which will be organised into one half day and four twilight sessions. It is important that you attend all sessions as each covers a different set of resiliency skills. We also hope that you will enjoy the informal and interactive nature of sessions and the opportunity to reflect on our busy lives.

Yours will be the first school in Northamptonshire to run the course and therefore we are keen to know what impact it has for school staff. We would be grateful if you can complete the enclosed evaluation questions before the first session, on 16th April 2012. Please bring the completed questionnaires along on the 21st April in the sealed envelope provided. Another questionnaire will be given to you following the last session in July. Your participation is voluntary so you do not have to complete these, and can withdraw at any time. All questionnaires are confidential and will not be shared with any members of school staff; they are for evaluation purposes only. Forms will be identified by number, used by the Educational Psychology Service only and will not be compared with anyone else's. You have the right to withdraw at any time from the research and your questionnaires will be destroyed once they have been scored. Data will not be stored by the service once it has been analysed.

Sometimes things will come to mind in the session, or after a session, which you might want to discuss further. It is good to identify someone with whom you feel happy sharing your thoughts and feelings between the sessions. Some people attending might be new to the area or find identifying someone to talk to difficult. At those times it's often good to call a well-known support line. The mental health charity MIND has an information helpline available on 0300 123 3393. The course facilitators will also be available if any member of staff wishes to discuss issues from the sessions. Please feel free to contact us in person or by phone at any time.

For further information please contact Unity Harding () or Suzanne Richer (01933 440289)

Many thanks for your help evaluating this course, and we look forward to seeing you on the 16th January.

Appendix 4

Evaluation pack enclosed with information letter

Appendix 5

3 brief questions on the sessions….

These questions are helpful for us to improve the programme in future so please give as much **detail** as possible. Session outlines are given below as a reminder! Your responses are completely anonymous.

1. How far was the content of 'Resilience for Life', including the strategies learned, relevant to your professional role and daily tasks in school?

2. What did you find most useful/helpful about the programme and what can you take from it?

3. What would you change if we were to run the programme again? You can omit, add or alter anything at all…

Please leave this form on the front desk before you go. Thank you!

Appendix 6

Individual totals for DASS-21

Pre-intervention	Post-intervention
12	10
10	8
14	12
15	12
17	13
11	11
12	9
9	7
14	12
10	9
18	13
12	9
12	11
15	12
11	10
14	11
12	10
11	7
15	12
13	11
10	9
13	11
10	7
16	13
15	11
12	10
18	14
11	9
14	9
10	7

	pre-intervention	post-intervention
Mean DASS score	**12.86666667**	**10.3**

Appendix 7

Individual totals for Resiliency Scale

Pre-intervention	Post-intervention
95	101
87	99
112	124
121	129
104	131
99	117
89	102
109	114
110	114
88	109
67	86
120	119
108	122
94	127
99	110
79	93
111	146
82	113
115	136
100	132
76	89
97	108
109	115
117	125
91	98
135	132
95	106
102	114
127	138
70	85

	pre-intervention	post-intervention
Mean DASS score	**100.2666667**	**114.4666667**

Appendix 8

Individual totals for Teaching Satisfaction Scale

Pre-intervention	Post-intervention
9	9
12	13
8	10
16	19
12	13
18	21
11	12
10	10
13	12
13	14
14	13
21	22
8	9
9	10
13	14
12	11
14	13
11	12
8	8
13	13
17	18
15	16
11	12
8	8
12	11
15	15
10	9
20	20
7	9
11	13

	pre-intervention	**post-intervention**
Mean TSS score	**12.36666667**	**12.96666667**