Applying a Cultural Historical Activity Theory Approach to Explore the Tensions Within and Between the Roles of Educational Psychologists and Primary Mental Health Workers When Supporting Mental Health Needs in Schools.

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Abstract

With the recent increase of Mental Health (MH) needs in Children and Young People (CYP) and budget cuts, exacerbated by the pandemic, there is a need to optimise support in schools. This research aims to look at how Educational Psychologists (EPs) and Primary Mental Health Workers (PMHWs) can operate in a Local Authority (LA) to best utilise resources to provide optimal support for CYP's MH needs in schools.

This research adopted a Third-Generation Cultural Historical Activity Theory (CHAT) framework to collect and analyse data from 6 EPs and 5 PMHWs practising in the same LA. Participants took part in semi-structured interviews to gain their views on their roles, each other's roles and the supports and constraints in their everyday practice. Thematic analysis was undertaken to identify themes which were then mapped onto each of the nodes on the CHAT framework.

This highlighted similarities and contradictions within and between the different professionals. EPs and PMHWs both aimed to support wellbeing in their practice, with EPs also supporting adults MH and PMHWs providing intervention for CYP MH diagnoses directly. Both EPs and PMHWs reported that they were constrained by educational pressures, time, and money. EPs reported that that they carried out short-term systemic, preventative work in schools whereas PMHWs tend to have longer direct therapeutic involvement with CYP. PMHWs had a greater understanding of the EP role compared to EPs of the PMHW role. These tensions within the different systems can be applied to develop future practice. This will ultimately then provide more effective support for CYP's MH needs. This has further implications for the EP role in supporting MH needs in schools, as well as working with other professionals. Future directions for research are also provided.

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Abbreviations

ACE Adverse Childhood Experiences
ADHD Attention Deficit Hyperactivity Disorder
AEP Assistant Educational Psychologist
ASD Autism Spectrum Disorder
AT Activity Theory
BPS British Psychological Society
CAMHS Child Adolescent Mental Health Service
CHAT Cultural Historical Activity Theory
CoP Code of Practice
CR Critical Realism
CYP Children and Young People
EHCP Education Health Care Plan
ELSA Emotional Literacy Support Assistant
EP Educational Psychologist
EPS Educational Psychology Service
GP General Practitioner
MH Mental Health
NHS National Health Service
LA Local Authority
PHE Public Health England
PMHT Primary Mental Health Team
PMHW Primary Mental Health Worker
SEMH Social Emotional and Mental Health
SENCO Special Educational Needs Coordinator
SEND Special Educational Needs and Disabilities
TA Thematic Analysis
TAF Team around the Family
TaMHS Targeting Mental Health in Schools
TEP Trainee Educational Psychologist
WHO World Health Organisation
YOT Youth Offending Teams

Chapter 1 Introduction

1.1 Introduction to Chapter

This chapter outlines the Mental Health (MH) difficulties experienced by Children and Young People (CYP); the prevalence in national and local contexts, and the subsequent negative outcomes for CYP who do not receive support for their MH needs. The chapter highlights the role of Educational Psychologists (EPs) and Primary Mental Health Workers (PMHWs) in supporting MH needs in schools. This chapter shows how both professional groups are well placed to support CYP's MH needs in schools, and yet there is currently little research on how they intersect with each other, therefore a need for a better understanding of their roles in supporting MH needs in schools. The chapter concludes by suggesting a need for research into how best to utilise the resources for supporting CYP's MH difficulties in schools, to provide optimal provision.

1.2 Definition and Terminology

The World Health Organisation (WHO) defines Mental Health as:

"Mental Health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (WHO, 2018).

We all have MH, however when our ability to stop coping with the usual stressors in life, feel enjoyment in the things we normally would feel and our thoughts and feelings take over our ability to carry out typical daily tasks, then we may be experiencing MH difficulties (Mind, 2017). It is important to note that MH difficulties are more than the absence of MH disorders or disabilities and can vary from commonly arising problems to more complex MH diagnoses (WHO, 2018).

This thesis adopts the terminology from WHO (2018), that MH difficulties can be understood as an individual ceasing to cope with the usual stressors and stopping enjoying the things they usually would in life. Furthermore, the individuals' thoughts and feelings overtake their ability to complete typical daily tasks (WHO, 2018). This thesis focuses on CYP's MH difficulties, specifically school aged children.

1.3 National Context

1.3.1 Prevalence

In the UK, one in four CYP report experiencing difficulties with their MH and one in ten children have a diagnosable MH condition (BPS, 2017). According to data from Public Health England (PHE), 50% of MH difficulties are recognised by the time a child reaches 14 years old (PHE, 2019). Suicide is currently the greatest killer of young people in the UK between 16 and 24 years, with an estimate of 180 CYP aged 10-19 years taking their own lives (ONS, 2019). There has also been an increasing trend in self-harm, a probable indicator of suicidal thoughts (Mundy et al., 2021).

1.3.2 Possible mental health triggers

MH difficulties can be triggered by life experiences such as trauma, violence, abuse, family difficulties, physical problems, and a family history of MH (Young Minds, 2021). Adverse Childhood Experiences (ACEs) have been linked to one-third of MH problems experienced by adults in adulthood (Kessler, 2010). It has been found adults who experienced four or more ACEs in their childhood are four times more likely to have reduced levels of mental well-being and life satisfaction (Mehta, 2013). Those CYP who are at more risk and highly overrepresented in taking their own lives consist of: those in the care system, CYP who abuse drugs and alcohol, those with a diagnosis of autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) (Mayes et al., 2013; Wan et al., 2019). Regardless of ACEs, and these high-risk groups, adolescence, and the developmental changes CYP experience from this, can cause strong feelings of confusion, fear,

doubt, and stress, affecting rationality and decision making (Mundy et al., 2021). These feelings can be too hard for some CYP to overcome which can lead to them taking their own lives in the worst-case scenarios (Young Minds, 2021).

1.3.3 Outcomes

Early experiences of MH difficulties in CYP have been linked to poorer life outcomes, such as imprisonment and non-explained exits from school (DfE, 2018). Not only this, CYP's experiences of MH difficulties in their early childhood have been linked with devastating outcomes, such as self-harm and death. In 2018-2019, 24% of 17-year-olds reported that they had self-harmed or experienced suicidal intent at some point in their lives, with 16% reporting high levels of psychological distress (NCB, 2020). Reports in 2018-2019 show the number of A&E attendances more than tripled from 2010 for those with a recorded diagnosis of a psychiatric condition under the aged of 18 (NHS Digital, 2020). These not only significantly impact CYP and their families but the wider community including schools (Mundy et al., 2021).

1.3.4 Access to treatment

Despite the high prevalence of MH difficulties experienced by CYP, just over one in three of those have access to NHS care and treatment, regardless of their diagnosable MH disorder (NHS, 2017). A survey carried out by Young Minds (2020) found 76% of parents reported a decline in their child's MH, whilst waiting for support from the Child Adolescent Mental Health Services (CAMHS). CAMHS have recently found themselves under enormous pressure with an increased demand for their services (Mundy et al., 2021). However, a survey from Censuswide, 67% of CYP stated they would prefer to access MH support without going to see their GP, although 47% reported they did not know how to access this support (Young Minds, 2020). More recently, the SEND and Alternative Provision (AP) green paper (2022) described the support for CYP with Education, Health and Care Plans (EHCPs), which often

involved CYP with social, emotional, and mental health (SEMH) needs, as 'too late' resulting in a 'vicious cycle' calling for more early intervention.

Although there has previously been a call for more joined up working between services (Green Paper, 2018), a report from PHE in 2019 identified gaps within local systemic work between partner agencies. This called for the need to create a outcomes framework and need for a better understanding across local services (PHE, 2019). This intended to identify the interplay of factors and benefits of adopting a whole systems approach to treatment (PHE, 2019).

1.3.5 Role of schools

Schools can play a pivotal role in supporting CYP's MH difficulties effectively at an early stage (BPS, 2017). CYP spend a great deal of their time in schools, building relationships with key adults and friends. In the Transforming Children and Young People's Mental Health Provision: A Green Paper (2018) it is stated there needed to be greater support within school and more optimal joined up working with the National Health Service (NHS) for CYP's MH and wellbeing. Every school was asked to appoint a Designated Senior Lead for MH to oversee MH and wellbeing approaches in schools (DfE, 2018).

1.3.6 Impact of the pandemic

The unforeseen Covid-19 pandemic has brought with it a further increase in MH difficulties experienced by CYP, with 41% of CYP reporting they felt their MH had regressed from the beginning of the pandemic to three months later (Young Minds, 2020). Not only this, 34% of the 1,081 CYP involved in the study, were accessing MH support from school and 45% from the NHS (Young Minds, 2020). This support was significantly affected due to the onset of the national lockdown in the UK. Since then, the government have been called to invest in MH support via these services to minimise the impact of the Covid-19 pandemic on CYP's MH difficulties (BPS, 2020).

The presented information highlights the high prevalence of MH needs in CYP and a high number of those at risk of devastating outcomes. There is a need to offer prevention and early intervention to avoid these detrimental life outcomes for CYP, their families' schools and wider communities. Despite this, there are enormous pressures on both schools and NHS services, such as CAMHS, because of the high demands nationally.

1.4 Local Context

1.4.1 Prevalence

The Local Authority (LA) in which this research will be carried out, has an estimated population of around 1.19 million people, according to the Office for National Statistics (ONS) 2018 data. Department of Education (DfE) data published in 2019- indicated there were 196,697 pupils in schools within the LA. Data collected across 2017/2018 led to estimations that 23,037 local CYP had mental disorders, aged 5-17 years old in this LA (PHE, 2018). This was the third highest level of MH disorders in the Southeast. Furthermore, in this LA, there have been 408 recorded hospital attendances, because of self-harm, for CYP aged 10-20 years from August to October 2021. This has also been exacerbated by the Covid-19 pandemic, with a notable increase from June 2020 to October 2021, with 14 urgent and emergency referrals in April and June 2021 (Mundy et al., 2021). Support for CYP's MH in 2020-2021 was one of the most common reasons for Early Help Social Care referrals, at 19%, in this area (Mundy et al., 2021).

1.4.2 Local Strategy

In the LA where this present research is carried out, an Emotional Wellbeing and Mental Health strategy for CYP was implemented between 2019-2022 (Mundy et al., 2021). As a result of this, the local priorities are to implement a short- and longer-term plan to address the increase of eating disorders and self-harm, by promoting prevention, early intervention, and a clearer pathway for referrals and support. The LA set out its aims to reduce suicide by 10% by 2021 by encouraging the NHS and Local Government to work together, to ensure current and future

capacity to provide appropriate support that meets need as well as improving preventative approaches.

1.4.3 Thrive Framework

Sitting alongside this, the primary mental health team (PMHT) within this LA have recently started to implement a ‘Thrive approach’ to support their work in supporting CYP’s MH difficulties. The Thrive framework aims to promote a needs-led approach to delivering MH services to CYP, their families and professionals (Wolpert et al., 2019). The thrive framework was developed at the Tavistock and Portman NHS Foundation Trust and aims to incorporate various professionals across education, health, social care, and community settings to promote shared-decision making and to create system change to provide a coherent resource-efficient community for MH support for CYP (Wolpert et al., 2019). This model has just started to be implemented at the time this current research was carried out.

1.5 Role of Educational Psychologist

The Educational Psychologist (EP) role has been around for over 100 years with the first EP, Cyril Burt, being identified in 1913, not long after the introduction of the Psychology discipline (BPS, 2013). EPs work with CYP aged 0-25 years and the adults around them. The EP role has evolved from undertaking cognitive assessments, to offering a wide range of work involving assessment, intervention, consultation, training, and research (Lee & Woods, 2017). In 2015, the new Special Educational Needs Code of Practice (SEND CoP) removed Behaviour, Emotional and Social Difficulties, as a category of need and replaced it with Social, Emotional and Mental Health (DfE, 2015), suggesting that EPs should support education in supporting the MH needs of CYP. In 2017 the British Psychological Society (BPS) highlighted the ability of EPs to work directly with schools to enhance staff knowledge and implement systemic interventions to support pupils with MH difficulties.

Despite this, some confusion remains around the role of EPs in supporting MH needs in schools, suggesting that EPs should primarily work within cognition and learning and prioritise EP work for cognitive assessments over MH work (Greig et al., 2019; Hoyne & Cunningham, 2019). Furthermore, research has found Special Educational Needs Coordinators (SENCOs) perceive the EP role as mainly carrying out assessments of learning (Andrews, 2017). Conversely, the EP role in supporting CYP's MH needs has been recognised by CAMHS professionals as supportive in understanding school systems and how they can impact on CYP's MH difficulties (Cane & Oland, 2014). They further suggest that EPs and CAMHS could work together to develop the specialist MH support for CYP in schools (Hulme, 2017). This indicates EPs have a key role in supporting CYP's MH difficulties in schools.

1.6 Role of Primary Mental Health Worker

The role of the Primary Mental Health Worker (PMHW) was developed in 1995 aiming to offer better support for CYP's MH and wellbeing within education (NFER, 2010). PMHWs are employed by the NHS, which sits in the health sector, whereas EPs sit within the education sector. PMHWs are professionals from a variety of backgrounds in health and social care who aim to offer support for positive MH and wellbeing within the community (NHS, 2017). They may work within education or other community areas such as children's centres or youth offending teams (YOTs) (Callaghan et al., 2003). PMHWs may receive referrals for CYP aged up to 18 years old from professionals such as teachers, doctors, or social workers (NHS, 2017). They are placed within PMHTs that operate within schools and may offer direct therapeutic intervention or assessments with CYP with mild to moderate MH difficulties, as well as training and consultations with adults (NFER, 2010). The aim of PMHWs is to bridge the gaps between CAMHS and community settings such as schools which ultimately aim to reduce referrals made to CAMHS (NFER, 2010). They play a vital role in ensuring CYP are referred to the correct services, reducing the delay in support for their MH difficulties (NFER, 2010).

1.7 EP and PMHW roles in schools

CYP spend a lot of their time at school and schools have a key role in improving CYP's MH (DfE, 2017). Although teachers are not health trained professionals and cannot carry out therapeutic interventions for CYP's MH needs (Glazzard, 2018), schools can play a role by referring CYP to specialist support and working jointly with other services to support these difficulties (DfE, 2017). CYP have also expressed their preference of receiving MH support in settings other than their GPs (Young Minds, 2020). Both PMHWs and EPs can play a role in supporting schools to support CYP's MH needs in schools. EPs have the knowledge of schools and training to support MH needs in CYP (Robson & McCartan, 2016). PMHWs can offer direct therapeutic intervention with CYP in schools (NFER, 2010). Together, schools can work with these outside professionals to enhance their role in identifying early presentation of MH difficulties in CYP.

1.8 Focus of this present research

Both EPs and PMHWs are pivotal in supporting CYP's MH needs in schools. In accordance with national and local strategies to implement more joined up working across the NHS and local government, including PMHTs and Education (DfE, 2018), this highlights a need for multiagency working between EPs and PMHWs, working in both PMHTs and schools. This present research thus aims to further investigate the roles of EPs and PMHWs in supporting CYP's MH needs in schools. It aims to outline the work both professional groups carry out, as well as the facilitating elements in their roles and the constraints which they face. By doing so, this research hopes to suggest how these roles can be optimised to work together to utilise local resources more effectively and offer greater support for the MH and wellbeing of CYP in schools, offering more positive outcomes for CYP's futures and society overall.

1.9 Summary

This chapter has highlighted the significant rates of MH difficulties and their potentially devastating outcomes both nationally and locally. The information suggests that schools are well placed to support CYP's MH needs. Both PMHWs and EPs work in schools and have the skills, knowledge, and training to make a positive impact in supporting CYP's MH difficulties in schools. There is a call for more multi-professional working across education and health sectors, the NHS, and local government, where EPs and PMHWs work to offer the best support for CYP at both preventative and early levels. This chapter makes a case for undertaking research in these areas as it argued that developing a better understanding of the PMHW and EP roles in supporting CYP's MH needs in schools could improve MH outcomes for CYP and utilise resources more effectively within the LA. There is yet to be research carried out focussing on these two professional groups specifically together. Furthermore, this is in line with local and national initiatives to improve the support for CYP's MH difficulties. The following chapter provides information about what is already known about the role of the EP and PMHW in supporting CYP's MH needs in schools.

Chapter 2 Literature Review

2.1 Introduction to Chapter

The aim of this chapter is to explore and describe the research that currently exists regarding the roles of Educational Psychologists (EPs) and Primary Mental Health Workers (PMHWs) in supporting Children and Young People's (CYP's) mental health (MH) needs in schools. The literature review was conducted with a view to meeting three key aims. Aim one was to look at what we currently know about how EPs and PMHWs support CYP's MH needs in schools. The second aim was to examine what facilitators and constraints there are to the roles of EPs and PMHWs in supporting CYP's MH needs in schools. The final aim was to see what we already currently know about EPs and PMHWs working jointly with other professionals, either in schools or in other contexts. The subsequent literature research question in this present review is:

What do we know about the roles and working relationships of EPs and PMHWs in supporting CYP's MH needs in schools?

For this current research, 'working relationship' captures how EPs and PMHWs work with other professionals who also work to support CYP's MH needs in schools and 'supporting' is defined as how their role is executed when doing so.

2.2 Search Strategy

On 15/12/21, the following databases were searched, PsychINFO, ERIC, PsycExtra, The Pep Archive, Psychology and Behavioural Sciences Collection, PsycArticles, PsycBOOKS, SocINDEX with Full Text, Education Source, PubMed, and Medline, via EBSCO host. Thesauruses from the individual databases were also used, to identify various key words that were related to the theme of

the question (working relationship, professionals, mental health). The search terms used are presented in Table 1.

Professionals	Mental Health	Working relationship
Educational Psychologist Primary Mental Health Worker Educational Professional Mental Health Professional CAMHS NHS Other professionals Allied professionals School nurses Primary Care worker	Mental Health Well being Emotional health Emotional Well being	Collaboration Multi agency working Multi professional working Multi disciplinary working Joined working

Table 1 Literature review search terms used

The term 'other professionals' was used to encompass the large number of various terminologies used for different professionals who may work alongside EPs and PMHWs. For this present research, it was decided that the search terms were to remain closely to the term Primary

Inclusion	Exclusion
• Primary empirical sources • Published in the English Language • Research carried out in the UK • Focus on the different roles of the professionals in supporting CYP's MH needs	• Focus is on specific interventions implemented in supporting CYPs MH needs in schools • Educational Psychologist data pre-SEND CoP in 2015 • PMHW pre introduction of the role in 1995 • Focus on post-18 as out of school age • Poor quality papers

Mental Health Worker due to the local agenda of this study. However, it is recognised that there is a more recent role of Education Mental Health Practitioners which could fall under this search term.

The limiter 'Subject Terms' was applied, and terms were combined using 'AND'. This limiter was used over other limiters such as 'included in abstract' limiter, as this narrowed the evidence too low in an already small field of research papers. The inclusion and exclusion criteria applied to the literature are outlined in Table 2.

Table 2 Inclusion and exclusion criteria

Articles were then screened to ensure they were written in English and from academic journals. A date range limiter was also used of 2015-2021 for EP data as this was when the idea of 'behavioural difficulties' was changed to 'social, emotional and mental health' because of the Special Educational Needs and Disabilities Code of Practice (SEND CoP) issued in 2015. As there was no literature on the PMHW role in schools retrieved, PMHWs in other settings where they work with CYP's MH needs were included. This resulted in 220 articles. Abstracts were then assessed against the inclusion and exclusion criteria, leaving 14 articles remaining.

After the inclusion and exclusion criteria were applied, the articles were reviewed for quality using the following evaluation tools:

- For qualitative research, Critical Appraisal Skills Programme (CASP, 2018) was applied.
- For quantitative papers, an evaluation tool for quantitative research studies (Long et al., 2002) was used.

This led to a further two studies being excluded. Appendix 1 provides a summary detail of the critical appraisal of the qualitative and quantitative papers.

2.3 Synthesis of Literature

2.3.1 Overview of included papers

Twelve papers were included and are listed in appendix 1, alongside excluded papers. Three papers focused on the role of EPs in supporting MH needs in schools, one of which is alongside CAMHS, two papers looked at the role of PMHWs in settings other than schools and seven included other professionals' experiences of either working with EPs or PMHWs or their views on their roles, including CAMHS professionals, MH practitioners, Educationalists, Educational Professionals and Schools. These papers were included to help to inform joint working possibilities as well as papers including the PMHW role in other settings than schools, as no research on the PMHW role in schools specifically was retrieved from the search.

The findings of the review are presented by synthesising what the papers reveal about: the role of EP's in supporting CYP's MH needs in schools, the role of PMHW's supporting CYP's MH needs, constraints they experience when supporting CYP's MH needs and joint working difficulties. Surprisingly, papers did not cover their successful and effective practices in supporting CYP's MH needs. Two studies were excluded based on quality, the details of which can be found in the table in appendix 1 marked red. The following sections provide an overview of the literature and have been organised into themes.

2.2.2 Role of EP in supporting MH needs in schools

Five of the articles explored the role of the EP in supporting MH needs in schools (Cane & Oland, 2015; Greig et al., 2019; Hulme, 2017; Sharpe et al., 2016 & Zafeiriou & Gulliford, 2020). The five papers describe a variety of ways in which EPs work to support MH needs in schools, these included, consultation to support school staff, delivering training to schools to support whole school development, supporting the family/school relationship, as well as a more individualised approach such as delivering specific interventions and carrying out individual casework. The main differences across the five papers were how the EP role differed in direct and indirect work with CYP which will now be explored.

2.2.2 (i) EP's role with parents to support MH

Three research papers featured the key role of EPs in supporting parents to provide optimal support for CYP's MH needs in schools (Cane & Oland, 2015; Greig et al., 2019; Sharpe et al., 2016).

Cane and Oland (2015) carried out a qualitative study to examine the outcomes and implementation of a Targeting Mental Health in Schools (TaMHS) project across four schools in the West Midlands. The local TaMHs project involved partners from education, health, and the voluntary sector. This specific project was led by 2 EPs from the LA, who helped deliver the project before holding focus groups with the school staff to gather their views on the project. 21 school staff members from four different schools across different geographical locations within the LA, participated in the focus groups regarding their views on this project in supporting CYP's MH needs in their schools. A thematic analysis was carried out to gather the main themes across the focus groups. The findings indicated that staff valued the EP role in facilitating parental involvement in supporting CYP's MH needs and that schools wanted to increase the quality of relationships with parents. Furthermore, they found because of the project, school staff empathised with parents and believed parents evenings and parent training would support the home school relationship to optimise support for CYP's MH needs in schools. It should be considered that EPs ran the focus groups which could have influenced the participants answers in the focus groups. It must also be noted that this project was only carried out in a small-scale local project in one area of the UK. These findings suggest that EPs can play a role in supporting the parents to support CYP's MH needs in schools.

In a quantitative study, carried out in Scotland, Greig et al., (2019) sent out an already piloted survey to all 32 LAs across Scotland. The survey was completed by the Principal Educational Psychologists (PEPs) from 19 of the 32 LAs. The findings were that PEPs reported that EPs were most confident in supporting CYP's MH needs through supporting parents by providing them with information and carrying out interventions and indirect work. These findings supported Cane and Oland's (2015), as they also found support for parents was a useful indicator of support for CYP's MH needs in schools, which could be provided by EPs. This survey was completed by the PEPs of the

EPSs; therefore, this could affect the bias of reporting and may not necessarily be representative of all EPs. It must also be noted this was carried out in Scotland, which could offer different opportunities because of different national and local initiatives and priorities for the EP role. These findings indicate that EPs have a key role in supporting parents to support CYP's MH needs in schools.

Sharpe et al., (2016) conducted a quantitative study to collect the views from senior leadership teams, across 593 schools in England, on MH support in their schools. A range of schools across different areas with different socio-economic statuses were included. The findings were of the 262 of all schools that responded, 54% used family work to support CYP's MH difficulties within their schools. Furthermore, they found 81% of this work was carried out by EPs, suggesting that EPs were the main external provision for support for MH needs in their schools. Like Greig et al., (2019), this survey was completed by the senior leadership teams and their perceptions of the EP role could differ from the EPs carrying out this work. Together, these findings may suggest that EPs play a role in supporting CYP's MH needs in schools by working with families. However, it is not known from this how much of the EP role directly involves parent work.

2.2.2 (ii) Delivering school training to develop whole school approaches to support MH

Two of the five papers featuring the EP role (Cane & Oland, 2015; Sharpe et al., 2016), highlighted the role of the EP in delivering school training to develop whole school approaches to support CYP's MH needs in schools.

Cane and Oland's (2015) findings also indicated a need for training for school staff to develop awareness of MH issues in schools and reduce negative staff attitudes. Furthermore, they found EPs provided opportunities for developing whole school awareness training and universal interventions to support children's well-being. This was described by the participants as being a pivotal role of EPs in ensuring training was cascaded throughout schools. These findings can be supported by Sharpe et al., (2016), who found that of the 262 schools that responded to the survey, 79% used staff training and 68% whole-school approaches to support CYP's MH difficulties within their schools. They found this

work was mainly carried out by EPs. This was found to be more common in schools with higher deprivation. These findings suggest that there is both a need for more staff training to develop whole school approaches to support CYP's MH difficulties that is already being carried out by EPs in some schools and suggests EPs are well placed to do more of this. Again, it is not known from this how much of the EP role is used to deliver staff training.

2.2.2 (iii) Supporting school staffs' wellbeing and practise to support MH

Two papers highlighted the role of the EP in working with school staff to support their well-being by managing their feelings (Zafeiriou & Gulliford, 2020) and alleviating practise constraints (Cane & Oland, 2015).

Zafeiriou and Gulliford (2020) carried out a qualitative study to explore EPs MH casework in schools. Five EPs took part in semi-structured interviews regarding their MH casework in schools. After carrying out a thematic analysis, they found that EPs were mainly contacted when adults in the schools supporting CYP's MH needs 'felt stuck'. This resulted in the EP becoming involved in four main areas: responding to staff's difficult emotions, joining theory with evidence, sharing hypotheses and challenging perceptions and planning. The research was carried out in only one LA; therefore, caution should be taken when generalising across other LAs.

Cane and Oland (2015) found in their research that school staff reported the TaMHS project delivered by EPs in their schools was useful in delivering staff training and developing whole school approaches. The participants explained this supported their own well-being which in turn enabled them to support CYP's MH needs. Staff reported that the delivery of the TaMHS project by EPs helped alleviate the stress and emotional impact staff had because of working with CYP with MH needs, as well as increasing their awareness, empathy, knowledge, skill, and confidence in carrying out this work. In addition, the project helped the school to develop a MH lead in the school who worked systemically to consider ways of alleviating practical constraints such as time, funding, and resources. Staff reported these approaches helped staff feel more able to support the MH needs of CYP in the

schools. The findings from both papers highlight the role of EPs in supporting adult's MH and wellbeing to support CYP's MH needs in schools.

2.2.2 (iiii) Working with CYP directly to support their MH

Most of the included articles position the role of the EP in supporting CYP's MH needs indirectly through supporting parent and school staff's wellbeing, as well as carrying out school training to develop whole school approaches. There are some findings within the research that suggest EPs do work directly with CYP to support their MH needs. Two papers found EPs carry out direct intervention work with CYP to support their MH difficulties in schools (Greig et al., 2019; Sharpe et al., 2016).

In Grieg et al's., (2019) survey, one of the most common implementations of the EP role in supporting CYP's MH needs in schools was direct work with CYP. Although this was carried out in Scotland, other research across the UK found 25% of 262 schools used mindfulness interventions to support CYP's MH needs in schools and the support for MH in their schools was mainly supported by EPs (Sharpe et al., 2016). This may not have been as high as the family work, whole-school approaches and staff training but does show that CYP's MH needs can be supported through EP direct work with CYP. It is not known from this literature whether EPs carried out the mindfulness interventions themselves or co-facilitated this.

In summary, the literature suggests that EPs are well placed to support MH needs in schools, however the types of work they engage in differs. The papers included in this review suggest that EPs work both indirectly carrying out parent support, training to support staff wellbeing and practise and develop whole school approaches as well as direct work with CYP involving interventions such as mindfulness to support CYP's MH needs in schools.

2.2.3 Primary Mental Health Worker Role in Supporting MH needs

Four papers focused on the PMHW role in supporting CYP's MH needs (Callaghan et al., 2003; Hickey et al., 2010; Lacey, 1999; Lambert et al., 2020). These papers did not specifically focus

on the role of the PMHW in schools but were included to demonstrate understanding around the PMHW role in other settings. All four papers described the PMHW role in a clear unified way as working collaboratively across teams of either CAMHS, GPs and Youth Offending Teams (YOTs).

Lacey (1999) carried out a quantitative study to gather the views on how the role of the PMHW had been interpreted across 169 MH trusts in England. Self-administered questionnaires were completed by staff from 98 different services. The questionnaire variables were then coded and analysed using SPSS. The findings were that the PMHW role was mostly perceived as carrying out consultations with adults about a CYP, delivering training to primary care staff, undertaking joint assessments, and undertaking direct work in the hope to bridge gaps between the different tiers of MH services and CAMHS. Findings suggested that participants hoped this work would prevent escalation of difficulties, reduce waiting lists and referrals to specialist services and provide early intervention for supporting CYP's MH needs. It is important to note that as the research was undertaken more than 20 years ago, the role of PMHWs in these trusts may have changed.

More recently, Hickey et al., (2010) sent out a questionnaire to heads of CAMHS and other NHS trusts that employed PMHWs. The questionnaires were then completed by 415 out of a possible 653 PMHWs. The questions focused on seven domains associated with the PMHW role: demographic information, professional characteristics, organisation and management, the interface between primary care and CAMHS development needs, job satisfaction, burnout, and job stressors. The findings indicated that PMHWs mainly provided consultation with adults regarding the CYP, training to school staff and sometimes direct intervention work with parents and their CYP, which mainly depended on their professional background. They also found the role was mainly deemed to be to close the gap between primary and specialist services to improve access to MH services for CYP. In addition, in this research, PMHWs were reported to take part in strategy planning and research development to support the MH needs of CYP.

In a different setting from the previous studies, Callaghan et al., (2003) examined 40 case studies of CYP in Youth Offending Teams (YOTs) who had worked with PMHWs. CYP were asked to complete a service checklist and the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). YOT staff who had been in receipt of consultation from the PMHWs were also asked to complete questionnaires. The data was independently rated by a researcher. As with the previous studies, they found consultation with YOT staff was an important aspect of the PMHW role in bridging work between CAMHS services and the YOT, and that direct intervention with CYP was also undertaken to support their MH needs. This included, Cognitive Behaviour Therapy, counselling, brief psychodynamic psychotherapy, and family therapy, depending on professional backgrounds. The PMHWs in this research carried out their role with the hope to offer quicker access to MH support for CYP by reducing waiting times. In addition to the findings in the other included papers, Callaghan et al., (2003) found that PMHWs also carried out risk assessments, supervision of court orders and undertook assessments for courts. These additional and different activities can be explained by the focus of the research being in YOTs and it is not known from this how the PMHW role would operate in schools.

More recently and in a different setting, Lambert et al., (2020) carried out a qualitative study to gather the perceptions of 9 GPs on the role of the PMHW in their service in supporting CYP's MH needs. The thematic analysis of the interview answers highlighted that the PMHW role was perceived to involve consultations with the GPs, training, and for direct therapeutic work with CYP. The GPs reported that they found informal case discussions with PMHWs helpful and supported their referrals to CAMHS. Furthermore, the GPs in this study shared that PMHWs helped improve their understanding of schools and when they felt stuck in supporting CYP's MH needs. These findings suggest PMHWs have a key role in promoting collaborative work between GPs, schools and CAMHS by using consultation, training, and informal case discussions. Although this paper did not focus on

the role of PMHWs in schools directly, it highlights how the PMHW role can bridge gaps between schools and other services.

The findings from these four papers suggest PMHWs play key roles in facilitating collaboration and bridging gaps between schools, GPs, YOTs, CAMHS and other NHS trusts. They do so by providing consultations to other professionals and parents. They may also offer training to other services to promote a better understanding of CYP's MH needs and sometimes offer direct work with CYP, although this can vary widely. The included papers suggest PMHWs may carry out more direct work than EPs however it is not known how this differs and how PMHWs can work with EPs as they do with other professionals and services.

2.2.4 Other professionals' roles in supporting CYP's MH needs

Three papers that did not focus on the EP and PMHW roles specifically, were included as they looked at the relationship between educational services and MH services (Vostanis et al., 2011; Vostanis et al., 2012; O'Reilly et al., 2018). These were included as EPs typically come from an education background and PMHWs from a MH background.

O'Reilly et al., (2018) carried out semi-structured interviews with adolescents, MH practitioners and Educational Professionals to gather their views on who should be taking responsibility for adolescents' MH. They carried out a thematic analysis and found that although adolescents rely on teachers for MH support, MH is not the primary role of teachers and they have limited skills in managing complex MH difficulties. The findings also indicated that parents had a responsibility for their child's MH. These findings support other research that highlighted the importance of parent's in supporting CYP's MH needs in schools (Cane & Oland, 2015; Greig et al., 2019; Sharpe et al., 2016). Furthermore, they suggest a need for other professionals to support with CYP's MH needs in schools.

In a study by Vostanis et al., (2011) a questionnaire was sent out to 150 staff across four CAMHS teams to investigate their knowledge on education and joint working. Associations between

variables that were established by statistical analyses were entered into a regression model alongside case vignettes that had been scored using a scoring system devised by the research team. The findings were that 85.4% of the CAMHS professionals reported having frequent contact with educational staff and 28.1% reported needing more knowledge of educational needs, with only 30.2% of staff having undertaken training in relation to children's educational needs. These findings suggest that CAMHS and education do work together to support CYP's MH needs in schools and there is a need for CAMHS to develop their understanding and knowledge of CYP's education needs.

As a result, Vostanis et al., (2012) carried out semi-structured interviews with 31 CAMHS staff and 5 educationalists after they had completed training to improve CAMHS professional's knowledge of education. Furthermore, their views were collected on the implications this training had for joint working between education and CAMHS. A thematic analysis was carried out to analyse the interview transcripts. The findings indicated that CAMHS staff felt that knowledge and competency in education was necessary to promote joint working between education and CAMHS. Furthermore, participants valued the importance of building relationships through a link person between education and CAMHS and there was a need for a link person between these two services to improve education. The participants also shared there was a need for more training, and they valued the training they had received. Furthermore, the findings were that time and resources limit the ability to carry out joint working between Education and CAMHS. It is not known from this literature whether EPs or PMHWs could be the 'link person' as suggested in this paper. These findings support Vostanis et al., (2011) previous research, suggesting that there is a place for Educational and CAMHS to work together to support CYP's MH needs in schools.

2.2.5 Constraints in supporting CYP's MH needs in schools

Ten of the included papers (Callaghan et al., 2003; Cane & Oland, 2015; Greig et al., 2019; Hickey et al., 2010; Lacey, 1995; Lambert, 2020; O'Reilly, 2018; Sharpe et al., 2016; Vostanis et al., 2011) described constraints that professionals encounter when supporting CYP's MH needs in schools.

The constraints consisted of capacity, funding, training needs, parent/carer/ home pressures and relationships with schools and other's perceptions of the role in supporting CYP's MH needs.

2.2.5 (i) Training needs impact on MH support

Four papers (Callaghan et al., 2003; Cane & Oland, 2015; Hickey et al., 2010; Vostanis et al., 2011) commented on the need for more training for school staff, parents, and MH professionals in CAMHS to provide more optimal support for CYP's MH needs.

Although Vostanis et al., (2011) primarily sought to explore how much CAMHS staff knew about educational issues and their confidence in working collaboratively with educational staff, some of the findings are relevant to this review. Vostanis et al., (2011) findings indicated that 28.1% of CAMHS staff reported needing more knowledge of educational needs, with only 30.2% of staff having undertaken training in relation to children's educational needs. They felt by receiving more training this would develop their knowledge around the impact of MH in education performance and how educational issues impact on CYP's MH. It must be considered that the self-report nature of this study could offer potential bias. However, these findings suggest that staff's training needs impact their ability in supporting CYP's MH needs. Although it is not known from this whether training needs impact on the EP or PMHW role in supporting CYP's MH needs in schools.

The school staff in Cane and Oland's (2015) research suggested that poor school staff awareness because of a lack of training, hindered the MH support school staff offered for CYP's MH needs in schools. The findings from the focus groups further suggested the TaMHs project, delivered by EPs, offered staff training that increased awareness, empathy, and confidence in supporting CYP's MH needs in schools. These findings suggest a lack of training for school staff hinders the MH support CYP receive in schools, but it is not known how training needs impact on the EP and PMHW role in supporting CYP's MH needs in schools.

Similarly, the need for more training to enable professionals to offer better support for CYP's MH needs was also found in other included papers (Callaghan et al., 2003; Hickey et al., 2010). In

Callaghan et al., (2003) study they found YOT staff reported that they needed more training around the implementation of strategies to create more successful interventions for supporting CYP's MH needs. They also found that participants in this study believed training would support their understanding in making more appropriate referrals to PMHWs to ensure CYP in the Youth Offending Service (YOS) received the specialist services and resources they needed for their MH needs. This literature does not indicate how training needs impact on EPs and PMHWs in supporting CYP's MH needs in schools.

However, the PMHWs in Hickey et al., (2010) research, reported that they felt they needed more training to support their role in supporting CYP's MH needs. Only 12% of participants reported they had attended recent training courses in supporting CYP's MH needs. The findings from this paper suggest that training needs of PMHWs hinder their roles in supporting CYP's MH needs. However, this research does not evidence if training needs affect the PMHW role in schools in supporting CYP's MH needs or whether this is the same for EPs.

2.2.5 (ii) Funding Issues impact on MH support

The findings from three papers included in this review highlighted the impact of the lack of funding in constraining professional's roles in supporting CYP's MH needs (Hickey et al., 2010; O'Reilly et al., 2018; Sharpe et al., 2016).

Although the O'Reilly et al., (2018) paper set out to explore professionals and adolescents' perspectives on where the responsibility of MH support for adolescents should lie, there were other findings from the interviews that are applicable to this review. The MH and Education Practitioners in this research expressed that they were constrained in supporting CYP's MH needs because of the lack of funding. This was true for both funding of specialist services and for staff training to enable effective support for MH needs. Supporting this, PMHWs also felt that funding limited their ability to support CYP's MH needs in the Hickey et al., (2010) study. The PMHWs reported that they felt a lack of

funding was a significant limiting factor in their ability to provide the support they wanted to for CYP's MH needs. These findings suggest that a lack of funding has an impact on the PMHW role as well as MH and Education Professionals in supporting CYP's MH needs.

As well as these professionals who shared that funding directly affected their roles in supporting CYP's MH needs in schools, the senior leadership staff in Sharpe et al., (2016) survey, reported that a lack of funding limited the access to MH support and specialist CAMHS services. The participants in this study believed this affected professionals' roles in supporting CYP's MH needs in schools. This supports the findings from O'Reilly et al., (2018) whose participants suggested funding issues impacted on CYP's access to specialist services. Overall, these three papers included in this review highlight the impact of the lack of funding in constraining PMHW's roles in supporting CYP's MH needs. It is not known from these included papers whether funding issues constrain the EP role in supporting CYP's MH needs in schools or the PMHW role directly in schools.

2.2.5 (iii) Capacity impact on MH support

Four papers included in this review found capacity, where demand exceeded supply, constrained EPs and PMHWs support for CYP's MH needs (Greig et al., 2019; Hickey et al., 2010; Lambert, 2020; Sharpe et al., 2016).

Two papers included in this review found capacity constrained the role of the EP (Greig et al., 2019) and PMHW (Hickey et al., 2010) in supporting CYP's MH needs. Greig et al., (2019) found capacity constrained the role of the EP in supporting CYP's MH needs in schools. Greig et al., (2019) found EPs had the tools to support MH needs in schools, but the PEPs of the EPSs in Scotland reported that EPs did not have enough capacity to carry out this work. Similarly, the role of the PMHW in supporting CYP's MH needs has also been constrained by capacity. In Hickey et al.,'s (2010) research, PMHWs felt they had insufficient time to provide the MH support CYP needed in primary care settings. These findings suggest that capacity is a key constraint on the EP and PMHW roles in supporting CYP's MH needs.

As well as this, the services EPs and PMHWs work alongside such as CAMHS and primary mental health settings such as GP practices, were also affected by capacity which constrained their roles further. In Sharpe et al.,'s (2016) research, the heads of schools reported that CAMHS had limited capacity and as such could not deliver enough school-based work. This was also similar in other primary care settings, where it was found that the capacity constraints of CAMHS (tier 3) often increased the pressure on capacity in tier 1 settings such as primary care settings and GPs (Lambert et al., 2020). In this study the GPs felt this impacted on the role of the PMHW in supporting CYP's MH needs. These findings together suggest that the limited capacity of specialist services such as CAMHS further impact on other professional's roles such as EPs and PMHWs in supporting CYP's MH needs.

2.2.5 (iiii) Parent/carer/ home and relationships with schools' impact on MH support

Three papers (Cane & Oland, 2015; Hulme, 2017; O'Reilly 2018) found the role of parents, carers, and the home impacted on professional's support for CYP's MH needs.

Although Hulme (2017) mainly sought to explore the joint working between EPs and CAMHS, they also found similarities within the constraints of the EPs and CAMHS professionals' roles in supporting CYP's MH needs. In their doctoral thesis, Hulme found that all participants in their study reported home and family life could be a possible stress on CYP's MH and affected the way the professionals were able to support CYP. The professionals explained that there were often tensions between theirs and parents' views. Furthermore, participants reported that parental pressure often negatively affected CYP's wellbeing which affected their roles in delivering MH support. These findings suggest that parent and home pressures can impact on a CYP and thus negatively affect the EP role in supporting CYP's MH needs in schools.

School staff in Cane and Oland's (2015) research reported school's relationships with parents and carers, particularly a lack of parent and carer involvement with school was fundamental in the

support for CYP's MH needs. The participants further suggested the need for more support for parental well-being to ultimately benefit CYP's MH needs. This research further suggested that the EP role could be utilised in supporting the relationship between home and school, to remove this constraint in support. However, it is not known from this research how the parent/carer involvement with the school impacts on the EP role in supporting CYP's MH needs in schools.

Supporting this, O'Reilly et al., (2018) found the MH practitioners and Education practitioners in their study reported that parental concerns around being stigmatised for reaching out for support for their CYP's MH difficulties often hindered support provided to CYP. This was crucial for early intervention in helping parents to ask for support for their CYP's MH difficulties at an early stage, to enable CYP to receive the right support at the right time. It is not known from this research how these impact on the EP and PMHW roles specifically in supporting CYP's MH needs in schools. Together the papers included in this review demonstrate the impact of parent/carer/ home pressures and relationships with schools in constraining support for CYP's MH needs, as well as constraints this has on the EP role. However, it is not yet known whether this constrains the role of the PMHW in supporting CYP's MH needs in schools.

2.2.5 (iiiii) Other's perceptions of the role in supporting CYP's MH needs

The findings from one paper included in this review found that other professional's views of the EP role being focused on cognition and learning rather than MH would often hinder the EP role in supporting CYP's MH needs in schools (Greig et al, 2019). Likewise, one other paper included in this review (Hickey et al., 2010), found the PMHW role was also constrained in supporting CYP's MH needs by primary care staff views in MH trusts of PMHWs in carrying out clinical work over other work.

The PEPs in Greig et al's (2019) survey suggested there is a significant gap in how EPs perceive their role in supporting CYP's MH difficulties to how the role is perceived in wider society. Their findings indicated that PEPs believed Government departments, funders and commissioners of

services who have the greatest influence on policy and provision of services did not perceive EPs as having a role in CYP's MH needs and support should be provided by CAMHS. This in turn limits EPs in supporting CYP's MH needs in schools.

Similarly, other's perceptions of the PMHW role were also found to hinder PMHW's support for CYP's MH needs (Hickey et al., 2010). The PMHWs in this study reported that they felt primary care staff working in their settings pushed for PMHWs to take on clinical cases to reduce the service caseload. This meant that PMHWs were unable to carry out as much consultation for adults, liaison, and training with staff as they hoped to. PMHWs in this study reported that this hindered their role in supporting CYP's MH needs as they were unable to reach as many CYP as they could. This study involved PMHWs working in NHS MH trusts, therefore it is not known whether other's perceptions of the PMHW role constrains the support for CYP's MH needs in schools specifically.

2.2.6 Joint working difficulties

Six papers included in this review suggested that there are key hindrances to joint working between professionals when supporting CYP's MH needs. Communication as a hindrance to joint working was found in six of the included papers Findings from three papers indicated that clearer referral pathways were needed to promote more effective joint working (Sharpe et al., 2016; Vostanis et al., 2012).

2.2.6 (i) Communication

Four of the included papers found a lack of communication to be a key constraint in joint working across different professionals in supporting CYP's MH difficulties in schools (Cane & Oland, 2015; Greig et al., 2019; Hulme, 2017; Vostanis et al., 2011).

The education practitioners and MH practitioners in Vostanis et al., (2011) research expressed improved communication was the key in building relationships between CAMHS and education. The participants in this study further suggested that a linking person between CAMHS and education would support the lack of communication across services. Supporting this, Hulme (2017) research consisted

of EPs as participants in looking at the joint working of EPs with CAMHS. Hulme (2017) interviewed 2 EPs, 2 CAMHS workers and 2 school staff to gather their views on the joint working of EPSs, CAMHS and schools. A thematic analysis was carried out and one of the main findings was that the participants felt the lack of communication between EPs, schools and CAMHS was a key hindrance to joint working which ultimately impacted on their roles in supporting CYP's MH needs.

Likewise, the PEPs in Greig et al., (2019) survey reported that ongoing communication with other agencies and MH services was a key barrier to delivering MH and wellbeing support in schools. In Cane and Oland's (2015) research, the school staff reported that the development of shared language between schools, EPs and CAMHS services supported communication difficulties which would in turn facilitate joint working. The participant's believed this increased their understanding around MH terms to use when working with other professional's which ensured CYP received appropriate support. These findings suggest that a lack of communication is a constraint to joint working for EPs working with other professionals to support CYP's MH needs in schools. This literature does not indicate how communication impacts on the role of PMHWs supporting CYP's MH needs.

2.2.6 (ii) Clear referral pathways

Two papers included in this review highlighted the need for clearer referral pathways in promoting more efficient joined up work to support CYP's MH difficulties in schools (Sharpe et al., 2016 & Vostanis et al., 2012).

The education practitioners and MH practitioners in Vostanis et al., (2012) research highlighted the need for joint protocols and referral pathways in enhancing relationships between professionals to provide better support for CYP's MH difficulties in schools. They suggested this would also support communication, which had been highlighted above as another hindering factor in joint working when supporting CYP's MH needs. Additionally, Vostanis et al.'s, (2012) participants suggested that training would help support the development of clearer referral pathways to optimise joint up work to provide better support for CYP's MH needs in schools. Supporting this, the school staff in Sharpe et

al.'s, (2016) survey suggested a need for clearer referral pathways to be established to support better joint working between professional's when supporting CYP's MH needs in schools. They further suggested that there is a need to examine what underpins positive working relationships between schools and specialist services. However, it is not known from this literature about the impact of unclear referral pathways on the roles of EPs and PMHWs and their joint working in supporting CYP's MH needs in schools.

2.2.7 Summary

To summarise, the papers included in this literature review highlight the roles EPs and PMHWs have in supporting CYP's MH needs in both schools and other settings. It is known from the included literature that EPs work with parents (Cane & Oland, 2015; Greig et al, 2019; Sharpe et al., 2016), deliver training to school staff to develop whole school approaches (Cane & Oland, 2015; Sharpe et al., 2016), support school staff's own MH and wellbeing (Cane & Oland, 2015; Zafeiriou & Gulliford, 2020) and work directly with CYP when working to support CYP's MH needs in schools (Greig et al., 2019; Sharpe et al., 2016). The research in this review also indicated that PMHWs take a collaborative and bridging role by also working with adults through consultation, training and liaison as well as carrying out direct therapeutic work with CYP to support their MH needs (Callaghan et al., 2003; Hickey et al., 2010; Lacey, 1999; Lambert et al., 2020). It is not known from this included literature how PMHWs support CYP's MH needs specifically in schools.

The included literature also highlighted the constraints to EPs and PMHWs roles in supporting CYP with their MH difficulties (Greig et al., 2019; Hickey et al., 2010; Lacey, 1995). These constraints were identified as training needs and funding issues for PMHWs (Hickey et al., 2010). For EPs, capacity, and other's perceptions of their role (Greig et al., 2019) as well as parent/carer/ home pressures and their relationships with schools (Hulme, 2017) constrained EP's roles in supporting CYP's MH needs in schools. The included literature also suggests PMHWs are affected by other's perceptions of their roles in supporting CYP's MH needs (Hickey et al., 2010). However, it is not

known from these papers what the constraints are to the PMHW role, in supporting CYP's MH needs in schools specifically. The included papers also highlighted the impact of communication in hindering joint working of EPs (Greig et al., 2019; Hulme, 2017) when working with other professionals to support CYP's MH needs in schools.

This present review does not indicate what joint working difficulties EPs and PMHWs experience when working to support CYP's MH needs in schools. Overall, there remains questions around the PMHW role specifically in schools when supporting CYP's MH needs, facilitators of the EP and PMHW roles in supporting CYP's MH needs in schools, their joint working together and any difficulties they may or may not experience. As a result, the subsequent chapter aims to outline the present study to answer the gaps in the current literature identified in this review.

Chapter 3 Methodology

3. 1 Introduction to Chapter

The previous chapters have presented an argument for the need to gain a better understanding of the roles of EPs and PMHWs in supporting CYP's MH needs in schools, to better utilise resources effectively in the LA to improve MH provision. This chapter describes how this has been approached in this present research and the key methodological features of the study. The chapter begins by outlining the main aims and purpose of this research leading to the research questions. It then goes on to highlight the ontological and epistemological positioning of this research. The decision to utilise activity theory is then explained, followed by an overview of who the participants were and how they were selected. After presenting the data collection and analysis methods, issues relating to trustworthiness and ethical considerations are outlined.

3.2 Aims and Purpose

The aim of this research was to understand how EPs and PMHWs roles in supporting CYP's MH needs in schools intersect to optimise local resources effectively. This hopes to provide a framework for the LA to maximise support available for CYP's MH needs in schools. Also, beyond this current context, to support other LAs who may have similar difficulties with the same need in question to optimise their local resources. The purpose of the research is explanatory, to explain what might happen given different situations, consequences, and actions (Strauss & Corbin, 1998). The explanatory purpose sought to provide a framework to support the current problem to move forward in the advanced context in which the research was carried out.

3.2.1 Research Questions

The overarching question this research focuses on is: How do the roles of EPs and PMHWs intersect to ensure resources in the LA are being utilised effectively to provide optimal support for CYP's MH needs in schools? There are three additional questions which explore this further:

1. What do EPs and PMHWs hope to achieve when working in their services to support CYP's MH needs in schools?
2. What factors facilitate or hinder effective practice for EPs and PMHWs when supporting CYP's MH needs in schools?
3. How have EPs and PMHWs worked with each other in a LA and how do they perceive each other's roles in supporting CYP's MH needs in schools and what factors affect this?

3.3 Orientation

All research is underpinned by philosophical and meta-theories (Braun & Clarke, 2021). This next section will consider the ontological and epistemological underpinnings this present research is based on.

3.3.1 Ontology

Ontology refers to the nature of reality and being- what we think we can know (Braun & Clarke, 2021; Guba & Lincoln, 2005). This study adopts a critical realism (CR) ontology which first emerged by Bhaskar (1975, 1979) following the merge between realism and relativism (Bhaskar, 2008). CR suggests the truth is out there however this truth is socially and contextually dependent (Pilgrim, 2014), this will have been informed by various conceptualisations, perspectives, representations, and interpretations (Braun & Clarke, 2021). This stance suggests that language and culture are important considerations when determining the truth (Maxwell, 2012).

3.3.2 Epistemology

Epistemology encompasses how researchers generate knowledge and how we believe we think we can know it (Guba & Lincoln, 2005). As this research adopts a CR stance which sits between ontological realism and epistemological relativism, the epistemological stance is

also CR as it suggests the ontological and epistemological stance is an emergence between the two (Braun and Clarke, 2021). This can be interpreted in various ways however the theoretical stance in this research suggests there is a truth out there therefore CR will provide a truth that's out there but dependent on the participant's realities (Fletcher, 2016). The researcher through reflexive thematic analysis will bring their own contextual interpretations, therefore an absolute truth is never reached (Braun & Clarke, 2021).

The underpinning of CR in this current study sits alongside the Cultural Historical Activity Theory (CHAT) framework that was also adopted in this study. Like CHAT suggests, CR pertains truth which is obscured by cultural context and language which will determine participant's perception of reality (Braun & Clarke, 2021). Resembling CHAT whereby there are processes that determine the Objects and Outcomes, CR indicates that the truth and how we come about that truth will be affected by subjectivity and processes (Braun & Clarke, 2021).

3.3.3 Cultural Historical Activity Theory Framework

Cultural Historical Activity Theory (CHAT) encompasses a huge area of research and developments; therefore, this current thesis cannot include it all. However, the main origins and developments of this theory and framework will be outlined before justification of utilising this framework in this thesis is given.

The present research utilised the application of activity theory as a methodical and analytic tool. CHAT theoretical perspective, originated from Lev Vygotksy's work in Russia during the mid-1920's and mid 1930's within the Soviet Union. This work from Vygotsky and his colleagues was influenced heavily by the social and cultural turmoil during the Russian Revolution (Leadbetter, 2017). Vygotsky emphasised that learning is not independent of social and cultural factors (Daniel, 2016). The framework is based on a social constructionist view that an individual's behaviour is impacted by the social interactions with others in the system it is in (Leadbetter, 2017). Vygotsky

emphasised the importance of mediation in learning and the impact of social and historical factors on actions within a system, as opposed to stimulus-response in behaviourism (Leadbetter, 2017). Vygotsky highlighted that in groups of people trying to work together there will always be discrepancies about what the objective (the object they are working on) is (Leadbetter, 2017).

Since Vygotsky's death, this framework has been developed by Engestrom (1999), a key researcher in this area, to provide researchers with a method to understand and describe the interaction between individuals and the environment in natural settings. Here, it is recognised that changes in the system can create tensions and contradictions for the people involved in them (Yamagata -Lynch, 2010). Using CHAT as a methodology, helps to identify how human activity and the environment in which it occurs co-evolve over time and change the direction of future work, when the individuals deal with new barriers and possibilities of work (Yamagata-Lynch, 2010).

Activity Theory (AT) and specifically CHAT has been growing vastly over the past 30 years and has been applied to various health, social, psychological, and political contexts (Leadbetter, 2017). More recently, CHAT has been applied to research in educational psychology and has potential to promote change and enhance the work of EPs (Bakhurst, 2009, Leadbetter, 2017). CHAT is applied to this study to identify gaps within local systemic work between partner agencies to promote a whole systems approach to treatment for MH needs in schools, in line with government policy (PHE, 2019).

3.3.3 (i) First Generation Activity Theory

Vygotsky's first generation of AT is based on the idea of mediation rather than the stimulus-response of actions in behaviourism (Engestrom, 2001). This argued that individuals could no longer be understood without the impact of their culture. Vygotsky developed the triangular model which emphasised the impact of mediation on the subject and object. The subject position on the triangle can be taken up by an individual who is working on the object (the thing that is being acted upon or focus of the activity) (Leadbetter, 2017). This interaction is impacted by the top of the triangle, the

mediation, which consists of the tools or artefacts used to act upon the object, which is influenced by social and cultural factors (Leadbetter, 2017). However, first generation AT was limited to an individual focus which led to the inclusion of collective and communal aspects of activities, forming second generation activity theory (Engestrom, 2001).

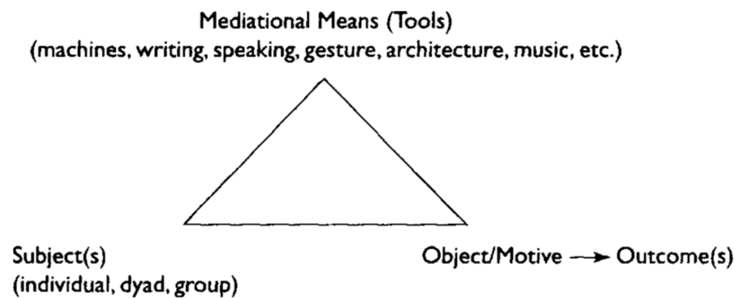

Figure 1: First generation activity theory model taken from Daniels (2001)

3.3.3 (ii) Second Generation Activity Theory

Vygotsky's initial development of AT was later expanded by his student Leonitiv to produce second generation AT which incorporated relationships between individual actions, the tools used and their outcomes with wider historical, cultural, social, and contextual factors (Engestrom, 2001; Leadbetter, 2017). This next generation of AT, included, rules, community, and division of labour, forming 6 nodes (sections) on the triangular model. These latter inclusions were based on Marxist thinking, involving other people who could be involved in any of the activities. This aimed to move away from 'action' which describes the act of a group or individual towards a goal to 'action' which entails the impact of a community which has its own 'object' and 'motive' (Greenhouse, 2013). Cole and Engestrom (1993) suggested that systemic contradictions and tensions affect human activity, creating pressure, which either hinders development or prompts growth. From this, the tensions, and contradictions between these different nodes on the activity systems which create conflict can be

identified and lead to change (Engestrom 1999). New systems can be created because of conflict resolution which will promote a better outcome (Greenhouse, 2013).

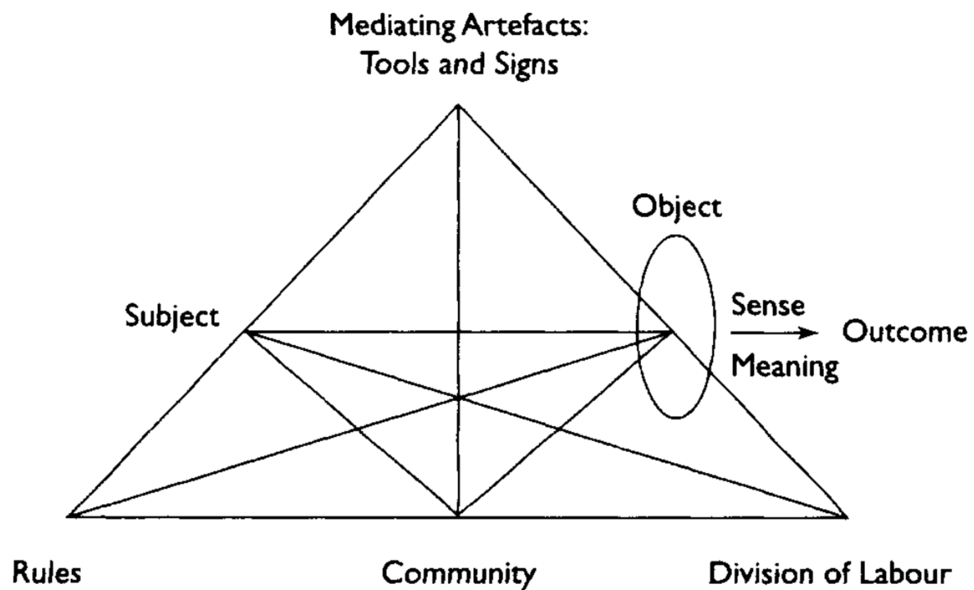

Figure 2: Second generation activity theory model taken from Engestrom, 1987, p.78, adapted from Daniels (2001)

Node	Description of the node
Subject	Who is the person/group/organisation perspective that we are taking?
Object	What is the focus or what is the person/group/organisation working towards? This can be very hard to define as this can be interpreted very differently depending on whose involved.

Outcome	What do they hope to achieve from working on that object?
Tools/Mediating Artefacts	What is being used to work on the object to reach the outcome?
Rules	What helps or hinders the work? What are the supports and constraints when working on the object towards the outcome?
Division of Labour	How is the work shared out and why? Who does what?
Community	Who else is involved in working on this object?

Table 3: A summary of CHAT nodes based on Leadbetter (2017) and Engestrom (1999)

3.3.3 (iii) Third Generation Activity Theory

The lack of cultural sensitivity and impact of different traditional perspectives the second generation offered triggered the development of Engestrom's Third Generation Activity Theory. This encompassed the impact of dialogue, multiple perspectives, and networks of interacting systems on the object and subsequent outcomes across two interacting systems (Engestrom, 2001). Within this generation, the object moves from an initial position to a collectively meaningful object before forming a jointly constructed object (Engestrom, 2001).

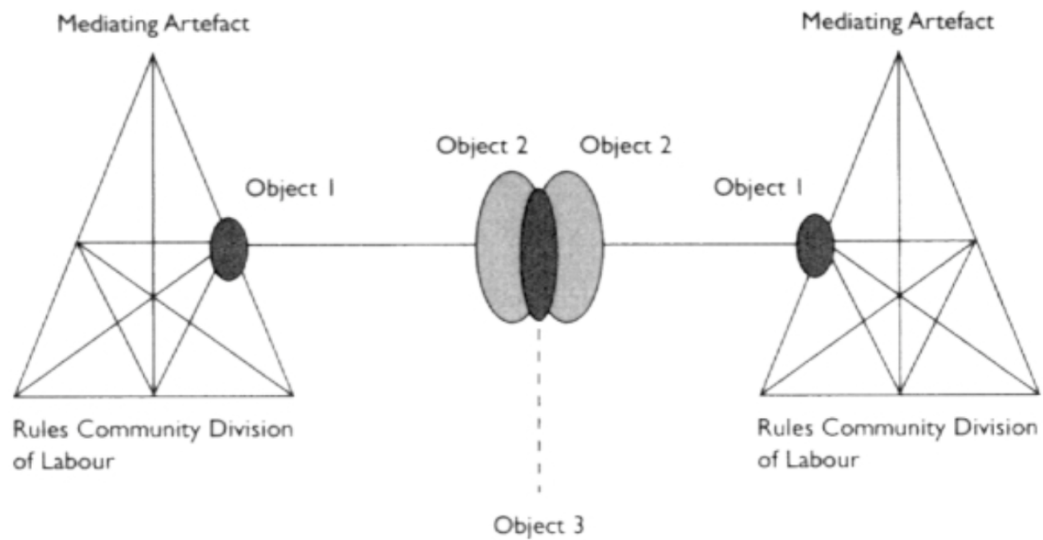

Figure 3: A third generation activity theory model of two interacting systems (Engestrom, 1999)

Third generation AT is based on five key principles. Firstly, the unit of analysis is collective, artifact mediated as well as an object-oriented system (Engestrom, 2001; Leadbetter, 2017), Secondly, activity systems are multi-voiced consisting of multiple points of views with different interests and traditions. The next principle is historicity, which implies that activity systems are formed over periods of time and historical components can impact on the system. The fourth principle, which is the most central to AT, are contradictions which are sources of tension which determine change and development within a system. It's the contradictions that are examined within and between systems to promote new ways of working (Engestrom, 2001). Finally, the last principle is the transformative nature of systems and by identifying contradictions new objects can be reconceptualised which may move individuals and systems away from their original norms (Engestrom, 2001).

Third-generation CHAT can be applied to multi-agency working as it encompasses the interactions of perspectives and networks across interacting systems (Greenhouse, 2013). AT has been applied to various multi-professional contexts recently to examine the interactions between the interacting systems and the impact this has on the object and subsequent new objects that may derive from these systems working together. By examining the tensions and contradictions between the

interacting systems, these highlight areas of change which can promote more optimal functioning of the wider organisation (Greenhouse, 2013).

3.3.4 Application to this present study

Although AT can be used to conceptualise activity, AT can also be applied to model organisational change (Bakhurst, 2009), this present research adopts the latter. With regards to this present study, support for CYP's MH needs in schools is part of a complex system, with many different individuals and systems involved (Bakhurst, 2009). There is a strong desire within the LA which is impacted by national movements as well as local projects from the professionals working within them to support the MH needs of CYP in schools (Bakhurst, 2009). However, it can be hard to achieve systematic analysis when managing complex real-lie data sets (Yamagata-Lynch, 2010). Third-generation CHAT enables researchers to identify systemic implications, by providing the researcher with a reference point to enable comparison between the themes that are derived from the data (Yamagata-Lynch, 2010). CHAT was applied as both a data collection and data analysis tool in attempt to provide a clear explanation of what factors impact on this object (support for CYPs MH needs in schools). Also, to offer a direction of how professionals can work alongside each other to minimise the lack of clarity surrounding this phenomenon.

Third-generation CHAT was decided to be included in this present research to investigate both the contradictions within each system of EPs and PMHWs operating in their own teams and the interactions between these services. This hoped to ultimately provide both an understanding of the object each professional group is working on as well as the possibility of new objects. Applying AT, provides the researcher with a manageable unit of analysis (Yamagata-Lynch, 2010). Real-world human experiences are complex, and it is hard to separate these out. Activity system analysis allows researchers to organise their analysis in a manageable way to extract meaningful data in a reliable way from complicated qualitative data sets (Yamagata-Lynch 2010). As well as this, another advantage of adopting this approach to this research allows the researcher to communicate findings

from the analysis and discuss the data sets in line with the units of activity identified in the analysis (Yamagata-Lynch, 2010). Third generation CHAT can be adopted as both participatory and interventionist role to help participants to experience change (Yamagata- Lynch, 2010). Taking an interventionist role, would involve carrying out Developmental Work Research (DWR) where participants would take part in focus groups to explore their views on the findings from the participatory part of third generation CHAT. This present research adopts only a participatory role because of the pressure of timescales of the doctoral thesis.

However, AT has been criticised by various researchers which provides limitations to adopting this approach to this present research. Bakhurst (2009) highlighted the vague nature of the 'contradictions' suggested by Engestrom (1999). The AT model bears a great deal of emphasis on contradictions; however, this is open to interpretation. This may be impacted by the different perspectives a researcher brings to the study depending on their views and positioning (Bakhurst, 2009). It is not without a doubt that this model is very flexible within both its descriptive and analytic nature, which offers both limitations and accreditations. Nonetheless, this framework was decided to be used as both a data collection and analytic tool for the purposes of this doctoral research as it provides the researcher with a tool to clearly identify the units of analysis within the system(s) and measure the interactions and subsequent contradictions to promote organisational change (Yamagata-Lynch, 2010).

3.3.5 Summary

CHAT can be used as both a descriptive and analytic tool. The former sets out to outline the main areas of the system where the latter aims to examine the relationships within the system(s) (Leadbetter, 2017). By applying this framework to this current doctoral research as both a data collection and analysis tool, the researcher hopes to be able to identify different aspects within the system and interacting systems, in line with Third-generation CHAT. Additionally, this present research also aims to encompass the fourth principle of AT, contradictions, within and between the

different professional groups of EPs and PMHWs. Activity systems analysis creates a clear method to help identify these contradictions (Yamagata-Lynch, 2010). By highlighting the areas of tension, they can be put forward to promote changes within the system and interacting systems (Engestrom, 2001) to utilise LA resources more effectively.

3.4 Research Method

3.4.1 Research participants

The populations of interest for this present research were both educational psychologists (EPs) and primary mental health workers (PMHWs). Purposive sampling was carried out from one Local Authority (LA) to ensure the participants were specifically selected due to them being the only ones to provide the data needed for the study. After agreement from the Senior Management Teams across the Educational Psychology Service (EPS) and Primary Mental Health Team (PMHT) within the same LA, EPs and PMHWs were invited to participate via an email from their head of services. This included information on the aims and expectations of the research (see Appendix 2). To allow time for potential participants to read the information and respond, EPs and PMHWs were given four to six weeks to reply depending on the response rate. The response rate was managed carefully by the researcher to ensure that there were both enough and not too many for the qualitative research. Six EPs agreed to participate via email within four weeks and three PMHWs within three weeks. Two more PMHWs replied via a prompt email to participate. Therefore, the final sample size was six EPs (six females) and five PMHWs (five females).

Although the sample size for this present study is small, this is typical for qualitative research. This number has been used for other research adopting a qualitative approach as the aim is to provide rich or thick descriptive accounts of the participants experiences (Smith et al., 2009).

The sample did not propose to represent the whole population, but to provide an in-depth explanation of the participants within their locality. Although, contextual information supports generalisability (Lincoln & Guba, 1985) to other localities, other EPs and PMHWs.

3.4.2 Data collection

Data on both EPs and PMHWs experiences supporting CYP's MH needs in schools was collected via interviews. As a result of the Covid-19 pandemic interviews were carried out online on zoom to ensure the safety of participants. Each participant engaged in one interview that lasted from around 45-60 minutes long. The interviews were semi-structured, and the questions consisted of open-ended questions with prompts under each one. This was to ensure that participants did not feel limited and could express their experiences freely, although prompt questions supported those that found this harder. The wording of questions differed depending on EPs and PMHWs. For example, EPs were asked about PMHWs and PMHWs were asked about EPs.

3.4.2. (i) Applying the CHAT framework to develop questions

The interview questions were each based on the different nodes of the AT framework (see appendix 3). This form of data collection had been successfully applied in other research studies that used a CHAT framework. The questions were developed based on the third generation AT framework using questions from various other CHAT studies and applying them to the present research (Durbin, 2009; Mwanza, 2001 Shanti, 2014; Yamagata-Lynch & Smaldino, 2007). Each question addressed each node, with the option of various prompt questions to apply if necessary. The researcher took the decision to ask the prompt questions if they felt it was necessary to elaborate participants answers further. Not all participants required the prompt questions.

Interviews were audio recorded via the zoom recording function. The transcription function on zoom was also used to support transcription. A second recording was carried out using the recording function on a separate secure laptop, to back up the recordings. The recordings were then transcribed following the interview.

3.4.2 (ii) Developing interview technique

A pilot interview was conducted to practise the CHAT questions and use of zoom in conducting the interview. As well as this, it was important to assess how the researcher asked the

questions and to ensure they were not influenced by their own biases coming from the EP field. This was particularly important when the researcher was asking the PMHW questions. The questions and interview technique were evaluated via a discussion at the end of the interview to ensure the questions were appropriate and the researcher yielded the data from the questions they needed to carry out this research. Discussion was also carried out about the use of zoom and the researcher checked their recordings and zoom transcriptions. The pilot participant felt the questions made sense and the use of zoom was sufficient. They also did not notice any bias in the approach the researcher took when asking questions aimed at the different professionals. However, it must be noticed that the pilot interviewee was a trainee educational psychologist (TEP) which could have caused further bias.

Researcher technique was continued to be reviewed throughout the interviews and notes were made immediately after each interview. This was particularly important when distinguishing the questions between EPs and PMHWs.

There is a potential issue of interviewer bias. My experience was a TEP who had experience in supporting CYP’s MH needs in schools. While I did not find it hard to remain non-judgemental and impartial, some of the participants were in the same service as myself. This may have influenced my role as a researcher as I could identify with the participants on a professional level. For instance, I was on one hand a little more relaxed with the EPs as I felt that I could relate to them on understanding their role in supporting MH needs in schools, however this also made me feel nervous at points as I wanted to present myself as a competent TEP. This in turn made me feel a little more relaxed and confident with the PMHWs as I felt that they did not know my professional role as well and were merely viewing me in my role as a researcher.

An additional issue was that participants did not always maintain their impartiality. For example, some of the PMHWs commented on how hard EPs were to reach which sometimes felt provocative and directed at me as a professional, taking away from my role as a researcher. The PMHWs kept asking whether the interview was a ‘confidential space?’. This led them to be able to

honestly share the emotional elements and the criticalities and frustrations they had experienced in their roles and service. As well as this, some of the EPs spoke a lot about the difficult context they had been in, which left me wanting to offer support however I had to remain impartial in my researcher role.

At times, some of the PMHWs would try and use the interview process to ask me questions about the EPS as they were aware I was in that service on placement. It was hard at times to refrain from answering their questions and have a conversation with them. I often had to explain I was able to talk to them afterwards but had to remain neutral during the interview process.

Some of the EPs became emotional in the interviews which offered them almost a therapeutic and cathartic space to share their experiences. They expressed at the end of the interviews that it was nice to have a space within their busy working schedules to reflect on their practice confidentially. As well as this, the EPs sometimes tried to identify with me and talk about things I may have done as a professional. Again, it was difficult at these times to refrain from relating to them as I was aware I was a trainee still trying to build relationships with colleagues in the service. At times some participants would call on things I have done in the service to support their answers.

Also, some participants would be careful in what they were saying about the service, as they perhaps felt that I may have fed this back to more senior managers within the service. Despite confidentiality and anonymity being stressed throughout the process, I do think some of the participants, particularly the EPs refrained from giving fully honest answers and disclosing full information as they may have felt that I would be aware of what or whom they were relating too. This was less for the PMHWs who seemed to disclose a lot more about leadership as they perhaps felt that I was unaware who they were talking about.

Despite this, I did feel that the EPs and PMHWs were very honest and shared lots of valuable in-depth information, which had great relevance to this current research.

As well as this, the impact of Covid-19 on this research may have also influenced data collection as the interviews were carried out online. Some participants completed the interview from their homes or offices. This could have influenced the answering of the questions as some may or may not have felt more open. Additionally, this may have affected the flow of the interviews, and some may have felt confident using this platform which could have altered how they partook in the interviews. The use of camera may have also affected participants ability to answer the questions if some felt this affected their focus within the interview.

3.4.3 Data analysis

3.4.3 (i) Inductive thematic analysis

Reflexive thematic analysis (TA) was applied to answer the three research questions, following Braun and Clarke's (2021) method. Inductive TA was the main form of reflexive TA applied to this research. Throughout data collection, specific points of interest were noted during and between interviews. The analysis followed the following six stages:

Phase 1 Familiarising yourself with the dataset

This phase started with transcription as the researcher transcribed all interviews from the recordings.

Following transcription, each interview was read through before coding commenced. Notes were made alongside the transcripts to record any initial thoughts and ideas. The zoom transcriptions were also referred to, to support the generation of the transcripts from the zoom recordings. The transcripts were then read through at least once before any initial coding began.

Phase 2 Coding

All participants transcripts were uploaded to Max QDA 20 to track the codes and themes. The EP and PMHW data set were placed into separate files on Max QDA 20, in order to work with the different data sets separately. At first the transcripts were arranged deductively under each node of the CHAT framework. This helped to match the data onto each node which could be linked to the

research questions. However, this became limiting for the researcher coding the data. It was difficult to fully immerse myself into the data when taking a deductive approach. The coding felt very surface level and at this point I decided to take 2 months away from analysis before coding the data inductively to ensure the inductive analysis approach was not influenced by the initial deductive approach. The node categories were removed, and the rest of the entire data set was coded systematically and inductively (see appendix 4 for an example of coding).

Taking advice from Braun and Clarke (2021) the datasets were worked through systemically working on each professional group at a time and coding segments of data. With reflexive TA both semantic and latent coding can be applied. The latter captures more implicit, unconscious meaning whereas semantic has more explicit meaning and uses language closer to the data (Braun & Clarke, 2021). This research adopted a mixture of both incorporating codes which sometimes used the language in the text, whilst also bringing some of the researcher's meaning to the codes in a latent way. Memos were produced for some codes to explain them further and any related notes and thoughts around them.

After the first initial stage of coding when going back to review the coded segments of data, it was noted that there were lots of duplicated codes, with over 2,000 codes for the EP datasets and 1,700 for the PMHW data sets. At this point the datasets and codes were worked back through to condense the codes and avoid duplication.

Phase 3 Searching for themes

Despite themes not intentionally being identified at the coding stage, the codes were colour coded to support the identified codes for specific data extracts. Mini mind maps were also produced during this stage which supported the grouping of codes and identification of themes.

Phase 4 Reviewing themes

At this point time was taken to reflect and retreat away from the TA process in line with Braun and Clarke (2021) suggestions. This enabled the researcher to take some time away from the process to critically reflect on the themes and to ensure they reflected the data.

Phase 5 Defining and naming themes

At this point, to support the defining and naming of themes, a handwritten approach was adopted. This entailed using sticky notes with different names on and moving them around within the CHAT triangle to support the researchers thinking (see appendix 5).

Phase 6 Producing the report

The report created the findings chapter. Each node of the CHAT framework was placed under the corresponding research question.

3.4.3 (ii) Deductive thematic analysis using a CHAT framework

Although an inductive stance was taken to carry out most of the data analysis, there was a deductive approach taken at the beginning and end to aid the organisation of the data under the CHAT framework. To support the production of the report, once the themes and subthemes had been defined and named, they were placed under each node on the CHAT framework. This enabled the data to be organised in line with the research questions, as each node was mapped under the research question.

Once data analysis has been undertaken and conclusions have been reached, participants will receive a brief summary sheet of the results and will be given an opportunity to discuss the findings with the researcher.

3.5 Trustworthiness

As this research is qualitative, it is not about whether this research matches a close real-world truth or can be repeated to form the same outcomes. Therefore, reliability and validity are considered in terms of trustworthiness in how this research is relevant to the people who work in this area

(Angen, 2000). Lincoln and Guba (1985) framework for ensuring trustworthiness of this present research is considered alongside the steps the researcher took to ensure trustworthiness.

3.5.1 Credibility

Credibility ensures the researcher can have confidence in the trustworthiness of the results from the research (Lincoln & Guba, 1985).

3.5.1 (i) Prolonged engagement

To support credibility, this present research was carried out in a local context that the researcher has been part of and continues to be part of for a prolonged period of time. This will help the researcher to gain an insight into the context this theory is developing and the ability to observe persistently to ensure prolonged engagement (Lincoln & Guba, 1985). By doing this, the researcher can be more confident that the research is carried out to accurately assess what it set out to identify (Robson & McCartan, 2016).

3.5.2 Transferability

Transferability enables the findings to be transferable and applicable in other contexts other than the present context this research is being carried out in (Lincoln & Guba, 1985).

3.5.2 (i) Thick description

In order to ensure this present research is transferable to other contexts, a thick description will be provided (Lincoln & Guba, 1985). In doing so, all information that the researcher draws on to inform the developing theory will be included by memo writing which will incorporate reflexivity comments, codes, and links (Sutcliffe, 2016). This provides transparency of how the researcher got to the theoretical framework, increasing the trustworthiness of the findings. This will then help other LAs in England and beyond decide whether they can transfer the theoretical model to their setting, based on the patterns and hypotheses the researcher drew on (Holloway, 1997). The research may be further transferable to other organisations where different professional groups are involved.

3.5.3 Dependability

As well as credibility and transferability, the researcher will take actions to ensure the dependability of the research to ensure the trustworthiness of the research. Dependability highlights the consistency of the findings and suggests how they could be repeated (Lincoln & Guba, 1985).

3.5.3 (i) Inquiry audit

The research will undergo an enquiry audit by an external researcher who is not involved in the research at question (Lincoln & Guba, 1985). This will occur when the researcher presents the research in a viva to an external examiner, from another university, who will question the process of the research and the final research findings (Robson & McCartan, 2016). This will ensure accuracy and validity of the study and highlight any required amendments to the research in order to make the research stronger (Lincoln & Guba, 1985). However, it must be considered that an enquiry audit will bring other interpretations of the research and relies on the assumption that there is a fixed truth that can be accounted for, from both the researcher and external researcher (Lincoln & Guba, 1985). This may create discussions around whether the present research or the points raised by the viva should stand. Careful consideration of both sides in this present research should be accounted for.

3.5.4 Confirmability

The final area of trustworthiness is confirmability which is concerned with the extent to which the data is shaped by the participants rather than the researcher's bias, motivation, or interest (Lincoln & Guba, 1985). Reflexivity has been considered in this present research to support confirmability, however there could have also been confirmability audit, audit trail and triangulation. It was felt by the researcher that this present doctoral thesis did not have the scope for this therefore will not be commented on for the purposes of this research.

3.5.4 (i) Reflexivity

It must be noted that qualitative research should not be considered without the researcher's own experiences and biases. Reflexivity consists of considering the knowledge

context and the researcher's positions and biases which they may or may not bring to their research (Lincoln & Guba, 1985).

To avoid false objectivity, the researcher's position and interests in the phenomenon are considered. In order to support reflexivity, the researcher kept a reflective diary which encompassed the researcher's experiences as they underwent the research journey. This included their own values, interests, and decisions they made (Lincoln & Guba, 1985). Regular supervision was also held to consider the researcher's biases which was particularly important at both the data collection and data analysis stages when working with the PMHW data from an EP perspective. Furthermore, to demonstrate this in this present doctoral thesis, an account of how the researcher came to this piece of work is noted in first person and italicised:

The decision to explore the role of EPs and PMHWs in supporting MH needs in schools came from my own experiences, which started when I was an Assistant Educational Psychologist (AEP), in an SEMH provision for boys aged 9-16 years old. As the AEP, I was keen to communicate with other MH professionals who could support the MH needs of the boys in the school. I often found myself confused about the joined working of the EP and PMHW roles, as well as other professionals, in supporting MH needs. This confusion continued when I started my doctoral training as a Trainee Educational Psychologist (TEP) and embarked on my first placement in CAMHS. During this time, I felt EPs were not always perceived as having a role in supporting MH needs, which added to my confusion and caused feelings of frustration.

When I started my LA placement, I noticed how separated from PMHWs and the PMHT EPs were, yet schools were reaching out to me to help work out the similarities and differences between us and how they could best utilise us to optimise the minimal resources provided to them. This left me curious about why different professionals, working across the same LA, did not always understand each other and what hindered this process. During this time, I encountered a local project in the service which hoped to provide more holistic support for

CYP's MH needs, by encompassing a variety of local services. As well as this, I discovered Cultural Historical Activity Theory (CHAT) for the first time and was intrigued by the application of this tool to real life social contexts to help tease out tensions and contradictions within and between professionals. This would hopefully highlight areas within services that needed adapting to provide improved services to their clients. By embarking on this research journey, I hope to discover more about why and where my confusion and frustrations have come from, which will hopefully provide more optimal support and better utilisation of local resources for supporting CYP's MH needs.

3.6 Ethical issues

Ethical approval from the Tavistock and Portman Trust Research Ethics Committee was obtained. Written approval from the two heads of services was also obtained.

3.6.1 Consent

Consent forms were disseminated alongside information sheets to participants. Participants were all asked to complete and return the consent forms before proceeding with the interviews. The researcher also obtained further verbal consent at the beginning of each interview.

3.6.2 Withdrawal

Participants were aware of their right to withdraw from the research at any point up to data analysis. They were also given the option to terminate the interview at any point they felt uncomfortable. This information was given in the consent form and participants were reminded verbally by the researcher at the beginning of each interview.

3.6.3 Anonymity and confidentiality

All transcripts were anonymised, and identifiable details were omitted. Recordings were identifiable by random initials only. Data was stored on a password protected computer. As well as this, identifiable data to the LA was adapted to ensure anonymity. Participants carried out their

interviews in a confidential space and the researcher ensured they were also in a confidential space. This was particularly important for the online platform of data collection.

3.6.4 Risk

It is identified that discussion around CYP's MH needs is emotive and therefore the possibility of causing distress in participants was supported by the researcher. There was the possibility that some participants may have experienced MH difficulties in their own childhoods or were parents of CYP with MH needs. As well as this, this research required participants to be reflective about their own practice during a particularly difficult time. The researcher was aware that participants may not have been operating in typical contexts which could be frustrating and upsetting for the professionals. The steps that were taken by the researcher to support the participants and reduce the risk of causing harm are outlined below.

3.6.4 (i) Mitigating upset, promoting respect & preventing harm

This present research could raise tensions between the different professional groups, whilst asking their views on theirs and other's roles in MH in schools. Participants were reminded to be respectful to other disciplines before and throughout the interviews. All participant's voices from both services will be heard, to also help reduce bias.

Throughout the interviews, the researcher monitored participants in case they were showing any signs of distress. Should this have occurred, a discussion would have taken place to explore whether a break or withdrawal would be helpful. In addition, at the end of the interviews the researcher enquired about participant's well-being and checked to ensure they were not showing any signs of distress. If this had occurred, the researcher would have provided an immediate debrief and, if necessary, would have arranged a follow up well-being check, including signposting to services whereby the participant could access support.

3.6.5 Data protection

All participants were made aware of how the data would be used and stored in accordance with the Data Protection Act 1998.

3.7 Summary

This present chapter demonstrates the ontological and epistemological positioning of this current research which influenced the methodology carried out to answer the main research questions. It has identified the application of CHAT in both the data collection, developing the research questions, process, and analysis of the data. It has also outlined a detailed description of the data collection and analysis to attempt to explain this particular phenomenon of this study. The reliability and validity of the research has also been considered as well as the wellbeing of the participants, including actions taken to ensure anonymity and data protection. The subsequent chapter highlights the main findings from the data analysis in line with each research question and the CHAT framework.

Chapter 4 Findings

4.1 Introduction to Chapter

This chapter provides an outline of the findings from this research in line with the research questions. Each question is addressed by firstly presenting the findings from EPs, followed by the findings from PMHWs. Then the tensions and contradictions across the two different systems and the professionals within them are presented. Accounting for the CHAT approach, the aim of this research is to reveal contradictions and tensions to demonstrate directions for future change within and between the two interacting systems. However, some similarities between the EPs and PMHWs will also be described to support contextual understanding as part of the wider research questions where it is felt useful to include these elements to avoid confusion. This will also be used to compliment the additional factors in the discussion section to consider the efficiency of local resources.

4.2 Overview of Findings

Appendices 6 and 7 provide an overview of the themes and subthemes identified from the EP and PMHW transcripts. The table below provides an overview of the themes and subthemes, organised in line with the corresponding activity theory nodes.

Node	EP Theme	EP Subtheme	PMHW Theme	PMHW Subtheme
Object	Promoting Overall Wellbeing		Mental Health Diagnoses	
			Wellbeing	
	Adult Mental Health Support		Neurodiversity	
Community	School Community		School Community	
	Outside of School	Community-Based Professionals		
		Family Context	Parent Support	

Tools	Relational Approach	Preventative Work	Direct Work and Early Intervention	
		Systemic Work	Work with Adults	Parent Work
		Intervention		School Staff
				Social Care Meetings
Rules	Resources	Time Issues	Resources	Time Issues
				Training Needs
				Money
		Emotional Capacity	Local and National Government Policy	Pressure from Government
				Local Decision Making
		Money	Social Care	Social Care Needs
	Others' Perceptions of The Role of the EP	Historical Conceptions		Social Care Provision
		Government Policy and Legislation	Educational Issues	
Division of Labour	Differing Levels of Engagement in EP Work	Own Interests and Passions	Team-Based Issues	Working Remotely
		Allocation of Link Schools		Positives of Working In the Team
	EP Views of PMHWs	No Clear Understanding		
		Early Intervention	Views of the EP Role	Statutory Work
				Joint Working
		Staff Support		
		Need for more Joint Working		

Table 4 Overview of the EP and PMHW themes and subthemes with each corresponding activity theory node

4.3 Findings in relation to RQ1- What do EPs and PMHWs hope to achieve when working in their services to support CYP's MH needs in schools?

Within the category 'Objects', two themes arose from EPs (promoting overall wellbeing and adult mental health support) alongside two themes from PMHWs (specific mental health difficulties and wellbeing) address this research questions.

Node	EP Theme	EP Subtheme	PMHW Theme	PMHW Subtheme
Object	Promoting Overall Wellbeing		Mental Health Diagnoses	
			Wellbeing	
	Adult Mental Health Support		Neurodiversity	

Table 5 The nodes, themes and sub themes that contribute to answering RQ1

4.3.1 Object: EP findings

4.3.1.1 Theme: Promoting Overall Wellbeing

All EPs claimed that emotional wellbeing and MH support should be the priority before any other educational demands are placed on CYP.

"... you also need to actively promote actively promote the well-being." (EP 5)

"And so, I think there's a national move, as well as you know there's work going on with Ofsted to try and think about how they better look at the personal development of students and emotional development rather than just academics." (EP 6)

"I don't mean that in terms of the education side for me, academic achievement and goals are secondary if, for some children, that's a contributing factor to them feeling anxious about school then that would be my focus on questions but my main priority I see first and foremost is I'm a psychologist, and I know every psychologist has a different spin, but I see that so my priorities are well-being." (EP 2)

EPs discussed how wellbeing and MH needs operated interchangeably as improved wellbeing would be both an outcome of their practice in supporting MH needs in schools and by supporting wellbeing there would be improved MH for CYP in schools. EPs described the importance of developing resilience in CYP. Furthermore, they explained the importance of CYP feeling a sense of

belonging and safety. EPs also talked about support for trauma to provide support for overall wellbeing. EPs described how they hoped to be proactive and preventative in their work when supporting CYP's MH needs. One EP argued that the term 'mental health; should be changed to 'wellbeing' to provide a more proactive, hopeful stance around MH by changing the language we use when referring to MH difficulties.

"...I know it's just a question of semantics and language, but I often talk about emotional well-being rather than mental health and it's not that I see those two things is different." (EP1)

4.3.1.2 Theme: Adult Mental Health Support

Not only did EPs discuss their hopes in supporting the MH needs of CYP in schools, but they also described their role in offering adult MH support to the adults working with the CYP, to promote more positive MH outcomes for the CYP in schools. Many of the EPs spoke about offering support for school staff's wellbeing, through consultation, training, or supervision. Some EPs described MH support for parents of CYP to create greater positive outcomes for CYP with MH needs.

"I believe very much in the research around the fact that, you know, the adults around the child needs to have the emotional capacity to be able to then provide the emotional capacity to children for their own mental health and well-being. So, I think from that perspective, it's about just thinking very much about the whole systems, and what we can do to influence everybody within that system so quite often even when I go in as an EP, I will often think, okay, if the children are not having a great time. What are the adults looking like around them and you often see that it goes all the way up the chain?" (EP 1)

4.3.2 Object: PMHW findings

4.4.2.1 Theme: Well-being

Similarly, to EPs, all PMHWs discussed their role in supporting wellbeing, including physical and mental wellbeing to support CYP's MH needs. PMHWs also spoke about developing resilience in CYP to promote greater well-being outcomes. Generally, PMHWs believed their roles

were focused on early intervention and prevention when low level MH difficulties begin to present in CYP.

"Resilience. I hope to achieve resilience. I hope to achieve them to be able to reach their goals, their hopes, their dreams. I want them to be able to go out and live and be curious and have a curiosity about learning." (PMHW 3)

"…schools end up talking to us about the children that are really struggling, or needing a lot of staff support, but I think our hope is that eventually we will get to talk about those children, who are only just showing signs of anxiety, or where things are happening in their lives. Like a bereavement, or parents splitting up or their normal everyday life experiences that might have an impact on their emotional development. And it's about getting in there early enough to prevent things getting to that more challenging complex entrenched point." (PMHW 1)

4.4.2.2 Theme: Specific Mental Health Difficulties

Unlike EPs, PMHWs discussed their role in providing support for specific MH difficulties. This included providing targeted support for anxiety, depression, eating disorders, PTSD, self-harm, and low mood. This suggests that PMHWs aim to provide support for CYP with specific MH disorders, as well as well-being.

"…we had also created a whole raft of separate bespoke trainings, which included Low mood, anxiety, self-harm PTSD and ADHD." (PMHW 5)

4.4.2.3 Theme: Neurodiversity

A further subtheme for PMHWs was neurodiversity which did not come up for EPs. Some of the PMHWs commented on their role in supporting CYP with a diagnosed neurodevelopmental condition. Many of the PMHWs reported that their work depended on the needs of the CYP and whether they had a diagnosis. Specifically, many spoke about working with CYP with ASD and how this should be supported separately from specific MH needs.

"We seem to have a lot of emotional regulation, a lot of young people with autism on our caseload at the moment or ADHD." (PMHW 4)

"So, we identified that quite a lot of the work that we were doing when it was helping parents to manage their children, particularly when their children were neurodiverse." (PMHW 5)

There were however differences in this amongst PMHWs, some PMHWs felt that EPs are more equipped to support CYP whose neurodevelopmental conditions have a larger impact on their well-being than their specific MH need. These PMHWs shared that it was important to understand a difference specifically between a MH issue and a need related to their neurodevelopmental condition.

"My understanding is that schools have a certain allocated amount of educational psychology time, which means that they tend to see the children with the educational issues and problems and needs that are affecting them, perhaps, the higher end of the spectrum." (PMHW 4)

4.3.3 Tensions and contradictions between EPs and PMHWs

4.3.3.1 Differences in Overall and Specific MH support for CYP

The main difference in EPs and PMHWs accounts about their practice related to the EPs being more focused on overall wellbeing, including promoting belonging and trauma support, whereas the PMHWs were more focused on 'treating' specific MH difficulties. PMHWs discussed how they see CYP and their families for 'treatment'.

"And we see young people and children and families for treatment sessions". (PMHW 4)

4.3.3.2 Differences in Involvement for Adults

Another key contradiction related to EPs perceived role in supporting CYP's MH needs in schools through provision of systemic, adult MH support. EPs discussed how their roles in supporting CYP's MH needs in schools involved working with staff members a lot of the time. Whereas PMHWs work tended to be focused on time with the CYP directly to support their MH needs. However, some PMHWs did talk about supporting parents of CYP to support them in supporting CYP, but this was focused on those with neurodevelopmental conditions and associated MH difficulties. This suggests there may be some differences between PMHWs in their aims in supporting CYP's MH needs in schools.

"I would say a key contribution that we can make as EPs, is that sort of systemic level of work, where we're supporting leadership teams, and

we're supporting staff, and to then be able to support the emotional well-being at that sort of universal level. But I think that's really where our unique contribution comes in." (EP6)

"I basically I do …intervention, I've said intervention, conduct interventions with children." (PMHW 3)

In summary, these findings suggest the EPs and PMHWs are working towards similar outcomes in improving overall well-being in CYP, including promoting resilience in CYP to support their MH needs in schools. There may be some specific differences relating to the degree to which they worked with adults and whether the emphasis was on diagnosed conditions.

4.4 Findings in relation to RQ2: What factors facilitate or hinder effective practice for EPs and PMHWs when supporting CYP's MH needs in schools?

Table 6 shows the nodes, themes and sub themes that contribute to answering RQ2. The themes and subthemes will be explored under each node for each professional group, as well as the tensions and contradictions within each professional group, before discussing the tensions and contradictions between the two professional groups.

Node	EP Theme	EP Subtheme	PMHW Theme	PMHW Subtheme
Community	School Community		School Community	
	Outside of School	Community-Based Professionals		
		Family Context	Parent Support	
Tools	Relational Approach	Preventative Work	Direct Work and Early Intervention	
		Systemic Work	Work with Adults	Parent Work
		Intervention		School Staff
				Social Care Meetings
Rules	Resources	Time Issues	Resources	Time Issues
				Training Needs
				Money
		Emotional Capacity	Local and National Government Policy	Pressure from Government

				Local Decision Making
		Money	Social Care	Social Care Needs
	Others' Perceptions of The Role of the EP	Historical Conceptions		Social Care Provision
		Government Policy and Legislation	Educational Issues	
Division of Labour	Differing Levels of Engagement in EP Work	Own Interests and Passions	Team-Based Issues	Working Remotely
		Allocation of Link Schools		Positives of Working In the Team
	EP Views of PMHWs	No Clear Understanding		
		Early Intervention	Views of the EP Role	Statutory Work
				Joint Working
		Staff Support		
		Need for more Joint Working		

Table 6 The nodes, themes and sub themes that contribute to answering RQ2

4.4.1 Community: EP findings

4.4.1.1 Theme: In school

EPs all commented on the importance of the roles of Emotional Literacy Support Assistant's (ELSAs) and Special Educational Needs Coordinators (SENCOs) and school counsellors in supporting CYP's MH needs in schools. EPs stated that these key roles support their role in facilitating support for CYP's MH needs in schools. These roles are important as these adults have the day-to-day relationship with the CYP.

"…but other people like ELSAs and school counsellors I think have that kind of day-to-day relationship with children that we don't, we struggle to have as kind of external professionals. So, I think they can often work as those key adults' kind of checking in and containing the children in the kind of day to day." (EP 3)

However, on the other side of this, these roles can constrain the support EPs put in place for CYP's MH needs. EPs commented on the role of the SENCO in this as they contract the work with

EPs. If the SENCO has not referred the CYP to the EP, then they may not get the MH support an EP can provide.

"…SENCOs are that really crucial role even though it's not under their job title, they are almost the triagers, they're the ones that have to make decisions on who they refer these to." (EP 2)

4.4.1.2 Theme: Outside School

Within this theme, EPs discussed the importance of outside services such as CAMHS, private counsellors, charities, and specialist teachers in providing support for CYP's MH needs in schools. Some EPs also commented on the introduction of other roles such as wellbeing practitioners linked to the NHS, but not understanding their role in the LA and how EPs could work with them to support CYP's MH needs in schools.

*"We've also got like the well-being nurses or something.
And this is, I mean, this seems to be loads going on at the moment and I don't quite understand it here with well-being practitioners and well-being nurses and they're based in hubs there's going to be these new mental health hubs that bring together local Authority third sector and NHS."* (EP6)

4.4.1.2 (i) Subtheme: Home

This subtheme captured EP's explanations of how home factors can constrain or support EP's practice when working with CYP's MH needs in schools. EPs discussed the importance of a stable home environment including the impact of money, food, and consistent housing in relation to this. EPs felt that if this stability is not there, then it is difficult to offer the MH support for CYP.

"Complicated home situation where they don't have enough money and they don't know where they're going to be living. Of course, you're anxious. Of course, of course, like, he can't concentrate in school. So, like, when we kind of say oh he's got anxiety when actually, he just needs his family, needs a home to live in and food on the table." (EP 5)

4.4.2 Community: PMHW findings

Like EPs, PMHWs discussed how support for CYP's MH needs in schools should be supported throughout the community and support can be divided into in-school and outside of

school. One PMHW highlighted the importance of everybody, including all in school and outside school professionals as well as parents, being involved in supporting CYP's MH needs in school. The PMHWs shared that if this support does not come from everybody around the child, then this will hinder the PMHW role in supporting CYP's MH needs in schools.

"Everybody, it's it's everybody's business, it's like safeguarding it's everyone's business whoever that young person comes into contact with, they need to have a positive experience, or they need to be supported to build the resilience to find strategies to be able to help positive experiences." (PMHW 3)

4.4.2.1 Theme: In school

All PMHWs stressed the importance of ELSAs, SENCOs, TAs, school nurses, school counsellors and home school link workers in facilitating support for CYP's MH needs. However, some PMHWs felt that the lack of contact they have with key adults in schools who support CYP every day, negatively impacts on the effectiveness of PMHW support for CYP's MH needs in schools. PMHWs felt that professionals in schools are not always aware of the PMHW role in supporting CYP's MH needs which can hinder referrals made to them as they often only come from one key person such as the SENCO, which prevents the possible support they could be providing for CYP's MH needs in schools.

"…but that means that we're missing out on a whole bunch of young people with mental health issues, who the teachers might be aware of but don't know who to refer to or don't know who to have conversations with." (PMHW 5)

4.4.2.2 Theme: External Services

Like EPs, PMHWs discussed the importance of external services, such as CAMHS, psychiatrists, art therapists and charities such as Barnardo's and the National Autistic Society, in filling in the gaps for MH support which PMHWs do not have the capacity for. PMHWs also shared these services can provide CYP with more specialised support that PMHWs do not have the skills or knowledge in. PMHWs shared the importance of CYP having access to specialist support such as specialist roles for specific issues.

"It's really helpful being able to go and talk to a psychologist or an Art Therapist or Psychiatrist, if you've got a specific issue about a child that you know that they could help with." (PMHW 4)

4.4.2.3 Theme: Parent Support

Like EPs, PMHWs spoke about, CYP's home environments having an impact on their MH needs. PMHWs highlighted different ways in which home environments constrained their work. Many of the PMHWs shared how their practice was sometimes hindered by a lack of relationships with parents. PMHWs felt that their role in supporting CYP's MH needs in schools has limited impact because the changes needed from parents in the home environment do not happen to optimise support for CYP's MH difficulties.

"...parents are not involved enough, they are not, they don't understand that they are pivotal in their child's mental health and well-being." (PMHW 3)

4.4.3 Tensions and contradictions

4.4.3.1 Parent relationships

The main contradiction between EPs and PMHWs within the community node was the lack of relationships PMHWs have with parents hindering their effective practice in supporting CYP's MH needs in schools. PMHWs felt parents played a significant role in supporting CYP's MH needs and when this support does not happen from parent's then the support PMHWs put in place for CYP is not as effective as it would be with optimal parent support. Contrastingly, EPs did not comment on the parent involvement specifically rather more on the home environment in terms of financial factors.

4.4.4 Tools: EP findings

4.4.4.1 Theme: Relational Approach

All EPs discussed the importance of utilising relationships to support their practice when working with CYP with MH needs in schools. EPs expressed how crucial it was to have a relationship with either the CYP or adults around them to facilitate the support for CYPs MH needs.

"I think a lot of the work I do is on developing relationships, and, and I always am coming back to the importance of relationships with everything I do." (EP6)

4.4.4.1 (i) Subtheme: Preventative Work

Most EPs discussed how preventative work was key in supporting CYP's MH needs in schools. This often-involved psychoeducation with school staff, parents and CYP themselves and starting this work before issues developed. However, most EPs felt that they were unable to carry out as much preventative work as they would like

"…early preventative skills so knowing that in my dream, in year 1and year 2 they struggle to talk about their feelings, let's get straight into ELSA let's not wait until they're struggling to talk about their feelings which results in big behaviour or whatever difficulties come out, or mental health needs come out let's just spot that they have a gap in their emotional literacy skills so let's get in there really early." (EP 2)

4.4.4.1 (ii) Subtheme: Systemic Work

As well as working preventatively, EPs discussed the use of systemic work to support their practice. This involved working with the adults around the child to develop whole school approaches.

"And then there's kind of the systemic work thinking with Senior leadership about leadership teams about their policies and practices, how do we change things that this whole school level, how do we plan." (EP6)

EPs discussed how they carried out consultations with management teams to think about behaviour policies, as well as staff supervision, and whole school training to empower the staff to support CYP's MH needs.

"Well, I work through others so it's it's not that I would be directly improving children and young people's mental health. I see myself very much as cascading skills so that I am enabling teachers, ELSAs, teaching assistants, the whole system really to improve the way that they meet their mental health needs in our schools." (EP 4)

However, EPs explained that there may be differences in what systemic work is carried out between EPs and schools depending on their own approaches in supporting MH needs in schools.

EPs believed that this may derive from their different personal interests and passions, which could also affect how their different teams support MH needs in schools.

*"And I think that each EP will probably be quite different in how they negotiate that work, based on what they're comfortable with, what they prefer to do what their interests are.
And so, I would probably often be doing lots of training or work with the leadership team and someone else might do more consultations or more assessments or whatever it is."* (EP6)

4.4.4.1 (iii) Subtheme: Intervention

The other main Tool identified within the EP transcripts was the use of intervention to support practice. Some EPs discussed how they used CBT approaches in their work as well as mindfulness and other therapeutic approaches. Some EPs felt that they did not have time to carry out intervention work to support CYP's MH needs. Differences were noted with how much intervention work EPs wanted to carry out. Some expressed that they felt that other professionals, such as PMHWs, should carry out direct intervention work, whereas others felt that they would like to be engaging in more direct intervention work with CYP.

*"The thing that I don't do much of is intervention that's like the fifth function isn't it of the EP? And, and I really enjoyed it when I did it in my training but it's just not something that schools prioritise my time for, it's very hard for me to go
to do weekly sessions, you know, after school if I had some particular part of time that was allocated that I could be much more flexible with. I think it's very hard for us, for me to be able to go back into that therapeutic intervention, even though
we can but what we can do is take a lot of those therapeutic techniques into our sessions with children when we're gaining their voice you know like let's do a hot cross bun together."* (EP 6)

*"And, I mean, I personally, you know, use a lot of my therapeutic work and advocate for it but there could be an EP that will certainly buy into that or CBT they might have seen lots of theories that have this is quite effective for children
so, you could be giving different messages you could be working differently."* (EP 2)

4.4.5 Tools: PMHW findings

4.4.5.1 Theme: Direct Work with Children

PMHWs discussed how they carried out direct treatment, over a fixed period, to support CYP with a specific difficulty. This involved CBT or other therapeutic approaches.

"And we see young people and children and families for treatment sessions so roughly, I can't remember how many a term, but at the moment I've got about 10 I'm seeing sort of every week or two weeks or so, and that's usually for, well it's for a range of different needs, we seem to have a lot of emotional regulation cases." (PMHW 4)

4.4.5.1 (i) Subtheme: Early Intervention

PMHWs described their role as being focused on early intervention to facilitate effective support for CYP's MH needs. PMHWs described times when their role was utilised at a later riskier level and how they viewed their role to be supporting at lower to medium

levels of risk, but due to the capacity of CAMHS they have worked with CYP at high risk levels of MH crisis. PMHWs expressed that their role is more successful at supporting CYP's MH needs in schools if they carry out intervention at an early level.

"I think that the main aim and our main focus as practitioners is about early intervention." (PMHW 1)

"And actually, what everybody does is very low level, kind of stuff until it gets to the primary mental health worker, who is holding the risk before it goes on to crisis. And the problem with the crisis is it's such a tight remit that the Primary Mental Health Worker is holding the majority of it." (PMHW 3)

"It can have a quite a positive impact, particularly if we are consulted early enough, or if we see young people early enough." (PMHW 4)

4.4.5.2 Theme: Work with Adults

Like EPs, PMHWs also used work with adults to enhance their role in supporting CYP's MH needs in schools. PMHWs described mainly holding parent workshops as well as using psychoeducation and consultation with school staff. PMHWs shared how this helped to empower staff and parents to help them feel more confident and equipped when supporting CYP's MH needs in schools.

"So, making staff feel confident in managing their own anxieties and getting worried about children's mental health. Helping them with how to respond, and when to refer, so the referral rates have gone down, because staff are feeling more confident in managing these things and the referrals that do come through are more appropriate referrals. So, I think in that sense it benefits the children because they're not being afraid of sitting on a waiting list and not getting support." (PMHW 1)

4.4.5.2 (i) Subtheme: Parent Work

As well as working with school staff, some PMHWs shared their experiences of utilising parent work to support CYP. Two PMHWs spoke about a workshop they devised, to support parents as co-therapists in supporting their CYP. This was particularly designed for parents of CYP with neurodevelopmental conditions and associated MH difficulties with their diagnoses.

"So, if a child is put on our primary mental health waitlist for anxiety, with ASD, and we think that the suitable mum, will be suitable for the course, then we would approach them and say this is what we can do. Otherwise, you'd be waiting on the list as well we've got a thirty-nine-week waiting list, but we can, we can do this.
And then if you try this then then you might not need to come back and it's yeah, that's how we do it. So, we are treating the child through the parents, yeah." (PMHW 3)

4.4.5.2 (ii) Subtheme: School Staff

Like EPs, PMHWs shared the work they carry out with school staff to aid effective practice. PMHWs used trainings, consultations and psychoeducation when working with staff to support CYP's MH needs in schools.

"And my role would also be to make sure that the schools have training and basic mental health awareness." (PMHW 5)

"And that's, I think one area that sometimes we do overlap with the educational psychologists particularly attachment, I think they were offering attachment training for a while." (PMHW 4)

4.4.5.2 (iii) Subtheme: Social Care Meetings

PMHWs shared that they tend to attend social care meetings such as Team around the Family (TAF) meetings. PMHWs suggested this was an important aspect of their practice in supporting CYP's MH needs in schools. They felt this helped professionals to consider all the different factors

that could be affecting a child's MH such as social care needs. Furthermore, PMHWs suggested this helped to keep all professionals on the same page to optimise support for CYP's MH needs.

"We participate in TAFs if that's needed, if there is sort of Child Protection you know safeguarding Child Protection, we have a role in supporting that part of the work as well." (PMHW 2)

4.4.6 Tensions and contradictions between EPs and PMHWs tools

4.4.6.1 Training

Both EPs and PMHWs reported that they carried out training with school staff to enhance their practice in supporting CYP's MH needs in schools. There was some overlap in trainings offered by both groups of professionals, particularly when training staff on attachment. Some PMHWs expressed how they felt skilled to carry out attachment training whereas others expressed how EPs may have more knowledge and skills in this area, therefore this should be the role of the EP.

"Yeah, the other is attachment training so one of our official core trainings is attachment, and again there's that overlap between us providing attachment training versus the compassionate schools from the Educational Psychology Service." (PMHW 1)

4.4.6.2 Work with Adults

As well as training, both PMHWs and EPs discussed their use of work with adults to support their practise in CYP's MH difficulties. Across both professional groups, consultation and psychoeducation were used to support both parents and school staff. EPs discussed their use of more systemic work with school staff whereas PMHWs spoke about parent workshops. Although there may be some differences, there are overlaps in the Tool's EPs and PMHWs are using in supporting CYP's MH needs in schools.

4.4.6.3 Time Involved with CYP

Another difference between the EP and PMHW roles is that PMHWs tend to have a more direct involvement over a longer period with CYP than EPs. PMHWs described the use of

'treatment' and direct intervention when supporting their practise in CYP's MH. However, some EPs expressed that they would like to carry out more longer-term therapeutic work with CYP.

4.4.7 Rules EP findings

4.4.7.1 Theme: Resources

All EPs articulated that insufficient resources were the biggest constraints in effectively supporting CYP's MH needs in schools. They spoke of limited human resources, including time and capacity, as well as limited financial resources in supporting their practice with CYP with MH needs.

4.4.7.1 (i) Subtheme: Time Issues

EPs shared that they had insufficient time to offer support for CYP's MH needs in schools. As well as this, they believed that long waiting lists often constrained support available for CYP's MH needs. EPs felt the time they gave to EHCPs, and statutory work hindered the MH provision they can offer.

"Yeah, so definitely the high level of statutory work we have can sometimes feel like a barrier to kind of that support. I think with a lot of mental health issues, obviously, it's much better to get in earlier and often it feels like the demand of the statutory work means that, there's not as much preventative work as we would like and therefore mental health issues kind of progress and get more severe before we're kind of involved." (EP 3)

"So, I think, as well, that's another, another tricky thing where it just feels like the young people aren't getting the care at the time that they need it because of long waiting lists, but then when they do receive the care they have to get discharged, because they've got to a point where actually they're not able to maybe engage with that successfully." (EP 1)

"Time, just time, what would give me time to give me time, I would need the number of my statutory assessments to be capped." (EP 4)

Furthermore, some EPs felt that they did not always have the time to undergo continuous professional development (CPD) to develop their ability to support MH needs in schools.

"So, I do think time for CPD not just time for accessing courses, but also being able to really understand and interpret the evidence base so that we can be giving that to schools I think it's really important." (EP 1)

4.4.7.1 (ii) Subtheme: Emotional Capacity

Most EPs spoke about their wellbeing impacting on their ability to support CYP's MH needs in schools. One EP talked about the secondary trauma experienced from working with challenging cases.

" It would be important to mention our own well-being as professionals and knowledge of secondary trauma you know we do all this work …What about us? What about compassion fatigue within the profession?" (EP 4)

EPs discussed how this led to high staff turnover because of EPs not being able to cope with both the high workload and lack of support for their own well-being. EPs felt the workload impacted on their ability to be creative and have the capacity to reflect, which ultimately constrained their ability to effectively support CYP's MH needs in schools.

"And that's hard to do when there's pressing things for the deadlines that are working around you, and it's about time but more, it's more workloads than time I think, and just feeling quite stressed, I think, and stress getting in the way of maybe what impacts upon my creativity as well you know you can't be free and think easily when, when you're feeling really stressed and I would say, I feel stressed about work more than 50% of the time." (EP6)

"We know in our field, everyone just gets to 2/3/4/5 years qualified and becomes private goes locum because the pay is so much more for doing essentially the same role, and there's got to be a way of looking at this systemically and thinking, we need EPs, we need enough EPs to do all of the statutory work, and all of this early intervention work yes that's a huge number of EPs. How are we going to keep them? How are we going to keep EPs having space to look after their own mental health to reflect to be effective to find passion in their job again?" (EP 2)

4.4.7.1 (iii) Subtheme: Money

A further subtheme under resources was Money. EPs felt that the SES status of CYP they worked with hindered the support they could offer CYP. For instance, one EP highlighted that EPs may be working to support a child's MH, yet they need better living conditions, before being able to offer MH support. They further explained that due to long waiting lists and their limited capacity, families tended to go to private EPs or other private professionals for support for their CYP's MH, which is not accessible for CYP from families of lower SES. EPs also felt the introduction of traded

models in EPSs limited access to MH support for CYP. EPs felt that not all schools have the finances to buy in EP time to support the MH needs of CYP in their schools.

"*But then equally there's like wider issues in terms of like, you know, poverty, all these social factors. We're trying to come in at a school level and try and put a plaster on what's a much bigger problem."* (EP 5)

"Obviously, the money thing whether they could afford to buy us in to do it if we were traded. I'm sure if we weren't traded, they'd go yeah, great." (EP 5)

4.4.7.2 Others' Perceptions of the EP role

EPs shared their experiences of other professionals and parents limiting their expectations of EPs to that of undertaking cognitive assessments. EPs felt that others did not always consider EPs as able to support MH needs, this included EPs views of how PMHWs may view the EP role.

"I think there's always that thing to do a cognitive assessment with a child because that's considered as all that we can do." (EP 1)

"I think also the way that we're seen by lots of school staff and other professionals we're maybe seen more as like supporting learning rather than being around mental health, specifically, and that might affect the kind of referrals that we're given from SENCOs and I think sometimes we're maybe not seen, I think some SENCOs see us being key for mental health but maybe it's not the way that most people see us and that might affect the kind of children we're referred to as well so having the staff and parents to have that wide understanding that we can support with mental health I think would be useful." (EP 3)

"I think often we misunderstand each other's roles we misunderstand the competencies and I guess the limits of each other's roles I think there's always that thing to do a cognitive assessment with a child because that's considered as all that we can do." (EP 1)

4.4.7.2 (i) Subtheme: Historical Conceptions

EPs believed others' perceptions of the EP role came from historical conceptions of the EP role. Particularly, participants felt that they have been positioned as carrying out cognitive assessments, which link to a 'within child' deficit model. Participants further shared that as a profession they have worked hard over time to adjust this thinking. The participants in this study also explained how this often constrains the work they do in supporting CYP's MH needs in schools, as schools ask EPs to carry out cognitive assessments over support for CYP's MH needs.

"But we often, we can be misinterpreted, even within a school it's just someone who runs cognitive assessments." (EP 2)

4.4.7.2 (ii) Subtheme: Government Policy and Legislation

Participating EPs believed wider system issues, such as government policy and legislation, hinder their roles in supporting CYP's MH needs. EPs explained that CYP's MH needs in schools are often perceived as 'bad behaviour' which results in them not receiving the correct support for their needs. EPs felt this is due to schools receiving mixed messages from the government and Ofsted regarding pushing academics and attainment and managing behaviour as well as supporting wellbeing. EPs in this study suggested this can create confusion in schools. As well as this, EPs felt their positioning in SEND from the local government in supporting the EHCP process has limited how much work they can do in supporting CYP's MH needs in schools.

"I think that's a stereotype, you know, an assumption, an assumption that children are always in control of their behaviour or deliberately acting in particular ways, rather than the idea that the behaviour is communicating that and depending on emotional experience.,
And so that blocks people from supporting them at the emotional level, and they just come in and this comes back to the education system and punitive approaches that are promoted by the DfE, and these behaviour hubs they're setting up by the minute but why are you setting up behaviour hubs and not well-being hubs? I don't know". (EP6)

4.4.8 Rules: PMHW Findings

4.4.8.1 Theme: Resources

Like EPs, PMHWs considered inadequate resources as one of the biggest constraints to their work in supporting CYP's MH. The resources they highlighted were human resources, time and training needs, and money. PMHWs felt there was not enough of them to carry out the demand of work.

4.4.8.1(i) Subtheme: Time Issues

PMHWs shared the time pressures they face which often hinder their practice. PMHWs felt that they do not have enough time for the demand of the MH needs of CYP in schools. One PMHW shared that they must adapt their time to see many different schools to meet the demands.

"I think you know when a school contacts you, they are looking for a responsive reactive response. They are wanting a reply and they are wanting to be heard, they are wanting to be in touch with someone. I get lots of, lots of requests, like today my day is filled with 15 minutes,20 minutes, half an hour slots of various people that have contacted me this week saying can I talk to you about a child. It never is just five minutes." (PMHW 1)

4.4.8.1(ii) Subtheme: Training Needs

PMHWs shared that they needed more CPD to be able to offer optimal support to CYP's MH needs in schools. PMHWs felt that they did not always have the training to support some of the issues that were referred to them.

"We've all flagged up a need for training for ourselves. And so, there's been a bit of a push recently for us all to have more CBT knowledge, and we've all flagged up that we need more trauma training and more ASD and ADHD training." (PMHW 1)

4.4.8.1(iii) Subtheme: Money

PMHWs shared that a lack of funding for their work from commissioners meant they did not always have the materials to deliver their sessions with CYP effectively. One PMHW even spoke about using their own money to buy resources in order to make their sessions with CYP as effective as possible.

"And I think we all naturally end up buying stuff anyway because we want to make the sessions, different and engaging and colourful and especially when you're working in primary. I think it's really difficult if you don't have those resources to really feel like you're doing a good job." (PMHW 1)

4.4.8.2 Theme: Local and National Government Policy

This theme captures PMHW's thoughts about a lack of understanding and support of their roles in supporting CYP's MH needs in schools from both local and national government policies. This included pressure on schools to support attainment over wellbeing, as well as local decisions around new model's PMHWs are to work within to support CYP's MH needs in schools.

4.4.8.2 (i)Subtheme: Pressure from Government

PMHWs discussed the pressures the government placed on school systems to push academics and attainment which means support for CYP's MH and well-being in schools can often come second. The PMHWs felt that this then hinders the referrals they receive as schools are focusing on the CYP's attainment rather than their MH support.

"It's all about how we can improve the school and the school's league tables and mental health seems to not be enough of a priority, within their schools." (PMHW 5)

4.4.8.2 (ii) Subtheme: Local Decision Making

Additionally, PMHWs reported feeling that they did not feel how they wanted to carry out their roles in supporting CYP's MH needs in schools was always understood by others, who were responsible for making the decisions. This involved managers in the LA who oversaw key decision making. For instance, some PMHWs felt the new I-thrive model being introduced at the time this research was carried out was not going to be effective and the LA did not have the resources to carry this out. Some PMHWs felt that this would remove some of the joined up working they already have in place with CAMHS. PMHWs also shared that they felt local decision making took too long in how to carry out their roles which then affected the support for CYP's MH difficulties in schools.

"And I think they're asking us to deliver an undeliverable model based on what we've seen so far… You know, you can't deliver a model that's undeliverable, you've got people sitting… people sitting in offices making decisions about things that they know nothing about, they don't actually deal with on a day-to-day basis." (PMHW 3)

*"And one of the advantages I think is being part of the CAMHS team, and that's one of the things that I hope we don't lose out on when we do move to the I thrive model because it's really helpful being able to go and talk to a Psychologist or an Art Therapist or Psychiatrist, If you've got a specific issue that they, you know that they could help with." (*PMHW 4*)*

"I think we get lip service, I'm sorry, but I think we get lip service… the length of time it takes in the NHS… it's money wasting, time wasting, and it's not conducive to supporting the children, the young people… I think what happens is they listen to us, but I don't think they know how to do it and how to solve it. It's, it's almost like we've gone yes, we'll take the contract, but obviously we don't have the resources to do it, and now they're madly trying to map it out and they'll be spreading us across thinly." (PMHW 3)

Contrastingly, some PMHWs felt positive about the new model and felt that it would support their practice in supporting CYP's MH needs in schools. These PMHWs expressed how the new model would enable PMHWs to carry out more early intervention again and reduce staffing issues. Furthermore, some PMHWs suggested that the new model may support more joined up working with other professionals, such as EPs.

"I think the new model will help with some of that, people just need to give it time." (PMHW 1)

"I think that's going to become even more obvious perhaps in the next sort of few years because we're moving into this, I thrive model which is a much more community skills-based model. "And it'd be interesting to see how Educational Psychologists link in with that as well." (PMHW 4)

4.4.8.3 Theme: Social Care

PMHWs agreed the influence of social issues such as the mental health and poverty of parents significantly hindered the impact of the PMHW in performing their roles. They felt that they could be providing MH support for CYP in schools, however if their environments at home were not stable then this would limit the effectiveness of their interventions. In addition to this, they felt that social care provision was not adequate which hindered the impact of their roles further. PMHWs also commented on the rise of these issues as a result of the Covid-19 lockdown, related to wider systemic issues.

"There might be more social issues or family issues around the lockdown. I have noticed, like many people in CAMHS, that there's been a real rise in mental health presentations and risk levels." (PMHW 4)

4.4.8.3 (i) Subtheme: Social Care Needs

PMHWs explained that a lot of their referrals they received were often a social care need. They felt that the CYP's MH needs were exacerbated by parental mental health, housing, and food problems. They felt it was hard to carry out effective MH interventions when these issues had not been addressed first and they had a huge impact on their roles in carrying out effective practice in supporting CYP's MH needs in schools.

"I will not take on things from social care, because things are never going to change until they've changed in family so I'm very boundaried there." (PMHW 3)

"So, there are early mental health symptoms, what they see are early mental health symptoms and, what it is, is emotional distress in the context of a dysfunctional or a traumatic social context." (PMHW 2)

4.4.8.3 (ii) Subtheme: Social Care Provision

PMHWs felt that the lack of adequate social care provision for CYP also hindered their roles as there was not the support available for CYP. Additionally, some PMHWs felt that their roles were often confused with social care roles and that until social care services had put support in place, then PMHWs were unable to offer effective MH support. One PMHW described how different services worked against each other and the 'lift and shift' of referrals meant that CYP were not receiving the support they required for their MH and social care needs. PMHWs expressed how there needs to be more joined up working with their roles and social care services to optimise support for CYP.

"So, they'll think mental health, not for us. So, everybody's in their little silos and do you know why bit first piece of work needs to be a social care response." (PMHW 2)

4.4.8.4 Theme: Educational Issues

PMHWs discussed their roles were often confused in giving advice on MH to education. PMHWs shared they were often asked questions on CYP's cognition and learning in schools but felt that this should be for other professional's such as EPs. They felt that sometimes their referrals were for a specific learning need which was not because of a CYP's MH which constrained their roles in schools in supporting MH needs. PMHWs shared that they often found it hard not to share their views on education that they felt would support a CYP's well-being. Furthermore, they felt the demands of education placed on CYP in schools impacted of difficult school systems on constraining their role in supporting CYP's MH needs in schools, as their educational attainment was prioritised over their MH and well-being.

"I think one of the constraints is that we are not supposed to give advice on education, which I probably learned the hard way." (PMHW 4)

"Umm, that most of the needs are down to the demands that young people are under within the education system." (PMHW 5)

4.4.9 Tensions and contradictions

4.4.9.1 Educational Demands

For EPs, their role in supporting CYP's MH needs in schools is constrained by outdated conceptualisation of the EP role that is overly focused on directing them to work on attainment and academic progress. This means that EPs are often asked to carry out cognitive assessments over support for CYP's MH needs in schools. For PMHWs, the educational demands of schools being focused on attainment and progress mirrors the conflicting focus of differing initiatives and performance measures from local and national government to raise attainment with high stakes and reduce MH needs at the same time. PMHWs felt that the initiatives to raise attainment often meant a CYP's MH and wellbeing was not prioritised and therefore they were unable to carry out support for their MH. A key difference between PMHWs and EPs was that PMHWs felt that they can just focus on MH issues, independently of thinking about curriculum access and attainment. Whereas EPs take an integrated approach and consider cognition and learning alongside MH. These differences fit within both EPs and PMHWs remits.

4.4.10 Division of Labour: EP Findings

The one theme, Differing Levels of Engagement in EP Work, placed within the Division of Labour node captured participants thoughts about the supports and constraints of EPs practice when they come to undertake MH focused work.

4.4.9.1 Theme: Differing Levels of Engagement in EP Work

EPs discussed how work was allocated within their teams and how this impacted on how MH support for CYP was delivered. The Differing Levels of Engagement theme captured the reasoning given to disparities in the amount and type of MH focussed work that EPs engaged in. Broadly, two influencing factors were highlighted; personal interests and schools needs and preferences.

4.4.9.1(i) Subtheme: Own Interests and Passions

EPs discussed how the role of the EP in supporting CYP's MH needs in schools was influenced by EPs interests and passions. Some EPs expressed how individual interests in the area of MH influences the type of work they contract with schools, including that of supporting CYP's MH needs.

"And I think that each EP will probably be quite different in how they negotiate that work, based on what they're comfortable with what they prefer to do what their interests are." (EP6)

4.4.9.1(ii) Subtheme: Allocation of Link Schools

EPs discussed how their work was mainly impacted by their link schools' needs for EP involvement in supporting MH needs in schools. Different schools were described as having different priorities and ways of working with EPs, impacting on the role of the EP in carrying out MH support for CYP. EPs felt that the longer they were able to stay with the schools the greater support they could put in place for CYP's MH needs as they had a stronger relationship.

"Okay, so we've all got link schools. So, I'd say we've all got a responsibility, in some way, it's not like we've got someone who does cognition and learning someone who does you know you're all going to be supporting mental health and well-being in some way." (EP6)

"The schools I've linked with…I've changed quite quickly like I've had them maybe for two years, three years maximum maybe and then I've switched patches or gone somewhere else. So somehow it's never enough time that the longer the time you can stay linked with that particular school like get in there some of those wider issues you can challenge them a bit more." (EP 5)

4.4.11 PMHW Division of Labour: PMHW Findings

The one theme, Team-Based Issues, placed within the Division of Labour node captured participants thoughts about the supports and constraints PMHW face when they support CYP's MH needs in schools.

4.4.11.1 Theme: Team-Based Issues

PMHWs shared how Team-Based Issues within their teams constrained their roles in supporting CYP's MH needs in schools. The Team-Based Issues theme captured the reasoning given

to factors that support and constrain their roles in supporting CYP's MH needs in schools. Broadly, two influencing factors were highlighted: working remotely and positives of working in the team.

4.4.11.1 (i) Subtheme: Working Remotely

PMHWs often felt isolated because of working in separate locations and not having an office base. PMHWs explained that this was exacerbated by the Covid-19 pandemic. They highlighted challenges relating to communication between themselves because of working remotely. They also felt this impacted on staff leaving as well as staff being redeployed which added to the feelings of isolation. PMHWs felt this had an unsettling impact on their roles.

"It's not like we see each other or have those kinds of working relationships, beyond a nice email with some of them and not for any, kind of, you know reason, it's just the reality of being in a team that works across the county." (PMHW 1)

"You know it's s kind of very unsettling for the professionals and families and we've lost a lot of people, people are going so that's had a massive impact on our service." (PMHW 3)

4.4.11.1 (ii) Subtheme: Positives of Working in the Team

PMHWs also highlighted how teamwork enhanced effective practice in supporting CYP's MH needs in schools. PMHWs felt regular team meetings were a particular important form of support whereby they shared ideas and supported each other. Supervision of each other was also important to PMHWs in supporting their roles in supporting CYP's MH needs in schools.

"It's been a bit different since the pandemic because we're not in the office as much, but it's nice we still have regular sort of team meetings, and we can check in with each other. It's good that some of us supervise each other too". (PMHW 4)

4.4.12 Tensions and Contradictions

4.4.12.1 Differences in Preoccupations between EPs and PMHWs

The main differences between the EPs and PMHWs was the differences in their preoccupations on what constrained and supported their roles in CYP's MH needs in schools. Unlike PMHWs, EPs tended to raise issues in the amount of MH work they engage in because of allocation of link schools and personal interests and passions. Another main difference was that unlike

PMHWs, EPs did not raise team-based issues. PMHWs were keen to discuss issues with their teams such as working remotely and feeling isolated as a result. However, as much as PMHWs were focused on concerns they also expressed positives of working within their teams which supported their roles in supporting CYP's MH needs in schools.

In summary, both PMHWs and EPs agreed that the school community and outside school factors such as external professionals and family and parental support could influence their roles in supporting CYP's MH needs in schools. EPs and PMHWs used similar tools when carrying out their roles such as intervention and work with adults around the child. However, a key difference was that for EPs a relational approach was important to them and under this carrying out preventative work. Whereas PMHWs tended to carry out more direct work at an early intervention level compared to indirect systemic work of EPs when supporting CYP's MH needs in schools. For both EPs and PMHWs they shared that Resources including time and money hindered their roles in supporting CYP's MH needs in schools. Both professional groups roles were impacted by the government and legislation however there were differences within this. EPs and PMHWs teams differed in how their work was divided in carrying out MH support for CYP and there were different preoccupations for these professionals in what hindered and supported their roles as a result of team factors.

4.5 Findings in relation to RQ 3: How have EPs and PMHWs worked with each other in a LA and how do they perceive each other's roles in supporting CYP's MH needs in schools and what factors affect this?

Table 7 shows the nodes, themes and sub themes that contribute to answering RQ3. The themes and subthemes will be explored under each node for each professional group, as well as the tensions and contradictions withing each professional group, before discussing the tensions and contradictions between the two professional groups.

Node	EP Theme	EP Subtheme	PMHW Theme	PMHW Subtheme

Division of Labour	EP Views of PMHWs	No Clear Understanding	Views of the EP Role	Statutory Work
		Early Intervention		Joint Working
		Staff Support		
		Need for more Joint Working		

Table 7 The nodes, themes and sub themes that contribute to answering RQ3

4.5.1 EP data findings

4.5.1.1 Theme: EPs views of PMHWs

EPs had mixed views on PMHWs, some were more familiar with their roles than others. Some EPs explained that they had never met PMHWs, whereas some had. The EP's views of PMHWs theme captured the differences in their views of the PMHW role and factors that may hinder joint working. Broadly, three influencing factors were highlighted: lack of understanding, early intervention, staff support and need for more joint working.

4.4.1.1 (i) Subtheme: No Clear Understanding

Most EPs reported that they did not have a clear understanding of the PMHW role. Most EPs hesitated and were unsure when asked about the PMHW role in supporting CYP's in schools. They felt that this was the biggest hindrance in working with them as they did not actually know what PMHWs do.

"What do they do? You know what, I'm not 100% sure, I don't know of any. I've never worked with any. I can make assumptions about what they do." (EP 5)

"Oh, I think I only know a little bit about Primary Mental Health Workers, I guess." (EP 3)

4.5.1.1 (ii) Subtheme: Early Intervention

Not all EPs were clear on the role of PMHWs, due to having little encounters with PMHWs in their schools. The EPs who were familiar with the work of PMHWs, or had worked with them, felt PMHWs had a key role in early intervention. Two EPs discussed the role of PMHWs in therapeutic support for CYP with MH needs. These EPs explained how PMHWs provide therapeutic interventions for CYP, before receiving support from CAMHS.

"And I think, although I haven't come across this in my school, but I think, they do brief therapeutic intervention. They're supposed to be that kind of early intervention before you would then perhaps have intervention from CAMHS and they're meant to be the bridge between school in school support, and CAMHS." (EP6)

"They get a diagnosis, and the more intense therapeutic stuff is not so common because I guess CAMHS just didn't have the capacity for it. But I guess that's what the mental health support workers are for kind of pick up on some of that." (EP 5)

4.5.1.1 (iii) Subtheme: Staff Support

Of the EPs that had some awareness of the PMHW role, it was suggested that PMHWs offer adult support to staff working with CYP with MH needs in schools. EPs suggested that this may involve having consultations with staff, supporting teacher training, and helping staff to implement MH support for CYP in school. These EPs suggested that as this is what EPs also do, this could create confusion for staff.

"I get the impression from what I understand, the job that they're doing, that they should be doing or that they are likely to be doing is helping to embed things like maybe teacher training in the schools, which again is something that we would want to be doing." (EP 5)

4.5.1.1(iiii) Subtheme: Need for more Joint working

All EPs suggested that there was a need for more joint working. The EPs reported that they and PMHWs provide similar training, which could cause confusion for staff and ultimately hinder the effective support for CYP. They felt that joint working could be effective in training, consultation, and assessment. EPs suggested that this would optimise the support for CYP's MH needs.

"And so, it's the same with training so that's another thing I think Primary Mental Health Workers do is training, and they do attachment training, and we do training on compassionate schools which covers similar areas.
And, if we did that training together the message would be the same… I think there's probably some inconsistencies and schools perhaps feeling overwhelmed by all these strategies from all these professionals…it would just be much more coherent and manageable for schools and then for the young person." (EP6)

4.5.2 PMHW findings

4.5.2.1 Theme: Views of the EP Role

PMHWs appeared to have a clearer understanding of the EP role than EPs had of the PMHW role. Most of the PMHWs saw EPs playing a key role in statutory processes including assessments for EHCPs. There was a consensus across the PMHWs that EPs are both hard to reach and have access to, because of the time pressures placed on them. PMHWs agreed that they would all like to do more joint working with EPs.

"Educational Psychologists are like gold dust, it's really difficult to get hold of a good Educational Psychologist, when you need to." (PMHW 5)

There were differences in perceptions about the EP role with meeting MH needs. One PMHW suggested that EPs are pivotal in education whilst PMHWs should only be involved when a child is experiencing MH difficulties.

"I've had Educational Psychologists in because it's not mental health, it's not mental health. It is education they're struggling with accessing the education I want to know why they're struggling and what the Ed Psych can do." (PMHW 3)

Contrastingly, another PMHW referred to an EP as a 'mental health professional' suggesting they do have a key role in supporting CYP's MH needs.

"I've been in a few meetings where I found it personally interesting and helpful to have the Educational Psychologist in that, but at times it's felt like yeah again there's just another Mental Health professional in the room." (PMHW 1)

4.5.2.1 (i) Subtheme: Statutory Work

All PMHWs discussed the role of the EP in statutory work, particularly with EHCPs. PMHWs discussed the key role of EPs in carrying out assessments and writing reports for EHCP requests. One PMHW shared that they thought EPs were only able to support CYP in schools if the CYP had an EHCP.

"Ed Psychs also carry quite lots of weight in any reports that they write, and any assessments that they carry out. So, for an EHCP for example, or support plan, then you kind of need that in order to be able to provide the support that the young person needs." (PMHW 5)

4.5.2.1 (ii) Subtheme: Joint Working

PMHWs all shared that they would like to work jointly with EPs. Most PMHWs shared that they had not carried out much joint work with EPs in the past however would like to do so.

"I don't have very much direct involvement with Educational Psychologists and actually I think that could be really valuable." (PMHW 5)

"I think it's interesting because we've recently been sent a list of all the Educational Psychologists in the areas, and the one in my area has sort of contacted me to try and hook up and see where we can sort of work together a bit more." (PMHW 4)

The main involvement of PMHWs with EPs had been in social care 'team around the child' meetings. One PMHW expressed that this was helpful as they were coming from a similar place which enforced messages of strategies to use when supporting CYP who were struggling with their MH. PMHWs felt that EPs coming from an Education background and PMHWs from a MH background complimented each other's roles well in generating joint ideas around strategies for CYP.

"Um, so my only involvement really with Educational Psychologists is within TAF meetings. And usually, the Educational Psychologist is very much on similar page to where I'm coming from, as in what strategies we might be able to put in place to support the young person. But whereas I'm coming from a purely mental health perspective an Educational Psychologist is also coming from an educational perspective and how can we help the young person to access education." (PMHW 5)

4.5.3 Tensions and contradictions between EPs and PMHWs

4.5.3.1 Work with Adults to Support CYP's MH needs

Both EPs and PMHWs suggested that they are both placed well to support staff in schools to help CYP's MH needs. This mainly involves holding consultations and trainings with school staff. The findings suggest that EPs and PMHWs may overlap on trainings such as attachment training. Furthermore, some PMHWs felt that EPs may have more knowledge in this area so should carry out this training or deliver joint trainings to develop PMHWs knowledge. This can create confusion for the staff accessing the training, which can then confuse the support delivered to CYP to support their

MH needs effectively. This indicates that clarity between the professionals should be sought to ensure consistent, clear support is delivered.

*"And to be honest, attachment is not an area that I feel an expert in, so I really don't mind letting the Educational Psychologist do that." (*PMHW 4*)*

4.5.3.2 PMHW view of EP role in Statutory Work and MH support

The findings indicate that PMHWs feel EPs key role is in statutory processes. EPs reported that statutory work often hindered their roles in supporting MH needs in schools, because the time pressures this placed on their roles meant they did not often have time for other work such as MH support as they would like to. The EPs in this present study felt that they can offer so much more than just statutory only, however this is what their time was currently being taken up on. Furthermore, some PMHWs felt that EPs perhaps should not support with MH difficulties, and this should be left to PMHWs and other MH professionals. In contrast to this EPs suggested that they wanted to do more work with PMHWs in supporting CYP's MH needs in schools.

4.6 Summary

In summary, EPs and PMHWs hope to support wellbeing when supporting CYP's MH needs in schools. The main difference within the work they focus on when supporting MH needs in schools is adult MH support for EPs and MH diagnoses and neurodiversity for PMHWs. When supporting these outcomes both EPs and PMHWs feel that the school community and outside school professionals and parents can support and constrain their roles in supporting CYP's MH needs in schools. Both EPs and PMHWs carry out intervention work to support their roles in MH needs in schools, however EPs take a relational approach when carrying out this work as well as preventative and systemic work. PMHWs tend to take a more direct role and their intervention work is focused on early-stage involvement.

Both EPs and PMHWs shared that they are constrained by resources, particularly time issues and money, as well as pressures from the government and legislation when supporting CYP's MH needs in schools. EPs shared that emotional capacity can often limit their roles in carrying out MH work and for PMHWs social care factors hinder their practice. Unlike PMHWs, EPs shared that other's perceptions of their roles can often limit how much MH work they carry out. EPs and PMHWs differed in their preoccupations of what hinders and supports their roles in their teams in carrying out MH work.

EPs had mixed views and understanding of the PMHW role in supporting MH needs in schools which was due to their previous or lack of involvement with PMHWs. The EPs who worked with PMHWs previously explained that they viewed the role of PMHW in early intervention and staff support. Contrastingly, all PMHWs were aware of the role of the EP mainly being in statutory work. Both EPs and PMHWs shared that they may be both carrying out similar trainings and consultations and they would like to carry out more joint working together which could incorporate these tools.

The next chapter is going to explore the main findings in further detail in relation to previous literature. The findings will also be explained further in line with psychological theory and future implications for the role of the EP and further research will be discussed, as well as the present research's limitations and dissemination of these findings.

Chapter 5 Discussion

5.1 Introduction to Chapter

This chapter provides a summary of the findings outlined in the previous chapter, presented under the research questions. In line with the Cultural-Historical Activity Theory (CHAT) approach, the main themes that relate to the tensions and contradictions between the professionals' groups are going to be discussed further alongside previous literature and psychological theory. These tensions indicate suggestions for organisational change and thus implications for local EP practice will be suggested. Further implications for wider EP practice will also be discussed. The strengths and limitations of this research are considered and directions for future research are given. The chapter ends with ideas for disseminating these findings and concluding comments.

The findings are discussed and reflected on alongside the overall research question in mind: How do the roles of EPs and PMHWs intersect to ensure resources in the LA are being utilised effectively to provide optimal support for CYP's MH needs in schools? The tensions and contradictions will be explored in line with the additional following research questions:

1. What do EPs and PMHWs hope to achieve when working in their services to support CYP's MH needs in schools?
2. What factors facilitate or hinder effective practice in supporting CYP's MH needs in schools for EPs and PMHWs?
3. How have EPs and PMHWs worked with each other in a LA and how do they perceive each other's roles in supporting CYP's MH needs in schools and what factors affect this?

A definitive approach is adopted when presenting the findings from this research, however the DWR collaboration has not yet occurred. Therefore, although the findings are presented here definitively, it will be taken back in the dissemination in a more collaborative way, retaining definitive elements to help guide the directionality of systemic change.

5.2. RQ1: What do EPs and PMHWs hope to achieve when working in their services to support CYP's MH needs in schools?

This research aimed to look at what EPs and PMHWs hope to achieve in their practice when supporting CYP's MH needs in schools to understand how their roles intersect and to optimise local resources. The main differences between EPs and PMHWs was that EPs aimed to support overall wellbeing and adult's MH needs to indirectly support CYP's MH needs. Whereas PMHWs main hopes for the outcomes of their work was to support wellbeing and MH diagnoses.

5.2.1 Overall Wellbeing and MH diagnoses

Most of the EPs and PMHWs suggested supporting CYP's wellbeing would promote more positive MH outcomes for CYP in schools. EPs tended to place an emphasis on promoting 'overall' wellbeing whereas PMHWs used the term wellbeing on its own. EPs in this research used the term 'wellbeing' when considering CYP's MH. EP 1 even suggested that there should be a change in language when talking about MH and the term 'mental health' should be replaced with 'wellbeing' when referring to CYP's MH needs in schools. This EP believed this promotes a more positive and optimistic view of MH. This finding supports other research that found that EPs tend to be reluctant to use the term 'mental health' in their work (Carney, 2017) and use the term 'wellbeing' instead. This difference may be due to the Tools, preventative and systemic work, EPs use in their practice. Alternatively, this difference could be explained by PMHWs other hope for their practice being treating MH diagnoses, which can also be explained by the Tools they use such as direct work with CYP and early intervention to treat MH diagnoses. The preferred term of 'well-being' rather than MH for EPs highlights a potential new direction for EP's practice when considering their roles in supporting MH needs in schools. This suggests the role of the EP should be focused on wellbeing of CYP to support their MH needs.

As well as wellbeing, PMHWs other Object of focus when they support CYP's MH needs in schools is that they hope to provide support for MH diagnoses. This supports previous research that found a large proportion of the PMHW role focuses on different MH problems (Hickey et al., 2010). These findings suggest that both EPs and PMHWs are working on similar Objects of wellbeing, however a key difference is that PMHWs are also hoping to support MH diagnoses when supporting CYP's MH needs in schools. To optimise local resources more effectively, EPs focus for their practice when supporting CYP's MH needs in schools could be wellbeing and for PMHWs supporting MH diagnoses. Going forward, schools should be referring to PMHWs when a child has received a specific MH diagnosis and EPs for overall wellbeing support for CYP at a lower, preventative level.

The need to support overall wellbeing for EPs and PMHWs may be explained by Maslow's Hierarchy of Needs (1943,1954). These findings suggest that if a child's basic needs aren't met such as their physiological and safety needs as well as their love, belonging and esteem, which are all vital for wellbeing, then they will not be able to reach their full potential in school. Participants in this study discussed how it was difficult to support CYP's MH when they did not have stable living conditions, access to food and sleep. EPs in this research also discussed how it was important for CYP to feel safe and a sense of belonging in school to support their MH, which are important for developing resilience. PMHWs discussed the impact of social care needs and lack of social care provision in ensuring these needs are met. This Object of focus for PMHWs could be explained by tensions under the Rules node, the PMHWs face when supporting CYP's MH needs in schools, such as social care difficulties. This suggests there needs to be more support for social care needs to support CYP's MH needs in schools.

5.2.2 Support for CYP with Neurodevelopmental Conditions

Interestingly, the theme 'Neurodiversity' was not an Object theme for EPs, however supporting neurodiversity was key for PMHWs when supporting CYP's MH needs in schools.

PMHWs shared how they work with a lot of CYP in schools with neurodevelopmental disorders, such as ASD and ADHD, when supporting MH needs in schools. There were, however, tensions within the PMHW participants around supporting ASD needs independently of MH needs. This could be explained by the Tools such as work with adults PMHWs use when supporting CYP's MH needs in schools. Some PMHWs discussed how they held parent workshops to support parents of CYP with neurodevelopmental conditions. This finding supports other literature that found PMHWs carry out work to support CYP with ASD and ADHD, however this tends to be more direct (Callaghan et al., 2003; Hickey et al., 2010).

Some PMHWs shared that they believed that they should only work with CYP with MH needs and not those with diagnosed neurodevelopmental conditions, unless they have a MH difficulty because of, or in addition to, their neurodevelopmental condition. These PMHWs suggested that neurodevelopmental conditions affect cognition and learning, therefore should not be positioned as MH difficulties. One PMHW suggested that EPs should be supporting neurodiversity as this is an 'educational issue'. This finding contradicts previous research that found PMHWs to have a role in supporting CYP with neurodiversity needs (Callaghan et al., 2003; Hickey et al., 2010). These findings suggest there are some differences in the PMHW profession on their Objects of focus when supporting CYP's MH needs in schools and further clarification around this is needed. It could be suggested from this that to optimise resources effectively, EPs should support CYP in schools with neurodevelopmental conditions alone from related MH needs and PMHWs should support those with a MH need related to their neurodiversity. This is important as research has found that CYP with ASD are more likely to carry out suicide attempts (Mayes et al., 2013). It is also crucial to consider the impact of professionals carrying out the same work could result in EPs and PMHWs in competition for survival and/or expansion of services. Therefore, it is important to be clear about the differences in Objects of their work.

5.2.3 Differences in Involvement with Adult's MH

A key difference in the EP's and PMHW's Objects and Outcomes, was support for adult MH as a focus within their practice. Unlike PMHWs, EPs shared that they hoped to provide support for the MH of adults working with CYP, suggesting this would indirectly support CYP's MH needs. EPs shared that the adults working with CYP with MH needs needed to feel supported for their own MH. This difference may be explained by the EP's Tools such as using systemic work to indirectly support CYP's MH needs in schools. In Zaferiou & Gulliford's (2020) research, they also found that EPs deal with adult's difficult emotions when carrying out MH casework in schools. Other research has also found that EPs play a role in supporting teachers wellbeing to help them to support CYP with SEMH needs (Rae et al., 2017). However, for PMHWs, adult MH support was not a theme for the Object of their work, despite work with adults being a tool they use when supporting CYP's MH needs. This may have been due to the PMHW role being more focused on provision of direct support for CYP's MH needs. This suggests for future practice, to optimise local resources, for EPs to support adult's MH in schools and PMHWs to focus their work with CYP directly.

Together, the main findings from research question one suggests that EPs and PMHWs roles may intersect by both supporting wellbeing. However, to optimise local resources more effectively, EPs could be focusing on promoting overall wellbeing at a preventative level, including support for CYP with neurodevelopmental conditions, and supporting adult's MH in schools to support CYP's MH needs indirectly. Whereas PMHWs could be supporting CYP in schools with MH diagnoses at a direct and early level as well as offering support for CYP with associated MH difficulties alongside their neurodiversity needs.

5.3. RQ2: What factors facilitate or hinder effective practice for EPs and PMHWs when supporting CYP's MH needs in schools?

This research aimed to look at what factors facilitate or hinder EPs and PMHWs practice when supporting CYP's MH needs in schools to understand how their roles intersect to optimise local resources effectively. The main differences between EPs and PMHWs was that PMHWs felt

lack of relationships with parents hindered their support for CYP's MH needs; however, this did not come up in this present research for EPs. EPs and PMHWs roles differed in the time they were involved with CYP, with PMHWs having longer involvement with CYP compared to EPs. Both EPs and PMHWs use training and work with adults through consultation to support their practice, highlighting overlaps across the professions, suggesting there needs to be better utilisation of resources. Both EPs and PMHWs in this present research felt educational demands constrained their roles in supporting CYP's MH needs in schools. Contrastingly, PMHWs tended to focus primarily on MH, whereas EPs on MH and educational needs together. There were also differences in the preoccupation's EPs and PMHWs had with how their work was divided within their teams which they felt either hindered or supported their roles. Team-based issues were explored by PMHWs such as working remotely as well as positives of their teamwork. EPs did not raise these factors but did discuss their allocations of link schools, personal interests, and passions in determining how their work was divided which either supported or constrained their roles.

5.3.1 Parent Relationships

There was a contradiction between PMHW's and EP's views about the family context and parental roles in supporting or constraining MH support for CYP in schools. EPs were inclined to share the importance of the family context in terms of the impact of CYP not having consistent housing, food, and money and how this hinders MH support. This is in line with Maslow's (1943,1954) hierarchy of needs that suggests that if basic needs are not met, then EP support for MH needs has less of an impact. This is linked to the EP Object discussed in the previous section of promoting overall wellbeing. PMHWs placed more of an emphasis on parents specifically their lack of support for their children in hindering the roles of PMHWs in supporting MH needs. Some of the PMHWs felt that parents need to do more and make changes in their parenting for PMHW support for CYP's MH needs in schools to be effective. These PMHWs felt that they could support their child, but the parents needed to work with them by also supporting and understanding the pivotal

role they have in their child's MH. This would offer CYP consistency which would optimise MH support more efficiently.

The role of parents in supporting MH needs has been raised in other EP research (Cane & Oland, 2015; Hulme, 2017 & O'Reilly, 2018). The EPs in this present research did not raise the role of parents in hindering their practice like the PMHWs did but did discuss Systemic Work which encompasses support for parents in facilitating the EP role. The EPs in this study perhaps had preoccupations with other facilitating and hindering factors to their roles in supporting CYP's MH needs in schools. There does not yet appear to be literature on the role of the PMHW with parents, perhaps due to the more recent introduction of the PMHW role compared to the EP role. This highlights a direction for future research to gain a greater understanding of the PMHW and parent relationship, to facilitate consistent support for CYP's MH needs.

The impact of the role of parents in supporting CYP's MH needs can be explained by Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1989). In this theory it highlights how the environment impacts on the individual in the middle which could be applied to understand CYP's difficulties. The role of parents in the microsystem can have a direct influence on CYP's wellbeing and suggests when considering MH, a holistic approach needs to be taken. PMHWs support for CYP's MH needs may be more effective if parents are stabilising factors in the home environment which will strengthen the impact of the PMHW in supporting CYP's MH needs. These findings have implications for PMHW's practice suggesting that PMHWs may need to consider working with parents more to optimise effective support for CYP's MH needs in schools. However, further constraints like the impact of time issues on the PMHW role may limit the capacity PMHWs have to work with parents.

5.3.2 Training

Both EPs and PMHWs discussed the application of staff training in facilitating their roles in supporting CYP's MH needs in schools. Most participants felt that training was crucial when

supporting CYP's MH needs in schools. EPs and PMHWs often delivered similar training to school staff. Some PMHWs felt that EPs were better placed than themselves to deliver attachment training, whereas other PMHWs believed they were well placed to deliver this type of training. Both EPs and PMHWs felt that delivering similar training could cause confusion for school staff and would not be the best utilisation of their resources. One PMHW shared that they would like to deliver joint trainings to schools with EPs to avoid this overlap, which would utilise both professional groups' knowledge and optimise support for school staff. However, EPs and PMHWs are both constrained by time so do not have capacity for this work currently.

In Hickey et al., (2010) research, the PMHWs wanted to deliver more training in their roles. In this research, PMHWs did express that they would like to deliver shared trainings with EPs as this would enhance the training by merging both professional group's skills and knowledge. This would not optimise local resource effectively, as both EPs and PMHWs are constrained by time issues in their roles in supporting MH needs in schools. PMHWs could deliver training related to more specific MH needs to optimise MH support for CYP's MH needs in schools. These findings imply that the LA need to decide which professional groups deliver what specific training to avoid overlap across EPs and PMHWs and optimise local resources more effectively. In the future if PMHWs and EPs have more time, then they could look at delivering joint trainings to support CYP's MH needs in schools. To optimise practice and local resources now, it is proposed that EPs should be delivering attachment training only and PMHWs could prioritise their time to carry out the direct intervention work.

5.3.3 Work with Adults

Both EPs and PMHWs shared that they worked with adults to facilitate their roles in supporting CYP's MH needs in schools. EPs and PMHWs worked with adults around the child either school staff, other outside professionals, or parents to support CYP's MH needs. These findings are supported by previous research which also found PMHWs work with adults to indirectly support

CYP's MH needs (Callaghan et al., 2003, Lacey, 1999, Lambert et al., 2020). Unlike EPs in this study, for PMHWs this included attending social care meetings. Although previous research has found EPs to work with social workers to support the MH and wellbeing of CYP (Shanti, 2014), this was not a Tool EPs use in facilitating or hindering their practice in supporting MH needs in this study.

Like PMHWs, the EP participants in this study, shared that consultation was a Tool they used to support CYP's MH needs in schools. This finding appears in other doctoral research that found EPs utilised consultation with adults to support the MH needs of CYP in schools (Hulme, 2017). EPs and PMHWs in this study were aware that school staff, parents, and other professionals who both PMHWs and EPs liaise with, may feel confused by varying information from different professionals. This may then lead to inconsistent support for CYP limiting the effectiveness of MH provision. EPs and PMHWs suggested that joint consultations with home, school, an EP and PMHW would optimise the support for CYP experiencing MH difficulties. They felt that by working together this could reinforce support and benefit CYP. This aligns with initiatives of multi-agency working promoted in LAs (Gaskell & Leadbetter, 2009) and other research that has found joint working to be effective in addressing the MH needs of CYP (Hulme, 2017). Like delivering trainings, this could put more pressure on EPs and PMHWs time. PMHWs and EPs need to ensure they are not both having the same consultations with the same adults about the same children for the same difficulties. However, a child may need both EP and PMHW support if they are presenting with MH and attainment difficulties. To optimise local resources, it is proposed that a child presenting with various needs should receive the support from either the EP or PMHW for their main need which could reduce their other needs if their main need is addressed effectively. If EPs and PMHWs have more time in the future, then joint consultations could be trialled to explore whether this results in an increased impact of MH support in schools.

5.3.4 Duration of Involvement with CYP

The findings suggest that EPs and PMHWs use similar Tools to support their work however the key difference between the professionals was the length of time they worked with a child for. Most PMHWs agreed that their role with CYP often consists of delivering an average of six sessions of a short-term intervention focused on a specific MH difficulty. However, some PMHWs shared that this time would increase if they felt it was needed, although they were often constrained by time issues. There were tensions within the EPs participants' views on how long EPs should or would like to be involved with CYP. Some EPs felt their work should focus on systemic change, involving short periods of time working with specific CYP and that PMHWs should carry out longer term intervention work with CYP. Other EPs shared that they would like to do more long-term work with CYP like therapeutic support, but they believe they are constrained by time issues and others' views of their roles that they do not have a role in therapeutic support for MH needs. This is supported by existing research that has found other professionals perceive EPs in carrying out cognitive assessments over other work which could affect the contracting between EPs and SENCO's (Greig et al., 2019).

Hoyne and Cunningham's (2019) research supports these findings further as they found EPs were keen to do more therapeutic work with CYP to support their MH needs, however they were not always able to. EP 4 suggested that EPs could work with PMHWs in supporting the delivery of long-term therapeutic interventions systemically by overseeing such interventions in schools. They felt this would bring together possibilities of both therapeutic and systemic work of EPs and create an opportunity for joined working between PMHWs and EPs. Given the time pressures on EPs, they do not necessarily have the capacity to carry out this work. These findings suggest that there are differing views, particularly amongst EPs, regarding how much time they spend working directly with CYP. Such views were framed within the context of limited time to perform a wide spanning role. To utilise local resources effectively, it may be greater value for money for PMHWs to carry

out the longer-term therapeutic work and EPs to continue working systemically to support CYP's MH needs indirectly to avoid adding further time pressures.

5.3.5 Educational Demands

Both EPs and PMHWs considered their roles in supporting CYP's MH needs in schools to be constrained by the emphasis schools place on academic progress and attainment. PMHWs believed this sometimes resulted in MH support not always being prioritised despite there being a recent push to support CYP's MH in schools (DfE, 2015; Green Paper, 2018). This may be because of the government initiatives to raise both attainment and MH, which can come at the expense of one another.

PMHWs also raised that their roles were often constrained in supporting CYP's MH needs as they often received referrals for what they perceived to be an 'educational' need such as issues with CYP's progress and attainment. PMHWs did not feel this was within their remit and they should be focusing on purely MH needs. PMHWs suggested that these referrals should be given to EPs, as EPs can support both MH and attainment. These findings highlight EPs and PMHWs roles may intersect by both supporting CYP's MH needs in schools, but EPs have a role in supporting attainment too which can have an impact on MH needs. This is supported by research which has found that MH is pivotal in attainment (Corcoran & Finney, 2014). This has implications for future practice that PMHWs should just be supporting CYP with MH needs only which of course has an impact on their attainment, however EPs in the LA can support CYP with comorbid MH and cognition and learning needs. This would optimise local resources more effectively by reducing overlap and ensuring both professional groups are able to carry out their roles.

5.3.6 Training Needs

EPs and PMHWs had different views on what supported and constrained their roles in supporting CYP's MH needs in schools. PMHWs felt their training needs was a constraint to carrying out their roles effectively in supporting CYP's MH needs in schools. PMHWs in this

research explained that they would like more training around CBT approaches, ASD and ADHD. This may link to the differences in PMHWs with working with CYP with neurodevelopmental conditions, as some PMHWs felt more comfortable supporting these needs than others. These findings are supported by Hickey et al.,'s (2010) research which found PMHWs required more training to carry out their roles effectively. Not all PMHWs in this present research felt they needed more training which could be explained by their differences in backgrounds, having come to the role with differing levels of experiences and via different routes (NFER, 2010). These findings have practice implications suggesting that PMHWs require further training to support their ability to carry out MH support for CYP. One PMHW suggested that EPs could train PMHWs in these areas, however it seems questionable that EPs will have the capacity and if this is not thought about the impact could be detrimental on EP's own wellbeing.

5.3.7 Emotional Wellbeing

EPs did not express the need for training to support MH needs in schools, which could be because of the high level of doctoral training they receive in a wide range of approaches. The key difference in constraint to their roles for EPs compared to PMHWs, was Emotional Capacity. This does not mean to say that PMHWs feel they do not experience difficulties with their own wellbeing when supporting MH needs in schools, but this could have been a different preoccupation for them at the time this research was carried out. Although, Hickey et al., (2010) found PMHWs in their study did not feel burn out despite reporting high workload, this research did not include the PMHW role in schools which could determine the differences in these findings.

EPs in this current study discussed how they felt their high workload and own wellbeing was impacting on their ability to carry out MH support effectively. One EP suggested they 'contain' lots of people, including CYP and the adults around them, yet they do not always feel contained in line with Bion's theory of container-contained (1970). Bion highlighted the importance of the professionals supporting others' MH to be supported for their own MH. EPs in this research felt the

lack of containment often leaves them feeling exhausted and not able to carry out their role effectively. Greig et al., (2019) also found that the emotional capacity of EPs constrained the EPs in supporting CYP's MH needs in schools in Scotland. These findings indicate practice implications for more support for EP's emotions and wellbeing which could be offered through more supervision and reducing workload pressures. PMHWs could carry out some of the MH work for EPs to reduce their workload whilst they have a vast number of statutory work to maximise local resource, although this would hinder their capacity of an already small number of PMHWs in the LA.

5.3.8 Social Care

PMHWs often felt that referrals they received should be made to Social Care instead. One PMHW even referred to this as 'lift and shift' within the LA system, whereby the expectation to meet need is simply being reallocated to another service. PMHWs felt that it was difficult to support the MH needs of CYP if they had unmet social care needs such as inadequate access to a stable home environment including poor housing, inadequate food, and inappropriate care. PMHWs argued there was insufficient provision within the LA to meet needs, caused by insufficient funds. Research has found that those who have experienced Adverse Childhood Experiences (ACEs), such as neglect, are more likely to be at risk of MH difficulties (Hughes et al., 2016) and there is an overrepresentation of those with social care involvement in suicide rates (Wan et al., 2019). This suggests the impact of MH support might be limited whilst social care needs are not addressed. This is in line with Maslow's (1943, 1954) hierarchy of needs that CYP's basic needs need to be addressed first, although MH support could work in parallel to this. This has practice implications for PMHTs, and Social Care suggesting they need to liaise with each other to optimise impact of support. This indicates a direction for future research in looking at the joint working between PMHWs and Social Care.

5.3.9 Others' Perceptions of Roles in MH

Both EPs and PMHWs felt the local and national government issues constrained their roles in supporting CYP's MH needs in schools. There were differences across the EP and PMHW participants. EPs felt their role in MH was often perceived differently by various people. They shared that many other professionals saw their role as assessing cognition and learning, carrying out cognitive assessments with CYP and not supporting MH needs. EPs shared that schools often asked them to carry out cognitive assessments over support for CYP's MH. It could be that schools believe a child has a cognition and learning need but once an EP works with them, they could unpick a MH need which could be contributing or hindering the child's development and attainment. EPs believed this was due to both historical ideas of EPs carrying out assessment work to measure IQ only, as well as government initiatives striving for attainment and achievement. This could pressurise schools to contract work which prioritises this over MH provision with their EP.

These present findings align with existing literature that has found EPs are not always considered as having a role in carrying out MH work. Greig et al., (2019) suggested that EPs need to advocate for their role in MH further, which supports the findings from one EP in this research who said, "that we need to start talking about what we do…can use psychology for more than just learning goals". Carney (2017) also found that EPs saw supporting SEMH needs as a core function of their roles, however, were reluctant to use the term 'mental health', which supports some of the EPs in this study who suggested the term 'wellbeing' should be used over 'mental health'.

Contrasting findings from other research found that schools referred MH needs to their Educational Psychology Service (EPS) over CAMHS (Gowers et al., 2004) which PMHWs fall under within this LA. This may be due to the relationship between schools and EPSs being located within the LA, rather than CAMHS which is under the NHS or perhaps the greater exposure schools have to EPSs over CAMHS. This suggests there are persistent differences amongst professionals on the role of EPs in MH, including EPs themselves which could be affected by other priorities within their work at different times. This highlights practice implications as PMHWs do not work in

cognition and learning and are not trained to carry out cognitive assessments. To optimise local resources that are under resourced, EPs should be supporting cognition and learning, MH needs that affect this and the MH provision that PMHWs do not have the capacity for. This may consist of EPs utilising systemic and preventative Tools to optimise their practice ensuring more CYP are reached at a wider level within an under resourced LA.

5.4. RQ3: How have EPs and PMHWs worked with each other in a LA and how do they perceive each other's roles in supporting CYP's MH needs in schools and what factors affect this?

5.4.1 Views of Each Other

Overall, EPs had less of an understanding of the PMHW role than the PMHWs did of the EP role. EPs often shared that they were 'unsure' about what PMHWs did, which may be due to a lack of exposure to the PMHW role. Only two EPs were able to say that they had worked with and had previous exposure to PMHWs. PMHWs were more confident in answering questions around their views of the EP role than EPs were of PMHWs. Although PMHWs were more confident in their knowledge of EPs generally, PMHWs did often suggest that the EP role was only within statutory work and cognitive assessments. This may be due to the current context of the EPS within the LA this present research was carried out, with the EPS operating as statutory only. Andrews (2017) findings support this, suggesting other professional's such as Special Educational Needs Co-ordinators (SENCOs) saw the EP role as carrying out cognitive assessments only and not MH support. EPs can offer a wider range of work such as consultation, training, intervention, and research as well as assessment. Currently, in this LA the EPs are constrained by the local context difficulties of statutory only meaning they are only carrying out this work. This research highlights the desire from the EPs in this EPS to want to do more varied work such as preventative, systemic, and therapeutic work. These findings highlight implications for local practice that there needs to be

both a push in increasing understanding of the PMHW role across this EPS and a greater understanding of the varied role of the EP across PMHWs in this LA.

5.4.2 Call for more Liaison between EPs and PMHWs

Both EPs and PMHWs felt there was room for more joint working although this featured more strongly in PMHW's responses. This may be due to PMHWs greater understanding of the EP role than EPs of the PMHW role. Participants across both groups suggested that joint working could involve liaison with each other about CYP in the same schools they are both allocated, which could optimise the support for their MH and ensure their provision did not overlap. The EPs and PMHWs felt joint consultations regarding the CYP would bring together the skills and knowledge of both professionals. The participants argued that a lack of communication between each other affects their abilities to liaise with each other about a child. This supports existing research that has also found communication being a key hindrance in joint working across professionals (Hulme, 2017; Vostanis et al., 2011). EPs also expressed that they do not always liaise with PMHWs as they do not have a sufficient understanding of their roles in supporting CYP. Other research has found that a lack of understanding of each other's roles can constrain work between EPs and CAMHS (Hulme, 2017). One PMHW suggested that an 'away day' would be a good start in increasing the understanding of each other's roles to support liaison with each other. This may be useful as existing literature suggests that there are many positives for multi-professional working which could lead to more optimal outcomes for CYP's MH needs (Gaskell & Leadbetter, 2009; Greenhouse, 2013). These findings suggest that EPs and PMHWs would like to liaise with each other more, however time, communication, and lack of understanding of each other's roles hinders this.

The limited local resources constraining EPs and PMHWs in their roles hinders liaison even further. Both EPs and PMHWs expressed that time and money are already constraining their roles in supporting CYP's MH needs in schools. If these professionals are already experiencing pressures within their own roles, then adding the extra demands of joint working within an already pressured

environment may limit the impact of MH support further. This suggests that to support liaison in the LA between these professional groups, then resources need to be provided first. This may have a two-way impact, if there is more liaison then resources may be maximised, as this could prevent overlap of work as Hulme's (2017) research found. These findings have implications for future practice suggesting PMHWs and EPs would like to liaise with each other more to support their roles in supporting CYP's MH needs in schools, but they require an increase in resources to allow for this work.

5.5 Implications for EP practice

The implications already suggested in this discussion focus directly on implications for the current LA, however the findings offer implications for wider EP practice in other LAs which will now be explored.

Applying CHAT frameworks to EP research has been a very recent phenomenon within EP literature (Gaskell & Leadbetter, 2009; Greenhouse, 2013; Leadbetter, 2017). This current research highlights how CHAT can be applied to both smaller and wider scale projects that look at interactions within and between systems. This offers great potential for EP teams who may be wanting to make a change either within their practice, for themselves or for their clients. For example, EPs could implement CHAT themselves when working with schools to bring about changes such as introducing new behaviour management policies within schools or supporting leadership teams in schools to make changes. CHAT can be applied at both small and wider scale research to consider what may not be working which promotes the direction for future change for EP practice.

These findings have also demonstrated the need to support EP wellbeing. This research highlights the MH impact EP practice has on supporting CYP's MH needs in schools on EP's own wellbeing. EP's own MH may be impacted which in turn impacts on the effectiveness of MH support for CYP's MH difficulties. Other issues within the systems such as resources and understanding of

the EP role from others may also contribute to EP's own MH and wellbeing. This can limit the capacity of the EP in feeling able to carry out MH work. Consequently, this has an impact on staff turnover, with greater rates of EPs leaving LA work and sometimes going into private practice. This then hinders the support available for CYP within the LA as there is a greater demand over supply of EPs to meet need. This suggests a need for greater support and awareness of the impact of MH work on EP's own wellbeing and MH. This could be supported through more supervision for EPs. It must be noted EP's wellbeing arose from this research which was carried out in a statutory only service. This could affect EP's capacity and mean the findings may only be generalisable to other EPSs that are currently statutory only. EPs could adopt learning from PMHWs team meetings as offering a MH containing space to support the EPs own MH when supporting other's MH.

Although there has been a big drive for multi-agency working within EP literature, this research suggests there are still areas of improvement and EPs have opportunities to build on this. EP's roles in supporting CYP's MH needs in schools could be supported by other professionals such as PMHWs to fill the gaps in their own practice. This could make their practice more effective and have a positive impact on their own wellbeing by 'sharing the load' which could also contribute to the reduction of the constraints in supporting CYP's MH needs in schools as found in this current research. This may offer more optimal utilisation of local resources, thus more effective support for CYP's MH needs in schools.

5.5.1 Implications for PMHW Practice

There are further implications for PMHW practice. This research offers a future direction for PMHW practice in taking a relational approach in their work. This could help support their difficulties with parental relationships to enhance their practice further. Additionally, this current study highlights the need for further research into the role of PMHWs in schools. There is a need for more training for PMHWs to support their practice when working with CYP's MH needs in schools.

There is also an opportunity for PMHWs to learn from EPs to support any team-based issues they may be experiencing.

5.6 Linking Findings with Psychological Theory

Although this research incorporates various psychological theories, some of which have already been referred to throughout this chapter, there are two overarching theories, systemic and organisational theory, that can be applied to the findings from this research to consider when implementing them into future practice. Psychoanalytic theory is also drawn on under the two main theories to offer explanations of some of the findings and difficulties that arise when applying systemic and organisational changes to promote more positive outcomes.

5.6.1 Organisational Theories

The application of CHAT framework aims to promote organisational change (Engestrom, 1999). Some of the themes identified in this study, particularly those related to others' perceptions and local and national government decision making, may be explained by the 'organisation-in-the-mind' theory (Hutton et al., 1997). 'Organisation-in-the-mind' describes what an individual believes in their minds of how an organisation should be run, including the activities, structures and how they are connected (Hutton et al., 1997). It describes the individuals own inner world, their own reality and thus how they interact with their environment (Hutton et al., 1997). There may be discrepancies with what the individual believes about the running of the organisation to what happens (Hutton et al., 1997). This may explain why some of the findings from this research generated by the participants differ from each other in the same LA. This creates tensions within the organisation, which CHAT identifies in this research, and can be used to promote change.

5.6.2 Systems Theory

Systems theory can further explain why it is hard to determine organisational change. For organisation change to occur, there needs to be an open system, meaning that the people within the system need to be open to change. When implementing the changes to local practice because of this

current research, it is important to consider how open the system is to changes, to increase the likelihood of the organisational changes to happen. Considering “hard” and “soft” systems will help to understand how to undergo these changes (Checkland & Poulter, 2006). Hard systems thinking refers to the problems that can be well defined, with definite goals and solutions, whilst being technologically and data driven (Checkland & Poulter, 2006). On the other hand, soft systems thinking describes the problems that are complex, difficult to define, with a social, political, and human activity component (Checkland & Poulter, 2006). The application of the CHAT framework to this study identifies findings which may be described as soft systems thinking as the themes and subthemes related to supporting CYP’s MH needs in schools can be very complex when changing human activity. Themes such as Resources and Local and National Government Policy involve social and political changes, therefore are soft systems thinking (Checkland & Poulter, 2006). This offers an understanding to why changes may be difficult to implement in this LA.

5.6.3 Psychoanalytic Theory

When organisational change is instigated, this can create anxieties within the individuals involved as well as within groups and the wider organisation. Bion (1961) defined workgroup and basic-assumptions mentalities when organisational changes occur. A work group mentality occurs when anxieties from the organisational changes are managed effectively, and the members can carry out the task at hand (Bion, 1961). However, when these anxieties are not managed, to defend against them, Bion (1961) described a basic-assumptions mentality, whereby the group does not function effectively, and members will start blaming others for the reasons why the group is not functioning.

This could explain the themes EPs and PMHWs suggested that they felt constrained their roles. The findings from this research suggest EPs felt time specifically the impact of the EPS being statutory only and constrained their role in supporting CYP’s MH needs in schools. To support the anxiety associated with this, EPs were found to be blaming others’ perceptions of them as well as government pressures of their role in cognitive assessments and supporting academic attainment

which constrained their role. PMHWs also discussed the impact of local and national government decision making when the thrive model was introduced in the PMHT as a new way of working. This may have served as a function to defend against some of their anxieties associated with this change. This may also have been true for both PMHWs and EPs that strongly felt the impact of resources in constraining their roles, which could defend against why they may not have been carrying out their roles as effectively as they could be. These mentalities should be considered when the findings from this present study are implemented into future practice to promote change in the LA. Psychoanalytic theory offers an understanding to why organisational change is complex, however the application of CHAT in this study helps to identify specific areas of change.

The findings from this present research can be explained by organisational, systemic, and psychoanalytic theories. These theories can also be applied to implement the changes highlighted by the tensions and contradictions within the findings from this research to stimulate more effective practice within and between EP and PMHW teams, to optimise the support for CYP's MH needs in schools, by utilising local resources effectively.

5.7 Strengths, Limitations & Suggestions for Future Research

5.7.1 Strengths

This research can be credited for offering a rich picture of this current LA. The findings provide in depth data which can be put into practice stimulating change within the LA. This may have been diluted if other LAs were included as each LA has different contextual difficulties.

Although this study may lack generalisability to other LAs in the UK, the study offers findings that can be applied to other LAs. Other LAs can apply the main findings to their contexts with PMHWs and EPs who may also be experiencing the same issues to optimise their local resources.

This current research can be credited for being the first study to investigate the role of the EP and PMHW directly together in supporting CYP's MH needs in schools. There is limited recent

research on the role of PMHWs, a gap this research fills. This offers opportunities to explore the intersection of these roles further in other contexts by prompting research in this area.

5.7.2 Limitations

As a result of the tight timescales of a doctoral thesis project, this research adopted a participatory role, rather than an interventionist role, to support the development of change, in line with third-generation CHAT. A key element of CHAT, developed by Engestrom and his team (1999) is the application of initial findings to a work environment, called a ‘Developmental Work Research’ (DWR). DWR is carried out after initial data is collected from observations and interviews. The aim of DWR is to hold workshops, like focus groups, to discuss the contradictions that derive from the original data to consider how these contradictions can determine change. Within DWR, participants are invited to comment and elaborate on the models presented within the AT framework. The workshops are recorded and can be used to inform discussion in subsequent workshops (Leadbetter, 2017). Although this research can be credited for highlighting the areas of change, this study could be improved by enhancing the data by collecting PMHWs and EPs views on the suggested changes in focus groups in line with DWR. This would offer a clearer picture of the direction for change within the LA.

Furthermore, if there was more time, observations could have been carried out of the different professionals interacting both within their systems and with each other. This would enhance the limitations of qualitative data, specifically semi-structured interviews as discussed in the methodology section. Considering Organisational Theory, this would enable researchers to examine ‘organisation-in-the-mind’ concepts (Hutton, 1997) in everyday practice through observation, which would provide further details on the tensions within the system.

There may be issues with generalisability of these findings as this was a small-scale doctoral research study, with eleven participants. This may not be fully representative of the wider EP and

PMHW profession. Caution needs to be considered when generalising these findings to other EPs and PMHWs.

Although, CHAT can be credited for offering new opportunities in EP research and other systemic issues, CHAT as a theoretical and analytic tool has been challenged by other researchers (Bakhurst, 2009, Levant, 2018). These researchers argue that it is important when applying this framework that the different strands of CHAT being used as theoretical and analytical tools are considered (Bakhurst, 2009). Some have challenged CHAT for being open to interpretation (Bakhurst, 2009). As this can be applied as a flexible model to data collection and analysis, this offers room for interpretation from the researcher implementing this framework in their work. This means the findings from CHAT research may be heavily influenced by the researcher. This could reduce extremely complex human processes within the AT triangle nodes which could be considered deductive. It is important to consider these points when applying CHAT as both theoretical and analytical tools.

The bias of the researcher conducting this present research also needs to be considered. The researcher was a Trainee Educational Psychologist (TEP) carrying out this research for their doctoral thesis. As the research looked at EPs and PMHWs, there could have been bias from the researcher when interviewing the EPs and PMHWs, whilst carrying out the analysis and writing this present paper.

There was personal drive from the researcher to focus on this specific area of research which arose from their own experiences as a TEP. Although, steps were taken to minimise such bias, this needs to be considered when evaluating this present research.

5.7.3 Suggestions for Future Research

To develop this research further, future research could apply DWR to examine professionals' views of the contradictions highlighted in this study. The findings from this current research could be presented back to EPs and PMHWs in this LA separately within focus groups then further focus

groups could be carried out with both professional groups for the professionals to discuss shared ideas. By doing this, this would firstly allow exploration of the findings, particularly the tensions and contradictions within the teams that need to be changed. This would offer a richer picture of the tensions which would increase further future directions and implications to promote change, as well as offering suggestions around implementing these into real life practice. This would allow for changes within the organisations to be moved forward and explorations of new objects such as focus on wellbeing over MH for EPs, as found in this present study. This may support 'organisation-in-the-mind' theory (Hutton et al., 1997) to explore the professional's realities to maximise the likelihood of implementing these changes.

This present research only consisted of two professional groups, however there are many other professionals and non-professionals involved in supporting CYP's MH needs in schools. Future research could include schoolteachers, SENCOs, ELSAs, other Psychologists, school counsellors and outside professionals such as CAMHS and charities to gather their views on the impact of EPs and PMHWs on CYP's MH. Parents could also be included in research to see how they interact with both EPs and PMHWs when supporting their child's MH needs and the impact this has. Further research may also include CYP themselves as they are ultimately at the centre of this practice to see how useful they feel the support is for their MH needs from the professionals. By incorporating these other participants, this could lead to a greater understanding of how the support for CYP's MH needs in schools is received and increase value for money of these local resources.

The research was only carried out in one LA; therefore, caution needs to be taken when generalising to other LAs. Other LAs could carry out their own research within their LAs to make it locality specific. A wider exploration would allow the findings to be generalised further to investigate whether similar tensions and contradictions are present more widely. This could then be used to support policy development on MH resources at both national and local levels.

5.8 Dissemination

At a local level, the research will be presented to both the EPS and PMHT within the LA it was conducted in. This will take place in a wider service day for EPs and a team meeting for the PMHWs. EPs and PMHWs will have the opportunity to ask questions and discuss implications of the findings for their practise. Following this, a proposed cross -service day will be proposed whereby both teams come together to take forward the recommendations from the single service meetings. This will allow the teams to jointly explore how to utilise local resources more effectively and provide optimal support for CYP's MH needs. The research will also be presented at meetings between the leads of the EPS and PMHT as part of local project development to enhance joined working between professionals to enhance MH support for CYP in the local area.

At a wider level, the findings will be presented to a different local area that is currently implementing more joined up working between their EPS and PMHT, to enhance their practice and optimise their local resources. The findings will also be presented to the wider doctorate course as part of a whole course event at the end of the academic year. There is also an ambition from the researcher to publish the findings in a journal that is likely to reach both sets of professional groups.

5.9 Concluding Comments

Although this research is not without its limitations, it is unique in that it is the first study to look at the role of EPs and PMHWs directly together. This research also adds to the very limited literature on PMHWs. This research is the first to investigate the intersection of both the PMHW and EP role in one LA to optimise local resources for MH needs in schools. The findings suggest that EPs and PMHWs may be hoping to achieve similar outcomes when working with CYP's MH needs in schools. To reduce conflict of interest, EPs could support overall wellbeing and adult's MH needs in schools whereas PMHWs can work with CYP's specific MH needs. This would reduce competition of survival of both professionals. The findings from this research also highlight that EPs and PMHWs may be using similar Tools to support CYP's MH needs in schools. To optimise local

resources, PMHW's roles should involve more longer-term therapeutic work to focus directly on CYP's MH needs independent of attainment needs. The findings suggest that EPs could offer training to staff and support for CYP's attainment difficulties which may be impacted by and impact on MH needs creating further difficulties.

The findings from this study indicate that EPs and PMHWs are both compelled by similar constraints to their roles in supporting MH needs, such as time and money. The main difference between EPs and PMHWs was that EPs felt constrained by emotional capacity to carry out their roles whereas PMHWs felt they required further training to enhance their practice in supporting CYP's MH needs in schools. PMHWs also expressed the impact of CYP's social care needs in reducing the effectiveness of their MH support for CYP in schools. PMHWs in this study had a greater understanding of the EP role than EPs did of the PMHW role suggesting more awareness should be promoted within the EPS. PMHWs viewed the EP role as mainly carrying out statutory work and cognitive assessments. Whereas EPs believed they have the skills to carry out MH work as much as they do statutory work and cognitive assessments. EPs would like to be having a more preventative role within their LA which increases their involvement in support for CYP's MH needs in schools.

To optimise current local resources, the EP role can support MH needs through statutory work however there needs to be increased investment from local and national governments to increase capacity to support EPs own wellbeing and enable them to carry out the work in MH needs that they aspire to do. This would support job satisfaction and minimise staff turnover. There also needs to be the same increased investment to support PMHW's capacity by expanding continuous professional development. This would optimise the support for both professional groups which would enable them to carry out their roles more effectively to maximise the impact of MH support for CYP in schools. This study offers further implications for local and wider EP practice and research.

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Appendices

Appendix 1: Critical Review of the Literature including excluded articles

Qualitative Papers

Paper	**Aims**	**Participants**	**Data Collection**	**Data Analysis**	**Findings**	**CASP Score**	**Limitations**
O'Reilly, M., Adams, S., Whiteman, N., Hughes, J., Reilly, P., & Dogra, N. (2018). Whose Responsibility is Adolescent's Mental Health in the UK? Perspectives of Key Stakeholders. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *10*(4), 450.	To explore the perspectives of professionals and adolescents on the frontline of who should be taking responsibility for adolescents Mental Health *Clear justification stated. Suitable for Qualitative*	54 adolescents 11-18 8 Mental Health Practitioners 16 Educational Professionals *Clear justification of having adolescents to give understanding of the professional's views, from a range of contexts*	Semi-structured questions, until saturation reached *Appropriate design, ethics and justification given. Questions designed well not to lead and create bias*	Thematic Analysis was used *Key steps outlined and data coded by 3 team members*	4 key themes identified: mental health is not primary role of teacher, teachers have limited skills to manage complex mental health difficulties, adolescents rely on teachers and responsibility of parents for their children's mental health	8 Green	*No mention of relationship of researcher to research* *Unsure on how data was recorded, no mention of why people weren't included*

					Thorough descriptions given and contradictions outlined		
Vostanis, P., Taylor, H., Day, C., Edwards, R., Street, C., Weare, K., & Wolpert, M. (2011). Child mental health practitioners' knowledge and experiences of children's educational needs and services. *Clinical Child Psychology and Psychiatry*, *16*(3), 385–405.	2 clear aims of exploring CAMHS professionals perspectives on education in order to enhance joined working and secondly to gather their views on a new training programme *Clearly justified and qualitative*	31 CAMHS staff and 5 educationalists *Clear reasoning around why not all participated in the study*	Semi-structured interviews *Qualitative and ethics given*	Thematic analysis was applied *Justification around coding programme also given*	Two key issues identified and 3 themes under one and 4 under the other	8.5 Green	*No mention of how data was recorded and gaps in the recruitment strategy such as who was contacted first, no discussion of relationship of researcher, a lot less education professionals*
Cane, F. E., & Oland, L. (2015). Evaluating the Outcomes and Implementation of a TaMHS (Targeting Mental Health in Schools) Project in Four West Midlands (UK) Schools Using Activity Theory. Educational	Understand the implementation of TaMHS projects, and the perception of this of the staff involved *Clear reasons and qualitative*	4 schools and 21 participants across the schools *Purposive sampling used to recruit*	Activity theory framework and four focus groups *Recording tools given and how*	Activity theory used as an analytic tool and thematic analysis *Reasoning around*	Findings outlined within activity framework and 7 key themes for supports and constraints given:	9 Green	*No comment on relationship between researcher and the research*

Psychology in Practice, 31(1), 1–20.		*participants with clear inclusion and exclusion criteria given*	*questions developed*	*inductive and deductive coding at different points given*	priorities and managing workload, time, funding, parents, planning and organisation, resources and staff attitude and training		
Gaskell, S., & Leadbetter, J. (2009). Educational psychologists and multi-agency working: Exploring professional identity. *Educational Psychology in Practice*, *25*(2), 97–111.	Explore views of EPs working in both EPSs and MATs *Clear justification of aims and qualitative*	10 EPs across 6 Local Authorities were included *Appropriate participants across different contexts*	Semi-structured individual interviews *Appropriate collection of qualitative data and ethics considered*	Some data analysed with a grounded theory approach and some using the activity analytic tool *Different aspects of analysis considered and justified*	4 issues under professional identity were highlighted: distinctive role of EP in MAT, group identification, development of skills and value *Flexible approach given to analysis*	5.5 Red	*No mention of how participants came to be included and researcher relationship* *No mention of ethics, further information and steps of analysis needed. Findings could be more clearly stated*
Hulme, H. (2017). How can Children and Adolescents Mental Health Services and Educational Psychology	Identify how effective joined working between	3 EPs and 3 CAMHS over different	Semi-structured interviews	Thematic analysis	3 key themes identified: joint working, mental health	9 Green	*Aims at the beginning could have been outlined more clearer, took*

Services work together more effectively to address the mental health needs of young people in school? [Dedcpsy, University of Sheffield].	CAMHS and EPs may happen *Main intentions outlined and qualitatively appropriate, relationship with researcher clearly considered*	hierarchical levels *Balanced number and different stages in the participants careers considered*	*Saturation considered and flexibility to support data collection, with ethical issues considered*	*Clear step by step guide provided*	in schools and EPs role in supporting mental health *Clearly outlined and explored*		*time to find these, contradictions in data could be explored further*
Zafeiriou, M., & Gulliford, A. (2020). A grounded theory of educational psychologists' mental health casework in schools: Connection, direction and reconstruction through consultation. *Educational Psychology in Practice*, *36*(4), 422–442.	Examine the processes of EPs supporting individual casework of MH needs in schools Clear outline and qualitative	5 EPs *Clear recruitment strategy given*	Semi structured interviews *Stages clearly outlined*	Immersive analysis in line with Grounded Theory *Need to give new ways of working and theory as limited topic*	Contacting EP when feeling stuck was main focused code, with 4 categories underneath: responding to adults' difficult emotions, joining theory with evidence, sharing hypotheses and challenging perceptions and planning	8 green	One LA, need to explain why some were excluded/including further for participation, no mention on researcher relationship

					Clearly grouped and linked later to literature in line with Grounded Theory		
Alice Kate Lambert, Alison Jayne Doherty, Neil Wilson, Umesh Chauhan, & Dushyanthan Mahadevan. (2020). GP perceptions of community-based children's mental health services in Pennine Lancashire: A qualitative study. *BJGP Open*, *4*(4).	Explore GPs perceptions of PMHWs *Clear and qualitative appropriate*	9 GPs *Clearly outlined purposive sampling and clear reasoning of why some did not take part*	Face-to-face semi-structure interviews *Pre piloted topic guide also used*	Thematic Analysis *Two researchers used to check coding and steps are clear*	Four main themes arose: the role of the GP, clarity on help available, getting advice and support and development needs	8 Green	*Just one area in the UK, saturation is not discussed, researcher relationship not discussed and ethical consideration for participants could be clearer*

Quantitative Papers

Study	**Method**	**Results**	**Discussion**	**Rating**	**Limitations**
Greig, A., MacKay, T., & Ginter, L. (2019). Supporting the mental health of children and young people: A survey of Scottish educational psychology services. *Educational*	Survey piloted in one Scottish EPS aiming to identify current practice of EPs in MH and key barriers, before sent to 32 LAs in Scotland, 21 returns from 19 LAs	EPs least likely to do direct MH assessment work and policy development, mot likely to do direct work with pupils and schools and indirect with parents/carers. 70%	Most view that they should support MH and have the skills and knowledge through CPD and initial training, however how their role is viewed in wider society differs.	Amber/Green	*Scottish context only, systems different, bias of self-report question, social desirability no info on the analysis run, ethical considerations unclear, only*

Psychology in Practice, *35*(3), 257–270.	*Information on inclusion criteria, anonymous, different geographical contexts of the country, urban and rural.*	had low confidence in MH risk work, 60% confident in conducting direct MH intervention and 85% with parents. Most schools interested in EPs as supporting MH. Most felt that knowledge and skills was a little barrier, but time and capacity was. 15 out of 21 responses said they would link with PMHW. *Clear reporting of results but little info on how the analysis was conducted, ethics unclear*	Policy and practice implications for commissioners and EPs themselves *Generalisation to professional development of EPs and government commissioners, suggestion of link with other MH workers*		*completed by PEPs- different career stages should be included.*
Gowers, S., Thomas, S., & Deeley, S. (2004). Can Primary Schools Contribute Effectively to Tier I Child Mental Health Services? *Clinical Child Psychology and Psychiatry*, *9*(3), 419–425.	A survey sent to all 291 primary schools in Cheshire aiming to clarify links with CAMHS. 186 schools returned, 64% response rate. *Information on exclusion criteria*	165 said they would refer to EPS and 83 to CAMHS on MH concerns. More training needed in identifying MH needs. No clear understanding of referral path.	Context issues considered as at this time 2 of the 4 CAMHS services were going through a change, so hard to identify how valid. Follow up survey in 2 years to be conducted. Clear	Amber/Red	*No comment on analysis used, minimal references, ethics not clear, one local area, generalisability issues, social desirability issues*

		Clear reporting on results	gaps in teacher training highlighted. *Clear future directions and practice and policy implications*		
Sharpe, H., Lereya, S. t., Wolpert, M., Ford, T., Owen, C., & Viner, R. (2016). Survey of schools' work with child and adolescent mental health across England: A system in need of support. *Child and Adolescent Mental Health*, *21*(3), 148–153.	A survey sent to all school staff in England aiming to gather views on specialist support for MH needs, differences in this and key barriers to supporting MH difficulties. Convenience sampling used, 593 accessed survey and 16 excluded leaving 577. *Clear inclusion and exclusion criteria, clear steps to analysis, wider population*	231 reported having specialist support, this was mainly secondary school, mainly using whole school approaches. Nearly two thirds reported 81% of support from EPs, CPs and counsellors used too. 60% reported funding from CAMHS. Two thirds reported capacity *SES considered, clear results, different factors of types of schools considered*	Challenges with joint work between CAMHS and schools, capacity of CAMHS biggest barrier, highlighting service needs to improve this service to schools. *Clear practice implications, links to national policy and future directions*	Green	*Questionnaires designed for leadership teams only, social desirability bias here, ethical considerations unclear, sample not fully representative of schools*
Vostanis, P., Taylor, H., Day, C., Edwards, R., Street, C., Weare, K., &	Questionnaire sent to 150 staff across 4 CAMHS teams to investigate their	85.4% reported frequent contact with educational staff, overall found local	Suggests more joint working with education needed, joint commissioning	Green	*Ethical considerations not clear, selection bias, numerical responses*

Wolpert, M. (2011). Child mental health practitioners' knowledge and experiences of children's educational needs and services. *Clinical Child Psychology and Psychiatry*, *16*(3), 385–405.	knowledge on education and views on joint working, 96 completed. *Clear inclusion and exclusion criteria, clear aims, clear statistical analysis given- between group comparison of categorical variables, Questionnaires supported by case vignettes, linear regression model on second hypothesis.*	education services to be helpful with supporting their knowledge. Most vignette scores were associated with reported knowledge scores, previous training linked to higher knowledge, more training needed. 28.1% reported needing more knowledge of educational needs and 30.2% only had specific training in relation to children's educational needs *Write up clear and links between the different methods of collections*	and developing relationships between MH staff and educationalists should happen *Clear future directions, in particular practice implications of training and policy development*		*and one questionnaire*

	Geographical considerations clear.				
Hickey, N., Kramer, T., & Garralda, E. (2010). Developing the primary mental health worker role in England. *Child and Adolescent Mental Health*, *15*(1), 23–29.	Aimed to evaluate the implementation of the PMHW role and PMHWs perceptions of the role. Survey questionnaire sent to 106 heads of CAMHS in England, leaving response rate of 63.5%	94% reported good link with their services, 69% provided consultation services to primary care staff and 75% to school staff. Training to school staff was reported mainly, 69% worked in schools and 77% in home settings, however those with psychology backgrounds were less likely to work in home settings. 48& reported tensions between tier 3 services who wanted them to do more individual case work to help manage the backlog, whereas PMHWs wanted to do consultation, liaison, and training. Mostly reported job satisfaction and only 12% reported	Need to support training for PMHWs, didn't support previous research of burn out and low satisfaction of staff. PMHWs help to improve access to mental health services for children and adolescents	Green	*Just head of services views this could affect validity, potential bias when reporting on other services and professionals, response bias*

	Comment on ethics audit so not needing ethical approval, inclusion, and exclusion criteria clear, demographics considered, geographical contexts considered, wide range of services involved.	attending training courses. *Links to other research to highlight the PMHW role*	*Link to government health initiatives, suggestions for further research and link to previous research*		
Callaghan, J., Pace, F., Young, B., & Vostanis, P. (2003). Primary Mental Health Workers within Youth Offending Teams: A new service model. *Journal of Adolescence*, *26*(2), 185–199.	Sample of 60 selected case studies, 40 considered appropriate after going through a service checklist in order to look at the direct clinical work of PMHWs in YOT and the PMHW consultation role, Likert scale used to assess consultation *Clear inclusion and exclusion criteria, use of outcomes scales, range of ages,*	Results highlight range of different work PMHWs offer and a need for more joint work, reasons for consultation varied *Quite generic commentary on results, clear tables and linked to*	Consultation is an important aspect of PMHW role, PMHW role offers key bridging work between CAMHS and YOTs, further research needed is identified *Linked to other research and implications for*	Green/Amber	*Bias due to individual cases affecting generalisability, more comprehensive outcome measures required e.g. numbers of re offending, this study is first phase*

	gender and offences, independent researcher rating scales	*demographic data giving explanations*	*further policy and practice development*		
Lacey, I. (1999). The role of the child primary mental health worker. *Journal of Advanced Nursing (Wiley-Blackwell)*, *30*(1), 220–228.	Intended to explore how the role of PMHW has been interpreted in each MH trust in England by sending a self-administered postal questionnaire, 169 services met the criteria and covered the right regional health authorities in England *Face validity considered, reliability addressed, inclusion and exclusion and sampling made clear, high external validity*	Average return rate of 59%, 98 out of 169 returned, varied disciplines, 30% time spent in consultation, 18% in training, 10% in joint assessment and 20% in direct work. 22% reported a reduction in referral rates, 17% increase and 5% neither. Mean waiting times was 22.4 weeks for PMHW. 66% planning on developing and retaining the PMHW role. *Different aspects of the services considered, linking results well, clearly outlined and use of graphs to support write up*	Linking back to previous research, nurses mainly fulfilling this role, consultation and direct work highest rate of work completed by the PMHWs, overall the more PMHWs the reduction in referrals (22.7%), suggestion of qualitative data to discover meaning *Future practice suggests of joint up assessments, linking explanations with results, further suggestions on future research too*	Green	*Lack of comment on ethics, lack of qualitative data makes it hard to understand meaning, data limited just to mental health trusts need to include education*

	as generalisable to the population of England, method of analysis outlined				

Appendix 2: Ethics Form and Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Tavistock and Portman Trust Research Ethics Committee (TREC)
APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact Paru Jeram (academicquality@tavi-port.nhs.uk)

FOR ALL APPLICANTS

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval

Is your project considered as 'research' according to the HRA tool? (http://www.hra-decisiontools.org.uk/research/index.html)	No
Will your project involve participants who are under 18 or who are classed as vulnerable? (see section 7)	No
Will your project include data collection outside of the UK?	No

SECTION A: PROJECT DETAILS

Project title	The role of Educational Psychologists and Primary Mental Health Workers in supporting Children and Young Peoples Mental Health Needs in schools		
Proposed project start date	March 2021	**Anticipated project end date**	May 2022
Principle Investigator (normally your Research Supervisor): Judith Mortell			
Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval			
Has NHS or other approval been sought for this research including through submission via Research Application System (IRAS) or to	**YES (NRES approval)** ☐ ☐ **YES (HRA approval)** ☐ **Other**		

the Health Research Authority (HRA)?	**NO**
If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.	

SECTION B: APPLICANT DETAILS

Name of Researcher	Emily Jane Crosby
Programme of Study and Target Award	Professional doctorate for child, community and educational psychology
Email address	ECrosby@tavi-port.nhs.uk
Contact telephone number	07590124630

SECTION C: CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES** ☐ **NO** If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES ☐ **NO**
Are you proposing to conduct this work in a location where you work or have a placement? **YES** **NO** ☐ If **YES**, please detail below outline how you will avoid issues arising around colleagues being involved in this project:
Confidentiality of participants will be respected at all times and their data will be anonymised.

Is your project being commissioned by and/or carried out on behalf of a body external to the Trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES** ☐ **NO**
If **YES**, please add details here:	

Will you be required to get further ethical approval after receiving TREC approval? If **YES**, please supply details of the ethical approval bodies below AND include any letters of approval from the ethical approval bodies (letters received after receiving TREC approval should be submitted to complete your record):	**YES** ☐ **NO**
If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:	
If you still need to agree these arrangements or if you can only approach organisations after you have ethical approval, please identify the types of organisations (eg. schools or clinical services) you wish to approach:	
Do you have approval from the organisations detailed above? (this includes R&D approval where relevant) Please attach approval letters to this application. Any approval letters received after TREC approval has been granted MUST be submitted to be appended to your record	**YES** **NO** ☐ **NA** ☐

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding ethical principles and to keep my supervisor updated with the progress of my research
- I am aware that for cases of proven misconduct, it may result in formal disciplinary proceedings and/or the cancellation of the proposed research.
- I understand that if my project design, methodology or method of data collection changes I must seek an amendment to my ethical approvals as failure to do so, may result in a report of academic and/or research misconduct.

Applicant (print name)	EMILY CROSBY
Signed	E.Crosby

Date	16.01.2021

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor/Principal Investigator	Judith Mortell

Supervisor –

- Does the student have the necessary skills to carry out the research?
  YES ☐ **NO** ☐
- Is the participant information sheet, consent form and any other documentation appropriate?
  YES ☐ **NO** ☐
- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?
  YES ☐ **NO** ☐
- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?
  YES ☐ **NO** ☐

Signed	
Date	

COURSE LEAD/RESEARCH LEAD

Does the proposed research as detailed herein have your support to proceed? YES ☐ NO ☐

Signed	
Date	

SECTION E: DETAILS OF THE PROPOSED RESEARCH

1. **Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**
This proposed research aims to look at the roles of Educational Psychologists (EPs) and Primary Mental Health Workers (PMHWs) in supporting children and young peoples (CYPs) mental health (MH) needs in schools. EPs have relevant skills and knowledge to support CYPs MH needs, as highlighted in The Special Education Needs and Disabilities (SEND) code of practice (CoP) (DfE, 2014). There has been a recent creation of a new role (PMHWs) by Child Adolescent Mental Health Services (CAMHS) to support CYPs MH needs in schools. This present research proposes to explore how EPs and PMHWs can be utilised effectively by the LA to maximise support for the mental health (MH) needs of children and young people (CYP) in schools. Participants will take part in qualitative semi-

structured interviews asking them about their and each other's roles. The interviews will aim to last around one hour per participant. The qualitative data will be analysed using an activity theory framework to generate themes. It is hoped that at least 3 professionals from each service will be interviewed to allow sufficient information and themes to be generated.

2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)

Around one in ten CYP have a diagnosable MH condition, with one in four showing signs of difficulty with their MH (BPS, 2017). There has been an increase in MH needs in CYP, exacerbated by the Covid-19 pandemic (YoungMinds, 2020). In two surveys conducted by Young Minds (2020) at the beginning of the pandemic and three months later, it was found that 41% of CYP felt that their MH had regressed since the beginning of lockdown, where 32% agreed the initial lockdown had increased their MH needs.

Despite greater public awareness and government investment, there has been a crisis in MH support for CYP between 2015-2020 (YoungMinds, 2020). In 2018, a Green Paper called for more support within schools and better joined up working with the National Health Service (NHS) (DfE, 2018). The introduction of the PMHW role was introduced in response to this. The aim of this role is to support the MH needs of CYP in schools (NHS, 2020). PMHWs provide consultation and training to professionals who work with CYP and their families (NHS, 2020). The aim is to tackle early identification and intervention as well as carrying out direct therapeutic work with CYP. PMHWs work with Child Adolescent Mental Health Services (CAMHS) and schools to identify those at risk (NHS, 2020). The PMHWs program is part of Improving Access to Psychological Therapy (IAPT) training and is made up of four days of supervised practice and one day of academic study (DfE, 2018). PMHWs have experience working in the field of child and adolescent mental health. This is a new, evolving role which is yet to receive much research into its efficacy and how it fits into the wider system of supporting CYPs MH needs.

The EP role has increasingly become involved in supporting CYPs MH needs. The BPS (2017) highlighted the ability of applied psychologists to work directly and indirectly with schools to increase staff knowledge and use systemic interventions to support pupils with MH difficulties. The Special Education Needs and Disabilities (SEND) code of practice (CoP) (2014) introduced MH needs into Education, Health, Care Plans (EHCPs). This highlighted the involvement of EPs in MH needs (DfE, 2014). In addition, EPs work in schools and have a good understanding of school systems, which can be used to support PMHWs roles in schools.

A recent report from Public Health England (2019) reviewed the approaches set out by the governments response to improving CYPs MH. The report identified gaps within systemic work across local partners. This resulted in a call for the development of an outcomes framework and a need for a better understanding across local services, in identifying the interplay of factors and benefits of adopting a whole systems approach (PHE, 2019).

Although, there are EPs and PMHWs that can support CYPs MH needs, it is unclear how these services can be best utilised in LAs to effectively support MH needs in schools.

Furthermore, there is a lack of clarity amongst other professionals such as SENCOs, who contract EPs work in schools, in how to best utilise their link EP in supporting MH needs (Andrews, 2017). This implies that having different services involved in the wider system of supporting CYPs MH needs can create difficulties and confusion for those contracting work.

In the local context of this proposed research, the PMHWs and EPs have started to hold weekly meetings to discuss how they can work together to best utilise their services for supporting CYPs MH needs. This has resulted from schools expressing their confusion about who to make referrals to. PMHWs and EPs in the local contexts have also reported that they're unsure how they can optimise provision when they are delivering separate provisions to the schools. The research aims to identify how the EP and PMHS roles can be best utilised to maximise provision for meeting CYP's MH needs.
In addition to supporting effective use of MH resources in the locality, the research aims to identify themes that may be useful for other LAs experiencing similar issues to consider and review.

3. **Provide an outline of the methodology for the proposed research, including proposed method of data collection, *tasks* assigned to participants of the research and the proposed method and duration of data analysis. If the proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)**

This research will take a Cultural Historical Activity Theory (CHAT) theoretical perspective which originated from Lev Vygotksy's work in Russia during the mid-1920's and mid 1930's. This has since been developed by Engestrom (1999) to provide researchers with a method to understand and describe the interaction between individuals and the environment in natural settings. This specific research will take a third-generation CHAT approach (see diagram in Appendix B). Third-generation CHAT studies aim to move an 'object' (in this present research supporting CYPs MH needs in schools) from an initial state of unreflected, situationally given 'raw material', to a collectively meaningful object constructed by the activity system, and to a potentially shared or jointly constructed object. This means data will be collected from each professional group (EPs and PMHWs) on the tools, rules, community and division of labour they have. This will generate an 'object 1' from each professional group (their views on supporting CYPs MH needs in schools) to 'object 2' (the interaction of the different views on supporting CYPs MH needs in schools within the system) to 'object 3' which will be a shared, jointly constructed view of both roles of the EP and PMHW in supporting CYPs MH needs in schools.

Participants will take part in semi-structured interviews that will last for 45-60 minutes. This form of data collection has been used successfully in previous CHAT studies to gain an understanding of participant's lived experiences of working in a system. The questions were developed through referencing interview schedules that have been used successfully with an Activity Theory Framework (Durbin, 2009; Mwanza, 2001 Shanti, 2014; Yamagata-Lynch, 2007). This framework facilitates data collection on the tools, rules, community and division of labour in each of the systems that contribute to firstly 'object 1' (each group of PMHWs and EPs views on supporting CYPs MH needs in schools) and then 'object 2' (the interaction of the different views of PMHWs and EPs in supporting

CYPs MH needs in schools). See Appendix for the interview schedule. The interviews will be recorded and then transcribed.

Braun and Clarkes (2006) model of Thematic Analysis (TA) will be used within the activity theory framework. There are a number of studies that have used TA with an activity theory approach (e.g. Yamagata-Lynch, 2003). This will take into account the 6 phases of TA: 1) becoming familiar with the data, reading and re-reading (transcribing); 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes and 6) write-up.

The analysis will take around 2-3 months from transcribing the interviews then analysing within the generated codes. Transcription of interviews can start after the first interview is complete. The plan is to start interviewing in May 2021 and to complete the analysis by the end of August 2021.

SECTION F: PARTICIPANT DETAILS

4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why these criteria are in place. (Do not exceed 500 words)

Written consent from the two heads of the services approving their team's participation will be obtained. Following this, information sheets (IS) and consent forms (CF) will be sent out to their teams. I have included on the info sheet the maximum number of participants I am seeking, making it clear that I will interview all participants who give consent up until the point I have reached capacity and will include participants in the order in which they respond. This aims to address the ethical issue of inviting more participants than I can accommodate. The inclusion criteria will be those who have worked in schools to support MH needs. This could be casework, consultation, intervention or training which has involved working with CYP with MH needs or working with the adults who work with the CYP with MH needs. The interviews will be conducted face-to-face in participants offices or a school in which they work or remotely. This gives participants the option in choosing where they feel most comfortable.

5. Please state the location(s) of the proposed research including the location of any interviews. Please provide a Risk Assessment if required. Consideration should be given to lone working, visiting private residences, conducting research outside working hours or any other non-standard arrangements.

If any data collection is to be done online, please identify the platforms to be used.

Interviews will take place in the usual place of work for all participants and the researcher, or in a private place of participants choosing, if they chose for the interview to take place remotely.

If interviewing takes place remotely, Zoom will be used.

6. Will the participants be from any of the following groups?*(Tick as appropriate)*

☐ Students or Staff of the Trust or Partner delivering your programme.
Adults (over the age of 18 years with mental capacity to give consent to participate in the research).

☐ Children or legal minors (anyone under the age of 16 years)[1]
☐ Adults who are unconscious, severely ill or have a terminal illness.
☐ Adults who may lose mental capacity to consent during the course of the research.
☐ Adults in emergency situations.
☐ Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).
☐ Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).
☐ Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).
☐ Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).
☐ Healthy volunteers (in high risk intervention studies).
☐ Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).
☐ Other vulnerable groups (see Question 6).
☐ Adults who are in custody, custodial care, or for whom a court has assumed responsibility.
☐ Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.
[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)
[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

7. Will the study involve participants who are vulnerable? YES ☐ NO

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from:

- the participant's personal characteristics (e.g. mental or physical impairment)
- their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness).
- where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable
- children are automatically presumed to be vulnerable.

7.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

If YES, a Disclosure and Barring Service (DBS) check **within the last three years** is required.
Please provide details of the "clear disclosure":

Date of disclosure:
Type of disclosure:
Organisation that requested disclosure:
DBS certificate number:

(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance). Please ***do not*** *include a copy of your DBS certificate with your application*

8. Do you propose to make any form of payment or incentive available to participants of the research? YES ☐ NO

If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research. Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

9. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)

Due to the entry criteria for the roles the participants perform, they will not require special arrangements. I will ensure to communicate in clear, accessible language and will provide opportunities for questions throughout the consent process and interviews.

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

10. Does the proposed research involve any of the following? ***(Tick as appropriate)***

☐ use of a questionnaire, self-completion survey or data-collection instrument (attach copy)
☐ use of emails or the internet as a means of data collection
☐ use of written or computerised tests
interviews (attach interview questions)
☐ diaries (attach diary record form)
☐ participant observation
☐ participant observation (in a non-public place) without their knowledge / covert research
☐ audio-recording interviewees or events
☐ video-recording interviewees or events
☐ access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes
☐ administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process
☐ performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction
☐ Themes around extremism or radicalisation
☐ investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)
☐ procedures that involve the deception of participants
☐ administration of any substance or agent
☐ use of non-treatment of placebo control conditions
☐ participation in a clinical trial
☐ research undertaken at an off-campus location (risk assessment attached)
☐ research overseas (please ensure Section G is complete)

11. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life?

YES ☐ **NO**

If **YES**, please describe below including details of precautionary measures.

12. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.

Whilst this isn't anticipated, should someone become distressed or uncomfortable, I would be able to support this given my experience on the doctoral training course and prior experience. My previous role working with adults and child participants in research projects equipped me with the skills to provide emotional support and make referrals where

necessary. I have experience on my current placement in supporting adults when they become distressed.
13. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words) **NOTE:** Where the proposed research involves students, they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.
For the participants, this provides an opportunity for their individual narrative regarding their own and other roles to be voiced. This provides participants with an opportunity to reflect on theirs and other's work. This could help them to feel more understood and empowered within their services. Participants will also have an opportunity to contribute to knowledge generation that could lead to improved ways of working and service delivery. This offers direct improvements for their own workloads and frustrations they may or may not be experiencing about theirs and other's roles in supporting MH needs in schools.
14. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)
• The researcher will be sensitive to the participants feelings throughout the interview and remind them that they can take a break and withdraw at any point if they need to. • At the end of the interview the researcher will check in with the participant to ensure they are not showing any signs of distress and if they are, they will be signposted to services they will be able to access support from following the interview if required. • In addition to this, the researcher will contact the participants a few days after the interviews to check on their well-being and ensure there has been no adverse consequences of the interviews.
15. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants.
At the beginning of the research, participants will have access to an information sheet with my contact details if they need to discuss any thoughts and feelings that may come up before, during or after the research. The information sheet will make it clear that participants have the right to withdraw at any time. At the end of the interviews, this information will be reiterated, and additional copies of the information sheets will be available to distribute if needed.

Once data analysis has been undertaken and conclusions have been reached, participants will receive a brief summary sheet of the results and will be given an opportunity to discuss the findings with me.
16. Please provide the names and nature of any external support or counselling organisations that will be suggested to participants if participation in the research has potential to raise specific issues for participants.
17. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

FOR RESEARCH UNDERTAKEN OUTSIDE THE UK

18. Does the proposed research involve travel outside of the UK?
☐ **YES NO**

If YES, please confirm:

☐ I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

☐ I have completed ta RISK Assessment covering all aspects of the project including consideration of the location of the data collection and risks to participants.

All overseas project data collection will need approval from the Deputy Director of Education and Training or their nominee. Normally this will be done based on the information provided in this form. All projects approved through the TREC process will be indemnified by the Trust against claims made by third parties.

If you have any queries regarding research outside the UK, please contact academicquality@tavi-port.nhs.uk:

Students are required to arrange their own travel and medical insurance to cover project work outside of the UK. Please indicate what insurance cover you have or will have in place.

19. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place. Please also clarify how the requirements will be met:

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

20. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES** **NO** ☐ If **NO**, please indicate what alternative arrangements are in place below:
21. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES** **NO** ☐ If **NO**, please indicate what alternative arrangements are in place below:
22. The following is a <u>participant information sheet</u> checklist covering the various points that should be included in this document. ☒Clear identification of the Trust as the sponsor for the research, the project title, the Researcher and Principal Investigator (your Research Supervisor) and other researchers along with relevant contact details. ☒Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved. ☒A statement confirming that the research has received formal approval from TREC or other ethics body. ☒ If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity. ☒ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support. ☒ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

☒ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.
☒ A statement that the data generated in the course of the research will be retained in accordance with the Trusts 's Data Protection and handling Policies.: https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/
☒ Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)
☒Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

23. The following is a consent form checklist covering the various points that should be included in this document.

☒ Trust letterhead or logo.
☒Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.
☒Confirmation that the research project is part of a degree
☒ Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.
☒ Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.
☒ If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.
☒The proposed method of publication or dissemination of the research findings.
☐ Details of any external contractors or partner institutions involved in the research.
☐ Details of any funding bodies or research councils supporting the research.
☐ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

24. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.

☐ Participants will be completely anonymised, and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?
☐ The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).
☒ The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).
☐ Participants have the option of being identified in a publication that will arise from the research.

☐ Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)
☐ The proposed research will make use of personal sensitive data.
☐ Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

25. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your participants are named or de-identified, please confirm that you will specifically state these limitations.

YES **NO** ☐

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

26. Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES NO ☐

If **NO**, please indicate what alternative arrangements are in place below:

27. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or

those purposes for which it was collected; please state how long data will be retained for.

☐ 1-2 years ☐ 3-5 years 6-10 years ☐ 10> years

NOTE: In line with Research Councils UK (RCUK) guidance, doctoral project data should normally be stored for 10 years and Masters level data for up to 2 years

28. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

☐ Research data, codes and all identifying information to be kept in separate locked filing cabinets.
☐ Research data will only be stored in the University of Essex OneDrive system and no other cloud storage location.
☒ Access to computer files to be available to research team by password only.
☐ Access to computer files to be available to individuals outside the research team by password only (See **23.1**).
☒ Research data will be encrypted and transferred electronically within the UK.
☐ Research data will be encrypted and transferred electronically outside of the UK.

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Essex students also have access the 'Box' service for file transfer:
https://www.essex.ac.uk/student/it-services/box

☐ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.
☐ Collection and storage of personal sensitive data (e.g. racial or ethnic origin, political or religious beliefs or physical or mental health or condition).
☒ Use of personal data in the form of audio or video recordings.
☐ Primary data gathered on encrypted mobile devices (i.e. laptops).

NOTE: This should be transferred to secure University of Essex OneDrive at the first opportunity.

☒All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

☐ All hardcopy data will undergo secure disposal. **NOTE:** For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.
29. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.
N/A
30. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:
N/A

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

30. How will the results of the research be reported and disseminated? ***(Select all that apply)***

☒ Peer reviewed journal
☐ Non-peer reviewed journal
☐ Peer reviewed books
☐ Publication in media, social media or website (including Podcasts and online videos)
☒ Conference presentation
☒ Internal report
☐ Promotional report and materials
☐ Reports compiled for or on behalf of external organisations
☐ Dissertation/Thesis
☐ Other publication
☒ Written feedback to research participants
☒ Presentation to participants or relevant community groups
☐ Other (Please specify below)

SECTION K: OTHER ETHICAL ISSUES

31. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

32. Please check that the following documents are attached to your application.

☒ Letters of approval from any external ethical approval bodies (where relevant)
☐ Recruitment advertisement
☒ Participant information sheets (including easy-read where relevant)
☒ Consent forms (including easy-read where relevant)
☐ Assent form for children (where relevant)
☐ Letters of approval from locations for data collection
☐ Questionnaire
☒ Interview Schedule or topic guide
☐ Risk Assessment (where applicable)
☐ Overseas travel approval (where applicable)

34. Where it is not possible to attach the above materials, please provide an explanation below.

Quality Assurance & Enhancement Directorate of Education & Training

Tavistock Centre

120 Belsize Lane

London

NW3 5BA

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

Emily Jane Crosby

By Email

6 May 2021

Dear Emily,

Re: Trust Research Ethics Application

Title: The role of Educational Psychologists and Primary Mental Health Workers in supporting Children and Young Peoples Mental Health Needs in schools

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me. I am copying this communication to your supervisor.
May I take this opportunity of wishing you every success with your research.
Yours sincerely,

Paru Jeram

Secretary to the Trust Research Degrees Subcommittee T: 020 938 2699
E: academicquality@tavi-Port.nhs.uk

cc. Course Lead, Supervisor, Research Lead

Appendix 3: Information Sheet and Consent Forms

Information Sheet

Title: The role of Educational Psychologists and Primary Mental Health Workers in supporting Children and Young Peoples Mental Health Needs in schools

Who is doing the research?
My name is Emily Crosby. I am a Trainee Educational Psychologist (TEP) in my second year of studying for the professional Doctorate in Child, Community and Educational Psychology. I am carrying out this research as part of my course.

What is the aim of the research?

This present research proposes to explore how EPs and PMHWs can be utilised effectively by the LA to maximise support for the mental health (MH) needs of children and young people (CYP) in schools.

It is hoped that participating will enable participant's voices to be heard on this matter, alongside providing an opportunity to reflect on their role and contribute to knowledge that could be used to improve outcomes in supporting CYPs MH needs in schools.

Who has given permission for this research?
The Tavistock and Portman NHS Foundation Trust has given ethical approval to carry out this research. The Local Authority Educational Psychology Service has also given permission for the research to go ahead.

Who can take part in this research?
EPs and PMHWs in the LA who have supported CYP's MH needs in schools.

What does participation involve?
If you agree to take part and if Covid-19 rulings permit, you will be invited to meet me at a venue that is convenient for you, your office or a school you work in. Alternatively, the interview will be conducted on zoom. I will then ask you questions about your role in supporting CYP with MH needs. All interviews will be recorded and transcribed. Recordings will be deleted after transcription. A summary information sheet will be provided to participants with the main findings once data analysis is complete, alongside an opportunity to discuss the findings with me.

What will happen to the findings from the research?
The findings will be presented within my thesis, which will be read by examiners and subsequently be publicly available to read, upon request, via Ethos (an electronic database, run by the British Library, that provides online access to UK doctoral theses). I may also publish the research at a later date in a peer reviewed journal. You will have the option to read a summary of my findings or the full thesis once completed. The findings will also be fed back in service development days and may be used to inform professional development activities.

Do I have to participate?
Participation in this research is entirely voluntary. If you do decide to participate but then change your mind, you can withdraw at any time up until the data has been analysed, at which point your participation will have already influenced the findings of the study.

Will my taking part in this study be kept confidential?
Yes. All records related to your participation in this research study will be handled and stored securely on an encrypted drive using password protection. Your identity on these records will be indicated by a pseudonym rather than by your name. The data will be kept for a minimum of 6 years. Data collected during the study will be stored and used in compliance with the UK Data Protection Act (1998) and the University's Data Protection Policy.

Are there times when my data cannot be kept confidential?
Confidentiality is subject to legal limitations or if a disclosure is made that suggests that imminent harm to self-and/or others may occur. The small sample size (8-10 EPs and PMHWs) may also mean that you recognise some examples and experiences you have shared in interviews. However, to protect your identity, pseudonyms will be used and any identifiable details changed.

Further information and contact details
If you have any questions or concerns about any aspect of the research, please contact me:
Email: ECrosby@tavi-port.nhs.uk
Telephone: 07590124630

If you have any concerns about the research then you can contactwho is the Trust Quality Assurance Officer . Her contact details are:
Email: pjeram@tavi-port.nhs.uk

Research Title: The role of Educational Psychologists and Primary Mental Health Workers in supporting Children and Young Peoples Mental Health Needs in schools

Please initial the statements below if you agree with them:	Initial here:

1. I have read and understood the information sheet and have had the chance to ask questions.	
2. I understand that my participation in this research is entirely voluntary and I am free at any time to withdraw consent up until data analysis, at which point my participation will have influenced the results, without giving a reason.	
3. I agree for my interviews to be recorded.	
4. I understand that my data will be anonymised so that I cannot be linked to the data. I understand that the sample size is small and specific to the Local Authority I am working in.	
5. I understand that there are limitations to confidentiality relating to legal duties and threat of harm to self or others.	
6. I understand that my interviews will be used for this research and cannot be accessed for any other purposes.	
7. I understand that the findings from this research will be published in a thesis and potentially in a presentation or peer reviewed journal as well as being fed back in service development days.	
8. I am willing to participate in this research and feel I meet the criteria of having experience of supporting CYPs MH needs in schools to participate.	

Your name: ………………………

Signed……………………………. Date…../…../…..

Researcher name: Emily Crosby

Signed…………………………….. Date…../…../…..

Thank you for your help.

Appendix 3 Interview Schedule based on AT framework

Object 1

1. What do you hope to achieve in supporting CYPs MH needs in schools?
PROMPTS: *Ways EPs/PMHWs practice is intended to improve outcomes for client, what would optimal support for CYPs MH needs in schools look like, how would you know yourself/team have reached this, how would the client (CYP) know if they were receiving optimal support, how would the adults around/ working with the CYPs know that optimal support is in place .*

• What impact does EPs/PMHWs work have on outcomes for the client?

Object 2

2. What do other professionals such as PMHWs/EPs do to support CYPs MH needs in schools?

PROMPTS: *Are there skills/knowledge/ work EPs/PMHWs can do to improve outcomes for client, are there skills/training/knowledge they have that better support CYPs MH needs in schools.*

- What impact does multi-professional's involvement have on outcomes for the client?
- Would working together be better in supporting CYPs MH needs in schools?
- What could EPs/PMHWs do to support your role in supporting CYPs MH needs in schools?

Possible Prompts to Use Through the Interview

Could you tell me more? What happened next? How come? What else? What else happened? What other reasons? Please tell me more about that. I'm interested in your reasons for that. What is your own view on this?

Unpicking the different professionals' roles in more depth

Community

1. Who else is involved with supporting CYPs MH needs in schools?
   PROMPTS: *People involved within the team (e.g. other EPs) and people involved outside the team (e.g. parents, child, local authority, supervisors, funders, PMHWs?)*

• What is their relationship/involvement with you?

Division of Labour

2. How are roles and responsibilities divided in your team in supporting CYPs MH needs in schools? PROMPTS: *Whether there is a lead agency or meeting facilitator; whether people are fully involved or partially involved; role expectations; overlaps; whether the roles are clearly defined and understood, what key work is carried out in the team to support CYPs MH needs in schools.*
   - How does this affect the way you work in the team?
   - How does this affect the way the whole team, and anyone else involved, works?

Tools

3. What means are used to carry out your work in supporting CYPs MH needs in schools?
   PROMPTS: *Meetings, methods of communication, action plans, protocols, resources available, record keeping, skills, training, knowledge, interventions.*
   - Why are they used?
   - How do they influence the way you support CYPs MH needs in schools?
   - How do they influence the way your team, and anyone else involved, carries out the work?
   - Is there anything else you need to enhance your role in supporting CYPs MH needs in schools?

Rules

4. What rules, regulations or expectations affect ways of supporting CYPs MH needs in schools? PROMPT: *Policies, statutory responsibilities, agency procedures, informal rules/ assumptions/expectations e.g. whose role it is to support CYPs MH needs in schools, level of training expectations.*
   - How do they affect your work in supporting CYPs MH needs?
   - How do they affect the way your team carries out the work in supporting CYPs MH needs in schools?
5. What supports or constrains the work you are doing in supporting CYPs MH needs in schools?

   PROMPT: *Time available, other responsibilities within your role (e.g. for EPs statutory work, drive for cognitive assessments, training, knowledge, specialised roles, etc.*

• How are any issues being addressed?

Appendix 4 Example Transcript with Coding

1 R: And just before we get into the main questions it'd be great to hear a bit about how long you've been a qualified EP for and a little bit about kind of your experiences and and maybe you're kind of journey into the doctorate.

..time in role

2 P11: Yeah. Okay, so I've been qualified for two years now, which is scary because I think that means I'm not newly qualified anymore.

..own interests and passions
..trauma
..adoption support
..EBSNA

3 And so, and before, so I trained at the Institute of Education.
4 And in my role at the moment my sort of, I think I'd say my key and interest is around social, emotional, mental health, and particularly around, early trauma, and adoption adoption is the area in which I did my thesis.
5 And, and also emotionally based school non attendance, I kind of two, kind of, specialist focuses that I have in my role, and then also linked with a short stay school, who for children who are excluded or at risk of exclusion at a Key Stage four site, I really enjoy doing that, I certainly think I've got an affinity to SEMH.

6 R: So, B we'll get into the first main question which is quite a big one.

7 P11: Yeah

8 R: what do you hope to achieve in supporting children and young people's mental health needs in schools?

..resilience
..EP working systemically not direct
..using senior leadership team more p
..adult mental health

9 P11: Wow, okay, I would say.
10 I think my main focus and hopes and aspirations, as an EP in this area is to build more capacity in the system. I would say a key contribution that we can make as EPs, is that sort of systemic level of work, where we're supporting leadership teams, and
11 we're supporting staff, and to then be able to support the emotional well being at that sort of universal level and sometimes more intense and kind of bring people in Key roles.
12 But I think that's really where our unique contribution comes, and I think then working in a multidisciplinary way with other services who might provide some of the more intensive therapeutic work, perhaps sometimes providing supervision to some of those

..EP see PMHW as doing direct therapy

..adult mental health

13 services where appropriate, but I think our role at that slightly kind of step away from the young person but very much with the adults, working with them. over time, I'd love to see it become a bit more community based where we are at the moment, I'd say in S, we don't have a very community based model of psychology, but sort of where we're much more and in the community and much more work with

..EP advocating for child
..eliciting pupil voice

14 parents as well. I think, where our role with young people, direct work with young people is as well placed is around gaining their

views I'm always really surprised how good we are at doing it.
15 And, on the contrary to that. How ill equipped schools can be to do that and again there's massive training needs there that we could be supporting systemically i think you know the the techniques we use I wouldn't say are, you know, very hard to do and
16 to use but maybe I undermine the years of claim that we go through to get to be able to use them. And so I think that's a really valuable role that we have in terms because I think once the voice and the child and being able to determine the support they get them for their mental health needs is really important.
17 And, and, Yeah, I know. We did some training around kind of brief therapeutic interventions when I was training, CBT approaches and play therapeutic play.
18 And I love that and I think if we could be doing that, more that would be great but we're very expensive way for schools to access that type of provision, I think.
19 And so, I'm not sure that's a sustainable way for for schools anyway to be accessing therapeutic services, although i'd love to do more work. Does that answer the question.

20 R: Yes. And I'm just wondering a bit more about what impact that work has on the outcomes for the client? The client being the child and young person.

21 P11: it's a good question because I don't think we're very good at getting the feedback on outcomes, necessarily, and it's always something I think about when I'm thinking about what do I want to develop, and then often it's the thing that gets lost I suppose
22 which is probably not a good thing.
23 But you so you focus on the doing and, and you have the review so you get a sense from reviews what the impacts been, but there's not a lot of concrete information sometimes.
24 But anyway, that's basically what I would hope, or what I know.

25 I do get feedback on training that I give or on supervision sessions that I give.
26 And I know that they often staff come away from those sessions feeling empowered and, either in terms of feeling more in control of what they're able to do or feeling more skilled in something that we're providing them with with talking about their approach.
27 and, and therefore, I would hope that then the impact that has on the child is that the adults around them are better able to support them and so therefore they're able to feel safer and enhance their sense of belonging in school.
28 I think a lot of the work I do is on developing relationships, and, and I always am coming back to the importance of relationships and everything I do.
29 And so I think, I think, and I have seen, and I know in some ways I suppose that, that helps staff to think about the supportive role they have and how they develop those relationships with students so they move away perhaps from thinking they're only

30 focuses on learning, and actually thinking about how they might develop relationships what other models that they could be using to support the development of relationships, especially in really tricky situations, and and gaining a new perspective so I would hope that students also feel more understood by the staff that are working with them, because we equip them to
31 recognize for example you all behaviours communication you know some of those kind of quite simple, simple ideas that are actually very difficult for staff to act upon in practice when you're in a busy school environment.
32 And I know from my direct work with students that they feel heard and listened to and very involved in some of the processes that I'll do with them and kind of make when I'm getting getting their voice, even if it's just a statutory assessment which we're
33 doing a lot of at the minute.
34 I think the impact of having a professional come in and listen to them. And, and use tools that are engaging and they can access makes a difference for a short amount of time and then hopefully a big amount of time in terms of the plan that's been put
35 into place but actually what the young person feels. At that time, and I often think I often talk about this but I think sometimes we think that you need to have an ongoing relationship with a student to make a difference, and for them to feel that they can talk to you, and of course there's ongoing relationships
36 are so important, but I think Part of the reason we get locked out of children on one off visits as well as the tools we use. I think it's the fact we're someone that they're not going to see again, I sometimes think there's as much value in that as an ongoing relationship because there's not a danger of them ruining the relationship by telling you those things and being honest to you they don't feel like they have to impress you, or like they have to not offend you.
37 And so I think giving young people an opportunity to express themselves, is something that they might in a way that feels open and free is an experience that I would hope they could take forward with them when they're thinking about how they express their
38 views and how they're views used can be respected and use to create a supportive plan.
39 So that's kind of like as an outcome but it's probably not a very measurable one.

40 R: no no that's brilliant and I think you've really answered that lovely so thank you so much. So just to kind of move away from your role and we'll come back to it a
41 bit later on.
42 And, and it's okay if you don't know about this you don't have an answer to this. But what do other professionals and for the purposes of this research primary mental health workers do to support children, young people's mental health needs in schools?

43 P11: So do you want me to just focus on primary mental health workers?

44 R: Yes please.

45 P11: Ok so, my understanding of primary mental health workers is Probably quite basic and, and I haven't had much, much exposure to them directly although I hear about their work.

46 So my understanding, is that they offer quite similar services to EPs in some ways in a different way so they.
47 I've heard that you know kind of doing assessments, often through consultation or through questionnaires and things to work out what the needs of children are.
48 I've come across some doing quite a lot of consultations with Parents particularly I think schools have often
49 refer when there's lots going on at home it's quite a good thing. Schools feel it's quite a good place for them to refer parents to and they might not yet be at the threshold for camhs.
50 So I think this they kind of build the parent confidence, but also give the parents someone to talk to you about these difficulties and who can receive it in a quite therapeutic way.
51 I think they do the same with school staff as well. And, and again that kind of the idea of building capacity in the adults around the child a bits like we would as EPs.
52 And I think, although I haven't come across this in my school but I think, they build down to do brief therapeutic intervention they're supposed to be that kind of early intervention before you would then perhaps have intervention from camhs and they're
53 meant to be the bridge between school in school support, and camhs. I was trying to think before I talked to you and I don't know that I have come across them doing therapeutic intervention within schools, but I might just not be privy to that.
54 And I don't know if I'm going off topic here because it was how do they, how do they support mental health in school wasn't it the question, but
55 when i. So my understanding is that every school has as a linked primary mental health worker.
56 But some of my schools don't seem to know that. So when I said have you talked to the primary mental health worker.
57 They sort of sat I don't know who that is we've never had contact. Other schools have lots of contact with them. I don't know I don't know how many of them there are in S supporting our schools, I don't know, I've never had a primary mental health worker make contact with me before.
58 Although I have with them, not many times I'm not putting them down for that at all, it's not like I've been ringing them every second but I sort of had a few conversations, probably when I've been involved with children and I know they've been involved. And, and I think it would be great to be linking up with them more. I'm sure you'll come on to that, with another question in a bit we'll be talking about that.
59 So, yes, my understanding is, they are there for early intervention

before camhs, and that they do a lot of work with the adults around a child they'll do assessment and some brief intervention with a child.

60 R: That's brilliant Thank you B and just kind of you were going on to my next question, and it's just thinking a bit about that kind of multi professional involvement and and just kind of thinking, you know, do you think it would work better if you did work together and also what kind of impact that would have for the child and young person?

61 P11: Yeah, I mean, I think my general rule is if you can work together do it together. It's hard to coordinate everyone. And I think part of the thing with being an EP that I'm noticing, when you try and work with other people is actually other people can quite comfortably work within their silos, because they, you know, primary mental health worker, that's mental health Speech Language therpaist that's communication interaction, but we rely on we need to we link up all of those different areas and we need. We yeah we do quite an oversight over each of those things because we're looking at how it interacts and what this means for the child.
62 So bringing people together in a multi professional way.
63 I think everyone in an ideal world would love to do that, but it's actually quite inconvenient and quite time consuming, when actually you can just carry on in your own little, you know in your own role and not need to necessarily link in with everyone else.So I think that's such a barrier to working together and sometimes I feel a bit like I'm hassling other professionals and they're always really lovely and polite and things but you just feel like actually it's only me that really needs this multi
64 professional not needs it I think we all need it and the child needs it but does that make sense, I think it. I think that's a huge, a huge barrier to it and if everyone would want to work together if we could.
65 And so I think what was the original question? I know it was about Multi-professional.

66 R: Yeah, it's just kind of what impact you think it would have on the child and young person?

67 P11: Okay, so I think we impact would mean that things were would happen in the, in the right order or the right way I think sometimes there's a little bit of this here and a little bit of that there, and you might not quite, sometimes you were halfway through working
68 with a child, and then you find out that someone's involved with them so i think you know if at the at the outset or if you if professionals knew someone else was involved, and they were to

compassionate schools which covers similar areas.
71 And actually if we did that training together the message would be the same. And I'm sure the messages are quite consistent, but we don't know that so I think there's probably some inconsistencies and schools perhaps feeling overwhelmed by all these strategies from all these professionals, whereas actually if it was right if they were going to agree that these are the important themes and these the types of things, it would just be much more coherent and manageable for schools and then for the young
72 person schools will actually do the things that we need them to do, rather than them thinking God this just seems like lots of meetings with lots of people with lots of different ideas being floated around.
73 So, it would skill up us like I'd love to know more about, you know, the therapeutic side of, you know, the knowledge that they might have about therapies I would learn through a meeting and I might have things that they might learn from me you know so there would also be the options of learning from each other, as well as the impact on the schools and the young people.

74 R: Yeah. Yes, brilliant, thank you and what what could primary mental health workers do to support your role B, as an EP?

75 P11: So I think, I think we I think we both probably need to do the simple thing of that more contact, making contact with each other. So, if, if they knew I was involved in it making contact with with me so that we can so that we can arrange or at least have a phone call if we can't do a meeting together just sort of touching base talking about recommendations and, you know, sometimes I find professionals are quite happy to share reports, but like it's not the same as talking it through you know sometimes
76 people are replacing have you not got my report but you know I do but I wanted to speak to you know speak about it.
77 And like ask questions so um so yeah engaging in discussions together.
78 And, and then kind of I guess it's like that higher level I'm noticing here I often think so much more systemically than the book from

..PMHWs doing attachment training
..PMHWs doing compassionate schools training
..joint training to schools
..need to do more joined working with PMHW
..not effective if there's too much overlap
..contact with PMHW
..need for more communication with other professionals
..PMHW joining planning meetings at the beginning
..shared case discussions together
..need to do more joined working with PMHW

primary mental health services for kind of people at the top to be really linked like commissioning to be linking in together
79 with local authority and thinking about right. What is the training that we're offering how do you have a coherent package What are you guys going to take what are we going to take doing joint training together so you've got you know, being available
80 and willing to do that training with schools so that they would have those two different viewpoints or two different areas of expertise that would would come together so I think a lot of it is about.
81 It won't always be the individuals it's got to be coming from the service. The making time and availability for collaborative working I think would be the kind of the first step, and then I can imagine its sort of working you know where EP might be involved and initial consultation that's joined and then they've been involved at the
82 review, but the primary mental health worker might do the intervention in between and they could be doing some brief therapeutic work and it might look something like that where they're doing a bit more on the ground kind of therapeutic stuff or they
83 could take on well up, you know, sharing the workload you do some work with the class teacher I'm going to focus on home, you know, whatever it might look like.
84 But it's all got to be, it's all got to come from a willingness I think there is a willingness, a, an availability and time to collaborate. Yeah, I think i's key.

85 R: That's really, really helpful. Thank you, B for that brilliant answer. So now moving away from primary mental health workers who else is involved with supporting children, young people's mental health needs?

86 P11: So outside of the school staff?

87 R: It could be people in your LA, outside of your LA. Who kind of in general who is involved in terms of supporting mental health needs?

88 P11: So in terms of service, you've got all

..need to do more joined working with PMHW
..not effective if there's too much overlap
..time issues
..EPs doing consultation
..need to do more joined working with PMHW
..joined consultations
..EP see PMHW as doing direct therapy
..EP working systemically not direct
..time issues

school staff and you got particular people within schools, you've got your your your trained professionals your elsa's your counselors that schools might have.
89 And often there isway too much put on ELSA's and counselors, and I think we should be scaling up other adults in school so be supporting mental health because it all just goes to the ELSA and then it's not like it's not anyone else's responsibility to

90 deal with them. And so in terms of local authorities Gosh okay. I don't want to just list them says I want to try to get okay so.
91 And obviously I mean within s we've got our specialist teachers, and they're sort of focused on either learning or the more behavior side of stuff.

92 Traditionally, they've been called behavior support, they're not anymore. I think they should be called emotional well being, something or other and so they're sort of like the level, kind of, before us and then we tend to get more complex they seem to get stepped up to us is how it works, where we are.
93 And so you kind of got.
94 Gosh.
95 Then you've got sort of services that are helping like A2E or inclusion when there's attendance issues. And, again, I think we've got inclusion teams very focused on the absence and the kind of punitive behavioral approach to getting children back
96 in and fines with Parents and that sort of thing. And, and it varies between workers but I think that there's more of a need to focus around emotional well being and understanding it as an emotionally based non attendance, not truancy.
97 And, but so I suppose they're there to help but I think there could be some more helpful work there. They've got A2E week, I think do do some more of that kind of work with children who are really struggling with their mental health and helping bridging

98 that gap back into school.
99 And so I guess that's kind of some of the some of the local it sounds really obvious, obviously EPs, and. And again, I think the focus of us on.

..ELSA's
..counselor
..ELSA's
..counselor
..specialist teachers
..EBSNA

100 We're often doing assessments right now that seems to be a huge focus and supporting thinking about what support arrangements and needed and what provision might be needed.
101 But I hope that when we can expand our offer when we're better staffed we'll be doing more of the preventative systemic stuff, and more consultation work, and then kind of like the NHS side of things so camhs.
102 So obviously primary mental health workers. We've also got like the well being nurses or something.
103 And this is, I mean, this seems to be loads going on at the moment and I don't quite understand it in S with well being practitioners and well being nurses and they're based in hubs there's going to be these new mental health hubs that bring together local Authority third sector and NHS.
104 So there's.
105 I know this kind of lots of change and things going on but I don't exactly know how that will work but I just hope it has the mixture of systemic and individual work as well.
106 And I think there's loads of third party stuff we're doing this work on EBSNA at the minute we talking to someone who knows a lot more about third sector.
107 And I think, I don't think in local authorities we're using enough of the third sector she was talk about all these charities I've never heard of, who can offer mentoring and do all of this amazing work with young people in the community and kind of thinking
108 about actually, yes we're talking about well being within school but we've got to think about it more broadly than that to be able to support them across all avenues areas of their life.
109 And so, yeah, I think there's. I don't know the answer with third sector but there's place to be one of the obvious charities are doing lots of work in schools.
110 I think there's a lot more local charities that schools could be making connections with other schools know about sometimes schools talk about something and I think gosh that's amazing that we've got that service.
111 I don't know as EPs that we always know what those services are. And we become quite, I think i'm often quite like oh let's think about camhs or local authority services, and I don't

..EP assessment of MH needs in schools
..EPs need to do preventative work
..EP working systemically not direct
..EPs doing consultation
..NHS systems
..EP working systemically not direct
..EBSNA
..charities to support SEMH needs in schools
..long term impact
..charities to support SEMH needs in schools
..charities to support SEMH needs in schools

..need to do more joined working with PMHW
..hinders to supporting mental health
..systemic barriers?
..need for more communication with other professionals

really think about what else might be, what else might be out there so I think, again it comes back to being
112 joined up and knowing who can do what, when and how that looks when you're working all together, and who links those things together who who holds all of this who, who is the like the lead on mental health in a local authority like god what a huge job
113 that would be but it feels.
114 Everything just feels, maybe it doesn't feel like this in every local authority. My suspicion is it, it does but everything just feels quite disjointed, and so like now I feel like I'm listing to you lots of different services that could help in some way.
115 What I should be doing or what in an ideal world, i think I should be telling you, this is the strategy that we have in our local authority.

116 And this is how we support well being in schools, and there's like this strand or this strand, or this strand, rather than. Oh, and there's a ton of other services there's this services this service does that make sense?

117 R: yeah

118 P11: there needs to be something.
119 there's loads of different services doing little bits of work, but no one's really talking to each other about what it is that they're doing. And, and, or not as much as they should be. And they're just just takes so much time to do that and to get a coherent pathway and coherent strategy and then you have a new head of the local authority and then they do another consultation and you get another
120 model that comes through with buzzwords on it, you know, I feel like I'm just getting on a rant now with your question but, yeah.

121 R: yeah. I mean, it kind of going on to my next question to you which was and you've kind of touched upon it, but,
122 asking a bit more about kind of like your relationship involvement with some of the, you know, services and the people you've just mentioned, so I don't know if you want to talk about that a bit more?

..need for more communication with other professionals
..hinders to supporting mental health
..statutory only
..EHCPS
..specialist teachers
..hinders to supporting mental health
..PMHW pre CAMHS and briding the gap
..need for more communication with other professionals
..need for more communication with other professionals
..need to do more joined working with PMHW
..traded services bringing in a time allocation model
..financial issues
..joint training to schools
..shared case discussions together

123 R: Yeah I think I'm
124 often I often want to and I think I'm trying to build relationships or with if there is a service I've not heard of, you know, whoever work with young person, especially at the minute we're doing loads of statutory assessments, I will try and make contact with any other professionals
125 that are involved to kind of have a chat with them about it, about, you know what it is they're doing.
126 And, but time is such a barrier to be able to link property with other services. So I would say, you know, as an EP service we've got quite good relationship with the specialist teachers and and you know some depending on like I've got some relationships with A2E because of case work I've previously been involved in and so now I can contact them here and there with little queries because you've got that link and. And there's like such barriers to. So even to connect say with camhs, Okay, you have to know the email
127 address of someone you can't just know their name, where they were from a local authority, you can know their name then you're there in your address book, and that's like such a little stupid thing, but to chase that person's email address or contact number becomes a thing you just can't fit into your day and then you don't contact them so there's something around the ease of access really impacts I think the relationships you have with different professionals and how much you're involved in working
128 with them.
129 I'd love to develop relationships with more third party organizations and work out what it is that they they support and how they're doing it. And, you know, I think.
130 Relationships are good between lots that I wouldn't say there's any kind of bad relationships I kind of, I wondered when wonder when we introduced trading and with charging for services.
131 Does that then become like the market of who competing for who gets what business from schools, if you're offering the same types of training.
132 But I kind of feel like there's so much work to do in schools, and there's so many different things that we could be working on, as long as someone or there's a team, spreading out

..shared case discussions together
..PMHW joining planning meetings at the beginning
..specialist teachers
..EP time with link schools in allocated area
..EP working systemically not direct
..EPs doing consultation
..EPs doing training in schools
..own interests and passions

the work, there's enough work to go around so I don't think there should be any competition, because we just need to focus on different things, and then People can buy into it.
133 But I wondered you know could that become. Sometimes we have these joint planning meetings and you've got us the speech and language therapist the stips, specialist teacher team, and kind of talk about this bit of training literacy training well everyone could do a bit on literacy training, and
134 sometimes it's an awkward moment of you know what I could do that well I could do that well I could do that. I don't think it's affected relationships I think it just Yeah. How is how my relationships, wasn't it with other services. I feel like I do feel like the relationship that is hardest to forge and maintain is with health.
135 And I think it's just because there another organization.

136 R: Yeah.

137 P11: Yeah. And, Yeah, very joint up in s.

138 R: No. Yeah, that's so much information now it's kind of going into my other questions but I think what we're going to do is going to come back to your role and thinking about your team.

139 Can you tell me a bit more about how roles and responsibilities are divided in your team in supporting mental health needs in schools?

140 P11: Yeah.
141 Okay, so we've all got link schools. So I'd say we've all got a responsibility, in some way, it's not like we've got someone who does cognition and learning someone who does you know you're all going to be supporting mental health and well being in some way

142 in our schools, through consultation or through training or through systemic works I think. And I think the each EP will probably be quite different in how they negotiate that

..own interests and passions
..EPs doing training in schools
..own interests and passions
..direct work with headteacher
..EP assessment of MH needs in schools
..own interests and passions
..parent work
..EPs doing compassionate schools training
..own interests and passions
..adoption support
..EBSNA

work, based on what they're comfortable with what they prefer to do what their interests are.
143 And so I would probably often be doing lots of training or work with the leadership team and someone else might do more consultations or more assessments or whatever it is.

144 So, but we're all kind of based on, we're all assessing what the needs are doing a needs assessment within our individual schools and then working out what's best for that.
145 So we kind of all got that base role that we've all got, and then we sort of have our special interests. So I think, then that depends on what projects you might take on or what training so we have some centralized training as you know in S, and which are offered and so you might sign up to offer emotion coaching to parents or the compassionate Schools program, so those of us with more of an interest in social, emotional, mental health, will probably put ourselves forward for those trainings and, and then we can also take on sort of, like, they're not really specialist roles, I think they call them specialisms but I don't know, there's kind of like, I don't actually know what they're called.
146 It's like special interest so like I was thinking, I support the adoption service, and I'm doing a project on emotionally based school non attendance.
147 But then we also have specialisms where you get paid more and it's like a pay grade up where you might be involved in that does that the virtual school or like lead it kind of it's like a promotion I guess where you leading on a particular area. So you can kind of the kind of divided up in those different levels, you've got what you're doing your link schools, then you've got what you might follow with your special interests, which might lead you to be involved in particular
148 projects or training. And then there's kind of this kind of step up promotion type role where you're leading on something.
149 And that's how they're kind of generally. Yes, that's how they're divided up, I guess.
150 But a lot of it is interest interest led really.

151 R: And how do you think that affects how you work in your team or how the whole team works?

152 P11: I think.
153 I think in our team, we've got quite a strong interest in social, emotional, mental health and quite a lot of us put ourselves forward to be involved in quite a lot of the projects related to that and I don't know if that's the case across all teams or not so I think it means we've got quite an infused and an energized team that are interested in these different areas. What was the question again?

154 R: So how it kind of affects how you work in your team or how the team works as a whole?

155 P11: Yeah. So I think it gives us a really strong base of interest and kind of able to bounce ideas off each other and I don't, I don't think we neglect other areas, I'm just trying to think what people, things people are involved in I think we all, lots of you know different interests and they're bringing lots of different knowledge into the team.
156 I suppose it means that we are all sharing ideas sharing knowledge and extending each other's knowledge because we're bringing what we're learning from those different places.
157 Yeah so I think it's only positive in that it probably builds to team dynamic team, the team's discussions and reflections together, and the knowledge that we have as a team.
158 I just trying to think if there are any drawbacks because we are a team that are particularly interested I don't know if there are any areas that we then don't pay attention to or neglect because we're quite focused on this, but if children aren't emotionally secure, They're not going to really learn so I think that's the right way for us to be focused on that rather than to have a team that's only focused on cognition learning. Yeah. Does that answer the question?

159 R: Yeah, no, that's, that's really helpful brilliant Thank you so much B, and just thinking about your role a bit more and you've told me a bit at the beginning about how you support mental health needs in schools

..own interests and passions
..promoting mental health first before academics in schools

160 but is there anything else that you use, to carry out your work in supporting mental health needs in schools for children and young people?

161 P11: So, I suppose, to think about the different levels of work I might repeat what I've already said to you.

162 R: that's fine that's great. Thank you.

163 P11: So I suppose you got like the assessment level. So, I spoke earlier about gaining pupil's views and things but there might be kind of other assessments that we might be thinking about using more kind of standardized measures or questionnaires you know SDQ's or your RCADS or your resiliency scales. I think a big thing that I try to do in my assessment of mental health needs and in all my work is be quite strengths focused and solution focused as well.
164 And, and sometimes that feels like a big difference between us and camhs is that we are strength, we are looking at needs we have to look at needs but sometimes you can see reports or look at the types of things they're doing it's a very deficit model,
165 which I guess fits with they are in a medical model right and it's not a that's a huge generalization and that's probably should, you know, provided in that's not that's not all camhs professionals.
166 So I think we might within my assessments, especially when there's a really complex SEMH casework is very much looking at what what are the resilience factors, what are the things we can build on here, rather than just focusing on the needs, and I think that can be really so important for young people who may have felt like they've been labeled as the naughty child or, you know, the difficult one, the one that's bringing lots of different challenging for want of a better word behaviors distressed speakers to
167 situation and for a school, sort of the assessment of needs and I think that's also when it's really helpful to link with other CAMHS professionals, because they will have their area of expertise is looking more in depth that those mental health needs
168 so they can often add more than I might have some some of my assessments I'm doing so

..EP assessment of MH needs in schools
..EPs implementing questionnaires with CYP
..Eps being seen as only doing cognitive assessment (+)
..Resilience building
..Eps being seen as only doing cognitive assessment (+)
..need to do more joined working with PMHW

that's like a really important point of collaboration i think is around that assessment its interesting as I'm talking I mean as I'm heading in my mind a lot.
169 They're really quite complex mental health needs you know are more complex. maybe rather than that, I have thought about whole school but you know, that's where my mind goes into more complex so you've got your assessment.
170 Got your consultation so working with, you know, parents and working with schools, and that is really about building capacity within the team around the child and again that's another really good point because I'm probably gonna end up saying it's all good point for collaboration, where you can have different perspectives and be agreeing different actions based on what needs to happen next, but we very much work in that consultation model in s, and building that capacity and the team around the child and got a sort of the training side of things, and with staff and supervision I think supervision for staff and we do supervision for elsas routinely, I really, I just started last year, with my relationship with my school, getting them to use my time to
171 supervise staff, and then we went to statutory only which then that didn't happen. As much as I wanted it to. I think that's a really important role for us to be supporting the emotional needs of and staff containing the container, and to enable them

172 to better support children in school.
173 And, as well as the kind of the more instructional training to build their capacity their knowledge or awareness of different types of social emotional health needs different interventions different strategies they can be using, and of facilitating
174 either you know through supervision reflective groups are really helpful and using things like,
175 what's that graphic one, it's like not matching up a circle of adults, things like that using creative ways to help them change their thinking about particular children I guess this is more consultation.
176 And then this kind of
177 the systemic work thinking with Senior leadership about leadership teams about their

..need to do more joined working with PMHW
..EP assessment of MH needs in schools
..interactions that go on around a young person
..joined consultations
..EPs doing consultation
..EPs doing training in schools
..staff supervision.
..statutory only
..adult mental health
..psychoeducation
..supporting staff to deliver intervention
..staff supervision.
..EPs doing consultation
..EP working systemically not direct
..direct work with headteacher

policies and practices, how do we change things that this whole school level, how do we plan. We did that, and staff well being PATH so using different. I think what we bring is we can bring some great tools to help staff teams, think about these things and think about well being and think about what steps they need to take so it's kind of that planning process with them. And it's like this huge big topic, actually, how do we break it down into something that's really actionable for you to achieve as a school and what would that look like in a year or five years. And then it My role is kind of a bigger project based work
178 so at the minute we're working on, and developing training and school staff for schools and school staff and supervision. Children who aren't attending so kind of by following us an evidence growing area of need within.
179 I think across the country. and actually then responding to that need and thinking about okay what do we do as EPs to support with that at different levels of that kind of your assessment your consultation your training.
180 I guess that's when the research element comes into it.
181 And I think the thing that I don't do much of is intervention that's like the fifth function isn't it of the EP, and, and I really enjoyed it when I did it in my training but it's just not something that schools prioritize my time for, it's very hard for me to go
182 to do weekly sessions, you know, after school if I had some particular part of time that was Allocated that I could be much more flexible with. I think it's very hard for us, for me to be able to go back into that therapeutic intervention, even though
183 we can but what we can do is take a lot of those therapeutic techniques into our sessions with children when we're gaining their voice you know let's do a hot cross bun together.
184 Let's think about what unhelpful thoughts you have or think about some solution focus stuff or draw upon motivational interviewing to think about what you know what stage of change are you at and what questions can I use to help you start to think about
185 moving forward to the next step. So I think we are drawing upon therapeutic techniques all the time and we put them into our training.

..direct work with headteacher
..whole schools approach
..whole schools approach
..staff supervision.
..EPs doing training in schools
..using senior leadership team more proactively
..EP assessment of MH needs in schools
..time issues
..EPs want to do more therapeutic and intervention work
..CBT model
..EPs want to do more therapeutic and intervention work

..CBT model
..EPs doing training in schools
..EP working systemically not direct
..EPs doing consultation

And we've just developed this training on EBSNA its all around Cognitive behavioral therapy, it's all about approaches, all around motivational interviewing all on solution focused stuff on PCP so we're kind of like taking, I feel like as EP we take a little bit from lots of different places and put it package psychology in a way that becomes accessible, whereas we might not always

186 be the ones that are delivering those psychological therapeutic interventions. Anyway, although consultations arguably be an intervention.

187 R: Yeah, that's that's brilliant Thank you, you've covered that really well. And do you think there's anything else you need to support your role Bas an EP, in supporting mental health needs? Or even enhance it.

..joined consultations

188 P11: Yeah, I think. I guess there's something around I was talking earlier kind of of strategy and coordination of an a wider approach that brings everything together so like, I'm part of this big system, and this is what we're aiming towards, so there's something kind of

189 big around that.

..Others perception of the EP role

190 And so that you kind of of guided in terms of of what your role is that's different to someone else's what, at what point do I feel like that's going to be for them, where you know they're going to take on that and take on this time I mean, it's time

191 to be able to coordinate more multi agency working.

..peer supervision
..need for more discussions with team

192 And I think with that time, as well as kind of being able to coordinate with other services also more reflection time individual reflection individual CPD, as well as joint reflection and Peer provision perhaps additional opportunities with other colleagues

..peer supervision

193 just to come together to think around these issues we've got a supervision group for those of the EPs that are working in specialist SEMH settings and kind of short stay schools.

..systemic barriers?
..shared case discussions together

194 And, which time has meant we haven't had as many of this year but when we have had them, they'd be really useful to problem solve cases so I think there's something about us

..systemic barriers?
..shared case discussions together

having time to reflect and be able to really think about these cases, and not necessarily cases but systemic issues that were coming across that might be interfering with systemic pressures.

..promoting mental health first before academics in schools

195 I mean I think what is needed, but this is not possible is a complete overhaul well it is possible, but it's not going to happen anytime soon is a complete overhaul of the education system.

196 It's just, especially secondary, And we just need this shift from academics and kind of that prioritizing academic attainment over everything else even though with it, you know there's messages that we aren't you know that we're that we're moving to, and

197 we are, I think we are getting better.

..systemic barriers?
..government barriers

198 I don't mean to be all doom and gloom, but the priority agenda, I think that comes down from Government is academic attainment. And that's just not conducive with forming relationships having time for students and supporting their emotional well being.

..promoting mental health first before academics in schools

199 So I think that there's this, and I'm so disappointed that covid didn't bring with it, the opportunity to do that. Like instead of stepping back the curriculum, we're trying to fit it all in and it's all about catch up instead of like well let's cut

200 out some of the crap from the curriculum and and focus on what's really important now.

..increase flexibility in the education system

201 And having much more flexible approaches to education so there's a vocational route that's not seen as the second best route that kicks you can achieve and though because it's a equally valid route so I think there's like this huge whole education system issue here that is.

..systemic barriers?

202 So, it's such a barrier to supporting mental health so in my role for my role to be supported of being able to support children's mental health, sometimes I'm trying to support a child to get back into school, who's not attending and supporting them back into a mainstream

..promoting mental health first before academics in schools
..EBSNA

203 school, and it's like actually do I want to support them back into this really high pressured academic environment that's too busy for them. You know, that's the goal of the adults around them.

..increase flexibility in the education system

204 they should be going back to a mainstream school, but not to a mainstream school in the way they're currently packaged because it's

..increase flexibility in the education system

just all wrong it's all upset.

..CPD

205 So, I mean that is a big ask to help my role, but I think it's the most important thing that would need to shift, but there's lots of little things we can do in the oh yeah extra CPD all that sort of stuff great that'll be fab, but I need this bigger change, please.

206 R: Yeah. Thank you, B and we're coming to the end, but I'm just wondering if there are any other kind of of rules or expectations or assumptions or regulations that kind of affect the ways of supporting mental health needs in schools

..EPs not being seen for mental health but learning and statutory

207 P11: that mental health needs are only for CAMHS. Okay, so I think that's an assumption is that, but that CAMHS is the only place to go for mental health needs.

..long waiting list
..PMHW pre CAMHS and briding the gap

208 And that, If there's a waiting list, we just wait on that waiting list. And that's the job done. I think that's a big rather than being like what are the things we can do because there's not enough support in schools and schools not quite sure where to go and they can't get to other support services. That's where primary mental health workers can have a really valuable role it's filling the gap when the waiting list you know and that's preventing them from needing to take that place and therapy because they might do some early intervention.

..increase flexibility in the education system
..department of Education

209 I think that's a stereotype, you know, an assumption, and assumption that children are always in control of their behavior or deliberately acting in particular ways, rather than the idea that the behaviors communicating that and depending emotional experience,

..department of Education

210 and so that blocks people from supporting them at the emotional level, and they just come in and this comes back to the education system and punitive approaches that are promoted by the DfE, and these behaviour hubs they're setting up but the minute why are you setting up behaviour hubs and not well being hubs, I don't know.

..relational approach

211 And so the, and that's another assumption that's a big barrier I suppose that punitive approaches are better than relational approaches the relational approaches are soft and Wooly, and spoiled children and mean

..relational approach

that they're never going to learn how

212 to live in the real world.

213 And that's a huge, you know, assumption in schools, it's very tricky behavior policies are a nightmare for supporting well being. Often, unless they have thought about it.

..schools behaviour policies

214 And Ofsted requiring particular wording in behavior policies that mean that schools want to change them but they think they can't, or they can't I don't know maybe they actually can't.

..issues around stigma of MH support

215 And maybe that's an assumption that they think they can't but they could, or maybe it's just a ridiculous thing that they actually they can't I don't actually know the answer to that.

..social factors affecting support (+)

216 And God there's loads of them there's loads of us and I think the one assumption that we are moving on from in society is that mental health difficulties are a sign of weakness. And, and I think, recognizing them being much better at recognizing the environmental components that might have impacted upon someone's mental health, I think, on the positive, that's, you know, we are.

..long term impact

217 I think we're moving towards a good assumption that mental health difficulties can affect any and do affect you know anyone from any walk of life, which then means we've got a more open discussion and discourse about it.

..whole schools approach

218 And as long as that's done properly, as long as schools don't pay lip service or not schools I don't want to blame schools because there's so many barriers for schools to do this stuff.

219 And, but I don't think we need not to be assumed that this is a light touch, give them a PSHE lesson once a year on mental health and it will be fine. It's got to be kind of it's got to be shown through the whole school through the whole system everyone's got to be on board with it so yeah I think we've moved away from the assumption that it's a quick

..EP working systemically not direct

220 fix, but I think there's still work to do to recognize that actually it has to this has to come from every part of the school system. And that's where other services, outside of schools can help I think that, yeah.

221 R: I mean, you kind of spoken a bit about how any of these issues being addressed, are they being addressed?

222 P11: So the. I think certainly as a service as an EP service, we're very much advocating for lots of relational and compassionate approaches and trying to talk to leadership teams through our compassionate schools Programs about about challenging, some of the behaviour
223 policies about supporting staff to recognize behavior.
224 I think there's always an issue that the schools you most need to get to those sessions, don't sign up to them. So I think you've always got a slight bias in the sample of schools that you get their own really up for it they're already on board.
225 That's why they come right.
226 So, I'm going to go into barriers aren't I. But I think there is this good work going on there. Where were you know and, you know, even just an individual consultations really advocating for relational approach is kind of some of the more national work was going on from some of the charities around,
227 you know, being attachment aware or trauma informed whatever they call it. So I think there is movement towards it there does seem to be two camps so behavior or relational approaches with no one. People seem a bit reluctant to cross side of the fence that you can be relational and have consequences, or, you know, you could, you know, and vice versa.

228 Anyway, so.
229 And so I think there's a national move, as well as a and you know there's work going on with ofsted to try and think about how they better look at the personal development of students and emotional development rather than just academics.
230 Yeah, what else I'm trying to think of some of the other assumptions and rules.
231 I think kind of, there are some good government initiatives around you know the the green paper which must be do they turn a different color after a while and it's white when they're in consultations so green is the final one. So probably like two years ago when I was training.

232 There's lots and there's lots of. I think support being offered to school, and there's lots of money being put into services.

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233 And like the hubs we've got coming up in S whatever they are. I just hope that it doesn't end up moving towards like an individual medical way of, we've got an early intervention to work one to one with children who are who are not, you know, as the
234 rest of the children are in the school.
235 And I hope that they're still supporting school systematically to think about early intervention i think is often thought of as when someone first starts bubbling up, give them some therapy, but like early intervention is having a system that supports
236 those needs from the outset.

237 Yeah, I think we do have services that helping with that but, yeah, yeah.

238 R: So my last question to you, B. And I just want to kind of really think about your way of working, what supports or constrains what you do in supporting mental health needs in schools?

239 P11: statutory assessments, the level of statutory assessments.

240 I had so much amazing work set up with my schools this year they've taken me quite a long time to work with them for a year at least a year, some of them, you know two three years.
241 And I'm shifting them slowly and slowly the ones that are more reluctant towards lets do a systemic project around, you know, to the project about compassionate school in one of my school I was doing well being projects you'd have staff supervision sessions, and then bam the service goes statutory only and had to cancel all that work that has been the biggest area for me being able to do preventative work in my schools.
242 So that's like a huge, huge area and constant and very right but very topical right now because all I'm doing is writing statutory assessments. So, yeah, I think that's a huge barrier and.
243 And I think that we often talk about time being a barrier right and it always it always you want more time, but actually the good thing about systemic work, is it often saves time because you're, you're having such a

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bigger impact with lead using less of
244 your time.
245 And I think this is like a personal barrier, which is like, like, creativity, in a way, so I wish I was more dynamic and like using different mediums.
246 more I think I can think of ideas, and being quite creative in the way we adapt approaches when we're working with schools and that's like a personal quality barrier, I think I wish I could crack and other barriers.
247 I suppose, heavy workload so whether we're doing statutory only or not. Typically I think we've got quite we get we are quite high number of schools in S that we're linked to.
248 And, and this space the time you have just to reflect on things and. And I think about what you're doing is just like go go go all the time, what's the next thing I've got to do, whether we're working statutory only or whether we're not.
249 And I think that time for reflection and that individual reflection, like Peer supervision, that'll be like the first thing that might go if I've got a busy week that obviously I don't go to that week because I've got to prioritize something else.
250 And maybe that comes back to personal, I need to take more personal responsibility and think of those things as being a priority. And that's hard to do when this pressing things for the deadlines that are working around you, and it's about his time but more, it's more workloads than time I think, and just feeling quite stressed, I think, and stress getting in the way of maybe that impacts upon my creativity as well you know you can't be free and think easily when, when you're feeling really stressed
251 and I would say, I feel stressed about work more than 50% of the time.
252 So you know, then it's that you don't really have the same level of movement, it's not always but negative stress you know stress and is sometimes positive but you know so yeah that's something related to workload and other barriers and kind of just making sure we've got access to really good CPD like in this area is just other CPD might take priority, but I think I would love to have more external speakers coming to talk to us in the way we get CPD delivered we have them sometimes but I'd like that more I suppose not a big

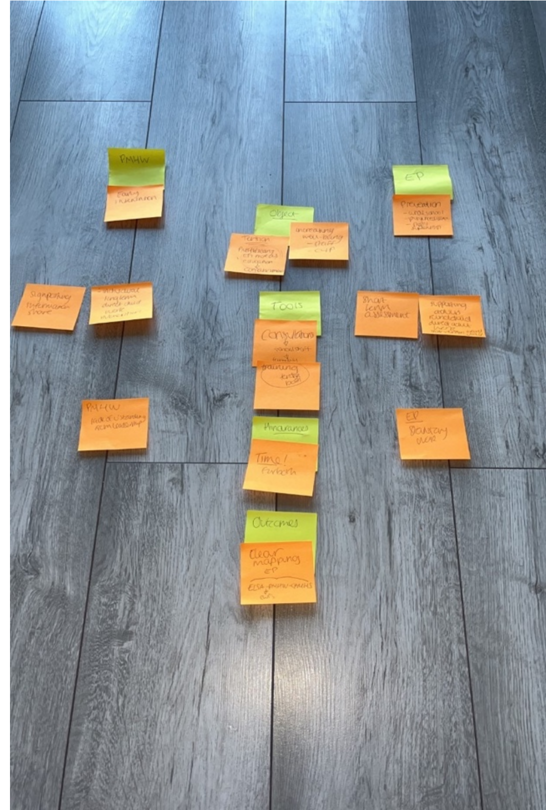
26/27

barrier, but if I wish, even better if.

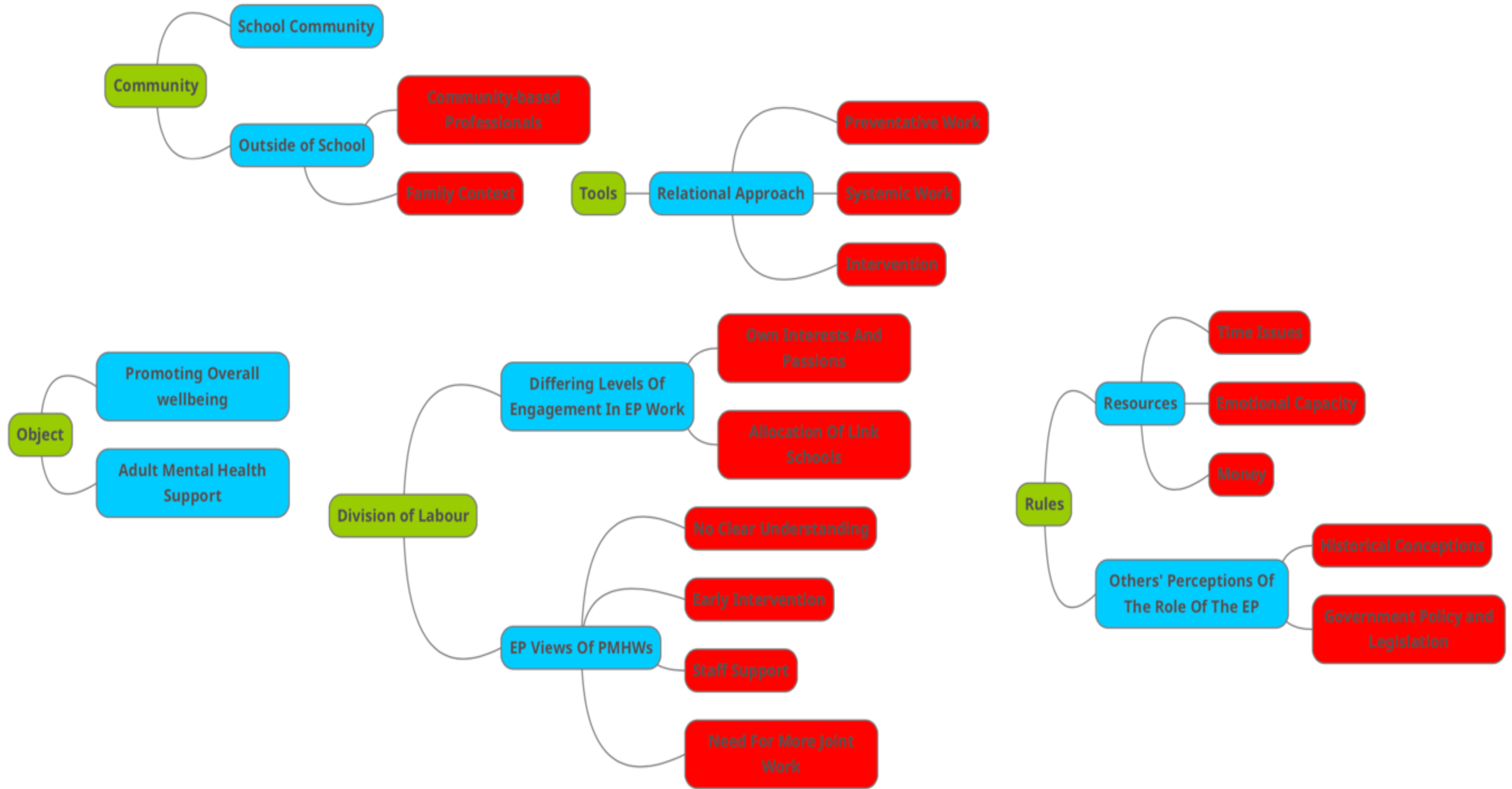
27/27

..EPs doing compassionate schools training
..relational approach
..EP working systemically not direct
..whole schools approach
..relational approach
..charities to support SEMH needs in schools
..relational approach
..promoting mental health first before academics in schools
..green paper
..government barriers
..financial issues
..EP working systemically not direct
..statutory only
..EHCPS
..time issues
..EPs need to do preventative work
..statutory only
..time issues
..time issues
..EPs want more time for creativity
..role capacity
..EPs needing time for reflection
..peer supervision
..need for more discussions with team
..role capacity
..EPs want more time for creativity
..EP well being
..EP well being
..CPD
..EP well being
..CPD

Appendix 5 Naming and Defining Themes



Appendix 6 EP Themes and Subthemes



Appendix 7 PMHW Themes and Subthemes