

The role of the school nurse in supporting the mental health of primary school children: A mixed methods study

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Declaration

I declare that the work in this thesis is entirely my own unless otherwise acknowledged.

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Date: 29 May 2024

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Abstract

Background: Mental health problems in children and young people (CYP) are a global public health issue and national priority. Yet, evidence indicates that CYP are not receiving support early enough. Few empirical studies have focused on school nurses' (SNs) contribution to supporting the mental health of primary-school-aged children. This study explores how SNs support children's mental health from the perspective of the SNs, primary-school-aged children themselves, parents, and teachers.

Methodology and Methods: An explanatory sequential mixed methods study underpinned by a pragmatist approach was conducted in Scotland. Phase One involved the administration of a national cross-sectional online survey comprising open and closed questions to nurses working in the school health service in Scotland. Phase Two employed a Single Qualitative Case Study design. Data collection involved online semi-structured interviews with qualified SNs, primary-school-aged children (9–11 years), parents and teachers in one health board area in Scotland. Creative, participatory methods were used in the interviews with children. Qualitative data were analysed thematically using the Framework Approach.

Findings: SNs recognised their vital role in supporting primary-school-aged children's mental health and their practice was holistic, strengths-based and innovative. The teachers had experience of working with SNs and this was positive. In contrast, primary-school-aged children and most parents had no experience of the SN and were unaware of the support they could offer and how to access them. They were clear that SNs should be accessible, approachable, and non-judgemental and building trusting relationships was viewed as being crucial. Barriers to SN involvement in mental health work, included workforce capacity, lack of resources, including retention of SNs, and the pandemic.

Conclusion: SNs have a key public health role in supporting primary-school-aged children's mental health and their contribution is valued by teachers' when they have experience of working with them. This thesis identifies areas to inform the mental health work of the SN and raise their profile as specialist community public health nurses.

Confirmation of Ethics Approval

I confirm that ethics approval was obtained for both phases of this study from the University NHS, Invasive or Clinical Research Committee. Neither the Phase One nor the Phase Two Study required NHS Research Ethics Committee approval as both were deemed to be Service Evaluation rather than research as defined within the NHS.

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Glossary of Terms

ACE	Adverse Childhood Experience
AfC	Agenda for Change
CAMHS	Child and Adolescent Mental Health Service
CPA	Child Protection Advisor
CYP	Children and Young People
DoH	Department of Health
GIRFEC	'Getting it right for every child'
HM	Her Majesty
HV	Health Visitor
LIAM	Let's Introduce Anxiety Management
MS	Microsoft
PPCT	Process, Person, Context, Time
NHS	National Health Service
NMC	Nursing and Midwifery Council
QCF	Qualifications and Credit Framework
RCN	Royal College of Nursing
SCPHN	Specialist Community Public Health Nurse
SCQF	Scottish Credit and Qualifications Framework
SN	School Nurse
SNs	School Nurses

UK	United Kingdom
UNICEF	United Nations International Children's Emergency Fund
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organization

Chapter One: Introduction to the Thesis

Introduction

Primary-school-aged children and young people (CYP) may have contact with the Specialist Community Public Health Nurse (SCPHN) School Nurse (SN) at different times and in different settings during their journey through school, with the purpose of promoting, supporting, and safeguarding their health and wellbeing. This thesis explores the mental health aspect of SN practice within the context of Scotland from the perspectives of SNs, primary-school aged children, parents, and teachers, addressing a gap in the research. It seeks to contribute towards an improved understanding of the SN contribution to supporting primary-school-aged children's mental health.

The research had three research questions:

1. How do children, parents, teachers, and school nurses currently experience and understand the work of the school nurse in supporting primary-school-aged children's mental health?
2. What factors influence their experiences and understanding?
3. How do their experiences and understanding inform the future work of the school nurse in supporting primary-school-aged children's mental health from an ecological and strengths perspective?

To address the research questions, this study used an explanatory sequential mixed methods design underpinned by a pragmatist approach. An online survey was utilised to obtain a snapshot of the mental health work of nurses working in the school health service across Scotland; and online semi-structured interviews to consider how children, parents, teachers, and SNs experience and understand the mental health work of the SN, factors influencing their experience and understanding, and how this can inform the future work of the SN.

This introductory chapter begins by positioning the thesis reflexively in relation to my professional background, explaining why I chose to do a PhD exploring SNs'

work supporting primary-school-aged children's mental health. To situate the study, this chapter provides some background information on CYP's mental health and the role of the SN, before embedding the thesis in the current policy and legislative context in Scotland. The chapter then moves on to provide an explanation of the significance of this study for SN practice. The chapter closes with an outline of the thesis structure to provide navigation and signposts.

1.1 Professional background

In this opening section, I discuss my professional background and outline the reasons why I chose to do a PhD exploring SNs' work supporting primary-school-aged children's mental health.

I am an experienced nurse academic, working within a specialist community public health nursing programme for health visiting students, holding registration with the Nursing and Midwifery Council (NMC) as a Nurse and a Specialist Community Public Health Nurse (SCPHN-Health Visitor (HV)). My role as a lecturer involves designing, developing, delivering, and evaluating a wide range of teaching, learning and assessment modalities, both face-to-face and online. Prior to this role, I worked as a Child Protection Advisor (CPA) in a large Scottish Health Board, from 2009–2014. In my role as a CPA, I had responsibility for: providing advice and support to health professionals who had child protection concerns; the provision of child protection supervision to health visitors and SNs; the provision of child protection training; and auditing of child protection records. Within this role, I became aware of the limited direct contact that some SNs had with children and families, particularly, children assessed by the health visitor as being vulnerable at their transition to school and transfer to the SN caseload. An inspection of children's services in this local authority area found that SNs did not always consistently identify the health needs of vulnerable children and families (HM Inspectorate of Education 2010). This finding contrasted with my previous experience, working as a health visitor in a different Scottish health board, where SNs regularly had direct contact with school-aged children. I was interested to discover why this should be the case, and, for my Master's dissertation, I chose to explore the child protection role of SNs in the health board area in which I was working at that time. The findings of that small-scale

qualitative study highlighted that the attitude of some SNs could be a factor influencing their involvement with school-aged children. One SN expressed the view that the role of the SN was to address the physical health of children and not any concerns regarding their emotional or social health and wellbeing, which sparked my interest, as I take a holistic view of health.

My interest in CYP's mental health and the role of the SN grew further in my current role. In this role, I became increasingly aware of the evidence base highlighting the impact of the social determinants of health on the outcomes for children across the life course, in particular on their mental health and the need for early identification and support (Marmot 2010). An initial literature search revealed a paucity of research focusing on SNs' contribution to supporting primary-school-aged children's mental health, thus confirming that this was an area worthy of investigation.

1.2 Background: Mental health and wellbeing of children

Over the last two decades, there has been global recognition that prioritising the mental health and wellbeing of CYP is essential to improve their outcomes across the life course (Herrman et al. 2005; Mnookin 2016; World Health Organization (WHO) 2022). Mental health is a fundamental component of health and wellbeing, encompassing every aspect of an individual's life, influencing their ability to learn, build and sustain relationships, and function effectively within their wider world (Herrman et al. 2005). The WHO (2001, p. 1) define mental health as:

a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

This definition, although positive and aspirational, has some limitations, in that it omits to reflect that mental health is on a continuum and will change depending on different experiences and events over the life course (Huber et al. 2011). Manwell et al. (2015) sought to identify mental health experts' perspectives on the core concepts of mental health through an online survey conducted in eight

countries. The findings revealed that there was lack of agreement on the core concepts of mental health and the perspectives of respondents were influenced by their worldviews. In addition, they identified that agency, control, and autonomy were considered by respondents to be integral components of a person's mental health and their ability to cope effectively with change in their environment and interact with others (Manwell et al. 2015). Similarly, a literature review by Shucksmith et al. (2009) to identify factors that influence CYP's views of mental health found that agency and control were viewed as being fundamental by CYP. Moreover, it was found that relationships and experiences and events in the CYP's wider world were viewed as factors that could positively and negatively impact on their mental health. It is acknowledged that mental health is a broad term, and NHS Health Scotland (2016) use it to refer to mental wellbeing and mental health problems. For this thesis, the definition I considered to be the best fit with the evidence on CYP's understanding of mental health is as follows:

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make healthy choices. (Centers for Disease Control and Prevention 2023).

Across each of the four nations of the United Kingdom (UK), improving and promoting CYP's mental health and wellbeing has been identified as a public health priority, with early intervention a key focus (Department of Health, Social Services and Public Safety 2014; Scottish Government 2018a; Public Health England 2019; Public Health Wales 2023). The evidence base linking stressful events in childhood, also referred to as Adverse Childhood Experiences, with an increased risk of mental health problems across the life course is substantial (Lucenko et al. 2012; Bellis et al. 2015; Couper and Mackie 2016). Furthermore, there is growing recognition that the development of mental health problems in childhood are linked to poorer mental and physical health in adulthood (Murphy and Fonagy 2012; Fryers and Brugha 2013). In 2017, it was estimated that 10–20% of CYP will experience a mental health problem (WHO 2017), with half of these developing before the age of 14 years (Kessler et al. 2005; Public Health

Scotland 2021). A more recent report indicates that one in ten CYP will experience a mental health problem (WHO 2022). To put this in context, within an average classroom of thirty children in Scotland, approximately three will have experienced a mental health problem by the time they reach sixteen years (Scottish Children's Service Coalition 2023). The development of mental health problems in childhood are linked to poorer mental health in adulthood (Fryers and Brugha 2013). Despite this, CYP experiencing mental health problems are not receiving the support they need early enough (Children's Society 2008, 2021; Smith et al. 2017), and the COVID-19 pandemic has added to the problem (Public Health Scotland 2024). There is some evidence suggesting that SNs could make a significant contribution to supporting children's mental health (Prymachuk et al. 2012; Turner and Mackay 2015); however, the evidence base is limited (Abhyankar and MacGillivray 2014; Campbell et al. 2014).

Mental health problems in CYP range from symptoms that impact on their emotional, social, and cognitive function to those that meet the criteria to be diagnosed as a mental illness. The Royal College of Paediatrics and Child Health (RCPCH) (2020) categorise mental health problems into the following four categories: emotional disorders (anxiety and depressive disorders, mania and bipolar affective disorders); behaviour disorders (patterns of repetitive and persistent behaviour that is disruptive and violent and violates the rights of others and social norms); hyperactivity disorders (inattention, impulsive and hyperactive); and others (for instance, autistic spectrum disorder, eating disorders and tic disorders). According to Public Health Scotland (PHS) (2022), the most common mental health issues affecting CYP in Scotland are anxiety, depression, self-harm and conduct disorders. In England, data from NHS Digital (2018) indicated that the prevalence of anxiety, depression, obsessive compulsive disorders and phobias in CYP had increased in 2017, whilst behavioural disorders and hyperactivity disorders had remained mostly stable (RCPCH 2020). However, the data do not include details of the most common conditions within the category of any mental disorders, despite this category being the most prevalent. Furthermore, as PHS do not collect data on the prevalence of mental health issues in CYP, it was not possible to establish which mental health issues were more prevalent or to identify trends. Nevertheless,

what is apparent is that emotional and behavioural disorders are the mental health issues that affect CYP the most.

The *Mental Health of Children and Young People in England 2022* survey (Newlove-Delgado et al. 2022) revealed that the rates of probable mental health disorders in children aged eight to sixteen years had increased from 12.1% (one in nine) in 2017 to 16.7% (one in six) in 2020, and in 2023 the rate had increased to 20.3% (one in five). Although there is no comparable data for Scotland, Wales or Northern Ireland, the national statistics for Scotland have highlighted significant increases in the number of referrals of children and young people to the Child and Adolescent Mental Health Service (CAMHS) since December 2021 (PHS 2023). These statistics suggest that, in common with England, the prevalence of mental health disorders in children aged eight to sixteen years has increased even further since I commenced my thesis. This is concerning, given the implications of poor mental health on the outcomes for CYP across the life course and serves to highlight the need for action to address the problem. This chapter will now focus on the Specialist Community Public Health Nurse-SN and their role in addressing children's mental health.

1.3 The Specialist Community Public Health Nurse-SN

SNs are NMC registered nurses or midwives who have completed additional qualifications to register as a SCPHN-SN (NMC 2022). They are autonomous practitioners who have a key public health role in promoting, supporting, and safeguarding the health and wellbeing of children and young people aged five to nineteen and upholding their rights (NMC 2022). Within Scotland, the title 'SN' should only be used by nurses who have successfully completed a postgraduate SCPHN-SN programme at Master's level (Glasgow City Integration Joint Board 2023). However, because only the title 'specialist community public health nurse' is protected in legislation under Article 44 of the *Nursing and Midwifery Order 2001*, and the title 'SN' is not, it can be used to refer to qualified and unqualified nurses working in schools. There is pressure to protect the title of 'nurse' in legislation (Royal College of Nursing (RCN) 2022), and the UK Government, as part of reforms to update the legislative framework for the regulation of healthcare professionals, considered an amendment to the *Health and Social Care Bill 2021*

to facilitate this. However, the amendment was not passed, and the title 'nurse' can still be used indiscriminately, risking public safety. The NMC, as part of their regulatory reform, are reviewing protected titles and parts of the register, including the specialist community public health nursing part (NMC 2023). It is not clear yet what the implications of the review will have for the future regulation of specialist community public health nurses. Nonetheless, robust regulation is essential and the title of both 'nurse' and 'school nurse' need to be protected to safeguard the public and the identity of the profession.

Specialist community public health nursing practice is underpinned by ten guiding public health principles that are arranged under the following four domains:

1. Search for health needs – to create and maximise health and wellbeing.
2. Stimulation of awareness of health needs – improve the health and wellbeing of individuals, groups, families, and communities.
3. Influence on policies affecting health – to influence the design and provision of services and policies to address the determinants of health.
4. Facilitation of health-enhancing activities – to work in partnership with individuals, groups, families, and communities to address health inequalities.

These four domains provide the framework for the current NMC Standards of Proficiency for SCPHNs (NMC 2004). However, the NMC published new Standards of Proficiency for SCPHN in May 2022, and the four domains have been replaced by six spheres of influence (NMC 2022). Despite this, they remain fundamental to SCPHN-SN practice and are evident within the new standards. SNs work in partnership with children, young people and families and health, education, social work, and other agencies, including the third sector, to identify health needs and improve the outcomes for children and young people. Their role focuses on addressing the wider determinants of health and working to reduce health inequalities by ensuring that services are equitable, inclusive, accessible, fair, and anti-discriminatory (Royal College of Nursing 2019; NMC 2022). A key element of their contemporary role is the provision of holistic,

person-centred, strengths-based, and culturally competent care where the needs of the child or young person are at the centre (NMC 2022).

School nursing has its roots in public health and the first SNs were introduced in the UK following the enactment of the *Educational (Administrative Provisions) Act* in 1907. These SNs were untrained, and their role was to assist school medical officers to inspect the health and physical condition of children following concerns about the poor health of many school leavers enlisting for the Army (National Archives n.d.). Similar to today, the issues impacting on the health of children and young people related to poverty, poor housing, and pollution. Over the last century, the SN role has developed, and the contemporary SN is now an autonomous practitioner, who is expected to not only lead public health services, but also to lead teams who deliver public health services effectively (NMC 2022). Anecdotally, the role of the SN was synonymous with the '*nit nurse*', and when talking to people in their 40s, 50s and 60s about the SN, many, including myself, remember lining up in the classroom for the SN to inspect their hair for headlice. This practice was stopped in the '90s, as it was acknowledged that it was degrading for children and stigmatised them. However, there have been reports in the media that some parents have been petitioning for this practice to be reinstated (Lepkowska 2008; Savill 2011), but, given the increasing importance on respecting and upholding children's rights and whole-school approaches to health promotion, this is unlikely to be realised.

The vital role of the SN in improving the health and wellbeing of children and young people has been acknowledged by the Governments in all four nations of the UK (Department of Health (DH) 2014; Scottish Government 2018b; Welsh Government 2017; Northern Ireland Executive 2016). It is noteworthy that, in Northern Ireland, the contribution of SNs has not been updated, given the unprecedented global challenges that have arisen since its publication over a decade ago. Nevertheless, the document was future-focused, and clearly highlights the public health role of the SN and the need to work collaboratively, focusing on early intervention and support to promote children's health and wellbeing. This vision is reflected in the NMC Standards of Proficiency for

Specialist Community Public Health Nurses (NMC 2022, p. 5), which presents the description of a SN:

SCPHN SNs (SNs) are autonomous practitioners who uphold the rights of school-aged children and young people at all times. Working collaboratively across health, education and other agencies, and as an integral part of a broader public health service, SNs advocate for optimum health for all school-aged children and young people, seeking to ensure that services are fair, inclusive, equitable, anti-discriminatory and positively influence health and wellbeing.

The inclusion of a rights-based approach in the new standards reflects the increasing recognition of the need for everyone to listen to and respect the views of children and young people and involve them in decisions that affect their lives (Department for Education 2014; Scottish Government 2015a).

Since September 2017, there has been investment in training SNs and the numbers of SNs have increased across the UK, from a total of 3595 qualified SNs on the NMC register to 4196 in March 2023, representing a 14.2% increase (NMC 2023). With respect to Scotland, the numbers have increased from 38 to 237 in the same time frame. The greatest increase in qualified SNs in Scotland was observed between September 2021 and March 2023, which reflects investment from the Scottish Government to increase the numbers. Although there has been investment in the recruitment of SNs, there are concerns that budget cuts have stalled this investment and that more needs to be done to build the public health capacity of SNs to meet the health needs of children and young people (Sammut et al. 2023). A report published by the Glasgow City Integration Joint Board (2023) outlines their concerns that the impact of reducing funding from the Scottish Government will have a significant effect on their ability to implement the SN pathway and effectively contribute to implementation of the Mental Health Strategy 2017– 2027 (Scottish Government 2017a). Arguably, their concerns are justified, given that, in the aftermath of the COVID-19 pandemic, the prevalence of mental health problems in children is increasing (Newlove-Delgado et al. 2022; Newlove-Delgado et al. 2023). SNs work at the interface between health and education and are well placed to provide support

to primary-school-aged children as they have a specific role and remit to work with the school-aged population to improve their health and wellbeing outcomes (NMC 2022). As a registered SCPHN-HV, it is my professional opinion that the SN has a role to play in supporting primary-school-aged children's mental health.

Within the UK, strategic policy for school nursing is devolved and, consequently, the guidance for the delivery of school nursing is different in each of the four countries. This chapter will now focus on the guidance for Scotland.

1.4 Guidance for nursing in schools

In Scotland, the guidance for nursing in schools is incorporated within the ten priority areas and pathways of the refocused SN role¹ (Scottish Government 2018b). As part of the *Transforming Roles Programme*, the Chief Nursing Officer (CNO) for Scotland announced that the role of the SN was to be refocused (Scottish Government 2013a) and plans were to be made to refresh the *Scottish Framework for Nursing in Schools* (Scottish Government 2013b). The *Scottish Framework for Nursing in Schools* was the forerunner of the current SN Pathway, and it was developed to provide guidance for the delivery of the school nursing service to children aged 5 to 18 years in the state education system as part of the Scottish Government's commitment to improving the health, wellbeing and aspirations of children and young people (Scottish Executive 2003). The framework set out to re-focus the contribution of nurses working in schools following the publication of *Nursing for Health* (Scottish Executive 2001a) and to attain consistent standards across school nursing services. It was a comprehensive document comprising of three areas: Service Organisation and Management, Service Delivery and Service Components with 26 standards to be achieved (Scottish Executive 2001a).

In common with many initiatives in Scotland, namely, *GIRFEC*, the *Scottish Framework for Nursing in Schools* was not rolled out consistently across the country. Though the CNO for Scotland had announced a refresh of the framework, this did not transpire, and instead, a national steering group with the

¹ For details of the ten priority areas and pathways, see *The School Nursing Role in Integrated Community Nursing Teams: School Nursing Priority Areas and Pathways* (NHS Scotland 2018a).

Scottish Executive Nurse Directors (SEND) was commissioned to work on developing, testing, and evaluating a refocus of the school nursing role during 2015 and 2016 (Chief Nursing Officers Directorate (CNOD) 2018). The CNO's vision for school nursing was to maximise their contribution to supporting school-aged children's health, wellbeing, and educational attainment by increasing their capacity and competence to reduce inequalities in health, prevent ACEs and make their approach to health promotion more focused and targeted (CNOD 2018).

The refocused role and the SN pathway initially consisted of nine priority areas, and it was piloted in two health board areas, NHS Tayside and NHS Dumfries and Galloway during 2015/2016 to test their feasibility and provide feedback to inform their future rollout. The Scottish Government commissioned the Scottish Collaboration for Public Health Research (SCPHRP) to evaluate the refocused role and Children in Scotland to consult with CYP to obtain their views of the new SN service. The evaluation identified some conflicting findings. On the one hand, there was greater clarity of the SN role, an increasing awareness of the SN contribution to the assessment and support process and value of their role, clearer priority areas and referral pathways, and an extension of their partnership working with agencies that they had not worked with prior to the pilot (Doi et al. 2017). Yet, on the other hand, there was lack of clarity about the priority areas and referral criteria and the role of the wider school health team. The SNs felt that they were less accessible to the wider school population, and they did not feel sufficiently prepared to support CYP with low to moderate mental health issues, which is significant, given that the mental health and wellbeing pathway was the most used and they had received training, described as 'extensive' prior to the pilot (Doi et al. 2017, 2018, p. 9). Furthermore, the consultation with school age CYP highlighted a lack of awareness of the work of the SN and the issues they could help with (Woodhouse et al. 2016), which is not surprising, given that SNs themselves felt they were less accessible to all pupils. The evaluation also highlighted inconsistencies in the collection and presentation of data by SN managers which may account for some of the conflicts and is a limitation of the findings (Doi et al. 2018). What is more, the two pilot sites were in areas of Scotland where there are low levels of deprivation and so the needs and

perspectives of the CYP may have been different from those attending schools in more deprived areas. Some SNs in the pilot sites declined to participate in the evaluation and they may have had different perspectives, which, again, could have influenced the findings.

Several recommendations were proposed, which included greater clarity about the pathways and the need for some refinements, additional training for SNs on the mental health and wellbeing pathway, in particular: training to develop their knowledge and skills and enable them to identify risks and deliver interventions and provide support; consistency in collecting and managing data on school nursing; and accessible information for CYP about the SN and the issues that they can help with (Wason et al. 2017; Woodhouse et al. 2016). Consequently, the priority pathway areas were amended and there are now ten under the overarching heading of vulnerable children and families and, below that, mental health and wellbeing and risk-taking behaviour.

Although the refocused role was envisaged for rollout in 2017/18 (Egan and McCormick 2017), implementation across Scotland has been patchy, and, in many health boards, not all the pathways have been implemented. For example, NHS Greater Glasgow and Clyde have only implemented three pathways (Glasgow City Integration Joint Board 2023). The Scottish Government has devolved power to the boards to implement the priority pathways as they see fit, and this has led to inconsistency in implementation. Furthermore, there has been a lack of sustained investment from the Scottish Government to increase the numbers of qualified SNs required to deliver the SN pathway, which is likely to have implications for the capacity of the SN workforce to meet the demands of the service. Notably, SN participants in the evaluation referred to the lack of Government funding to support SN development in comparison to the investment in health visitors following enactment of the *Children and Young People (Scotland) Act 2014* (Doi et al. 2018). Budget cuts and a global pandemic have impacted on implementation of the SN pathway. Nevertheless, the re-focused SN role is more targeted to working with vulnerable children, young people and their families who have additional needs, and may fall into one or more of the ten priority pathway areas. It also provides a clear distinction between their role and

the role of the wider school health team which can include healthcare support workers, community children's nurses and other registered nurses working within schools.

Before moving on to situate the study in the policy and legislative landscape in Scotland, it is pertinent to briefly outline the role of the wider school health team and the evidence supporting this model of working.

1.5 Role of the wider school health team

The role of the wider school health team is to support the qualified SN to deliver universal school health services, such as public health screening in or close to schools (Scottish Government 2018b). In 2008, the Scottish Government set up the Health and Wellbeing in Schools Project with the aim of creating an integrated school health team to focus on meeting the needs of the most vulnerable CYP (Scottish Government 2011). The findings revealed that the introduction of support worker roles released registered practitioners, for instance SNs and teachers, to focus on the provision of early interventions to more vulnerable children, enabling them to spend more quality time with this group of children. This concurs with the findings of Doi et al. (2018) in their evaluation of the SN pathway. The outcomes of the Health and Wellbeing in Schools Project (Scottish Government 2011) were not formally evaluated, which is a limitation of the project findings. However, this model of working has been adopted within the SN pathway.

This chapter has so far provided the background to the study and discussed the role of the SN and guidance for nursing in schools within Scotland. The chapter now moves onto situate the study within the key policy and legislation that influences school nursing practice.

1.6 Policy and legislative context

Within Scotland, a theme running throughout the policy and legislation supporting the delivery of health and social services, including children's services, is a commitment to ensure that all children and young people have the best start and are supported to achieve their full potential across the life course.

1.6.1 Getting it Right for Every Child

Getting it Right for Every Child (GIRFEC) is the key policy driver underpinning Children's Services, reflecting the ambition of the Scottish Government that Scotland is the best place in the world to grow up and every child and young person should be able to fulfil their potential and have their rights respected and protected (Scottish Government 2022a). GIRFEC is a policy framework and a national approach to working with children, young people, and families with the intention that they receive the right support at the right time by the right people (Scottish Government 2022a). GIRFEC is underpinned by the *United Nations Convention on the Rights of the Child* (UNCRC) (United Nations Office of the High Commissioner on Human Rights 1989), which affords children and young people in Scotland with rights, and, to an extent, it also protects children's rights to be listened to and involved in decisions that affect them. A limitation of the UNCRC, however, is that it does not place a legal duty on Scotland to adhere to international law and, therefore, the rights of children and young people cannot be enforced and fully protected (Scottish Government 2024).

Scotland has been committed to upholding the rights of school-aged children, and, in 2004, the Children's Charter, more frequently referred to as 'The Charter' was published following consultation with CYP to obtain their views on what they thought was required to protect them (Scottish Executive 2004). More recently, evidence of this commitment to uphold children's rights has been reflected in their support of the Unicef UK Rights Respecting Award (UNICEF UK 2022) and their plans to incorporate the UNCRC into Scots Law. To this end, in 2021, the *UNCRC (Incorporation) (Scotland) Bill* was introduced to the Scottish Parliament and passed unanimously. The journey to enactment has not been so straightforward, and the Bill was legally challenged by the UK Government (BBC News 2021). However, following amendments, it received Royal Assent on 7 December 2023, and became the *UNCRC (Incorporation)(Scotland) Act 2024*, herein referred to the *UNCRC Act 2024*, on 16 January 2024. This is a landmark event for Scotland, as it is the only country in the UK to fully implement the UNCRC, ensuring that children's rights are truly embedded within policy, legislation, and practice.

GIRFEC provides a shared language and resources to foster a consistent and integrated approach to supporting, promoting, and safeguarding the health and wellbeing of children and young people, and it is considered to be a ground-breaking framework as it threads through all policies affecting children and young people in Scotland (Coles et al. 2016). The Scottish Government (2010) describe it as *'the golden thread that knits together our policy objectives for children and young people'* (p. 3). The GIRFEC framework is holistic, child-centric, rights-based and outcomes-focused, and its theoretical underpinning is influenced by Ecological Systems Theory (EST) (Bronfenbrenner 1979), which views the child, which, for this study is the school-aged child, as being at the centre of four nested and interconnected systems of influence, which impact on child development (the microsystem, mesosystem, exosystem and macrosystem). The key focus of EST is establishing the right environment for children to grow up and to achieve their full potential, which resonates with current Scottish Government policy and practice. For this study, EST provided the theoretical basis to explore the SN mental health work with primary-school-aged children.

GIRFEC was first introduced in 2006 in response to *For Scotland's Children: Better Integrated Children's Services Report* (Scottish Executive 2001b), which highlighted the need for improvements in children's services to better integrate them, with the aim of improving outcomes for children and young people, particularly the most disadvantaged. This report was a significant milestone in Scotland's children and young people's policy landscape as it outlined an Action Plan for the development of a single Children's Services system with a focus on early intervention and prevention to support the welfare of children (Scottish Executive 2001b). Subsequent reports, including: *'It's Everyone's job to Make Sure I'm Alright': Report of the Child Protection Audit and Review* (Scottish Executive 2002a), and *Growing Support: A Review of Services for Vulnerable Families with Very Young Children* (Scottish Executive 2002b), also highlighted the need for more effective information sharing and partnership working with agencies, families and communities, transparent referral processes, and assessments that included the views of children and young people. However, whilst the Scottish Government are creative and ambitious in their policy developments, when implementing policy initiatives, they tend to devolve these

at a local level, an approach which is often referred to as the ‘Scottish approach’ (Coles et al. 2016 p. 336). Consequently, instead of achieving a consistent, integrated and joined-up approach to practice, there were inconsistencies in the approach to the implementation of GIRFEC across Scotland. For example, it was my experience, working as a Child Protection Advisor in one health board area, that there were differences in the GIRFEC processes in the three different local authorities, which was challenging for practitioners. Due to these challenges, and to ensure a consistent approach to implementation, GIRFEC was legislated in the *Children and Young People (Scotland) Act 2014*.

1.6.2 *Children and Young People (Scotland) Act 2014*

The *Children and Young People (Scotland) Act 2014*, herein referred to as *The Act*, is a significant piece of legislation, on several counts. First, it acknowledges the rights of children and sets out the duties of Scottish Ministers and public authorities in relation to protecting children’s rights, tasking them with reporting every three years on their progress in seeking the views of children and increasing public and professional awareness and understanding of the UNCRC (Section 1). There has been criticism that *The Act* does not go far enough, as it includes no legal requirement for Scottish Ministers to respect and act on children’s views and enforce their rights (Kilkelly and Lundy 2020). Moreover, the Scottish Government’s progress on incorporating the UNCRC into Scots Law has also been criticised, as its implementation was felt to be too slow (Scottish Parliament 2023; Children and Young People’s Commissioner Scotland 2023). The recent passing of the *UNCRC Act* in January 2024 addresses this criticism, as the rights of children will be embedded into domestic law, and there will be a requirement for Scottish Ministers to enforce their rights. Hence, *The Act* remains a significant piece of legislation that reflects the aspirations of Scotland to be the best place for children to grow up.

Second, it defines, the concept of ‘wellbeing’ as comprising eight indicators of wellbeing which are: safe, healthy, achieving, nurtured, active, respected, responsible, and included (Section 96). In practice these are commonly referred to as SHANARRI (Scottish Government 2023a) and are now thoroughly embedded into the practice of all professionals working with children and young

people. Nonetheless, it is acknowledged that within practice there are flaws in defining wellbeing in this way as it is broad and open to differences in interpretation. For example, what is perceived as a safe by one professional, may not be considered the same for another, and, indeed, differences in professional thresholds may also influence perceptions. There is also criticism that *the Act* does not define wellbeing; instead, it describes it, which again can result in differences in interpretation (Tisdall 2015; Tisdall and Davis 2015). Nonetheless, having a broad definition of wellbeing outlined in legislation provides some consistency in the assessment of children's wellbeing needs. Third, it established a framework mandating that the delivery of children's services in Scotland are integrated and the need for services to work in partnership to support children, young people, and families at the earliest opportunity (Section 9). However, despite legislation to integrate health and social care in Scotland, namely, *The Public Bodies (Joint Working) Scotland Act 2014*, which came into effect in 2016, and the creation of 31 health and social care partnerships in Scotland (Scottish Government 2015b), NHS health boards and local authorities are under no obligation to integrate services for children, and there are differences in the integration of children's services across Scotland (Health and Social Care Scotland 2023).

Although the Scottish Government have set out with the best of intentions to improve outcomes for children and young people through wide-ranging policy and legislation, arguably, they have created confusion and inconsistencies in the delivery of services for children across the country by giving NHS Boards and local authorities discretion in their integration and implementation. The CYP policy and legislative landscape within Scotland is complex and continuously changing, and the Scottish Government are consulting on a National Care Service which would see services for children integrated into adult services (Scottish Government 2022b). This has the potential to risk any progress being made towards the integration of children's services within health and social care and education, and at a time of budget cuts and rising costs, there is also a risk that investing in services, such as the SN service, will no longer be a priority. This research study may therefore be of interest to SNs seeking evidence to

support their contribution to supporting school-aged CYP's health and in improving their outcomes across the life course.

1.7 Significance of the research to SN practice

This research provides insight into the mental health work of the SN within Scotland from the perspective of SNs, but also of primary-school-aged children, parents and teachers, thus adding to the evidence base. The Phase One study was a national cross-sectional study and is the only one to my knowledge that has sought the views of nurses working in the school health service in Scotland, specifically in relation to their mental health work with primary-school-aged children. The study was conducted when the refocused SN pathway and priority areas were being implemented and so it provides information outlining their involvement in supporting primary-school-aged children's mental health at that time. It also sheds light on changes to school nursing practice related to the refocused role and perceived challenges, adding to the evidence base on SN practice in Scotland.

The fieldwork for the Phase Two study took place during the pandemic when schools had been closed due to lockdown measures, and it offers insights into SNs', children's, parents', and teachers' perspectives of the SN mental health work in Scotland during a significant time. The use of creative participatory methods, which were adapted for use online with the children, may be of interest to SNs who may wish to consider how they could apply them for use in their practice. In addition, the findings from this study can inform the education, training, and practice of SNs, not only in Scotland, but globally.

1.8 Summary

This chapter began by positioning the thesis reflexively in relation to my professional background, and providing an explanation for why I chose to do a PhD exploring SNs' work supporting primary-school-aged children's mental health. To situate the study, the chapter provided some background information on mental health issues in CYPs and the role of the SN, highlighting that, although mental health issues in CYP are increasing, they are not receiving

support early enough. The chapter then moved onto embed the thesis in the current policy and legislative context in Scotland, before providing an explanation of the significance of this study for SN practice. The chapter now closes with an outline of the thesis structure to provide navigation and to signpost the reader.

1.9 Structure of the thesis

The thesis has eight chapters, including this, the Introduction.

In Chapter Two, I focus on school-aged children, their mental health, and the school as a setting, not only for education, but also for health promotion, and I set this in the context of relevant policy and legislation. It also explores ecological systems theory and why I chose to view the research through an ecological lens.

Chapter Three is the literature review, and it explores existing literature on the role of the SN in supporting primary-school-aged children's mental health and the interventions they use. It also considers children's, parents' and teachers' experiences of the SN and their perspectives on mental health. Themes are presented utilising the components from the Process-Person-Context-Time Model (Bronfenbrenner 1995) to position the literature within an ecological framework.

In Chapter Four, I explore the methodology and research design used for the study and discuss the steps that I took to assure the quality of the study and its ethical integrity.

Chapter Five presents the results from Phase One. The results are situated within the PPCT Model (Bronfenbrenner 1995). To facilitate a logical flow of the narrative, the findings are presented by beginning with *Context*, followed by *Time*, *Person* and *Process*, which aligns with the Model.

Chapter Six presents the findings from Phase Two. To facilitate a logical flow of narrative, the findings are presented beginning with *Time* as this had an impact on all three themes. This is then followed by *Person*, *Process*, and *Context* and the associated themes and subthemes.

Chapter Seven integrates and discusses the findings in relation to the aims and research questions, extant literature, policy, and research.

In Chapter Eight, I summarise the key findings, the strengths and limitations of the study, and recommendations for future research, policy, practice, and education.

Chapter Two: The School-aged Child, Mental Health, and their Wider World

Introduction

This chapter considers the school-aged child in the context of their wider world. Supporting their mental health does not take place in a vacuum. On the contrary, it takes place within the context of a family, school, and community, and is influenced by the wider determinants of health (WHO 2014). It is widely recognised in Scottish policy that it is the interaction between the child, people and their environment that is essential for their development across the life course (Scottish Government 2022a). Pearce et al. (2019) represent this interrelationship well in their combined model of Bronfenbrenner's (1979) ecological systems theory and Dahlgren and Whitehead's (1991) Rainbow Model, which highlight the need for public health interventions across all levels to address inequities and inequalities in health for children and young people. Pearce et al.'s (2019) model is particularly useful for SCPHN practice as it provides a visual representation of the different spheres of influence that act on a child's health and wellbeing and their interconnection at key times across the life course (Whittaker and Cowley 2021). The fieldwork for Phase Two took place during the global COVID-19 pandemic, one of the most significant periods in the history of the 21st century, and, undeniably, a vulnerable time for school-aged children, especially for those from disadvantaged backgrounds (Residori et al. 2023).

2.1 Ecological perspective

Ecological theory has been widely used in research within the field of mental health (Eriksson et al. 2018) and research involving children within the context of school (Singer et al. 2021), hence it was deemed relevant for this research, given that school-aged children were involved in this study. Although this study takes an ecological perspective, it did not set out to test the application of ecological theory. Rather, it showcases the practical application of ecological theory in the

field of school nursing and in the context of their mental health work with school-aged children, and currently there are no similar published studies.

Ecological theory can be traced back to the work of Park (1936), who suggested that human ecology could be considered as an extension of the ecology of plants and animals due to the interrelation between individuals and their environment. Arguably, he introduced the concepts of *context* and *processes*, key elements of Bronfenbrenner's (1995) Bioecological Systems Theory, whereby, *context* referred to the environment and society within which individuals live and *processes* referred to the interactions between them. However, it is Bronfenbrenner (1979) who is most widely recognised for his contribution to the understanding of human development and is probably best known for Ecological Systems Theory (EST) in which he proposed that children and young people's development is influenced by their environment and the social relationships they have with people at four different interconnected levels. These four levels are: the microsystem (parents, family, school, health services and the church), mesosystem (the interactions between people in the microsystem), exosystem (neighbours, social services, mass media, local politics and industry), and the macrosystem (attitudes and ideologies of the culture), most often visually represented as nested concentric rings.

The focus of ecological systems theory is on establishing the right environment for children and young people in which to grow up and to achieve their full potential, which resonates with the vision of the Scottish Government that Scotland is the best place in the world for children to grow up (Scottish Government 2013c). Yet, this approach is not without criticism, and Neal and Neal (2013) contend that the conceptualisation of Bronfenbrenner's (1979) initial EST, depicted as concentric rings nested inside each other, fails to emphasise the influence that social relationships exert within and between each system. This concurs with Eriksson et al.'s (2018) systematic review findings, which identified that most research studies using Bronfenbrenner's (1979) EST utilised his initial version but omitted to consider the social interactions between and within each system. They concluded that the studies providing the most useful recommendations to promote mental health and guide mental health

interventions are those where the early concepts of his EST clearly reflect the interaction between and within the ecological systems (Eriksson et al. 2018). In view of this, I chose to depict the early concepts of Bronfenbrenner's (1979) EST as a networked model as it more clearly demonstrates the interaction within and between the micro, meso and exo systems. I also used the *Process-Person-Context-Time (PPCT) Model* (Bronfenbrenner 1995), which was a later version of his work on human development and bioecological systems, to facilitate the application of the theory to my research. See Figure 2.1 and Section 2.1.1 for further discussion.

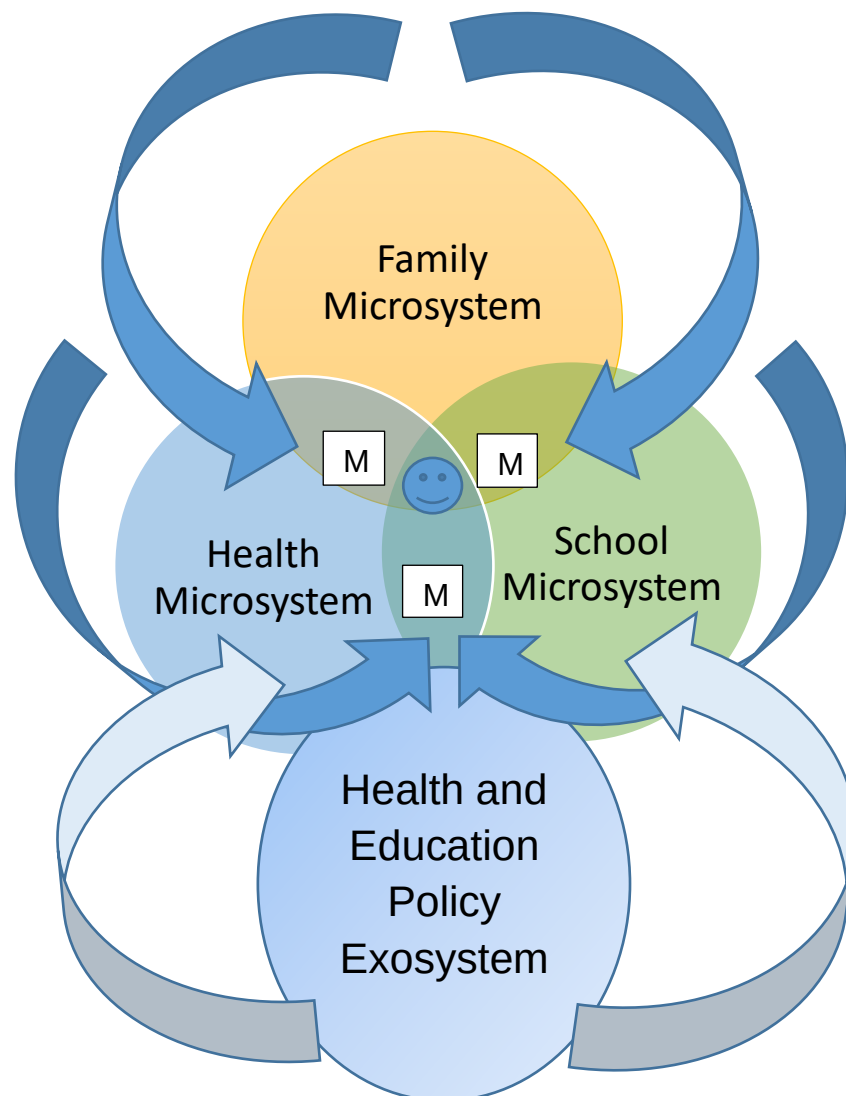


Figure 2.1: Networked Ecological Systems Model Adapted from Neal and Neal (2013) and Bronfenbrenner (1979, 1995)

Code:**Person:**

- Child at the centre:

**Process:**

- Mesosystem: M: Interactions and relationships between the people in the microsystems. This can be school/family, family/health, health/school and family/school/health.

Context:

- Family Microsystem: Parents/Carers and siblings
- School Microsystem: Peers, Headteacher, classroom teachers, classroom assistants, peers
- Health Microsystem: School Nursing Team, GP, School Health Service, CAMHS
- Health and Education Exosystem: Policies and legislation

Time:

- Microsystems: During interactions with people in the family, school and health microsystems, e.g., having a meal with family, group work with peers in the classroom, meeting the SN.
- Mesosystem: How often the interactions and relationships between people in the microsystems take place, for example, days, weeks, months, years.
- Macrosystem: Culture, attitudes and beliefs within the Child's Wider World.
- Chronosystem: Environmental events and conditions that occur over the life course and impact on the child for example, transition to secondary school, school closures.

2.1.1 Bioecological Systems Theory

Bioecological Systems Theory (Bronfenbrenner 1995), as the name suggests, includes not only the ecological systems that contribute to human development, but also the biology of the individual. Bronfenbrenner, like many, was overly critical of his own work, and was critical of his earlier theory (1979) as it omitted to include crucial elements of a child's development, including their biological, psychological, and behavioural development (Bronfenbrenner 1989, cited in Lerner 2005, p. xiv). It is easy to see why he was critical, as these elements of a child's development had been considered by other child development theorists, for example, Vygotsky (1978) and Erikson (1958). To address this, he integrated these elements into Bioecological Systems Theory (Bronfenbrenner 1995), and he developed the Process-Person-Context-Time (PPCT) model to enable the application of Bioecological Systems Theory in practice (Xia et al. 2020). The

premise of this model in keeping with his previous theory is that each of these four components is interrelated and all four are required to enable a child to develop to their full potential and achieve positive outcomes across the life course (Bronfenbrenner 2005). In relation to *Process*, Bronfenbrenner (1995) referred to Proximal Processes, which he considered to be the quality of an interaction and how this interaction influenced what he referred to as 'an outcome of interest'. *Person* referred to an understanding of the characteristics of a person and how these influenced the proximal processes, and *Context* related to the ways in which the proximal processes are influenced by the environment, while *Time* referred to sociohistorical time. Arguably, the success by which one can assess that a person has achieved their full potential is through the specification of developmental outcomes, and Bronfenbrenner (2005, p. 88) acknowledged that, in his theory, there was no clear definition of a developmental outcome. He therefore proposed that, when using the PPCT Model and defining a developmental outcome, in addition to clearly specifying how the context within which a child is developing influences the shape of their future development, the processes that lead to the developmental change are also clearly specified. Tudge et al. (2016) contend that Bronfenbrenner's (1995) Bioecological Systems Theory is often misused in research, and the reasons for this include the complexity of the theory, and lack of detail on how to apply the theory in practice. They suggest that researchers should clearly outline the key elements of the PPCT Model, use methods that can facilitate assessment of the interactions and the four elements, and use the data to critically evaluate the theory (Tudge et al. 2016).

I did not set out to test the application of the theory, as the GIRFEC approach is informed by ecological theory. In contrast, I used the principles and four key elements of Bioecological Systems Theory to inform each stage of the research process. For example, *Process* refers to the interactions between the school-aged child and the SN, their parents, and the teacher and how they can support the child's mental health. *Person* refers to the school child aged 9–11 years and their parents, and the qualified SNs delivering school nursing services in their area. *Context* refers to the child's wider world, which, for this study, includes the school and their home. *Time* refers to the period of time when the fieldwork was

conducted, which was April to July 2021, during the middle of a global pandemic on a scale never seen before in the 21st Century.

2.2 Family

For most children and young people, and indeed adults, their first memories are linked to their family and home (Clark and Kehily 2013), although, for some, these memories may not be happy ones. Nevertheless, the family unit is one of the most important influences and sources of support on our lives across the life course and can be defined as '*a group of persons directly linked by kin connections, the adult members of which assume responsibility for caring for children*' (Giddens 1998, p. 384). Indeed, the global pandemic shone a light on the importance of the family to support children and young people and adults through one of the most challenging times in this century (Residori et al. 2023).

Traditionally, when thinking about families, a 'normal' nuclear family may have been considered to comprise two parents of different genders (usually married), and their biological children. The society within which we live is now more culturally diverse, with a diversity of family compositions that change over time within society, but also across the life course for individuals. Golombok (2015) contended that the quality of a child's relationship with family members and their social world is more valuable than the family form in which they are brought up. More recently, a literature review commissioned by the UK Government into the role of the family in the aftermath of the pandemic concluded that improving outcomes for children and young people across the life course is more reliant on the quality of relationships within the family than the composition of the family (Children's Commissioner 2022).

Thus, it is the quality of the child and young person's relationship with members of their family and the social world that plays a more significant role in influencing their mental health and wellbeing than the type of family in which they are brought up. Gerhardt (2015) contends that children develop their understanding of others and sense of self through their earliest experiences of relationships, which ultimately influences the formation of relationships across their life course. Hence, the family unit is a vital part of the school-aged child's wider world and is

likely to be considered by children to play a significant role in supporting their mental health.

2.3 School

School is often associated by the lay public as a setting for education and a place of learning, it is less well known as a setting for health (Pulimeno et al. 2020). Yet, there are links between education and health and the outcomes for children and young people across the life course. For example, the closure of schools during the COVID-19 pandemic had a disproportionate effect on the educational attainment of the most disadvantaged children and young people (UNESCO 2022; Scottish Government 2022c). Whilst the impact of the pandemic will have long lasting effects, it has highlighted the critical role of schools as a place of learning, social connection, and a setting for health (UNESCO 2022).

2.3.1 Attendance at school

In Scotland, it has been mandatory for children to attend school since the enactment of the *Education (Scotland) Act 1872*. This act applied to children and young people aged 5 to 13 years and their attendance could be part-time, however, it was not until the *Education (Scotland) Act 1945* that the school leaving age was increased to 15 years and provisions made to include not only primary and secondary education but also nursery and further education. The current school leaving age of 16 years was not increased until the 1970s when *The Raising of the School Leaving Age (Scotland) Regulations 1972* came into force. There has been no change to the school leaving age since then.

The *Education (Scotland) Act 1872* is significant in the history of children's rights in Scotland as it acknowledged the right of all school-aged children to receive education to develop skills in reading, writing and arithmetic. Moreover, it could also be argued that Scotland has been aspirational in her vision to improve outcomes for children and young people, as, following the reformation in 1560, the education of children was considered a national priority. Nevertheless, it was not until the enactment of the *Education Act 1696* that it became compulsory for schools to be established in all parishes across Scotland (University of Edinburgh 2015). These schools were funded by the local parish and the local parish had

the responsibility of employing a teacher, referred to as a 'schoolmaster'. This contrasts with the funding of schools in the present day, which are funded by the local Education Authority, apart from those that are independent schools and receive their funding from other means. Only children attending public schools were included in the study, as most independent schools employ a qualified nurse based in the school, whereas in public schools, the SN is a visitor to the school.

2.3.2 School as a place of learning and development

Within Scotland, local authorities are responsible for the provision of education for children and young people as legislated within the *Education (Scotland) Act 1980*. In addition to outlining the responsibilities and duties of the Education Authority, in Section 30, it also set out the duties of parents to provide their children with education by ensuring their attendance at school. Since its implementation, this Act has been updated to reflect changes in legislation aimed at protecting and promoting children's rights. For example, the *Standards in Scotland's Schools etc. Act 2000*, the *Equality Act 2010* and the *Children and Young People (Scotland) Act 2014* were introduced. In addition, the *Schools (Health Promotion and Nutrition) Scotland Act 2007* aims to ensure that schools are health promoting.

In 2010, the Curriculum for Excellence (CfE) was implemented into schools with the aim of placing children at the centre of their learning, enabling them to become '*Successful learners*', '*Confident individuals*', '*Responsible citizens*' and '*Effective contributors*', referred to as the four capacities (Scottish Executive 2006). CfE links closely with the GIRFEC approach and the approach to the assessment of children's learning is holistic and outcomes-focused, taking into consideration the eight indicators of wellbeing, safe, healthy, achieving, nurtured, active, responsible, respected and included (SHANARRI) (Scottish Government 2023a). Teaching and learning activities are more pupil-centred and the role of teachers is as a facilitator of learning, or, as Priestley and Minty (2013, p. 6) describe, an 'agent of change'. A key feature of CfE in contrast to its predecessor, the 5–14 curriculum, is that it is less prescriptive and offers flexibility in the delivery of the curriculum by teachers, and, in addition to the traditional

focus of ensuring that children can read, write and do arithmetic, it places a focus on ensuring that children and young people are equipped with not only the knowledge but the skills and attributes required to achieve their full potential across the life course (Scottish Government 2008), which is in keeping with an ecological approach. One of the features of CfE is the notion of topic areas, whereby teachers can link the teaching of eight curriculum areas with the aim of reinforcing learning, for example, health and wellbeing could be linked to expressive arts or to religious and moral education (Education Scotland 2023). Learning about relationships and friendships and emotional wellbeing and help-seeking behaviour are examples of topic areas under the umbrella of health and wellbeing. These topics are taught at key stages across the curriculum, from the early level, which is pre-school to P1, through to the senior level, which is S4, S5 and S6 (RHSP 2022) with the aim of building children's resilience to cope with the challenges of everyday life.

Nevertheless, there is criticism of CfE from educationalists. For example, a qualitative study to explore teachers' experience of CfE found that, whilst the flexibility of the curriculum offered teachers more autonomy, it also led to inconsistencies in the content taught, and inconsistencies in its implementation in different schools, with some schools being at a more advanced stage than others (Priestley and Minty 2013). Moreover, following criticism regarding unwieldy documentation and guidance, and delays by the Scottish Government taking action to revise the guidance for teachers, Education Scotland (2016) developed their own guidance and support resources for teachers to help streamline the application of the curriculum in the practice setting. Nonetheless, there remains criticism of CfE, as, a decade since Priestley and Minty's (2013) study, there remain inconsistencies in the content taught within schools across Scotland, including the relevance of some topics in contemporary society, for example, limited focus on cultural diversity (Campbell and Harris 2023). The curriculum framework still lacks clarity and the documentation is laborious (Bogle 2021; Campbell and Harris 2023), and the attainment gap, which the CfE had in part set out to reduce, has widened and stalled in some topic areas in comparison to 2018/19 (Scottish Government 2022c), leading to poorer outcomes for the most disadvantaged children and young people. However, it is acknowledged

that the pandemic has adversely impacted on children's learning and development across the UK (Education Endowment Fund 2022).

The recently published report, *All learners in Scotland Matter: The National Discussion on Education* (Campbell and Harris 2023) has found, through their consultation with school-aged children, parents, carers, teachers, organisations, agencies and communities, that, despite the flaws in CfE, the four capacities continue to be relevant in contemporary society. Moreover, they were found to be a key strength of the curriculum in promoting learners who are positive and prepared for participating in '*democratic citizenship*' (p. 62). Campbell and Harris (2023) conclude that, with revisions and the '*right change*', CfE has the potential to promote a better future for school-aged children and to prepare them for the challenges of contemporary society.

2.3.3 Whole-school approaches to mental health and wellbeing

The concept of whole-school approaches is not new, and the school as a setting for health promotion dates back to the Ottawa Charter for Health Promotion (WHO 1986). Schools are uniquely placed to promote the health and wellbeing of not only school-aged children, but also parents, families, school staff and communities, and the WHO (2023, n.p.) defines a health-promoting school as:

one that constantly strengthens its capacity as a healthy setting for living, learning and working.

Improving the health and wellbeing of school-aged children is one of eight priority areas within CfE, and all teachers have a responsibility to deliver content on health and wellbeing across the curriculum (Scottish Government n.d.). CfE promotes the adoption of whole-school approaches and the two most relevant frameworks that applied to this study were *Applying Nurture as a Whole School Approach* (Education Scotland 2017) and the *Whole School Approach Framework for Schools to Support Children and Young People's Mental Health and Wellbeing* (Scottish Government 2021a). But, although there is an expectation for teachers to work in partnership with their colleagues in education, such as home link staff, and with other services, such as health, educational psychologists and sports coaches, the CfE guidance does not specifically

mention the SN, despite their role as a specialist community public health nurse for school-aged children and young people (NMC 2004, 2022). Moreover, the *Whole School Approach Framework for Schools to Support Children and Young People's Mental Health and Wellbeing* (Scottish Government 2021a) only makes one reference to the school nursing service, on p. 21, in relation to their role in supporting children's emotional health and wellbeing. It makes no reference to the refocused SN role or the specialist school nursing priority areas and pathways, of which the mental health and wellbeing pathway is one of two key areas for referral and intervention (Scottish Government 2018b). This is an oversight, as evidence from the evaluation of the refocused SN role clearly highlighted that most referrals to the SN in the pilot sites were for support provided under the mental health and wellbeing pathway (Doi et al. 2017).

In 2006, Debell and Tomkins contended that the SN was the only NHS health professional with the responsibility to specifically address the health needs of school-aged children and young people. However, more than a decade later, despite the intention of the Scottish Government to promote more integrated working across children's services, the role of the SN in the early identification, promotion and support of children and young people's mental health appears to have been overlooked. Instead, there appears to be a drive towards the use of school counsellors, which, although important in a whole-school approach to promote good mental health and wellbeing, their role is not one of early intervention. On the contrary, counselling is an intervention used by school counsellors when a school-aged child has already been identified as having issues with their mental health and wellbeing and has been defined as:

a professional activity delivered by qualified practitioners in schools. Counsellors offer troubled and /or distressed children and young people an opportunity to talk about their difficulties, within a relationship of agreed confidentiality. (British Association for Counsellors and Psychotherapy (BACP) cited in Dale 2017, p. 1)

Currently, several Scottish Education Authorities have advertised for school counsellors for school-aged children from 10–18 years, however, within the job description, there is no specific reference made to working with the SN or the

school nursing service, although, it does state that counsellors will work within a wider multi-disciplinary team, and specific reference is made to CAMHS and social work services. The omission of the SN and school nursing service does suggest that within education services there is lack of recognition of the SN role. Notably, the school nursing pathway guidance document is vague, and the accompanying appendices provide very brief details of the action and interventions that SNs should take upon receiving a referral. Therefore, despite the SN being a specialist in promoting the health and wellbeing of school-aged children and young people, there is a lack of clarity about their contribution within whole-school approaches to supporting school-aged children and young people's mental health.

2.4 Community

The community in which we live has a significant influence on our health and wellbeing across the life course, and, similar to our family and school, our experience of the community as we grow up can be associated with both positive and negative memories. For some school-aged children, the community in which they live is a safe place, with good housing, clean air, opportunities to play outside and a network of support from friends and neighbours. However, for others, the community may be a risky place, due to pollution, traffic, litter, violence and neighbours who engage in risk-taking behaviour. Yet, the community is about more than just place, it is also about sharing common interests and characteristics, and, crucially, it is about the relationships that people have with others (Jackson 2021). On the one hand, these can be supportive, providing people with a sense of belonging and building their resilience, but, on the other hand, they can ostracise people, which can make them vulnerable and can impact adversely on their mental health and wellbeing. Naidoo and Wills (2016, p. 239) have defined a community as:

a group of people living in the same place or sharing a common characteristic.

This definition, whilst simple and concise, omits to include the importance of the relationships and interactions between people within a community and the impact

they can have on children and young people across the life course. Green et al. (2015) contend that it is the social connection between people that is integral to a community, whilst Barrett (2015) asserts that communities are complex. I adopted the definition of community proposed by Brint (2001, p. 8), as it acknowledges relationships, place, values, and the interactions between them, which fits with an ecological perspective:

aggregates of people who share common activities and/or beliefs and who are bound together principally by relations of affect, loyalty, common values, and/or personal concern.

Barrett (2015) suggests that a resilient community is one where there is trust, respect, responsibility, and co-operation. These elements are reflected within GIRFEC and the four capacities of CfE and are key components of the Relationships, Sexual Health and Parenthood education resources (RHSP Resource Network 2022). The school community provides an invaluable network of support for many school-aged children and families, and this has never been more evident than during the pandemic, when lockdown measures were introduced (Child Poverty Action Group (CPAG) 2020). A survey of parents and school-aged children in England, Scotland and Wales, conducted during the pandemic, found that whole-class activities helped children to maintain connections with the school community, and support from the school, especially more personalised support, helped to support the emotional wellbeing of both parents and children (CPAG 2020).

In contrast to the experiences of parents and children, a cross-sectional survey of SNs working in the UK during the pandemic found that contact with children was difficult, as some schools did not permit them on the premises, and, similarly, contact with school staff was also found to be a challenge (Sammut et al. 2023). Arguably, these findings imply that education staff may not consider SNs to be part of the school community, despite their specialist public health role. Indeed, one of Sammut et al.'s (2023) recommendations included the need for SN to be placed within school communities in leadership and co-ordinator roles in recognition of their role as a specialist public health practitioner.

2.5 Summary

This chapter has considered the school-aged child in the context of their wider world through an ecological perspective. It has argued that supporting their mental health takes place within the context of a family, school, and community, and is influenced by the wider determinants of health and quality of the school-aged child's relationships with family members and people in their social world. The COVID-19 pandemic led to school closures, and it is acknowledged globally that this has impacted adversely on the educational attainment of the most disadvantaged children and young people. Added to this, it has also had a negative impact on the mental health of children, especially the more disadvantaged.

Within Scotland, whole-school approaches to mental health and wellbeing and nurture are advocated, yet the contribution of the SN has been overlooked, and there is only one reference to the school nursing service in the *Whole School Approach Framework* published by the Scottish Government in 2021. This is despite evidence from the evaluation of the refocused SN role highlighting that most referrals to the SN were due to concerns about school-aged children's mental health and wellbeing. Thus, there seems to be lack of recognition of the specialist public health role of the SN in supporting primary-school-aged children's mental health.

Chapter Three now moves on to consider and review the literature.

Chapter Three: The Literature Review

Introduction

This chapter provides a critical overview and analysis of the literature to identify the key gaps and the limitations of existing research and a justification for this study. I undertook a Scoping Review and details explaining why I selected this approach, the search strategy, and the results obtained, are provided below, followed by a detailed critical discussion of the literature related to the SN role and their work in supporting the mental health of school-aged children. The literature linked to SNs', school-aged children's, parents', and teachers' experiences and understanding of the SN and their mental health work will also be considered. The chapter will conclude with a summary of the review findings and some considerations of the limitations of the chosen literature review approach.

3.1 The purpose of the review

A literature review is an essential prerequisite of any research study to identify what is known about the topic and to justify the need for the study (Creswell and Creswell 2018). Hart (2018, p. 13) defines a literature review as:

The selection of available documents (both published and unpublished) on the topic which contain information, ideas, data and evidence written from a particular standpoint to fulfil certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed.

Yet, this definition omits to highlight the plethora of different types of literature review that the researcher can select when planning their study. Grant and Booth (2009) outline 14 different types of literature review, highlighting the strengths and limitations of each, but also confusion in the use of terminology. They concur with Arksey and O'Malley (2005) that researchers need to be explicit when

describing the literature review process to ensure that it is transparent, rigorous, and replicable (Grant and Booth 2009). A scoping review of the literature was selected as I deemed it to be the most appropriate approach to obtain evidence from published and unpublished research and policy documents to inform the research questions and the research design. Scoping reviews have become more widely used within health and social care research (Campbell et al. 2023), but there is variation in the way in which they are conducted and reported, which can impact on the rigour of the findings (Pham et al. 2014; Tricco et al. 2016). Pham et al. (2014) and Tricco et al. (2016), in their scoping reviews of scoping reviews, concluded that standardisation of the process of conducting a scoping review is required to ensure consistency. Pham et al. (2014) recommend the use of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA). More recently, this checklist has been revised to make it more applicable for scoping reviews (Tricco et al. 2018).

There are several frameworks that can be used to inform a scoping review. For example, the original five-step process proposed by Arksey and O'Malley (2005) and the six-step process proposed by Levac et al. (2010). Arksey and O'Malley's (2005) framework was selected, as it does not stipulate the requirement to have a team of reviewers involved in the process and this study was conducted by a single researcher. It is recognised that the absence of a team approach is a limitation of this review as it impacts the rigour of the process due to the risk of bias (Levac et al. 2010). Nevertheless, there is acknowledgement within the literature that there is 'no single "ideal type" of literature review' (Arksey and O'Malley 2005, p. 20).

The Systematic Review is considered to be the 'gold standard' of literature reviews, due to the rigorous processes involved in searching, identifying, appraising, synthesising, and reporting all the evidence that meets the inclusion criteria to answer the research question (Smith and Noble 2016). Nevertheless, systematic reviews are not without limitations, and these can include their tendency to focus on single study designs that utilise a quantitative methodology (Arksey and O'Malley 2005; Grant and Booth 2009; Gupta et al. 2023). In contrast, scoping reviews offer researchers the opportunity to search more

broadly for evidence that facilitates the collection of all available and relevant evidence on the research topic (Arksey and O'Malley 2005). It is recognised that this can be at the expense of quality, as scoping reviews do not seek to assess the quality of evidence, rather, they seek to map out the terrain and identify what is known about the topic and identify gaps in the evidence (Arksey and O'Malley 2005; Grant and Booth 2009; Gupta et al. 2023). Nonetheless, one of the key strengths of the scoping review is that, similar to the systematic review, the processes involved require a systematic approach to searching for literature, providing a transparent and replicable audit trail (Grant and Booth 2009).

3.2 Conducting the review

A scoping review is defined as:

A type of evidence synthesis that aims to systematically identify and map the breadth of evidence available on a particular topic, field, concept, or issue, often irrespective of source (i.e., primary research, reviews, non-empirical evidence) within or across particular contexts. (Campbell et al. 2023, p. 3)

The review was conducted in line with the five stages suggested by Arksey and O'Malley (2005).

3.2.1 Stage 1: Identifying the research question

The initial research question was:

What is known about SNs' contribution to supporting primary-school-aged children's mental health?

The PICO (Population, Intervention, Comparison and Outcome) framework was used to help develop the question and subsequent search terms (CASP 2024; Aveyard 2023). The population was primary-school-aged children, the intervention was the school nurse, the comparison was mental health, and the outcome was support.

3.2.2 Stage 2: Identifying relevant studies

Relevant published literature was identified by searching key electronic databases: CINAHL, British Education Index, Medline-OVID and Medline-EBSCO, Child Development and Adolescent Studies, Applied Social Sciences Index (ASSIA), the Cochrane Library, PsycINFO (EBSCO Host), Psychological and Behavioural Sciences Collection (EBSCO Host), the NHS Centre for Reviews and Dissemination, and STIRGATE. This was supplemented by hand searching reference lists. Grey literature associated with doctoral theses was identified by searching the Stirling Online Research Repository (STORRE) and the University eTheses Service. In addition, grey literature associated with research reports, government documents and working papers was identified by consulting with other academic experts in Nursing, Midwifery and Allied Health Professionals (NMAHP) research and NMHAP policy. Two searches were completed; one at the outset of the study, and an updated one which was performed in 2023.

Parameters for the search, including key words, search terms and time limits, were developed to facilitate the search. Because this study focuses on the SNs' mental health work within the context of Scottish legislation and policy, and because there are differences in the role in other parts of the world, limiters were applied to geographical area. This was possible on MEDLINE, and CINAHL Complete, but not for all databases used. In respect of the age range of the CYP, it proved challenging to set such limits, as some databases (MEDLINE-OVID and the BRITISH EDUCATION INDEX) did not provide the facility to narrow the search to specific age ranges. In this case, the limiters were child and adolescent or young adult for MEDLINE-OVID, and children and teenagers for the British Education Index. For the other databases (CINAHL Complete, MEDLINE-EBSCO, Child and Adolescent Developmental Studies), the limiters applied were 'child aged 6-12 years'. It is acknowledged that the differences between the databases limit the accuracy of the search.

For the first search the time parameter was set as 2001 to reflect policy change in Scotland following the publication of *For Scotland's Children* (Scottish Executive 2001b). For the second search, the time parameter was changed to

2004-2023 as it was felt that the NMC *Standards of Proficiency for Public Health Nursing* (NMC 2004) published in 2004 reflected the role of the SCPHN-SN. Key words and search terms, including multiple combinations of these, included: 'school nursing' or 'SN', 'school aged children', 'school-aged children', 'children', 'child', 'school age kids', 'kids', 'adolescent', 'young adult', 'pupil', 'teacher', 'parent', 'mental health', 'mental illness', 'mental disorder', 'psychiatric illness' and 'experience', 'perceptions', 'attitudes', 'views', 'feelings'. Boolean 'AND' or 'OR' searches using Subject Index, MeSH and Truncation were included.

3.2.3 Stage 3: Study selection

To select relevant studies, inclusion and exclusion criteria were set at this stage, as recommended by Aveyard (2023) (Table 3.1).

Table 3.1: Inclusion and exclusion criteria for literature search

Inclusion criteria	Exclusion criteria
Peer reviewed and grey literature (unpublished work) and policy documents	Opinion pieces
English language only	Non-English language
Full text only	Abstracts only
Sample/focus is SNs	Publication does not clearly include SNs
Mental health problems specific to primary school aged children (6-12 years)	Publication does not focus on mental health problems specific to school aged children (6-12 years)
Teachers, children, and parents' experiences of the SN and their mental health work	Publication does not focus on teachers, children, or parents' experiences of the SN and their mental health work
2004-2023	Before 2004
Europe, Scandinavia, and the United States of America (USA)	Non-European, Non-Scandinavian or Non-USA

The databases yielding the greatest number of articles were CINAHL complete, Medline-EBSCO and the British Education Index. Publications included in the review were selected following the review of each title and abstract, followed by the retrieval and review of the full text, which led to the final included papers.

3.2.4 Stage 4: Charting the data

A Literature Review Spreadsheet in Word Excel was used to chart the following information:

- Author(s), date of publication, study location
- Study populations
- Aims of the study and research questions
- Methodology and methods used
- Findings, limitations, conclusions, and key comments

3.2.5 Stage 5: Collating, summarising and reporting the results

For this stage, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 Flow diagram was used to present the results of the literature search (Tricco et al. 2018; St Michael's Hospital 2019) (see Figure 3.1). The Critical Appraisal Skills Programme (CASP 2024) checklists were used to critically appraise sources of research evidence. The findings of the literature search are presented in Appendix 1, which provides a summary of the included sources of evidence and relevant data. The included publications were dated from 2004 to 2023, with the majority being published after 2014, reflecting a growing awareness globally that children's mental health is a public health concern.

Of the thirty-four publications included in the review, four were systematic reviews, two were scoping reviews of reviews, five were literature reviews, seven were surveys, seven were qualitative studies, five were mixed methods, one was a realist evaluation, one was a cluster-randomised controlled trial, one was a narrative inquiry, and one was a policy document.

Twenty of the included publications were from the UK, of which five were from Scotland. Six of the publications included studies from multiple countries. Five of

the publications were from Sweden, one was from Norway, one was from Finland, and one was from the USA. Twenty-five of the publications included SNs, seven included children and young people and one included parents.

Drawing on the literature, seven key themes were identified: education and training of SNs for their mental health work, SNs' mental health work, SNs' perceptions of their mental health work, primary-school-aged children's perceptions of the SN, parents' perceptions of the SN, teachers' perceptions of the SN, and barriers and challenges. Many of the included papers linked to more than one theme, for example, Chase et al. (2010) and Prymachuk et al. (2012). Themes are presented utilising the first three headings from the Process-Person-Context-Time Model (Bronfenbrenner 1995) to position the literature within an ecological framework. They will, however, not be presented in that order, as it is essential to first gain an understanding of the role of the SN, a key '*person*' within the ecological system of the school, before exploring the literature associated with their interactions (*Process*) with school-aged children, parents and teachers and the school-aged child's wider world (*Context*). *Time* is concerned with changes taking place within the wider world of the school-aged child and impacting on the mental health work of the SN. This is an overarching concept which is discussed throughout the literature review and, for this reason, it is not included as a subsection.

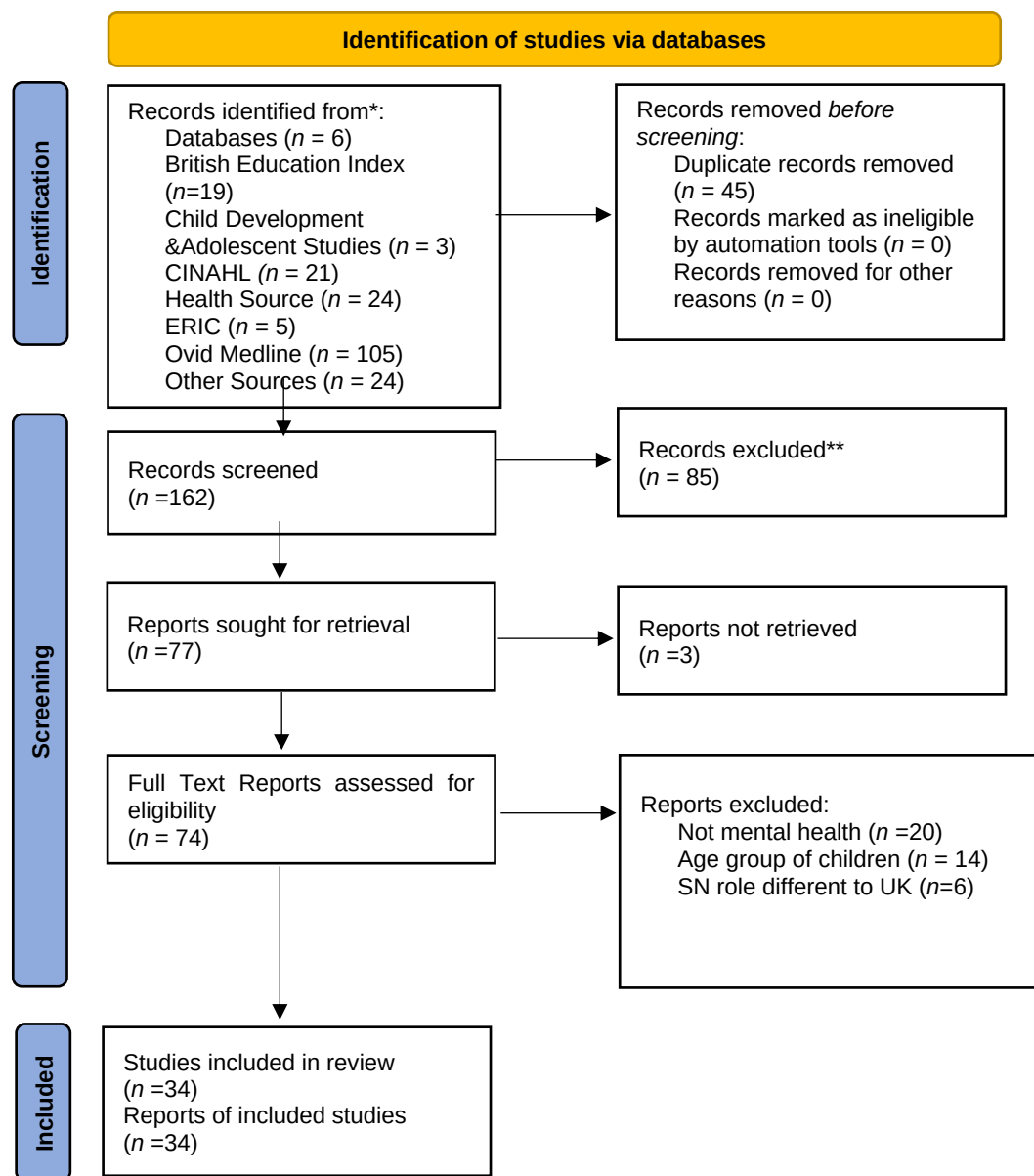


Figure 3.1: Literature search study flow diagram (Tricco et al. 2018)

*Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).

**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.

3.3 Person

Gaining an understanding of the role and mental health work of the SN is the focus of this study, and, within this section aligned to the PPCT Model (Bronfenbrenner 1995), literature pertaining to their role and mental health work is reviewed (*Person*).

3.3.1 Clarity of the role

Within the literature, the role of the SN lacks clarity, which is perhaps not surprising, given that globally the educational preparation and guidance for SN practice differs. For instance, in Norway, the educational preparation and qualifications required are similar to the UK in that they need to be registered nurses and complete an additional one-year postgraduate qualification in public health nursing (Skundberg-Kletthagen and Moen 2017). Similarly, in Finland, SNs are qualified public health nurses with a bachelor's degree (Markkanen et al. 2021). In contrast, the situation in the United States of America (USA) differs depending upon the state (Willgerodt et al. 2018). For example, some states require SNs to have completed a bachelor's degree and post-registration training in school nursing topics and a licence to practice as a SN, whilst in other states there are no educational requirements (Denehy 2007; Willgerodt et al. 2018). Although the National Association of SNs (NASN) in the USA have recommended that the minimum level of education for SNs is a bachelor's degree from an accredited college or university and a licence to practice as a registered nurse NASN (2022, n.p.), as they are not a regulatory body, they are unable to mandate their recommendations. Consequently, it is up to each state to make these decisions, which results in the variation in educational preparation in the USA.

Within the UK, a review by the Children's Commissioner for England (2016) to examine school-aged children's access to SNs concluded that the role of the SN as a frontline practitioner was essential as they had opportunities to support children's mental health. Yet, the review also highlighted a lack of clarity regarding the SN role and called for more clarity about their role and remit and greater efforts to promote their role in supporting children's health (Children's Commissioner for England 2016). Two decades earlier, a qualitative study,

conducted between 1995 and 1996 to explore and identify the role of the SN in meeting the needs of children in schools in England, highlighted confusion surrounding their role and responsibilities and the need for clarity of professional roles (Lightfoot and Bines 2000). It is noteworthy that the policy document *Getting it right for children, young people and families: Maximising the contribution of the school nursing team: Vision and Call to Action* (Department of Health 2012), which aimed to clarify the role and contribution of the SN in England, appears to have had limited impact. Moreover, DeBell and Tomkins' (2006) scoping review of school nursing practice and the Royal College of Nursing's (Ball 2009; RCN 2012, 2016) surveys of SN practice across the UK also highlighted a lack of clarity of the SN role and a variety across practice.

Prymachuk et al. (2012) identified that the quality of the professional relationships between SNs and education staff was linked to communication and lack of understanding of the SN role. Although the researchers do not refer specifically to lack of clarity, they do refer to teachers' lack of understanding of the SN role. This would suggest that the SN role is unclear, otherwise, teachers would have a clear understanding of their role. Skundberg-Kletthagen and Moen (2017) contend that SNs are perhaps ineffective at defining their role clearly to others. In contrast to the literature highlighting a lack of clarity of the SN role, within Scotland, the evaluation of the refocused SN role highlighted increased clarity of the role to SNs and relevant agencies (Doi et al. 2018). This may have been partly because the refocused role was defined, and nine priority areas for SN intervention were clearly identified. Thus, SNs were clear about their role and remit and therefore more effective at defining their role to others. This may also explain why the wider school team identified that they were unclear about their role as it was not clearly defined within the initial SN pathway. Indeed, this was one of the recommendations arising out of the evaluation (Doi et al. 2018).

3.3.2 Education and training of SNs for their mental health work

There were several examples in the literature linking educational preparation and training of SNs in mental health issues to their confidence and involvement in supporting school-aged children's mental health. A qualitative study conducted by Spratt et al. (2010a) to explore SNs' role in supporting school-aged children's

mental health in Scotland revealed that lack of knowledge and skills in mental health impacted their confidence in supporting children with mental health problems. For instance, some SNs reported that they did not feel well prepared for this aspect of their role. Similarly, studies by Wilson et al. (2008), Prymachuk et al. (2012) and Skundberg-Kletthagen and Moen (2017) to explore the mental health work of SNs identified that lack of confidence, knowledge and experience were barriers to their involvement in supporting school-aged children's mental health. This was closely linked to lack of education and unmet training needs for their mental health role. More recently, a mixed methods study by Turner et al. (2022) revealed that difficulty in accessing training was perceived by SNs to impact negatively on the effectiveness of their mental health work. Taylor-Beirne and Taylor-Beirne (2022) conducted an integrative review of the literature to determine the role of the SN in supporting school-aged children with existing and emerging mental health issues. Their review focused on research within the UK and included six studies (Haddad and Tylee 2013; Haddad et al. 2010; Spratt et al. 2010; Prymachuk et al. 2012; Haddad et al. 2018; Doi et al. 2018). They concluded that SNs lack training and resources to enable them to provide effective support to school-aged children with emerging and existing mental health issues. Taylor-Beirne and Taylor-Beirne (2022) acknowledge that their review has several limitations, which include the small sample size of some of the included studies, the lack of differentiation between qualified and unqualified SNs and the exclusion of the views of school-aged children and other health and education professionals. Their recommendations included the need for future research to include the views of school-aged children to explore if SNs are the most appropriate professional to support their mental health, providing justification for this study.

A descriptive study, conducted by Markkanen et al. (2021) in Finland, to describe the role of SNs in supporting school-aged children's mental health revealed similar findings to those of Prymachuk et al. (2012) and Skundberg-Kletthagen and Moen (2017). The researchers identified that, although most of the SN participants felt that their knowledge and skills in supporting school-aged children's mental health was adequate, almost one-third of participants identified training needs for their mental health practice, particularly in relation to

assessment tools and interventions and methods to support school-aged children with culturally diverse needs (Markkanen et al. 2021).

Haddad et al. (2018) used a cluster Randomised Controlled Trial to investigate if a specifically designed mental health training programme for SNs, known as the QUEST project, would increase their knowledge and skills in the identification and recognition of depression. The study involved 146 SNs working in primary health care trusts in London who were randomly assigned to either the control group or the training intervention. The content of the training programme was based on the learning needs of SNs which had been identified during an earlier study by the researchers to explore SNs involvement, knowledge, attitudes and training needs for their mental health work (Haddad et al. 2010). The training was delivered over one full day and followed up four to six weeks later by a half-day session. Interactive teaching methods were used and participants were provided with a package of resources. To evaluate the success of the training programme in increasing knowledge and attitudes, Haddad et al. (2018) utilised a validated attitude scale, the Depression Attitude Questionnaire (DAQ) (Botega et al. 1992), and they also developed twelve vignettes to evaluate skills development. They completed baseline measures at the beginning of the training programme and then repeated these at three- and nine-months post training. Haddad et al. (2018) found that the training programme was effective in increasing SNs knowledge in the identification and management of depression. It was also linked to an increase in their confidence in this aspect of their work at the three month follow up, but not at nine months post training. Haddad et al. (2018) do not provide explanations why this may be the case, and if there were differences between the participants who held the SCPHN qualification which is a limitation of the findings. In addition, caution is required when interpreting the findings as the use of vignettes may have been linked to higher scores in the recognition of depression; the SN service in London may differ to the SN service in other geographical locations, and the attrition of participants during the study may have introduced bias. Nonetheless, the study does indicate that when training is tailored to the learning needs of SNs, it is more effective.

In contrast, to these studies, evaluation of the refocused SN role in Scotland revealed that, despite providing SNs with extensive training, although they felt prepared to identify mental health issues, they did not feel prepared to deliver interventions designed to support school-aged children with low to moderate mental health issues (Doi et al. 2018). Some of the SNs in Doi et al.'s (2018) study felt that the training focused too much on theory and not enough on the practical application of assessment tools and interventions. Added to this, their findings also highlighted that, even when SNs did feel skilled to deliver interventions, they did not have the resources to implement them in practice. Resource was also an issue linked to staff capacity, and there were concerns expressed from participants that releasing some staff to complete their specialist community public health nursing programme would add to existing pressures on the school nursing service (Doi et al. 2018). Thus, it is not simply the provision of education and training that is required to prepare SNs to feel confident to support children's mental health, education and training needs to be relevant to the learning needs of SNs and it needs to be applicable to their practice. In addition, SNs need to be provided with the resources, including staff, to enable them to implement interventions to support children's mental health.

3.4 Process

Gaining an appreciation of the extant literature on SNs', school-aged children's, parents', and teachers' experiences and understanding of the mental health work of the SN and the interventions they use was crucial to identify what is known about the interactions between them (*Process*).

3.4.1 SNs' perceptions of their work supporting school-aged children's mental health

There is a growing body of literature on SNs' perceptions of their work in supporting school-aged children's mental health. Yet, much of the literature focuses on their work with secondary-school-aged children and not primary-school-aged children who are the focus of this study. For instance, Ravenna and Cleaver (2016) conducted a scoping review to explore SNs' experiences of managing young people with mental health problems. This study focused

specifically on the SNs' perceptions of their mental health work with adolescents in secondary schools.

Much of the recent literature originates from Nordic countries, in particular, Sweden, Finland and Norway, which, similar to the rest of the world, have seen an increase in the prevalence of mental health problems amongst the school-aged populations over the last decade (Skundberg-Kletthagen and Moen 2017; Anttila et al. 2020). Although the education and health systems in these countries differ from the UK, there is recognition from their governments, in line with the WHO Health Promoting School initiative (WHO 1997, 2021), that the school is a setting for promoting mental health and the SN has a role in that (Anttila et al. 2020). Since 2020, the number of studies originating from the UK has increased, and four studies were located; two scoping reviews (Turner et al. 2022; Cook et al. 2023), an integrative review (Taylor-Beirne and Taylor-Beirne 2022), and a cross-sectional survey (Sammut et al. 2023). It is evident from the extant literature that SNs perceive that they have a role to support school-aged children's mental health, and that this is a key aspect of their public health practice.

One of the most recent UK studies was conducted by Sammut et al. (2023) to obtain SNs' perspectives of their work with children and young people in the UK during the COVID-19 pandemic. This was an online cross-sectional survey and included participants from across the UK ($n=78$). Although the focus of their research was not specifically on SNs' work in supporting school-aged children's mental health, participants were asked about their work, which includes mental health. The SNs in Sammut et al.'s (2023) study expressed frustration at not being able to intervene early due to their child protection workload, which increased during the pandemic, a lack of resources, especially specialist mental health services, and restrictions in their access to schools. They perceived that mental health issues in children and young people had increased during the pandemic and that their work had become reactive to issues rather than targeted at working in a proactive way to prevent issues. However, due to the small sample size and methods of recruitment, which used social media platforms and professional organisations that not all SNs in the UK may use, caution is required

in interpreting the findings. Nonetheless, it is noteworthy that child protection workload and lack of resources are issues that are frequently highlighted in research exploring SNs' perceptions of their role in supporting school-aged children's mental health (Prymachuk et al. 2012).

Similarly, Garmy et al. (2023), in their online cross-sectional survey to investigate Swedish SNs' perspectives of the impact of the pandemic on children and young people aged six to nineteen years, identified that the SNs working in vulnerable areas felt that mental health problems had increased. This is not surprising, given the increasing evidence that the social determinants of health impact on the health and wellbeing of children and young people across the life course (Marmot et al. 2020). Yet, this contrasts with the perceptions of 64% of SNs working in other areas who perceived that the mental health of school-aged children was very good or good. Furthermore, the SNs in Garmy et al.'s (2023) study perceived that mental health problems were more common in girls than boys. Headache and stomach-ache, and problems with relationships with their peers and family were the main reasons given for girls' contact with the SN. In contrast, the main reasons for boys pertained to sports injuries and wounds. Nonetheless, caution is required in interpreting these findings in relation to primary-school-aged children as the age range of the children was broad and not broken down into primary- and secondary-age children. The researchers also acknowledge that the response rate (10%) and recall bias were limitations.

It is notable that, over a decade earlier, Clausson et al.'s (2008) survey of Swedish SNs, which aimed to use their knowledge and experience to gain a better understanding of school-aged children's health, also found that the SNs perceived school-aged children's mental health to have declined, especially in girls and children from vulnerable backgrounds. Similar to the findings of Garmy et al. (2023), the SNs reported that the main reasons that girls contacted them was due to headaches, and relationship problems. Nevertheless, caution is required when interpreting the findings of both Clausson et al.'s (2008) and Garmy et al.'s (2023) studies, as there are some differences in the role of the SN compared with the UK. For instance, in Sweden, it is mandatory for a qualified SN to be present at every school, whereas this is not the case in the UK. SNs in

the UK are unlikely to have contact with primary-school-aged children complaining of headache or stomach-ache, though it is acknowledged that these may be symptoms of mental health problems, such as anxiety. Dina and Pajelic (2014), in their qualitative study to describe SNs' experiences of identifying mental illness in primary-school-aged children, found that, where children visited the SN frequently complaining of headache or pain or self-harming behaviours, there was often an underlying mental health problem. Anxiety, depression, agitation, and other neuropsychiatric disorders were problems that the SNs in Dina and Pajelic's (2014) study had experience of identifying. Prymachuk et al. (2012) also highlight self-harm, substance misuse, eating disorders and anxiety as mental health problems that SNs had experience of working with in their study. However, the SNs reported that they did not feel as comfortable supporting children with these issues (Prymachuk et al. 2012). These findings support Wilson et al.'s (2008) Scotland-based study, which revealed that self-harming, eating disorders, externalising behaviours and family difficulties comprised the cases that caused SNs the most worry.

Similarly, Skundberg-Kletthagen and Moen (2017) found that self-harming, eating, and behavioural issues were also areas for concern in their Norwegian study. In addition, they revealed that poor self-esteem was an issue for girls, whilst substance misuse, sleep problems and suicidal thoughts were reasons why boys contacted the SN. Caution must be taken when interpreting these findings in relation to primary-school-aged children. Although the inclusion criteria specified that the nurse was working with children and adolescents aged 11–18 years, the findings do not specify clearly what mental health issues affected children aged 11 years.

More recently, Markkanen et al. (2021) found that depression, anxiety, and family stressors were the main mental health issues that SNs in their study reported. Their study comprised a national survey of 136 SNs working as a SN and members of the Finnish Public Health Association. The survey tool used was adapted from the Mental Health Needs and Practices in Schools Survey, which was validated for use in the USA and comprised open and closed questions (Stormont et al. 2011). The response rate was 21%, which limits the

transferability of the findings. Nonetheless, the findings are similar to those of the Swedish and UK studies, which does support Markkanen et al.'s (2021) findings.

Altogether, the findings of the studies included in this section indicate that self-harming, anxiety, depression, and family difficulties appear to be the main mental health problems with which the SNs in the UK and Nordic countries are involved. Moreover, they serve to highlight that internationally SNs perceive that there is an increase in mental health issues in school-aged children, but they also highlight the need for more research to explore and evaluate the contribution of the SN.

3.4.2 Job satisfaction

The review of the literature found that SNs perceive the support of school-aged children's mental health as a key aspect of their work and that this is associated with job satisfaction. For instance, Prymachuk et al. (2012) found that SNs in their study valued their mental health work and viewed it as being an essential part of their work with school-aged children. Haddad et al. (2010), Dina and Pajelic (2014), Skundberg-Kletthagen and Moen (2017), Markkanen et al. (2021), and Vejzovic et al. (2022) revealed similar findings, but these were more related to the importance of this aspect of their role. A qualitative study conducted by Jonsson et al. (2019) in Sweden to identify SNs' experiences of working with school-aged children with mental health problems revealed that the SNs found their work rewarding as it provided them with opportunities to have an impact on the children's health and to develop professionally and personally. Furthermore, Sherwin (2016), in her narrative study to explore how SNs provide emotional support to children and young people, found that being able to make a difference was very rewarding.

Wilson et al. (2008) set out to describe health visitors' ($n=71$) and SNs' ($n=100$) workload, and to identify problems and sources of satisfaction in relation to their work with children and young people with psychological, emotional, or behavioural problems. This study was conducted in Scotland and comprised a national survey. The findings indicate job satisfaction is essential, but they also reveal that the cases SNs found to be the most satisfying were supporting school-aged children who were self-harming (Wilson et al. 2008).

3.4.3 Professional advice and support

While the SNs in Wilson et al.'s (2008) study obtained job satisfaction in supporting children who are self-harming, they also reported these cases to be the most worrying. They also expressed frustration at their lack of access to professional advice and support, and indicated that there were issues making referrals and delays in accessing specialist support (Wilson et al. 2008). This led to the SNs reporting feelings of being overwhelmed due to the difficulty in accessing mental health professionals directly for advice and support, and the complexity and number of cases. Similarly, Skundberg-Kletthagen and Moen (2017) and Vejzovic et al. (2022) found that SNs reported difficulties in accessing specialists, including psychologists. Skundberg-Kletthagen and Moen (2017) suggest that this may account for SNs' reports of feeling alone in their work supporting school-aged children's mental health. This is consistent with the findings of Dina and Pajelic (2014) and Vejzovic et al. (2022). The SNs in Dina and Pajelic's (2014) study expressed feelings of loneliness when the school counsellor was not available. In contrast, Vejzovic et al. (2022) found that feelings of loneliness were more associated with the sense of responsibility the SNs felt when managing school-aged children with mental health issues. These studies indicate that the emotional toll of supporting children's mental health and the lack of support from specialists are crucial factors impacting on their practice.

Sherwin (2016) and Jonsson et al. (2019) identified that the emotional involvement of providing emotional support to vulnerable school-aged children led some SNs to feel very anxious. Jonsson et al. (2019) also found that, although some of the SNs were aware of the growing numbers of school-aged children with mental health problems, they had not anticipated the emotional labour involved. The SNs in Sherwin's (2016) study had access to informal peer support and what she refers to as '*organisational support*', however, they voiced the need for more support, especially for newly qualified SNs (Sherwin 2016, p. 33). Wilson et al. (2008) recommended that SNs should be provided with ongoing supervision and professional support from psychological services. Almost a decade later, this continues to be a recommendation for school nursing mental health work (Sherwin 2016; Skundberg-Kletthagen and Moen 2017; Jonsson et al. 2019).

3.4.4 Primary-school-aged children's perceptions of SNs' mental health work

There is a paucity of literature exploring primary-school-aged children's experience and understanding of the role of the SN in supporting their health and wellbeing. In relation to the support of their mental health, no studies were located. The focus of most studies was on the experience of secondary-school-aged children, and primary-school-aged children were therefore excluded. For example, one of the largest and most well-known studies is the British Youth Council (BYC 2011) study of secondary-school-aged children in England, which comprised an online survey and focus groups. The aim of the study was to obtain secondary-school-aged children's experiences of the current school nursing service and to explore their views and priorities for the future of the service. Similarly, Healthwatch Leeds (2014) conducted a survey of secondary-school-aged children to determine their views of a new High School Drop-In service delivered by SNs. Booth (2015) sought secondary-school-aged pupils' views on what they want from the SN service, while Bulmer and Webster (2016) surveyed secondary school pupils aged 14–15 years to seek their views on how they would like to access the SN.

Only three studies were located that sought the views of primary-school-aged children and met the date limiter (Chase et al. 2010; NCB Health and Social Care 2015; Woodhouse et al. 2016). However, of these three studies, one was excluded (National Children's Bureau (NCB) Health and Social Care 2015). The NCB consulted with children aged 7–12 years ($n=10$) and children aged 5–11 years ($n=6$) regarding their views of communication with health professionals (NCB Health and Social Care 2015). Whilst the NCB Health and Social Care (2015) study was relevant due to the age group, it was excluded for two reasons. Firstly, the focus was not specifically on children's views of the SN. Secondly, although questions were asked that included the term 'nurse', there was ambiguity in relation to what constituted the field of nursing. For instance, as the interviews took place in a hospital setting, it is possible that the children only considered nurses working in a hospital setting.

Chase et al. (2010) sought to explore primary- and secondary-school-aged children's views of nurses in schools in England in their mixed method study comprising a literature review and a case study design. Similar to the NCB Health and Social Care (2015) study, there was ambiguity in the use of the term '*nurse*' and '*nurses in schools*' and it was not clear whether the researchers were referring to the SCPHN-SN. For example, community children's nurses visit schools, but they are not SNs. Moreover, because the title '*nurse*' is not protected in statute, it can be used to refer to the first aider in schools. Chase et al. (2010) did not focus specifically on the mental health work of the SN. Nonetheless, their study was included as it examined the different roles and responsibilities that nurses working in schools assume in relation to the promotion of children, young people and the family's health in and through schools (Chase et al. 2010). It is widely recognised that health is a broad concept, comprising physical, mental, and social wellbeing (World Health Organisation 1948, p. 1), which provides justification for this decision to include this study.

Chase et al. (2010) used focus group discussions to obtain the views of primary-school-aged children. A total of 71 children in Years 5 and 6 participated in the study, of which 37 were girls and 34 were boys. Members of school staff were involved in selecting children to participate according to the inclusion criteria to ensure a balance of academic ability and gender and to reflect cultural, social, and economic diversity. It is not clear how many focus group discussions took place in each school, but the researchers do indicate that the focus groups comprised about six children and were approximately 40 minutes long. The findings indicated that school-aged children value SNs when they know who they are and what they do (Chase et al. 2010). Children who had experience of support from the SN expressed that they found the nurse helpful. In relation to the qualities that the children expected of a SN, these included being approachable, friendly, non-judgemental, sensitive, and able to listen. Some children expressed the importance of knowing the SN before feeling comfortable to share their worries, but, generally, primary school children were confused about who the SN is, and, in some schools, children thought the SN was the person in school providing first aid. In other schools, however, children had an awareness that a nurse visits the school (Chase et al. 2010).

In 2016, the Scottish Government commissioned Children in Scotland to consult with children and young people in primary and secondary schools in the two early adopter sites for the refocused SN role. The aim of the consultation was to obtain their views on the role of the SN to inform the development of the refreshed school nursing framework (Woodhouse et al. 2016). The children and young people were purposefully selected by head teachers and guidance teachers to ensure that they represented the health needs for the nine priority areas identified in the proposed SN pathway (Woodhouse et al. 2016). However, this approach to recruitment may have introduced bias. The sample comprised 34 school-aged children from one primary and one secondary school in the two early adopter sites ($n=15$ in P6/7, and $n=19$ in S2–5). Data collection methods comprised workshop sessions facilitated by 2–3 members of Children in Scotland and a staff member from the school. Similar to the findings of Chase et al. (2010), the children and young people in Woodhouse et al.'s (2016) study expressed a lack of awareness about who the SN is, and only 12 out of the 34 children stated that they knew who their SN was. There was also confusion and lack of awareness about what SNs do and the problems they can help with. Despite this, when asked who they would speak to about issues that worried them, the primary school children indicated that they would consider seeking help from other people, including the SN. This contrasted with the views of the secondary-school-aged children who suggested that, if they were to seek support, they would not choose to seek support from the SN (Woodhouse et al. 2016).

Woodhouse et al. (2016) also identified that the children and young people wanted the SN to be available and accessible, and privacy and confidentiality was deemed to be essential. Moreover, they wanted the SN to be kind, a good listener, non-judgemental and trustworthy. This is consistent with the findings of Chase et al. (2010), but also the excluded studies (British Youth Council 2011; Healthwatch Leeds 2014; Booth 2015). One of Woodhouse et al.'s (2016) key findings related to the issues for which the children and young people wanted support. These included physical health, mental health, and social issues. Furthermore, they wanted information and support to understand and cope with anxiety and worry, relationships, including friendships, bullying, conflict within families, anxiety and caring responsibilities, disabilities, autism and attention

deficit hyperactivity disorder (ADHD), healthy eating, diet, sleep, and personal care. Woodhouse et al. (2016) also highlighted that the primary school children expressed anxiety and worries about illness within the family, and how to cope if a close family member received a diagnosis. They were also worried about the transition to high school. In contrast, the secondary school pupils expressed worries about bereavement and loss and body image and confidence. Barriers to accessing the SN included feeling anxious about talking to the SN if they had not met them before and did not know them.

When asked their views on how the SN service could be developed to support them, a variety of views were expressed in respect of location and settings for contact. While some children and young people would prefer to see the SN at home, others indicated they would prefer contact at school. Additionally, community centres and online support were also suggestions. Ensuring their privacy and confidentiality during contact was the main concern expressed by the children and young people. For example, some children did not feel that contact in the home would be private from their family, whilst others were concerned that their peers would notice if they had to miss class to see the SN (Woodhouse et al. 2016).

Several recommendations were made to inform the redesign of the school nursing service in Scotland. These included flexibility and choice for the school-aged child in respect of location and settings for contact, accessible information about SNs and the support they can offer, and clear policies about confidentiality and information sharing. Moreover, Woodhouse et al. (2016) recommended that SNs work on building familiarity with school-aged children to develop trusting relationships. They also recommended further research with school-aged children to explore the barriers to accessing the SN in more detail. It is notable that these recommendations reflect those of earlier studies, such as Chase et al. (2010), raising questions regarding the extent to which policy makers and commissioners of school nursing services listen to the voice of children.

3.4.5 Parents' perceptions of the SN mental health work

Research exploring parents' perceptions of the SN and their work in supporting school-aged children's health is scant, and only six studies were located

(Kirchofer et al. 2007; Nguyen and Somrongthong 2009; Read et al. 2009; Chase et al. 2010; Maughan and Adams 2011; Yildirim et al. 2017). However, none of these studies explored parents' perceptions that focused specifically on SNs' work in supporting primary-school-aged children's mental health, indicating a gap in the knowledge base and justification for this study. Nevertheless, Chase et al.'s (2010) study was included, as it included the views of parents of primary-school-aged children in relation to the SN role in promoting health and wellbeing. Twelve parents participated in the study, and Chase et al. (2010) found that, where the parents were involved in the school and had contact with the SN, they had an awareness of the SN role and remit and valued the SN's contribution. For instance, some parents felt that SNs would be able to discuss sensitive topics with their children better than teachers could. In contrast, there were other parents who were unaware that SNs visited their child's school and were unaware what they did. The parents in Chase et al.'s (2010) study suggested that the profile of the SN needed to be raised so that parents and children knew what they did.

3.4.6 Teachers' perceptions of the SNs' mental health work

Research on teachers' perceptions of the SN and their role in supporting school-aged children's mental health is limited. While there are studies exploring teachers' views of mental health in schools and how they can support pupils (Graham et al. 2011), they do not explore their perceptions of how the SN supports or can support school-aged children's mental health. Four studies were located that sought primary school teachers' perceptions of the SN (Kirchofer et al. 2007; Chase et al. 2010; Maughan and Adams 2011; Biag et al. 2015), however, only one was included (Chase et al. 2010). Three of these four studies were conducted in the USA (Kirchofer et al. 2007; Maughan and Adams 2011; Biag et al. 2015), however, as the role of the SN in these studies was different to the role of the SN in the UK, they were excluded.

Chase et al. (2010) recruited a total of 16 school staff working in primary schools in the five case study sites. The school staff comprised head teachers, deputy head teachers, learning mentors, learning for life programme workers, family support workers (employed by schools), inclusion officers, wellbeing co-

ordinators, pastoral support tutors, re-integration and safeguarding managers, and school administrators/first aiders. A limitation of this study, however, is that the researchers did not clearly specify the number of qualified teachers included in the sample. Although there are some participant quotations from head teachers, it is difficult to ascertain teachers' views of the SN. Nevertheless, it is possible to identify a few key findings from the head teachers' comments.

In one case study site, the deputy head teacher highlighted the importance of building relationships with vulnerable families. She indicated that the high turnover of SNs at her school made it difficult for SNs to build relationships with families and to offer appropriate support. Similarly, in a different case study site, teachers and school staff felt that regular visits from the SN facilitated opportunities to build relationships. Additionally, another head teacher in a different case study site indicated that, because her communication with the SN had improved, the liaison between agencies working with families was more effective. Moreover, she suggested that it had improved the engagement of families and '*increased*' outcomes (Chase et al. 2010, p.44). The findings also revealed that, in some case study sites, the profile and visibility of SNs and the understanding of their work had increased due to initiatives, such as the FRIENDS programme (Stallard et al. 2008) and promotional materials (Chase et al. 2010). Thus, teachers' perceptions and understanding of the SN appear to be associated with their experience of contact with the SN and knowledge of their role and remit. This is consistent with the perceptions expressed by school-aged children and parents (Chase et al. 2010), highlighting the need for SNs to be visible in schools to enable them to build relationships with teachers, school-aged children and their parents to effectively intervene and provide support.

3.4.7 SN mental health interventions

The evidence base for effective, validated SN mental health interventions is limited (Abhyankar and MacGillivray 2014; Turner et al. 2022; Pawils et al. 2023). This is despite recommendations that SNs need to become involved in developing the evidence base (Wainwright et al. 2000; Wilson et al. 2008). In 2014, the Scottish Government commissioned a systematic review of the effectiveness of interventions delivered by SNs for school-aged children aged 0–

19 years to inform the development of the refocused SN framework (Abhyankar and MacGillivray 2014). The researchers conducted a rapid systematic review of the empirical literature and concluded that the evidence base for effective interventions was limited due to the poor methodological quality of the research studies. Moreover, Abhyankar and MacGillivray (2014) identified a lack of studies focusing on SNs' mental health interventions, and, of the 28 publications included in their review, only six studies related to mental health (Fothergill et al. 2003; DeSocio et al. 2006; Stallard et al. 2008; Carnevale 2011; De Wilde et al. 2011; Stice et al. 2011). Of these, only two focused on primary-school-aged children (DeSocio et al. 2006; Stallard et al. 2008), and two were UK studies (Fothergill et al. 2003; Stallard et al. 2008).

Fothergill et al. (2003) conducted a systematic review of the literature to find and appraise screening tools used by SNs in schools to identify emotional, psychological, and behavioural problems in adolescents. It is noteworthy that they were unable to evaluate the effectiveness of screening tools as they did not find any evidence. In contrast, Stallard et al. (2008) conducted a quasi-experimental study of a CBT-based emotional prevention programme delivered by SNs with primary-school-aged children. This intervention, known as FRIENDS, was delivered as a universal intervention in schools and was found to reduce anxiety and improve self-esteem. Follow-up research identified that the effects of the intervention were still effective 12 months later (Stallard et al. 2008). However, as this study did not include a control group for comparison, caution is required when interpreting the findings (Abhyankar and MacGillivray 2014).

The Scottish Government also commissioned a scoping review of reviews to support SN interventions in a school-aged population in preparation for the refocused SN role (Campbell et al. 2014). Twelve reviews were included in the scoping review, of which three were Cochrane Systematic Reviews focusing on mental health and wellbeing interventions (Ekeland et al. 2004; Merry et al. 2011; Langford et al. 2014). The quality of the included reviews was assessed by using the AMSTAR checklist questions, which is a validated tool for assessing methodological quality (Shea et al. 2017). In relation to the effects of the intervention and the quality of evidence, none were classified as high grade, and

most interventions fell into the classification of moderate grade evidence (Campbell et al. 2014).

The aim of Ekeland et al.'s (2004) review was to determine whether exercise interventions can improve self-esteem among children and young people. The results revealed that these were associated with short-term effects on self-esteem. Due to the small number of low-quality trials included in the review, the researchers concluded that more research is required and advised caution when interpreting the findings (Campbell et al. 2014). Merry et al. (2011) set out to investigate whether psychological or educational interventions or both (universal and targeted) are effective in preventing the onset of depressive disorders in children and adolescents aged 5 to 19 years. The findings of this systematic review suggest that, in comparison to no intervention, targeted and universal interventions may be effective in preventing depressive disorders (Merry et al. 2011). Nevertheless, they concluded that more research is needed to identify which interventions are the most effective. The aim of Langford et al.'s (2014) systematic review was to assess the effectiveness of the Health Promoting Schools (HPS) framework in improving the health and well-being of students and their academic achievement. Sixty-seven studies were included in this review, of which two were related to mental health. The inclusion criteria for children included in the studies was that they were aged 4 to 18 years and attending school. The results identified that there was no evidence linking the HPS framework to improved mental health in school-aged children.

Campbell et al.'s (2014) scoping review of reviews concluded that the mental health interventions that had the most beneficial effects on school-aged children's mental health for a period of at least 12 months after the intervention included psychological/educational interventions for the prevention of depression. However, a limitation of their review is that, for most of the included studies, it is either not stated or not reported who had delivered the intervention. For example, neither Ekeland et al. (2004), Merry et al. (2011) or Langford et al. (2014) provide these details. Therefore, it is not possible to establish which, if any, of the interventions were delivered by the SN.

Turner and Mackay (2015) conducted a review of the literature to explore the impact of SN interventions relating to mental health and behaviour change in England. Although they do not clearly state the type of literature review conducted, details are provided of the search strategy and method of evaluation, suggesting this was a scoping review. Turner and Mackay (2015) aimed to answer four research questions, two of which were looking to elicit what outcomes SNs in England achieve in relation to behaviour change and mental health, and what methods of evaluation of intervention SNs undertake and consider to be good practice. Twenty-nine papers were included in the review, and most of the studies were descriptive, focusing on local projects involving single sites and non-representative samples in England. The findings revealed that SNs were viewed as unique professionals with effective communication and interpersonal skills. Access to and engagement with the SN service by young people was reported to be good, bringing beneficial outcomes in relation to emotional health and lifestyle issues (Turner and Mackay, 2015). The scoping review highlighted several gaps and barriers, which included: the need for additional training or support, particularly in relation to challenging behaviour (Buckland et al. 2005), mental health (Prymachuk et al. 2012), and lack of time, competing priorities and organisational issues impacting on SNs' ability to deliver interventions. In addition, the scoping review also revealed that the involvement of young people in service development was patchy and sometimes tokenistic, especially in relation to sexual health (Hayter et al. 2012). Turner and Mackay (2015) concluded that SNs need to evaluate services and they need national guidance on how best to do that. They made several recommendations, which included: the need for future research to develop guidance for evaluation; examination of evidence of good practice in evaluation; and to seek to explore the views of SNs and stakeholders in the value and effectiveness of the implementation of the guidance in practice.

Turner et al. (2022) conducted and published the results of a mixed methods study to review the available evidence on nurse-led interventions and to understand the role of nurses in promoting children and young people's mental health and emotional wellbeing across the UK. Their study comprised a scoping review and a Delphi study. The findings of Turner et al.'s (2022) scoping review

of the literature supports Abhyankar and MacGillivray's (2014) and Campbell et al.'s (2014) unpublished systematic reviews. Similarly, Turner et al. (2022) also found it difficult to establish the role of the SN in delivering interventions to support school-aged children's mental health, as many of the studies did not identify whether nurses and/or SNs were involved. Moreover, some studies provided limited details regarding the type of intervention delivered. Thus, only 18 studies were included in their review, of which seven originated from the UK. However, there are several limitations of the included studies in this review. These relate to differences in the types of interventions and outcome measures and variation in the role of nurses and their involvement in the intervention (Turner et al. 2022).

More recently, Pawils et al. (2023), in their review of reviews to evaluate the effectiveness of SN interventions globally, concluded that, apart from SN interventions to address asthma and diabetes, the quality of the evidence is limited. Similar to Abhyankar and MacGillivray (2014), Campbell et al. (2014) and Turner et al. (2022), they found issues with the methodological quality of the research studies, thus affecting the quality of the evidence. Furthermore, they highlighted issues with what they referred to as the 'concept' of the SN. For example, they identified differences in the training, role, and remit of SNs across the globe, which made it difficult to compare studies and is therefore a limitation of their findings. Although Pawils et al.'s (2023) review does not focus specifically on mental health interventions, it does highlight the need for more robust evaluation of SN interventions to address school-aged children's mental health. The researchers also recommended that qualitative studies should be included in evaluation designs.

So far, this chapter has considered literature pertaining to the role of the SN, and SNs', primary-school-aged children's, parents' and teachers' perceptions of their mental health work to discover what is known. It is apparent from the studies reviewed that issues with the methodological quality and validity of interventions designed to support school-aged children's mental health is an issue and that more robust research is required. The chapter will now move onto consider the

context within which SNs work to understand what is known about the challenges and barriers to their mental health work.

3.5 Context

The *context* within which the SN works includes not only the school, but the child's home and the community, all being part of the school-aged child's wider world. In this section, literature relating to the barriers that impact on the mental health work of the SN are reviewed.

3.5.1 Barriers to SNs' mental health work

Lack of time, resources and workload capacity are constraints that have been associated with school nursing practice in the UK for decades (Wainright et al. 2000; Croghan et al. 2004). Yet, these issues are not confined to the UK and have been highlighted in research with SNs working in Sweden, Finland, Norway and the USA (Skundberg-Kletthagen and Moen 2017; Jonsson et al. 2019; Markkanen et al. 2021; Vejzovic et al. 2022; Hoskote et al. 2023). In nine of the included studies, lack of time, resources and workload capacity were perceived by SNs to impede their ability to work effectively and support school-aged children's mental health (Wilson et al. 2008; Spratt et al. 2010a; Prymachuk et al. 2012; Sherwin 2016; Skundberg-Kletthagen and Moen 2017; Jonsson et al. 2019; Markkanen et al. 2021; Vejzovic et al. 2022; Hoskote et al. 2023; Sammut et al. 2023). Wilson et al. (2008) found that just over a quarter (28%) of the SNs in their study cited lack of time and workload as barriers to their capacity to provide a good service to young people. In addition, the SNs highlighted that providing support to school-aged children with psychological, emotional, and behavioural issues was time-consuming (Wilson et al. 2008). Similarly, a national survey by Haddad et al. (2010) to investigate SNs' involvement, attitudes and training needs for their mental health work found that 55% of SNs reported that their mental health work took up one-third of their time, whilst 23% reported that it took up over half of their time (Haddad et al. 2010). Although the reason for this difference is not clear, the findings do highlight that the provision of mental health support comprises a significant part of the SNs' workload (Haddad et al. 2010).

In addition to the time-consuming nature of mental health work, the child protection workload of SNs was also cited as a barrier in several studies. Spratt et al. (2010a) and Prymachuk et al. (2012) found that child protection took up a significant amount of the SNs' time, due to the time-consuming nature of the work. This finding is echoed in the most recent study by Sammut et al. (2023). Although the aim of Sammut et al.'s (2023) study was to obtain SNs' perspectives of working during the pandemic, their findings highlight that a large part of the SNs' work is involved with child protection. Consequently, Sammut et al. (2023) found that SNs had less time to focus on their mental health work. Similarly, Sherwin (2016) found that the unpredictable nature of child protection work made it difficult for the SNs in her study to work consistently with children, leading to frustration.

Tensions between the reactive and proactive workload of SNs have featured in several studies over the last two decades. For instance, Spratt et al. (2010a) identified tensions in the SNs' mental health work, between proactive work, such as mental health promotion, and reactive work, for example, a child self-harming. Likewise, the SNs in Jonsson et al.'s (2019, p. 205) study also described tensions and the analogy of 'running more for fire alarms instead of preventing the fires in the first place' was used to convey this. This was also a finding in surveys of SNs' perspectives of their work during the pandemic (Hoskote et al. 2023; Sammut et al. 2023). Hoskote et al. (2023) found that SNs in their survey had less time to focus on supporting children's mental health as they were required to support COVID-19 duties. In contrast, Sammut et al. (2023) found that the impact that pressures on mental health services had on the SNs' workload resulted in the SNs having to manage more complex cases. Moreover, issues with staff absence due to COVID-19 added to the workload of SNs, and they felt that expectations of their service were unrealistic (Sammut et al. 2023).

Many of the studies have also highlighted that SNs do not feel confident to support children's mental health due to lack of knowledge and skills (Wilson et al. 2008; Prymachuk et al. 2012; Vejzovic et al. 2022). Wilson et al. (2008) revealed that 17% of SNs in their survey felt that they lacked knowledge and skills in working with school-aged children with psychological, emotional, or

behavioural problems. The researchers concluded that access to specialist support from psychological services, supervision and mental health training is essential to enable SNs to effectively support school-aged children with mental health issues (Wilson et al. 2008). Nevertheless, the association between mental health training and increased SN confidence to support school-aged children's mental health is tenuous. Although most SNs in Haddad et al.'s (2010) study expressed the need for more training in mental health problems, a clear link between previous training in mental health and SN confidence was not identified. Moreover, Haddad et al. (2018) found in their evaluation of a specially designed training programme to increase their knowledge and skills in the identification and recognition of depression, that although the confidence of SNs increased three months post training, their levels of confidence at nine months had waned.

The evaluation of the refocused SN role in Scotland supports these findings (Doi et al. 2018). Doi et al. (2018) found that, despite the provision of extensive training to prepare the SNs for their refocused role, they still expressed lack of confidence in the mental health aspect of their role. Haddad et al. (2010) suggest that the content, duration and length of time since SNs completed mental health training could be factors associated with their lack of confidence. However, the SNs in the realist evaluation had recently received training to prepare them for their refocused role (Doi et al. 2018). Doi et al. (2018) found that most SNs in their study felt that the training was too theoretical and did not prepare them with the practical skills and tools they needed to deliver interventions to support children's mental health. This suggests that the content of mental health training needs to be directly relevant to SN practice to enable them to confidently support school-aged children's mental health.

Yet, despite this, only a few studies have clearly outlined SNs' perceptions of their training needs to equip them with the knowledge and skills required for their mental health work. Training in assessment and interventions were identified in four of the included studies (Wilson et al. 2008; Haddad et al. 2010; Skundberg-Kletthagen and Moen 2017; Markkanen et al. 2021). For instance, the SNs in Skundberg-Kletthagen and Moen's (2017) study expressed the need for assessment tools and interventions to be available and suitable for their needs.

In addition, brief courses and training in motivational interviewing were also perceived as being necessary by some SNs to help them to better support school-aged children's mental health and facilitate strengths-based conversations with children (Skundberg-Kletthagen and Moen 2017). Similarly, Haddad et al. (2010) found that SNs wanted training in how to deliver psychological interventions and how to manage self-harm and recognise anxiety and depression. The findings of Wilson et al. (2008) and Markkanen et al. (2021) support the need for training in interventions to support school-aged children's mental health. They also highlight that more evidence on the effectiveness of interventions is needed, which is consistent with Campbell et al.'s (2014) scoping review. Pryjmachuk et al. (2012) concur, but they also recommend joint training initiatives with CAMHS and school staff to support early intervention and to promote more effective partnership working. Skundberg-Kletthagen and Moen (2017) do not make any recommendations in respect of joint training, but they do suggest that more opportunities for SNs to share knowledge and experience with other agencies would be beneficial for their mental health work. Similarly, Vejzovic et al. (2022) recommend that SNs should be provided with ongoing education and opportunities to obtain guidance and support from specialists such as psychologists.

Bohnenkamp et al. (2019) describe a concurrent mixed method study of SNs from five states in the USA to facilitate a multilevel stakeholder-driven process to refine the Mental Health Training Intervention for Health Providers in Schools (MH-TIPS). This training programme was developed by the Center for School Mental Health at the University of Maryland School of Medicine in partnership with the NASN and the Center for Mental Health Services in Pediatric Care at the John Hopkins Bloomberg School of Public Health. The aim of the training was to develop school health providers' competence in managing the needs of students with or at risk of emotional and behavioural difficulties, impacting on their learning. Bohnenkamp et al. (2019) found that the SNs were positive about the training programme and felt that with modifications it could facilitate their practice in supporting school-aged children's mental health and educational outcomes. The SNs also indicated that, to support their mental health work, they needed training in assessment, interventions, referral processes, psychotropic

medication, communication skills and collaborative working. In addition, training in understanding legal issues, scope of practice and confidentiality, addressing barriers related to language, culture, stigma, and emergency crisis management were also viewed as being necessary (Bohnenkamp et al. 2019). Time, staffing issues, resources, and commitment to engage with the training process were regarded as barriers to the uptake of training and their professional development (Bohnenkamp et al. 2019). These findings are consistent with those of Wilson et al. (2008), Spratt et al. (2010a), Prymachuk et al. (2012), Sherwin (2016), Skundberg-Kletthagen and Moen (2017), Jonsson et al. (2019), Markkanen et al. (2021), Vejzovic et al. (2022), Hoskote et al. (2023) and Sammut et al. (2023). Similar to Vejzovic et al. (2022), Bohnenkamp et al. (2019) recommend continuing professional development as opposed to one-time training. They suggest that training should be linked to existing professional meetings, although they do not provide a reason to explain this. It is possible that Bohnenkamp et al. (2019) have taken cognisance of the barriers that the SNs expressed to ensure that the best use is made of their time and resources.

The review of the literature has revealed various barriers impacting on the mental health work of the SN. Nonetheless, there is also evidence pointing to factors that facilitate SN mental health practice. Whilst the SNs in Bohnenkamp et al. (2019) study highlighted barriers to accessing mental health training, including the ability to attend in-person training, they also indicated that a balance of online and in-person training would be useful. It is notable that this study was conducted prior to the pandemic when most training was delivered in-person. In contrast, during the pandemic, the delivery of training needed to move online. Anecdotally, many organisations offering online training found that the number of attendees increased. For instance, the number of attendees at Practice Assessor and Practice Supervisor development training delivered at the University of Stirling doubled. Post-pandemic, online training continues to offer learners a flexible and accessible means to engage in continuing professional development and to share learning. Garrad-Cole et al. (2021, p. 7) contend that:

online collaborative learning may be superior to F2F teaching in terms of academic quality and flexibility.

The suggestion is that online training has the potential to increase opportunities for SNs to share their learning, supporting Skundberg-Kletthagen and Moen's (2017) recommendations in relation to sharing knowledge and experience with other agencies. Nevertheless, the findings of Bohnenkamp et al.'s (2019) study should be interpreted with caution, as it was conducted in the USA where there are vast differences in school nursing and there were some limitations in the sampling approach.

3.6 Summary

This chapter has provided a critical review and analysis of the literature to identify what we know about the SN and their work in supporting school-aged children's mental health. Although there is recognition that the SN has a public health role focused on early intervention and health promotion, there is confusion and lack of clarity surrounding their role and remit and a variety of different modes of practice, not only within the UK, but also globally. SNs perceive that they have a significant role to play in supporting school-aged children's mental health, and this is evidenced in the growing number of studies exploring the contribution of their work. Yet, most of the studies identify barriers impacting on their ability to effectively support school-aged children's mental, in particular, lack of time, workload capacity, lack of resources and training needs. It is notable that these barriers are not new and were identified in studies conducted more than a decade ago. Nevertheless, there is some recent evidence indicating that online training could facilitate access to mental health training for SNs.

Of the studies available that have sought to obtain school-aged children's, parents', and teachers' perceptions of the SN, we know that SNs are valued when they are visible and when children, parents and teachers know who they are and what they do. However, many of the studies have highlighted that school-aged children and their parents lack awareness of the SN. Where children, parents and teachers have had experience of the SN, building trusting relationships were regarded as being essential. Parents and school-aged children look for the SN to be available and accessible, and children want their SN to be kind, a good listener and someone they can trust. In addition, teachers want the SN to be visible in schools. However, the focus of much of the literature

is on the SNs' work in supporting adolescents and not children attending primary school. Added to this, many of the studies have been conducted in Nordic countries and there are differences in the health and education systems there, which does place some limits on their relevance to Scotland and the UK. Although the updated search of the literature led to the identification of more recent research studies, there remains a paucity of published research studies, specifically those exploring children's, parents' and teachers' experiences and understanding of the SNs' contribution to the support of primary-school-aged children's mental health. This is despite a growing body of literature linking adverse childhood experiences with the development of mental health problems in childhood and poorer health outcomes across the life course.

Situating the literature within Bioecological Systems Theory (Bronfenbrenner 1995) has highlighted opportunities to consider how the theory could be applied to inform not only the research process but also SN practice.

The next chapter outlines the overall study aim and research questions, its methodological approach, and the research design.

Chapter Four: Methodology

Introduction

As indicated in Chapter Three, although it is recognised globally that the SN has a public health role focused on health promotion and early intervention, there is a paucity of studies focusing specifically on the SNs' contribution to supporting the mental health of primary-school-aged children. Using an explanatory sequential mixed methods approach and adopting an ecological lens, this research explores the SNs' work in supporting primary-school-aged children's mental health from the perspectives of SNs, school-aged children, parents, and teachers. The data collected in the first phase of the project, informed the selection of the case, and shaped the topics for discussion in the individual interviews in the second phase of the project.

This chapter outlines the methodology and methods employed and provides an account of the decisions made in designing this research study. The rationale for choice of research design, the theoretical and philosophical perspectives underpinning the study, justification for the choice of research methods and quality assurance methods are discussed. The chapter concludes with a discussion of the ethical considerations and a short summary.

4.1 Aims of the research and research questions

4.1.1 Study aim

The aim of this study was:

To explore primary-school-aged children's, parents', teachers', and SNs' experiences and understanding of the mental health work of the SN; and to identify their contribution to supporting and improving children's mental health.

4.1.2 Research questions

1. How do children, parents, teachers and SNs currently experience and understand the work of the SN in supporting primary-school-aged children's mental health?
2. What factors influence their experiences and understanding?
3. How do their experiences and understanding inform the future work of the SN in supporting and improving primary-school-aged children's mental health from an ecological and strengths-based perspective?

4.2 Research Design

The design of this study has been shaped in response to the research questions to ensure that the methodologies selected were the most appropriate to answer them. In the early stages of my doctorate, it became apparent that a qualitative approach alone would not be sufficient to fully answer the research questions. The diversity in SN practice within the UK and globally, and the refocus of the SN role in Scotland, indicated a need to examine their current practice, specifically in relation to their work supporting the mental health of primary school children, before exploring it in more depth. To this end, I employed an Explanatory Sequential Mixed Methods Research design, a core design integrating quantitative data collected in phase one followed up by qualitative data collected in phase two (Creswell and Creswell 2018). Before describing my research design in more detail, I consider it is necessary to provide a detailed justification of the philosophical perspective supporting the adoption of a mixed methods design. In the following three subsections, I will present my philosophical and paradigmatic stance and outline my commitment to a way of knowing the world and producing knowledge.

4.2.1 Philosophical perspective: pragmatism

A pragmatist approach was deemed to be the most appropriate for this study as the research design was flexible, inductive, abductive and emergent. It focuses on the fit between the research questions and the research methods, facilitating flexibility in the selection of methods and processes to best meet the researcher's

needs and address the research questions (Johnson and Onwuegbuzie 2004; Creswell and Creswell 2018). This contrasts with quantitative and qualitative approaches that rely on the philosophical stance being aligned to the research questions. Pragmatism is considered by some to be the third paradigm (Tashakkori and Teddlie 1998; Johnson and Onwuegbuzie 2004). It is a worldview that reflects choice in the research process and the design of studies, providing researchers with opportunities to combine different methodological approaches (Glogowska 2011). Moreover, it can support researchers to link the theoretical framework to the research design due to its emphasis on developing shared meaning and making a difference (Shannon-Baker 2016). Pragmatism as a philosophical stance is closely linked to the work of John Dewey. Dewey was of the view that our experiences are linked to our feelings, beliefs and actions and rooted in our social world (Morgan 2014).

Pragmatism is particularly suited to research studies using a mixed methods design as it draws on and uses the strengths of objective and subjective epistemologies (Biesta 2010). It is acknowledged that a pragmatist approach may not be an appropriate philosophical stance for all mixed methods research studies (Biesta 2010; Shannon-Baker 2016). Nonetheless, I considered that pragmatism was the best fit with my ontological and epistemological position.

4.2.2 Ontological considerations: what is reality?

Ontological issues are the ones that are concerned with how the social world is perceived (Bryman 2016). Grix (2002, p. 179) suggests that the research process is influenced by a person's world view and '*shaped*' by the experience they bring. He contends that the questions that we ask, how we ask them, and how we set about answering them is shaped by our ontological position (Grix 2002).

It is my position that how we make sense of the social world is dependent on context, place and time and our relationships with others. Moreover, it is my position that we all have different values, beliefs and experiences which influence our understanding of the world. This means that how we see and understand the social world is dependent on our upbringing, the environment and society in which we live, and the interaction between each of these elements. Each element is inter-connected, and their inter-relationship shapes our reality of the world.

Ontologically, my position fits with an ecological perspective, as discussed in Chapter Two, Section 2.1. Next, I consider how we know about the world.

4.2.3 Epistemological considerations: how do you know something?

Epistemological issues are those that are concerned with our theory of knowledge and how we know something. Bryman (2016) contends that epistemology is concerned with what is regarded as appropriate knowledge about the social world; the stance the researcher adopts influences the way the research is carried out. There are several ways of knowing about the world, and these include: inductive, deductive, retroductive and abductive logic (Ormston et al. 2014). Inductive logic refers to knowledge that is developed via a bottom-up approach involving observations, whereas deductive logic refers to knowledge that is based on a theory or hypothesis and utilises a top-down approach (Ormston et al. 2014). In contrast, retroductive logic refers to knowledge that is identified by the researcher that explains what caused a situation or event to occur (Easton 2010), whilst abductive logic refers to knowledge that provides explanations to understand the research findings (Johnson and Onwuegbuzie 2004).

It is my epistemological position that knowledge is socially constructed through the relationships and experiences that people have in their social world. Social constructivism is widely associated with Vygotsky (1978, 1986), who theorised that children construct their learning through a socio-cultural context. According to Berger and Luckmann (1991) and Hammersley (1992), it is the interaction between individuals that influences their subjective experience and understanding of the social world. I consider that building trusting relationships with people is key to learning about their experiences and understanding of the world. Epistemologically, my position fits with an ecological perspective. Furthermore, it aligns with my decision to adopt a pragmatist approach, as discussed above, in section 4.2.1. For this study, I deemed it essential to construct knowledge and understanding about the mental health work of the SN through inductive and abductive methods of inquiry, both of which are associated with Mixed Methods Research designs.

4.2.4 Mixed Methods Research

Mixed methods research (MMR) is becoming more widely used within nursing and healthcare research (Glogowska 2011; Shorten and Smith 2017; Vedel et al. 2019). MMR is associated with a number of strengths that were considered to be of value for this study. Firstly, MMR can provide opportunities to study a phenomenon in greater breadth and depth than that offered by a single methodology (Glogowska 2011; Shorten and Smith 2017). Secondly, it can offer researchers the opportunity to answer questions seeking to confirm and explore issues at the same time (Armitage 2007). Thirdly, it can facilitate the triangulation of data, increasing the credibility of the findings (Bryman 2008). Fourthly, depending upon the design adopted, it can provide more robust evidence to inform theory and practice (Johnson and Onwuegbuzie 2004). However, it was acknowledged that MMR also brings challenges, especially for novice researchers. I was cognisant of the additional time required to conduct the studies and the need for support in designing the survey instrument. Nonetheless, mixed methods research was appropriate to address the aims and research questions of this study.

Several mixed methods typologies were considered, particularly in relation to which paradigm should have the most emphasis and which order the quantitative and qualitative phases should be arranged (Johnson and Onwuegbuzie 2004; Creswell and Creswell 2018). For this study, in cognisance of the aims and research questions, the qualitative strand was dominant, and the ordering of the phases was sequential, beginning with the quantitative phase, which was designed to inform Phase Two, the qualitative strand. This strategy fits with Design Nine: quan --> QUAL of Johnson and Onwuegbuzie's (2004) nine Mixed-method design matrix, where the use of capitalisation indicates which phase has higher priority and which paradigm is dominant. However, Johnson and Onwuegbuzie (2004) do not provide a detailed description of the type of mixed methods design, although they do provide a helpful research process model outlining eight steps. In contrast, Creswell and Plano Clark (2018) describe three core mixed method designs: Convergent, Explanatory Sequential, and Exploratory Sequential. Of these three designs, the Explanatory Sequential Mixed Methods Design was selected as it was the design that was the best fit

with the study aims and research questions. Explanatory Sequential Mixed Methods designs are associated, as the name suggests, with explaining the quantitative results to provide a more in-depth understanding of the research problem (Creswell and Creswell 2018).

This study comprised an initial quantitative phase: a national cross-sectional online questionnaire of registered nurses/midwives working in the school health service in Scotland. The purpose of Phase One was firstly to examine their current work in supporting primary-school-aged children's mental health and, secondly, to inform the selection of the case for the qualitative phase. In Phase One, I expected to find a variation in SN practice and use of the title SN, and I had a hunch that the implementation of the refocused SN pathway was at different stages across Scotland. I also hoped to discover whether SNs were involved in supporting primary-school-aged children's mental health and to identify whether there was practice in any of the fourteen health board areas that could exemplify SNs' mental health work. Phase Two utilised a single qualitative case study methodology and enabled me to build on the Phase One results and to explain them and provide a more in-depth, nuanced understanding of SNs' work supporting primary school children's mental health.

In addition to the three core mixed methods research designs described by Creswell and Plano Clark (2018), Guetterman and Fetters (2018) suggest that, when researchers are using case study and mixed methods designs, they should make explicit whether the case study is embedded within the mixed methods design, or the mixed methods is embedded within the case study. They contend that, by making this explicit, it can add value to the integration of the data sets. For this study, I embedded the case study within the core explanatory sequential mixed methods design in a complex adaptation for Mixed Methods-Case Study Design (MM-CS) (Guetterman and Fetters 2018). Please refer to Section 4.3.2 for details about the case selected.

4.2.5 Theoretical Framework

The theoretical basis for this study draws on two complementary theories: Bioecological Systems Theory, in particular the PPCT Model (Bronfenbrenner 1995), and Dossey's Holistic Nursing Theory (Dossey 2008). Bronfenbrenner's

(1995) PPCT Model proposes that children's development is influenced by their environment and their social relationships with people on four different interconnected levels (see Chapter Two, Section 2.1.1 for a discussion on Bioecological Systems Theory). Each stage of the research process (sampling, recruitment, data collection and analysis, dissemination) was informed by the four key elements of Bioecological Systems Theory (Process, Person, Context and Time) and helped support the decisions I made. Gaining an understanding of the influence of social relationships and support networks, particularly in relation to the mental health work of the SN, were key to addressing the research aims and questions. In addition, my skills in establishing and fostering relationships with gatekeepers were essential to facilitate access to participants and to collect data. This study also draws on Dossey's Holistic Nursing Theory, also known as the Theory of Integral Nursing (Dossey 2008), as it provides a framework to underpin the work of the SN and support them to cope with the experiences, feelings and needs of the people with whom they work, which is essential for their mental health work and which can be emotionally taxing (Garmy et al. 2021). This theory comprises five core components which include: healing, metaparadigm of nursing theory, patterns of knowing, the four quadrants, and conclusion of all components (Dossey 2008). The interconnectedness of these five components is a crucial factor underpinning Dossey's theory. The concepts of '*person*' and '*context*' and relationships are also key factors associated with this theory and of relevance to the mental health work of the SN.

There are clear links between Dossey's Holistic Nursing Theory and Bronfenbrenner's (1995) Bioecological Systems Theory in relation to the concepts of *Person* and *Context*. The concept of *Process* and *Time*, as outlined in Bronfenbrenner's (1995) PPCT Model, are also evident within Dossey's theory (2008), albeit to a lesser extent. For instance, Dossey (2008) refers to the four quadrants in the fourth component of her Holistic Nursing Theory. These four quadrants are referred to as 'I', 'It', 'We' and 'Its' and they are the processes whereby a practitioner, in this case the SN, interacts with an individual, the school-aged child or young person, to gain a greater understanding of their perspective of the world to aid in the provision of holistic care. Moreover, the

interaction of the nurse with other practitioners and the interaction of the nurse with the community, for example, family, friends, and school, are also key elements associated with holistic nursing care (Dossey and Guzzetta 2000).

With respect to the concept of *Time*, while Dossey does not explicitly refer to this concept, she does include socio-political factors and knowledge of these and their influence on holistic nursing care. This was particularly relevant for this research study, given that it was conducted during a global pandemic which impacted on everyone's everyday life and school nursing practice. Besides, time is a significant concept that is associated with the outcomes of holistic nursing care (McKivergin 2000), and the emphasis on outcomes in holistic nursing theory to support the 'person' was pertinent to contemporary school nursing practice, as the GIRFEC approach and the Post-Registration Standards for SCPHN (NMC 2022) are also outcome-focused. Furthermore, there are links between Dossey's (2008) theory and Antonovsky's (1980) Theory of Salutogenesis, and the movement towards total health through strengths-based practice. For instance, Dossey (2008) refers to 'healing' and the movement towards integral health and the development of personal growth at the biopsychosocial level. More recently, she contends that her theory is contemporary and can enable the nurse to influence positive health at the family and community level and connect 'me' to 'us' to 'all of us' (Dossey 2020, n.p.). Thus, Dossey's (2008) Holistic Nursing Theory offered a lens whereby school nursing practice was viewed through a dynamic whole system, strengths-based and person-centred approach complementing Bronfenbrenner's (1995) Bioecological Systems Theory, which was the main theory underpinning the thesis. The links between the theories and their key components and areas of overlap is illustrated diagrammatically in Figure 4.1. In the next section, I will explain and discuss the methodology used to conduct the research project.

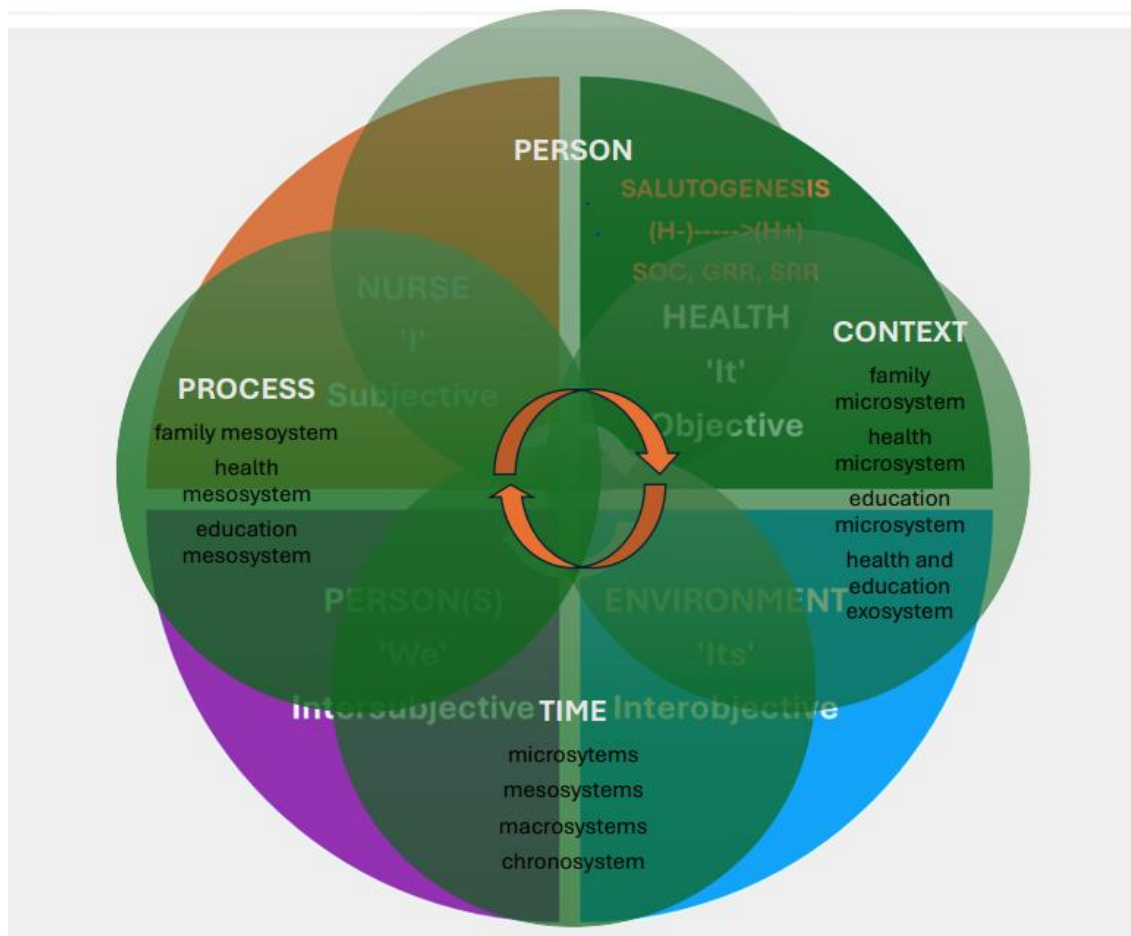


Figure 4.1: Combined PPCT Model, Holistic Nursing Theory and Theory of Salutogenesis adapted from Bronfenbrenner (1995), Dossey (2008) and Antonovsky (1980)

4.3 Research Methodology

This section will be divided into two subsections and will utilise the Good Reporting of a Mixed Methods Study (GRAMMS) guidance developed by O’Cathain et al. (2008) to structure the discussion of the MMR design and to describe each method. The first subsection will focus on the Phase One Study, beginning with explanation and justification for the use of a cross-sectional online questionnaire, before moving on to discuss sampling, recruitment, data collection and data analysis. The second subsection will focus on the Phase Two Study, beginning with explanation and justification for designing a single qualitative case study, followed by discussion of the sampling approach, recruitment, data collection and analytical approach. Figure 4.2 below provides an illustration of the sequence of the phases. As explained in Section 4.2.4, the Phase One study was designed to collect data to inform the selection of the case in Phase Two

and it also informed the topic guides and the questions that I asked participants in connecting the methods. In a sequential explanatory mixed methods study, Creswell and Creswell (2018) explain that the data analysis for each phase should take place separately, followed by the interpretation of the results. To this end, the results from Phase One are presented in Chapter Five, the findings from Phase Two are presented in Chapter Six, and, in Chapter Seven, I discuss how the findings from Phase Two explain and build on the results from Phase One.

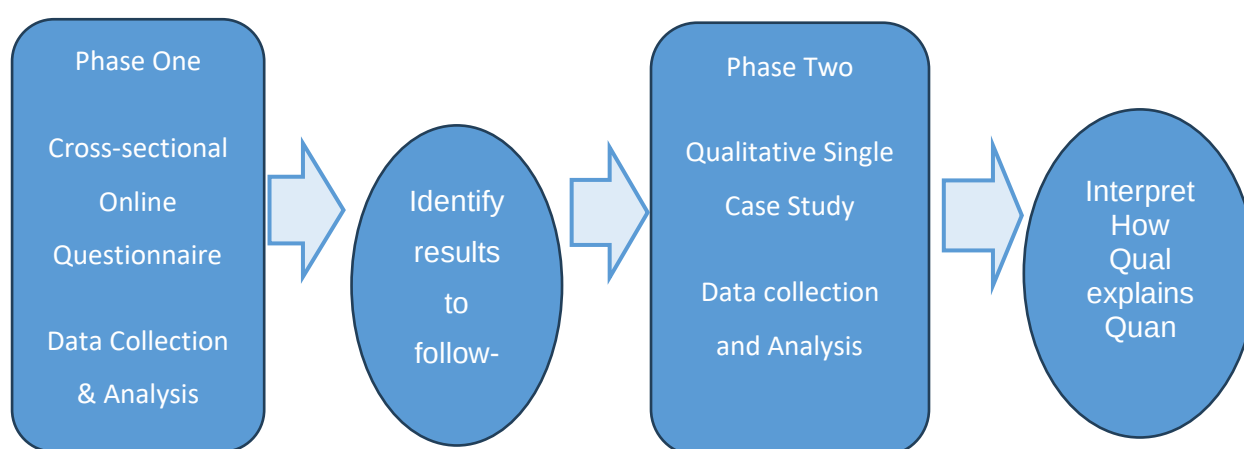


Figure 4.2: Explanatory Sequential Mixed Methods Study (Creswell and Creswell 2018)

4.3.1 Phase One: national cross-sectional online questionnaire/survey design

An online questionnaire was designed to address research questions one and two (see Section 4.1.2). This methodology was selected as it is particularly appropriate for collecting data from a specific population (Granello and Wheaton, 2004; Parahoo, 2014; Creswell and Creswell 2018), and where some participants can be hard to reach (Wright 2005; Van Selin and Jankowski 2006). The online questionnaire was cross-sectional, as I sought to collect data from nurses and/or midwives working in the school health service in Scotland in the Autumn of 2018 to identify their practice in supporting primary-school-aged children's mental health at that specific point in time. Cross-sectional questionnaires are associated with the collection of data from a specific population at a single time period (Wang and Cheng 2020), which was

particularly appropriate for this phase of the research where I was planning to obtain a snapshot of SN practice and identify salient aspects to explore in depth in Phase Two.

Survey designs have previously been used with SNs. For example, the RCN have conducted several surveys to obtain evidence on school nursing, including the impact of service delivery changes and new models of service provision (Ball 2009; RCN 2016). However, these surveys were not designed to specifically explore the mental health aspect of their work. Surveys have also been used in combination with other methods, for example, Thomas and O’Kane (2000) used their survey to map out and identify relevant aspects of social workers’ practice with children in looked-after care to explore further in the second stage of their research project. Likewise, Watson et al. (2006) combined a survey followed by a Case Study to explore the ways in which multi-agency services make a positive difference to families and children with complex healthcare needs. Hence, the survey/questionnaire design was considered to have utility for this mixed methods study.

Online surveys/questionnaires can be used to collect quantitative and/or qualitative data and they are particularly useful when there is a need to collect data from a large population that is not restricted to one geographical area (Wright 2005). Scotland is a small country, but it covers a wide geographic area and has many difficult-to-reach places (see Chapter Five, Figure 5.1). Therefore, this methodology provided greater opportunities to reach SNs in hard-to-reach geographical locations, such as the Western Isles. I did consider the use of a telephone survey but rejected this due to resource and ethical issues. For example, SN Leads in each board area would need to have provided me with contact numbers for all the nurses working in their school health service. I would also have needed to factor in time to recruit participants and to collect data. As a part-time doctoral student and full-time academic, this was not practical or realistic.

Nevertheless, in selecting this methodology, I was cognisant that the response rate to online surveys/questionnaires can be poor and that this would be a limitation of the Phase One study (Watt et al. 2002; Granello and Wheaton 2004;

Wright 2005; Nulty 2008; Coughlan et al. 2009). Nonetheless, gaining the perspectives of as many SNs working in Scotland as possible was fundamental to answering the research questions and ensuring that my decisions regarding the selection of the case for Phase Two was informed and purposeful. Hence, the online questionnaire was the best fit to address the aims and research questions and was congruent with a pragmatist approach. It enabled me to examine and identify current SN practice in supporting primary school children's mental health in the autumn of 2018, and aided the selection of the case for Phase Two.

4.3.1.1 Phase One sampling approach

It is acknowledged that survey/questionnaire research designs are usually associated with random sampling, which is a type of probability sampling (Coughlan et al. 2009; Creswell and Creswell 2018). In contrast, purposive sampling, also known as purposeful sampling, is a type of non-probability sampling and more closely aligned with qualitative methodologies (Ritchie et al. 2014). It was my intention to seek the perspectives of all NMC registrants working in the school health service in Scotland. I did not wish to select a random number of participants from this population.

Purposive sampling has previously been used in survey designs seeking to explore the views of professionals. For example, Graham et al. (2011) used this sampling approach in their Australian study to obtain teachers' perspectives of school pupils' mental health and to ascertain their confidence in the provision of support. I selected a purposive sampling strategy, as it was congruent with the study aims and research questions.

4.3.1.2 Phase One sampling frame

In September 2018, there were 43,257.5 whole-time equivalent nursing and midwifery staff working in the national health service in Scotland on Agenda for Change Bands 5-7 (NHS Scotland 2018b) (Figure 4.3). Of this population, 281.4 were whole-time equivalent qualified nurses working in the school health service in Scotland on Agenda for Change Bands 5-7 (NHS Scotland 2018b) (Figure 4.3). The whole population of qualified nurses working in the school health

service were invited to participate in the online questionnaire. Qualified nurses working in independent schools were not invited to participate as their role and remit varies from those working in the NHS school health service. There were 83 responses across the range of bands and data from each of these respondents were included in the analysis.

NHSScotland Workforce Statistics				MI1	MI2	MI3	MI4	MI5	MI6	MI7	MI8	MI9	MI10	MI11	MI12	MI13	MI14	MI15	MI16	MI17	MI18	MI19	MI20	MI21	MI22	MI23	MI24	MI25	MI26	MI27	MI28	MI29	MI30	MI31	MI32	MI33	MI34	MI35	MI36	MI37	MI38	MI39	MI40	MI41	MI42	MI43	MI44	MI45	MI46	MI47	MI48	MI49	MI50	MI51	MI52	MI53	MI54	MI55	MI56	MI57	MI58	MI59	MI60	MI61	MI62	MI63	MI64	MI65	MI66	MI67	MI68	MI69	MI70	MI71	MI72	MI73	MI74	MI75	MI76	MI77	MI78	MI79	MI80	MI81	MI82	MI83	MI84	MI85	MI86	MI87	MI88	MI89	MI90	MI91	MI92	MI93	MI94	MI95	MI96	MI97	MI98	MI99	MI100	MI101	MI102	MI103	MI104	MI105	MI106	MI107	MI108	MI109	MI110	MI111	MI112	MI113	MI114	MI115	MI116	MI117	MI118	MI119	MI120	MI121	MI122	MI123	MI124	MI125	MI126	MI127	MI128	MI129	MI130	MI131	MI132	MI133	MI134	MI135	MI136	MI137	MI138	MI139	MI140	MI141	MI142	MI143	MI144	MI145	MI146	MI147	MI148	MI149	MI150	MI151	MI152	MI153	MI154	MI155	MI156	MI157	MI158	MI159	MI160	MI161	MI162	MI163	MI164	MI165	MI166	MI167	MI168	MI169	MI170	MI171	MI172	MI173	MI174	MI175	MI176	MI177	MI178	MI179	MI180	MI181	MI182	MI183	MI184	MI185	MI186	MI187	MI188	MI189	MI190	MI191	MI192	MI193	MI194	MI195	MI196	MI197	MI198	MI199	MI200	MI201	MI202	MI203	MI204	MI205	MI206	MI207	MI208	MI209	MI210	MI211	MI212	MI213	MI214	MI215	MI216	MI217	MI218	MI219	MI220	MI221	MI222	MI223	MI224	MI225	MI226	MI227	MI228	MI229	MI230	MI231	MI232	MI233	MI234	MI235	MI236	MI237	MI238	MI239	MI240	MI241	MI242	MI243	MI244	MI245	MI246	MI247	MI248	MI249	MI250	MI251	MI252	MI253	MI254	MI255	MI256	MI257	MI258	MI259	MI260	MI261	MI262	MI263	MI264	MI265	MI266	MI267	MI268	MI269	MI270	MI271	MI272	MI273	MI274	MI275	MI276	MI277	MI278	MI279	MI280	MI281	MI282	MI283	MI284	MI285	MI286	MI287	MI288	MI289	MI290	MI291	MI292	MI293	MI294	MI295	MI296	MI297	MI298	MI299	MI300	MI301	MI302	MI303	MI304	MI305	MI306	MI307	MI308	MI309	MI310	MI311	MI312	MI313	MI314	MI315	MI316	MI317	MI318	MI319	MI320	MI321	MI322	MI323	MI324	MI325	MI326	MI327	MI328	MI329	MI330	MI331	MI332	MI333	MI334	MI335	MI336	MI337	MI338	MI339	MI340	MI341	MI342	MI343	MI344	MI345	MI346	MI347	MI348	MI349	MI350	MI351	MI352	MI353	MI354	MI355	MI356	MI357	MI358	MI359	MI360	MI361	MI362	MI363	MI364	MI365	MI366	MI367	MI368	MI369	MI370	MI371	MI372	MI373	MI374	MI375	MI376	MI377	MI378	MI379	MI380	MI381	MI382	MI383	MI384	MI385	MI386	MI387	MI388	MI389	MI390	MI391	MI392	MI393	MI394	MI395	MI396	MI397	MI398	MI399	MI400	MI401	MI402	MI403	MI404	MI405	MI406	MI407	MI408	MI409	MI410	MI411	MI412	MI413	MI414	MI415	MI416	MI417	MI418	MI419	MI420	MI421	MI422	MI423	MI424	MI425	MI426	MI427	MI428	MI429	MI430	MI431	MI432	MI433	MI434	MI435	MI436	MI437	MI438	MI439	MI440	MI441	MI442	MI443	MI444	MI445	MI446	MI447	MI448	MI449	MI450	MI451	MI452	MI453	MI454	MI455	MI456	MI457	MI458	MI459	MI460	MI461	MI462	MI463	MI464	MI465	MI466	MI467	MI468	MI469	MI470	MI471	MI472	MI473	MI474	MI475	MI476	MI477	MI478	MI479	MI480	MI481	MI482	MI483	MI484	MI485	MI486	MI487	MI488	MI489	MI490	MI491	MI492	MI493	MI494	MI495	MI496	MI497	MI498	MI499	MI500	MI501	MI502	MI503	MI504	MI505	MI506	MI507	MI508	MI509	MI510	MI511	MI512	MI513	MI514	MI515	MI516	MI517	MI518	MI519	MI520	MI521	MI522	MI523	MI524	MI525	MI526	MI527	MI528	MI529	MI530	MI531	MI532	MI533	MI534	MI535	MI536	MI537	MI538	MI539	MI540	MI541	MI542	MI543	MI544	MI545	MI546	MI547	MI548	MI549	MI550	MI551	MI552	MI553	MI554	MI555	MI556	MI557	MI558	MI559	MI560	MI561	MI562	MI563	MI564	MI565	MI566	MI567	MI568	MI569	MI570	MI571	MI572	MI573	MI574	MI575	MI576	MI577	MI578	MI579	MI580	MI581	MI582	MI583	MI584	MI585	MI586	MI587	MI588	MI589	MI590	MI591	MI592	MI593	MI594	MI595	MI596	MI597	MI598	MI599	MI600	MI601	MI602	MI603	MI604	MI605	MI606	MI607	MI608	MI609	MI610	MI611	MI612	MI613	MI614	MI615	MI616	MI617	MI618	MI619	MI620	MI621	MI622	MI623	MI624	MI625	MI626	MI627	MI628	MI629	MI630	MI631	MI632	MI633	MI634	MI635	MI636	MI637	MI638	MI639	MI640	MI641	MI642	MI643	MI644	MI645	MI646	MI647	MI648	MI649	MI650	MI651	MI652	MI653	MI654	MI655	MI656	MI657	MI658	MI659	MI660	MI661	MI662	MI663	MI664	MI665	MI666	MI667	MI668	MI669	MI670	MI671	MI672	MI673	MI674	MI675	MI676	MI677	MI678	MI679	MI680	MI681	MI682	MI683	MI684	MI685	MI686	MI687	MI688	MI689	MI690	MI691	MI692	MI693	MI694	MI695	MI696	MI697	MI698	MI699	MI700	MI701	MI702	MI703	MI704	MI705	MI706	MI707	MI708	MI709	MI710	MI711	MI712	MI713	MI714	MI715	MI716	MI717	MI718	MI719	MI720	MI721	MI722	MI723	MI724	MI725	MI726	MI727	MI728	MI729	MI730	MI731	MI732	MI733	MI734	MI735	MI736	MI737	MI738	MI739	MI740	MI741	MI742	MI743	MI744	MI745	MI746	MI747	MI748	MI749	MI750	MI751	MI752	MI753	MI754	MI755	MI756	MI757	MI758	MI759	MI760	MI761	MI762	MI763	MI764	MI765	MI766	MI767	MI768	MI769	MI770	MI771	MI772	MI773	MI774	MI775	MI776	MI777	MI778	MI779	MI780	MI781	MI782	MI783	MI784	MI785	MI786	MI787	MI788	MI789	MI790	MI791	MI792	MI793	MI794	MI795	MI796	MI797	MI798	MI799	MI800	MI801	MI802	MI803	MI804	MI805	MI806	MI807	MI808	MI809	MI810	MI811	MI812	MI813	MI814	MI815	MI816	MI817	MI818	MI819	MI820	MI821	MI822	MI823	MI824	MI825	MI826	MI827	MI828	MI829	MI830	MI831	MI832	MI833	MI834	MI835	MI836	MI837	MI838	MI839	MI840	MI841	MI842	MI843	MI844	MI845	MI846	MI847	MI848	MI849	MI850	MI851	MI852	MI853	MI854	MI855	MI856	MI857	MI858	MI859	MI860	MI861	MI862	MI863	MI864	MI865	MI866	MI867	MI868	MI869	MI870	MI871	MI872	MI873	MI874	MI875	MI876	MI877	MI878	MI879	MI880	MI881	MI882	MI883	MI884	MI885	MI886	MI887	MI888	MI889	MI890	MI891	MI892	MI893	MI894	MI895	MI896	MI897	MI898	MI899	MI900	MI901	MI902	MI903	MI904	MI905	MI906	MI907	MI908	MI909	MI910	MI911	MI912	MI913	MI914	MI915	MI916	MI917	MI918	MI919	MI920	MI921	MI922	MI923	MI924	MI925	MI926	MI927	MI928	MI929	MI930	MI931	MI932	MI933	MI934	MI935	MI936	MI937	MI938	MI939	MI940	MI941	MI942	MI943	MI944	MI945	MI946	MI947	MI948	MI949	MI950	MI951	MI952	MI953	MI954	MI955	MI956	MI957	MI958	MI959	MI960	MI961	MI962	MI963	MI964	MI965	MI966	MI967	MI968	MI969	MI970	MI971	MI972	MI973	MI974	MI975	MI976	MI977	MI978	MI979	MI980	MI981	MI982	MI983	MI984	MI985	MI986	MI987	MI988	MI989	MI990	MI991	MI992	MI993	MI994	MI995	MI996	MI997	MI998	MI999	MI1000	MI1001	MI1002	MI1003	MI1004	MI1005	MI1006	MI1007	MI1008	MI1009	MI1010	MI1011	MI1012	MI1013	MI1014	MI1015	MI1016	MI1017	MI1018	MI1019	MI1020	MI1021	MI1022	MI1023	MI1024	MI1025	MI1026	MI1027	MI1028	MI1029	MI1030	MI1031	MI1032	MI1033	MI1034	MI1035	MI1036	MI1037	MI1038	MI1039	MI1040	MI1041	MI1042	MI1043	MI1044	MI1045	MI1046	MI1047	MI1048	MI1049	MI1050	MI1051	MI1052	MI1053	MI1054	MI1055	MI1056	MI1057	MI1058	MI1059	MI1060	MI1061	MI1062	MI1063	MI1064	MI1065	MI1066	MI1067	MI1068	MI1069	MI1070	MI1071	MI1072	MI1073	MI1074	MI1075	MI1076	MI1077	MI1078	MI1079	MI1080	MI1081	MI1082	MI1083	MI1084	MI1085	MI1086	MI1087	MI1088	MI1089	MI1090	MI1091	MI1092	MI1093	MI1094	MI1095	MI1096	MI1097	MI1098	MI1099	MI1100	MI1101	MI1102	MI1103	MI1104	MI1105	MI1106	MI1107	MI1108	MI1109	MI1110	MI1111	MI1112	MI1113	MI1114	MI1115	MI1116	MI1117	MI1118	MI1119	MI1120	MI1121	MI1122	MI1123	MI1124	MI1125	MI1126	MI1127	MI1128	MI1129	MI1130	MI1131	MI1132	MI1133	MI1134	MI1135	MI1136	MI1137	MI1138	MI1139	MI1140	MI1141	MI1142	MI1143	MI1144	MI1145	MI1146	MI1147	MI1148	MI1149	MI1150	MI1151	MI1152	MI1153	MI1154	MI1155	MI1156	MI1157	MI1158	MI1159	MI1160	MI1161	MI1162	MI1163	MI1164	MI1165	MI1166	MI1167	MI1168	MI1169	MI1170	MI1171	MI1172	MI1173	MI1174	MI1175	MI1176	MI1177	MI1178	MI1179	MI1180	MI1181	MI1182	MI1183	MI1184	MI1185	MI1186	MI1187	MI1188	MI1189	MI1190	MI1191	MI1192	MI1193	MI1194	MI1195	MI1196	MI1197	MI1198	MI1199	MI1200	MI1201	MI1202	MI1203	MI1204	MI1205	MI1206	MI1207	MI1208	MI1209	MI1210	MI1211	MI1212	MI1213	MI1214	MI1215	MI1216	MI1217	MI1218	MI1219	MI1220	MI1221	MI1222	MI1223	MI1224	MI1225	MI1226	MI1227	MI1228	MI1229	MI1230	MI1231	MI1232	MI1233	MI1234	MI1235	MI1236	MI1237	MI1238	MI1239	MI1240	MI1241	MI1242	MI1243	MI1244	MI1245	MI1246	MI1247	MI1248	MI1249	MI1250	MI1251	MI1252	MI1253	MI1254	MI1255	MI1256	MI1257	MI1258	MI1259	MI1260	MI1261	MI1262	MI1263	MI1264	MI1265	MI1266	MI1267	MI1268	MI1269	MI1270	MI1271	MI1272	MI1273	MI1274	MI1275	MI1276	MI1277	MI1278	MI1279	MI1280	MI1281	MI1282	MI1283	MI1284	MI1285	MI1286	MI1287	MI1288	MI1289	MI1290	MI1291	MI1292	MI1293	MI1294	MI1295	MI1296	MI1297	MI1298	MI1299	MI1300	MI1301	MI1302	MI1303	MI1304	MI1305	MI1306	MI1307	MI1308	MI1309	MI1310	MI1311	MI1312	MI1313	MI1314	MI1315	MI1316	MI1317	MI1318	MI1319	MI1320	MI1321	MI1322	MI1323	MI1324	MI1325	MI1326	MI1327	MI1328	MI1329	MI1330	MI1331	MI133
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health service in their Board area by emailing them on 30 August 2018 with information about the study (Appendix 2).

In addition to seeking their permission to recruit, I also sought their support in providing me with the contact details of the Lead for School Nursing in their area to act as a key individual to distribute by email the respondent invitation letters, information leaflets and an anonymous web-based link to the online questionnaire to all nurses and/or midwives who met the inclusion criteria (Table 4.1). I also sought permission for the key individual to send a reminder email to all eligible nurses and/or midwives in their area two weeks after the questionnaire opened to maximise the response rate.

Permission was obtained from all of the Executive Nurse Directors by the 14 September 2018.

Table 4.1: Phase One inclusion and exclusion criteria

Inclusion Criteria	Exclusion Criteria
Nurses employed in the school health service in Scotland	Nurses who are not employed by the school health service in Scotland
Nurse who are currently on the NMC Register as a registered nurse or registered midwife	Nurses or midwives who are not on the NMC register
Nurses who are currently on the NMC register as a registered SCPHN	No informed consent provided
Informed Consent	

4.3.1.4 Phase One data collection

Data were collected using an online questionnaire that was designed using the online survey tool, Online Surveys (Jisc 2024) (previously known as Bristol Online Surveys). This online survey tool was selected as it is the one that the university recommends, and it is fully compliant with the UK General Data

Protection Regulations 2018, as defined by the *Data Protection Act 2018*. The questionnaire was distributed via an anonymous web-based link which was emailed to the respondents during the recruitment process (see Section 4.3.1.3). It comprised 26 questions grouped under five sections which were informed by the review of the literature and the research questions. Sections 1 and 2 were designed to obtain demographic data and comprised closed questions. However, there was the option to tick 'other' for Questions 3, 5 and 7 should respondents identify with a different gender, have a different professional qualification, or different level of qualification. Sections 3, 4 and 5 were designed to obtain data exploring the experiences and understanding of respondents and comprised a variety of types of questions, which included a selection list, Likert Scale, multiple choice with multiple answers, and multi-line free text. For the Likert Scale questions, respondents were asked to read the statements and to indicate how much they agreed or disagreed with the statements. The five sections were named as follows:

Section 1: About you, qualifications and experience (8 questions)

Section 2: About your post as a SN (4 questions)

Section 3: About your work as a SN (8 questions)

Section 4: Multi-agency and partnership working (3 questions)

Section 5: Transforming school nursing: refocused SN programme (3 questions)

The questionnaire was piloted by a SCPHN-SN educator and three SCPHN-HV students who had worked in the school health service for several years prior to commencing their health visiting programme. I wanted to ascertain whether there were any issues with the web-based link, whether they were able to access and download the participant information leaflet and certificate of completion, how long the questionnaire took to complete, whether it was easy to navigate, and whether there were any issues with the wording and flow of the questions. I also obtained feedback from an experienced academic within the Faculty of Health Sciences and Sport who provided helpful advice regarding the layout of the sections so that they did not appear on the same screen, and about the wording on the information sheet.

4.3.1.5 Phase One data analysis

Analysis of the data in Phase One involved analysing both quantitative and qualitative data collected from the online questionnaire. This section will begin by discussing the analysis of the quantitative data, followed by a discussion of the analysis of the qualitative data.

4.3.1.5.1 Quantitative data

The quantitative data comprised categorical and ordinal data (Thomas 2017). For instance, the questions in Section 1 seeking to elicit the gender and age group of respondents are examples of categorical data, whereas the questions using the Likert Scale to elicit the extent to which respondents agreed with a statement are examples of ordinal data. The process of analysing the quantitative data began once the online questionnaire closed on the 16 November 2018 and it involved two stages. Firstly, I examined the data carefully to see what the data were telling me and to identify whether there were any obvious discrepancies, a technique described by Thomas (2017, p. 260) as 'eyeballing'. Secondly, I used Microsoft Excel to support the process of describing and summarising the characteristics of the data, a technique referred to as descriptive statistics (Vetter 2017). My decision to perform descriptive statistics was based on the aims and research questions and the need to describe the key characteristics of nurses/midwives working in the school health service in Scotland in a format that was simple and manageable. I did consider conducting inferential statistics, but rejected this technique as I did not want to make inferences about the data or work out probabilities.

In the first step, when eyeballing the data, I looked at and read through each of the 83 responses and wrote down notes in my fieldwork diary. Online Surveys provides an analysis feature whereby it produces a report of all the collated responses which are presented in the format of Pie Charts, except for free-text data, which are displayed as lists. I saved a copy of this to my secure research drive. In addition, I saved a copy of each response submission to my secure research drive and labelled them SN1-83. During this stage I noticed that it was not possible to rely on the analysis report, as some of the questions had more than one option to tick, making it difficult to accurately decipher the data. For

example, Q5 asked respondents what professional qualifications they currently had registered or recorded with the NMC, and they could tick all that applied. The issue with the design of this question was that the calculation of percentages by Online Surveys was inaccurate. Consequently, it was necessary to 'clean' the data to detect and address flaws. Van den Broeck et al. (2005) contend that this is a crucial part of the data analysis process.

To support the process of cleaning the data, I drew on the expertise of a quantitative researcher within the faculty who advised me to use the function in Online Surveys to enable the download and export of the data into Microsoft Excel to allow me to analyse the responses in greater depth and detect any discrepancies. Online Surveys provided me with the opportunity to customise the export, for instance including a unique response number for each respondent, the date and time of the response submission, and include section headings. It also provided an option to code responses for export and import into statistical software to select the format required. The choices for coded exports included the option to Zero index all multiple choice, multiple answer, selection list and scale questions, Reverse index values for all multiple choice, multiple answer, selection list and scale questions, and Combine scale/rank values into a single column where possible. The selection of format included MS Excel 2003 and older, MS Excel 2007 and later, Comma Separated Values, SPSS and Tab Separated Values. After careful consideration and taking cognisance of the aims and research questions, I selected to include the unique response number and date and time of response submission and include section headings and to code the responses as Zero index and to export the data into MS Excel 2007.

I exported and saved the Excel spreadsheets in my secure research drive, saving one copy as Uncoded Results to indicate that the data in this spreadsheet comprised the responses in the format of text, and another copy where the responses had been coded and saved it as Coded Results. Unlike the Uncoded version, the responses as outlined above were coded with a Zero Index. For example, Q3 asked participants to tick which category best describes their gender. The categories included female, male, prefer not to say and other. Eighty-two responded 'female', which were coded as a zero, and one responded

'male', which was coded as a one. For Q2, which asked participants what category best describes their age, the categories were coded from zero to four, with zero indicating the lowest category (18–25 years) and four indicating the highest category (55–64 years). I also chose to save a duplicate copy of the Uncoded Results as a working copy in preparation for the next step in the process of cleaning the data.

The next step involved systematically working through each of the questions, particularly those where percentages were calculated to detect any discrepancies such as mentioned previously with Q5. There were several similar discrepancies that were remedied following recalculation using the sample size ($n=83$), for instance, Q9, which asked respondents to tick which category represented their current job title and had the option to select 'other'. Once I had completed the descriptive statistics, the next stage in analysing the Phase One results was to analyse the qualitative free text data.

4.3.1.5.2 Qualitative data analysis

The qualitative data (free text) were analysed thematically using the 'Framework Approach' which was developed by Ritchie and Spencer in the 1980s at the UK Centre for Social Research (Spencer et al. 2003). The Framework Approach has been used widely in nursing research to support thematic analysis (McMillen 2008; Smith and Firth 2011; Swallow et al. 2011; Hackett and Strickland 2018). Due to the large number of responses, I decided to use the framework matrices available in NVivo 12 to aid with managing the indexing and charting of the qualitative free text data as there were eight open-ended questions and twelve questions that had 'other' as an option. The number of responses to the eight open-ended questions were: Q16a ($n=44$), Q17a ($n=31$), Q17b(i) ($n=64$), Q18a ($n=18$), Q20 ($n=74$), Q21a ($n=25$), Q22a(i) ($n=27$), and Q25a ($n=29$). The comments ranged between eight and 237 words.

The number of responses to the 'other' option questions were: Q5a ($n=5$), Q7a ($n=11$), Q9a ($n=9$), Q13a ($n=36$), Q15a ($n=8$), Q19a ($n=15$), Q22a ($n=9$), Q23a ($n=11$), Q24a ($n=2$), Q24b(i) ($n=13$). The comments ranged between two and 100 words.

The analytical process I used for each dataset followed the process of framework analysis outlined by Spencer et al. (2014), which comprises five interconnected stages beginning with familiarisation through to the mapping and interpretation of the data (see Figure 4.4). These stages of framework analysis are broadly similar to the first five stages of Braun and Clarke's (2022) reflexive thematic analysis and required immersion in the data and ongoing reflection supported via the use of my reflective diary to note down my thoughts. It is acknowledged that Braun and Clarke (2022) and Parkinson et al. (2016) suggest that the structured approach could result in researchers applying it to their data with limited reflection, and in a task-oriented manner. Whilst I agree that the systematic nature of this approach does make this a possibility, I found that it provided flexibility and facilitated the process of moving backwards and forwards across the data and enabled iteration. This was particularly the case when constructing the thematic framework. In addition, writing down my thoughts in my reflective diary provided me with space to consider whether any of my preconceptions were influencing my analysis and potentially introducing bias into the results. An explanation of the process I used now follows.

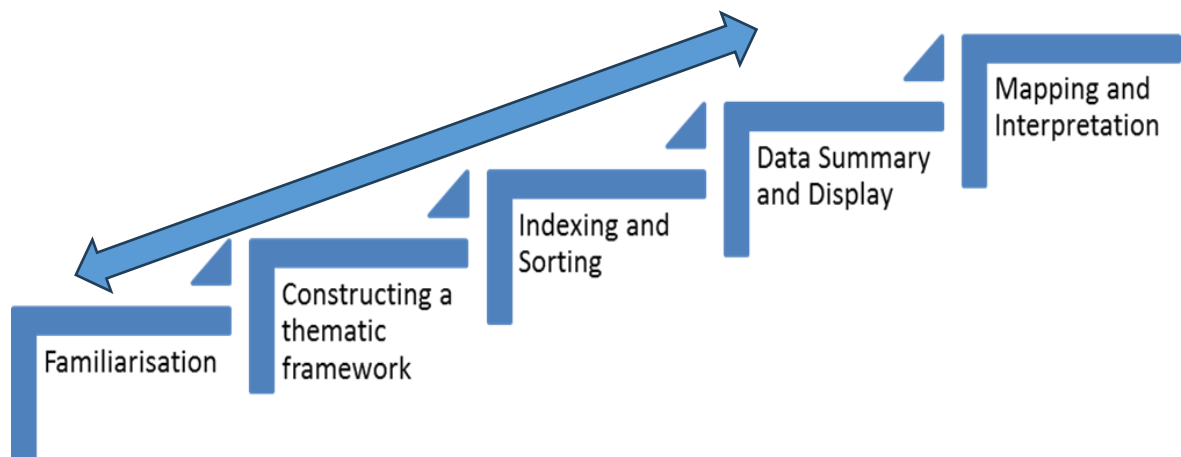


Figure 4.4: Thematic framework ladder

Stage 1: Familiarisation

I read the report of the collated responses several times and then read the individual responses to familiarise myself with them. During this phase I noted

down any key comments made by respondents in my fieldwork diary to aid in the identification of any similarities and differences (see Figure 4.5).

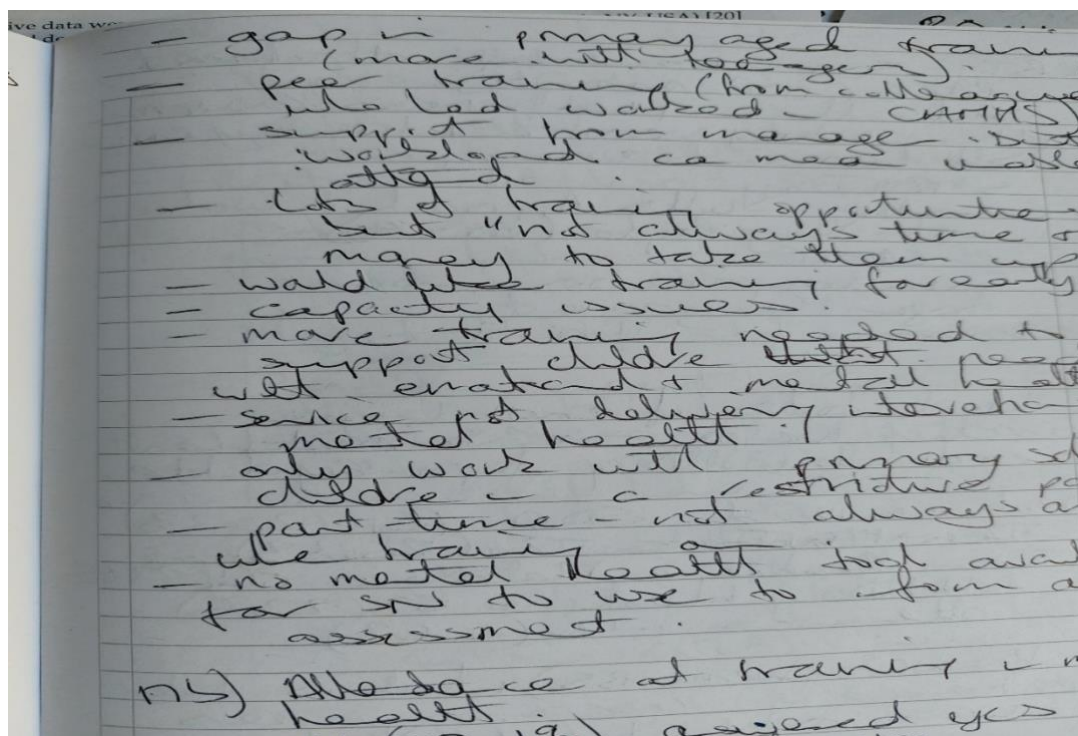


Figure 4.5: Excerpt from my fieldwork diary

Stage 2: Constructing a thematic framework

I exported all eighty-three individual responses into NVivo 12 and named them from SN1-83. I then developed a thematic framework to aid with indexing and labelling the transcripts (Appendix 3). The development of the thematic framework was informed by the topic headings from the questions and emergent themes arising during the familiarisation stage.

Stage 3: Indexing and sorting

The next step involved going through and reading each individual response, making decisions on what label(s), referred to as nodes in NVivo 12, were relevant and related to the same topic and then applying them to segments of relevant free text to index and sort them. This took time to ensure that I was consistent in applying the labels to ensure the process was rigorous. An example of indexing a response under the label 'Mental Health Work of the School Nurse' can be found in Figure 4.6.

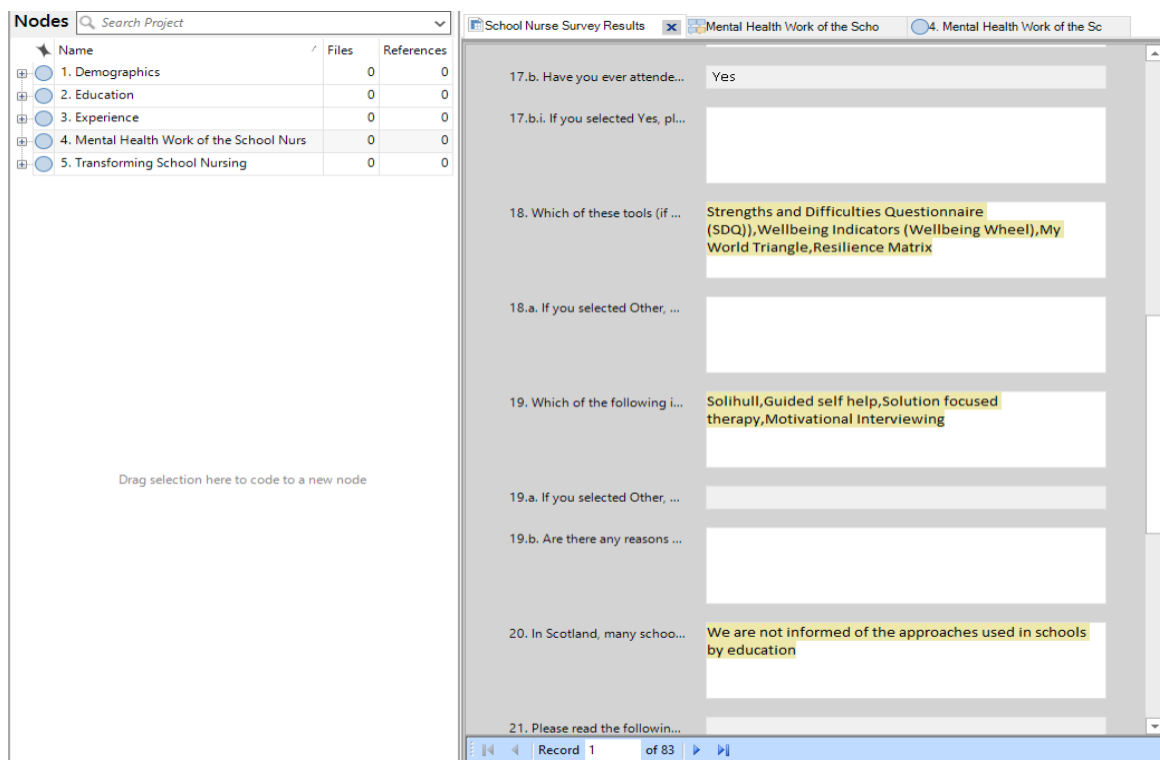


Figure 4.6: Phase One excerpt of indexing

Stage 4: Data summary and display

Once I had indexed all the responses that included free-text data, the next stage was to begin the process of developing the charts and summarising the data. I used the Framework Charts, referred to as Framework Matrices in NVivo 12, to help manage this stage. An extract of a Framework Chart for the Mental Health Work of the School Nurse can be found in Figure 4.7. The data in this chart included the individual responses and it also included a column to record any comments that I had in relation to my initial interpretation. This stage also involved the selection of key information from the responses and summarising and charting them under the subheadings. I used the highlight function to assist with this process as it supported the linkage of the data in the chart to the individual response. See Figure 4.8 for an illustration of this for SN12.

Framework Matrices	Experience	School Nurses and Children's M	School Nurse Survey Results	Survey Respondent	Mental Health Work of the School Nurse
Name Education Experience Mental Health Work of the School Nurse School Nurses and Children's Mental Health Phase 1 Transforming School Nursing	A : 4.1 Experience and views of identifying children in need of early intervention for their mental health and emotional well-being	B : 4.2 Experience and views of supporting children's mental health and emotional wellbeing	C : 4.3 Interventions and approaches to support children's mental health	D : 4.4 Liaison with Named Person	
76 : SN76 2. Age \Which category best describes your child's age? 3. Gender \Which best describes your child's gender? 4. Ethnicity \Which best describes your child's ethnicity?					
77 : SN12 2. Age \Which category best describes your child's age? 3. Gender \Which best describes your child's gender? 4. Ethnicity \Which best describes your child's ethnicity?	Strengths and Difficulties Questionnaire (SDQ)\My World Triangle Resilience Matrix	Q4. Unfortunately due to the immunisation programme and no immunisation teams within NHS Grampian (Aberdeenshire) 75% of workload is taken up with the programme and only 25% time is left for the whole year to cover x1 Academy and x4 feeder primaries approx. 1800 children therefore I work in an area which promotes a referral system from teachers/parents/pupils If after assessed as requiring the child was assessed as requiring tier 3/4 intervention. Additionally, if parent/child requested intervention just prior to a long school holiday e.g. 6 week summer break then it may be more appropriate for them to be sign posted to G.P. dependant on the intervention required and the concern reported.	Health Promoting Schools/Nature Schools Classroom/quiet room in the school Enabling the child to learn and flourish in a supportive environment, identifying barriers to learning and implementing strategies and support to help these children integrate back into their classroom learning environment		
	Strengths and Difficulties Questionnaire (SDQ)\My World Triangle Resilience Matrix	As required based on child protection and safeguarding	Health Promoting Schools/Nature Schools Classroom/quiet room in the school	My workload is reactive rather than proactive. As all children are assessed as requiring tier 3/4 intervention, I am sign posted to G.P. dependant on the intervention required and the concern reported.	

Figure 4.7: Phase One extract of framework chart (SN12)

Education Experience School Nurses and Children's M					
Fr	A : 1. Demographics	B : 2. Education	C : 3. Experience	D : 4. Mental Health Work of the School Nurse	E : 5. Transforming School Nursing
3 : SN11	35-44 years old White Female Greater Glasgow and Clyde Community Staff Nurse Fulltime-all year	Registered Nurse-Adult Bachelors Degree Not currently undertaking further study	Length of time since initial registration 5-10 years Length of time in school nursing 1-4 years Training in Mental health Attended Scotland's Mental Health First Aid	Experience and views of identifying children in need of early intervention She disagreed with the statements that being actively involved in identifying school age children in need of early intervention is an important part of her work. The tools that she uses are the MWT and Resilience Matrix. Experience and views of supporting children's mental health She strongly agrees that providing them with support	Experience and views on implementation of the SN pathway She is aware that the SG are planning to implement it, but she doesn't know if it has been implemented in her area. Experience and views of home visiting She currently visits children at home to assess their mental health and she strongly agrees that home visiting provides an opportunity to develop a more effective therapeutic relationship and a more accurate assessment. She also
4 : SN12	45-54 years White female Grampian School Nurse Part-time-term time only	Registered SCPHN-HV Bachelor's Degree Not currently studying.	Length of time since initial qualification more than 25 years Length of time in school nursing 5-10 years Training in children's mental health She has not attended for training Facilitators and Barriers to accessing training Whilst her manager is supportive, she indicates that workload is a barrier:	Experience and views of identifying children in need of early intervention She strongly agrees that the identification of children in need of early intervention for their MH is an important part of her work, however, she disagrees that she is actively involved in identification. She explains that this is due to the immunisation programme which takes up 75% of her workload: "Q4. Unfortunately due to the immunisation programme and no immunisation teams within NHS Grampian (Aberdeenshire) 75% of workload is taken up with the immunisation programme."	Experience and views of implementation of the SN pathway She is aware that the SG is planning to implement the new SN Pathway. However, she answered that it has not been implemented in her area. Experience and views of home visiting She currently visits at home and delivers interventions in the home, but she neither agrees or disagrees that home visiting allows her to build a more

Figure 4.8: Phase One Extract of Data Summary (SN12)

Stage 5: Mapping and interpretation

The final stage involved the mapping and interpretation of the data and the development of themes and subthemes. During this stage I found myself moving backwards and forwards across the Framework Charts and data summaries to begin the process of interpreting and making sense of the data to identify common themes and subthemes. This involved the creation of more charts to aid in the development of the themes and subthemes. At this stage, I used MS Word to create these charts as I found it easier and simpler to create them in a table format. Please see Table 4.2 for the Phase One themes and subthemes.

Table 4.2: Phase One themes and subthemes

Theme One	Subtheme
Supporting children's mental health	SNs' perceptions of their mental health role
	Building effective relationships
	SN interventions
Barriers to identification & support of mental health issues	Workload capacity
	Child protection
	Lack of knowledge and understanding of the SN role
	Lack of resources for primary-school-aged children
Educational preparation and training in mental health	Perceptions of educational preparation
	Access to mental health training
	Lack of training targeted at primary-school-aged children's mental health

4.3.2 Phase Two: Qualitative single case study

For this phase, I used a qualitative single case study design to build on the findings from Phase One. This methodology was selected as it seeks to examine a phenomenon in detail, and it is connected with constructing the whole picture, and, as Thomas (2017, p. 23) states, viewing it from 'many angles'. As the aim was to explore SNs' experiences and understanding of their work in supporting primary-school-aged children's mental health, a case study design was considered to be congruent with the research aims and research questions.

Indeed, it is suggested that case study design is suited to ‘*how*’ and ‘*what*’ questions (Yin 2018), and this phase sought to address research questions one, two and three, which asked ‘*how*’ and ‘*what*’.

Within the literature, the case study approach has been employed in research with children and with SNs seeking to develop a detailed understanding of their views (Hall 2010; Chase et al. 2010; Spratt et al. 2010b). For example, Hall (2010) employed an exploratory single case study design to obtain children’s views about organisational influences on their mental health and wellbeing. In contrast, Chase et al. (2010) used a multiple case study to examine the ways in which nurses support and contribute to promoting and safeguarding the health and wellbeing of children and young people. Further, Spratt et al. (2010b) used multiple case studies to examine SNs’ contribution to supporting young people’s mental health.

It is acknowledged that designing a good case study is challenging (Yin 2018), and the literature relating to case study methodology is confusing, especially in relation to defining a case study (Yazan 2015). For example, the three key research methodologists associated with case study methodology, Stake (1995), Merriam (1998) and Yin (2018), each have different opinions on the definition of a case study. For example, Stake (1995) leans towards constructivism and refers to case study methodology as an ‘*art*’ in the title of his seminal book, whilst Yin (2018, p. 15) leans towards positivism and refers to it as ‘*an empirical method*.’ Nonetheless, what they have in common is the need to ensure that the ‘*case*’ is clearly specified and that it has a clear ‘*boundary*’. Thomas (2017) suggests that researchers should carefully consider the purpose, approach and process when designing a case study, as these will assist in defining the type of case study.

The purpose of this phase was to explore in depth participants’ experience of the work of the SN in supporting primary-school-aged children’s mental health. The approach needed to be flexible and holistic to facilitate the collection of data from four different groups of participants. This was especially relevant with respect to involving children in the research and gaining access. This required the ability to establish and foster relationships with gatekeepers in the NHS, the Education Department of the Local Authority and at the level of the school and family.

Stake's (1995) approach to case study aligns with my epistemological and theoretical underpinnings as he talks about the need for a flexible design that uses a holistic approach and where knowledge is socially constructed. Moreover, he takes the view that '*the case is an integrated system*' (Stake 1995, p. 2), where the relationship between the researcher and the participants and the context of the research is crucial. Hence, this approach fits with an ecological perspective.

The 'case' was the qualified SN team, and the 'boundary' was one health board area in central Scotland. The selection of the case was informed by the results from Phase One, which highlighted that, in one health board area, only qualified SCPHN-SNs were using the title 'SN', which contrasted with some other board areas. The results also indicated that this health board had implemented the Emotional/Mental Health and Wellbeing Pathway (Scottish Government 2018b). These were both of particular relevance to the research aims and questions as I wanted to develop an in-depth understanding and, as Thomas (2010, p. 576) suggests, produce '*exemplary knowledge*'.

4.3.2.1 Phase Two study site

The study was conducted in one NHS health board area in central Scotland which serves a population of approximately 305,710 people across a geographically diverse area in 2021 (Scottish Government 2021b). The school nursing team in the study site provides school nursing services to schools situated in three Local Authority Education Departments.

4.3.2.2 Phase Two sampling approach

Purposive sampling was used to deliberately and purposefully select information from participants as it was congruent with the aims and research questions and case study methodology. In contrast to Phase One, where I purposefully selected participants from one group (nurses working in the school health service in Scotland), participants from four different groups were purposefully selected for the Phase Two study. These groups included qualified SNs, primary-school-aged children, parents and teachers who met specific inclusion criteria which makes this sampling approach purposive. The reason for selecting a heterogeneous sample was to obtain not only the perspectives of SNs of their mental health

work, but also to obtain the experiences and understanding of users of the school nursing team. Purposive sampling has previously been used in studies employing a case study design. For example, Spratt et al. (2010b), as part of a large mixed methods study to examine local authorities, schools and their partners' responses to behaviour deemed to be triggered by poor mental health, purposively selected six school-based interventions. Similarly, Chase et al. (2010) purposively selected parents, children and teachers for their multiple case study design. Thus, I deemed purposive sampling to be appropriate for the requirements of this study.

4.3.2.3 Phase Two sampling frame

The size of a sample is a key consideration to ensure that it is representative of the population being studied, and to assure the rigour of the study (Ritchie et al. 2014; Vasileiou et al. 2018). It is acknowledged that novice researchers are often anxious regarding the size of the sample, and I recall early discussions with my supervisors where I asked them the question, 'how many participants are enough?' However, their answer to this question was 'it depends'. For this qualitative study, my decision regarding sample size was based on the need to recruit participants who would enable me to adequately address the research aims and questions and achieve richness of the data (Baker and Edwards 2012; Creswell and Creswell 2018). In addition, my decision was also influenced by potential issues in accessing participants and time constraints, which Ritchie et al. (2014) advise researchers to consider carefully when designing a sample.

Initially, when I submitted my ethics proposal, I had intended to recruit: $n=6$ SNs; $n=12$ school age children aged 9–11 years (primary 6); $n=12$ teachers; and $n=12$ parents from two primary schools, one in an affluent area and one in a deprived area. However, I encountered challenges in accessing children, parents and teachers for my study. For example, when I approached the head teacher at a primary school in an affluent area to seek her support with my study, she advised me that she had no experience of the SN and that there were no issues with mental health in her school. In contrast, the head teacher at a primary school in a deprived area was very supportive of my study, and I made the decision to reduce the sample size to $n=6$ school-age children aged 9–11 years (primary 6);

$n=6$ parents, and $n=6$ teachers. To ensure diversity, I drew up a Sample Matrix (Table 4.3) with the intention of recruiting an equal number of women and men from each group, and participants from Black, Asian and Minority Ethnic groups (BAME), as the literature review identified that they are an under-represented group in school nursing research.

Table 4.3: Phase Two sample matrix

Primary Criteria	SNs (SCPHN-SN)	School-aged children	Parents	Teachers
Women	3	3	3	3
Men	3	3	3	3
BAME	1–2	1–2	1–2	1–2

4.3.2.4 Phase Two recruitment of participants

SNs were recruited via the Lead Nurse for School Nursing in the board area following receipt of ethics approval from the University NICR Ethics Committee (Appendix 4). Permission was granted to recruit on the 18th June 2019, however, this had to be put on hold until the 6 July 2020 due to a period of leave of absence and the postponement of fieldwork due to COVID-19 restrictions. On the 6th of July, I emailed the service manager for health visiting and school nursing with an information pack and invitation email to forward to all qualified SNs meeting the inclusion criteria. At that time the school nurse team comprised six qualified SNs.

Access to approach schools was granted by the Head of Education at the Local Authority on the 16th May 2019 following a written request and completion of the relevant documentation. I sent emails to head teachers in two schools with information about my study and to seek their permission to recruit. Permission was granted by the head teacher at one of these primary schools. The other head teacher was not interested in her school being involved in my study. The plan had been to meet with the head teacher in March 2020 and to commence data collection in May 2020. However, due to COVID-19, this was not possible as the schools were closed and fieldwork within schools was not permitted.

Consequently, to allow fieldwork to commence, it was necessary to make minor amendments to my data collection methods to assure my safety and that of participants, and to facilitate access to parents, children and teachers. I achieved this by obtaining permission from NICR in the form of Chair's Action and from the local authorities to use university networks to promote my study and to recruit participants who met the following inclusion criteria:

- SN with SCPHN-SN qualification working in the Scottish School Health Service
- Primary School Teacher working in a Scottish local authority primary school
- Parent of a child aged 9–11 years enrolled in a Scottish local authority primary school
- Child aged 9–11 years enrolled in a Scottish local authority primary school

I sought and obtained permission from the Deans of the Faculties of Health Sciences and Sport, Arts and Humanities, and Natural Sciences to email staff in their faculties to invite them to participate in my study. The Programme Directors of the Postgraduate Education Programmes in the Faculty of Social Sciences and the BSc Nursing Programme agreed to post an announcement to students on their programmes informing them about my study. To ensure that teachers, children and parents were recruited from local authority schools within the boundary of the case, the recruitment email and announcement clearly identified the health board area and the inclusion criteria. See Table 4.4 for details of the final sample.

Table 4.4: Phase Two Final Sample

School-aged children (9–11 years)	Qualified SNs	Primary School Teachers	Parents of school-aged children (9–11 years)
Planned: <i>n</i> =6 Girls: <i>n</i> =3 Boys: <i>n</i> =3	Planned: <i>n</i> =6	Planned: <i>n</i> =6	Planned: <i>n</i> =6
Actual: <i>n</i> =8 Girls: <i>n</i> =3 Boys: <i>n</i> =5 BAME: <i>n</i> =1	Actual: <i>n</i> =6 Women: <i>n</i> =5 Men: <i>n</i> =1	Actual: <i>n</i> =2 Women: <i>n</i> =1 Men: <i>n</i> =1	Actual: <i>n</i> =7 Women: <i>n</i> =6 Men: <i>n</i> =1 BAME: <i>n</i> =1

4.3.2.5 Phase Two data collection

Data were collected between August 2020 and June 2021 using online MS Teams in one-to-one semi-structured interviews. This data collection method is flexible and interactive, enabling the collection of rich in-depth information and the opportunity to clarify areas of uncertainty and respond to the participant's direction (Bryman 2008). Semi-structured interviews have strong links with case study designs and, according to Yin (2018), are a key source of evidence. They have previously been used in case study designs with SNs, teachers and school-aged children. For example, Jonsson et al. (2019) used semi-structured interviews to obtain Swedish SNs' experiences of working with school-aged children with mental health problems, while Chase et al. (2010) used a combination of focus group and individual interviews with school-aged children, parents, teachers and SNs. It had been my intention to use focus group interviews with follow up interviews as this research method is frequently used for the collection of qualitative data, particularly in research with children where the researcher seeks to obtain their views, opinions, experiences and perceptions. For example, they have been used to explore primary school children's social and emotional experiences (Hall 2010). However, due to the lockdown restrictions it was not possible to access schools. I could have chosen to arrange online focus groups, but decided against this as I did not feel I had the skills or confidence to facilitate them.

A total of 23 interviews were conducted with participants from each group (see Table 4.4 for final sample). The interviews with the SNs and teachers ranged from 45 to 95 minutes, and the interviews with the parents and the children ranged from 21 to 33 minutes. I used an interview guide with a list of topic areas to ensure consistency in asking questions and to aid in prompting discussion (Green and Thorogood 2018). The feedback from the Advisory Group meetings and analysis of the online questionnaire was used to inform the development of the topic areas and the interview questions. The interviews took place online using MS Teams, apart from one with a SN, which took place over the telephone due to issues with the internet. They were arranged at times that were convenient to the participants, for example, the interviews with the children took place after school, one interview with a teacher took place in the evening, and another interview took place during the participant's and the researcher's annual leave.

Creative participatory data collection methods were used in the interviews with the children to maintain their interest as it is acknowledged that children have varying preferences (O'Reilly and Dogra 2017). The participatory methods that were used involved the use of some of the picture communication symbols from the Talking Mats™ Consulting Children and Young People Resource and a Worry Monster (Multi-Sensory World 2024). Talking Mats™ is an evidence-based low technology communication tool which was developed at the University of Stirling to assist adults and children with communication difficulties to express their thoughts and opinions so that they can communicate more effectively (Murphy et al. 2007). A Talking Mat™ comprises three sets of picture communication symbols, a visual scale, topic, options and a space to display them (Murphy et al. 2007). The tool has been used in research with children and young people to explore their views. For instance, Murphy and Mackay (2015) used Talking Mats™ to explore what matters to young people with complex and exceptional health needs and their families during health transitions. Cignan et al. (2016) used them to explore how children and young people with an intellectual disability feel about undergoing clinical procedures, while Backman and Karlsson (2020) used them to explore children's perspectives of mealtimes when living with a gastrostomy.

The Consulting Children and Young People Resource was developed following a research study conducted by Mackay and Murphy (2012) to investigate whether the adaptation of the Talking Mats™ framework would support young people with complex needs in mainstream secondary school to improve the quality of their involvement in setting targets for their individualised educational plans. The resource is based on GIRFEC and comprises symbol sets covering three topics from the My World Triangle, which are My Wider World, What I do, and Support and My Body and Skills. It also includes a set of eight symbols representing the eight wellbeing indicators from the National Practice Model (Scottish Government 2022d). The topics can be used separately to facilitate conversations with children to explore and support them to express their views. After careful consideration and taking cognisance of the challenges in recruiting participants for Phase Two, I decided to use a combination of the symbols from each of the three topics. Prior to the interviews, I reflected on how I would use the symbols, and which questions from the Talking Mats™ resource would best support the children to express their views. Following some conversations with colleagues and SNs, I decided to use Talking Mats™ for two questions:

1. If you had worry or felt anxious and had that funny feeling in your tummy or a fuzzy feeling in your head, who would you tell?
2. What worries do you think that boys and girls your age would like help with?

I used the 'Health' symbol from the Wellbeing Indicator and the 'Mood' symbol from the My Body and Skills topic pack to denote mental health as the topic area. Due to the pandemic and the need to move my fieldwork online, I was unable to use the original package that had been purchased when I had completed Talking Mats™ training in March 2018. I did not have funding to purchase the digital package, and so I created a whiteboard using OneNote and took photographs of the visual image option symbols to enable the children to see them on their screen. The children were encouraged to select symbols and place them on the whiteboard. I then used the symbols to facilitate a conversation and support the children to express their views on the questions outlined above. It had originally been my intention to use a top scale as recommended by Talking Mats™, as

they can support participants to reflect on open questions. The top-scales that are suggested to be most effective with the Consulting Children and Young People resource are Happy (things going well)/Not Happy (things are not going well)/Unsure (not sure if things are going well). However, due to the need to conduct the interviews online, and the questions I was asking, the top-scale suggested by Talking Mats™ was not appropriate when I came to interview the children. For instance, when I conducted the first two interviews, I asked the children to indicate whether the picture symbol they selected would be something they thought a child ‘would worry about’ or ‘not worry about’, or if they were ‘not sure’. However, I found it difficult to move the picture symbols on the whiteboard and, due to the time it was taking me to move the symbols, the children were becoming disengaged.

The Talking Mats Research Group have developed criteria to establish what can and cannot be called a Talking Mat™ in a research study. To meet their criteria, researcher(s) need to exemplify the following: describe the top-scale, state whether open questions are being used and provide examples, and use the Talking Mat™ to facilitate opportunities for participants to provide their views on a topic. Although I selected a topic and provided the children with opportunities to express their views and talk about mental health by asking open questions, because I took the decision to abandon use of the top-scale, this participatory activity did not meet the criteria to be called a Talking Mat™ (Murphy et al. 2023). Nonetheless, the picture-supported activity did encourage the children to talk, suggesting a need for a review of the Talking Mats™ criteria to make it more inclusive and flexible.

A Worry Monster is a soft colourful toy that has a zip-up pocket that children can use to post any worries that they may have, and it is a resource that the SNs said they used during the interviews. The technique involves asking children to write down or draw their worries on a post it note or piece of paper and then they are encouraged to feed them to the Worry Monster who will eat them. The idea behind the technique, which draws on cognitive behavioural therapy, is to help children who are anxious to address and cope with their feelings (Baird 2019). It is a technique that is recommended by Educational Psychologists and

Occupational Therapists (Glowscotland.org.uk 2020; Hussey 2022) and was suggested by SNs at a webinar. I used the Worry Monster to facilitate a conversation with the children to help them to think of five worries that they might post into the Worry Monster's mouth. To do this, I showed the children my worry monster and explained it to them. Following this, to help facilitate a conversation to explore their worries or worries that they thought a child their age might have, I used the symbols from the CYP Resource. The children were asked to select symbols and then I moved them and placed them on the whiteboard. I then encouraged them to reflect on their choices and asked them to tell me why they thought they would be a worry.

4.3.2.6 Phase Two data analysis

The data analysis process followed five stages, as follows:

Stage 1: Familiarisation

The analytical process for Phase Two began at the end of the first interview, when I wrote down notes in my fieldwork diary to record my experience of the interview. This included noting down my observations of the participant's body language, tone of voice, and who was present, especially in the case of the children, and to consider the way in which I asked questions to identify whether I could have asked them more effectively. The transcription of the interviews provided an opportunity to begin the process of familiarisation with the data and, during this phase, I used my reflective diary to record my thoughts. Transcription involved viewing and listening to the MS Stream recording and transcribing its audio recording. I had also obtained permission to make digital audio recordings, and I also listened to these to ensure that the transcriptions were as accurate as possible. For one interview I was unable to use MS Teams, and for that participant I listened to the digital audio recording only. Gale et al. (2013) suggest that the page margins in the transcript should be wide enough to provide space to add in notes and codes. Initially, the line spacing I used for the SN transcripts was only 1.0 line spacing, which made it slightly challenging to read the text (see Figure 4.9). I changed it to 1.5 line spacing for the transcripts with the parents, children and teachers, which I found much easier to read (see Figure 4.10).

I: Uh Uh

P: Em, so I suppose I would kinda try and use that approach if the referral came in like that. Em, and sometimes when you get down to the nitty gritty of it, the behaviours are due to a child being anxious. Predominantly anxious, I would say, I've had, I've only had one child being referred to me because the teacher felt that their mood was low.

I: Uh uh

P: So then what I would do is walk alongside them. Em, I would use the skills that I have learned from LIAM.

I: Uh uh

P: Work with the child and the parent. The child has work to do and the parents. They are crucial, and I learned that by reading all the research as well. Em, that you know they are crucial in being able to, not only understand and support what is going on, but practising with their child. And em, any kind of strategies that we can put in place. One really good one was on a wee girl who was really really stressed, em and she wasn't sleeping. That's it, it came to me as a sleep referral. That's another way that they sometimes come in.

I: Ok

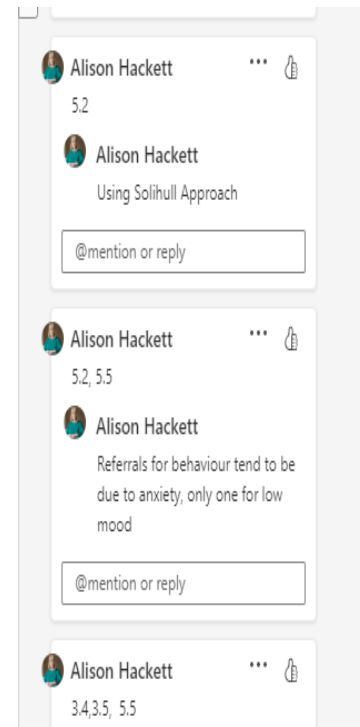


Figure 4.9: Example of a SN coded transcript

I: Maybe, ok. We will put that in a maybe.

C: Yeah, it would normally depend on whether I trust them or not. Like if the school nurse is there from when I started school then yeah. Well right now I'd be trusting him or her.

I: Yes, so trust is important? Yeah?

C: Yeah.

I: Yep. Anyone else there?

C: Pets

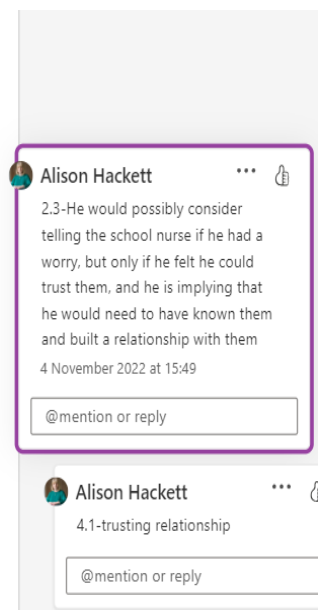


Figure 4.10: Example of a child coded transcript

Completed transcripts were read several times and I listened to the recordings for each dataset to aid familiarity and to immerse myself in the data. This was particularly time-consuming for the SN and the teacher interviews, as the interviews ranged between 40 and 90 minutes. Nonetheless, I found it very useful, as there were some differences in my recollection following the child interviews. For example, at the end of one child interview, I had noted in my fieldwork diary that the interview had gone well, however, when transcribing it, I noted on the digital recording that the child had become fidgety earlier than I had recalled at the time, and he appeared keen for the interview to end. During the process of familiarisation, I used my reflective diary to record my thoughts, and, as suggested by Spencer et al. (2014), I used Post-it Notes to write down initial themes that linked to topic areas from the interview topic guide and emergent ideas from participant experiences. An example can be found for the teachers in Figure 4.11. This was helpful as it informed the development of the initial thematic frameworks and the development of labels. These were then applied to the data to reduce, organise and make it more manageable, as there were pages of data, which did feel overwhelming.

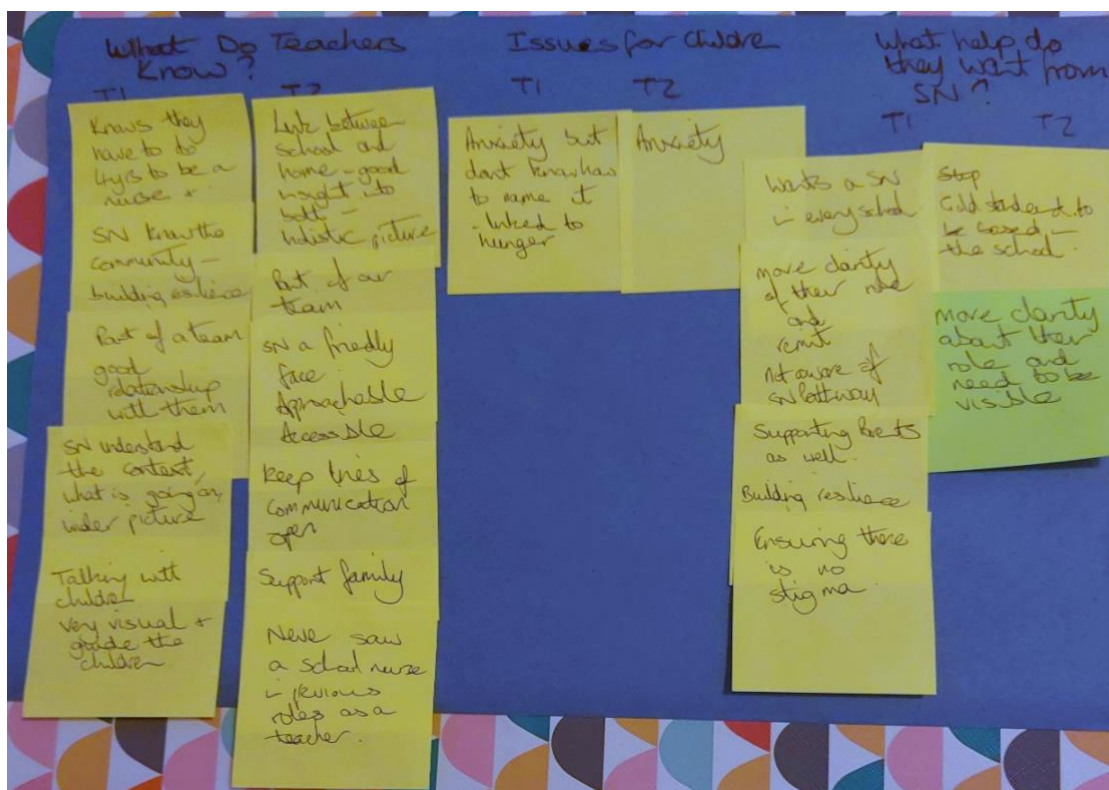


Figure 4.11: Phase Two example of Post-it Notes for initial themes

Stage 2: Constructing a thematic framework

While there are worked examples of how to apply framework analysis to analyse qualitative data (Swallow et al. 2003; Ward et al. 2013; Parkinson et al. 2016), I could not locate any that explained whether a separate thematic framework should be developed for each dataset. Following discussions with more experienced researchers, I decided to construct a thematic framework for each dataset because there were differences in the questions that I asked participants, and I considered it necessary to ensure that the themes and subthemes of the thematic framework aligned with the voice of the participants. Moreover, Parkinson et al. (2016) highlight the potential risk of moving onto the mapping and interpretation stage of the analytical process before the data is indexed and sorted if care is not taken when constructing the thematic framework. One of the challenges that I encountered was waiting until I had collected all the data for Phase Two before constructing the thematic framework for each dataset. As a result, this impacted on the timescales to complete the analytical process. Nonetheless, it did provide me with invaluable thinking time, and Braun and Clarke (2022) do advise that good reflexive thematic analysis should not be rushed. The thematic framework used for the SNs can be found in Appendix 5.

Stage 3: Indexing and sorting

Initially, I had planned to use NVivo 12 to support the management and thematic analysis of the data, and I used this successfully with the free-text data from Phase One. However, for Phase Two, intermittent issues with accessing the NVivo 12 software when working from home, and competing priorities, mainly from my teaching and assessment workload, impacted on the timescales that I had allocated to complete the analysis. Consequently, I took the decision to use MS Word with Tracked Changes to index and sort the transcripts, beginning with the SN dataset. To apply the initial thematic framework, I indexed the first SN interview transcript by reading through it line by line and applying the labels to segments of text (Spencer et al. 2014), by highlighting the text and then clicking on the comments and adding in the number of the label (see Figures 4.8 and 4.9). For some segments of text, more than one label was applied if the text linked to more than one theme or subtheme. Once I had completed the indexing of the first transcript, I reviewed and amended the framework as the wording of

some of the labels was not specific enough, for example, in relation to SNs' experiences. To facilitate the inclusion of emergent ideas, I included a label titled 'other issues' (Spencer et al. 2014).

Stage 4: Data summary and display

Once I had completed indexing and sorting the SN transcripts, the next step was to begin the process of summarising and charting. This involved creating separate charts for each of the initial themes and subthemes from the Thematic Framework supported by using Microsoft Excel Spreadsheets. Summarising the interview transcripts took longer than I had anticipated as I initially included too many direct quotations, which made it challenging to read due to the amount of information in each cell. Parkinson et al. (2016) recommend that the summaries are concise, as their purpose is to reduce the data to make it more manageable. Following informal discussions with research colleagues and a review of the worked example by Ward et al. (2013), I revisited the summaries and began to edit them by removing the quotations and adding an asterisk to denote a significant participant quotation and the page number to make it easy to locate the quotation in the transcript (see Table 4.5 for an extract of Thematic Chart Five). This process was completed for each dataset, which comprised 23 interviews, and this made it easy for me to move up and down and across the data.

Table 4.5: Extract of Thematic Chart Five: Mental Health Practice

SN	5.1: Settings for MH work	5.2: Interventions/ Approaches	5.3: Experience & Understanding	5.4: Perspectives on Preparation	5.5: Experience of multi-agency working	5.6: Facilitators/Challenges
SN1	Home visits, p. 7, line 36 Drop-Ins, p. 8, line 22 Go for a walk, p. 8, line 31	See 4.1/4.2 Holistic approach, p. 1 Creative, varied and person-centred, pupil-led, p. 6 LIAM programme, p. 7, lines 5-6 Would like to do Prework on emotions and social prescribing, p. 15, lines 11-15 Solihull, p. 8, line 42 Mindfulness, p. 11, line 3	Working with child and parent, p. 6, line 13 Work with school, p. 7, line 15 Relationship building, p. 8, line 34	See 3.2 School nursing course and LIAM training helpful, p. 3, line 15 Lots of opportunities to attend good training, p. 4, line 7	Talks positively about working with other professionals/families/agencies, p. 22	See 6.4 The pandemic, redeployment, capacity especially child protection work. Impacts on ability to take on mental health referrals, p. 22, line 17. Worries about that. Technology a frustration, p. 20, line 10 Need to be more visible, p. 21, line 17
SN2	Other SNs do home visits. She does not unless risk assessed first, p. 2, lines 17/18 See in health centre or school, p. 2, line 19	Unsure when I asked her initially. But paused and said LIAM and Wellbeing Passport that she developed, p. 2, line 28 Does not like Solihull, p. 2, line 35	See 5.6 Working one to one with the children Supporting parents and the child, p. 9, line 20 Building resilience of the community and not just resilience of the child, p. 10, line 5	Does not feel SN course prepared her for MH work with children, p. 3, line 23 Does not feel SN are trained for their MH work, p. 9, line 10	See 5.6 Unrealistic expectations from other agencies, p. 4, line 37 and p. 5, lines 1-2	Need more resources as needs to buy resources, p. 3, line 38 Frustrated at not being able to do mental health work due to child protection and capacity, p. 5, line 28 Not in schools due to pandemic and less visible, p. 5, line 18 Not in a position to support children, p. 9, line 34

Stage 5: Mapping and interpretation

The next stage of the Framework Approach involved mapping and interpretation. Srivastava and Thomson (2009) suggest that a schema can be helpful at this stage of the analytic process, and I created diagrams of themes and subthemes in MS Visio, as the diagrams provided a tool to help me more clearly visualise the relationships between them. There were several iterations at this stage and an example of an initial schema for Theme Two can be found in Figure 4.12 below.

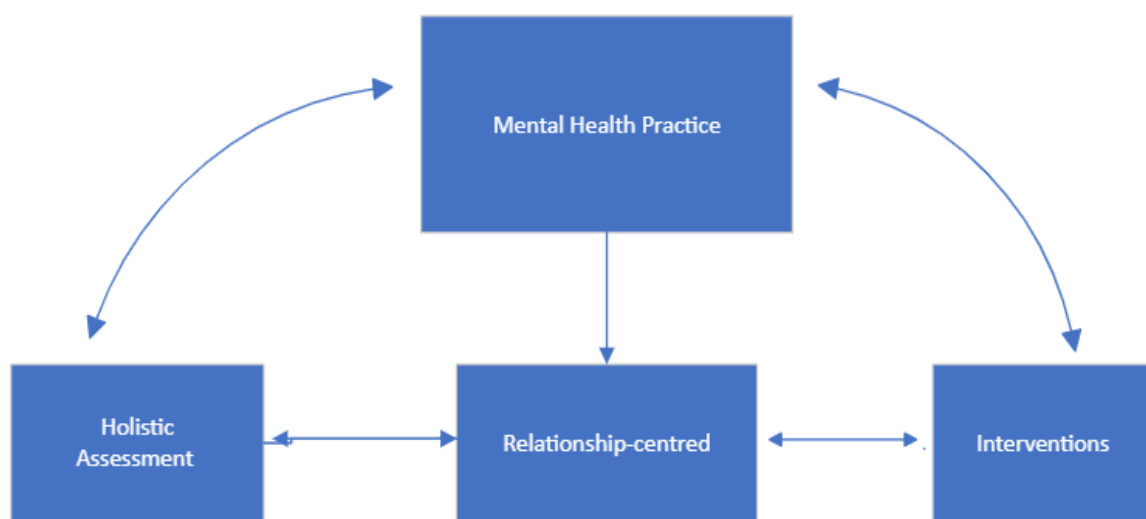


Figure 4.12: Initial Schema for Theme Two

This stage involved constructing more charts and moving backwards and forwards across the data for the purpose of clarifying information and making sense of it. Participant quotations were selected that supported the development of the themes and subthemes, and this stage involved iteration as the theme title did not initially include 'SN' (see Table 4.6 for an extract of the development of Theme Two). Three themes and eight subthemes were identified (see Table 6.1 in Chapter Six). It is acknowledged that naming the themes carefully is fundamental to give voice to the participants' experiences and that they reflect the core meaning of the theme (Hackett and Strickland 2018; Braun and Clarke 2022). I found it challenging to develop creative, snappy names and therefore made the decision to name them practically, as I felt this conveyed my interpretation of the findings more meaningfully.

Table 4.6: Development of Theme Two: Mental Health Practice

Column A	Column B	Column C
Data charted in 4.2	Elements/dimensions identified-in order identified in chart	Subthemes
SN1: 'It's more about relationship building, and sometimes it's about helping a child and a parent who are at logger heads, and the parents are, and to help the child to understand that their parent is worried too' (p. 9) 'I love it when I actually have a kid that I can build a relationship with first before I, sometimes you need that before you can do any good work. You're getting nothing, you know. That is the first thing that any kid will tell you, trusting relationship. I count on you. If you say you're going to be there. Can I count on you? I think sometimes you don't need any fancy interventions like I say, let's go for a walk, you know? Sometimes it's what I call planting the seed, especially with a teenager. Planting the seed, three months down the line, do you know what xxx, I have decided to do this...even with a family, planting the seed, people being able to rely on you' (p. 22)	Highlights importance of building relationships with child and parent to help them understand each other's perspectives. Obtains job satisfaction from building relationships with children. In her experience, building a trusting relationship with children and parents is crucial for the effectiveness of mental health interventions. She also highlights the importance of being reliable and empowering children.	Relationship-centred practice

During this stage, I made the decision to combine the four data sets to allow comparison of participants' experiences and understanding and to aid in the development of key themes and subthemes. Because I used similar areas of questioning across the interviews, this helped to support the merging of the participant datasets.

This process involved completing charts such as the example in Table 4.6 for each data set, which enabled me to identify similarities and differences. For example, when developing Theme 1: Understanding of mental health and the issues impacting primary-school-aged children, the theme was initially titled 'Knowledge and understanding of school nurse mental health work'. However, during the mapping and interpretation of the data sets, it became apparent that the lack of knowledge and understanding of the SN role and remit by teachers, children and parents was a factor influencing the participants' experiences and understanding of the SN (Research Question 2), and a barrier to accessing mental health support from SNs. Consequently, this led to the development of Theme 3: Barriers to accessing mental health support from SNs and the associated subtheme: Lack of awareness of the SN role and remit.

4.4 Quality assurance

Assuring the quality of the research is an essential prerequisite when designing and conducting any research study. According to Holloway and Wheeler (2010, p. 297), health researchers need to be cognisant of the '*truth value*' of their research whilst also demonstrating its credibility and validity for healthcare practice. However, within the literature there is a lack of consensus regarding the criteria used to define the quality of a study (Bryman 2008; Lewis et al. 2014). This is especially the case for Mixed Methods Research, which can be confusing for the novice researcher. Fàbregues and Molina-Azorín (2017), in their systematic review of the literature on the quality of MMR studies, found that researchers used a variety of different terms, including 'construct validity', 'validity', 'rigour' and 'quality', to describe aspects of quality assurance. It is generally acknowledged that, for quantitative research, the quality criteria include reliability, validity, and generalisability (Creswell and Creswell 2018), whereas, in qualitative research, Lincoln and Guba's (1985) criteria of 'trustworthiness' which incorporates credibility, transferability, dependability and confirmability, is often used (Cameron 2011). However, Lewis et al. (2014) contend that reliability and validity can be used as criteria to demonstrate the quality of qualitative research, thus, leading to a lack of clarity and consistency when considering how to assess the quality of mixed methods research.

Bryman (2008) suggests that, when assuring the quality of a mixed methods study, it is essential to ensure that the following four criterion are demonstrated:

1. The design of the study is relevant to the research question.
2. A rationale is provided for using mixed methods.
3. The procedures used to conduct the study are transparent.
4. The findings are integrated.

Similarly, Brown et al. (2015) and Halcomb (2018) contend that it is vital for mixed methods researchers to ensure that the study has been conducted rigorously and that the conclusions reflect the findings of the overall study.

To assure that the quality of this study was robust, I used the four criteria suggested by Bryman (2008) and employed a reflexive approach, which is discussed in Section 4.5. I considered using the criterion outlined in the Mixed Methods Appraisal Tool (MMAT) 2018 (Hong et al. 2018), but, as training in the use of the tool is recommended and I had not received training, I chose not to use the tool. At the design stage, the decisions that I made were based on the aims of the study and the research questions and ensuring that these were congruent with my philosophical approach. These have been clearly articulated in Section 4.2. In addition, the rationale for the selection of a sequential mixed methods research study were stated clearly in Section 4.2.4.

The procedures used to conduct the study have been reported with a rationale for my decisions earlier in this chapter. In Phase One, the survey instrument I used was a validated online tool and it was piloted prior to data collection. The survey tool, Online Surveys (Jisc 2024), enabled me to download the results onto an Excel spreadsheet, which facilitated accuracy in analysing the results. Moreover, the results of the online survey correlate with the findings of previous studies exploring the role of the SN validating the results (Creswell and Creswell 2018). The results also correlated with the findings from Phase Two, further demonstrating their validity.

Triangulation is an approach that can be used to assure the robustness of research studies, and it is an approach associated with case study designs

(Stake 1995; Yin 2018; Thomas 2021). Triangulation refers to the collection of a variety of different sources of evidence and its use is regarded as being a key strength of case study designs (Yin 2018). For this study, I collected data using two different methods and from four different groups of participants, which enabled me to confirm and validate the results from Phase One with the findings from Phase Two. This is exemplified in Chapter 5, Section 5.3.1.2 and Chapter 6, Section 6.3.1.1. Added to this, it also helped to confirm my interpretation of the data and the development of themes, ensuring it was true to the participants' experiences and understanding (Creswell and Creswell 2018).

Braun and Clarke (2022) recommend the use of an electronic or paper trail to demonstrate the quality of thematic analysis. I used the Framework Approach (Spencer et al. 2003), which supported the management of the data in both phases of the study. The rigorous processes involved in each stage of the analytical process, as described and demonstrated with exemplars in Section 4.3, facilitated the development of a transparent audit trail. It is acknowledged that this is a key strength of the Framework Approach (Gale et al. 2013; Ward et al. 2013; Hackett and Strickland 2018).

Bryman (2008) contends that mixed methods researchers should provide details about how the findings were integrated. Similarly, O'Cathain et al. (2008) suggest that a description of where the integration has taken place and in what way and any insights gained from the integration should be clearly articulated. Details regarding the integration of the findings and the insights gained are discussed in Chapter Seven, and the strengths and limitations of this study are discussed in Chapter Eight. The reporting of this study has been consistent with the Good Reporting of a Mixed Methods Study (GRAMMS) checklist, which was developed by O'Cathain et al. (2008), providing further assurance to the reader that this study was conducted rigorously.

In addition to the four criteria suggested by Bryman (2008), and the GRAMMS checklist, I also adopted a reflexive approach to assure the rigour of the study (Green and Thorogood 2018).

4.5 Reflexive approach

According to Green and Thorogood (2018, p. 14) '*researchers should subject their own research practice to the same critical analysis that they deploy when studying their topic*'. It is recognised that taking a reflexive approach can increase the rigour of the study by making transparent the researcher's values and beliefs and the way in which they may have influenced interpretation of the research findings (Bulpitt and Martin 2010; Freshwater et al. 2010; Green and Thorogood 2018). Braun and Clarke (2022) contend that reflexivity is an ongoing process and is never complete and this resonates with my practice and preferred learning style, which is reflective.

As highlighted in the previous section, I maintained a reflective diary from the start of my study and used it to record my feelings, thoughts and the decisions that I made throughout the process and to reflect on my role in the research. Initially, I used a paper diary and then, from late 2021, I found using OneNote Notebook more accessible and easier to locate my diary entries. The diary helped me to record and reflect on the challenges I experienced during the research study, especially navigating ethical permission and accessing participants. However, it also helped me to reflect on my skills and how my research skills and confidence had developed, supporting Braun and Clarke's (2022) contention that writing a reflexive diary is one of the most beneficial practices in which a researcher can engage.

In addition to maintaining a reflexive diary, I also chose to transcribe the interviews myself, which enabled me to raise my awareness of my influence on the participants' accounts. For example, in my first SN interview, the SN was very enthusiastic and keen to talk, but the interview lasted 90 minutes. Although I did check with the participant after 60 minutes that it was okay for them to continue as I had not asked all of my questions. On reflection, I did feel that I could have asked the questions more succinctly, as this may have resulted in more concise answers. Yin (2018) advises that reflexivity can help researchers to consider whether the conversational nature of participant interviews has led the researcher to unwittingly influence the participant response. I was conscious of that situation with one of the interviews I had with a child. The child became

fidgety earlier than my recollection at the time and this may have influenced their answers towards the end of the interview so that they could get it finished (see Figure 4.13 for an extract of a OneNote diary extract). For both situations just described, using a reflexive approach, and critically reflecting before, during and after action, enabled me to consider my role in the research and the influence that my views of the SN may have on what participants told me. It also allowed me to remain flexible and adaptable and to ensure that I conducted the research with integrity.

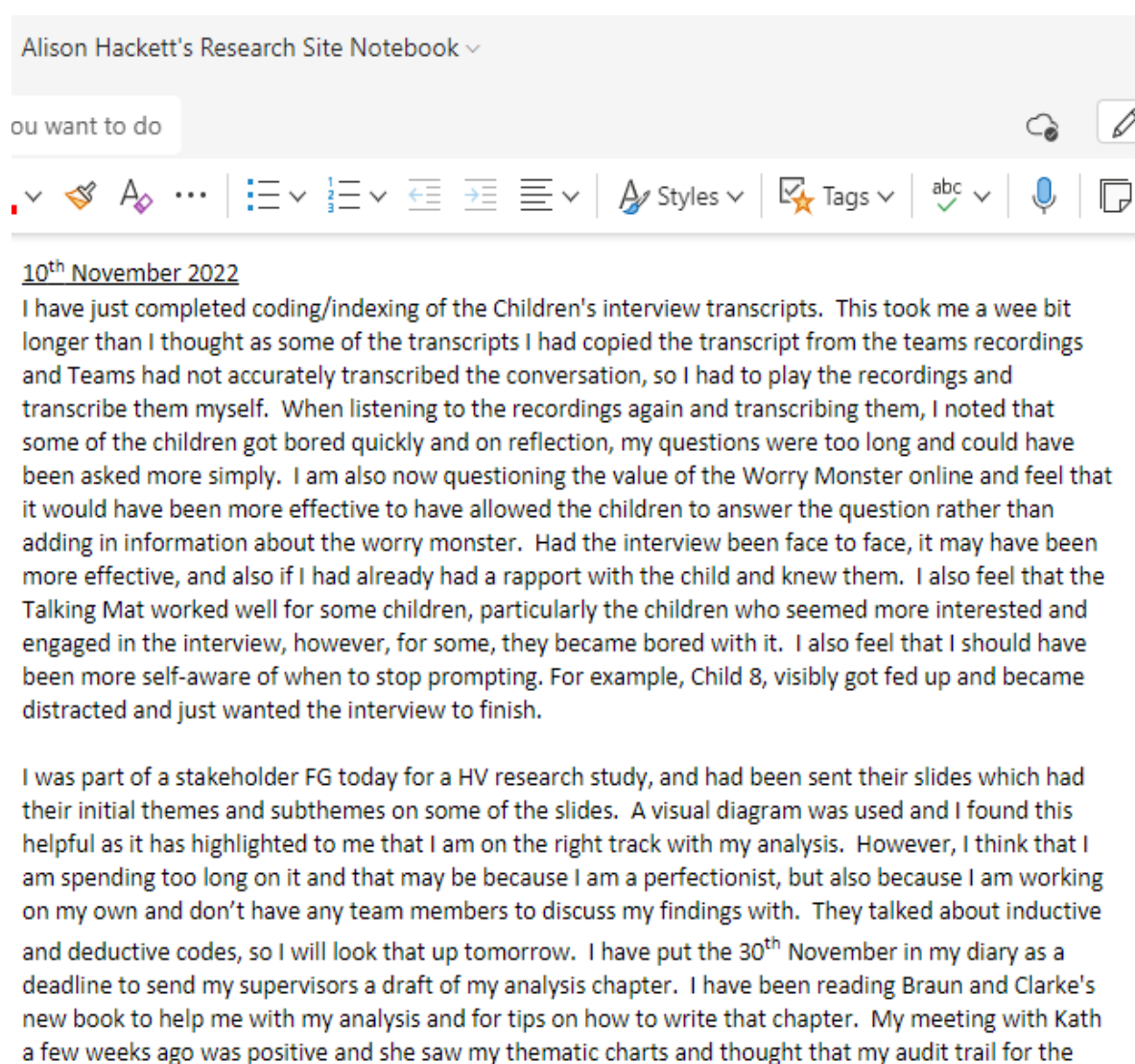


Figure 4.13: Extract of entry in OneNote research diary

In summary, this section has discussed the decisions and actions that I took to ensure that the study was conducted rigorously, and that the quality of the research was robust. This chapter will now move onto discuss the decisions I made to ensure the safety and wellbeing of the participants and myself and mitigate any risks. I was cognisant that the topic of mental health can be difficult for people to talk about and may be emotive for participants, especially if they have experience of mental health problems.

4.6 Ethical considerations

It is acknowledged when designing and conducting research with adults or children that researchers should ensure that they adhere to ethical guidelines and carry out 'good' research (Alderson 2004, p. 98). As an experienced Registered Nurse, it is my duty to adhere to and uphold the professional standards within *The Code* (NMC 2018) which pertain to practice, learning and research. Moreover, as *The Code* aligns with the Caldicott Principles for NHS ethical standards and data protection legislation (National Data Guardian 2020), it was incumbent upon me to assure the highest ethical standards and best outcomes for participants.

The design of this study was emergent, flexible, and inductive, which made it challenging to plan and to manage ethical issues. Moreover, as the research involved children, who are regarded as a vulnerable group (UK Research and Innovation 2023), there was an increased need to consider and mitigate for all expected and unexpected issues to ensure the integrity of the research was maintained throughout the study. One issue that I had not anticipated was the global pandemic, which necessitated an adjustment to the data collection methods for Phase Two and amendment of the recruitment protocol (see Section 4.5.2). The four components of Bronfenbrenner's (1995) Bioecological Systems Theory provided a helpful framework to ensure that the ethical principles were viewed through an ecological lens, especially with respect to building and fostering relationships with gatekeepers and participants.

4.6.1 Ethical principles

Beauchamp and Childress (2019) propose four research principles:

- Respect for Autonomy
- Beneficence
- Non-maleficence
- Justice

These four principles were used to guide my consideration of the ethical issues throughout this study. These are now discussed in relation to the Person, with particular emphasis on the child.

4.6.1.1 Respect for autonomy

Respect for autonomy is concerned with ensuring that the views, opinions, and perspectives of people are taken into consideration. Researchers must uphold the right of participants to express their views, opinions, and thoughts and to listen and act upon them. This is essential for vulnerable groups such as children, who are often not included in research due to the additional ethical considerations required. Children have the right to express their views and to have them listened to and acted upon (United Nations 1989; Scottish Executive 2004). Moreover, listening and involving children in decisions can add authenticity to the study and richness of the findings (Kellett 2005). Children's participation in decision making can also provide opportunities for them to develop transferable skills, in particular, negotiation, thinking, decision making and networking skills (Davey et al. 2010), which can increase their confidence and sense of self-worth (Kellett 2005; Todd 2007).

To ensure that the information leaflets, consent forms and topic guides were presented in a child-friendly format and clearly written, and that the proposed participatory methods were appropriate, I set up an Advisory Group for Phase Two. The Advisory Group comprised six children aged 9-11 years from a primary six class and a group of four teachers. Following very active engagement in the groups, especially from the children, I used their feedback to inform the topic guide (Appendix 6) and to make amendments to the participant information

leaflet. For instance, I changed the picture symbols to present their drawings (Appendix 7).

4.6.1.2 Beneficence

Beneficence is concerned with ensuring that the welfare and best interests of participants are considered (Varkey 2021). This was vital when considering the involvement of children in my study, as their participation could have resulted in missing learning in the classroom. Therefore, the interviews were arranged outwith school hours and at a time that was convenient for the children and the parents. I acknowledged that discussing mental health could be a sensitive topic, and so neither the child nor adult participants were asked questions relating to their own mental health. Some children and parents disclosed their own issues and I responded to these with respect and sensitivity. The children had access to immediate support from their parents if this had been required. Parents had support from their families and the SNs, and teachers had support from their peers. Should the situation have arisen, I was prepared to signpost participants to sources of support.

There were no direct benefits to participants from participating in this study, but they may have benefited through discussing their experience and being involved in the research process. It is acknowledged that children's participation in research can increase their confidence and sense of self-worth (Kellett 2005; Todd 2007) and provide opportunities to develop transferable skills such as negotiation, thinking and decision making, and increase their knowledge (Laws and Mann 2004; Davey et al. 2010). All participants received a certificate of participation to thank them for taking part (Appendix 8). In addition, the children were provided with a surprise £10 Amazon voucher at the end of the interview to thank them. Neither the parents nor the children had been informed about this until the end of the interview to ensure that it did not influence their decision to participate.

4.6.1.3 Non-maleficence

Participants have the right to be protected from harm when participating in research (United Nations 1989; Alderson 2004; British Educational Research

Association 2018). It is vital that researchers ensure that they do no harm to participants, do not deceive them, and protect their privacy, as these are fundamental human rights (Human Rights Act 1998). All participants were well informed about the purpose of the study, why they were being invited to participate, what their involvement would entail, how their data would be used and their right to choose to participate. They were also offered the opportunity to contact me to ask questions about the study prior to making the decision to take part.

4.6.1.4 Justice

Justice refers to the requirement to treat people fairly and equitably (Varkey 2021). In relation to children, it also refers to the need for researchers to consider the balance of power in their relationship with the child (Graham et al. 2013) and consider which children will be included or excluded from the research. Because this study was not funded and I had no resources to pay for interpreting services, I made the decision that participants who did not understand English would not be selected to take part in the study. However, this situation did not arise. In relation to including children and parents in the research who may have communication difficulties and supporting them to express their views, I attended training in the use of Talking Mats™ (see Section 4.3.2.5).

4.6.2 Gaining Ethics Permission

Ethical approval was sought and granted from the University of Stirling Ethics Committee (NHS, Invasive or Clinical Research Committee) in two stages: first for Phase One (Appendix 4) on 19 July 2018; and then for Phase Two (Appendix 10) on 26 April 2019. NHS Research Ethics Committee approval was not required as both phases were deemed to be Service Evaluation rather than research (Appendix 11). Access permissions were granted by the Executive Nurse Directors in each Scottish Health Board for Phase One and the Executive Nurse Director in the Phase Two case study site. In addition, for Phase One, in three of the fourteen Boards, the Phase One study was registered as Quality Improvement and in two Boards as Clinical Audit. The Phase Two study was registered with the Research and Development Department in the case study

site with the same registration number, as it was considered as a continuation from Phase One.

Ethics permission to recruit teachers, children and parents was sought and obtained from the Education Department in the case study site (Appendix 12). Due to the pandemic, adjustments had to be made to the planned fieldwork to allow the qualitative interviews to take place online using MS Teams or by telephone instead of in schools. This required the completion of a risk assessment and submission of a change to NICR. Access permission was received on the 15th September 2020 from the local authority education department to use MS Teams or Google Meet. However, due to the pandemic and issues gaining access to recruit teachers, children and parents from schools, it was necessary to amend the protocol in March 2021 to recruit teachers, parents and children via University Channels. I submitted a minor amendment on 22 March 2021, and this was approved by Chair's Action. Access permissions were sought and obtained from the Deans in the Faculty of Health Sciences and Sport, Arts and Humanities and Natural Sciences and the Programme Director of the UG Nursing Programme to recruit parents and children. Access permissions for teachers were sought and obtained from the three Local Authority Education departments and the Programme Director for the Postgraduate Education Programme.

4.6.3 Consent

Informed consent was requested from all participants for both phases of the study. For Phase One the information pack with the anonymous web-based link was emailed to all nurses working in the school health service in Scotland. For nurses who chose to participate, the questionnaire landing page included information about the study, a link to the participant information leaflet and an invitation to complete the informed consent form. At the end of the questionnaire, participants were asked for final consent before submitting the completed questionnaire (Appendix 13).

For Phase Two, the information leaflets (Appendices 7, 14 and 15) containing information about the study and contact details were sent out via email. The information leaflets and consent forms were sent to each parent's email address

to share with their child. The information was provided in a range of accessible formats to ensure that participants, especially the children, understood what was involved, what methods would be used to collect data, where the study would be conducted and what would happen with the data and findings of the study (Fry et al. 2017). Participants were required to read and sign the Consent Form (Appendices 16, 18 and 19) to indicate that they had provided informed consent, and these were returned via email. Participants were informed that their participation was voluntary and that it was their choice to participate if they wished. Likewise, they were also advised that they could withdraw from the study at any time without providing an explanation. It is acknowledged that participants can sometimes change their mind and, for this reason, informed consent was re-confirmed throughout the study (Todd 2012).

4.6.4 Competence

Written voluntary informed consent from the child wishing to participate in the research was sought, in addition to consent from their parent (Appendix 17). It was essential to assess whether the child was competent to provide their consent, as children have different levels of understanding depending on their age and stage of development (O'Reilly and Dogra 2017). I considered the following four elements: the child's understanding of the information provided; their ability to retain information; their ability to make a balanced decision based on the information provided; and their ability to communicate their decisions and wishes. Prior to commencing the interviews with the children, I explained who I was and provided information about the study and confidentiality. I also checked that they were still interested in taking part and asked whether they had any questions. The children included in this study were able to demonstrate each of these elements, providing evidence of their competence and capacity to consent. It was not necessary to seek assent, as each child demonstrated their capacity to consent. However, had this situation arisen, I would have facilitated the child's participation in accordance with the United Nations Convention on the Rights of the Child (United Nations 1989), and made sure that parental consent was obtained.

4.6.5 Anonymity

Every effort was made to protect the anonymity of participants in both phases of the study. For Phase One, no personally identifiable information was collected. Participants were asked to provide details of their gender, ethnic minority and the health board/local authority area where they work. For Phase Two, minimum personal data was collected, and this included, the name, email address and telephone number of participants for communication purposes only. The data were anonymised by labelling transcripts, charts, drawings, and photographs with a participant identification code to ensure that participants could not be recognised when writing and disseminating the findings of the study. Participants were informed that it may not be possible to assure their anonymity, but every effort would be taken to maintain their anonymity and disguise their identity. The name of the local authority, the schools and the health board area have not been identified.

4.6.6 Confidentiality, privacy, data protection and storage

All data have been treated confidentially and managed in line with the University Policy, the General Data Protection Regulations 2018, *Data Protection Act 2018* and through adherence to the *NMC Code (2018)*. The data have been stored securely on the University of Stirling server and will be retained for ten years in line with the University research policy and data protection regulations so that it is available for re-use in future research.

For Phase One, the online questionnaire did not record IP addresses and no personally identifiable information was collected. A numerical code was used to label the questionnaire responses and I analysed the data.

For Phase Two, I transcribed the data myself, which reduced the risk of revealing the identities of participants to a third party. Regarding privacy, the child's rights to privacy were carefully considered in respect of the need to have a parent or other trusted adult present during interviews. This decision was flexible to ensure that the rights of the child to freely express their views were balanced with their right to protection. I considered the following factors: the age of the child; their wishes; any vulnerabilities such as a mental health problem; communication

difficulties; the wishes of the parents; and my feelings when fieldwork commenced (O'Reilly and Dogra 2017). All the child participants were offered the opportunity to have a parent or trusted adult present during the online interviews with me.

I am a member of the Protecting Vulnerable Groups Scheme, which is managed by Disclosure Scotland and which provided assurance to gatekeepers of my suitability to do regulated work with children. I was cognisant that, if a situation were to arise where I had concerns about the safety of a child, that I would have a responsibility to report these to the Named Person, who is usually the head teacher in primary schools (*Children and Young People (Scotland) Act 2014*; NMC 2018; Scottish Government 2023b), and make the parents aware of any concerns. No such situations arose during the fieldwork.

4.7 Researcher position

Throughout this research study, I was cognisant that my position as researcher was more powerful than that of the participants, especially the children, due to their age and cognitive ability. Lundy's (2007) Model of Participation provided a guiding framework to facilitate children's participation in this study. The framework is underpinned by Article 12 of the UNCRC, that children have the right to be heard. It comprises of four key elements which are space, voice, audience and influence (Lundy 2007). Space refers to safe, inclusive opportunities for children to develop and express their views. Voice refers to the facilitation of children's views, whilst audience pertains to the need to listen to children's views, and influence refers to the need to act upon children's views as appropriate (Lundy 2007). To ensure that the balance of power was more equal, semi-structured interviews using participatory methods were used to collect data with the children in Phase Two. With respect to the element of 'space' due to issues gaining access to schools due to gatekeepers and the lockdown restrictions, I explored all avenues possible to ensure that primary-school-aged children could be included in my research and provided with opportunities to express their views about the SN.

To ensure that I was prepared to obtain the ‘voice’ of the child, I attended training in Advanced Interviewing Skills with Children at the Scottish Social Sciences Graduate School in 2017 and training in the use of Talking Mats™ in 2018. These training sessions were invaluable during the interviews with the children as the knowledge and skills provided me with techniques to encourage the children to talk and express their views. The training also highlighted the need to be flexible to meet the diverse needs of children and empower them to express their views (Lundy and McEvoy 2012). With respect to ‘audience’, I used my eyes and my ears to actively listen to the children as it is acknowledged that listening involves more than just hearing (Lundy 2007). I observed the children’s non-verbal cues, and reflected back their responses to ensure that I had understood what they were telling me. In addition, I clarified with them when I was unsure about their response to my questions. Throughout the research, I utilised a reflexive approach to consider and reflect on issues regarding power and how my researcher role might influence the research process and the data. To this end, as discussed in Section 4.5, I maintained a reflective diary to record my feelings, thoughts and the decisions that I made.

The findings of the Phase One study have been written into a summary report that was sent to the Executive Nurse Directors for onward dissemination to nurses and or midwives working in the school health service in Scotland. They were also shared at the 2nd Research Conference for Nursing, Midwifery and Allied Health Professionals Conference at the University of Edinburgh in November 2023. The research findings for Phase Two will be written into a summary report and shared with participants. They will also be disseminated at conferences and in publications with the intention of influencing and informing the future work of the SN in supporting primary-school-aged children’s mental health.

4.8 Summary

This chapter has outlined the aims and research questions and provided a detailed account of the methodology and methods used, namely a cross-sectional online questionnaire followed by a single qualitative case study. It has also provided explanations for the decisions made in designing this research

study. These were linked to my ontological and epistemological position, and theoretical framework, which drew on Bioecological Systems Theory, in particular the PPCT Model (Bronfenbrenner 1995) and Dossey's Holistic Nursing Theory (Dossey 2008). Gaining an understanding of the influence of social relationships and support networks, especially in relation to the mental health work of the SN were key to addressing the research aims and questions.

The rationale for selecting an explanatory sequential mixed methods research design has been discussed and justification for adopting a pragmatist approach. The chapter has described in detail the Phase One study design, followed by that of the Phase Two study, and the analytical approach adopted for each phase. The processes followed to assure the quality of the research and the ethical considerations have been discussed, including consideration of my position in the research.

The thesis now continues by presenting the result of Phase One in Chapter Five and the findings of Phase Two in Chapter Six.

Chapter Five: Phase One Results

Introduction

This chapter presents the results of the national cross-sectional online questionnaire used in Phase One. As outlined in Chapter Four, the descriptive statistics were analysed using MS Excel and are presented as frequency and percentage. The Framework Approach was used to manage and thematically analyse the free-text data (Spencer et al. 2003). Three main themes were identified, 'Supporting children's mental health', 'Barriers to identification and support of mental health issues' and 'Educational preparation and training in mental health'. The results are reported in line with the Consensus-Based Checklist for Reporting of Survey Studies (CROSS) results (Sharma et al. 2021). In addition, the results are viewed through an ecological lens, and the four components of the PPCT Model (Bronfenbrenner 1995) are used to situate the results, beginning with *Context*, followed by *Time*, *Person* and *Process*. This order has been used to facilitate a logical flow of the narrative.

5.1 Respondent characteristics

In September 2018, there were 281.4 whole-time equivalent qualified nurses and/or midwives working in the school health service in Scotland on Agenda for Change Bands 5–7 (NHS Scotland, 2018b). There was a total of 83 responses to the online questionnaire, which represents a response rate of 29.5%.

5.2 Descriptive statistics

5.2.1 Context

Respondents were represented from all 14 health board areas in Scotland. See Figure 5.1 for a summary of participant location. Most participants were women ($n=82$; 98.8%), and one (1.2%) was a man, and all described their ethnicity as white. The average age range was 45–54 years ($n=40$; 48.1%). See Table 5.1 for a breakdown of the age categories.

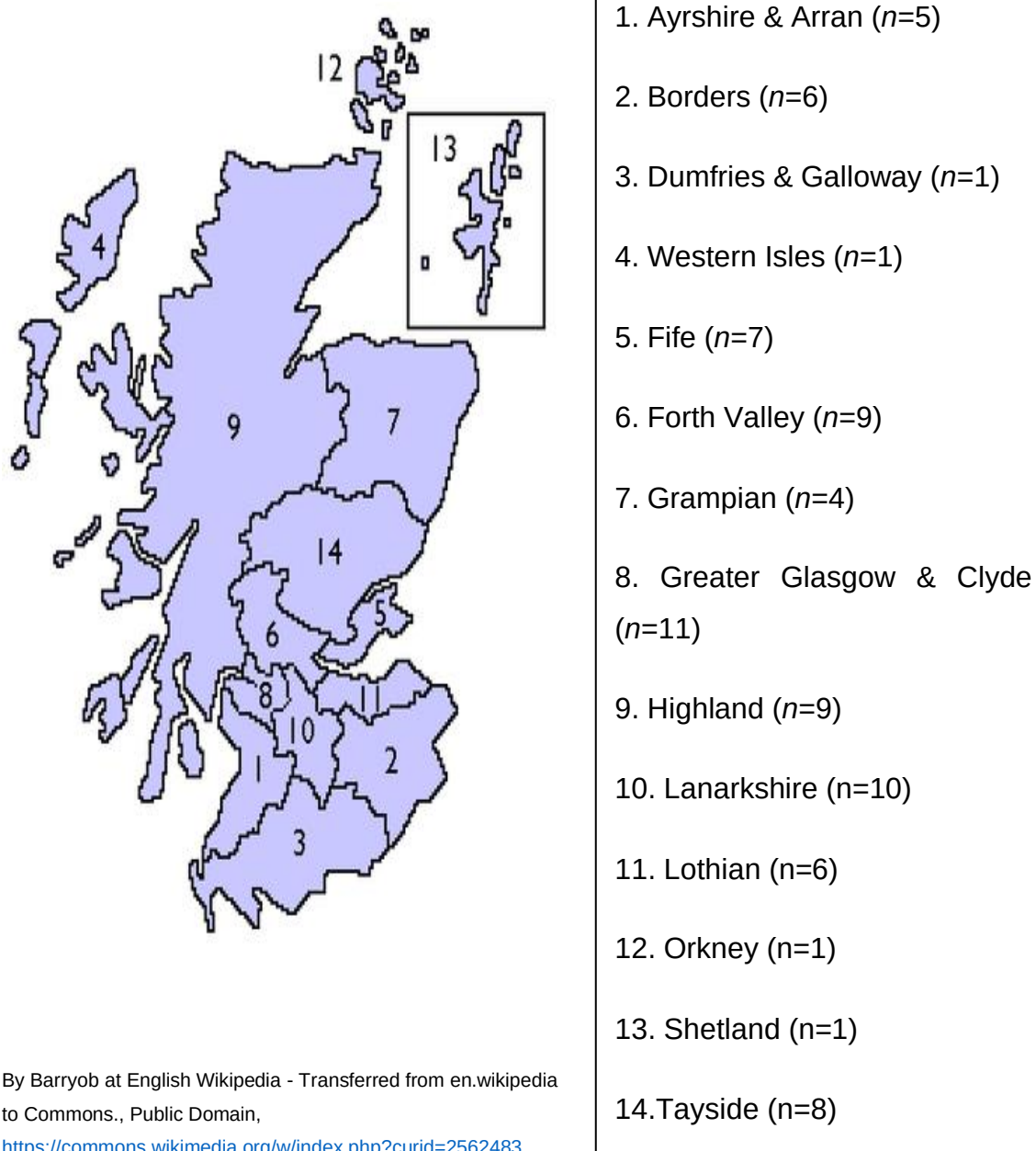


Figure 5.1: SN Participation via NHS Health Board Area

Table 5.1: Phase One: Age range of nurses working in schools

What category best describes your age?	Frequency	Percentage
18–25	2	2.4
26–34	3	3.6
35–44	25	30.1
45–54	40	48.2
55–64	13	15.7
65 and over	0	0
Prefer not to say	0	0

5.2.2 Time

The data were collected pre-pandemic. At that time, schools were open and there were no restrictions on access to schools by SNs. A variety of working patterns was represented with just under one-third working full-time. There was also a range of visiting patterns to the primary schools ranging from ‘never visiting the school’ (2.4%) to ‘other’ (43.3%), which included a variety of reasons. For instance, when ‘other’ was selected, many of the free text comments included ‘as required’. Details of the visiting patterns can be found in Table 5.2. The SNs had contact with primary school children in a range of locations, the two most common being a quiet room in the school (90.3%) and the child’s home (80.7%). See Table 5.2 for more details. The Scottish Government were planning to implement the refocused SN pathway, and more than half of participants (64.7%) indicated that it had been implemented in their area of work. However, ten (11.8%) participants indicated that it had not been implemented in their area and seven (8.2%) did not know. Of the respondents who opted to provide further details ($n=13$), most indicated that they were working towards implementation, whilst others indicated that they had partially implemented some of the pathways. One respondent indicated that, in their area, they had participated in a short-life working group looking at training needs and the design of referral forms.

Table 5.2: Phase One: Working pattern, frequency of contact and location of contact

How many hours are you contracted to work per week?	Frequency	Percentage
Full-time term time only	8	9.6
Full-time all year	32	38.6
Part-time term time only	16	19.3
Part-time all year	26	31.3
Other	1	1.2
Prefer not to say	0	0
How often do you visit each primary school in your caseload?		
Weekly or more	16	19.2
Monthly or less	29	34.9
Never	2	2.4
Other	36	43.3
Prefer not to say	1	1.2
Where do you have contact with primary-school-aged children?		
Classroom	33	39.7
Quiet room in the school	75	90.3
Home	67	80.7
Community Room	20	24
Drop In Clinic	9	10.8
Wellbeing Meeting	26	31.3
Prefer not to say	1	1.2

5.2.3 Person

All respondents were qualified nurses or midwives, but most were Registered Nurses-Adult (65%). Thirty-one (37.3%) were also on Part 3 of the NMC register as Specialist Community Public Health Nurses (SCPHN), but only 14 (16.8%) reported that they were registered SCPHN-SNs. The highest level of qualification was a Master's degree, and four (4.81%) had achieved this award. Thirty-four (41%) were currently undertaking further study, of which 30 (36.1%) were studying at SCQF Level 11 (Master's degree). Sixty-four (77.1%) participants had attended training in mental health, and two (2.4%) responded that they did not know. Seventeen (20.5%) responded that they had not attended any mental health training.

The sample represented an experienced workforce with 49 (59%) respondents reporting that they had been qualified for more than 25 years since their initial registration as a nurse, and 47 (56.6%) reporting that they had worked as a SN for five years or more. It is notable that the length of experience with the largest number of responses (27.7%) was between one and four years, indicating investment in increasing the numbers of qualified SNs in Scotland. The respondents had a range of job titles, but nearly half (49.4%) described their job title as a 'SN'. Six (7.2%) respondents were students, and the titles used were 'Student SN' and 'SN Trainee'. Of the respondents who opted to provide additional details, job titles included 'Community Staff Nurse', 'Public Health Nurse', 'Team Leader/Clinical Teacher', and 'Student Public Health Nurse in Schools'. See Table 5.3 for additional details about the participants' qualifications, and Table 5.4 for details about their length of experience and job title.

Table 5.3: Phase One: Professional qualifications and current academic study

What professional qualifications do you have currently registered/recorded with the NMC? Please tick all that apply.	Frequency	Percentage
Registered Nurse-Adult	54	65
Registered Nurse-Mental Health	9	10.8
Registered Nurse-Child	18	21.7
Registered Nurse-Learning Disability	4	4.8
Registered Midwife	4	4.8
Registered SCPHN-SN	14	16.7
Registered SCPHN-HV	10	12
Registered SCPHN	7	8.4
Registered Practice Teacher	3	3.6
Registered Teacher	0	0
Other	3	3.6
Prefer not to say	0	0
What is the highest level of qualification you have been awarded?	Frequency	Percentage
Higher National Certificate	1	1.2
Diploma	12	14.5
Bachelor's Degree	36	43.4
Postgraduate Certificate	6	7.2
Postgraduate Diploma	13	15.7
Master's Degree	4	4.8
Doctorate	0	0
Other	9	10.8
Prefer not to say	2	2.4
What is the highest level of qualification that you are currently studying?		
SCQF Level 9 module (Degree Level)	2	2.4
SCQF Level 10 Module (Honours Degree Level)	2	2.4
SCQF Level 11 (Master's Degree)	30	36.1
SCQF Level 12 (Doctoral Level)	0	0
Not currently undertaking further academic study	46	55.4
Prefer not to say	3	3.6

Table 5.4: Phase One: Length of experience as a SN and job title

How many years have you worked as a SN?	Frequency	Percentage
Less than 1 year	13	15.7
1–4 years	23	27.7
5–10 years	18	21.7
11–15 years	12	14.5
16–20 years	11	13.3
21–25 years	5	6
More than 25 years	1	1.2
Prefer not to say	0	0
What is your current job title?		
SN	41	49.4
School Health Nurse	4	4.8
Staff Nurse for Schools	10	12
SN Team Leader	9	9
SN Practice Teacher	2	2.4
Specialist SN	4	4.8
SN Trainee	5	6
Student SN	1	1.2
Community SN	3	3.6
Other	4	4
Prefer not to say	0	0

5.2.4 Process

This section reports the results of the closed survey questions that sought to explore SNs' views on their work in identifying and supporting primary-school-aged children's mental health.

5.2.4.1 Identification of primary-school-aged children in need of early intervention to promote and improve their mental health

Over three-quarters (79.5%) of respondents perceived that the identification of primary-school-aged children in need of early intervention to promote and improve their mental health was an important part of their work. In contrast, when asked whether they were actively involved in this aspect of their work, it is notable that 25 (30.1%) participants indicated that this was not the case. The respondents were also asked to indicate what assessment tools they use to assess the mental health and emotional wellbeing of primary-school-aged children. The main assessment tools that they used were the My World Triangle (86.7%), the Resilience Matrix (77.1%), and the Wellbeing Indicators (75.9%), followed by the Strengths and Difficulties Questionnaire (73.5%). Twelve (14.5%) respondents ticked the box 'Other', whilst one (1.2%) indicated that they would use the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Of the twelve respondents who ticked 'other' and opted to provide further information, six indicated that they used the Young Person's Core (YP-CORE) Assessment Tool (Child Outcomes Research Consortium (CORE) 2023), two used the Revised Children's Anxiety and Depression Scale (RCADS) (Chorpita et al. 2000). Other tools that were used included the Spence Children's Anxiety Scale (Spence 2021), the PHQ-9 Depression Test Questionnaire (Kroenke and Spitzer 2002), the Children's Global Assessment Scale (GCAS) (Shaffer et al. 1983), and the Let's Introduce Anxiety Management (LIAM) resources (NHS Education for Scotland 2021) and 'All about me' emotions flash cards which had been purchased by the respondent online. One respondent had developed a resource called 'My Health, My Voice Wellbeing bag' that was being tested in their health board area. Added to this, one respondent commented that WEMWBS had been removed from the SN pathway.

Respondents were asked about their confidence in using assessment tools such as the GIRFEC National Practice Model (Scottish Government 2022d) to assess and make informed judgements about the mental health and emotional wellbeing of primary-school-aged children. Most (83.1%) indicated that they felt confident about their assessment and decision-making skills.

5.2.4.2 Supporting primary-school-aged children's mental health

Respondents were specifically asked about supporting primary-school-aged children's mental health. Most respondents (92.8%) reported that this was an important part of their work, and nearly three-quarters (72.3%) indicated that they were actively involved in providing support to primary-school-aged children in need of early intervention to promote and improve their mental health.

Respondents were asked about their confidence in delivering interventions to support, promote and improve primary-school-aged children's mental health and emotional wellbeing. Nearly two-thirds (62.6%) indicated that they felt confident to deliver interventions to support primary-school-aged children's mental health. However, a notable proportion (21.7%) indicated that they did not feel confident to deliver interventions.

5.2.4.3 SN Approach

A large proportion (87.9%) responded that they used a person-centred and strengths-based approach when working with primary-school-aged children and their families, whilst two (2.4%) responded that they did not use this approach. It was not possible to establish what approach these respondents used when working with school-aged children and their families as there was no 'other' option provided.

5.2.4.4 SN interventions

The respondents were asked to indicate from a drop-down list of 14 interventions, which ones they currently used to support primary-school-aged children's mental health and emotional wellbeing. They were also offered the opportunity to add comments to a free-text box if they used an intervention that was not listed. The intervention that received the most responses was parenting support (76%), followed by home visits (74.7%), Solihull (62.7%) and Motivational Interviewing (32.5%). For those who opted to add further details ($n=15$), two indicated that they would use LIAM, one indicated they would use a solution-focused approach and not therapy, one indicated they would use a kit bag, and another indicated it that would depend on the issue, but would comprise just talking to the child. However, one respondent indicated that they would only be working directly with

upper primary school children, and another indicated that most interventions are carried out by partner agencies. One respondent commented that they used to use Health Spots and Drop-Ins, but, despite these being identified as good practice, they no longer run due to staffing issues. For additional details, please see Figure 5.2.

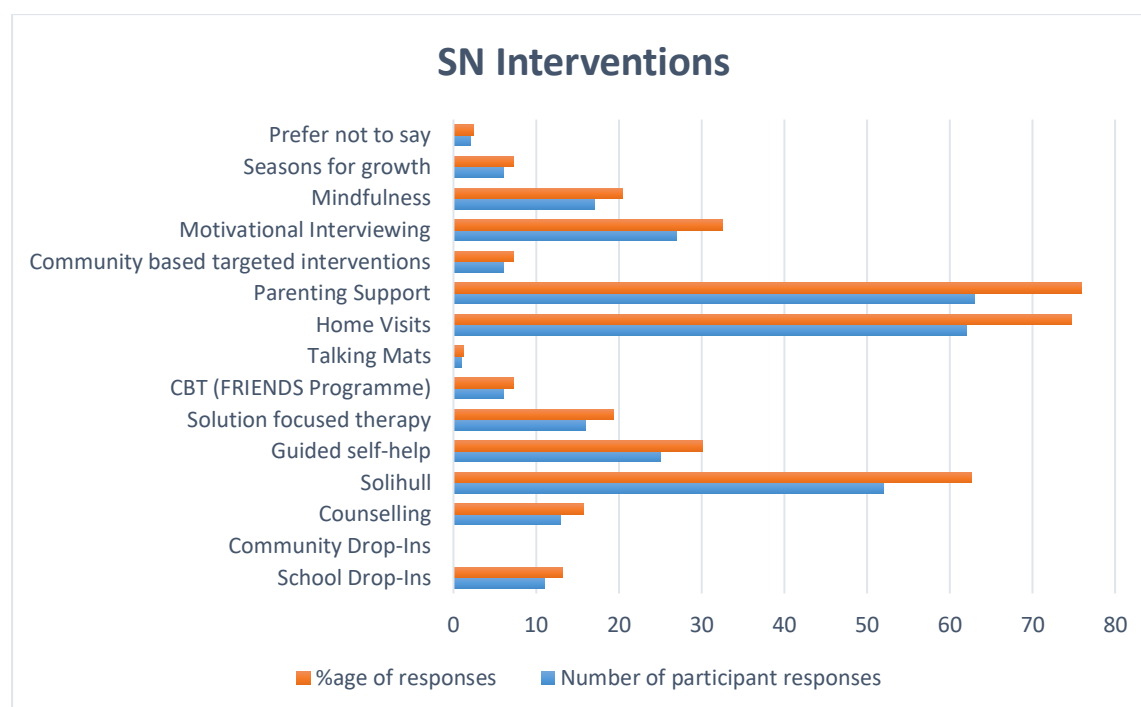


Figure 5.2: Phase One SN interventions

Home visiting is an important aspect of the new SN pathway in Scotland, and respondents were asked to indicate whether they visited primary-school-aged children at home to assess their mental health and emotional wellbeing and to deliver interventions to promote, support and protect their mental health and emotional wellbeing. Fifty-four (65%) indicated that they did currently visit at home for assessment purposes, whilst 53 (63.8%) indicated that they delivered interventions in the home. Most (85.5%) responded that home visiting affords them the opportunity to make a more accurate assessment of the child's wellbeing, the people who care for them, and their wider world. When asked whether home visiting offers the opportunity to develop a more therapeutic relationship with children and their parents/carers, 26 (31.3%) strongly agreed with this statement and 40 (48.2%) agreed. Thirteen (15.7%) neither agreed nor disagreed, whilst three (3.6%) disagreed, and one (1.2%) strongly disagreed.

Respondents were provided with an option to expand on their answers, however, the respondent who strongly disagreed did not provide a free-text comment, and it was not possible to ascertain the reason for their response.

Respondents were asked to provide reasons why they would not provide an intervention to a primary-school-aged child. There were 54 (65%) responses to this question. These included: if the child did not want to engage, if the parent(s) did not agree/consent, if specialist teams were involved, if the child had behavioural issues, non-attendance at school, if any assessment indicated an intervention would not be appropriate, and, if in discussion with the child, family and head teacher it was identified that the SN was not the best person to deliver an intervention. However, workload capacity, time and factors relating to lack of knowledge, skills, and confidence of the SN to deliver interventions were also reasons why respondents would not offer an intervention.

5.2.4.5 Partnership working

Respondents were asked about their liaison with the health visitor at the transition from preschool setting to primary school. Nearly three-quarters (73.5%) indicated that they liaised closely with the health visitor. However, seven (8.4%) disagreed, two (2.4%) strongly disagreed, and 13 (15.7%) neither agreed nor disagreed. In contrast, in relation to their liaison with schools at transition, specifically the head teacher, less than half (47%) indicated that they liaised closely with the head teacher. A notable proportion (28.1%) indicated that they did not have close liaison with the head teacher at transitions. Nonetheless, most (93.4%) responded that head teachers/teachers would contact them for advice and support if they had a concern about the health and wellbeing of a pupil. Nearly three quarters of respondents (71.1%) reported that working relationships with community paediatricians were good, and a large proportion (85.9%) indicated that their working relationship with social work was good. Added to this, 60 (72.3%) responded that they obtained support and advice from CAMHS when they needed it.

One question was about their working relationship with school-aged children. A large proportion (89.5%) indicated that they had a good working relationship with children. In relation to parents and carers, more than three-quarters (80.7%)

indicated that parents/carers contacted them for advice and support about their child's health and wellbeing. Of the respondents who contributed additional information regarding their contact and liaison with health visitors, head teachers, social work, community paediatricians and parents/carers, there were 25 responses. Several indicated that parents and carers are unaware of the school nursing service and would not know how to access the SN. One indicated that they rely on schools to promote the service, whilst another responded that, if a head teacher knows the SN, they will contact the SN for support. Working relationships were mentioned by several respondents. One indicated that they had lost their good working relationship with social work due to the centralisation of the social work team, which had impacted on communication. Another indicated that their relationship with primary-school-aged children was limited.

5.2.4.6 Referrals/Requests for assistance to the SN service

Respondents indicated that the main source of referral to the SN service was from the school, followed by social work, GPs, and child protection nurse advisors. For example, 55 (66.3%) responded that they mostly received referrals from the school (head teacher/teachers). There were several professionals and agencies that they indicated they did not receive referrals from. These included community children's nurses, community link workers and educational welfare officers. For additional details, please refer to Figure 5.3.

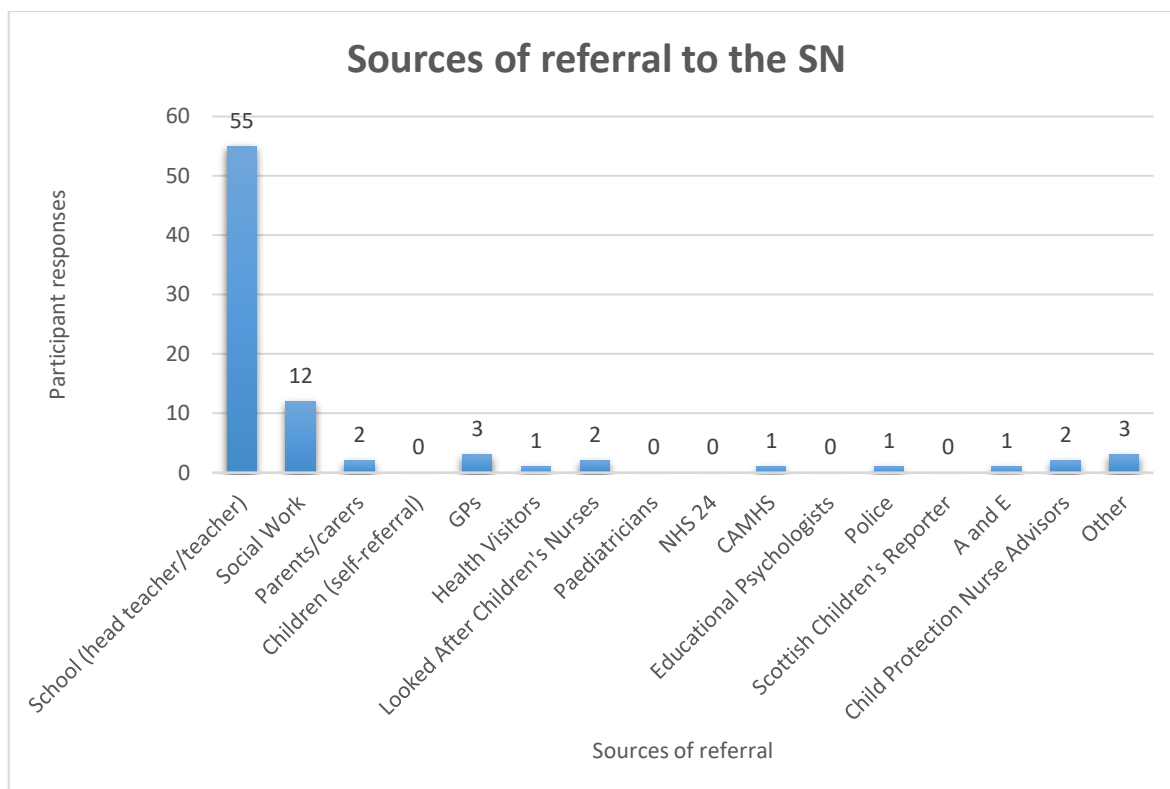


Figure 5.3: Phase One Sources of referral to the SN

Respondents were also asked to indicate the ways in which they received referrals or requests for assistance. This question required them to tick all that applied. Email correspondence (74.7%), referral form (72.3%) and telephone calls (68.7%) were found to be the main ways in which the SNs received referrals. Of the 11 respondents who took the opportunity to provide further details, one responded that opportunistic face-to-face and review meetings were common methods of referral. However, most responded that a referral form was currently or in the process of being the only method of referral to their service, except for parents or children. A rationale was provided by one respondent, and it was due to requests from teachers during visits to school being missed. Refer to Figure 5.4 for more details about the methods of referral.

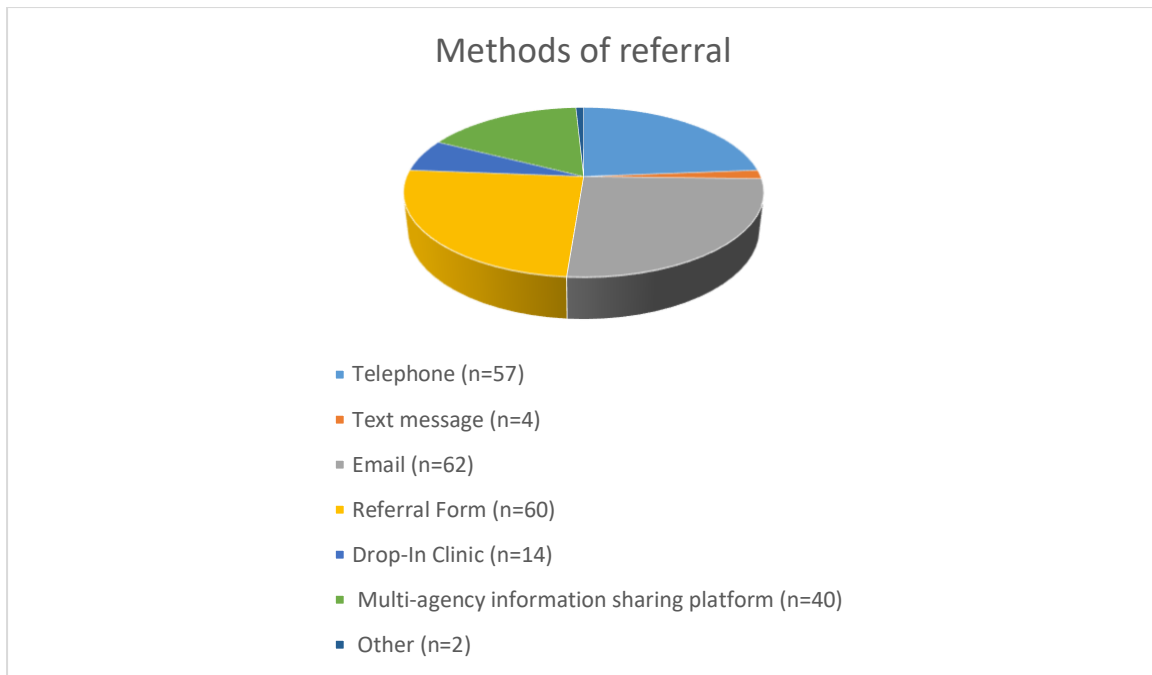


Figure 5.4: Phase One: Methods of referral

5.2.4.7 Support to attend mental health training

Respondents were asked to indicate whether their employer provided opportunities for them to keep up to date with new developments related to their work in supporting primary-school-aged children's mental health and emotional wellbeing. Fifty-five (66.3%) indicated that they were provided with opportunities for continuing professional development, while 57 (68.7%) indicated that they were provided with time to attend training and updating in mental health and emotional wellbeing. However, nine (10.8%) indicated that they were not provided with time to attend training. Of those opting to provide additional information, their comments indicated that, despite there being opportunities to undertake training, workload capacity, and lack of time and money impacted on their ability to attend training. One respondent indicated that part-time working impacted their ability to attend training, as it was often scheduled for days when they were not available.

5.3 Qualitative Findings

The findings presented in this section are drawn from the free-text responses on the questionnaire. Theme 1 and Theme 3 link to *Process*, whilst Theme 2 links to *Context*.

5.3.1 Theme 1: Supporting children's mental health

5.3.1.1 Subtheme: SNs' perceptions of their mental health role

Respondents recognised that they had a role in identifying and supporting primary-school-aged children's mental health. They were also aware of the importance of early intervention and support to promote and improve primary-school-aged children's mental health and emotional wellbeing. One respondent highlighted the link between early intervention and improved outcomes for children:

It's so important to identify and provide early intervention for children with emotional and mental health difficulties, as research shows us that early intervention leads to better outcomes for children. (SN77)

Despite this, some respondents felt that the role of the SN was unclear to other professionals and, as a result, they were not involved until it was too late to offer early support and intervention:

The role of the SN is usually identified when a child's mental health/wellbeing is at crisis point. At this stage we often miss the chance of providing early intervention support ... A clear defined role which would include early intervention/assessments would be a clearer role as there is a lot of uncertainty in the school nursing role. (SN5)

Some respondents referred to changes in their role that impacted adversely on their work in supporting children's mental health:

The role of the SN within [...] has been changed throughout my four and a half years in post. Previously we would have received referrals from schools/GP and HVs to request support for children and young people with low level mental health wellbeing concerns and carry out a specific

piece of work with them e.g., SPIRIT work. However, this no longer occurs. At this point in time, we will review our referrals and then if it is appropriate carry out an initial visit to determine what service would be the most appropriate to signpost onto. (SN34)

In addition, implementation of the new SN pathway appeared to have had an impact on the capacity of some SNs to offer support to school-aged children:

Most of the school nursing team would be positive about supporting primary school children, as we used to previously do it before changes were implemented within our service from a strategic level. (SN65)

We previously had a LAC team dealing with just LAC. This is now part of school nursing within this area and with all the other themes within the new model it does not leave time to deal with core children. (SN74)

Many of the respondents commented that they do not directly support the children as their role is to provide support to the parents of primary-school-aged children with mental health and emotional health needs:

My role is generally to support the parent of primary school age children to improve their mental and emotional health and to refer on to agencies for further support e.g., Cedar Project and Hopscotch. (SN41)

We generally do not support primary school children directly at present, although we will work with parents in programmes such as Solihull ... (SN66)

In relation to direct contact with school-aged children, most responded that it would depend on the needs of the children, the needs of referrals, and needs of the service:

... we do not work directly with primary school children outwith a group setting/child health surveillance screening or for looked-after children health needs assessment which would be carried out within a quiet room within the school and would have parent/carer present. (SN67)

Added to this, the needs of the school influenced the frequency with which SNs visited schools in their caseload and visiting patterns to schools varied widely. For example, one respondent commented:

Visits to primary school happen when there is a need. One school can be visited several times per month but that is not mirrored in other schools. (SN3)

In contrast, several respondents commented that they would visit annually if no children were requiring input from the SN, whilst others indicated that it could be weekly or monthly or as required. A key thread running through the responses was 'need' and the vulnerability of the children and the association between social disadvantage and mental health:

There are 8 primary schools in my caseload. I am in some of my primary schools on a weekly basis, these are my schools where the children that I am seeing are on the child protection register or are looked after and accommodated. These schools are also the primary schools that refer pupils to me under the priority areas of the new SN pathway (most referrals I receive are for mental health and wellbeing concerns). These schools are in socially deprived areas. I have only been in 2 of my primary schools on 1 occasion when I came into post to introduce myself, these schools are in affluent areas, have not had children on the child protection register or LAC and have made no referrals into the SN service under the new SN pathways. (SN77)

Searching for health needs is one of the four domains of specialist community public health nursing practice (NMC 2004), and one respondent commented that they used every opportunity to do this. Yet, for vulnerable school-aged children, contact appeared to be only once per year:

Due to geography and number of schools covered I cannot be in every school, every week. Every school is attended for P1 and P7 screenings and Flu immunisations (we still do them as the school nursing team). However, every opportunity is used in the search for health needs – any concerns you discover in immunisations ... I see all LAC children from

the age of 5 and search for all health needs for them, at a minimum yearly. I also see all home-schooled children yearly. (SN36)

It is acknowledged that, for school-aged children and their families, the transition from preschool to primary school and from primary school to secondary school can be a stressful time and can impact on their emotional wellbeing and academic attainment (West et al. 2010; Roberts 2015; White 2020). White (2020) recommends that planning and effective partnership working are essential, especially between health services, the school and parents and CYP. The role of the SN at times of school transition was variable. Some respondents commented that they had face-to-face meetings with health visitors and education staff, and sometimes accompany the health visitor on home visits, however, these SNs tended to be in the minority. In contrast, there were more responses indicating that their service would only be involved in close liaison with the health visitor and education at transition if the child had already been identified as requiring support:

The health visitor hands over children that fall within our Child Protection. Core families and those who have health needs that are being addressed appropriately are not handed over at transition. (SN55)

I would only liaise closely with the headteacher, health visitor etc. at transition if there has been a need identified with the child and I am actively involved in supporting them. (SN73)

It is noteworthy that some respondents indicated that in previous years they had been involved in transition, but in 2018 that had not been their experience. The reason for this related to workload capacity, changes in data protection regulations and the new SN pathway, with some SNs indicating that the criteria for handover was changing:

Transitions are being looked at and improved, however, we start the new SN pathway 1st November 2018 and resources will initially be used for direct referrals to the school nursing team. (SN36)

One problem is under the refocused model of school nursing what is additional to HV is not additional to SNs. (SN61)

Added to this, the role of the Named Person was also reported to be an issue impacting on the involvement of the SN at transition, and there was a feeling that SNs were being excluded from the process. For instance, one respondent commented:

Handover at transition is directly from health visitor to head teacher, as we are not a named person we are not included in this discussion. (SN66)

It is clear within Annex 8 of the SN Transition Pathway (Scottish Government 2018b) that SNs should be involved in the handover for CYP who are on an Additional Health Plan Indicator (HPI) due to current health issues, including LAC. In contrast, for CYP who have no outstanding health issues and are on a Core HPI, under the transition pathway, there appears to be no role for the SN, other than notification that the CYP is transferred to their caseload, which may explain why SNs feel excluded from the process.

5.3.1.2 Subtheme: Building effective relationships

Building and maintaining effective relationships with other professionals and children and families was regarded as vital by participants. Some respondents indicated that it had taken time to establish, and that the effectiveness of the communication was reliant on the attitude of other professionals towards the SN service:

I have really good communication with services within health and multi-agency services. This however has taken a long time to establish, and it often depends on the individual practitioners, but I think this is a very important requirement to address children and young people's needs ... (SN33)

Others indicated that they had been required to invest effort into developing effective working relationships, and that understanding each other's role was key to sustaining these relationships:

Working relationships are extremely important and I feel that I have worked hard to achieve effective relationships. Understanding each other's role is crucial to nurture effective working relationships. (SN45)

It was also apparent that the head teacher played a pivotal role in regulating access to the SN service, and this seemed to be very dependent on the head teacher's knowledge of the SN, whereby they were more likely to contact the SN for support if they knew who they were:

If a head teacher knows you, they will contact the School Nurse but this is becoming less frequent. (SN66)

However, respondents indicated that it was challenging to build relationships with primary-school-aged children due to limited contact with them:

As we do not work directly with primary aged children without request/referral – our relationship with the primary aged child is limited. (SN68)

There was a sense of frustration from the SNs at the limited contact they had with CYP, especially primary-school-aged children, which impacted on their ability to build trusting relationships with children, which is key when planning and delivering supportive interventions.

5.3.1.3 Subtheme: SN interventions

Respondents indicated that they used a variety of interventions to support primary-school-aged children's mental health. Parenting support, home visits and the Solihull Approach were the three main interventions used. The Solihull Approach is an evidence-based intervention that aims to support parents to develop nurturing and responsive relationships with their child and equip them with the skills to sensitively contain their child's emotions (Douglas and Johnson 2019). Respondents were offered the opportunity to specify whether they used any other interventions. Several indicated that they used Let's Introduce Anxiety Management (LIAM), which is an evidence- and competency-based training resource developed by NHS Education for Scotland and Professor Paul Stallard from the University of Bath. The resource is based on cognitive behavioural

therapy and designed to support children and young people to manage symptoms of mild–moderate anxiety (NHS Education for Scotland 2024). One respondent used a different CBT-based resource called ‘What to do if you worry too much’. This resource is an interactive self-help book for children aged 6 to 12 years (Huebner 2005).

One respondent commented that they used to offer health promotion drop-in sessions in school, but these interventions were no longer being delivered due to changes in the service. This SN felt that this was a missed opportunity for early intervention, especially for children who were hard-to-reach:

Unfortunately, the health service I work for made the decision to no longer offer health promotion or ‘drop-in sessions at school’. I feel this is a missed opportunity in reaching hard to reach children that maybe missing from a ‘refer into service’. (SN77)

Home visits were viewed by one respondent as being the ‘gold standard’. A key benefit of visiting at home was the opportunity it offered SNs to assess the home environment, the child’s interactions in the home and the relationships between family members. The ability to make a holistic assessment was seen as a benefit:

Home visits allow me to assess the child’s home environment as well as relationships between family members. (SN46)

Home visits and school-based visits are vital to assess the child and family needs as a whole. (SN18)

Listening to the voice of the child and allowing them to express their feelings about their health was also regarded as an essential feature of home visiting:

Home visiting is very important in providing information to contribute to GIRFEC SAA part 11 but providing the school age child the opportunity of being able to verbalise their own views about their health. (SN16)

However, there were mixed views on the best environment in which this should take place. Whilst several respondents indicated that they felt the home environment provided children with more opportunity to verbalise their views, in

contrast, some felt that children spoke more freely and preferred to be seen in school as it offered more privacy, especially from parents:

I find that when I visit children in school, they are able to talk more freely than at home. Some parents do not like to leave you alone. (SN54)

Several respondents indicated that the purpose of visiting at home was to provide parenting support to enable the parents to support their child's needs:

Usually, home visit would be carried out with parents at home and if suitable the child would be present. Usually, the referral is to support the parent with the child's needs so they can support their child. (SN67)

However, many respondents highlighted barriers to home visiting, the most common being lack of capacity due to size of caseload, lack of staff and working hours:

Due to staff shortages, we have had limited resources to follow the new pathway and offer more home visits, however, hopefully this will change in the near future when staffing is addressed. (SN51)

Ideally, I would like to do more home visits and provide more family support in the house, but the size of my caseload and my part-time working hours does not allow for this unfortunately. (SN77)

Additionally, one respondent highlighted that the home environment might not be the best place to have contact with the child as it may be the cause of the child's mental health issues:

... this is not always advantageous to the young person as their home circumstances may be the cause of their poor mental health. (SN22)

It is recognised that there are factors within the home that can and do impact on children's mental health, such as domestic abuse, parental substance use and the physical condition of the home. Yet, as some SNs highlighted, the home visit provides an opportunity for a holistic assessment to identify factors impacting on the child's health and wellbeing so that they can be addressed.

5.3.2 Theme 2: Barriers to identification and support of mental health issues

5.3.2.1 Subtheme: Workload capacity

Workload capacity, in particular, shortages of staff, was the main issue reported by respondents to impact on their ability to intervene early and provide support to promote the mental health and emotional wellbeing of primary-school-aged children. One respondent commented that:

If we had a larger team our service could provide more direct group work in schools, but staffing capacity can sometime prevent this. (SN67)

Another commented that, as there was no immunisation team in their area, two-thirds of their workload was taken up with the childhood immunisation programme.

Several respondents expressed frustration that they were unable to effectively support children's mental health:

I feel strongly that SNs have an important role in supporting children with their mental and emotional wellbeing. However, we lack resources, training and staffing for this to be done effectively at present. (SN26)

One respondent expressed disillusionment with school nursing due to austerity measures and service changes and was concerned about SN capacity to deliver interventions. There was also a sense of frustration expressed at the length of time CYP were waiting to be seen by CAMHS, and a feeling that children were being let down by Children's Services. One SN expressed concern that constraints on the SN service meant they could not offer early intervention to support children's mental health:

I feel our current system is letting these children down as we as a service are unable to provide vital early intervention. (SN77)

In addition, concern was expressed that there were not enough resources available for the SN service to intervene early and improve outcomes for CYP across the life course:

... resources need to be invested in as there is certainly an increase in emotional and mental health difficulties within young people that can have a life-long impact and can have a major impact on mental health now and in the future. (SN33)

Overall, respondents indicated that there was a lack of resources and a need for investment in the school nursing service due to the increasing numbers of children experiencing emotional and mental health problems and the long-term impact of this on their mental health.

5.3.2.2 Subtheme: Child protection

Most respondents reported that a large proportion of their workload was taken up dealing with child protection issues and looked-after children's assessments, which resulted in a reactive rather than a proactive approach to their work:

My workload is reactive rather than proactive. It's all child protection becoming involved with the child and family following IRD or invite to an initial child protection meeting. Also, reactive requests for health assessments as per CEL16 requirements. (SN16)

In addition, lack of regular supervision to support their practice was identified as an issue. It is notable that one respondent indicated that they did not want supervision from their line manager:

SNs require resources to use, promote talking about emotions, access to education and regular supervision (not from line managers) to allow open discussion that allows offloading of concerns. (SN29)

Another respondent, who had experience of supervision with CAMHS in a previous role as a Looked After Children's Nurse, suggested that her colleagues who did not have her level of experience or training would value supervision with specialists in CAMHS:

All the other SNs have NOT had my level of training or experience and have verbalised how they would really value supervision from CAMHS and the level of training I received. (SN16)

Overall, respondents indicated that they felt they would benefit from regular supervision to enable them to discuss concerns about the children on their caseloads.

5.3.2.3 Subtheme: Lack of knowledge and understanding of the SN role

Several respondents reported that they felt that parents, families, children, communities, and other professionals did not know what SNs could offer and did not understand their role due to not being based in a school:

Not being based in schools creates a barrier to knowing the families and families/children and young people knowing you. This is something we are working on. I personally feel if the community gains a better understanding of who we are and the support we can offer, then we will be able to identify children sooner and support in a more efficient manner. (SN36)

We are not based in schools and children don't know how to reach us. (SN26)

Many parents do not know we exist. (SN52)

Added to this, some respondents indicated that they felt that the Scottish and UK Governments did not recognise the positive contribution that SNs make:

I feel school nursing and all its positive work is not recognised enough by local government, central government, and social media/news. (SN18)

There was also some frustration expressed regarding other agencies, for example, social work's unrealistic expectations of what the SN service could offer:

It is not possible for the school nurse to continue in-filling the gaps for other services. A clear defined role which would include early intervention/ assessments would be a clearer role, early intervention/prevention. Too much is being asked of the school nursing role due to LAC and CP. (SN4)

Overall, the responses highlighted that the SNs felt that there was lack of awareness of their role, not only from children and parents, but also from other professionals, because they were not visible in schools. Added to this, there was a sense that their public health role and contribution to supporting children's mental health was not valued or recognised.

5.3.2.4 Subtheme: Lack of resources for primary-school-aged children

Many of the respondents indicated that much of their work in supporting school-aged children's mental health was targeted at adolescents. They also reported that many of the resources they used were for adolescents and that there were limited resources available to support primary-school-aged children's mental health:

There also needs to be more resources aimed at younger children. (SN7)

... we are crying out for our own resources and training in tier one to two early intervention, mental health support. (SN9)

One respondent suggested that they would find it helpful if there was a resource centre where they could obtain resources which they could adapt for use with different children, whilst another indicated that there was a lack of guidance on what resources to use and how to use them. This respondent also questioned whether these resources were evidence-based:

There is no structure or advice as to what work we should be doing to support these children. I am unsure if the resources are even evidence based. Some guidance for resources is greatly lacking. (SN46)

The views of the respondents highlighted that there was not only a lack of resources for use with primary-school-aged children, but a lack of clear guidance on what resources to use and which resources were evidence-based.

5.3.2.5 Subtheme: Variation in implementation of the new SN Pathway

Respondents highlighted that, across Scotland, there was variation in implementation of the priority pathways and a lack of clear direction:

School Nursing needs more clear direction. Guidance, pathways, and support to develop standardised practice and training instead of trying to be everything for all needs for school age children. (SN16)

One respondent indicated that they felt strongly that there should be consistency in the roll out of the pathway, similar to the Health Visiting Universal Pathway:

I also feel very strongly that we should all be doing the same thing rather than each HSCP choosing which pathways they deliver on, who delivers it and how it is delivered. We need to be in line with HVs and all be doing the same pathways. (SN53)

It was evident from the responses that the implementation of the SN Pathway was at different stages across Scotland, leading to inconsistencies. There was also a sense that they wanted more guidance on the pathways and the resources to use. It was of interest that some wanted a pathway similar to the HV Universal Pathway (Scottish Government 2015c) to standardise their practice.

5.3.3 Theme 3: Educational preparation and training in mental health

5.3.3.1 Subtheme: Perceptions of educational preparation

There were a variety of views on educational preparation for SN mental health work. Several respondents reported that they did not feel well prepared for the level of intervention they required to deliver:

I feel very unprepared for this pathway. We receive ad hoc standalone training via study days but receiving more referrals in this area as CAMHS seeing children with more severe mental health issues. (SN41)

Moreover, some indicated that there was a lack of content on emotional/mental health and wellbeing within their postgraduate school nursing programmes:

Having just completed the SCPHN-SN qualification I believe there should have been more on emotional/mental health and wellbeing. (SN60)

Similarly, some respondents suggested that the training they had received in emotional and mental health did not adequately prepare them for their mental health work in supporting primary-school-aged children:

... the type of training that has been provided is more suitable when working with adolescents. There has been little training or resources that can be used when working with a younger child. (SN70)

One respondent commented that they felt more equipped than some of their colleagues to support primary-school-aged children's mental health because they had a mental health background:

I do feel more than equipped to support primary age children's mental health and wellbeing. I do know my school nursing colleagues who do not have a mental health background do not feel equipped to do this, it's such a huge part of the job now ... (SN77)

Overall, there were mixed views on their educational preparation and training for their mental health work. Issues were associated with lack of content on mental health within SN programmes and limited training on interventions and resources to use with primary-school-aged children.

5.3.3.2 Subtheme: Access to mental health training

Respondents suggested that they were provided with opportunities to attend mental health training. A large proportion indicated that they had attended LIAM (Let's Introduce Anxiety Management) training, whilst others indicated that they were waiting to attend that training. Scotland's Mental Health First Aid and ASSIST training were identified as the most frequently attended training programmes. Some reported that they had received informal training from peers (colleagues who had worked in CAMHS). One respondent highlighted that they would have preferred if the training sessions had been attended by education staff:

It would be better if these awareness days were mixed alongside education staff, as they are the key people who identify concerns to school nursing team. (SN4)

However, for some, although there were lots of training opportunities, workload demands, cost and lack of cover meant they could not attend, especially for those who worked part-time. Some respondents referred to synchronous online training, highlighting that it is not always available and not always effective:

National training events can be difficult to attend due to cost and time for travel. Video conferencing is not always available for training events, if training events include workshops/group work it doesn't work. (SN36)

Another barrier to accessing training was linked to resources, which meant that some services were unable to deliver training. For instance, one respondent commented in relation to LIAM training:

... trainers within area, refuse to roll out the training at present to school nurses despite requests for this specific training. (SN29)

Thus, although training opportunities were available for SNs, and many of the respondents had attended mental health training, there were a variety of barriers that impacted on the uptake of training.

5.3.3.3 Subtheme: Lack of training targeted at primary-school-aged children's mental health

A significant finding was a gap in training targeted at primary-school-aged children with one respondent describing it as a 'huge gap' (SN7). Several respondents commented that most of the training was focused on teenagers, although some acknowledged that it could be adapted. There was also a demand for training for supporting younger children:

I have received training in relation to emotional and mental health-LIAM, Mental Health First Aid for Young People, Self-harm. All seem to focus on older children but can be adapted in Primary settings. Training specifically for early years would be useful. (SN17)

Training in practical interventions was highlighted as a gap in practice, with one respondent commenting:

There is a severe lack of training in practical interventions to be used in school health. (SN9)

Some respondents also indicated that they would like more training in the identification and support of children with mental health problems:

I feel more training on identification and support would be good. (SN36)

Despite the availability of mental health training, respondents expressed a need for training that was based on practical interventions they could use to support the needs of CYP. They also wanted specific training tailored to identify and support primary-school-aged children's mental health as they felt this was a gap.

5.4 Summary

This chapter has presented the quantitative results and the free-text (qualitative) findings from Phase One. The responses to the online questionnaire have identified that the sample comprised an experienced workforce with an average age range of 45–54 years. There was representation from each Health Board area across Scotland, but, in relation to the diversity of the workforce, only one of the participants was a man and all described their ethnicity as white. However, this is representative of the gender ratio and the proportion of those who identify as white working in the health service (Scottish Government 2023c). There was evidence indicating that the numbers of SNs in Scotland were increasing, and over a third of the participants indicated that they were currently studying at Master's level. Despite this, only 16.8% of respondents were registered SCPHN-SNs and, in some Boards, the title SN was not confined to those who had completed a SCPHN-SN programme.

The respondents recognised their role in the identification and support of primary-school-aged children's mental health and the importance of early intervention. Building and sustaining effective relationships with other professionals and the children and families was viewed as being essential. However, some respondents highlighted that this could take time and was reliant on the effectiveness of communication with other professionals and an understanding of each other's role and responsibilities. Others indicated that

having limited time to spend with children made it challenging to build relationships with them, and this was a source of frustration.

A variety of interventions were used by respondents with parenting support, home visits and the Solihull approach being the three main interventions used. Some used the LIAM programme if they had received training in this intervention.

Workload capacity, lack of resources and training, specifically those focused on primary-school-aged children's mental health, were cited as barriers to the identification and provision of support. A further barrier was a lack of knowledge and understanding of the SN role, with many suggesting that parents and children are unaware that there are SNs. This is perhaps not surprising, given that the study highlighted variation in the implementation of the SN pathway across Scotland, with some respondents indicating that the mental health aspect of their work lacks clarity.

The findings from Phase Two will now be presented in Chapter Six.

Chapter Six: Phase Two Findings

Introduction

This chapter presents the findings from the Phase Two qualitative study, which addressed the three research questions:

1. How do children, parents, teachers, and SNs currently experience and understand the work of the SN in supporting primary-school-aged children's mental health?
2. What factors influence their experiences and understanding?
3. How do their experiences and understanding inform the future work of the SN in supporting primary-school-aged children's mental health from an ecological and strengths perspective?

The Phase Two findings comprise the accounts of SNs, teachers, primary-school-aged children, and parents. In addition, photographs of some of the Talking Mats™ made with the children to support them to share their views are included. An interview topic guide, comprising open questions, was used to ask participants about their experiences and understanding of the SN and how they support school-aged children's mental health. Their views of what is required to inform the future work of the SN to better meet the mental health needs of school-aged children was sought. As the existing literature highlights, little is known about primary-school-aged children's experience and understanding of the SN and how they can support their mental health. Therefore, to appropriately support them, it was essential to know how they account for this experience. As outlined in Chapter Four, three key themes and several subthemes were identified (Table 6.1). The importance of relationships between the SN and school-aged children, parents, and teachers and between children, parents and teachers was a thread running throughout the interviews. Added to this was my role as researcher and the role of the head teacher as a gatekeeper to accessing support from the SN. These are both explored in this chapter within the relevant theme and subtheme.

Table 6.1: Phase Two: themes and subthemes

Themes	Subthemes
Theme 1: Understanding of mental health and the issues impacting primary-school-aged children	Mental health, self-care, and the wider world Children's Worries
Theme 2: SNs' mental health practice	Relationship-centred practice Holistic perspective SN interventions
Theme 3: Barriers to accessing mental health support from SNs	Lack of awareness of the SN role and remit Gatekeeping role of schools Workload capacity

As with Chapter Five, the findings are situated within the PPCT Model (Bronfenbrenner 1995). Figure 6.1 illustrates which themes link to the components of the PPCT Model. To facilitate a logical flow of the narrative, the findings are presented beginning with *Time*, as this had an impact on all three themes. This is then followed by *Person, Process, and Context* and their associated themes and subthemes. Verbatim quotations are used to illustrate the accounts of the participants. In relation to the children, some photographs of their completed Talking Mats™ are also used to illustrate their responses. Regarding the identification of the persons referred to in the quotations and photographs:

- 'I' represents the interviewer, SN is a SN (SN1, SN one, SN2, SN two); P is parent (P1, parent one, P2, parent two); C is child (C1, child one, C2, child 2); T is teacher (T1, teacher one, T2, teacher two).
- 'TM' represents Talking Mat™

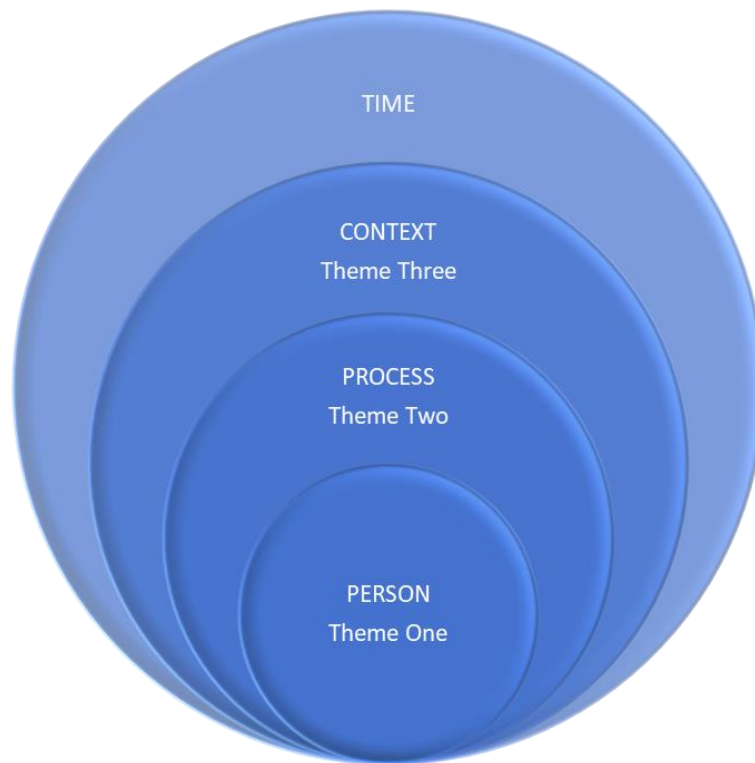


Figure 6.1. Phase Two: PPCT Model linked to themes

6.1 Time

The data for Phase Two were collected during the COVID-19 pandemic when there were restrictions on access to schools by SNs, parents, and other visitors, including researchers. Scotland and the rest of the UK went into lockdown on 23 March 2020, and schools were closed for all children, apart from those who were identified as vulnerable and children of key workers. Teaching for most children was delivered remotely and online. Interviews with the SNs took place online in August 2020, when schools had just reopened. Scotland went back into lockdown on the 5 January 2021, and schools were again closed to children, apart from those identified as vulnerable and children of key workers. Schools reopened again to all primary-school-aged children on the 15th of March 2021 (Audit Scotland 2023). The interviews with teachers, primary-school-aged children and parents took place online between April and July 2021.

6.2 Person

6.2.1 Demographics

6.2.1.1 School-aged children

Eight children aged 9–11 years participated in my study, five boys and three girls. Seven of the children were white and one child was Asian. Two children were siblings. One child indicated that they were on the autistic spectrum, and this was confirmed by their parent. The youngest child was 9 years old and the oldest 11 years. The mean age was 10 years. The children attended local authority primary schools in one health board area in Scotland. The schools were in Scottish Index of Multiple Deprivation Index (SIMD) area Deciles 5 to 9, and Quintiles 3 to 5. The mean decile was 7 and the mean quintile was 4. Thus, these schools were in the 10% least deprived areas within the local authority areas.

My decision to include children in this age group was based on two reasons. First, research seeking the views of school-aged children on the role of the SN in the UK has tended to focus on children in secondary schools aged 12–15 years (British Youth Council 2011; Booth 2015). Second, middle childhood (children aged between six and twelve years) is a crucial time in an individual's lifespan as it is a period where there is significant developmental change (Del Giudice 2014, 2015). During this stage, the cognitive abilities of children become more advanced, particularly their abstract thinking and problem-solving skills (Mah and Ford-Jones 2012; Blume 2014). Children also develop the ability to reason with their peers and adults and they also develop the capacity to reflect and to view things from a different perspective during this stage (Eccles 1999). I considered it essential to obtain their experiences and understanding of the SN and their views on how SNs could provide support as they would provide valuable insights and add to the evidence base.

6.2.1.2 Parents

The parent participants included six mothers and one father. Seven of the parents were white and one was Asian. All the parents were in employment. One parent disclosed that their child was on the autistic spectrum. Their children

attended local authority primary schools in one health board area in Scotland in the SIMD areas outlined in 6.2.1.1.

6.2.1.3 Teachers

There were two qualified teachers, one woman and one man, both white. One teacher had completed the Postgraduate Certificate in Education and had 10 years' experience working as a teacher. The other had completed the Initial Teacher Education qualification and had 23 years' experience. One was currently undertaking further study. Both were employed full-time and had experience of working in different health board and local authority areas. One teacher was a deputy head teacher at a local authority primary school in SIMD area Decile 3, Quintile 2. The other was a principal teacher at a local authority primary school in SIMD area Decile 1, Quintile 1. These schools were both situated in the same local authority area and were in the 10% most deprived areas within that local authority area.

6.2.1.4 SNs

Five of the SNs were women and one was a man, and all were white. One was a SN Team Leader and Clinical Teacher. They were all employed full-time in one health board area which provides school nursing services across three local authority areas. Three covered primary and secondary schools in one of the local authority areas, of which 15% of the residents live in the 20% most deprived areas in Scotland (SIMD 2020). Two covered schools in a local authority area where 12% of the residents live in the 20% most deprived areas in Scotland (SIMD 2020). All the SNs were registered SCPHN-SN, and one was also a registered SCPHN-HV. Two had completed Community Practice Teacher SCQF Level 11 modules, and only one was supervising and assessing SCPHN-SN students at the time of interview. Five had completed the Postgraduate Diploma in School Nursing between 2016 and 2020, whilst one had completed their school nursing qualification at bachelor's degree level in 2000. Two had completed postgraduate study in child welfare and protection. None of the SNs were currently undertaking further study to complete their Master's degree. The length of time working in the SN service ranged between two and twenty years, while the length of time in post as a qualified SN ranged from one to twenty years.

6.2.2 Theme One: Understanding of mental health and the issues impacting primary-school-aged children

One of the themes identified during the interviews with the participants was their understanding of mental health and the issues that impact on the mental health of primary-school-aged children. Theme One explains participants' understanding of mental health and the predominant perspective that it is viewed in the context of an individual's interaction with their wider world. Added to this, it also explains the participants' perspectives of the issues that primary-school-aged children worry about.

6.2.2.1 Subtheme: Mental health, self-care, and their wider world

To explore how participants experience and understand the work of the SN in supporting primary-school-aged children's mental health it was essential to explore their understanding of mental health and the language they use to describe it. Overall, participants had a clear understanding of the term 'mental health' and most accounts referred to thoughts and feelings and how they affected an individual's wellbeing. There was an awareness that everyone has a state of mental health and that a range of factors can impact on it. In addition, there was recognition from the adults that I interviewed that there was a need to reduce the stigma associated with mental health. This was illustrated in the account from one parent who talked passionately about the need for education to help children to understand their emotions and to normalise them:

I think developing something that teaches children the understanding of mental health would remove that stigma ... a little more information on that side of things could have been a little bit more, that is why I think and feel this way. This is normal or maybe this is not normal and maybe I should actually talk to somebody about this. (P4)

Similarly, the SNs also raised the need to have conversations with children and with parents to educate them about mental health and to normalise emotions such as anxiety. For example, one SN commented:

Everybody has to learn that actually being anxious is a normal thing at times and can be helpful. It's not always, but it doesn't mean that there's something wrong. (SN4)

Except for one child who was very shy and hesitant in responding to interview questions, the children clearly articulated their understanding of the term 'mental health'. When asked what it meant, their accounts included 'how you feel', being 'happy', and 'how your brain reacts':

Like how you feel, like how your brain reacts to something. (C4)

One child indicated an awareness that mental health was more than just about how you feel, but also about an individual's interaction with their environment:

So, like what goes on in your head when what's going on outside. (C3)

Whilst another child described the importance of self-care to maintain health:

It means like you gotta keep healthy and it is like, so you do it like, sometimes you gotta take some time for yourself so that you are not working all the time. (C8)

In relation to the parents and teachers, for some, mental health was viewed as being on a continuum, where health could vary:

Like we all have mental health and, on a continuum, like it can be good sometimes and poor at other times, you know. (P7)

For others, it involved emotional health and wellbeing but not physical health. For one parent, whilst they understood mental health as a broad concept, their understanding tended to focus on mental health conditions:

It could be anything from something I would say simple because I myself have ADHD. It could be something as simple as that, and it could go straight bipolar, schizophrenia. (P4)

However, the commonly held view was that mental health involved being able to cope with and manage their thoughts, feelings, and emotions and keep them in

balance. This fits with what I was hearing from the SNs in relation to the importance of being able to regulate one's emotions. Moreover, one of the teachers indicated that emotional regulation is important to enable people to participate actively in the world:

... not everybody can be happy all the time, but that you can regulate and manage your emotions and keep yourself on a balance that allows you to be an active participant in the world. (T2)

In addition to emotional regulation, the importance of self-care and the need to care for the brain to be able to function and learn was viewed as being essential by parents and teachers. It is notable that the following account from one of the teachers is very similar to the account of Child Eight above and serves to illustrate how articulate the children were in expressing their views:

... looking, keeping care of your own self, and your brain basically how you function, because without it you know, you are not going to be able to learn ... (T1)

It is acknowledged that our beliefs and understanding of the concept of 'health' change over time and are socially constructed (Naidoo and Wills 2016). The concept of time within the context of an individuals' journey across the life course was highlighted as a factor that influenced participants' perspectives of mental health. For example, one of the parents explained that their understanding of mental health had changed over time:

... mental health is coping and how you are in yourself. If you said mental health when I was younger, you'd think that someone was ill. But mental health to me is actually, it's how, it's like it's your wellbeing. And it's not just your physical, it is in your head and how you are with your thoughts and your feelings, is where mental health is for me. (P5)

Similarly, one of the SNs reflected on her experience of school nursing in the 1990s where the focus was on promoting physical health. She indicated that within society there had been a move towards a greater focus on promoting

children's mental health and that this was reflected within the refocused SN Pathway:

I can look back and draw parallels between school nursing in the nineties and where we are now. And it is a refocus on the mental health rather than only on the physical health ... we have moved forward in society and there has been a focus on children and young people's mental health. (SN6)

The societal shift that this SN refers to was evident within the participant accounts. It was clear that there was an awareness and understanding of the concept of mental health amongst all participants. Moreover, parents, teachers and SNs indicated that there was a need to intervene early to educate children and people about mental health.

6.2.2.2 Subtheme: Children's worries

During the interviews with the SNs, teachers, and parents, in their experience, the main issue that children presented with was 'anxiety'. The reasons they suggested for children's anxiety were very broad and ranged from anxiety about friendships and bullying to anxiety about going to school and the transition from primary to secondary school. The COVID-19 pandemic was linked to children's anxiety about moving to secondary schools because the lockdown restrictions and school closures had impacted on the social interaction of children. In addition, as the transition days had taken place online, the children had missed out on opportunities to visit the secondary school and to meet their new teachers and peers face-to-face. This perception is illustrated well in the following comment:

They are anxious about the period of transition, that has been quite difficult because they have missed that transition time where they are going up and seeing high school or meeting new people. So that has all kind of been lost for that year group. (SN6)

However, in contrast, SNs mentioned that some of the children they had been working with before the pandemic became less anxious and worried and presented as being happier during the lockdown:

In lockdown, a lot of the children that I was working with who were anxious were living their best life. They were having a great time. They weren't anxious, they weren't worried. They were happy, they were, you know, and you've got to ask yourself what are we doing that makes these children so anxious in their normal day-to-day life that they are happier in a global pandemic? (SN4)

The interview with this SN remains vivid in my memory as she talked about a conversation that she had had with a teenager during the pandemic. During that conversation, the teenager had indicated that the lockdown restrictions had provided him with space and time to reflect:

He had said 'I feel like the world is on hold and it's allowed me time to breathe'. And I thought wow, that's really powerful. (SN4)

Anecdotally, this was a feeling expressed by many people during the pandemic, although it is acknowledged that this was not the experience for everyone. Nonetheless, it does serve to highlight the importance of place and time and how they can positively and negatively influence a person's mental health and emotional wellbeing. Furthermore, this teenager's comment implies that school and the fast pace of everyday life are factors that impact on children's mental health. There was a strong feeling from parents, teachers, and SNs that parental anxiety was often at the root of children's anxiety. For example, one of the parents commented:

Parents I feel are often overly anxious about their children's wellbeing and often read into stuff that isn't there. (P1)

One of the SNs also commented that, following a closer assessment of the situation, the child is often not anxious:

Everything is about anxiety and actually when you dig a bit deeper, and ask a few more questions, a lot of the time they are not anxious at all, it is the parents who are anxious in my experience. (SN2)

The impact of the lockdown on children's relationships with their peers was viewed as a problem by parents. Parents mentioned that their child had found the social isolation from their friends more difficult to cope with than adjusting to the online and remote learning environment. For example, one parent commented:

Not getting to see their friends when there was lockdown. They weren't at school, you know, so not getting to see their friends, more the kind of social aspect we found, not so much the classwork and the work they had to do at home. But it was kind of losing the connection with their friends. (P7)

Children were asked about 'worries' as this is the language that the SNs in the Advisory Group advised me to use when interviewing the children. Additionally, I used the phrases 'butterflies in your tummy' and a 'fuzzy feeling in your head' to explain to the children what a worry might feel like. Again, these were phrases that the SNs suggested that I should use. But these were also phrases that I heard the teachers using to explain how children with anxiety might describe their feelings. For example, one teacher commented:

They don't know how to name it. So, it's like, 'I've got butterflies', and what I have noticed is that a lot of the ones who have anxiety say is, 'I am hungry'. (T1)

Exploring the worries that the children might have or that they thought children their age might have was challenging. There were three main reasons for this. Firstly, I had not had an opportunity to meet the children before the interviews. Secondly, because the interviews had to take place online due to the lockdown restrictions, it was not possible to use all the interactive tools that I had planned. Thirdly, conducting the interviews on MS Teams was challenging due to the physical barrier, which made it more difficult to establish a rapport with the children. It is acknowledged that knowing someone and being able to trust them

is important to children when they consider asking for help (Woodhouse et al. 2016). This may have impacted on their willingness to divulge information during the interviews. Added to this, I also felt that some of the children thought that I was testing them, which made some appear reluctant to offer a response to some questions. For example, one child frequently responded, 'I don't really know'. During the interview with this child's parent, the parent indicated that the child often became anxious if unsure about something or did not understand it:

He is one of those characters where he looks all confident, but he does get anxious about certain things. He gets anxious if he doesn't understand something he is asked to do. (P2)

Nonetheless, with some probing and the use of a picture-supported conversation approach using the picture symbols from Talking Mats™ and my Worry Monster (Figure 6.2), it was possible to explore the children's worries and support them to talk about them.



Figure 6.2: Worry Monster

I found it helpful to ask the children to think of five worries that a child their age might have and that they would want to post into the Worry Monster. The children expressed worries about a variety of different things, including their appearance, making friends, attending activities and clubs, trying new things, money, talking

and making choices and social media. An example of a picture-supported activity for Child 8 can be found in Figure 6.3. The child was given time to look at a selection of picture symbols from the Consulting Children and Young People Primary Ages 7 to 12 Talking Mat™ (Mackay and Matthews 2019). When he selected one, I would move it up to the top of the mat. He suggested making friends because he thought that some children might have different interests and different 'talking skills' which could make it difficult for them to make friend. Social media is at the bottom of the mat as it was not something that he worried about, but something that he thought would be a worry for lots of his friends. Covid was added to the board as I asked him if COVID-19 might be a worry for children his age, and he thought that some of his friends might worry about it because they think it will not end, or they might get it, or it might be a risk to their family.

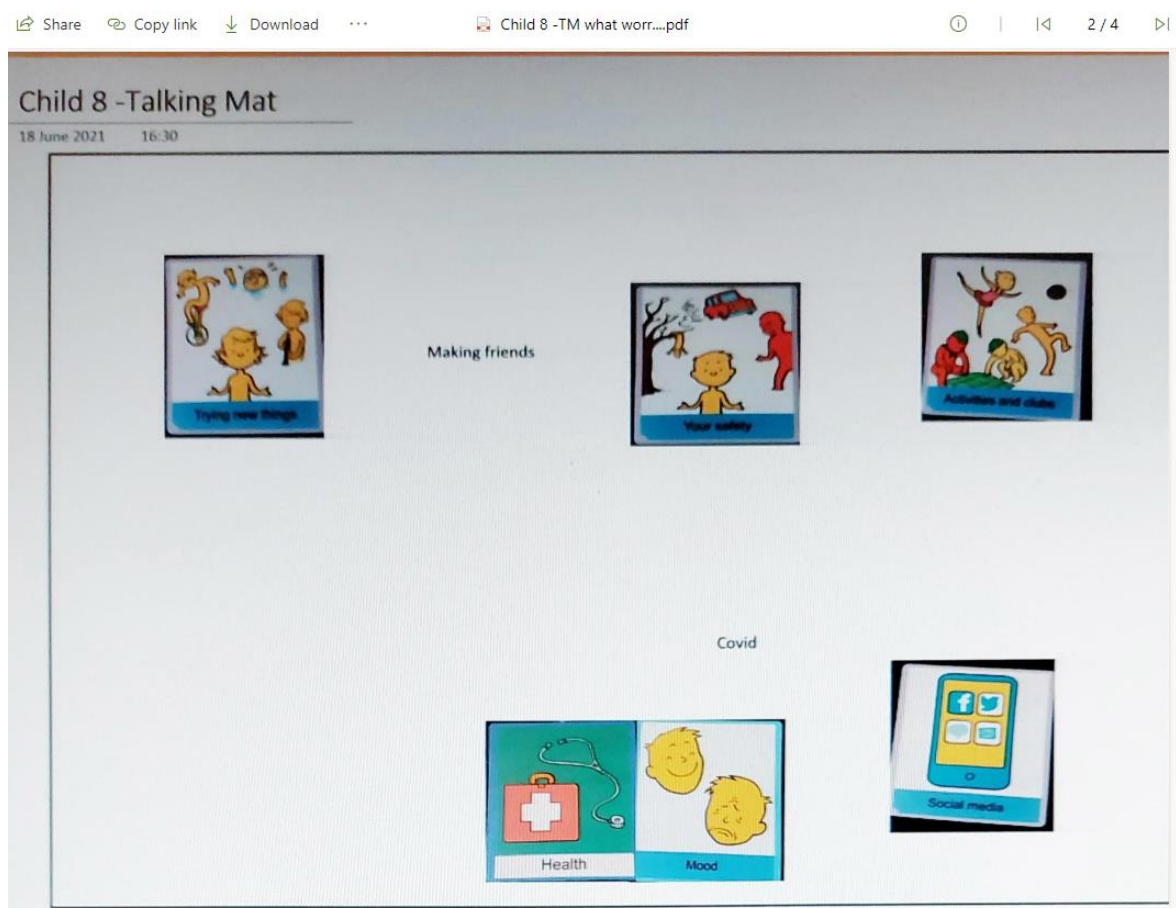


Figure 6.3: Child 8 TM: What worries would a child your age like help with?

There was no difference between the girls' and boys' perspectives of the importance of their appearance. Both referred to the way you look as a reason why children might make fun of someone, in particular in relation to skin colour:

Recently in school people have been making fun of people for the way they look. Mostly just their hair, or if they have freckles or skin colours and stuff like that. (C4)

During one of the interviews, one child talked about their experience of social media and how they had experienced bullying due to the colour of their skin. The child explained that they had posted a photograph of themselves and had received replies telling him his face was ugly:

I use YouTube and stuff, but well I did use stuff where other people can comment. But then tons of my school friends reported me and because I had apparently posted my face which they think is ugly. (C3)

This was a very powerful interview and this child's account made me feel upset and ashamed that he was made to feel this way within Scotland, which is meant to be the best place in the world to grow up. Despite anti-bullying guidance intended to address prejudice-based bullying (Scottish Government 2017b), these accounts highlight that racial prejudice persists in Scottish primary schools and impact on children's mental health.

Worries about attending activities and clubs and trying new things were also linked to the children's anxiety about being watched by others. The children expressed worries about being made fun of by their peers if they did not perform well and about receiving negative feedback intended to hurt their feelings. These views are illustrated well in the following comment:

I do a lot of gymnastic competitions, and I am worried that I'm gonna mess up really bad. I normally do better when I'm not at a competition, cause I'm like scared cause there's so many people there watching me, and when I go to like the clubs at schools and things. Like I think that is gonna, people are gonna be really mean. (C6)

Similarly, the children expressed worries about talking in class and these were associated with their relationships with others. How the teacher made them feel was mentioned as an issue they worried about. There was anxiety expressed about being put on the spot by the teacher and not feeling prepared to provide the correct answer, as illustrated in this comment:

Well, normally the teacher puts us on the spot, it makes everybody really nervous. (C6)

However, for others, worries about talking were related to their relationships with their peers, the behaviour of other children and being able to express their thoughts and opinions. One child indicated that it could be difficult for some children to talk as other children talked too much:

Usually, people have like struggled talking with people outside. They struggle to talk because usually they can't get a word in. (C5)

The children also expressed some worries about their behaviour and the behaviour of others and how this could affect the choices they made. There was an awareness that the behaviour of some children may be caused by neurodiverse conditions such as autism and attention deficit hyperactivity disorder:

Because like they could have autism or something and people can make fun of you. (C1)

One child indicated that behaviour could be used by children to seek attention, and that making a choice to choose the correct behaviour could be difficult:

... like some people want attention. That's why they do bad stuff in school, so they're like should I do the right thing, or should I do the wrong thing for attention? So, I think that might be hard for them making the choice. (C3)

Despite the media coverage of the pandemic during the fieldwork, in contrast to their parents, the teachers and the SNs, the children did not raise COVID-19 as an issue that they were worried about. However, when I asked them specifically

about the pandemic, most of the children expressed worries that life might not go back to normal. There were concerns that they might not see their friends or family, and one child was worried that they could die:

I: *Have you worried at all about coronavirus?*

C7: *Yeah*

I: *What made you worry about coronavirus?*

C7: *If one of my family or friends get it and then em, then I might not be able to see them, or they could die.*

In contrast, one of the children expressed frustration and boredom about the pandemic and indicated that the daily media coverage of the pandemic was unhelpful as it made her feel worried:

One thing that didn't help was that we had to watch Newsround every day that it was on, and it would always go on about coronavirus which did not help. So, that's one of the things that is very very annoying about COVID. Em, 'cause that makes you worry about it a lot 'cause it is like, there is another outbreak. That is very very boring. (C5)

Similar to the accounts of some parents, several of the children referred to missing out on activities due to the pandemic. One child talked about missing out on a school trip to an outdoor centre and not being able to support children in primary one as a buddy:

Everybody in my class is sad because we miss, because we have to miss like Dalguise and everything ... and we didn't get little buddies either. And everybody was like really, really excited to get buddies. And everybody's like, we should have gotten put in a bubble with the P1s and things. (C6)

In addition to worries about the loss of connections with relatives and friends due to not being able to see them if they were ill or if they had died, the youngest child I interviewed also talked about being worried that he might be kidnapped. I

was unsure that I had heard him correctly and asked him to clarify, and he confirmed that this is what he had meant. When I explored why he was worried about being kidnapped, he explained that he was worried about being taken away from his family:

Just 'cause you really don't want to be taken away from my family and friends. (C7)

Although this is the account of one child, it summarises what I heard during the interviews with all participants, that relationships with family, friends, peers, and teachers are important to children. It also supports the view of the SNs and teachers that anxiety is one of the main issues that impacts on children's mental health. In addition, the views of the parents, teachers and SNs regarding what children worry about were broadly similar to the worries expressed by the children. Where they differed was that some of the children expressed worries about racial prejudice linked to appearance. There were also concerns about how they are perceived by others, especially by their peers and teachers, which can make them feel nervous and anxious.

6.3 Process

As outlined in Chapter Two (Section 2.1.1), this component of Bronfenbrenner's (1995) PPCT Model refers to the quality of interactions between people of interest and how this influences their outcomes (Bronfenbrenner 2005). One of the emergent themes from the Phase Two findings was the influence that the mental health practice of SNs can have on supporting primary-school-aged children's mental health.

6.3.1 Theme Two: SNs' mental health practice

During the analytical process, there were three recurring factors pertaining to the mental health work of the SN. The first related to the importance of relationships between the SN, children, parents and teachers and the characteristics required for effective relationship building. The second related to the importance of taking a holistic perspective, and the third related to interventions used by SNs to support children's mental health. These three factors are fundamental to SCPHN

SN practice and combined to form the theme SNs' Mental Health Practice and the three subthemes.

6.3.1.1 Subtheme: Relationship-centred practice

During the interviews, as highlighted in Theme One, it was evident from all the participant interviews that building and sustaining relationships with people is important for good mental health. This is reflective of the comments made by SNs in the Phase One study (see Chapter Five, Section 5.3.1.2). It is recognised within Scottish policy, for instance, GIRFEC, that relationship-based practice is essential for working effectively with CYP and their families (Scottish Government 2022a). Moreover, within the literature, albeit that relating to social work, relationship-based practice is associated with improved outcomes for CYP and families (Trevithick 2003; Ingram and Smith 2018). The decision to name this subtheme relationship-centred practice in preference to relationship-based practice was because relationships were at the centre of participant accounts.

The interviews with the children identified that they placed great importance on the establishment of trusting relationships. All of the children highlighted that they would expect to know the SN and feel able to trust them before they would feel comfortable sharing their worries with them:

I say if I knew them from my P1 then I could tell them now because I've known them for so long. If they just came in today and I had no idea who they were, I wouldn't really want to tell them because I don't know who they are and their personality and things. (C6)

It was also important for the children to feel that their views were being listened to and that the person was able to empathise with the child:

Listening to every word they say and actually thinking like how they would feel in the same spot as who they are listening to. (C3)

This child also highlighted the importance of the listener being able to act on the concerns raised and being objective as he talked about an experience where he had not felt listened to and his concerns acted upon:

And can do something about it cause em, because when I was younger, just to tell them, because I got blamed, even though I didn't do anything.
(C3)

Reflecting on the interview with this child led me to wonder if it was possible that he did not feel listened to and supported within school because of racial prejudice. It was evident from his accounts that he experienced racial prejudice from his peers. Additionally, he did not have a good relationship with his teacher, which was illustrated in his comment about being blamed for something that he did not do. It is not possible to say that his teacher was prejudiced. However, the findings of Kennelly and Mouroutsou's (2020, p. 1) qualitative study of five students "*of colour*" from a secondary school in Scotland do suggest that discrimination and bias against children from different ethnic backgrounds exists in Scottish schools.

Relationships with family and friends were important to the children in this study. Similar to the findings of Woodhouse et al. (2016), in response to being asked: "If you had a worry, is there anybody that you would tell?", most of the children told me that they would tell their family first, followed by friends, and some children indicated that they would tell a teacher:

Em family probably would be one of them and then teachers as well. (C2)

Some of the children also told me that they would talk to their pet, as illustrated in the picture-supported conversation with Child 5 (Figure 6.4).

Talking Mat: Child 5

23 April 2021 16:00

If you had a worry who would you tell?

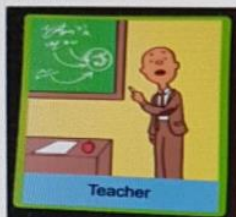


Figure 6.4: Child 5 TM: If you had a worry who would you tell?

Yet, in contrast to the findings of Woodhouse et al. (2016), the children did not indicate the SN as someone they would tell, and one child commented:

I personally wouldn't tell the SN. (C6)

When I explored this with this child, it was evident that the reasons why she would not tell the SN is because she had not met the SN and would not confide in someone who she did not know or have a relationship with. Similarly, Chase et al. (2010) found that children in their study expressed the need to know the SN and to feel comfortable with them before confiding in them. So, if the SN is not known to children and visible within schools, it is understandable that children would not contact and reach out to them. Building a trusting relationship needs time and, crucially, it needs people to be known to one another.

One of the children demonstrated agency and clear decision-making skills as she made associations between the reason for her worry and the person she might tell. She provided an example to explain her views:

Well, it would depend on what worry it would be. If it was a specific one, like if it is like to with work, and maybe if I was falling behind or struggling, then I would definitely tell the teacher. If it was an actual worry, then I would probably tell my friends. (C5)

When I asked this child if she would talk to her parents about any worries that she might have, she indicated that she would not because she does not have worries when she is at home:

I don't really tell them worries, because when I get home, I don't have any worries. (C5)

During the interview, I remember feeling surprised that this child would not talk to her parents about her worries, as most of the other children had indicated that they would speak to their family first. However, on reflection and considering how mature this child was in her responses to my questions, it should not have come as a surprise, as this study found, in line with Kerns and Abtahi (2017), that children's relationships change during middle childhood and attachments to friends become stronger. Moreover, this child's account indicated that she felt safe and secure in her home environment.

During the interviews with the parents, relationships between children and their family and with people in the school were identified as being important. The parents talked about the skills and attributes that they felt were important to support children to open up and discuss their worries. For most parents, being approachable was one of the key attributes that they felt was important for building relationships:

So, within the learning environment, I would like to think that there would be someone who the children would feel would be approachable, whether that is a nurse or a teacher. (P4)

Parents indicated that they would like to think that their child would speak to them first about a worry, whilst also cognisant that they may wish to speak to someone else instead:

I do like to think they would tell us. I think we have tried to be very open in terms of approachable and all the rest of that. But equally, you know we are not necessarily at the top of their list, and they may not want to tell us because they might think we would be disappointed or whatever.
(P1)

Similar to the children, the parents indicated that trust was important. One parent highlighted that being open and honest with children is fundamental in supporting children to share their worries with their parents and with others:

... she was thankful that I had done it the way it was handled, so we didn't, she didn't lose trust in me. And that is one thing that I don't want to do was to lose trust, because then she won't speak to anybody. (P5)

Another parent suggested that if the SN was present more often in the school that would provide the children with opportunities to build up a trusting relationship with them:

Being there more often so that the kids know who the nurse is, and like the same nurse being there instead of different so that they can kind of build up a relationship of trust, a trusting relationship that they feel they could go and speak to the nurse about any concerns. (P7)

Other attributes that the parents indicated were important for building relationships included being friendly, warm, accessible, a good listener and creating an environment where the child feels safe. These are qualities that Bidmead et al. (2016) identified were important to parents and health visitors in their study exploring the health visitors' contribution to the parent/health visitor relationship. Likewise, the SNs in this study referred to these qualities, but they also indicated that it was important to be kind:

And you must be really kind, and you can use all of that, and I think it just makes them feel more comfortable. (SN1)

SNs suggested that sharing some personal information can help to build and foster relationships with children and parents. For example, one SN commented:

There is certainly an amount of personal information that you can share that can help to foster a relationship positively, and I have done that previously. (SN5)

Similar to the accounts of the children who indicated that they need to know the SN to feel able to trust them and share their worries, this was the dominant view expressed by the SNs:

It is whoever they have got a relationship with. Whoever, can relate to a child, is where they will go to speak to and that can be anybody ... They need the relationship, the relationship needs to be there. There needs to be a hook, so that you feel you can speak to a person. (SN6)

This perspective was also reflected in an account of another SN, who talked about the importance of being able to talk to parents and children at the right level. However, she did not relate this to her role; instead she referred to the support workers in schools who she felt knew the parents well:

They are the ones who know the parents really, well, who can speak to the parents on a level that they're comfortable with. (SN4)

Although the SNs talked passionately about the importance of building relationships with school-aged children to support their mental health, there was some frustration expressed that they had little opportunity to do that:

I think personally that I should be sitting in a school to be able to build up these relationships with the children and be able to work with them and actually support them where it is needed. But that is not how it is. I spend my whole time as a nurse sitting at a desk. (SN2)

In addition to building relationships with children and parents, the SNs also talked about the importance of building relationships with other professionals, teachers, and schools. It was evident from their accounts that they perceived it as their responsibility to make connections with schools and other agencies to make them aware of their role:

... it's about the relationships, we maybe have with teachers and staff, and that's all down to the individual, like myself I make sure that I build relationships with the schools, so that they know who I am, and the social workers, I am always on the other end of the phone. (SN2)

The experiences of the SNs reflect some of the responses in Phase One with respect to their views on their relationships with other agencies (Section 5.3.1.2). The implication is that SNs need to invest time and effort to nurture effective working relationships.

During the interviews with the teachers, it was apparent from their accounts that the SNs they worked with were proactive in building and sustaining relationships. For example, one of the teachers made the following comment:

To make sure that you know, they are the best SN team that I have worked with I would say. (T1)

Similar to the accounts of the children, parents, and the SNs, the teachers indicated that building and sustaining relationships is fundamental to effectively supporting children's mental health. They highlighted that being approachable, accessible, and friendly are the key qualities required to build effective relationships. It was evident from their accounts that the knowledge that the SNs had of the community and the families and children was important for making a difference to the children's health:

It was just making a difference and you know the children were responding to the SN team, and they worked fabulously. We have a really good link with the SN team because, obviously they know, they know the area longer than I have, you know what I mean, so they know the children, they know the families. (T1)

Additionally, teamwork and open line of communication between the SN team and the school was viewed as vital for effectively supporting not only the child, but also the family:

I feel very lucky that within our school, the SN and my other NHS colleagues that we work with in our setting, that actually those lines of communication are very open and easy, and we do have a lot of things in place that support. (T2)

This teacher also suggested that parents valued the support of the SN because of the communication between them and the SN's insight into family life:

The communications between the parent and our SN, em, both are very valued by the parent because she feels very much supported by that, and also that I am part of that as well. (T2)

Human valuing is synonymous with person-centredness (McCormack et al. 2013), and it is one of the key elements that comprises a health visiting orientation to practice (Cowley et al. 2015). The participant accounts highlighted that they expect SNs to be kind and empathic and actively listen to them, all qualities associated with human valuing and person-centred approaches to practice.

6.3.1.2 Subtheme: Holistic perspective

Within nursing, holism is not a new concept, and it is recognised within several nursing theories, including Dossey's Holistic Nursing Theory, also known as the Theory of Integral Nursing (Dossey 2008). Holism in nursing refers to the whole person, taking into consideration their biological, social, psychological, and spiritual needs (Dossey 2008). The NMC (2018) expect all nurses to utilise a holistic approach to care, and all specialist community public health nurses to complete holistic health assessments (NMC 2022). During the interviews, 'holistic' was a recurring term used by SNs, parents, and teachers to describe SN practice.

In the interviews with the SNs, three approaches to their public health practice were identified. These included a holistic approach, a strengths-based approach,

and a medical or preventive approach. A holistic approach was the most widely expressed view, which reflects the findings of Phase One. The SNs indicated that they felt it is important to build the resilience of children, families and communities, as illustrated in this comment:

It is about working with the parents to support the children. So, it is all about building the resilience of a community and not just the resilience of a child. (SN2)

In addition to a holistic and strengths-based approach, the findings suggest that SNs view their practice through an ecological lens, taking into consideration not only the needs of the school-aged child and their family but also their community and the need to build and maximise community capacity.

SNs talked about their work in assessing children's mental health and the need to make a whole assessment of the child. A dominant view was the importance attached to making a holistic assessment of the child and taking into consideration the child's development, their wider world and what they need from their parents or carers. This was discussed in relation to the National Practice Model (Scottish Government 2022d) as illustrated in this comment:

I would start with a holistic health assessment really and look at using the GIRFEC assessments, the national practice model ... (SN3)

However, there was some criticism levelled at the GIRFEC assessment tools, in relation to duplication. One view indicated that they felt that there is too much emphasis on collecting information on the social factors influencing the child's health to the detriment of physical and mental health:

I feel like sometimes we almost drop a bit of focus on physical and mental health because we get drawn into the sociology side of the child which is often done from another area, social work or education. (SN5)

There were a range of strongly held views about the participation of children and parents in the assessment process. SNs who considered it important to obtain and listen to the views of children, talked about giving the child a voice:

We can do an assessment, but also, we can get the children to do their assessment too. Em, and that includes their mental health. I do use it as a framework. I use the theory behind it as well, all about giving them their own voice, about taking their own views into consideration. (SN1)

This contrasts with a more exceptional view, where the SN indicated that, although her assessment was based on information gathered from the parent and the child, they were not included, and she did not share her assessment:

We don't include the parents and I don't include the child. It's my assessment and I use the information I have gained from the parents, and I suppose the child, but it is my assessment, and it doesn't get shared. (SN2)

On further probing to uncover a little more about this SNs' assessment practice and why she said she didn't include the parents or the child, I was able to clarify that, although she completes a 'My World Triangle' with the information gathered from the child and parents, she does not ask the child to complete a self-assessment, which implies that their involvement in the assessment process is limited.

Visualisation was used by some SNs and teachers to describe the assessment of children. A common metaphor used by SNs was 'obtaining an overall picture' of each individual child. Similarly, during the interviews with the teachers, they used the metaphor of a picture, as illustrated in this comment:

It is that holistic picture of supporting a family, em to ensure that everyone's wellbeing needs, physical, emotional and so on are met. (T1)

One of the parents talked about a holistic view of their child at school:

I suppose it is that holistic view isn't it of your child at school. At the moment it feels very narrow, this is your class teacher and that's kind of it. (P2)

When I explored this with her, she explained that, within the school, the parents are informed about the support from the teacher. But they are not made aware

of any other professionals that may be able to support their child. This is discussed in Theme Three, as it linked to the gatekeeper role of schools.

6.3.1.3 Subtheme: SN interventions

To answer research question one, I sought to explore participants' experiences of SN interventions to support primary-school-aged children's mental health. I was especially interested to reveal whether their experiences reflected the results of Phase One and the extant literature.

The interviews with the children and the parents, and to some extent the teachers, revealed that there was limited knowledge and understanding of the SN role (see Section 6.4.1.1). Consequently, they were unaware of the interventions that the SN could deliver to support children's mental health. For example, two of the parents referred to interventions that had taken place in their school to support children's emotions called Emotion Work, but they were both unsure whether the SN was involved, as illustrated in this comment:

I am aware that there are initiatives in place for supporting the kids in terms of their mental health. Em, but as I say, I wasn't aware that it was a particular individual that was leading this. So, whether I am seeing the work of the SN, and the SN is behind the scenes, I don't know. (P2)

Similarly, another parent referred to the LIAM programme, but it was her understanding that it was the teachers that delivered this programme and not the SN:

One of the teachers [...] went on, em, it was called, oh LIAM, and the acronym was LIAM and it was all about mental health. So, they were doing that, but it was the teacher doing it not the nurse. (P5)

When I asked the parents how they thought the SN could help to support children's mental health, they all suggested that the SN could intervene by talking to the children about mental health and their emotions. One of the parents also suggested that the SN could provide skills-building group sessions and personal interventions for the children with the greatest need:

I don't know whether there could be any kind of mass interventions or intervention targeted for everybody. But there could be personal interventions like for very needy children or whoever has the greatest need for counselling sessions or something like that with the children. That is something that could be offered. Em, some skills, skill building sessions, so like for groups or social skills, looking at the diagnosis of the child. (P3)

Similarly, the accounts of the children also revealed that they thought that the SN could help them by talking to them and being nice, implying that communication and interpersonal skills are important, but also, that children view talking as an intervention. For example, when I asked one child how the SN could help them, he replied:

They would sit down and talk to you and ask if everything is okay and like ask if you want anything ... (C2)

In relation to the teachers, initially when I asked them whether they were aware of any interventions that the SNs use to support children's mental health, they both said no. However, it was evident during the interview with one teacher that he had observed the SN delivering interventions, but he could not name them. For example, he commented:

So, no, I can't name any specific you know interventions or what they're called, sorry. But, you know, I've seen them in action. I've seen them talking things through with children. It is very visual, I would say. A lot of visual you know to talk through and guide it, that sort of thing. (T1)

This teacher's experience of observing the SNs using visual imagery and talking interventions fits with what I was hearing and observing during the interviews with the SNs. The SNs described a 'toolbox' of interventions that included a range of resources. They became animated when talking about the interventions they used with the children. This was particularly the case in relation to the interventions where they used visual imagery. Examples included breathing exercises and guided visualisation using Maltesers, Coca-Cola bottles, and mind jars, as illustrated in this comment:

I love a bit of mindfulness, the mindful Malteser, however, it doesn't last very long (laugh). And the younger kids love a mind jar, so it's very visual, you shake it like a snow globe thing, and it's quite relaxing watching a snow globe anyway. But when you say to them about, like tell me, give me words about how your mind is, and a lot of them will say 'fizzy', my mind's fizzy. (SN1)

The SNs also talked about interventions where they walked and talked with the children to support their mental health. Similar to the parents, children and the teachers, the dominant view of SNs was the need for interventions to help children and their parents to talk about mental health and emotional wellbeing. SNs highlighted the importance of early intervention, suggesting that they should be in schools facilitating group work to educate children about their mental health:

We should be doing pieces of group work in school with young people right from an early age because then they know if we teach them ... if we teach them that literacy round and about their mental health or emotional wellbeing, then that's half the battle. So, and that we can only do that if everybody's talking about it. (SN4)

It is notable that the SNs who had worked in the school nursing service prior to the implementation of CfE indicated that it had resulted in the school nursing service handing over health promotion in schools to teachers. For example, one SN commented:

I have been in the team since 2004, so a lot of the health promotion work was done en mass. We used to do a lot of health fairs, em, parents' nights, so you know. All that kind of stuff. When Curriculum for Excellence came in, it was handed over, and we were only to be doing supplementary, targeted work. (SN1)

Opportunities to be able to socially prescribe interventions, such as art therapy and running groups, were more rarely expressed. The dominant view was that the needs of the child had to be at the centre when deciding on what intervention to offer, as illustrated in this comment:

It's going back to whatever a child needs. If that child needs to speak to you but doesn't want to speak to you in a usual format, we can either go for a walk or go out you know. (Laugh), I don't know if we would have the budget to go to golf! (SN6)

Psychoeducational interventions to help the children to talk about their feelings were mentioned consistently during the interviews. Examples included the use of a Worry Monster, such as the one I used in my interviews with the children. However, more creative examples were described. For example, one SN became animated when describing making a treasure box or a safety box with children. The child and the SN would decorate a shoebox together. The child could then put in items such as a picture of a loved one or anything that makes them feel happy. She explained that when the child was feeling overwhelmed, they could go to their safety box and take out the items that remind them of “*how amazing they are*”. It was evident from her account that she obtained a lot of job satisfaction from her work:

We have one thing I do quite a lot with them is we make treasure boxes or safety boxes. So, it's basically a shoebox and we paint and colour them in. These are the interventions that you love to do because actually the kids love them as well and this the really good part of the job. (SN4)

The SNs had received training in the LIAM programme (see Section 5.3.1.3), and some were trained to use Decider Skills (The Decider[®] Limited 2023). Both of these programmes use cognitive behaviour therapy to support children to manage and regulate their emotions and mental health. However, at the time of the study, the SNs indicated that they were not using LIAM due to staffing issues in CAMHS and not having access to supervision from a psychologist.

In addition to interventions with the children, the SNs also talked about interventions they used with the parents to help contain the parent's anxiety. All the SNs had been trained in the Solihull approach and used this to support parents to develop an understanding of their child's behaviour, although there were mixed views. For instance, one SN felt it was more relevant for use by health visitors. Despite this, the dominant view was that the approach helped

SNs to communicate and work more effectively with parents to help them to understand what behaviour is appropriate for their child's age and stage of development:

One of the biggest things I use from Solihull is having a sit down with the parents and the children and having a look at the behaviours, and the stage of development that they are at ... (SN5)

The children and the parents were looking for the SN to deliver interventions where they were available to talk and listen to the children. It is notable that the interventions that provided the SNs with the most job satisfaction were the ones where they were involved in talking and interacting in an activity with the child:

You get a lot of job satisfaction from working with kids. I've worked with the kids my whole life and it's great. And that is the best bit about the job working with kids and families and making a wee difference to them. (SN3)

Moreover, SNs also highlighted that being able to work directly with children and families to make a difference to their outcomes was a privilege. A common thread running through the participant accounts about SN interventions was the importance of the relationship between the SN, the child, and the parent.

6.4 Context

The context, as explained in Chapter Two (Section 2.1.1), refers to the wider world of the child, which includes the school and the child's home.

6.4.1 Theme Three: Barriers to accessing mental health support from SNs

The SN participants in Phase One highlighted several barriers that impacted on their role and their work supporting primary-school-aged children. Similarly, an emergent theme from Phase Two pertained to barriers that impacted on access to mental health support from SNs. Three main barriers were identified during the interviews with the SNs: children, parents, and teachers. They included a lack

of awareness of the SN role, the gatekeeping role of schools, and workload capacity. These are discussed in the following three subthemes.

6.4.1.1 Subtheme: Lack of awareness of the SN role and remit

The SNs indicated that there was a general lack of knowledge and understanding of their role and that children, parents and professionals do not know who the SN is or what they do. This perception reflects the findings from Phase One, but also confirms the findings of Woodhouse et al. (2016). One SN commented:

... there is still an element of people don't know what we do, whether it is nit nurse etc. ... (SN6)

Whilst another commented that:

... I don't even think they know we exist ... when we turn up at core groups and things and you introduce yourself as the SN, they think you are the person who sits in the school that sends the kids home when they are not well ... (SN2)

This perception fits with the findings from Phase One, but it also reflects what I was hearing from the children, parents, and teachers. The children's accounts revealed that they did not know that there was a named qualified SN for the primary school. Three of the children were adamant that their school did not have a SN. One child stated:

I am sorry because our school doesn't have a SN. (C3)

Whilst another commented:

Well, we don't have one ... (C5)

It became apparent very quickly during the interviews that the person the children thought was the SN was the first aider in the school. Most of the children described this person as someone who gave them an icepack if they hurt themselves or plasters when they had a fall in the playground:

So, my finger was really hurting, and I went to go to the SN to get an icepack. (C4)

One child talked about the 'nurse' helping a child in her class who was having an asthma attack:

... like the nurse person, they will come, cause someone, someone in my class nearly had an asthma attack one time. (C6)

When I asked the children for their thoughts on how the SN could help to support their mental health, the children were unsure, and a frequently used phrase was 'I don't really know'.

One child indicated that it would be helpful if children knew who the SN was and where to access them if they needed them:

... I think that it would be helpful if people knew that they were there and they could talk to them and things ... (C6)

This child also highlighted that it was important to know the SN as a person, to feel comfortable to share any worries:

... if I knew them from my P1 then I could like tell them now because I've known them for so long. If they just came in today and I had no idea, I wouldn't really want to tell them because I don't know their personality and things. (C6)

Similar to the children, the experience of the parents who I interviewed was that they had no knowledge that their child's school had a named qualified SN:

... I wasn't aware that there was a SN associated with the school ... (P3)

One of the parents indicated that they had always thought that the person in the school reception was the SN:

... occasionally I get a wee slip if they have bumped their head or cut themselves. I have always assumed that was the SN ... she is probably not the receptionist, but she stands at the front desk ... I have certainly not met anybody in a nurse's uniform at the school. (P1)

Whilst another indicated that their child's school did have a SN and that this person had previously been the health visitor:

... our SN is my old health visitor and the only reason why I know she is the SN is because she was stepping back from being more the health visitor and going down the SN route. (P5)

Experience of the SN as a child was more rarely expressed by parents. For parents who did recall contact with a SN when they attended school, their recollections included going to see the SN for their immunisations, and hearing and vision tests:

Probably myself as a child, just getting vaccinations, but I think that's the only time I can remember. (P7)

One parent also recalled standing in line in the classroom with her peers waiting to have her head checked for headlice by the 'nit nurse'. This parent also indicated that she had no recollection of mental health support when she attended school:

I wasn't aware of there being any mental health assistance if you like when I was a child ... but there was the nit nurse that came round in my day. (P6)

Parents lacked knowledge about the qualifications that SNs require for their job, although two parents were aware that they needed to be qualified nurses. One of these parents thought that they needed a degree in nursing and perhaps to complete further study at Master's level:

It would be a nursing degree and I think that they have to do extra, do they have to do a Master's? (P7)

This parent also indicated that she thought that the role and remit of the SN included health promotion and talks with the children in schools. However, this contrasted with the accounts from most of the other parents I interviewed who indicated that they had no knowledge of what the SN work involves. A comment made by one of the parents captures this well:

I don't really know what the SN is supposed to be doing. That doesn't even feature in any of the school communications, any of their policies or any of their newsletters or anything. (P3)

The interviews with the teachers highlighted that, in contrast to the parents and children, they did have experience of the SN. The teachers understood that the SN had a public health role, working not only with children and their families, but also with the community:

They understand the context, they understand what is going on, they get that wider picture, cause they are working in the community ... they can see you know the different issues in different settings and different zones. (T1)

Added to this, they were aware that the SN required to be a qualified nurse. But they were unclear whether SNs required to specialise and complete further qualifications as captured in this comment:

... I am just presuming that she has some! I do know that our SN is a very experienced practitioner and I do know that she has additional qualifications, I believe in paediatric nursing. But no, I don't actually know ... (T2)

This account fits with the experience of the SNs who indicated that professionals do not know that the SN is a specialist and educated to Master's level:

They don't know that we are specialist nurses. They definitely don't know that. They don't know that you're educated to Master's level ... it's hard to equate a nurse who makes a treasure box and colours in and makes a mind jar, to somebody who's highly educated ... (SN4)

Although the interviews with the teachers indicated that they had some knowledge and understanding of the SN role, their accounts highlighted that there was some lack of understanding and lack of clarity of the SN role in supporting primary-school-aged children's mental health. For instance, despite

their senior roles within their schools, they were unaware that the SN role had been refocused and that there was a SN pathway:

I have not heard of the school nursing pathway ... I think it would be for trainee nurses? (T1)

In addition to the lack of knowledge, understanding and clarity of the SN role, SNs identified the need '*to be more visible*', not only in schools, but also in the school community and on social media. The quality of the school nursing service was linked to visibility and accessibility, as illustrated in this comment:

I think for young people, if you are known, you are easy to access, and you can give a better-quality service. (SN6)

Similarly, during the interviews with the parents, teachers and children, the need to know who the SN is, what they do and how to contact them was expressed as being important. The recurrent view expressed was that, if you do not know who the SN is and have never met them, how would you be able to recognise them? This thus confirms the views of SNs that they need to be more visible and accessible if their service is to effectively contribute to supporting primary school children's mental health. When I asked parents for their thoughts on what would help parents to contact the SN, there was consensus that there should be information when children start primary school. The parents' suggestions included information packs, information in the school newsletters and the school social media platforms, a photograph of the SN in the school reception and SNs being present at parent nights. These views are illustrated in this comment:

I think when your child first goes to school you get a pack and I think it would be good for them to be at parents evening when you first go to see the school [...] and actually the nurse is there to introduce herself, to say how she can be contacted or a leaflet put in the pack to say how they can be contacted. (P5)

Aligning with this perception, SNs expressed frustration that their role and what the school nursing service can offer to children and families was not more widely advertised. The dominant view was that workload capacity was a factor

influencing the ability of SNs to promote their service and increase awareness and understanding of their role. However, in contrast, the SNs also indicated that, if they were to promote their service, this would lead to an influx of referrals that they would not have the capacity to cope with. The following comment reflects one participant's view:

At the moment it is a bit of a vicious cycle because you don't want to advertise yourself too much because you don't have the capacity to deal with what the referrals would be. I know that there would be a lot of referrals. So, you're trying to stem it back until you have got capacity, which is quite frustrating. (SN3)

The views of teachers and parents in this study, and the SNs in Phase One, suggest that schools, especially the head teacher, have a gatekeeping role that influences the visibility and accessibility of the SN service. This concurs with previous research conducted by Wainwright et al. (2000) over two decades ago. They identified that the commitment of schools to include SNs in school-based health education influenced SN involvement.

6.4.1.2 The Gatekeeping role of schools

It became apparent during the interviews with the parents, that schools, in particular the head teacher, influenced their access to the SN for obtaining advice and support for their child. Some parents indicated that they were advised by the head teacher to contact the teacher, depute head teacher, or head teacher in the first instance, if they had any concerns about their child:

I mean, our first point of contact, regardless of what it is, we are always told to either contact the class teacher or we have two deputies in the school ... (P2)

However, another parent highlighted that they had enquired about support from the SN on several occasions due to concerns about their child's health needs and had not received any information. They had also been informed that there was not a SN for the school:

I think that I have asked about the SN a couple of times, but I probably didn't get any answers. They said there isn't one, she doesn't come here or something like that. This is not her remit. (P3)

Although the teachers I interviewed talked positively about their experience of working with the SNs allocated to their schools. It became evident that the depute head teacher and/or head teacher were pivotal in deciding whether the SN should be involved where there were concerns about a child's mental health. For example, one teacher stated:

For mental health I would say we probably tend to go more Ed Psych than the SN team. (T1)

Added to this, during the pandemic, anxiety from teaching staff about SNs visiting the school and the need for the senior management team to contain that anxiety was a factor impacting on their decision to involve the SN:

... our school got hit heavily with the Kent variant, so we got wiped out. So, there was a lot of staff anxiety management as well you know, 'we don't want the nurse', you are front line and blah blah blah. And we just have to manage that aspect as well. (T1)

These accounts fit with the experiences of some SNs in Phase One, especially the influence of the head teacher in promoting and regulating access to the SN service (see Section 5.2.4.5). This is also reflective of my experience as a researcher attempting to gain access to children in schools. However, it is notable that, during the interviews with the SNs in this study, although their contact with school-aged children was restricted due to the lockdown measures and school closures, they did not highlight that gaining access to school-aged children was an issue due to the gatekeeping role of head teachers. On the contrary, most indicated that their workload had increased, and they were receiving more contact from schools seeking their involvement.

Sometimes when you are having these regular conversations with your head teachers, it ramps up the referral rates. (SN1)

The relationship the SN had with the head teacher appeared to be closely linked to referrals and contact for advice, in that head teachers were more likely to contact the SN if they knew them, had experience of their involvement with children and had developed a good relationship. It is relevant to add that, at the time of the fieldwork with the SNs, schools had been closed due to the pandemic and the summer holidays and were just re-opening, so this is likely to have impacted on SN practice and influenced their experiences. In addition, some SNs indicated that they had contacted the head teachers in all their caseload schools to let them know that they were back after being redeployed, and this may explain the increase in referrals. As the interviews with the SNs took place prior to the interviews with teachers and parents, I did not explore the role of the head teacher as a gatekeeper with them. Nonetheless, what does appear to be crucial for facilitating the involvement of SNs where there are concerns about the mental health of CYP is their relationship with head teachers. The relationship needs to be positive, and the head teacher needs to have a good knowledge and understanding of the SN role and their mental health work.

6.4.1.3 Subtheme: Workload capacity

The scoping review of the literature and the findings from Phase One identified that a key barrier impacting on SN involvement in supporting the mental health of school-aged children is their workload. Similarly, workload capacity was consistently expressed as a barrier to the mental health work of the SNs in this phase of my study. So, although the fieldwork was conducted during the pandemic, concerns about workload capacity have been raised in research with SNs for over a decade (Wilson et al. 2008). The SNs expressed frustration at their workload due to two main factors: staffing issues and volume of child protection and looked-after children's cases. Several reasons for staffing issues were identified. The dominant view pertained to issues with the recruitment and retention of qualified SNs, which meant that the SNs were required to cover vacant caseloads. Job grading was a recurring factor suggested by the SNs in this study as a reason why SNs leave the profession. It was also suggested that newly qualified SNs left the profession as the job was not what they had expected when they had commenced the training. There was also a strong feeling

expressed that there was lack of recognition of their specialist education and value of their role in comparison to health visitors and family nurses:

... But until we are recognised on a par with family nurse and health visiting, we are not going to retain staff. I think we are losing, we are spending so much money training people and they're leaving as soon as they are done, and so, so that's the retention of staff is absolutely crucial. And it really feels at the moment that we are just getting nowhere with that. (SN4)

Moreover, the SNs also highlighted that, due to the pandemic, many of them had been deployed to support acute services. Their experience is reflective of SNs across the UK during the pandemic (Sammur et al. 2023). Added to this, the SN service had also been impacted by staff absence due to some contracting COVID-19. Consequently, this had an impact on SN involvement in supporting school-aged children's mental health, leading to frustration. The following comment illustrates this view:

.... We did have another two staff nurses; they were redeployed at the beginning of COVID. They returned last week, but they were redeployed on Monday. So, that's where we are. Staffing will always be a problem to be able to do the work we want to be able to do. (SN2)

There was also frustration at the impact that staffing issues had on the implementation of the SN mental health and wellbeing pathway. This comment sums up the views of participants:

I think certainly, mental health and wellbeing it is just threaded through every part of our work, whether it is child protection or LAC. It is obviously still a big focus, em looking at the emotional wellbeing of the children and young people, but it is just really, it is staffing issues. We can't implement it like we would like to. (SN3)

Similarly, the teachers indicated that the limited numbers of SNs impacted on their ability to provide effective support for primary-school-aged children's mental health. The teachers suggested that there needed to be investment in SNs to

increase the numbers available to provide support. The vulnerability of children and families was linked to increasing need for support as illustrated in this comment by a teacher working in a school in SIMD Decile 3:

... in my setting, it is the extreme that get the support sort of thing. We could require support a lot and we could require ten SNs easily. (T1)

During the interviews with the SNs, a lack of resources was also highlighted as an issue impacting on their workload capacity. There were two key reasons suggested for this. First, they described a lack of clinical psychologists to provide coaching and supervision for the delivery of the LIAM programme and training in Decider Skills. The impact of this was that the LIAM programme and Decider Skills training had to be suspended during the pandemic and thus SNs were unable to offer these interventions. Second, there was persistent criticism of the time required to search for and make resources to use with the children. Added to this, some SNs were buying resources to support their mental health practice:

If I want to do a bit of work with a child, I am looking myself online to see what I can find, or I am reading in books to see what is there. Em, we buy all our own resources and workbooks and if you see books on Amazon, we are buying them, they are not being bought by the service. So, I would say with mental health it's em, not where it should be. (SN2)

However, a contrasting view was expressed by a SN team leader suggested that the school nursing team were being provided with resources to support their practice:

All are getting resources in regard to books and equipment that the school nurse needs to work with. (SN6)

The volume of their child protection and looked-after children's cases was consistently expressed as being a barrier to their involvement in mental health work. The main reasons suggested for this were due to the unpredictability of child protection work and the need to prioritise this aspect of their workload. There was an overall feeling that this limited the time that SNs had to focus on providing mental health support. Moreover, the SNs indicated that the numbers

of child protection cases had increased during the pandemic. For example, one SN commented:

I think because of COVID, child protection just has really escalated, in just the past month...we have a huge number in the rural areas of [...]. It is very rare to have a child protection case there. We maybe have one at a time, and I think we have about five or six different families ongoing through it at the moment. (SN3)

Despite this, the SNs talked passionately about the need to be flexible and adaptable so that they could provide some mental health support. The following comment reflects their views:

I think, probably the the, certainly, the CP and LAC component of the job severely limits the free time, and other time in our weekly calendar em to make time to do mental health support. And probably as an attempt to do something rather than nothing, em rather than offer a four-week programme with maybe half hour or hourly sessions, em, then I have maybe tried to adapt. (SN5)

These views are reflective of the experience of SNs working in the UK during the pandemic (Sammut et al. 2023). SNs talked about their experiences of beginning a piece of work with a child and then being required to cancel at short notice. They expressed concern at not being able to work as planned with children and the impact of cancelling appointments on the mental health and wellbeing of the child and their family. Their experience concurs with the findings of Sherwin's (2016) narrative inquiry to explore how SNs provide emotional support to children and young people. Furthermore, there was concern that their child protection workload prevented them from intervening early and being able to effectively support school-aged children. For example, one SN commented:

I think challenges as well are influx of child protection work, and it all comes in and it is all vitally important. But what it has made me worry about is the mental health referrals that always get put back. They get put back, they get put back, and by the time I get to them, will they be

early intervention anymore, or will they? Do you know? So that worries me. (SN1)

The overall feeling of SNs, teachers and parents was that the numbers of SNs needed to be increased to enable them to support children's mental health. The dominant view was that the SN needed to be working in the community and building relationships with the children, the school, and the community. The following comment is reflective of these views:

... it goes back to getting more SNs in the school community ... the community will be their school and their surrounding community, so they will begin to get know the children ... you begin to know your area, your schools, your concerns around the community. (SN6)

This account was striking as it clearly emphasised the value that this SN placed on knowing not only the school community, but also the wider community, and how this could help SNs to build connections with children, their families, the school, and the community, informing their mental health work with school-aged children. In addition, it served to highlight that the perspectives of SNs in this study were influenced by each component of the Ecological Systems Theory (Bronfenbrenner 1979), as there was an understanding of the link between the child, their wider world and building relationships.

6.5 Summary

This chapter has presented the findings from the Phase Two Study, which employed a case study design and qualitative interviews with participants. The findings confirm and help to explain the results of Phase One and the scoping literature review that parents, children and teachers lack knowledge and understanding of the SN role and their mental health work. Children and parents were unaware that there are SNs for schools, and the children associated the first aider in the school with the SN. The interviews identified consensus that SNs need to be visible in primary schools and that they need to be accessible to children and their parents if their service is to contribute more effectively to supporting primary-school-aged children's mental health. One child suggested

that they would find it helpful if they knew where to access the SN so that they could talk to them if needed. The parents aired views that revealed the factors influencing their understanding and experiences of the SN mental health work, helping to inform our understanding of what is needed. Parents indicated that the SN service should be promoted and offered several suggestions how this could be achieved. Likewise, there was recognition from SNs that they needed to promote their service to make it more visible. Yet, they expressed some reluctance to actively promote their service due to concerns regarding a lack of capacity to cope with requests for assistance, and this was a significant source of frustration to them.

The teachers talked positively about SNs' contribution to supporting children's mental health when they had direct experience of working with them. They aired views emphasising that SNs' knowledge of the local community, the families and children is essential in making a difference to the health of the children in their schools. However, they highlighted that their experience of contact with SNs was not the same for all schools, and there was an association between more frequent SN contact and schools in more deprived areas. Relationships were viewed by participants as being vital for working effectively with children, parents, teachers, and other professionals. Trust was important to the children, and they placed great importance on the need to know the SN and feel able to trust them before they would feel comfortable to share any worries. They also stressed the need for SNs to be kind and empathic and to actively listen to them and to take action to address their concerns. Similarly, the parents identified these as being key attributes they would expect SNs to demonstrate, but they also highlighted the need for SNs to be non-judgemental and for the school nursing service to be non-stigmatising.

Participants shared a similar understanding of the term 'mental health', with most referring to thoughts and feelings and how these affect a person's wellbeing. There was also an awareness that everyone has mental health and that it can be affected by different factors and that it can vary over time. Some children talked about the influence of the environment, while others were aware of the importance of self-care. The teachers and SNs expressed views indicating that

emotional regulation is essential to enable people to actively participate in the world. SNs, parents and teachers aired views emphasising the need to normalise emotions such as anxiety through health education interventions. Anxiety was the main issue impacting on children's mental health with friendships, schoolwork, and family at the core of children's worries. Although the study was conducted during the pandemic, the children did not raise it as a worry until they were specifically asked about it. The main concerns they expressed about the pandemic related to not seeing their friends or family and uncertainty that life may not go back to normal.

The SNs felt that they had a clear role to play in supporting primary-school-aged children's mental health and talked enthusiastically about the interventions they use in their mental health work. The importance of relationships between the SN, the child and the parent were a common thread running through participant accounts about SN interventions. Yet, they also aired views expressing disillusionment at the service due to barriers impacting on their capacity to effectively support primary-school-aged children's mental health. These barriers included their child protection workload, lack of resources and staffing issues, and there was a feeling that their work was reactive rather than proactive. Despite this, the interviews found that SNs expressed job satisfaction when working with children, and most evidenced a holistic, strengths-based, and person-centred approach to their practice.

Further interpretation of the findings presented in this chapter, and the results presented in Chapter Five, are summarised, synthesised, and discussed next in Chapter Seven.

Chapter Seven: Discussion

Introduction

This chapter draws on and integrates the findings from Phase One and Phase Two, discussing them in relation to the aims and research questions, extant literature and relevant policy, theory, and SN practice. As outlined in Chapter Four (Section 4.4), a crucial element in assuring the quality of a mixed methods study is making explicit how the findings are integrated and interpreted. This study utilised an explanatory sequential mixed methods design and, in line with Creswell and Creswell (2018), the results from Phase One were presented in Chapter Five, and the findings from Phase Two were presented in Chapter Six. This chapter now knits them together, discussing how the findings from the case study explain and build on the results from the online questionnaire. The chapter begins by revisiting the aim of the study, and the research questions.

This study set out to explore primary-school-aged children's, parents', teachers' and SNs' experiences and understanding of the mental health work of the SN, and to identify their contribution to supporting and improving children's mental health. Although previous studies have explored the mental health work of the SN, the scoping review of the literature (Chapter Three) revealed that few studies have focused on their role with primary-school-aged children, and few have sought the views of children, parents, and teachers. In light of this, I sought to answer the following questions:

1. How do children, parents, teachers and SNs currently experience and understand the work of the SN in supporting primary-school-aged children's mental health?
2. What factors influence their experiences and understanding?
3. How do their experiences and understanding inform the future work of the SN in supporting and improving primary-school-aged children's mental health from an ecological and strengths-based perspective?

These three questions have been used to frame the discussion and interpretation of the findings to facilitate a logical flow of the narrative, beginning with research question one.

7.1 How do children, parents, teachers and SNs currently experience and understand the work of the SN in supporting primary-school-aged children's mental health?

The children and parents' experience and understanding of the SN and their work in supporting primary-school-aged children's mental health was based on their knowledge of who the SN is, and their contact with the SN. In line with Woodhouse et al. (2016) and Chase et al. (2010), I found that the children and most parents had no knowledge or experience of contact with the SN. Likewise, SNs in both phases, and the teachers in Phase Two, highlighted that children and parents do not know that there are SNs. The views of teachers in the Teachers' Advisory Group complemented these as they also informed me that children and parents would not know about the SN. Although the teachers had experience of working with SNs in their current roles, due to the vulnerability of many of the children this was not reflective of their previous experience of working across different primary schools and within different local authorities. Furthermore, they had limited knowledge that the SN was a specialist in community public health nursing, nevertheless, they did know that they were qualified nurses.

Although the children and most parents had no experience of contact with the SN or knowledge of their mental health work and the teacher's had limited knowledge, they did have a clear understanding of the concept of 'mental health'. Most referred to thoughts and feelings and how these affect a person's wellbeing. There was an awareness that everyone has mental health and that it is on a continuum and can be affected by different factors and that it can vary over time. Emotional regulation was cited by both teachers and SNs as being essential to enable people to actively participate in the world and to help build their resilience. This is reflective of the recommendations of Weare (2015) in the document, *What works in promoting social and emotional well-being and responding to mental*

health problems in schools? and the *Mental Health and Wellbeing: Whole School Approach: Framework* (Scottish Government 2021a). What was striking about the children's accounts was how articulate they were in describing the term 'mental health' and how they related it to their own experiences, for instance, one child talked about feeling sad, and others referred to their brain and their head and how they work. Some children talked about the influence of the environment, while others were aware of the importance of self-care and the need to keep healthy. Similarly, over two decades ago, Roose and John (2003) found that the children in their study, who were aged ten and eleven years, were able to clearly articulate their understanding of mental health and associated it with their thoughts and feelings. Roose and John (2003) concluded that children aged ten to eleven years had the cognitive ability to discuss mental health and contribute their views on the development of services. Conversely, Harden et al. (2001) in their systematic review concluded that CYP associate mental health with mental health problems and can find it challenging to link it to their own experiences. Nevertheless, a key message is that children in middle childhood understand the term mental health, and, in my research, how it related to them as a person and to their environment. This may be linked to the emphasis on health and wellbeing in the school curriculum, in particular promoting CYP's mental, emotional, social, and physical wellbeing (Scottish Government n.d.). The media coverage about mental health during the pandemic, especially regarding the importance of self-care (Nealon 2021), may also have influenced the children's understanding (Walsh 2009).

My research also revealed that SNs, parents and teachers believe that health education interventions are required to normalise emotions such as anxiety. Parents, teachers and SNs aired views highlighting that, in their experience, anxiety was the main issue impacting on primary-school-aged children's mental health, albeit many believed that children were anxious because their parents were anxious. Similarly, Creswell et al. (2021) in the Co-SPACE longitudinal study of parents and carers of CYP, found that, during the pandemic, parents of children aged four to ten years were more anxious than parents of CYP aged eleven to eighteen. In common with Prymachuk et al. (2012) and Dina and Pajelic (2014), the SNs in Phase Two voiced that they identified mental health

problems, especially anxiety, when following up referrals to support children with sleep or behaviour problems, and sometimes headaches and tummy aches. Friendships, bullying, worrying about going to school, transition to secondary school and family were considered by the adult participants to be at the core of children's worries. Similarly, the children suggested that the main worries for their age group included friendships, their appearance, trying new things, schoolwork, and social media. The children's worries, apart from those related to social media, are consistent with the findings of Shucksmith et al. (2009) and Woodhouse et al. (2016), and relationships with people, especially family, friends, peers, and teachers are viewed as being important by children. I identified that children's relationships with people played a key role in how they felt about themselves, especially regarding how they are perceived and treated by others. This was significant in relation to feeling happy and comfortable at school, but also when describing who they would feel comfortable confiding in if they had a worry, with most children stating that they would confide in their family first. In line with the findings of Roose and John (2003), the children in my research indicated that they would not contact or confide in the SN as they do not know who they are and whether they could trust them.

Though the fieldwork for Phase Two was conducted during the pandemic, and the interviews with the children took place just after Scotland moved into Level Three restrictions, the children did not raise COVID-19 as an issue that children may worry about until they were specifically asked about it. The main concerns they expressed about the pandemic related to not seeing their friends or family members and uncertainty that life may not go back to normal. Notably, SNs highlighted that some CYP they had been working with before the pandemic due to anxiety were not feeling anxious during the first lockdown when schools were closed. This finding concurs with those of a longitudinal study of more than 60,000 school-aged CYP in England during 2020, that CYP's self-reported wellbeing was higher than before the lockdown, with children aged ten to eleven years reporting the highest average wellbeing (ImpactEd 2021). In the aftermath of the pandemic, there have been concerns about poor school attendance, and a report commissioned by the Welsh Government to review this issue acknowledges the school setting as a key reason (Rowlands 2022). It is possible

that factors in the school setting may be a cause of anxiety in CYP, and, for some, school may not be associated as a safe, nurturing environment and a place where they feel respected. Indeed, El Zaatari and Maalouf (2022) contend that CYP's sense of belonging in school is affected by their interactions with teachers and peers and friends within the school environment, and at significant time periods, such as transition.

Previous research has found that SNs believe they have a vital role in supporting school-aged CYP's mental health and that this is an important aspect of their work (Prymachuk et al. 2012; Skundberg-Kletthagen and Moen 2017; Anttila et al. 2020). The findings from both phases concur with these studies, as they also identified that early intervention was viewed as being essential to improve outcomes across the life course, although this was a source of tension due to constraints on their practice (see Section 7.2 for discussion). As discussed in Chapter Three, the review of the literature identified a paucity of research focusing specifically on SN interventions to support school-aged CYP's mental health. The findings from both phases revealed the use of a wide range of interventions, including mindfulness, guided self-help, motivational interviewing, and CBT, which concurs with the findings of Turner et al. (2022). However, I also found that in Phase One, parenting support, home visits and the Solihull approach were the main interventions used. These interventions were also used by SNs in Phase Two, which is reflective of the increased focus on home visits within the SN pathway (Scottish Government 2018b). What was notable from their accounts was that one of the key purposes of using these interventions was to support the parent and help contain their anxiety, so they could effectively support the child, which mirrors their use in health visiting practice (Cowley et al. 2015). Notably, this reflects the experience of some parents and the teachers, who suggested that it is often the parent who is anxious.

When describing interventions used to help children to cope and regulate their emotions, especially those using guided visualisation, the SNs became animated and clearly enjoyed this aspect of their mental health work. Although the teachers were unable to name interventions used by SNs, one described observing the SN using visual imagery. The SNs also described innovative and creative ways

of adapting their practice in response to the lockdown restrictions, and instead of home visits, many talked about a 'walk and talk' intervention with the child, and the Near Me digital platform (Digital Health and Care Scotland 2024). Likewise, Cook et al. (2023) found that SNs in their study also used a range of innovative interventions including 'walk and talk'. Building trusting relationships was the golden thread underpinning the SNs' interventions and was regarded by them as being vital for the provision of effective support. Moreover, this was echoed by the teachers, and although the children and parents did not have experience of the SN, they were clear in their accounts that building a relationship with the SN would be essential to feeling comfortable to approach them for support. I also found that SN practice was described as being holistic by SNs and teachers, but their accounts also identified that the SNs used a strengths-based and person-centred approach to their practice. Cowley et al. (2015, p. 3) contend that health visiting practice is characterised by an 'orientation to practice' that is salutogenic, person-centred and views the person in the context of their environment. Likewise, my research has identified that SN practice shares this orientation to practice and contributes to a greater understanding of how Dossey's (2008) Holistic Nursing Theory and Bronfenbrenner's (1995) Bioecological Systems Theory underpin contemporary SN practice.

Lack of confidence, knowledge, experience and unmet training needs have been identified in previous research as barriers to SN involvement in delivering mental health interventions to support school-aged children's mental health (Wilson et al. 2008; Prymachuk et al. 2012; Skundberg-Kletthagen and Moen 2017). Difficulty in accessing training has also been identified as a barrier (Turner et al. 2022). My findings revealed that extensive mental health training was offered, however, in Phase One, some of the responses highlighted that training could be more difficult to access if SNs worked part-time. In Phase Two, all the SNs worked full-time, and they had all been trained in the LIAM programme, and most had been trained in Decider Skills. However, the pandemic and shortage of psychologists to provide supervision meant that some training had been suspended, and the LIAM programme could therefore not be delivered. What was significant about their accounts was the differences in their perceptions of training and its value for their practice. This appeared to be linked to the attitude

of the SN, their length of experience working in the SN service, and the relevance of the training to their practice. Similarly, Doi et al. (2018) found that the relevance of mental health training for SN practice was crucial and there was a need for training in practical interventions.

Similar to previous research, in addition to training, the lack of resources, staffing issues and child protection workload were identified as being barriers to their capacity to effectively support primary-school-aged children's mental health (Wilson et al. 2008; Haddad et al. 2010; Prymachuk et al. 2012). Although I found that the SNs in Phase Two expressed job satisfaction when working with children, it also revealed a degree of disillusionment with the SN service. In common with the findings of Sammut et al. (2023), the SNs described their work as being reactive rather than proactive, and the analogy of 'firefighting' was used by one SN to describe this. What is more, I also found that some of the SNs in Phase One also commented that their work was reactive rather than proactive, and, notably, this was prior to the pandemic. It is remarkable that this tension in the SN workload is not new and was highlighted by Spratt et al. (2010a) over a decade ago, which does question the value placed on the provision of universal services for CYP by policy makers and recognition of the SN role by commissioners of SN services.

7.2 What factors influence their experiences and understanding?

There were a range of factors that influenced participants' understanding of the mental health work of the SN, the most significant, as indicated in section 7.1, being related to their awareness and knowledge of the SN role. In Phase One, the respondents indicated that the SN role lacked clarity and visibility, most suggested that primary-school-aged children and parents would be unaware that there are named SNs for schools. Similarly, in Phase Two, the SNs shared this view, proffering that children and parents associate the SN with the first aider in school. This perception was borne out during most of the interviews with the children and parents, with many children associating contact with the SN as going to get an icepack and a plaster. In addition, a minority of children aired strong views that their school did not have a SN, and some of the parents also

expressed this view, albeit not as strongly. There were also parents who had recollections of their experience of contact with the SN when they were children, and these included the 'nit nurse' and being given immunisations.

The views of the children and parents are reflective of the findings of previous research (Chase et al. 2010; Woodhouse et al. 2016), although these studies did not focus specifically on the mental health aspect of the SN role. In common with Chase et al. (2010) and Woodhouse et al. (2016), my research found that children and parents need to be provided with information about the SN so that they know who the SN is, what they do, the issues that they can help with and, crucially, how to access them. It is acknowledged that most school handbooks include a small section with information about the SN service. Indeed, most of the parents remembered receiving a copy of the handbook when their child started school, but they did not recollect there being any information within it about the SN. It is possible that this information was not considered relevant to them at the time.

In common with Doi et al. (2018), I found that SNs consider their role to be less visible and accessible since the introduction of the SN Pathway due to changes in their practice. These changes included drop-in sessions no longer being offered and health promotion activities in school being stopped. There were several reasons underlying these changes, and these included the role of the SN being more targeted on vulnerability, child protection and looked-after children, changes to the referral system and health promotion not being included as a priority area in the SN pathway. The SNs in Phase Two expressed views that these changes had impacted on their ability to be actively involved in mental health work and to have contact with children and their parents in school or at home. These views help to explain the finding from Phase One, that the frequency of visits to schools were dependent on the vulnerability and need of the children and the needs of the school. The SNs in both phases of my study indicated that they visited schools in the most deprived areas more frequently than schools in more affluent areas, albeit less than a fifth of the SNs in Phase One visited schools in their caseload weekly or more. Indeed, this reflects the experience of the teachers who both worked in schools located in the 10% most

deprived areas within the local authority area and described frequent contact with the SN at their schools (Scottish Government 2020b). It also explains why the children and the parents had no experience of the SN, as their schools were in the 10% least deprived areas in the local authority (Scottish Government 2020b).

While it is acknowledged that the risk of mental health problems is greater in CYP who are living in the most disadvantaged households (Murphy and Fonagy 2012; WHO 2022; Yang et al. 2023), justifying the need for more targeted support from SNs, it is also recognised that the prevalence of mental health issues in CYP from all backgrounds is increasing. According to McDaid and Park (2022) in their report on the economic case for the prevention of mental health in the UK, poor mental health cost the Scottish economy £8.8 billion in 2019. Yet, this does not include the unseen personal costs to the child and their family that impact on their quality of life, such as being socially isolated and stigmatised due to their mental health. I found that parents expressed concerns that their children had found it more difficult to cope with the social isolation from their friends during the pandemic than the change to a remote learning environment. The parents were also very aware of the stigma associated with mental health, and the need for education about mental health, which supports McDaid and Park's (2022) contention that primary prevention could be cost-effective for the economy. Primary prevention is integral to specialist community public health nursing practice and is clearly articulated within the new field-specific standards of proficiency for SCPHN-SNs (NMC 2022) in relation to mental health and wellbeing. Yet, in both phases, the SNs were not involved in prevention. Notably, SNs who had worked in the SN service prior to implementation of the CfE indicated that it had impacted on their preventive role as it resulted in them handing over health promotion activities in school to teachers.

Issues with the capacity of the SN workforce has long been identified as a constraint on their practice in the UK (Haddad et al. 2010), and SNs in both phases cited workforce capacity as an issue that constrains their mental health work. In Phase One, shortages of staff were highlighted, but limited details were provided to explain the reasons for this. The accounts of the SNs in Phase Two also cited shortages of staff as an issue and several reasons were expressed. In

common with Sammut et al. (2023), redeployment of SNs into acute services during the first lockdown left the service depleted of staff, and staff absence due to contracting COVID-19 added to the problem. However, the recruitment and retention of qualified SNs was a significant source of frustration as it meant that they were required to cover vacant caseloads in addition to their own caseload.

There were two main reasons cited for the problem of retaining SNs; one of these pertained to expectations of the job, and that it was not what SNs expected when they began their SCPHN-SN programme. The second related to job grading. There were strong feelings expressed that SNs were leaving the profession as the grading of SNs was not equivalent to the job grading of health visitors (who are graded at Agenda for Change Band 7 in Scotland). Consequently, they felt that there was lack of recognition of their specialist education and lack of value attributed to their role. It is notable that, two decades earlier, Croghan et al. (2004) revealed similar findings and suggested that the grading of SNs should be addressed to aid in the retention of SNs and raise awareness of the value of their role. The redeployment of SNs during the pandemic also contributed to their feelings of being undervalued (Sammut et al. 2023).

Access to schools and to school-aged CYP has been highlighted in previous research with SNs as being a barrier to their work in the identification of health needs and the support of CYP (Lightfoot and Bines 2000). Lightfoot and Bines (2000) and Prymachuk et al. (2012) found that the ethos of the school and the attitude of senior members of the teaching team, in particular the head teacher, influenced the extent to which SNs could be involved in working with CYP and delivering interventions. Similarly, some SNs in the Phase One study aired views highlighting that they were more likely to be contacted by the head teacher when there were concerns about a child if the head teacher knew them. The interviews with the parents and the teachers in Phase Two indicated that the head teacher and depute head teacher had a gatekeeping role in regulating access to the SN service. Many of the parents suggested that they were advised by the head teacher to contact the class teacher or the depute head if they had any concerns about their child. This advice seems to be perfectly reasonable, given that children spend a large proportion of their time in school. Nonetheless, one parent

highlighted that, despite asking the school on several occasions for information and support from the SN due to concern about their child's health needs, a referral was not made. The parent had been informed that the school did not have a SN, and the concern was not the remit of the SN, which implies that the head teacher and teaching staff lack knowledge and understanding of the SN role and remit.

Moreover, during the interviews with the teachers, albeit there were only two in this study, it was evident that it was the head teacher or the depute head who would make the decision regarding the professional they thought should be involved when there were concerns about a child's mental health. It is noteworthy that, one teacher, who was a depute head, despite having talked positively about the support the SN provides at their school, stated that they would seek support from the Educational Psychologist rather than the SN team. Neither of the teachers in this study were aware of the SN pathway and the priority areas, and therefore, it is possible that their lack of knowledge of the refocused SN role explains the teacher's decision making and choice of professional. This would also help to explain the parents' experience of being unable to access support from the SN service due to the head teacher's lack of knowledge about the role and remit of the SN. This does, however, raise a concern regarding the rights of CYP to receive support from the right person at the right time, as the findings suggest that, within schools, access to the SN service is controlled by the views of head teachers, which may be at odds with those of the parent and the child (Spratt et al. 2010b).

It is notable that the SNs in Phase Two did not refer to issues in gaining access to school-aged children due to head teachers' attitudes towards them. It is possible that this was because the interviews with SNs took place when schools were just beginning to open following the lockdown and the school summer holidays, and SNs had just returned to SN practice after being redeployed. What was significant about the SN experiences, was the importance they placed on fostering positive relationships with head teachers. Their accounts indicated that they were proactive in contacting head teachers when they returned to practice following redeployment, raising awareness of their service and availability.

Previous research by Chase et al. (2010) found that head teachers and teachers' experiences of contact with the SN was associated with a greater knowledge and understanding of the SN role and remit. I found that SNs can and do build positive relationships with head teachers, but to do this effectively and increase understanding of their mental health work, they need to be visible in schools.

7.3 How do their experiences and understanding inform the future work of the SN in supporting primary-school-aged children's mental health from an ecological and strengths-based perspective?

Consensus emerged during the interviews with parents, teachers and SNs that promoting the SN service was required to raise its visibility and increase awareness of the role of the SN and their mental health work. Although participants offered practical suggestions for how this could be achieved, for example, information about SNs in school handbooks and newsletters and attendance at transition events, there was a complex interplay between what SNs perceived was required, and what they felt they could offer. This was closely associated with factors impacting on their workload capacity and their sense of agency.

I found, during the interviews with SNs, that, whilst they recognised the need to actively promote their service, there was some reluctance due to concerns that their service would be unable to cope with requests for assistance. Indeed, this was a significant source of frustration to them as they were committed to making a positive difference to the health of school-aged CYP. Arguably, their frustration and disillusionment with the constraints on their mental health practice is linked to feelings of being powerless to achieve change, within the context of the health, education, and political systems in which they work (Broussard 2007). Broussard (2007) found, in her study on empowerment in SN practice, a link between SNs' feelings of being in control and their sense of empowerment. Although I was unable to locate literature on SN agency, the work of Priestley et al. (2016) on teacher agency is relevant to my findings, as they view teacher agency through an ecological lens. Priestley et al. (2016) emphasise that the past experiences of teachers, and the social context in which teachers' work, influences their agency,

whilst the culture within schools and the resources available can serve to promote or impede it. This lends support to my findings and contributes to our understanding of why the SNs felt frustrated and disillusioned. Priestley et al. (2016) contend that a supportive culture and social structures based on trusting relationships are essential for teachers to achieve change. This research has also found that the same is true for SNs which highlights the interconnection between the environment and social relationships.

I found that the teachers' experiences of working with the SNs in the case study site was positive, especially the SNs' knowledge of the local community, the families, and the children, which they felt were vital in making a difference to the health of the children in their schools. In addition, the teachers and the SNs emphasised the need to build the resilience of the community to be successful in building resilient families and resilient children. The proverb, 'it takes a village to raise a child', comes to mind, and, in fact, Reupert et al. (2022, p. 1) propose a 'village approach' based on ecological systems theory to support working with families facing adversities. What was significant about the perspectives of the SNs and teachers was their view that SNs need to be working in the community and building relationships to identify concerns. It is significant that the teachers suggested that the gold standard would be to have a SN based in every school, reflecting a recently published report campaigning for a SN in every school in England (College of Medicine and Integrated Health, School and Public Health Nurses Association and Queens Nursing Institute 2024). These findings point to the need for SNs to be included in whole-school approaches to mental health, working together with teachers, parents, children and people within the child's wider world to intervene early to promote good mental health and build resilient children and families.

7.4 Summary

This penultimate chapter has integrated the findings from Phases One and Two and discussed them in relation to the aims, research questions, literature and relevant policy, theory and SN practice. It has provided explanations to show how the findings from the case study build on the results from the online questionnaire to address the research questions.

A key thread running through the findings is the importance of relationships for gaining access to children in schools, and the provision of effective support to build not only children's resilience, but also the resilience of their family and the community, to promote good mental health. This research found that SNs do contribute to supporting primary-school-aged children's mental health through a variety of interventions, but the extent of their involvement is constrained due to various factors, many of which are outwith their control.

My conclusions, contributions to the field of SCPHN-SN, and recommendations for future research, policy, practice and education, including the strengths and limitations of the research, are presented in Chapter Eight.

Chapter Eight: Conclusions

Introduction

Little attention has focused on exploring SNs' contribution to supporting primary school children's mental health. Using a mixed methods research design, this thesis has explored their mental health work and generated a rich, contextualised understanding of SNs', children's, parents', and teachers' experiences, building on and strengthening the evidence base to support their contribution.

In this final chapter, I present my conclusion and the contributions that this research offers to the field of SCPHN-SNs and their work in supporting primary-school-aged children's mental health. The chapter begins with a summary of the main findings, followed by the strengths and limitations of the study, before presenting the implications and recommendations for future research, policy, practice, and education. The chapter will close with final reflections on the learning gained from completing my thesis.

8.1 Summary of the main findings

- Children's, parents' and teachers' experiences and understanding of the SN and their work in supporting primary-school-aged children's mental health is based on their knowledge of who the SN is, and their contact with the SN.
- Children and most parents had no knowledge of the SN role, while teachers had some and they valued the contribution of SNs when they had experience of working with them.
- Participants shared similar views that SNs need to be accessible, approachable and non-judgemental and building trusting relationships was perceived as being essential to the provision of effective support.
- Children, parents, and teachers shared similar understandings of the concept of 'mental health', with most referring to thoughts and feelings and how these affect a person's wellbeing. There was also awareness

that mental health is on a continuum, that it can be affected by different factors, and that it varies over time. SNs and teachers emphasised the importance of emotional regulation to support children to participate actively in the world and build their resilience.

- Anxiety was cited by SNs, parents and teachers as the main issue impacting on primary-school-aged children's mental health, albeit many believed that children were anxious because their parents were anxious. Friendships, bullying, worrying about going to school, transition to secondary school and family were considered by the adult participants to be at the core of children's worries. Similarly, the children suggested that the main worries for their age group included friendships, their appearance, trying new things, schoolwork, and social media. COVID-19 was not raised as a worry by children until prompted about it, and their worries related to not knowing when or whether life would go back to normal. SNs found that the CYP they had been working with before the pandemic due to anxiety were not feeling anxious during the first lockdown when schools were closed.
- SNs use a wide range of interventions, including mindfulness, guided self-help, motivational interviewing, and CBT, however, parenting support, home visits and the Solihull approach were the main interventions used to help support parents' and contain their anxiety. During the pandemic the SNs described innovative and creative ways of adapting their practice and, instead of home visits, many used 'walk and talk' interventions.
- The SNs were committed to making a positive difference to the health and wellbeing of school-aged CYP and believe they have a vital role in supporting their mental health, but they expressed frustration and disillusionment at the constraints on their practice, describing their mental health work as being reactive rather than proactive.
- Workload capacity, lack of resources and lack of knowledge and understanding of the SN role are barriers to the provision of prevention and early intervention. The pandemic was also cited as a barrier.
- The SNs had been offered extensive mental health training, but the value of the training appears to be linked to the attitude of SNs and influenced

by their length of experience as a SN and its relevance to their practice. They expressed a need for training in practical interventions and resources for use with primary-school-aged CYP.

- Implementation of the SN Pathway varies across Scotland, and there appears to be inconsistency and lack of guidance on resources to use.
- The SNs' orientation to practice was holistic, strengths-based and person-centred. Building trusting relationships with children, parents and teachers were central to their practice and a golden thread running through their interventions.

8.2 Contributions to the field of SCPHN-SN practice

This research provides insight into the mental health work of the SN within Scotland from the perspective of SNs, but also those of primary-school-aged children, parents and teachers, adding to the evidence base. The Phase One study was a national cross-sectional study and is the only one to my knowledge that has sought the views of nurses working in the school health service in Scotland, specifically in relation to their mental health work with primary-school-aged children. The study was conducted when the refocused SN pathway and priority areas were being implemented and so it provides information outlining their involvement in supporting primary-school-aged children's mental health at that time. It also sheds light on changes to school nursing practice related to the refocused role and perceived challenges, adding to the evidence base on SN practice in Scotland.

My study has also addressed identified gaps in the literature in relation to children's, parents' and teachers' experiences and understanding of SNs' mental health work by directly engaging with them and seeking their views, thereby contributing new knowledge to the field. By conducting research with children, parents and teachers, and by asking them about their experiences of the SN, this research has created insights into their understanding and this information will be helpful to inform the future practice of SNs to reflect their needs and expectations.

My study drew on Bronfenbrenner's (1995) Bioecological Systems Theory and Dossey's (2008) Holistic Nursing Theory to provide a lens through which to view SN mental health practice and, to my knowledge, this is the first study in the field of SCPHN-SN practice to utilise this theoretical perspective. The principles and four elements of the PPCT Model (Bronfenbrenner 1995) informed each stage of the research process and were applied through each stage of the study, which contributes to the knowledge base on the application of Bioecological Systems Theory (Bronfenbrenner 1995). To address criticism that this theory is often misused in research, details of the four key elements and how they were being applied were provided in Chapters Three, Four, Five and Six. Applying the PPCT Model in this way offers insights into its use for research and practice in the field of specialist community public health nursing and for research with children.

This chapter now considers the strengths and limitations of this study and the implications and recommendations for future research, policy and practice.

8.3 Strengths

This study has several strengths. Firstly, the scoping review of the literature identified and synthesised a large body of literature and specifically pertains to the SN mental health work with primary-school-aged children, addressing an identified gap in the literature.

Secondly, the online questionnaire with nurses working in the school health service in Scotland was a national cross-sectional survey focusing specifically on exploring the work of SNs in supporting primary-school-aged children's mental health, addressing an identified gap in the literature, and this provides insights into SN mental health practice in Scotland. Moreover, in contrast to previous surveys of SNs working across the UK, which have low response rates from Scotland (e.g., 4% RCN 2016 and 3% Sammut et al. 2023), the response rate of 29.5% is significantly higher and therefore more representative of Scottish SN practice. The average response rate for online surveys is reported to be approximately 33% (Nulty 2008), although, more recently, Menon and Muraleedharan (2020) suggest that response rates range between 25 and 30%. Thus, the response rate to my survey can be considered as good.

Thirdly, I set up Advisory Groups to seek the views of SNs, teachers, children and parents on the wording and layout of information leaflets and consent forms and topic guides and their feedback resulted in refinements to enhance clarity and readability, and the amendment of some of the interview questions. I also obtained their thoughts on the participatory methods I was planning to use for data collection to ensure that they were child-friendly, inclusive, and set at the right educational level. The use of creative participatory methods in the one-to-one semi-structured interviews with the children helped to facilitate conversations with them and support them to talk about their experiences and understanding enabling their views to be heard.

Fourthly, I conducted case study interviews with four distinct groups of participants, each requiring different skills to effectively collect data. The complex ethics process and the amendments required due to unexpected global events added to the challenges of gathering data and my skills in building relationships with gatekeepers were a key component in successfully executing the research study.

Finally, I used bioecological systems theory as an organising theory across the whole research process which serves to exemplify the practical application of ecological theory in the field of school nursing; and specifically in the context of their mental health work with school-aged children. Currently there are no similar published studies, and this can be considered novel.

8.4 Limitations

There are some limitations of this study. First, Phase Two was undertaken in one health board area and the sample size of the participating SNs, children, parents, and teachers was relatively small ($n=23$), thus caution is required when interpreting the findings. Nonetheless, the study was not designed for the purpose of generalising the findings. Rather, it was an instrumental case selected to understand the mental health work of SNs working in one health board area in Scotland.

Secondly, only two teachers were recruited to the study, therefore, their perspectives may not reflect the views of teachers working in other schools in the case study area or more broadly across Scotland and the UK. Nevertheless, they do reflect the views of the teachers in the advisory group, and therefore they can help inform future SN practice and the implications and recommendations for practice, research, and education.

Thirdly, the children attended primary schools that were in the 10% least deprived local authority areas and, therefore, their experiences of the SN may not reflect the experiences of children attending schools in more deprived areas. Nevertheless, they do reflect the views of children in the advisory group and the experience of children reported in previous research.

Fourthly, no parents attended the meeting set up for the Advisory Group of parents and, instead, I shared the information leaflets and consent forms by email with two parents I knew who had children aged 9–11 years to obtain their views. Because the parents knew me, this may have influenced their views.

Fifthly, the interviews were conducted online due to lockdown restrictions, and it was difficult to develop a relationship with the participants, particularly the children. It is possible that participants may have shared more information if I had been able to meet them prior to the interviews. Due to the need to move my fieldwork online, I had to adapt my Talking Mat™ resource to use it online, as the resource I had purchased was the original version and not the digital version. However, due to the nature of the interview questions, I had to abandon the use of a top-scale, as stipulated in the Talking Mats™ principles, as it was not appropriate during the interviews. For this reason, the technique I used cannot be called a Talking Mat™ (Murphy et al. 2023), despite the fact that it did support children to express their views.

Finally, from the outset of the research I have acknowledged my perspectives about the role of the SN in promoting and supporting primary-school-aged-children's mental health. As outlined in Chapter One, although I am a SCPHN, I am not a SN and have not worked as a SN and my perspectives are shaped by the literature, policy, the standards of proficiency for SCPHN (NMC 2004) and by

my experience in practice. As an empirical researcher, I kept an open approach throughout my study, critically reflecting on my role in the research and justifying the decisions that I have made at each stage of the research process. I believe this minimises any risk of bias in the study.

8.5 Recommendations for future research

There is a need for research to evaluate SN mental health interventions, particularly the innovative ‘walk and talk’ intervention adopted during the pandemic, to assess the process, benefits and barriers of taking a SN intervention outdoors. A realist review of SN interventions for promoting and supporting school-aged children’s mental health would build on my findings and provide SNs with evidence to support their practice.

Performing research on the media coverage about mental health during and after the pandemic and its impact on primary-school-aged children would help to address some of the findings outlined in my thesis and increase understanding of the role of the media in developing children’s health literacy. To this end, a qualitative study involving primary-school-aged children, parents and teachers would be helpful.

It would be useful to analyse the practical application of the PPCT Model for SN practice to assess the benefits and limitations. This may be of value for educators when designing SCPHN education.

8.6 Implications and recommendations for policy and practice

8.6.1 Policy

This research suggests that the role and remit of SNs needs to be included and clearly articulated in whole-school approaches to mental health. We already know whole-school approaches may help to address the associated issues of anxiety and poor school attendance (Rowlands 2022). My findings on teachers’ experiences of working with the SN imply that the SN is in a unique position to build trusting, nurturing relationships, not only with CYP, but also with their

families and the community, as they are at the interface between the school, the CYP, the family and the community.

This study provides a clear steer for commissioners of SN services to prioritise investment in the SN service to increase and retain the SN workforce and provide them with the required resources to support school-aged children's mental health. In Scotland, consideration should be given at a national level to recognise the specialism of SN by performing a review of the national job description and ensuring that financial recognition of this role is in line with health visitors and family nurses. This is necessary, given that SCPHN-SN education is delivered at Master's level, and that the role is more autonomous to meet the increasingly complex, diverse, and changing needs of school-aged CYP. There is a risk that failure to review the grading of SNs to reflect their specialist public health role will result in more SNs leaving the profession. It may also become more challenging to attract and recruit registered nurses or midwives into the profession, to the detriment of the health, wellbeing and attainment of CYP.

The evidence from my research points to the need for consistency in the implementation of the SN pathway across Scotland and consistency in the assessment tools and resources used to ensure equity of SN services. The current SN Pathway is focused on targeted intervention, but my research implies that a universal service, focusing on primary prevention and developing the resilience of children, families and communities, is likely to be more cost-effective. My findings highlight that children and most parents do not know who the SN is and what they do. This implies that SNs need to be visible in schools, and, therefore, consideration should be given to developing a SN Universal Pathway, similar to the HV Universal Pathway (Scottish Government 2015c) that sets out the minimum contacts to be offered to all school-aged children by SNs. A SN Universal Pathway would ensure consistency of SN practice across Scotland. It would also offer an opportunity to promote the SN service at a national level so that children, parents and teachers know what SNs do, and how to access them, thereby raising the profile of SNs in supporting not only CYPs mental health, but also their health, wellbeing and attainment.

8.6.2 Practice

My findings on the participants' understanding and experiences of the SN and their role in supporting children's mental health prompt a direction of travel for SNs to promote their role within schools and the community to raise their profile and increase awareness of their contribution as SCPHNs. They should embrace the new SCPHN standards (NMC 2022) and exercise their autonomy, agency and leadership skills to influence policy and practice and ensure that their role is included in and clearly articulated in whole-school approaches. Adopting an ecological perspective to SN agency may help to explain why SNs continue to lack visibility in schools despite repeated recommendations from research. It may also support SNs to exercise their agency to influence commissioners of SN services and policy makers to act. SNs will also need to work more strategically to demonstrate the value of their service and promote investment in the SN workforce and commissioning of SN services. Creating demand for their service by using social media platforms to advertise their role may be what is required for policy makers and commissioners to increase SN numbers, as recommendations from research over the last two decades have not had an impact. However, I appreciate that this is likely to impact on their capacity to respond to referrals, and this will be a challenge.

SNs need to be visible in schools and within the community, and they should apply their advanced communication skills to build relationships with schools and create opportunities for the SN to be introduced to parents and children at key transition times. A photograph of the SN should be clearly displayed within the school and a monthly update from the SN on the school Facebook page and/or school newsletter should be considered. Information needs to be accessible when parents require it and given that we live in a digital age, information about the SN needs to be in a digital format that is easily accessible.

Perhaps the time is right, with the NMC regulatory reform and review, for SNs to consider whether their title accurately reflects their role, given that SNs are not based in schools. The title of Health Visitor for Schools may be a more accurate representation of their role and remit, although I do acknowledge that this suggestion will be controversial.

8.6.3 Education

Higher Education Institutions providing SCPHN-SN programmes should ensure that the curriculum includes content on mental health and evidence-based interventions that can be used practically to support primary-school-aged children's mental health. There is also a need to ensure that the curriculum prepares them with the skills to lead SN services, influence policy and strategy, and promote the visibility and profile of the SN service to address the determinants of health and associated inequalities.

There is a need to educate initial teacher education students and primary school teachers about the role and work of the SN to increase their knowledge and understanding. My research implies that there is a need to increase literacy about mental health to normalise anxiety and to support early identification and support. Applying the PPCT Model (Bronfenbrenner 1995) as part of a whole-school approach could provide a lens to identify opportunities to support children's mental health and improve their health and wellbeing outcomes. Therefore, SNs should be involved in promoting health and wellbeing in partnership with teachers by using their specialist knowledge and skills in health promotion interventions to intervene early to promote good mental health. Because outdoor learning is part of the core curriculum and is associated with challenge and enjoyment for children and has been found to be a low- or no-cost experience (Mannion et al. 2015), the innovative 'walk and talk' intervention used by SNs during the pandemic could be a cost-effective intervention to support and promote CYPs mental health.

8.7 Conclusion

The SN has a vital contribution to play in supporting primary-school-aged children's mental health as part of a whole-school approach. The development of trusting relationships with the child, parents, teachers, and key people in the child's wider world are crucial for the provision of effective and early support. To achieve this, it is fundamental that SNs are working in schools and the community to promote good mental health and build the resilience of the school-aged child and the people in their wider world, as their mental health work is 'all about the

relationships'. This will require a commitment from commissioners of service to invest in the recruitment and retention of SCPHN-SNs.

8.8 Final Reflections

Completing this thesis has been a journey of ups and downs, and, on several occasions, I have considered giving up. To do that, however, would have meant letting down the people who gave up their time to share their experiences with me, and, crucially, not allowing their voices to be heard on a topic that has even more significance than when I began. The Scottish Government are interested in the findings from my thesis to inform future policy, and this is an exciting prospect, as my research will have impact and should make a positive difference to SN practice and the mental health of CYP.

Completing my thesis has enabled me to develop my research skills and has provided an opportunity to conduct research with children that will be invaluable for planning and conducting future research. It has also provided an opportunity to gain a deeper insight into the work of SNs, adding to my knowledge, understanding and experience of SN practice. The evidence base for SN practice is limited, but research in the field is growing, and I look forward to developing collaborations with researchers in the field.

Now I have reached the end of my journey, and can look back at the research process, I have pondered about whether I would do anything differently. With hindsight, I think that the digital version of Talking Mats™ would have been more flexible for use in face-to-face and online environments, and it may also have been preferable and more familiar for the children as I have been surprised by my two-year-old grandson's manual dexterity using a tablet. I have also considered whether I needed to use the adapted Talking Mats™ resource in the interviews with the children and whether my decision to use them was to meet my needs or those of the children. I have found this quite difficult to answer, as the university had paid for my training and the resources to use for my research, and so I wanted to use it, but I also wanted to ensure that I provided opportunities to support the children's participation. Whilst I found that adapting the resource helped to provide prompts to encourage children to share their views with me,

especially some of the boys who were a bit shy, I also found it clunky, and some children became a bit fidgety. However, I do feel that it was the right decision at that time and without it I do not think I would have been able to explore the children's views in as much depth.

The pandemic added an additional layer of challenge to my studies, especially negotiating fieldwork, and this did have an impact on timescales. If I had not completed Phase One, I would have completed my study sooner. However, I would not have gained skills in conducting survey research or mixed methods. I feel that gaining access to participants would have been more challenging without my skills in relationship building and the networks that I had developed in my professional practice. It also taught me that I am more resilient than I thought, and that I am lucky that I have a supportive family and friends and a network of support in my working community. Yet, this is not the case for many CYP and their families who are living with adversity. Completing my thesis has reinforced how essential it is to intervene early through primary prevention to promote good mental health and build the resilience of children, families, and communities.

My final thought is that developing 'a trusting relationship' with the child is perhaps the most important intervention for effective SN practice to support and promote children's mental health and improve their outcomes across the life course. If we are to get it right for every school-age child, we need to create environments where they feel safe, respected and listened to by people in their wider world. SNs' orientation to practice is holistic, strengths-based and person-centred and they are in a good position to support children to flourish working in partnership with families, teachers and communities.

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Appendix 1: Included Studies

Author(s)	Source	Year	Country	Study Aim	Study Design	Methods	Study Population	Findings	Limitations
Abhyankar, P. and MacGillivray, S.	Unpublished Research Report (NMAHP-RU).	2014	Multiple (USA, Canada, UK, Australia, Sweden, Denmark, Finland, Netherland)	To outline the best model to achieve positive outcomes for CYP aged 5-19 and the role of the SN in delivering these in school and via a public health community role	Systematic Review	Rapid systematic review	SNs CYP aged 5-19 years	Schools with a SN are associated with an increased chance of identifying health concerns than those without a SN. SN interventions tend to be targeted towards supporting CYP with known health issues. Interventions that involve parents and children are effective in increasing knowledge, changing beliefs and health indicators. The FRIENDS (CBT) programme delivered by SNs had a preventive effect in the short and	Lack of studies (n=3) focusing on mental health interventions delivered by SNs. The FRIENDS programme did not include a control group.

								long term and was also an intervention. A mental health education programme delivered by SNs was associated with increased understanding of mental illness and factors causing mental ill health, stress and suicide in CYP aged 10-12 years.	
Bartlett, H.	The British Journal of School Nursing	2015	UK (England)	To explore and analyse primary research regarding the role of the school nurse in the provision of care for children and young people with mental health needs.	Literature review	Systematic review	SN CYP aged 5-19	Paucity of literature focusing on the SN role in providing mental health support. CYP had limited contact with the SN and expressed need for SN to be more accessible. Workload, lack of training in mental health and lack of awareness of SN role barriers to their practice.	Indicates this was a systematic review of the literature, but not reported in line with a systematic review. No details about the quality of the included studies.

Bohnenkamp, J.H., Hoover, S.A., Connors, E.H., Wissow, L., Bobo, N. and Mazyck, D.	The Journal of School Nursing	2019	USA	To use a multilevel stakeholder-driven process to refine the Mental Health Training Intervention for Health Providers in Schools (MH-TIPS)	Concurrent Mixed Methods Study	Key informant interviews Focus Groups Quantitative Survey	SN Experts (n=6) SN (n=20)	The SNs were interested in attending in-service CPD on mental health and it was identified as a training need. Participants wanted training on assessment, interventions, referral and psychotropic medication. Barriers to attending training included workload, staffing issues and lack of resources.	The study was conducted in the USA and the role of the SN may be differ from that of the SN in the UK. There is a lack of detail about the characteristics of the participants.
Campbell, P., Pollack, A., Levati, S., Frost, R., Calvely, E. and Williams, B	Unpublished Research Report (NMAHP-RU)	2014	Multiple (Europe, North America and Australasia)	To identify evidence based, effective intervention that are deliverable by SNs to a school-age population in the areas of mental health	Scoping Review of Reviews	Identification of effective school-based interventions relevant to study aims	Children and adolescents (3-20 years)	Psychological/educational interventions may have a beneficial effect on the prevention of depression for approximately one year when compared to no intervention. Emotional wellbeing interventions may have a detrimental effect on mental health	The review may not have captured all the available literature as it was a rapid review. Sample sizes of include reviews were small and most

				and emotional wellbeing, safeguarding, sexual health and substance misuse				Anti-bullying interventions may not be effective for improving mental health Lack of evidence comparing interventions to attention control or interventions using a placebo. More research required on the benefits of exercise for CYP mental health and emotional wellbeing	of the trials were judged to have moderate or high risk of bias. For most of the included studies it is not stated or reported who delivered the intervention
Chase, E., Chalmers, H., Warwick, I., Thomas, F., Hollingworth, K. and Aggleton, P.	The British Journal of School Nursing	2019	UK (England)	To examine some of the different ways in which nurses are enable and supported to contribute to the promotion and safeguarding of children and	Mixed Methods	Four stages: Literature review; Interviews with national stakeholders; Telephone survey of nurse managers;	National stakeholders (n=23) PCT/LA stakeholders (n=31) SN Managers/Leads (n=34)	Variation in practice, issues with capacity of school nurses to effectively support school-aged children's health. CP work took up a considerable amount of their time and they were less involved in health promotion. Lack of reliable data to help SNs	Small sample of school nurses. Information taken from managers and stakeholders on school nursing time and caseload rather than

				young people's health and wellbeing within school settings. There were 4 RQs.		Five in-depth case studies-used interviews and focus groups.	SNs (n=10) Parents (n=12) School-aged CYP (n=204) School staff (n=39)	identify health needs. Schools and agencies lack understanding of SN contribution. Need for more feedback from children. Conflicting demands on SN between reactive and proactive work.	from the school nurse perspective.
Children's Commissioner for England	Children's Commissioner for England	2016	UK (England)	To investigate the SN role in child protection.	National Survey	Open and closed questions	SNs (n=775)	SNs work is often reactive rather than proactive. Most of the SNs felt that school-aged CYP were unaware of the SN service. Barriers to the SN role included administration which took up twice as much time than their direct work with CYP. Their safeguarding and child protection work took up a significant amount of their time.	Guidance for SNs in England is different to Scotland. Sample included SNs working across England and the role of SNs working in independent schools may vary from SNs working in the health service.

Clausson, E.K., Kohler, L. and Berg, A	Scandinavian Journal of Public Health	2008	Sweden	To use their knowledge and experience to better understand schoolchildren's health problems and link to their socioeconomic background and gender.	National Survey	Structured and open-ended questions	SN (n=129)	The SNs felt that children's mental health had deteriorated, and issues were increasing amongst girls and in disadvantaged housing areas	SNs assessment of the socioeconomic characteristics was uncertain, and bias may have been introduced in relation to societal views.
Cook, G., Appleton, J.V., Bekaert, S., Harrold, T., Taylor, J. and Sammut, D.	Journal of Advanced Nursing	2022	UK	To examine how school nurse practice evolved as a result of the pandemic.	Scoping Literature Review	Scoping Review using Arksey and O'Malley's framework (2005)	SNs	SNs were adaptable in their practice and creative in their response to the pandemic to ensure CYP received the school health service. They worked closely with professionals in the multi-disciplinary team. Awareness of the SNs public health role increased during the pandemic. However, their expanded public health role impacted on	Generalisability of findings is limited as most derived from the USA and most were opinion pieces and not primary research.

								and added to their already heavy workload.	
Debell, D. and Tomkins, A.S.	Amicus/CPHV A	2006	UK	To understand school nursing practice across the UK and to identify the evidence base and any gaps	Scoping Literature Review	Scoping Review	SNs	SNs service are diverse in each nation of the UK and this makes it challenging to represent the service to stakeholders and commissioners. There are also differences between government policies and their implementation into practice. There is a lack of knowledge on the relationship between SN costs and benefits of the SN service. Research into SN practice is difficult to access.	Researchers have not highlighted any limitations. Limited details of the methodology used and search findings.
Dina, F. and Pajelic, Z.	Global Journal of Health Sciences	2014	Sweden	To describe Swedish school nurses experience of their work with schoolchildren	Qualitative Study	Semi-structured interviews	SNs (n=10)	SNs use different tools when working with CYP with mental health issues. The tools used most frequently included motivational interviewing,	Small number of participants. Researchers do not state the limitations or

				with a mental illness.				regular health talks, individual and family counselling and promoting children's confidence. Working co-operatively with parents was important and involving the family.	strengths of the research.
Doi, L., Wason, D., Malden, S. and Jepson, R.	Scottish Government	2017	UK (Scotland)	To assess how, whom and under what circumstances the new school nurse pathway works and to provide learning and training prior to the national roll out of the pathway.	Realist Evaluation using quantitative and qualitative data (mixed methods)	Interviews and focus groups.	SNs (n=27) SN managers (n=6) Members of wider school health team (n=8)	MH and wellbeing pathway was the one most used but SNs found the most challenging. Though SNs were provided with extensive training they still lacked confidence and skills to deliver mental health interventions. No noticeable difference between SN with or without specialist practitioner qualification (SPQ). SNs felt that they were less accessible to CYP but their relationship	Only 5 of the nurses had an SPQ and 1 had a public health nursing qualification. Lack of clarity if these were registered SCPHN-SN. 6 SNs and 6 wider health team members did not participate.

								with the limited number of children and families using service was stronger.	
Doi, L., Wason, D., Malden, S. and Jepson, R.	BMC Health Services Research	2018	UK (Scotland)	To assess how, for whom and under what circumstances the programme works to provide learning to support SN training and national roll-out	Mixed Methods using a realist evaluation approach	Individual interviews Focus Groups Programme documents	SNs (n=27) SN managers Members of wider school health team	The SN programme provided enhanced opportunities for early identification of health and wellbeing needs. Of the 9 pathways, the MH and wellbeing pathway was the one most used. SNs felt less confident working with CYP with low to moderate mental health cases and referred complex cases to CAMHS. The pathways increased awareness of the SN role but there were uncertainties around the role of the wider school health team.	The study sites were in relatively affluent areas.. A few SNs declined to take part and their views may have differed and influenced the findings.

Ekeland, E., Heian, F., Hagen, K.B., Abbott, J. and Nordheim, L.	Cochrane Database of Systematic Reviews	2004	Multiple (USA Canada Nigeria Australia)	To determine if exercise alone or as part of a comprehensive intervention can improve children and young people's self-esteem	Cochrane Systematic Review	Systematic Review	CYP aged 3-19	Exercise may be effective in the short-term in increasing CYPs self-esteem.	Small number of participants in the included studies. Not clear what type of exercise and in what setting is most effective.
Garmy, P., Rahr, C., Persson, L. and Einber, E.L.	The Journal of School Nursing	2023	Sweden	To investigate SNs' perspectives on school-aged children and young people's health during the pandemic	Cross-sectional survey	Web-based survey	SNs (n=225)	Main findings associated with SNs perceptions of mental health during the pandemic between girls and boys; differences in health between deprived and affluent areas; and common reasons for spontaneous visits to the SN. During the pandemic the mental health of CYP decreased. It showed a greater decrease in girls and SNs working in vulnerable areas rated CYP physical and mental health as poorer than that	Poor response rate (less than 10%). No specific response options for anger management, depression or suicidal ideation. Views of CYP not sought and possibility of recall bias

								of CYP from other areas. Headache and stomach-ache were the main reasons why girls visited the SN, but sports injuries and wounds were most common reasons for boys.	about mental health. SNs based in schools which differs from the UK.
Haddad M., Butler, G.S., and Tylee, A.	Journal of Advanced Nursing	2010	UK	To identify school nurses views on their role, training needs and attitudes towards depression in young people.	Cross- sectional UK-wide Survey	Postal Questionnaire	SNs (n=258)	Almost half of respondents had not received any post- registration training in mental health. Training needs included brief psychological interventions and how to deliver these, self-harm and how to recognise depression and anxiety. They expressed a need for more effective communication and support with CAMHS. Inadequate time and staffing levels were identified as barriers to enable appropriate	Respondents recruited via professional organisations and this may have introduced bias as SNs who were not members were excluded. Response rate lower than expected and limits generalisability of the findings

								involvement in this area of work	
Haddad, M., Pinfold, V., Ford, T., Walsh, B. and Tylee, A.	International Journal of Nursing Studies	2018	UK (England)	To evaluate the effectiveness of a bespoke short training programme.	Cluster-randomised controlled trial	Vignettes were used to detect depression and attitudes measured using the Depression Attitude Anxiety Questionnaire	SNs (n=146)	Training was linked with improved knowledge about depression and a significant increase in the recognition of depression at 3- and 9-months post training. SNs confidence also increased when working with young people experiencing a mental health issue. The SNs were more optimistic about depression outcomes but continued to defer the management of depression to specialists.	Loss of participants during the study may have introduced bias and the generalisability of the findings. Recruitment was first come, first serve and may have attracted SN services that were more interested in the study.
Jonsson, J., Maltestam, M., Tops, A.B. and Garmy, P.	The Journal of School Nursing	2019	Sweden	To describe SNs' experiences of working with children with	Qualitative Study	Semi-structured Interviews	SNs (n=14)	SNs obtained job satisfaction from working with CYP with mental health problems. They also found it rewarding. However, they also found	Sample size was small and it did not include any male SNs.

				mental health problems.				this emotionally challenging.	
Langford, R., Bonell, C.P., Jones, H.E., Poulio, T., Murphy, S.M., Waters, E., Komro, K.A., Gibbs, L.F., Magnus, D. and Campbell, R.	The Cochrane Database of Systematic Reviews	2014	Multiple (USA, Australia, Germany, Finland, Switzerland, Canada, Spain and Netherlands)	To assess the effectiveness of health promoting schools framework in improving health and wellbeing of school aged children	Cochrane Systematic Review	Systematic Review	CYP aged 4-18 years attending school or college	They found two studies focusing on mental health, but no evidence that the HPS framework was effective. Recommend further research to establish effectiveness of the approach.	The quality of the included studies was low to moderate. The conduct of some studies introduced bias and this together with the small number of studies included limited the ability to make conclusions about the effectiveness of the HPS framework
Markkanen, P., Anttila, M.	Children	2021	Finland	To describe in detail the role of Finnish SNs in supporting	National Survey	Open and closed questions	SNs (n=136)	Depression, anxiety, and family stressors were the	Poor response rate (21%) which limits

and Valimaki, M.				student's mental health at school, the mental health problems SNs identify and how they prepare themselves to support student's mental health, interventions used and barriers to supporting student's mental health				main mental health issues that SNs reported.	transferability of the findings
Merry, S.N., Hetrick, S.E., Cox, G.R., Brudevold-Iversen, T., Bir, J.J. and McDowell, H.	Evidence-Based Child Health: A Cochrane Review Journal	2011	Multiple	To determine if psychological or educational interventions or both, are effective in preventing the onset of depressive	Cochrane Systematic Review	Systematic Review	CYP aged 5 to 19 years and did not have a diagnosis of depression	Targeted and universal depression prevention programmes may prevent the onset of depression when compared to no intervention at 3 to 9	The lack of a placebo and lack of clarity about allocation concealment limit the

				disorders in children and adolescents.				months and 12 months post intervention.	confidence of the findings.
Pawils, S., Heumann, S., Schneider, S.A., Metzner, F. and Mays, D.	PLoS One	2023	Multiple (USA, UK, Italy, Poland and Germany)	To examine the effectiveness of school nurses in promoting children's health.	Overview of Reviews	Overview of Reviews based on Biondi-Zoccai (2016) guidelines	SNs	The reviews focused on SN led interventions. Only 2 studies in the review focused on SN led mental health interventions. Computerized CBT was found to reduce child anxiety following the intervention. The Reynolds Adolescent Depression Scale (RADS) indicated a reduction in depressive symptoms following coping skills intervention compared to CYP in the control group	Issues with the methodological quality of the reviews. Limited details on ratio of SN to CYP and there are differences in the qualifications, role and remit of the SN. Reference to the SN mental health intervention in the reference list is incorrect.
Prymachuk, S., Graham, T., Haddad,	Journal of Clinical Nursing	2012	UK (England)	To explore the views of SNs regarding	Exploratory Qualitative Study	Focus groups x 4	SNs (n=33)	SNs felt mental health was difficult to define. They valued their	Did not include views of CYP. Undertaken in

M., and Tylee, A.				mental health problems in young people and their potential for engaging in mental health work with this group				involvement with YP and viewed the mental health aspect of their role as essential. They expressed a strong belief that YP should be listened to. Many of the SNs did not find the title 'school nurse' to be helpful and found it to be a hindrance due to its association with something being wrong. Lack of confidence Identified as a barrier to their mental health work which was associated with a lack of education and training. Other barriers to doing mental health work included workload and poor relationships with CAMHS workers and teachers and tensions with these professionals due to a misunderstanding of the	2 English cities with a limited number of participants which limits the transferability of the findings. Inconsistencies in the way the focus groups were conducted, and different researchers conducted the FG interviews. Participants were self-selecting which increases the risk of bias.
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								role of the SN. SNs suggested shadowing CAMHS professionals and training. Supervision and peer support was felt to be a support.	
Public Health England.	Department of Health and Public Health England.	2014	UK (England)	To provide a framework for local commissioners and providers of school nursing services in England.	Policy Document	N/A	N/A	Sets out what the core SN service can offer and also innovative ways that SN services can be commissioned and developed to ensure seamless delivery of public health for school-aged children and young people. The document highlights SN pathways which include: safeguarding, transition from HV to SN, Youth Justice, DA, Emotional health and wellbeing, young carers and sexual health.	Framework is for the SN service in England.

Sammut, D., Cook, G., Taylor, J., Harrold, T., Appleton, J. and Bekaert, S.	International Journal of Environmental Research and Public Health	2023	UK	To collect information on how SNs' work evolved due to the COVID-19 pandemic with a focus on their work with vulnerable children and young people.	National Cross- sectional online survey	Survey using open and closed questions	SNs (n=78)	Increasing safeguarding workload and increase in number of children with emotional and behavioural issues, anxiety, depression and peer relationship issues. The service became reactive rather than proactive and there was reduced visibility of the child. SNs reported unrealistic expectations of what their service could offer.	Poor response rate. The small sample size makes it difficult to make strong conclusions. The researchers highlight that they did not obtain details of participants gender or age and as the study used online methods and social media it may have attracted younger SNs.
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Sherwin, S.	Community Practitioner	2016	UK (England)	To increase understanding of how SNs provide support to children and young people in the context of their everyday work.	Narrative Inquiry	Unstructured individual interviews	SNs (n=11)	Importance of regular support and building trusting relationships. Challenges linked to emotional investment required by nurses to provide the support required and workforce capacity and demands of the service. SNs identified lack of investment in them but also felt they had an important role. Being able to make a difference was viewed by SNs as rewarding. Needed to be more visible, agency of the school nurse	Small sample size. Aims and research questions differed in different sections of the paper. For example in the conclusion the aim was to explore how SNs provide emotional support to CYP, yet emotional support was not referred to in the aim in the methodology section or in the 4 RQs.

Skundberg-Kletthagen, H. and Moen, O.L.	Journal of Clinical Nursing	2017	Norway	To explore school nurses' experiences with and attitudes towards working with young people with mental health problem in the school health services	Qualitative exploratory study	Open-ended cross sectional study questionnaire	SNs (n=284)	SN lacked confidence and knowledge in working with children and adolescents with mental health problems which was a barrier to the provision of support. SNs required more support and supervision and appropriate assessment tools and clear guidance on their role in the assessment of adolescent's mental health	Researchers did not discuss the limitations of this study. However, as the study was undertaken in a Norwegian context this limits the transferability of the findings due to the differences in SN role in different countries. Do not specify clearly what mental health issues affected children aged 11 years.
Spratt, J., Philip, K., Shucksmith, J.	Pastoral Care in Education	2010	UK (Scotland)	To explore the nurses' role in	National Survey	Telephone interviews	SN managers (n=25)	4 main themes: relationships of trust they built over time, offered a confidential service	Did not seek to explore SNs views of their role supporting

J., Kiger, A., Gair, D.				supporting mental health. To explore the extent to which SNs view their role as enhancing resilience and the tensions and challenges faced by nurses in delivering mental health support in schools.				within limits, detached from the school system, and trained nurses working within a public health model combining medical expertise and a holistic perspective. Tensions between reactive and proactive work	children's mental health. These may have been different from school nurse managers. Not all health boards in Scotland took part in the study.
Stallard, P., Simpson, N., Anderson, S., Goddard, M.	European Child & Adolescent Psychiatry	2008	UK (England)	Not stated. However, it appears to be a study evaluating an emotional health CBT intervention	Quasi-experimenta I (before and after study)	Training Programme	Children aged 9-10 years (n=106)	3 months and 12 months following the intervention, children's anxiety had shown a significant decrease and an increase in self-esteem. By the 12 month follow-up, 9 of the high-risk	Aims of the study not clear. Sample size was small and follow up period relatively short. There was also no control group.

				delivered by SNs				children had moved into the low-risk category.	
Taylor-Beirne, J. and Taylor-Beirne, S.	British Journal of Child Health	2022	UK	To identify school nurses' role supporting school-aged children with mental health difficulties.	Integrative literature review	Integrative Review	SNs School-aged CYP aged 5-19 years	Paucity of literature on SN role in supporting school-aged children's mental health. SNs in a unique position to support school-aged children with emerging and existing mental health issues. SNs lack of knowledge and lack of resources in SN teams, including lack of support from CAMHS are barriers to their practice	Only six studies included in the review which limits the transferability of the findings. Included studies did not include the perspectives of children, parents and teachers.
Turner, G., Mackay, S.	The British Journal of School Nursing	2015	UK (England)	To explore the impact of school nurse interventions relating to mental health and behaviour change in England	Literature Review	Unclear.	SNs	CBT interventions delivered by SNs are associated with positive outcomes for CYP. Satisfaction with SN interventions is associated with a caring, non-judgemental attitude and listening skills.	Limited details about methodology used to conduct the review. Literature review focused on England

								Confidence to deliver mental health interventions is linked to training. There was a lack of formal evaluation of SN interventions and a need for more robust and consistent evaluation. Workload, lack of time and staffing issues are barriers to the evaluation of interventions.	which limits the transferability of the findings. Potential for bias in the included studies as majority focused on local projects with non-representative samples. Small number of papers focusing on mental interventions
Turner, J.B., Cooper, L., Woodward, A., Painter, J., Day, P., Hazelby, G.,	British Journal of Child Health	2022	UK	To understand the role of nurse-led interventions in promoting children and	Mixed Methods	Scoping Review and a Delphi Study	Nurses working with young people's emotional and psychological wellbeing	Dearth of literature especially from the UK on nurse-led interventions to promote CYP mental health.	Limited details about the literature review methodology. Unclear how

Harrop, D., Moore, K.				young peoples' mental and emotional wellbeing across the UK.				Therapeutic relationship important for delivering effective interventions. Early intervention to address resilience, emotional regulation and to prevent ongoing mental health issues were regarded as important by nurses. The effectiveness of these was impacted by challenges in accessing training and supervision. Nurse-led interventions included the Solihull Approach, CBT, motivational interviewing and mindfulness-based approaches.	many of the included papers focused on SN interventions and how many SNs participated in the Delphi Study.
Veizovic, V., Carlson, L., Lofgren, L. and	Pediatrics	2022	Sweden	To describe the experiences of school nurses in the identification of mental illness	Inductive Qualitative Study	Semi-structured F2F interviews	SNs (n=11)	Three categories were identified and the researchers' present details of the findings under each category: the need to share	One SN cancelled her interview and it is possible that she could have

Bramhagen, A.				in primary school pupils.				responsibility, feelings of uncertainty and inadequacy, the importance of relationships	contributed additional data.
Wilson, P., Furnivall, J., Barbour, R.S., Connelly, G., Bryce, G., Phin, L., and Stallard, A.	Journal of Advanced Nursing	2008	UK (Scotland)	To describe HVs and SNs workload and to identify problems and sources of satisfaction in relation to their work with CYP with psychological, emotional, or behavioural problems	Survey	Self-completion questionnaires	SNs (n=100) HV (n=71)	28% of school nurses cited lack of time as a barrier to providing a good service to young people. HVs and SNs cited a lack of training in this area. Self-harming, eating disorders, externalising behaviours and family difficulties comprised the cases that caused SNs the most worry. SNs found that supporting CYP who were self-harming was most satisfying aspect of their role.	Received responses to approximately half the questionnaires distributed but do not know numbers who received the questionnaire. Some completed questionnaires had missing responses.
Woodhouse, A., Bainbridge, J., Miller, J.,	Children in Scotland	2016	UK (Scotland)	To explore what SNs do (past/future roles), what	Qualitative Study	Workshops	Primary and secondary school children	Only 12 children knew who their SN was. Only 3 were receiving support from the SN. There was	Workshop sessions short and sample size small

Thomson, C., Gray, H.				types of issues SNs could help with, what might help YP to know more about the SN role, what might stop them seeking help or making contact and how SN services be accessed moving forward.			in P6/7 and S2- 5 (n=34)	confusion about what SNs do and the problems they can help with. The issues of concern to them included mental and physical health problems, bullying, difficulties with friends and family problems	therefore the findings may not be representative of all school- aged CYP.
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Appendix 2: Request Permission to Recruit Email: Phase One

RE: Request for permission to recruit nurses working in school health service to a research study

My name is Alison Hackett and I am a part time PhD student in the Faculty of Health Sciences and Sport at the University of Stirling. This study is being undertaken as part of my PhD in Health Sciences. The study has been approved by the University of Stirling NHS, Invasive or Clinical Research (NICR) Ethics Committee and it does not require NHS REC Approval.

This is an in-depth study about the work of the school nurse in supporting primary school-age children's mental health in Scotland. It is anticipated that the findings from the research will identify the school nurse contribution and aid earlier intervention and support for children's mental health.

I am seeking to recruit participants for the first phase of the study and am looking for permission to administer an online questionnaire to registered nurses/midwives working in the school health service in your health board or health and social care partnership. Participants will receive an Information leaflet which I have attached for your information and a link to the online questionnaire and consent form. Their participation in the study is entirely voluntary.

If you are agreeable to the study, I would be very grateful if you could provide me with the contact details of the Lead for School Nursing in your area so that I can email them to seek their help in disseminating the invite email, participant information leaflets and the link to the online questionnaire to participants meeting the inclusion criteria.

I shall look forward to hearing from you.

Yours sincerely

Alison

.....

Appendix 3: Thematic Framework Phase One

Thematic Framework for indexing and summarising School Nurses and Children's Mental Health Phase 1

Conventions for Data Summaries

Plain Text=direct summary of what participant has said

Italics=quote from participant

Bold Text=heading

Underlined text=a comment, observation or analytical note by the researcher

1. Demographics

- 1.1. Age range
- 1.2. Gender
- 1.3. Ethnicity
- 1.4. Geographic Location
- 1.5. Job Title
- 1.6. Hours contracted to work
- 1.7. Other

2. Education

- 2.1. Pre-registration
- 2.2. Post-registration
- 2.3. Academic Qualifications
- 2.4. Current Academic Study
- 2.5. Other

3. Experience

- 3.1. Length of time since first qualification
- 3.2. Length of time in position as a school nurse
- 3.3. Training in children's mental health eg attendance at low impact anxiety management (LIAM) Training; cognitive behavioural therapy (CBT); screening for depression; Scotland's mental health first aid for young people
- 3.4. Facilitators/Challenges to accessing mental health training
- 3.5. Other

4. Mental Health Work of the School Nurse

- 4.1. Experience and views of identifying children in need of early intervention for their mental health and emotional wellbeing eg experience and views of assessment. Knowledge and use of Assessment tools.
- 4.2. Experience and views of supporting children's mental health and emotional wellbeing eg experience and views of providing support. How involved are they and how involved do they think they should be.
- 4.3. Interventions and approaches to support children's mental health eg what interventions do they use to support primary school age children's mental health. What experience and understanding do they have of nurture schools and the use of nurturing and strengths based approaches.
- 4.4. Liaison with Named Person at transition eg Health Visitor from preschool setting to primary setting and Head Teacher from preschool setting to primary school and from primary to secondary school.
- 4.5. Experience of multi-agency and partnership working eg relationships with parents, children, community paediatricians, health visitors, social workers, head teachers and teachers. Contact and referrals and requests for assistance, how are these made and from whom.
- 4.6. Perspectives on preparation and support for their mental health work eg how well prepared do they feel? How confident do they feel? Where can they access support?
- 4.7. Other

5. Transforming School Nursing

- 5.1. Experience and views on the implementation of the School Nurse Pathway eg has the pathway been fully or partially implemented where they work. Perceptions of any facilitators or challenges to implementation in their area.
- 5.2. Experience and views of home visiting eg do they visit children and families at home and do they deliver interventions in the home. What are their views of this aspect of their work
- 5.3. Recommendations/suggestions/key areas for improvement for future work in identifying and supporting primary school children's mental health
- 5.4. Other – any other impact of transforming school nursing

Appendix 4: Ethics Approval Phase One

JE/TB



NHS, Invasive or Clinical Research (NICR)
Committee

Room G10
Pathfoot Building
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 467390
Email: nicr@stir.ac.uk

Dear Alison

Exploring school nurses' work in supporting children's mental health NICR (17/18) Paper 053

Thank you for your email of July 17th which included the following attachments:

- Cover letter
- Appendix 1
- Appendix 3
- Full dataset trial form (amended)

I am pleased to advise that your study has been granted approval, and wish you and your team all the best.

May I remind you of the need to inform NICR (nicr@stir.ac.uk) prior to making any amendments to this protocol, or any changes to the duration of the project and provide notification of study completion. A site file of all documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the NICR webpage at:

<http://www.stir.ac.uk/research/integritygovernanceethics/researchethics/formsandguidance/>

Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

NICR 17/18 – Paper No 053
Please quote this number on all correspondence

Yours sincerely

A handwritten signature in blue ink, appearing to read 'J. Evans'.

Dr Josie Evans
(Depute Chair)

Appendix 5: Thematic Framework Phase Two-SNs

Thematic Framework for indexing and summarising School Nurses and Children's Mental Health (SNACMH) Phase 2

Plain Text=direct summary of what participant has said

Italics=quote from participant

Bold Text=heading

Underlined text=a comment, observation or analytical note by the researcher

1. Demographics

- 1.1 Gender
- 1.2 Ethnicity
- 1.3 Job Title
- 1.4 Hours contracted to work
- 1.5 Other issues

2. Education

- 2.1 Pre-registration
- 2.2 Post-registration
- 2.3 Academic Qualifications
- 2.4 Current Academic Study
- 2.5 Training eg child protection, courses other than mental health
- 2.6 Other issues

3. Experience

- 3.1 Length of time since first qualification
- 3.2 Length of time in position as a qualified school nurse
- 3.3 Length of time in school nursing service
- 3.4 Training in children's mental health eg attendance at low impact anxiety management (LIAM) Training; cognitive behavioural therapy (CBT); screening for depression; Scotland's mental health first aid for young people, Solihull

- 3.5 Facilitators/challenges to accessing mental health training
- 3.6 Importance of experience specifically in relation to mental health work of the school nurse eg trained as a Mental Health Nurse
- 3.7 Other issues

4. Skills required to support the mental health work of the school nurse

- 4.1 Communication verbal and non-verbal eg experience and views of importance of communication skills
- 4.2 Building relationships eg experience and views of importance of building relationships, attributes required eg kind, caring
- 4.3 Assessment and decision making eg experience and views of assessment. Knowledge and use of Assessment tools such as GIRFEC NP Model.
- 4.4 Transferable eg reflection
- 4.5 Health promotion
- 4.6 Intuition
- 4.7 Other issues

5. Mental health work of the School Nurse

- 5.1 Settings used for their mental health work eg home, clinic, school, virtual
- 5.2 Interventions and approaches used to support children's mental health eg what interventions do they use to support primary school age children's mental health. What approaches do they use eg holistic, person centred? experience and understanding do they have of nurture schools and the use of nurturing and strengths based approaches?
- 5.3 Experience and understanding of supporting children's mental health eg experience and views of providing support. How involved are they and how involved do they think they should be. Do children and parents know who they are and how to contact them?
- 5.4 Perspectives on preparation for their mental health work eg how well prepared do they feel? How confident do they feel? Has their preparation had an impact on their practice?

- 5.5 Experience of multi-agency and partnership working eg relationships with parents, children, community paediatricians, health visitors, social workers, head teachers and teachers. Contact and referrals and requests for assistance, how are these made and from whom.
- 5.6 Facilitators/Challenges/Barriers to their mental health work eg lack of resources, capacity, Covid, support from management, technology, visibility, clarity of role.
- 5.7 Other issues

6. Support

- 6.1 Supervision eg what type of supervision is offered and how often?
How does this influence their mental health work?
- 6.2 Peer support eg what is their experience of peer support?
- 6.3 Management eg what is their experience of support from management in relation to supply of resources, attendance at training, promoting the service?
- 6.4 Recommendations/suggestions/key areas for improvement for future work in identifying and supporting primary school children's mental health
- 6.5 Other issues

Appendix 6: Topic Guide: Children

Topic Guide for Interviews: Children

Beginning

Re-introduce myself and the research. Check that they are still interested, whether have any questions. Explain confidentiality. Check consent. Show recorder, record and play back: who will listen (me), where I will store it, and anonymity (made up names or numbers).

Check if any questions before start?

Place the Health picture at the bottom. Today we are going to talk about how the school nurse can help children's mental health.

Can you tell me what mental health means?

Inform the child what the term mental health means: (Use TM Picture card)

Everyone has mental health. It is about our emotions and feelings and things that happen in our lives and how we cope with them. It affects how you think and feel and how you behave. So our mental health can be good and we hope it's always good, but sometimes it's not and sometimes it can make us feel as if we've got a sort of a fuzzy, a funny feeling in our tummy like butterflies when we are worried about things and sometimes it can make us have a funny feeling in our head as well if we are worrying about things and we feel a bit anxious about things.

Now Share Screen and show icons for Health and Mood

Experience and Understanding of the School Nurse Work

What do children know already?

1. Can you tell me about a time when you were in contact with a school nurse?
 - a. Tell me a bit more about that. If unable to describe move onto Q6
2. What did you like the most about the school nurse's responses?
3. What has the school nurse done to make things better for yourself?
4. Is there something you would like them to have done differently?
5. Is there something else they could have done?
6. Can you think of any ideas why a child your age might see the school nurse?
7. Where do you think children might see the school nurse? May need to prompt-in school, home, health centre

Influences on children's understanding of the SN work in MH

What do children say influences their understanding of the SN work?

1. Can you tell me where you have seen or heard information about the school nurse?

Tell me a bit more about that.

Now Use the Talking Mat and the Worry Monster

Support from the school nurse

What support do children want from the school nurse for their mental health?

1. If you had a worry or felt anxious and had that funny feeling in your tummy or a fuzzy feeling in your head who would you tell? I have some pictures here of people you might tell explain them and then ask if they can think of 5 people they might tell
2. What worries do you think that boys and girls your age would like help with? Show the worry monster and explain it and ask what 5 worries they think that children their age might put into the worry monster
3. How do you think the school nurse could help children your age if they had worries or with some of those worries?
May need to provide some suggestions.
4. Has there been a time where you felt you wanted to share a worry and you did or didn't feel able to do that? Depending on answer:
5. What encouraged you to share a worry?
6. What prevented you from doing so?
7. What would help you to get in touch with/speak to the school nurse?

Endings

Includes: Thanks, and certificate. What will do next – will email the Amazon voucher for taking part. Tell them that I still need to speak to other children and parents and that will take quite a long time but when finished will make sure they get something in writing which tells them what came up (no-one will know who said what). Check how feeling, give info sheet numbers for sources of support.

13/03/2021

Appendix 7: Participant Information Sheet-Children

NICR (18/19) 039

UNIVERSITY of
STIRLING



Who am I?

Hello, my name is Alison Hackett. I work at the University of Stirling teaching nursing and health visiting students.

What is the research about?



This research is about finding out if children, parents, teachers and school nurses think that the school nurse can help to support children's mental health and what support they would like.

Why is the research being done?

We don't know enough about what help primary school children want to support their mental health. I'd like to know more about this to help children get the support they need.



Why have I been invited?

Because you are a child aged 9-11 years and your views are important.

What will happen to me if I take part?

You will be invited to take part in an interview with me. I will ask you some questions about the school nurse and how you think they can help children if they have a worry or concern. You will take part in some activities such as drawing, writing and talking about made up





You may also be invited to take part in a group discussion with other girls and boys. You will be given some questions to talk about and take part in activities such as drawing, writing and talking about made up scenarios. I would like to record the interviews and group discussions. I would also like to take photographs of the work you make during the interview and group discussions.

Are there any benefits of taking part?

You may enjoy talking about your experiences and taking part could improve your communication skills and confidence.



Are there any risks of taking part?

There are no risks of taking part in this research. But, if you had any worries or felt uncomfortable then it would be okay for you to ask to leave the room to go to speak to a trusted adult about it.

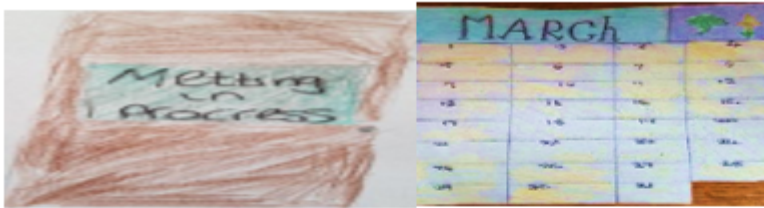
Will anyone know what I have said?



The information you give will be confidential and no-one will be able to tell who said what. When I write up what you and the other children have told me, I will use made up names. Any information that could identify you will be changed or removed. The only time that I would pass anything on, is if someone tells me that they or another child are not safe.

What will happen to the research findings?

I will write a report and they will be published in journals and presented at conferences. You will not be identified in any report or publications. You will be given a copy of the report.

Where and when will the interviews take place?

The interviews will take place online on MS Teams or Google Meet.

Do I have to take part?

No. You don't. If you agree to take part you will be asked to sign a consent form. If you change your mind and you want to pull out of the research at any time then that is okay. You would not need to give a reason.

What if I want to find out more about the research?

If you would like more information please ask your parent or trusted adult to contact me at alison.hackett@stir.ac.uk.

How do I get involved?

If you would like to take part, complete and return the consent form to me at alison.hackett@stir.ac.uk.

Thank you, Alison

Appendix 8: Certificate of Participation: Child



Appendix 9: Certificate of Participation: Adult

INICK (10/12) 032

VCLSI011 T.U

CERTIFICATE OF PARTICIPATION

**Thank you for taking part in my research study:
The school nurse and children's mental health: an exploratory study**

Signature Alison Hackett Date _____

**UNIVERSITY of
STIRLING** 

Appendix 10: Ethical Approval Phase Two

JE/TB



NHS, Invasive or Clinical Research (NICR)
Committee

Room G10
Pathfoot Building
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 467390
Email: nicr@stir.ac.uk

Dear Alison

**Exploring school nurses' work in supporting children's mental health
NICR (17/18) Paper 053**

Thank you for your email of July 17th which included the following attachments:

- Cover letter
- Appendix 1
- Appendix 3
- Full dataset trial form (amended)

I am pleased to advise that your study has been granted approval, and wish you and your team all the best.

May I remind you of the need to inform NICR (nicr@stir.ac.uk) prior to making any amendments to this protocol, or any changes to the duration of the project and provide notification of study completion. A site file of all documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the NICR webpage at:

<http://www.stir.ac.uk/research/integritygovernanceethics/researchethics/formsandguidance/>

Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

NICR 17/18 – Paper No 053
Please quote this number on all correspondence

Yours sincerely

A handwritten signature in blue ink, appearing to read "Josie Evans".

Dr Josie Evans
(Depute Chair)

Appendix 11: REC not Required Phase Two

1/28/2019

Result - Scotland

[Go straight to content.](#)



Do I need NHS REC approval?

i To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

The school nurse and children's mental health: an exploratory study

IRAS Project ID (if available):

246261

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in Scotland**. However, **you may need other approvals**.

You have answered **'YES'** to: Is your study research?

You answered **'NO'** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?

Question Set 2

- Will your study involve potential research participants identified in the context of, or in connection with, their past or present use of services (adult and children's healthcare within the NHS and adult social care), including participants recruited through these services as healthy controls? And/or: Will your research involve potential research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

www.hra-decisiontools.org.uk/ethics/ScotresultN1.html

- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information in, or likely to come into their possession?

Question Set 3

- Does your research involve recruiting adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Will your research involve whole organs retained from a post mortem examination carried out on the instructions of the Procurator Fiscal?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor? And/or: Will your research involve the analysis of DNA from materials that do not contain cells (for example: serum or processed bodily fluids such as plasma and semen) and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health and Social Care (England)?

If your research extends beyond **Scotland** find out if you need NHS REC approval by selecting the 'OTHER UK COUNTRIES' button below.

OTHER UK COUNTRIES

If, after visiting all relevant UK countries, this decision tool suggests that you do not require NHS REC approval [follow this link for final confirmation and further information.](#)

[Print This Page](#)

NOTE: If using Internet Explorer please use browser print function.

From: [REDACTED]
Sent: 13 May 2019 08:06
To: [REDACTED] Alison Hackett <alison.hackett@stir.ac.uk>
Subject: RE: Phase Two of my PhD Study

Hi Alison

Yes, I would agree with Allyson and consider this service evaluation (QI project registration number E702).

Kind regards



Quality Improvement Facilitator



Tel: 01324 614303
emma.wakefield@nhs.net

Appendix 12: Ethical Approvals Education



Alison Hackett



Date: 16 May 2019

Dear Alison

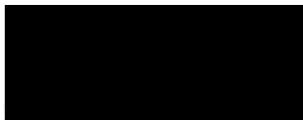
Request for Research

Thank you for completing the pro-forma regarding your research request.

I have signed the pro-forma which is attached.

Final approval should be sought from individual Headteachers. Please include a copy of my approval letter when you make contact with establishments.

Yours sincerely



Chief Education Officer

Sent: 06 April 2021 12:39
To: Alison Hackett <alison.hackett@stir.ac.uk>
Subject: Research request

CAUTION: This email originated from outside University of Stirling. Do not follow links or open attachments if you doubt the authenticity of the sender or the content.

Good afternoon Alison,

It was lovely to speak to you and gain further clarification of your research. To confirm, if you intend to recruit families, children and teachers through University channels you do not need gain permission from [REDACTED] providing that your request is open to those from other local authorities and not only [REDACTED] employees. Should any [REDACTED] employee chose to take part in your research they will be doing so as a student of Stirling University.

I have taken guidance from our legal and data compliance teams. They have advised that any research or publication should not disclose details relating to an individual or provide any details that can relate back to an individual.

Please do not hesitate to contact me if you wish to discuss this further.

Kind regards

[REDACTED]

[REDACTED] **Lead Officer (Secondment)**

Schools, Learning & Education | [REDACTED]
[REDACTED]

From: [REDACTED]
Sent: 11 May 2021 10:23
To: Alison Hackett <alison.hackett@stir.ac.uk>
Subject: Research Request

CAUTION: This email originated from outside University of Stirling. Do not follow links or open attachments if you doubt the authenticity of the sender or the content.

Ms Hackett

Thank you for your email below and I can advise that we would be agreeable for this to happen. We will leave it with you to arrange this through the university, to identify volunteers.

Regards

[REDACTED]

Personal Assistant to Director of Children's Services

Email: [REDACTED]

[REDACTED]

[REDACTED] To: Alison Hackett

Thu 01/04/2021 10:24

CAUTION: This email originated from outside University of Stirling. Do not follow links or open attachments if you doubt the authenticity of the sender or the content.

Dear Alison.

Thanks for clarifying.

If the notice is going out via the University Portal and the teacher you mention is happy to volunteer for it in their own time, then that is absolutely fine.

Best wishes with your research.

[REDACTED]

[REDACTED] Improving Outcomes Engagement Officer
Education Service, [REDACTED]

[REDACTED]

Appendix 13: Participant Consent: Phase One

Consent Form

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that:

- I am under no obligation to take part in the study.
- All information provided by me will be treated with the strictest confidence.
- I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study

- ☐ Yes, I agree
- ☐ No, I do not agree

Appendix 14: Participant Information Sheet: SNs and Teachers



Participant Information Sheet: School Nurses and Teachers

Research Project: The school nurse and children's mental health: an exploratory study



Invitation

You are being invited to take part in this research. Before you decide to do so, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Ask if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

Who am I?



Hello, my name is Alison Hackett and I am a part time PhD student at the University of Stirling. I work as a Lecturer and I am a registered nurse and health visitor. I am interested in early intervention and how school nurses can contribute to supporting children's mental health. This study is being undertaken as part of my research studies. It has been ethically approved by the University of Stirling NHS, Invasive & Clinical Research Ethics Committee.

What is the study about?

I want to find out parents, children, teachers and school nurses' experience and understanding of the school nurse work in supporting primary school-age children's mental health. Evidence suggests that children are not receiving support early enough and it is hoped that the findings will identify the school nurse contribution and lead to earlier intervention.

Why have I been invited?

You have been invited because you are employed as a qualified school nurse in a Scottish Health Board area or you are employed as a teacher in Scottish Local Authority Primary School.

What will taking part in the study involve?

You will be invited to take part in a one to one interview that should take no longer than 60 minutes. The interview will allow you to discuss your experience and understanding of the school nurses' work in supporting primary school children's mental health; factors that influence your experience and understanding and your thoughts on their future contribution. The interview will take place during working hours within NHS premises for school nurses and within the school for teachers employing social distancing. However, if you would prefer, arrangements can be made for the interview to take place via MS Teams or the telephone at

a time convenient to you. You may also be invited to take part in a focus group discussion. The focus group should last no longer than 60 minutes and you will only have to attend once. These will take place during working hours within NHS premises for school nurses and within the school for teachers. The interviews and focus group discussions will be audio recorded. The recording will be deleted once the information is written up.

Do I have to take part?

No. It is up to you whether you take part. Your participation is voluntary.

Are there any benefits of taking part?

There are no direct benefits to you from taking part in this study. However, you may benefit through discussing your experience and by being involved in the research process. You may also enjoy the opportunity to influence service provision and aid earlier intervention and support for primary school children's mental health.

Are there any risks of taking part?

In any study there is a possibility that you may feel uncomfortable talking about some topics, you may also know some of the other participants and there is a risk that you may share some personal or confidential information by chance. However, I do not wish for that to happen. All participants will be asked to respect confidentiality but this cannot be guaranteed. You do not have to answer any question that makes you feel uncomfortable. In the unlikely event of the discussion leading you to visible distress, I will stop the interview or focus group or terminate it completely. You can access a wide range of support, including counselling from the Occupational Health Department in your area of employment if required.

Can I withdraw from the study?

Yes. You will be free to change your mind and withdraw from the study at any point without explanation, by advising me of this decision. If you do this then any interview material will be removed from the study, and no further information will be collected.

Is the information I provide confidential?

Yes. All the information collected will be confidential and anonymous. Confidentiality shall only be breached where the interviewer believes that something you have told them, places you or others at serious risk. In this instance, they are obliged to pass this information on to the relevant persons. All the data collected will be stored securely at the University of Stirling in accordance with the Data Protection Act (2018). Electronic data will be stored on a password protected university computer/laptop and hard copies in a locked filing cabinet in a locked office. The only people who will have access to your data will be myself and my supervisors, Dr Kathleen Stoddart and Dr Greg Mannion.

How will my information be used?

Should you decide to take part in the research study, the information provided by you during the interview will be recorded, transcribed and anonymised. A code will be used to anonymise the data. Audio recordings will be destroyed once transcription is complete. The data will then be analysed and published in my PhD thesis. The data may also be used later

in reports, journal articles and conference talks. These anonymised data will not allow any individuals or your employing authority to be identified or identifiable. No personal information will be presented and any information that may identify you will be removed or changed.

Legal basis for processing personal data.

As part of the project, minimal personal data relating to you will be recorded. This will be processed in accordance with the General Data Protection Regulation (GDPR). Under GDPR, the legal basis for processing your personal data will be public interest.

How do we get involved?

If you would like to take part, please complete and return the consent form in the addressed envelope provided.

Who can we contact for more information?

If, after reading the leaflet, you have any questions or would like to discuss the study further, please contact me at alison.hackett@stir.ac.uk. If you would like to speak to or raise concerns with someone independent of the study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport at jayne.donaldson@stir.ac.uk.

Your rights.

You have the right to request to see a copy of the information we hold about you and to request corrections or deletions of the information that is no longer required. You have the right to withdraw from this project at any time without giving reasons and without consequences to you. You also have the right to object to us processing relevant personal data however, please note that once the data are being analysed and/or results published it may not be possible to remove your data from the study. You have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (<https://ico.org.uk/concerns/>).

The University's Data Protection Officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to data.protection@stir.ac.uk in the first instance.

Thank you for considering helping with this study, the thought and time you have given to consider this research invitation is greatly appreciated.

Alison

Appendix 15: Participant Information Sheet: Parents



Participant Information Sheet: Parents

Research Project: The school nurse and children's mental health: an exploratory study



Invitation

You and your child are being invited to take part in this research study. Before you decide, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Ask if there is anything that is unclear or if you would like more information. Take time to decide whether or not you wish to take part.

Who am I?



Hello, my name is Alison Hackett and I work at the University of Stirling teaching nursing and health visiting students. I am a registered nurse and health visitor. I am interested in early intervention and how school nurses can help to support children's mental health. This project is part of my research studies. It has been ethically approved by the University of Stirling Research Ethics Committee.

What is the study about?

I want to find out parents, children, teachers and school nurses' experience and understanding of the school nurse work in supporting primary school-age children's mental health. Evidence suggests that children are not receiving support early enough and it is hoped that the findings will identify the school nurse contribution and lead to earlier intervention.

Why have we been invited?

You have been invited because you are a parent/guardian of a child aged 9-11 years and your experience is important to my study.

What will taking part in the study involve?

You will be invited to take part in a one to one interview that should take no longer than 60 minutes. The interview will take place online using MS Teams/Google Meet or via the telephone at a time convenient to you. The topics to be discussed will be about your experience of the school nurse, factors that have influenced your experience and your thoughts on the support the school nurse can provide to support children's mental health. With your permission, your child may be asked to take part in the study. After gaining consent from both you and your child, your child will be invited to take part in a one to one interview on MS Teams/Google Meet which should take no longer than 60 minutes. Your child will take part in activities such as drawing, writing and discussing made up scenarios. You and your child may also be invited to attend a group discussion (focus group), although due to the

pandemic this is unlikely. If invited to a group discussion, they should take no longer than 60 minutes, be online and you would both only have to attend once. The interviews and focus group discussions will be audio recorded. The recording will be deleted once the information is written up.

Do we have to take part?

No. It is up to you whether you and/or your child take part. Your participation is voluntary.

Are there any benefits of taking part?

You and your child may also benefit through discussing your experience and by being involved in the research process. Taking part could help to develop your child's communication skills and confidence.

Are there any risks of taking part?

In any study there is a possibility that you may feel uncomfortable talking about some topics, you may also know the other participants if invited to a focus group and there is a risk that you may share some personal or confidential information by chance. However, I do not wish for that to happen. You do not have to answer any question that makes you feel uncomfortable. In the unlikely event of the discussion leading you to visible distress, I will stop the interview and focus group or end it completely. An information leaflet detailing sources of support will be provided should they be required.

Can we withdraw from the study?

Yes. You will both be free to change your mind and withdraw from the study at any point without explanation by advising me of this decision. If you do this then any interview material will be removed from the study, and no further information will be collected.

Is the information we give confidential?

Yes. All the information collected will be confidential and anonymous. Confidentiality shall only be breached where the interviewer believes that something you have told them, places you or others at serious risk. In this instance, they are obliged to pass this information on to the relevant persons. All the data collected will be stored securely at the University of Stirling in accordance with the Data Protection Act (2018). Electronic data will be stored on a password protected university computer/laptop and hard copies in a locked filing cabinet in a locked office. The only people who will have access to your data will be myself and my supervisors, Dr Kathleen Stoddart and Dr Greg Mannion.

How will our information be used?

Should you decide to take part in the research study, the information provided by you as well as from your child (if asked to take part) will be typed up and anonymised. The data will published in my thesis. It may also be used later in reports, journal articles and conference talks. Should this happen, your personal details will remain anonymised at all times. No personal information will be presented and any information that may identify you will be removed or changed.

Legal basis for processing personal data.

As part of the project, minimal personal data relating to you will be recorded. This will be processed in accordance with the General Data Protection Regulation (GDPR). Under GDPR, the legal basis for processing your personal data will be public interest.

How do we get involved?

If you and/or your child would like to take part, please complete and return the consent forms in the addressed envelope provided.

Who can we contact for more information?

If, after reading the leaflet, you and your child have any questions or would like to discuss the study further, please feel free to contact me alison.hackett@stir.ac.uk. If you would like to speak to or raise concerns with someone independent of the study, please contact Professor Jayne Donaldson, Dean of the Faculty of Health Sciences & Sport at jayne.donaldson@stir.ac.uk.

Your rights.

You have the right to request to see a copy of the information we hold about you and to request corrections or deletions of the information that is no longer required. You have the right to withdraw from this project at any time without giving reasons and without consequences to you. You also have the right to object to us processing relevant personal data however, please note that once the data are being analysed and/or results published it may not be possible to remove your data from the study. You have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (<https://ico.org.uk/concerns/>).

The University's Data Protection Officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to data.protection@stir.ac.uk in the first instance.

Thank you for considering helping with this study, the thought and time you have given to consider this research invitation is greatly appreciated.

Alison

Appendix 16: Participant Consent Form: School Nurses and Teachers

Participant Consent Form: School Nurses and Teachers

Title of the Project: The school nurse and children's mental health: an exploratory study



Please initial box

I confirm that I have read and understood the information sheet and this consent form and had an opportunity to ask questions about the research study.

I understand that:

- My participation is voluntary and I am free to withdraw at any time during the study, and withdraw my data without giving a reason, and without penalty.
- The interviews will be audio-recorded.
- If I withdraw during the focus group session, my contribution up to that point will be retained in the study.
- When data analysis has started/results are published it may not be possible to remove my data from the study.
- My responses will be kept anonymous and I give permission for members of the research team to have access to my anonymised responses.
- That I will not be named in any research outputs but I could be identified by people I know through the stories I tell.
- Any data that leave the research team will be fully anonymised so that I cannot be identified.

I give permission to be quoted directly in Alison's thesis and for them to be used afterwards in teaching and research publications providing that these are kept anonymous so that I cannot be identified.

I agree to take part in this study.

Name of Participant..... Signature.....
Date:.....

Name of Researcher..... Signature.....
Date:.....

Please return this consent form in the addressed envelope provided. Thank you.

Appendix 17: Consent form for parents for their child's participation



Consent form for parents for their child's participation

Title of the Project: The school nurse and children's mental health: an exploratory study



Please initial box

I confirm that I have read the information sheet and had an opportunity to ask the Researcher any questions

I give permission for [name] to take part

I confirm that I have discussed this with my child and they are happy to take part if selected

I confirm that I am happy for my child to be interviewed and for this to be part of the research

I confirm that I am happy for any audio recording of their voice and photography that will include any material they have made to be used afterwards as part of the research and for these to be used in subsequent teaching and publications

I give permission for my child to be quoted directly in Alison's thesis and for these to be used afterwards in teaching and research publications providing that they are kept anonymous so that my child cannot be identified

I understand that:
My child is under no obligation to take part in the study

All information provided by my child will be treated confidentially

My child has the right to withdraw from this study at any time without explanation

Print Name:..... (Parent/Guardian) Signed.....

Date:..... Name of School:.....

Please return this consent form to alison.hackett@stir.ac.uk. Thank you.

Appendix 18: Participant Consent Form: Parents

Participant Consent Form: Parents

Title of the Project: The school nurse and children's mental health: an exploratory study



Please initial box

I confirm that I have read and understood the information sheet and this consent form and had an opportunity to ask questions about the research study

I understand that:

- My participation is voluntary and I am free to withdraw at any time during the study, and withdraw my data without giving a reason, and without penalty
- The interviews will be audio-recorded
- If I withdraw during the focus group session, my contribution up to that point will be retained in the study
- When data analysis has started/results are published it may not be possible to remove my data from the study.
- My responses will be kept anonymous and I give permission for members of the research team to have access to my anonymised responses.
- That I will not be named in any research outputs but I could be identified by people I know through the stories I tell.
- Any data that leave the research team will be fully anonymised so that I cannot be identified.

I give permission to be quoted directly in Alison's thesis and for them to be used afterwards in teaching and research publications providing that these are kept anonymous so that I cannot be identified

I agree to take part in this study

Name of Participant..... Signature.....

Date:.....

Name of Researcher..... Signature.....

Date:.....

Please return this consent form to alison.hackett@stir.ac.uk.

Thank you.

Appendix 19: Consent Form: Children

NICK (18/19) 039

version 3.0

Consent Form: Children

Research Study: The school nurse and children's mental health: an exploratory study



Please tick the box

I have read and understood the information sheet and been able to ask Alison questions about the research study.

☐

I agree to take part in the research if I am invited by talking to Alison.

☐

I understand that I do not have to take part and I can change my mind and pull out at any time without giving a reason.

☐

I understand that the interview and group discussion will be audio-recorded.

☐

I am happy for my voice to be recorded and photographs of my drawings and any writing to be used when Alison writes up the research.

☐

I understand that the information I give will be confidential and no-one will be able to tell what I said.

☐

Child's Name Signature.....

Date.....

Parent's Name..... Signature.....

Date.....

Researcher's Name Signature.....

Date.....

Please return this consent form to alison.hackett@stir.ac.uk. Thank you.

Alison