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The mental health and emotional needs of secondary age students in the United Kingdom

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ABSTRACT

There is a growing policy focus on children and young people's mental health. The United Kingdom (UK) government has positioned schools as being well-placed to identify children and young people's mental health needs and to provide appropriate intervention. At the same time, school staff report a lack of skills, knowledge and systems to support the early identification of mental health needs in order to inform appropriate intervention. The aim of this study was to explore the mental health and emotional needs of secondary age students from schools across the North West of England. Eight hundred and eighty-four students aged between 11 and 16 completed an online questionnaire comprising the Short Moods and Feelings Questionnaire (SMFQ), which measures depressive symptoms and the Human Givens Emotional Needs Audit (ENA), which explores the extent to which fundamental emotional needs (e.g., for attention, control and security) are met. The findings suggest prevalence rates of mental health and wellbeing difficulties increase with age. Emotional needs as measured in the ENA were found to moderately correlate with total scores on the SMFQ, suggesting the importance of supporting these identified needs in promoting wellbeing. Additionally, the ENA could potentially offer insight into why students may be experiencing problems, signposting practical areas of support. It is therefore proposed to be a measure that schools could use to identify factors contributing to children and young people's experience of mental health and wellbeing and possible areas for intervention.

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KEYWORDS

Adolescents; mental health; emotional needs; screening; intervention

Introduction

Recent research indicates that in the United Kingdom (UK), one in eight children and young people (CYP) aged 5–19 experiences clinically significant mental health difficulties, as assessed by clinically trained raters, using International Classification of Diseases (ICD-10) criteria (Sadler et al., 2018). Two thirds of these (66.4%) had made contact with a professional service in the past year. This

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suggests that the incidence of mental health difficulties is increasing, as previous figures documented a ratio of one in 10 (Green et al., 2005). Along with increasing rates, some populations, including CYP with a non-heteronormative identity, with adverse life events and with special educational needs and disabilities (SEND) appear to be at greater risk of developing mental health difficulties (Sadler et al., 2018). Adolescence is acknowledged as an age range where mental health rates appear to increase (Patalay & Fitzsimons, 2017); other studies indicating that half of all mental health difficulties begin before the age of 14 (R. C. Kessler et al., 2007) and three quarters of life-long mental health difficulties occur before the age of 24 (R.C. Kessler et al., 2005). Adolescence can, therefore, be considered a critical life stage (Hagell et al., 2013) and a period of increased vulnerability in relation to the development of mental health difficulties (McLaughlin & King, 2015). The experience of mental health difficulties in CYP is associated with school exclusions, self-harm, substance abuse, increased risk of suicide and gaining future employment (Clayborne et al., 2019). The prevalence rates and impact of mental health difficulties have resulted in CYP's mental health being recognised as a large public health challenge (Sadler et al., 2018).

There exists an ongoing challenge in meeting the mental health needs of CYP in England and internationally (Department of Health & Department for Education, 2017). The proposals in the UK government's green paper on CYP's mental health highlighted the role that schools can play in meeting CYP's mental health needs (Department of Health & Department for Education, 2017). These focus on improving funding for frontline mental health services, training teachers to identify and support those experiencing problems, and incentivising schools to appoint a mental health lead and represent a significant shift of responsibility for CYP's mental health onto schools. Although the Department of Health and Department for Education (2017) green paper considers schools as being well-placed to identify and support CYP's mental health needs, there are concerns in relation to schools' capacity to identify and support them. For example, school systems mainly target academic outcomes and attendance not mental health (Lereya et al., 2019). This was reflected in a recent survey where only 3% of schools had policies in place regarding CYP's mental health (Brown, 2018). In relation to teachers, schools report limited staff capacity (Patalay et al., 2016), whilst teachers self-report feeling under too much pressure and already feeling overstretched to take on additional responsibilities in relation to CYP's mental health needs (O'Dowd, 2018). In addition to school's readiness to adopt additional responsibilities in relation to mental health, there are concerns that CYP themselves are not seeking help for mental health difficulties (Wilson et al., 2007).

Where there is consensus, schools are well-placed in the position to play a role in the early identification of CYP at risk of mental health difficulties (Anderson et al., 2019). Through early identification, CYP at risk can be identified

and interventions can be offered to address difficulties (Department of Health & Department for Education, 2017). Universal screening involves all members of a school population undertaking brief assessments, designed to identify CYP at risk of developing mental health difficulties (Humphrey & Wigelsworth, 2016). The approach involves school-based staff, after having received appropriate initial training (Humphrey & Wigelsworth, 2016), using brief, valid and reliable assessments as part of a multi-tiered approach to supporting students (Kettler et al., 2014). These enable opportunities for potential early identification and are suggested as an appropriate first step for schools in understanding their CYP's mental health needs (Severson et al., 2007). Schools would also gain important indicators of mental health of populations and subgroups (e.g., adolescent girls) which may then be used in school improvement planning and policy development and provide evidence of outcomes beyond academic attainment and attendance (Humphrey & Wigelsworth, 2016). Screening is also considered a crucial step in moving away from current mental health systems which focus on individual problems rather than population-based preventive services (Gutkin, 2012) and towards more proactive, preventive efforts, rather than waiting for CYP to fail before addressing their needs (Albers et al., 2007). Screening mental health has been found to promote the identification of those CYP at high risk of developing mental health difficulties (Dowdy et al., 2016). Adolescents are considered reliable reporters of their mental health, whereas a parent has a tendency to underestimate the difficulties a CYP might be experiencing, suggesting that adolescents may be at risk of their symptoms not being recognised (Kim et al., 2018). This is a pertinent observation as, in the UK, 75% of CYP who experience mental health difficulties do not access the support they need (Kelvin, 2014).

In summary, given the current evidence suggesting increasing mental health difficulties, prevalence rates and consequences for CYP and increased responsibilities in schools, the present study investigates the prevalence of mental health difficulties in a sample of adolescents through universal screening. Furthermore, potential risk and protective factors were assessed through exploring CYP's mental health needs. The study has the potential to add to the current understanding of mental health difficulties in adolescents with regard to prevalence, populations and subgroups at greatest risk and in identifying possible mental health needs, which when met/unmet may explain the observed prevalence rates.

Methods

Research design

The research involved a cohort study, using an online quantitative questionnaire at a single time point, to explore the relationships between students' self-

reported wellbeing, in terms of depressive symptoms, and the extent to which they felt their emotional needs were being met. The study also sought to establish patterns across the dataset, in terms of identifying which groups of students might be more vulnerable to experiencing mental health problems and/or not being able to get their emotional needs met.

Sampling and participant recruitment

The study was commissioned by a group of principal educational psychologists (PEPs) from the North West (NW) of England in conjunction with the host university, who sought to understand some of the factors affecting reported increases in prevalence rates. The PEPs approached secondary schools within their locality to take part in the study. Five schools who volunteered to participate represented a range of school types for sex, size, status (alternative provision, mainstream secondary) and Ofsted rating and collected data between June 2019 and January 2020. The full sample was 922 adolescents. In relation to gender, 49.9% identified as female, 46.5% identified as male and 3.6% identified as non-binary (combined 'transgender' and 'prefer not to say'). In relation to year groups, 31.1% were in year 7 (aged 11–12), 16.9% in year 8 (aged 12–13), 32.2% in year 9 (aged 13–14), 13% in year 10 (aged 14–15), and 6.4% in year 11 (aged 15–16). In relation to ethnicity, the sample had a lower proportion of participants classified as White British (53.1% vs national figures of 67%) and a higher proportion of Black participants (17.9% vs national figures of 6%).

Procedures

The purpose of the study was explained to school Special Educational Needs Coordinators (SENCOs) and senior leaders. Parents were informed of the study through the school's normal communication channels (text, email, letter, newsletters, and social media) and asked to notify the school if they objected to their child participating. The survey was computer-based using the digital interface, Qualtrics (Qualtrics, Provo, UT). Students accessed information technology (IT) suites during form time and logged into the questionnaire. A participant information sheet and consent form were built into the computer-based questionnaire. Form tutors remained on-site to support students in accessing the questionnaire and in answering any queries. Once students consented to the study, they answered some demographic questions and school information before completing two embedded mental health questionnaires. The questionnaire took approximately 20 minutes for students to complete. Prior to the current study, a pilot study was undertaken in one secondary school in the North West of England to develop the above protocol. Ethical approval was obtained from the university ethics committee. Following participation, schools

were sent an analytic report of their data explaining how these compared to the aggregated data of all participants.

Measures

Mental health

The pupil's mental health was screened using the Short Mood and Feelings Questionnaire (SMFQ) (Angold et al., 1995). The SMFQ is a self-report scale comprising 13 items derived from the original 33-item Mood and Feelings Questionnaire (MFQ) (Angold et al., 1995). The SMFQ assesses depressive symptoms in CYP (8–18 years of age). Items are presented as statements in relation to the previous two weeks, such as '*I felt lonely*' or '*I didn't enjoy anything at all*'. Each item is rated on a 3-point Likert scale (0 = 'not true', 1 = 'sometimes', and 2 = 'True'). High levels of depressive symptoms among CYP are defined by a cut-off score of 8 or higher (Angold et al., 1995). The SMFQ has been found to have high reliability (α 0.87) (Kuo et al., 2005) and satisfactory criterion validity ($r = .65$ to $.70$) (Thabrew et al., 2018). However, as a result of an administrative error translating the physical questionnaire into an electronic questionnaire, the item '*I felt I was no good anymore*' was not included. For the purposes of analysis, a mean score for the 12 items was included and added to create a score for 13 items. The researchers justified this on the basis that a) the SMFQ is intended for screening purposes only and so is not diagnostic; b) the items selected to create the SMFQ from the original 30-item Moods and Feelings Questionnaire (MFQ) all measure affective and cognitive aspects of mental health and so a mean score could be justified; c) the SMFQ only produces a total score and so missing an item would not affect any subdomain scores; d) the results of the 12-item SMFQ were similar to recent studies completed with the correct 13-item SMFQ; e) although intended as a measure of depression, there are findings that the SMFQ has been unable to distinguish between adolescents with depression only from those who may also have anxiety or anxiety only (Kent et al., 1997), which further emphasizes the limitations of the measure.

Emotional needs

The extent to which students' emotional needs were met was assessed using the ten-item Emotional Needs Audit (ENA) (HGI, 2006). In measuring emotional needs fulfilment, the ENA aims to identify where the potential problems and distress in someone's life might be located through assessing the extent to which a person's emotional needs are being met (Griffin & Tyrrell, 2003). The ten items covered are as follows: security, receiving attention, giving attention, control, feeling part of wider community, privacy, emotional connection to others, sense of status, sense of competence, and meaning (Griffin & Tyrrell,

2003). If these emotional and/or physical needs are not met in healthy, balanced ways, individuals may experience mental distress and develop mental illness (Griffin & Tyrrell, 2003). The ENA was used in an earlier unpublished pilot study of 154 students in one secondary school (Waite, 2018). The pilot study found the emotional needs, with the exception of emotional connection to others, significantly correlated with scores on the SMFQ. It was, therefore, considered that the ENA could be used in a larger study to provide data on factors that may be associated with mental health difficulties using this conceptualisation of mental health. It was also hypothesised that the ENA may provide information on possible areas for intervention, which may have greater utility for schools than purely diagnostic data. It also potentially offers some explanatory power in investigating why CYP reporting high scores on the SMFQ might be experiencing emotional distress.

The ENA is a self-report scale comprising 10 items. Items are presented as questions such as '*Can you obtain privacy when you need to?*' or '*Do you feel you receive enough attention?*' Each item is rated on a 7-point Likert scale (1 = 'no', i.e., the need is unfulfilled to 7 = 'yes', i.e., the need is fulfilled. The middle score indicates 'sometimes'). Emotional needs are considered unmet if participants score ≤ 3 on any item area (HGI, 2006). The ENA has been found to have high internal consistency (α 0.84), satisfactory test-retest reliability ($r = 0.46$), very high sensitivity (80%) and a good receiver operating characteristic (ROC) (0.81) (Tsaroucha et al., 2012).

The sample for the current analysis was 884 responses. Of these there were 787 with complete data for the SMFQ and 848 with complete data for the ENA.

Data analysis

IBM SPSS Statistics 23 for Windows was used for all analyses. Descriptive statistics and frequencies were run in order to examine the distribution of data and check that the data fell within the expected range of answers according to the response sets on the questionnaire. Categorical data (gender, ethnicity, year group) are presented as numbers and percentages. Mean differences between groups (gender, year group) were analysed by ANOVA. Statistical analyses are presented as means. Due to a small sample size ($n = 28$) of non-binary participants (those who identified as transgender or prefer not to say), mean differences were not statistically analysed as the findings would not be representative of the non-binary population and may also skew differences between gender and year groups. Correlations between SMFQ and individual ENA dimensions are presented as Pearson's correlation coefficients. All tests were two-tailed (tests for the possibility of a significant relationship in both directions).

Results

SMFQ scores

The SMFQ mean scores by year group can be seen in [Table 1](#). SMFQ sum scores were calculated to provide an indicator of severity of depressive symptoms with scores equal to or greater than 12 considered indicative of the experience of depressive symptoms at a clinical level (Thabrew et al., 2018). As can be seen in [Table 1](#), mean scores for the SMFQ and percentage of participants experiencing depressive symptoms at or above the clinical cut-off level remain relatively stable across years 7, 8 and 9. The ratio of participants experiencing depression at a clinical level increases from approximately 19% at year 7, to 30% at year 10 and 46% at year 11.

There was a statistically significant main effect for year group [$F(4, 777) = 8.086, p = <0.001$], with a small effect size ($\eta_p^2 = .04$, Cohen, 1988). Post-hoc comparisons using the Tukey HSD test indicated that the mean scores for the year 7, 8 and 9 groups were significantly ($p = .01$) different from the year 11 group. The results indicate that the experience of depressive symptoms increases with age, with year 11 participants reporting significantly higher mean scores than their year 7, 8 and 9 counterparts.

The mean SMFQ scores by gender can be seen in [Table 2](#). The mean scores indicate that, on average, those participants identified as non-binary report higher levels of depressive symptoms, which are close to the clinical thresholds. Female mean scores are observed to be higher than male mean scores. The ratio of female participants experiencing depressive symptoms at a clinical level is over 23%, for male participants over 16%, while for participants identified as non-binary, the ratio is nearly half (48.28%).

There was a statistically significant main effect for gender [$F(1, 777) = 26.710, p = <0.001$], with a small effect size ($\eta_p^2 = .03$, Cohen, 1988). The results indicate that the experience of depressive symptoms is significantly higher for female participants versus their male counterparts.

Table 1. Descriptive statistics of the SMFQ by year group.

Year Group	SMFQ Mean	SMFQ SD	Above SMFQ threshold (≥ 12)
7	7.23	6.10	19.07%
8	7.02	5.57	18.38%
9	7.22	5.98	15.04%
10	8.92	6.53	30.1%
11	11.86	8.32	46.3%

Table 2. Descriptive statistics of the SMFQ by gender.

Gender	SMFQ Mean	SMFQ SD	Above SMFQ threshold (≥ 12)
Female	8.34	6.28	23.53%
Male	6.71	5.86	16.05%
Non-Binary	11.92	8.71	48.28%

There was a significant interaction effect for year group and gender [$F(4, 777) = 2.665, p = <0.05$], with a small effect size ($\eta_p^2 = .01$, Cohen, 1988). The findings indicate that although depressive symptom scores increased generally from year 7 to year 11 for all students, this increase was particularly dramatic at year 11 for the female participants.

ENA scores

Mean scores for emotional needs by year group (see Table 3) were calculated. These reveal that significant differences for the ENA are similar to the SMFQ in that scores for either measure appear relatively stable across years 7, 8 and 9. At year 10, a number of significant differences can be observed in ENA mean scores for individual emotional needs, suggesting that in year 10 the extent to which participants' emotional needs were being met declined significantly.

There was a statistically significant main effect for year group for emotional needs, with small effect size (Cohen, 1988) for security [$F(4, 840) = 5.277, p < 0.001$] ($\eta_p^2 = .025$); receive attention [$F(4, 838) = 5.940, p < 0.001$] ($\eta_p^2 = .028$); give attention [$F(4, 833) = 4.359, p < 0.01$] ($\eta_p^2 = .021$); sense of control [$F(4, 831) = 8.976, p < 0.001, (\eta_p^2 = .041)$]; feeling part of a wider community [$F(4, 832) = 9.655, p < 0.001$] ($\eta_p^2 = .044$); privacy [$F(4, 836) = 3.958, p < 0.01$] ($\eta_p^2 = .019$); and meaning [$F(4, 831) = 4.347, p < 0.01$] ($\eta_p^2 = .020$) and status [$F(4, 821) = 4.690, p < 0.001$] ($\eta_p^2 = .022$). For competence, the effect size was moderate: [$F(4, 831) = 5.073, p < 0.001$] ($\eta_p^2 = .068$); No significant main effects were found for year group for the emotional need of emotional intimacy.

Post-hoc comparisons using the Tukey HSD test indicated significantly different mean scores between different year groups in relation to the emotional needs. These are outlined in Table 3.

Table 4 shows mean scores for emotional needs by gender. It should be noted that the mean scores for non-binary students are not reported, due to the small number within the sample.

There was a statistically significant main effect for gender, with a small effect size (Cohen, 1988) for the emotional needs of receive attention [$F(1,$

Table 3. Descriptive statistics of the ENA by year group.

ENA (Emotional Needs)	Year 7 Mean	Year 8 Mean	Year 9 Mean	Year 10 Mean	Year 11 Mean
Security	5.42	5.46	5.41	4.92	4.66
Receive attention	5.40	5.25	5.48	4.64	4.99
Give attention	5.75	5.58	5.55	5.17	5.16
Sense of control	5.34	5.28	5.04	4.46	4.23
Feeling part of a wider community	5.10	4.82	4.76	4.08	3.74
Privacy	5.64	5.56	5.81	5.24	5.06
Emotional intimacy	5.28	5.16	5.20	4.78	4.78
Status	5.07	4.94	4.93	4.43	4.31
Competence	5.51	5.64	4.97	4.46	4.32
Meaning	4.96	4.82	4.62	4.18	4.33

Table 4. Descriptive statistics of the ENA by gender.

ENA (Emotional Needs)	Female	Male
Security	5.27	5.37
Receive attention	5.18	5.39
Give attention	5.60	5.48
Sense of control	4.88	5.24
Feeling part of a wider community	4.62	4.85
Privacy	5.61	5.58
Emotional intimacy	5.34	4.94
Status	4.82	4.94
Competence	5.03	5.29
Meaning	4.61	4.78

Note. Children and young people who identified as non-binary are not included for analysis due to the small sample size.

838) = 4.616, $p < 0.05$] ($\eta_p^2 = .032$); sense of control [$F(1, 831) = 10.657$, $p < 0.001$] ($\eta_p^2 = .013$); feeling part of a wider community [$F(1, 832) = 9.790$, $p < 0.01$] ($\eta_p^2 = .012$); emotional intimacy [$F(1, 835) = 5.375$, $p < 0.05$] ($\eta_p^2 = .022$); competence [$F(1, 831) = 11.065$, $p < 0.001$] ($\eta_p^2 = .013$); and a very small effect size for meaning [$F(1, 831) = 3.982$, $p < 0.05$] ($\eta_p^2 = .005$, Cohen, 1988). No significant main effects were found for gender for the emotional need for security, given attention, privacy, and status.

The female participants' mean scores for the emotional need of emotional intimacy with others is significantly higher than the males' mean scores. Although not significant, female participants also had higher mean scores for the emotional needs of giving attention and privacy, indicating that females felt that their needs in all three areas were better met than those of the males. The male participant mean scores for the emotional needs of receiving attention, control, feeling part of the wider community, competence and meaning are all significantly higher than the female mean scores. Although not significant, male participants also had higher mean scores for the emotional needs' security and status.

Relationships between ENA and SMFQ scores

To explore whether the ENA could be considered to measure constructs of depression and therefore be used to identify areas for intervention, the two measures were analysed to see if there was a relationship between the measures (see Table 5).

The relationship between emotional needs (as measured by the ENA) and depressive symptoms (as measured by the SMFQ) was investigated using Pearson product-moment correlation coefficient. As Table 5 indicates, there was a large (Cohen, 1988), negative correlation between the SMFQ and sense of control [$r = -.528$, $p = 0.01$], with high levels of depressive symptoms associated with lower levels of feeling in control. There was a medium (Cohen, 1988), negative correlation between the SMFQ and the emotional needs;

Table 5. Correlation between the ENA and SMFQ.

ENA (Emotional Needs)	SMFQ
Security	-.371**
Receive attention	-.447**
Give attention	-.207**
Sense of control	-.528**
Feeling part of a wider community	-.378**
Privacy	-.334**
Emotional intimacy	-.228**
Status	-.390**
Competence	-.476**
Meaning	-.337**

** $p < 0.01$.

security [$r = -.371, p = 0.01$]; receive attention [$r = -.447, p = 0.01$]; feeling part of a wider community [$r = -.378, p = 0.01$]; privacy [$r = -.334, p = 0.01$]; status [$r = -.390, p = 0.01$]; competence [$r = -.476, p = 0.01$]; and meaning [$r = -.337, p = 0.01$], with higher levels of depressive symptoms associated with lower levels of security, receiving attention, feeling part of a wider community, privacy, status, competence and sense of meaning. There was a small (Cohen, 1988), negative correlation between the SMFQ and the emotional needs; give attention [$r = -.207, p = 0.01$]; and emotional intimacy [$r = -.228, p = 0.01$], with higher levels of depressive symptoms associated with lower levels of giving attention and emotional intimacy with another person.

Discussion

The findings reported in the current study indicate that average levels of self-reported mental health difficulties increase significantly between years 9 (13–14 years of age) and 11 (15–16 years of age). The findings also indicate that female students (around 24%) are at higher risk of meeting clinical thresholds than their male counterparts (16%). The average levels of mental health difficulties in the current study, as reported by the SMFQ, are higher than those reported in previous studies (see Patalay & Fitzsimons, 2017), this may be a result of the current study's methodology of using self-report at every year group. Previous studies, such as Patalay and Fitzsimons (2017), often use parental reports below the age of 14. The high levels of mental health difficulties found at year 11 (around 46% of CYP above the SMFQ clinical threshold) support previous research which indicates that trajectories of mental health difficulties peak in mid-to-late adolescence, towards the ages of 15–17 years of age (Ferro et al., 2015).

It has been suggested that possible explanations for the observed increase in depressive symptoms self-reported during adolescence are due to social, psychological and biological changes undertaken by CYP during the adolescence stage of development (Thapar et al., 2012). Factors associated with increases in

mental health prevalence over the adolescent period include decline in parental relationships (Sheeber et al., 2007); intensified experience of emotions (Allen & Sheeber, 2008); increased academic pressure (Hutchings & Kazmi, 2015); reduced sleep (Smaldone et al., 2007); and increased social media use (Kushlev et al., 2016). In relation to factors associated with gender, female adolescents have been found to report lower satisfaction with their appearance, health, friendships and how they use their time (Children's Society, 2015); higher levels of loneliness (Brooks et al., 2015) and are more likely to experience violence and abuse in relationships (Barter et al., 2015).

In the current study, CYP's self-reported experience of depressive symptoms was found to be associated with the extent to which their emotional needs were met (ENA). This finding was expected as Human Givens theory can be considered to integrate biological, psychological and social factors in relation to a person's mental health and wellbeing (Griffin & Tyrrell, 2003). The results from the ENA generally show a relatively stable period between years 7, 8 and 9 before declining significantly in years 10 and 11 with significant differences between genders.

It is beyond the scope of the current study as to what factors may have contributed to the decline in the extent to which CYP emotional needs are being met and why female adolescents report generally lower levels than male counterparts. The findings do, however, highlight specific areas for targeted intervention. For example, CYP's sense of competence and control appear to significantly decline in years 10 and 11. Years 10 and 11 are a time of high academic pressure from the completion of high stake exams. Existing literature suggests 13% of CYP in years 10 and 11 can be classified as highly anxious in relation to academic assessments (Putwain, 2008). The end of year 11 also represents a challenging period of change for adolescents, for example, the transition to adulthood, further education, employment or training (Hayton, 2009). During this period adolescents are also developing increasingly independent relationships and moving towards independent living (Hayton, 2009). Research exploring the mental health of adolescents who progress through further education and into higher education (universities) suggests increased prevalence rates of mental health difficulties (Thorley, 2017). This is in response to increasing academic demands and pressures to achieve high grades (Thorley, 2017). In comparison, it is suggested that adolescents who transfer to full-time work, apprenticeships, or vocational college courses experience mental health gains (Symonds et al., 2016). This could be inferred to suggest adolescent experience of the education system and its high stakes and academic pressure is a key contributor to the mental health and wellbeing of adolescents.

In hypothesising a link between mental health and high stake exam pressure, it could be inferred that the year 11 CYP in the current study may have been experiencing low self-efficacy and academic self-concept. Putwain (2019) suggests control and competence may be related and argues that feelings of

competence have a basis in self-efficacy and academic self-concept. Control is the belief that one can exert an influence over learning tasks and outcomes, and perceptions of learning and one's learning skills form the basis of control (Putwain, 2019). Within the current study, it could be hypothesised that early intervention during year 9, targeting domains of competence (e.g., self-efficacy, academic self-concept) may increase scores on the ENA elements of competence and control. This may also reduce the experience of depressive symptoms and act as a protective factor against depressive symptoms in year 11. However, exploring this would require future longitudinal research.

Limitations

The use of self-report only data is a limitation of the current study and may have been a factor in the high prevalence rates reported. The use of self-report only data was made in response to findings that children as young as seven years old are able to report on their own mental health (Sharp et al., 2006), the research being conducted in a context of increasing recognition of the United Nations Rights of the Child, and its emphasis on CYP's voice being actively sought and valued, and the reported low agreement levels between different reporters of CYP's mental health (Cheng et al., 2018). The use of an online questionnaire may have also contributed to the number of incomplete data entries. Had the questionnaire been in the form of pen and paper, with CYP handing completed questionnaires into school staff, there may have been a higher number of participants completing the questionnaire. The online questionnaire was also missing one item from the SMFQ, although a rationale has been provided for still including the data remains a limitation. There are also limitations in relation to the relatively small scale of the research, small number of year 11 students and non-binary students. This makes it difficult to draw conclusions and generalise findings to a wider population.

Humphrey and Wigelsworth (2016) detailed how universal screening could help identify and provide intervention strategies for individual students. This was not possible in this study as the survey was completed anonymously. A more sophisticated interface could provide individual feedback students although this would need to be carefully managed to ensure that this did not alleviate concerns or distress. This is particularly notable, given that only Brown (2018) found that only 3% of a 90-strong school sample had a published mental health policy online, indicating limited structures within schools for supporting mental health and wellbeing. A more appropriate approach might be to therefore use the ENA data to identify areas in which students identify unmet needs with the single school context, and then undertake additional formal or informal data collection to identify areas in which practice might be enhanced (e.g.,

provision of additional quiet areas for students can achieve privacy; greater recognition of wider student achievement for receiving attention). Additionally, further research could address whether the ENA could be used to support individual students identified at risk, within a supportive whole-school environment.

Notably, this survey was conducted prior to the COVID-19 health emergency, the UK lockdown, which resulted in many students not attending school between March and September 2020, and in early 2021, and uncertainty over final exam arrangements. Early indications suggested some potential benefits to student mental health from the initial period of lockdown (Widnall et al., 2020); although it remains to be seen how the heightened emotionality caused by ongoing uncertainty, loss and change reported by teenagers (Demkowicz et al., 2020) affects students on their return to school. However, the authors believe that, within this context, the need to monitor CYP's emotional needs and well-being and to intervene and respond according, is even more paramount.

Implications for practitioners

For many school-based practitioners, it is anticipated that many of the findings in this study will essentially provide evidence for what they already 'know'. It is perhaps unsurprising that the findings from the current paper indicate a need for practitioners to consider the mental health needs of older secondary age students such as those in years 10 and 11 and identify female and non-binary students as potentially more vulnerable. This section of the paper therefore aims to clarify how school-based practitioners can use these findings to support the mental health and wellbeing of the students they support

As described in the Limitations section, school staff could use findings of a whole-school screen based on SMFQ and ENA data to identify areas of practice which could be enhanced to support student mental health and wellbeing. This could involve further data collection and consultation, and perhaps most importantly involve the students themselves. Atkinson et al. (2019) found that when consulted, secondary students were adept at both identifying and planning for processes which could be supportive of students' mental health and wellbeing. Using the findings of the ENA and mental health audit could offer a starting point for students, school staff and parents and inform practical and responsive school mental health policy.

Using the ENA in a more targeted way, within a secure online screening system, might be possible, but as Humphrey and Wigelsworth (2016) advocated, this should be underpinned by high-quality staff training, a clarification of the purpose of screening and its broader goals, and routinised and regular screening. Additionally, data from the survey should be triangulated with teacher and parent data, and with the views of students themselves. Structured support for different levels of need, available to students and their families, should be

detailed, defined and publicised, and involve appropriate links to external agencies (Atkinson et al., 2019).

In considering the existing research and the findings that years 10 and 11 are significant periods, there is a need for policy makers to consider the extent to which high stakes exams and academic pressure may be contributing to the phenomenon of increased mental health difficulties in adolescents. The ENA offered a possible explanation in the self-reports of declining senses of control and competence. It can be suggested that practitioners consider using the ENA as a tool for whole school mental health screening. The ENA correlated with self-reports of depression and as such provided possible explanations as to why the adolescents may have been experiencing symptoms of depression. The ENA also provided a clear link between assessment and intervention in highlighting control and competence as clear areas for targeted intervention within the participants of the current research.

Conclusion

This large-scale survey into the mental health and wellbeing of CYP attending secondary schools in the North West of England identified groups of students who might be vulnerable to mental health difficulties using the SMFQ, but also gave some explanation as to why this might be, using the ENA. It is hoped that it will stimulate discussions about how school-based practitioners can identify, and respond to, the mental health and wellbeing needs of the students they support; within school systems that have structured, well-defined and responsive support systems. It is also acknowledged that without consideration of wider policy issues, the role of school-based practitioners in supporting student mental health and wellbeing will continue to be extremely challenging.

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