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An Exploratory Study on Educators' Experiences of the Mental Health Needs of High School Learners in the North West Province

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Research Report

Submitted in partial fulfilment of the requirements for

the Degree of Master of Arts in Social and Psychological Research

in the Department of Psychology, School of Human and Community Development, Faculty of Humanities, at the University of the Witwatersrand, Johannesburg, South Africa

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Masters of Arts in Social and Psychological Research –Research Declaration

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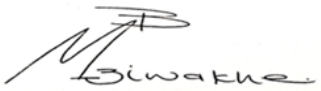
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Abstract

An Exploratory Study on Educators' Experiences of the Mental Health Needs of High School Learners in the North West Province

In many developing countries, including South Africa, adolescents' mental health receives little attention within the larger field of mental health. This is despite the probability that developing mental health problems is significantly higher during adolescence than in any other developmental period. In line with the interpretivist paradigm approach, this study employed a qualitative research approach and adopted an exploratory and descriptive research design. The study aimed to explore and describe educators' experiences of the mental health needs of high school learners in the North West province of South Africa (North West). A semi-structured interview was used to collect data from 11 high school educators. Data in this study were analysed using thematic analysis. Understanding psychosocial development in relation to identity development in adolescent mental health and the ecological systems theories served as a theoretical framework for understanding the phenomenon under study. This study's findings indicated that factors affecting learners' mental health include disrupted family structures, child-headed households, poverty, sexual abuse, school violence, bullying, and psychoactive substances among learners. The findings also highlighted the importance of establishing school-community partnerships and the essential role the school-based support team plays in addressing the psychosocial needs of learners. Conversely, mental health stigma, social worker delays in addressing the psychosocial needs of learners, and ancestral calling were identified as barriers to learners seeking and accessing psychosocial services in schools. Based on the findings from this study, some recommendations to contribute to the mental health of high school learners include the development of age-specific and appropriate mental health policies and interventions. Further contributions would be to increase education funding to employ school nurses and social workers and establish positive school-community partnerships.

Keywords: mental health, educator experiences, high school learners

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List of Abbreviations

Abbreviations	Definitions
CMHA	Canadian Mental Health Association
DBE	Department of Basic Education
DoE	Department of Education
DoH	Department of Health
GAD	Generalised Anxiety Disorder
HPCSA	Health Professions Council of South Africa
HOD	Head of Department
LMICs	Low-Middle-Income Countries
PTSD	Post-Traumatic Stress Disorder
SAD	Social Anxiety Disorder
SADAG	South African Depression and Anxiety Group
SAFMH	South African Federation for Mental Health
SAPS	South African Police Service
SBST	School-Based Support Team
Stats SA	Statistics South Africa
TA	Thematic Analysis
UN	United Nations
WHO	World Health Organization

An Exploratory Study on Educators' Experiences of the Mental Health Needs of High School Learners in the North West Province

Chapter One

Background, Rationale, and Scope of Study

1.1 Introduction

The focus of this research study is on educators' experiences of the mental health needs of high school learners in North West. According to the South African Schools Act 84 of 1996, a learner is any individual obtaining or required to acquire an education. Chapter 1 is used to describe the main ideas and consider the study's relevance and potential contributions. The chapter also provides an overview of the research study, followed by the clearly defined research questions and research aim and objectives. The research approach, research design, research paradigm, data collection process, and data analysis used in the study are then discussed to provide a broad outline of the study. Finally, an outline of this research report is provided at the end of this chapter.

1.2 The Mental Health Context

Global mental health is a grave concern (Ganasen et al., 2008; World Health Organization [WHO], 2003a). The United Nations (United Nations [UN], 2014) expressively maintains that in both underdeveloped and developing countries, mental health is not highly prioritised; thus, significantly fewer resources are dedicated to mental than to physical health. From this perspective, in many developing countries, including South Africa, adolescents' mental health receives little attention within the broader mental health field (Kleintjies et al., 2010; Muribwathoho, 2015; Plüddemann et al., 2014). It is worth noting that "there is no health without mental health" (Schneider et al., 2016, p. 153); therefore, the mental health of individuals forms an essential foundation for their physical, emotional, and social well-being (Meyer et al., 2019; Mfidi, 2017).

To emphasise, approximately half of all mental health and substance-related problems begin by the age of 14 (Meyer et al., 2019; Paruk & Karim, 2016) or during high

school (Mazzer & Rickwood, 2015). Approximately three-quarters of mental health problems develop by the age of 18, which results in a substantial global socioeconomic burden (Radez et al., 2019). Approximately 20% of children and adolescents experience mental health concerns (Meyer et al., 2019; Mfidi, 2017; Reinke et al., 2011) and the prevalence of mental health concerns in children younger than 18 years increases to 25% in children from less than optimum environments (Reinke et al., 2011). Therefore, the adolescent years are crucial for identifying and addressing mental health problems and promoting mental well-being (Mazzer & Rickwood, 2015).

Adolescence is, therefore, considered the most crucial psychosocial developmental stage because it is here that adolescents develop their identity, which forms a foundation for their future mental health (Lök et al., 2017). Considering this, the likelihood of developing mental health disorders during adolescence is much higher than in any other developmental period (Lök et al., 2017; Velasco et al., 2020). Given these circumstances, over the past 5 years, the Department of Health (DoH) has been collaborating with the Department of Basic Education (DBE) to develop an integrated school health policy for South African schools (Mfidi, 2017). However, learners continue to experience mental health challenges despite the developed framework that promotes learner health (Mfidi, 2017).

In summary, the main points of this introductory chapter are:

1. Mental health is not given the same priority as physical health in developing and underdeveloped countries.
2. Within the larger field of mental health, adolescent mental health receives little attention in many developing nations, including South Africa.
3. The probability of developing mental health problems throughout adolescence is significantly higher than during any other developmental stage.
4. Half of mental health and substance-related problems have their onset around 14 years, and 75% of mental health problems begin before the age of 18, indicating that the first onset of mental health problems often occurs during high school years.

5. South African learners continue to face mental health issues despite the existence of an integrated school health framework.

Given the grave concern for learners' mental health, exploring and describing the mental health needs of learners will enable the understanding of the mental health needs of high school learners. Using this understanding, the researcher can make recommendations to be considered for promoting the mental health of high school learners within the South African context.

1.3 Rationale and Contextualisation of this Research Study

There is a threefold rationale for this study. First, there is a significant gap in the global literature on school-based mental health practices and interventions (Reinke et al., 2011). Second, in most parts of Africa, there is a great paucity of information regarding the mental health of children and adolescents (Bella et al., 2011; Mokitimi et al., 2019). Similarly, as Reinke et al. (2011) maintained, there are few small-scale surveys on the perceptions of educators on the mental health needs of learners or their readiness and role in supporting learners with mental health needs. Last, Mokitimi et al. (2019) affirmed that child and adolescent mental health continues to be neglected at a policy level despite the burden of child and adolescent mental health disorders. Furthermore, Mokitimi et al. (2019) articulated that no provincial child and adolescent mental health policies or implementation plans in South Africa support the national Child and Adolescent Mental Health Policy. HIV/AIDS, tuberculosis, maternal health, and child mortality were the primary focus of the provincial health policies, while the provincial health policy made almost no mention of child and adolescent mental health services (Mokitimi et al., 2019).

This study addresses the gap in research by exploring and describing the experiences of a sample of educators regarding their learners' mental health needs. The findings of this study provide information about contextual mental health needs, possible interventions to prevent and address mental health problems, and ways to promote mental health in schools. The study findings emphasise the urgent need to develop and implement mental health policies for children and adolescents, thus underlining the significant need to

develop specialised promotive, preventive, curative, and rehabilitative mental health interventions for learners. Furthermore, understanding the crucial role that schools play in learner mental health, the research findings have implications for the pre-service and in-service preparation of educators to address the mental health needs of learners.

1.4 Research Questions

Considering the above context, the primary research question to better understand the mental health needs of high school learners is: 'What are the educators' experiences of the mental health needs of high school learners in the North West province of South Africa (North West)?'

The sub-questions drawn from the primary research question are:

1. What are the factors that might affect learners' mental health?
2. What are learners' needs for support services?
3. What psychosocial services are available in schools?
4. What are the barriers to seeking and accessing psychosocial services in schools?

1.5 Research Aim and Objectives

This aim of the study was to explore and describe educators' experiences of the mental health needs of high school learners in North West.

The research objectives of this study were to explore and describe the following:

1. Factors that might affect learners' mental health.
2. Learners' needs for support services.
3. The availability of psychosocial services in schools.
4. Barriers to seeking and accessing psychosocial services in schools.

1.6 Research Design and Method

1.6.1 Research Approach and Design

This study employed a qualitative research approach involving an exploratory and descriptive research design. In addition, an interpretivist paradigm was used to investigate and comprehend educators' experiences of high school learners' mental health needs.

1.6.2 Data Collection Process

The data in the study were collected using individual, telephonic semi-structured interviews. Interviews were recorded with permission of the participants.

1.6.3 Data Analysis

Thematic analysis (TA) was used to analyse the data. First, interviews were transcribed, then the open-coding strategy was used to identify initial codes, working back and forth to produce a comprehensive set of themes from the different codes.

1.7 Outline of the Research Report

Chapter 1 is an introduction to the study and its context, as well as the study rationale, aim, and research questions. The background literature relating to the study is presented in Chapter 2.

Chapter 2 highlights some of the critical issues related to adolescent mental health, the role of educators in mental health promotion in schools, and the findings of previous research studies.

Chapter 3 outlines the methods used to conduct the current research study. This chapter discusses the research approach, design used, and the applied research paradigm. Details are also provided about the study participants, data collection procedures, and ethical considerations taken while conducting the study.

In Chapter 4, the results chapter, the data from the participants' interview transcripts are analysed.

Chapter 5 contains a discussion of the results of the findings presented in Chapter 4. This discussion chapter integrates the results of the current study with previous research findings.

Chapter 6 is the concluding chapter of the research report. It includes a summary of the research findings and considers the study's significance and implications. The limitations of the study are also considered, and recommendations are made for future research.

Chapter Two

Literature Review

2.1 Introduction

The purpose of Chapter 2 is to review the literature on the mental health of high school learners and their mental health needs. This chapter provides a general overview of the definition of key concepts of mental health. The chapter also contains a discussion on the mental health of learners in schools, the mental health of learners from a global and local perspective, and child and adolescent mental health policy. Psychosocial services in schools and barriers to seeking and accessing psychosocial services in schools are also described. Finally, this chapter concludes with a discussion of the theoretical framework underpinning the study.

2.2 Definition of Key Concepts

2.2.1 Definition of Mental Health

Mental health can be supported and promoted in every individual, whether they have mental health problems or not (Kutcher & Wei, 2018). Mental health is vital for an individual's overall health and their capability to succeed in their community, academic, and work settings (Swapnajaidupally, 2015). With this in mind, Mazzer and Rickwood (2015) expressly articulated that the concept of mental health has taken on incomplete meanings. For instance, the term *mental health* has been used to indicate both the presence or absence of mental illness. This is why mental health is often associated with mental health problems, with the emphasis placed on mental health problems instead of mental wholeness (Engelhardt, 2016).

An integrated approach to mental health must consider human interactions and the humans' ability to interact with their surroundings in ways that promote their overall health (Mazzer & Rickwood, 2015) In other words, the concept of mental health incorporates the whole context of mental health rather than only mental health illness (Engelhardt, 2016).

Engelhardt (2016) further added that mental health integrates positive and negative associations that contribute to an individual's interaction with life's challenges.

To exacerbate the problem of an unclear meaning, the term mental health has multiple definitions. Multiple definitions make it challenging to provide an accurate meaning (Kutcher & Wei, 2018) as the term is socially constructed and socially defined based on the assumptions and values of societies (Engelhardt, 2016). In other words, different societal groups may have different assumptions about mental health, depending on their values. Fortunately, the literature cites plentiful studies focused on the positive aspects. Different definitions of mental health attempt to capture what mental health means by applying emotional, cognitive, and behavioural capacities to deal successfully with negative and positive life challenges (Kutcher & Wei, 2018).

WHO defines mental health as a "state of well-being in which the individual realises 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" (WHO, 2001, p. 1). Simply stated, mental health can be defined as a sense of well-being that enables individuals to recognise their own strengths, be resilient, productive, and successful, and positively contribute to their society. Additionally, WHO (2003a) maintained that concepts of mental health include welfare, self-belief, independence, interdependence, competency, and the ability to recognise one's own intelligence and emotional intelligence. Furthermore, mental health is about promoting the accomplishment of personal and communal goals (WHO, 2003a). In a like manner, Galderisi et al. (2015) asserted that mental health is a state of balance, enabling individuals to have emotional and social intelligence, be resilient, and possess the ability to promote and maintain the interrelationship between one's physical health and state of mind. In light of this, the comprehensive context of what mental health entails, definitions provided by WHO (2001, 2003a), and Galderisi et al. (2015) distinctly describe the term mental health and focus for the whole context of mental health.

Notably, according to the DoH (n.d.), the mental health of children and adolescents refers to the ability to develop and maintain an optimal level of psychological functioning and

well-being. Within this view, the mental health of children and adolescents incorporates their sense of identity and self-worth, healthy relationships with family and peers, capacity to be productive, and capacity to optimally develop through cultural resources.

More concisely, as stated in the above reference, adolescents' mental health can be defined as their ability to obtain and sustain positive psychological and optimal human functioning. The preceding author maintained that the mental health of children and adolescents is defined by a sense of positive worth experienced through caring family relationships and friendships, demonstrating competence at school, and the ability to cope with daily challenges. Another critical point is that developing an individual's emotional, social, physical, intellectual, and moral capabilities is essential to mental health promotion.

2.2.2 Definition of Mental Health Problems

Several terms such as *mental illness*, *mental health issues* (Mind, 2017), *mental disorders*, and *mental distress* (Granrud, 2019) are used to define *mental health problems*. Mental health problems are common human experiences and can include conditions such as depression, anxiety (Mind, 2017), generalised anxiety disorder (GAD), social anxiety disorder (SAD), panic disorder, and post-traumatic stress disorder (PTSD) (Mental Health Foundation, 2015, 2016).

Mental illness is a health condition that significantly affects individuals' emotions, thought processes, perception, behaviour, daily functioning (American Psychiatric Association, 2022; Loreto, 2017), and empathy (Zartaloudi & Madianos, 2010). Loreto (2017) stated that mental health problems also interfere with an individual's emotions, thoughts, and behaviour, but to a lesser degree than a mental illness. According to the Substance Abuse and Mental Health Services Administration (2016), mental illness is diagnosed using a standardised criterion.

2.2.3 Definition of Mental Health Needs

Sartorius (2015) stated that, although vague, the term mental health needs is usually used when there is a need to develop mental health services or programmes for individuals

experiencing mental health problems. This author also stated that mental health needs could describe individuals' and communities' need for interventions for mental health conditions (Sartorius, 2015). With this knowledge in mind, in this research report, mental health problems refer to common human experiences that include a range of self-reported mental health symptoms described in the literature. These symptoms include anxiety, depression, social withdrawal, anti-social behaviour, self-harming behaviour, and PTSD.

2.3 Adolescence and Mental Health

2.3.1 Understanding Adolescent Mental Health

Mental health problems can be experienced by anyone (Shung-King et al., 2019). According to the Mental Health Foundation (2016), mental health problems increase during middle and late adolescence. The onset of approximately 50% of mental health problems occur around age 14 (Chaulagain et al., 2019; DoH, 2013; Hosseinkhani et al., 2020; Sawyer & Patton, 2018; Velasco et al., 2020), and around 75% of cases begin before age 18 (Velasco et al., 2020).

Adolescence is a developmental period between childhood and adulthood (Janicijevic et al., 2017; Hosseinkhani et al., 2020; Louw & Louw, 2014; National Academies of Sciences, Engineering, and Medicine, 2019; Weiten, 2013), which begins with the onset of puberty (Banati & Lansford, 2018; Louw & Louw, 2014; Sawyer & Patton, 2018; Sigelman & Rider, 2018). In line with Louw & Louw (2014), who maintained that depending on individual differences, and biological and sociocultural influences, adolescence can begin at any age between 11 and 13 years and end at any age between 17 and 21, the adolescent population, encompasses individuals aged 10-19 years (STATS SA, 2022, 2018d) or even up to 10-24 years (Sawyer et al., 2018). Additionally, according to Babicka-Wirkus et al. (2023), early adolescence encompasses the ages between 12 and 14. In like manner, Sokol (2009) maintained that adolescence begins roughly during middle and high school between ages 12 through 18.

The stage of adolescence is accompanied by profound biological, cognitive, emotional, and psychosocial development (Bornstein & Putnick, 2018; Janicijevic et al., 2017; Shung-King et al., 2019), hormonal changes, and moral and sexual development (WHO, 2017). These changes place adolescents at greater risk of developing mental health problems as they transition from childhood to adulthood (Chukwuere et al., 2021, 2022; UN, 2014). While this life stage is an exciting period of identity exploration, establishing self-identity, striving for autonomy, and exploring romantic relationships (Shung-King et al., 2019), it is also a period of emotional turmoil (Babicka-Wirkus et al., 2023; Lee et al., 2018; Demir et al., 2010; Fukuda et al., 2016) and significantly increased risk of developing mental health problems (Demir et al., 2010; Fukuda et al., 2016). The UN (2014) affirmed that mental health problems adversely affect adolescents' development, socioeconomic integration, quality of life, and relationships with parents, peers, romantic partners and educators. Additionally, adolescents who experience mental health problems may be at a greater risk of poverty due to stigma, social exclusion, and fewer academic opportunities.

2.3.2 Good Mental Health and Poor Mental Health of Adolescents

Kutcher and Wei (2017) articulated that stress, and negative emotions, thoughts, and behaviours are part of good mental health, and that a sign of good mental health is using coping strategies to deal with stressful life events, build resilience, and successfully overcome challenges. Good mental health enables individuals to have thoughts, emotions, and behaviours that help them cope with daily stress (Mind, 2017).

Conversely, poor mental health may result in individuals experiencing difficulties in dealing with the everyday stresses of life (Mind, 2017). In the same light, when learners are ill-equipped to deal with stress, their flight-or-fight response might be triggered because the learner perceives normative stress as a danger, which can develop into mental health problems associated with anxiety (Engelhardt, 2016). The UN (2014) stated that stress and trauma have been associated with disrupted social interactions, decreased overall productivity, poor academic performance, and the onset of mental health problems such as

anxiety, depression, and PTSD. The authors of the UN report stated that approximately 50% of episodes of depression are due to a stressful life event. Notably, chronic social stress during adolescence can lead to episodes of anxiety and subsequent depression by age 20 (Loreto, 2017).

2.4 Consequences of Learner Mental Health Problems

2.4.1 Psychosocial Risk Factors and Learner Mental Health

It is important to understand what factors may affect the mental health of learners in order to effectively address mental health needs and promote learners' mental health.

Inequality and lack of access to resources and services can intensify mental health problems (Shung-King et al., 2019). Mental health problems are associated with a vicious cycle of poverty (UN, 2014). Poverty can significantly impact learners' educational outcomes, as it can determine their school attendance, classroom participation, and ability to concentrate in classroom settings (South African Human Rights Commission [SAHRC], 2006).

Equally important, adverse life events such as the termination of a romantic relationship have been associated with severe depression (UN, 2014). Nguyen et al. (2013) argued that, concerning their love life, adolescents have anxiety about their romantic relationships and parents prohibiting them from being romantically involved. Nguyen et al. (2013) affirmed that learners attracted to individuals of the same gender may develop poor mental health and attempt suicide because they are stigmatised and discriminated against. This could be partially attributed to the fact that same-gender attraction is a concept that is not clear to everyone, even though patterns and practices have evolved over the years (Nguyen et al., 2013).

The development of mental health problems have been associated with unsafe sexual behaviour and communicable diseases (UN, 2014). In like manner, adolescent mental health problems are worsened by psychosocial factors such as HIV and AIDS (Mokitimi et al., 2018; SAHRC, 2019). Furthermore, Paruk and Karim (2016) articulated that

mental health problems in adolescents are associated with pregnancy and the potential of developing psychopathology later in adulthood. For this reason, adolescents may experience challenges transitioning from adolescence to adulthood (Bella et al., 2011; Mazzer & Rickwood, 2015; Swick & Powers, 2018).

Substance use has profound negative implications on mental health (Mind, 2017; UN, 2014). In addition, drug and alcohol abuse is also linked to adolescent delinquency (DoH, 2003). Low resistance to peer pressure has been associated with drug and alcohol use and the development of mental illnesses during adolescence (Loreto, 2017). In some instances, adolescents may become dependent on alcohol as a coping mechanism for their mental health problems (DoH, 2003).

2.4.2 Internalising and Externalising Problems of Learners

During their lifetime, approximately 20% of children and adolescents will have mental health concerns (Kleintjies et al., 2010; Lök et al., 2017; Meyer et al., 2019; Mfidi, 2017; Reinke et al., 2011; Schulte-Körne, 2016) in the form of interpersonal and emotional maladjustments (Mfidi, 2017). Furthermore, learners with emotional and interpersonal challenges usually display internalising or externalising problems (Marsh, 2016; Mfidi, 2017), Internalising problems include worrying (Bertills, 2010; Olivier et al., 2020) and feeling anxious and depressed (Babicka-Wirkus et al., 2023; Marsh, 2016; Mfidi, 2017; Nikstat & Riemann, 2020; Olivier et al., 2020), and being socially withdrawn (Babicka-Wirkus et al., 2023; Marsh, 2016; Mfidi, 2017). Internalising symptoms worsen with age (Pedersen et al., 2019).

Externalising problems are characterised by impulsivity (Nikstat & Riemann, 2020), hostility, irritability, disobedience, violence (Marsh, 2016; Mfidi, 2017), and antisocial behaviour (Bertills, 2010). Marsh (2016) maintained that learners' mental health problems are characterised by difficulties in managing their thoughts, emotions, or behaviours.

2.4.3 Prevalent Mental Health Problems in Learners

Engelhardt (2016), Nebhinani and Jain (2019), and Parodi et al. (2021) articulated that anxiety disorders are common in adolescents. This is why educators are more aware of the mental health problems such as anxiety experienced by their learners. Similarly, depression and psychological distress are the most common diagnoses in adolescents (Tomlinson et al., 2022; Velasco et al., 2020). Moreover, Fukuda et al. (2016) articulated that adolescents are more likely to develop mental health problems such as conduct disorders, violent behaviour, and eating disorders. Thus, learners who experience mental health problems may exhibit noticeable difficulties at school and in everyday functioning (Kutcher & Wei, 2017). Consequently, learners with a greater risk of developing mental health problems and committing suicide are at risk of poor academic performance (Nadeem et al., 2011). Suicide is one consequence of unfulfilled mental health needs of learners (Cooper & Hornby, 2018) and remains the top cause of death among adolescents (Bilsen, 2018; Cooper & Hornby, 2018). Another critical point is that mental health problems might result from untreated social, emotional, and behavioural problems (Mfidi, 2017).

Untreated mental health problems may become severe and treatment-resistant, resulting in secondary psychiatric disorders (Loreto, 2017). Furthermore, untreated mental health problems in adolescents may make them more vulnerable to poor sexual and reproductive health, inadequate self-care, and unemployment (Fukuda et al., 2016). Additionally, Radez et al. (2019) stated that untreated mental health problems are associated with adverse health, academic and societal outcomes, and high levels of substance abuse, self-harm, and suicidal behaviour. Independent living and social integration are, therefore, negatively affected by the inability to transition to work due mainly to untreated mental health problems during adolescence.

2.5 Mental Health of Learners in Schools

2.5.1 Academic Stress and Mental Health

Learners experience various stressors, such as academic stress and parents' increasing expectations to achieve exceptional academic performance. These stressors can be linked to the onset of mental health problems (Hosseinkhani et al., 2019; Subramani & Kadhiravan, 2017). Both Hosseinkhani et al. (2019) and Subramani and Kadhiravan (2017) have identified academic stress and parents' increased expectations for outstanding academic performance as stressors that burdening learners, resulting in mental health problems. With this in mind, mental health problems may hinder individuals' emotional, educational, and social success.

Previous research indicates that learners with mental health problems are susceptible to having poor academic performance (Agnafors et al., 2020; Mfidi, 2017; Simelane et al., 2022), poor quality of life (Mfidi, 2017), and dropping out of school (Bella et al., 2011; Mazzer & Rickwood, 2015; Simelane et al., 2022; Swick & Powers, 2018). In contrast, academic excellence results in the positive mental health of learners (Subramani & Kadhiravan, 2017). Additionally, learners with good mental health are generally resilient, perform better academically, and have healthy relationships (Shah & Beinecke, 2009).

2.5.2 School Violence and Bullying

According to the SAHRC (2006), school-based violence primarily manifests in bullying, which encompasses repetitive physical and non-physical behaviours. School-based violence may have far-reaching consequences such as increased school absenteeism, poor academic performance and achievement, increased school dropout, and increased suicide among learners. In addition, higher levels of anger and depression among learners exacerbate the risk of self-harming behaviour and perpetrating violence against others (Flannery et al., 2004).

Flannery et al. (2004) argued that even though schools are relatively safe, witnessing or experiencing violence at school is associated with emotional and behavioural problems.

This violence can range from bullying and threats to homicide. These authors also stated that school violence is related to mental health problems, such as anxiety, dissociation, depression, PTSD, and self-destructive and aggressive behaviour. Similarly, the impact of school violence on victimised learners includes psychological trauma and various symptoms, such as poor self-esteem, feelings of loneliness, and humiliation. These symptoms might result in mental health problems in later life (SAHRC, 2006). Additionally, exposure to violence at school might result in bystanders avoiding responsibility and the victim experiencing irremediable harm, especially if the aggressive or violent behaviour persists over extended periods (Flannery et al., 2004).

To illustrate, bullying refers to repeated physical, verbal, or psychological aggression, characterised by a power imbalance to cause harm, threats of ongoing aggression, and an instilled sense of terror in the victims (SAHRC, 2006). The preceding authors described the difference between physical and non-physical bullying. Physical forms of bullying are "pushing, hitting, kicking, biting, spitting, intentional damage to property, theft, and extortion." Non-physical bullying involves "teasing, name-calling, whispering campaigns, exclusion, and threats of harm" (SAHRC, 2006, p. 6).

Although bullying in the form of aggression and victimisation appears to decline in high school, it can have pervasive and long-lasting effects on learners' social and emotional functioning (UN, 2014). Notably, most bullying incidents tend to occur in the absence of educators or in unsupervised areas of the school, such as school restrooms and play fields (SAHRC, 2006). Over of the past years, just as the use of technology has evolved, so have bullying methods. This means that bullying does not only occur at school, but cyberbullying can happen in the learners' safe space, 24 hours a day (Mental Health Foundation, 2016), increasing the risk of mental health issues such as depression and anxiety (National

Academies of Sciences, Engineering, and Medicine, 2019). Bullying can have detrimental effects on adolescents' mental health, making them prone to developing anxiety, depression (Fazel et al., 2014; Obregón-Cuesta et al., 2022; Owusu et al., 2022) , self-

harming behaviour (Fazel et al., 2014), and depression during adulthood (Mental Health Foundation, 2016; Owusu et al., 2022). Earlier research studies have shown that bullied learners have poor academic performance and are prone to increased insomnia (AlBuhairan et al., 2017; Obregón-Cuesta et al., 2022), hopelessness, loneliness, low self-esteem, depression, suicide ideation, and suicide attempts (AlBuhairan et al., 2017).

Furthermore, research has suggested that learners exposed to violence at school can suffer psychological or academic harm, have feelings of powerlessness because they cannot help the victims, or become hyper-vigilant of their environment and the people around them (Flannery et al., 2004). Victims and witnesses of violence experience devastating impacts on their mental health (Mosome et al., 2011).

The UN (2014) affirmed that, in most instances, more emphasis is given to victims of bullying, whereas perpetrators of bullying and violent events might also suffer from mental health problems. These authors further illustrated that victims of bullying are 12 times more likely than non-bullied adolescents to be gang members and more than 13 times more likely to have carried a weapon. In the case of victims, adverse effects of bullying might persist into adulthood in various forms, such as intimate partner violence, borderline personality disorder, antisocial personality, emotional disorders, and suicide ideation (AlBuhairan et al., 2017).

2.6 Mental Health of Learners from a Global and Local Perspective

2.6.1 International Context

A study conducted in Vietnam revealed that psychopathology and life stress contribute to the suicidal behaviours of adolescents in rural areas (Nguyen et al., 2013). Additional studies undertaken in Vietnam reported that in a year, 10% of learners had suicidal ideation (Nguyen et al., 2013). The preceding researchers affirmed that reports of suicidal ideation were more prevalent in female learners than male learners, and the prevailing rates of suicidal behaviour increased with age.

A study undertaken in China showed that 10% to 30% of adolescents in China have mental disorders (Zhang et al., 2011). Mental health problems were more prevalent in learners from disadvantaged backgrounds than learners from advantaged backgrounds (Zhang et al., 2011). However, the same authors highlighted that the prevalence of behavioural, emotional, and somatoform disorders among learners from less advantaged and advantaged backgrounds were similar.

Other findings were documented in a study in India, showing that approximately 70% of adolescents suffered from mental health problems, and 50% of these learners did not complete high school (Venkataraman et al., 2019). A different Indian study on promoting the mental health of children and adolescents revealed that approximately 50 million Indian children and approximately 9.8 million Indian adolescents suffered from severe mental illnesses (Hossain & Purohit, 2019). Several studies reported that the prevalence rates of children and adolescents developing mental disorders fluctuated from 1.06% to 5.84% in rural areas and 0.8% to 29.4% in urban areas (Hossain & Purohit, 2019). These findings indicate that the prevalence of mental health problems among children and adolescents in urban areas is much higher than in rural areas.

An American study revealed that suicide is the third leading cause of adolescent death (Nadeem et al., 2011). The Youth Risk Behaviour Survey (YRBS) conducted in 2007 indicated that in the 12 months before the survey was conducted, 15% of learners considered attempting suicide, and 7% of learners attempted suicide one or more times (Nadeem et al., 2011). Furthermore, these researchers found that 11% of learners planned to attempt suicide.

A study undertaken in Canada revealed that approximately 1 in 5 young people have mental health disorders, and only 20% of those who require mental health care receive it (Wei et al., 2011). These researchers concluded that the poor mental health of Canadian learners results in poor educational achievement, dropping out of school, substance abuse, emotional and behavioural problems, increased mortality rates, and suicidal behaviour.

2.6.2 The African Context

There is insufficient information on the mental health of children and adolescents in most parts of Africa (Bella et al., 2011). Bella et al. (2011) reported that a few studies have revealed that between 15% and 20% of children and adolescents have mental health disorders. These figures are similar to the established prevalence rates in other regions of the world. The authors stated that the range of mental health disorders described in a small scale of African studies includes anxiety disorders, depression, and conduct disorders.

2.6.3 South African Context

Similarly, there is a paucity of literature on the prevalence of mental health concerns among South African adolescents (Mokitimi et al., 2019). Plüddemann et al. (2014) argued that the small number of studies conducted in South Africa tends to be characterised by limitations relating to sampling representativeness and accuracy of results as there are few valid psychological measuring assessments. Their study revealed that 14.9% of learners had a significantly increased risk of developing mental health illnesses. These findings were consistent with the research conducted by Cortina et al. (2012), which showed that 14.3% of children in Africa experience psychological challenges and mental health problems. Plüddemann et al.'s (2014) research also indicated that adolescent girls often develop internalising mental disorders and that adolescent boys are significantly at risk for developing externalising mental disorders. Their study also showed that adolescent girls have a greater risk of developing mental health disorders than adolescent boys. Consequently, the increased probability of female learners developing mental health problems (Schulte-Körne, 2016) might result in them being more frequently absent from school than male learners (Swick & Powers, 2018).

According to Muribwathoho (2015), in another South African study conducted by the DoH and DBE in 2012, approximately 17% of children and adolescents between 6 and 16 years had poor mental health, with increased rates of various mental health disorders. The author mentioned above affirmed that, based on the 2014 results by the South African

Depression and Anxiety Group (SADAG), the leading cause of death among adolescents is suicide, and approximately 5% of adolescents commit suicide every month. Furthermore, the author stated that depression, which occurs in 8.3% of adolescents, is the leading cause of suicidal ideation in this developmental group (Muribwathoho (2015). In like manner, Meyer et al. (2019) indicated that in South Africa, one in five high school learners have attempted or had thoughts of suicide.

A study conducted by the South African Federation for Mental Health (SAFMH) in 2018 revealed that 25% of learners between the ages of 15 and 19 reported having experienced feelings of hopelessness, 18% had suicidal ideation, and 18% had attempted to commit suicide (Statistics South Africa [Stats SA], 2020). Notably, in South Africa, childhood adversity increases the probability of developing mood disorders, PTSD, major depression, and substance-related disorders, each contributing to learners dropping out of school (DoH, 2013).

Reddy et al. (2010) conducted a South African study on the risk behaviours of secondary school learners attending public schools in South Africa. The study revealed that nationally, approximately 1 in 8 learners had used alcohol before age 13. The same study showed that nationally, approximately 5.2% of learners used marijuana before age 13, with grade 10 learners having a significantly higher prevalence of marijuana use.

2.7 Child and Adolescent Mental Health Policy

Worth noting, WHO (2017) stated that as the most rapid and formative stage of human development, adolescence has profound implications for national policies and programmes. According to the DoH (2013), South Africa continues to face challenges regarding mental health. Nevertheless, there were no officially endorsed documents on the National Mental Health Policy for South Africa before the development of the National Mental Health Policy Framework and Strategic Plan 2013-2020.

Compared to other health priorities in South Africa, mental health services still do not receive adequate resources and funding (DoH, 2013). To emphasise, a study conducted by

Mokitimi et al. (2018) reinforced the evidence of previous studies regarding the neglect of child and adolescent mental health despite mental health problems among children and adolescents being the most significant global burden of disease. With this in mind, the National Child and Adolescent Mental Health Policy of 2003 provided a framework for the policy development and implementation plans regarding child and adolescent mental health across all nine South African provinces. However, current provincial child and adolescent mental health policies are publicly unavailable (Mokitimi et al., 2018).

2.8 The Promotion of the Mental Health of Learners

2.8.1 The Role of the School in Learner Mental Health Promotion

Learners spend more than half their day time in school (Fazel et al., 2014; Hosseinkhani et al., 2020; Kumar et al., 2011; Mazzer & Rickwood, 2015; Reinke et al., 2011) ; making the school environment crucial for nurturing learners' mental health and well-being (Fazel et al., 2014; Kumar et al., 2011; Mazzer & Rickwood, 2015; Reinke et al., 2011). Because of their crucial role in learner mental health (Bella et al., 2011; Mfidi, 2017), schools can help address mental health needs on various levels (DoH & DBE, 2012; National Academies of Sciences, Engineering, and Medicine, 2019). Moreover, schools can provide their learners with cost-effective mental health services (DoH, 2003; National Academies of Sciences, Engineering, and Medicine, 2019). Therefore, schools are an appropriate environment to identify and address the mental health needs of learners (Engelhardt, 2016), promote mental health, and provide interventions that bridge the gaps of unmet mental health service needs (Bella et al., 2011). Additionally, schools can help learners become resilient and equip them with coping skills (Weare & Nind, 2011).

2.8.2 Understanding Educators' Role in Learner Mental Health Promotion

According to the Education Laws Amendment Act 4 (1999), an educator is any person appointed at a school to teach and provide educational and psychological services. Educators can identify learners with mental health problems (Johnson et al., 2011; Mazzer &

Rickwood, 2015; Mfidi, 2017; Shelemy et al., 2019; Swapnajaidupally, 2015; Zurakat, 2015) since they interact with learners daily (Mellin et al., 2017; Venkataraman et al., 2019).

The role of the educator is also to support the learners' needs as part of the integrated response of the school and to refer learners to mental health professionals such as school counsellors, social workers, or psychologists (Kutcher & Wei, 2017); keeping in mind that social workers are more likely than psychologists to provide school-based mental health services (Fazel et al., 2014). Educators are excellent gatekeepers and referral sources for mental health services because they are skilled at identifying mental health problems in learners (Fazel et al., 2014). Additionally, educators can promote the mental health of learners by providing mental health interventions (Johnson et al., 2011; Mazzer & Rickwood, 2015; Mfidi, 2017).

However, Fazel et al. (2014) affirmed that educators are frequently required to prioritise educational targets. Educators are restricted by school policies that limit the type of services they can provide. This restriction consequently limits their ability to meet specific learners' needs. With no further training, educators may not feel confident identifying and addressing mental health problems and providing learners with the support they require (Shelemy et al., 2019). Regardless of how appropriate preventive measures are in promoting mental health, mental health challenges are inevitable; thus, educators should receive sufficient mental health training to provide effective support to learners (Engelhardt, 2016).

The perceived self-efficacy of educators influences how they respond to mental health problems in educational institutions and how they address the mental health needs of learners (Mazzer & Rickwood, 2015). Perceived self-efficacy refers to a person's confidence in their abilities to succeed (Bandura, 1977; Mazzer & Rickwood, 2015). Previous studies have revealed that educators are usually uncomfortable discussing mental health with learners and are unsure how to help learners with emotional problems (Shelemy et al., 2019). Educators with positive self-efficacy are more confident in identifying and supporting learners with mental health needs (Mazzer & Rickwood, 2015).

Equally important is a positive educator-learner relationship. The positive relationship is pivotal for a learner's enhanced academic performance and the positive development of a learner's social skills, self-esteem, and well-being (Mental Health Foundation, 2016). In addition, educators can contribute to adolescents' formation of positive identity (Kasinath, 2013; Verhoeven et al., 2018). There should be a balance between the psychological needs of adolescents and the social demands made on them in order for them to achieve a mature identity (Chen et al., 2007).When there is a conflict or a lack of support from adults at home, the high-quality educator-learner relationship becomes even more crucial as it provides the learners with the sense of security and social support crucial for positive mental health (Mental Health Foundation, 2016).

2.9 Psychosocial Services in Schools

2.9.1 Definition of Psychosocial Services

During adolescence, mental health problem management includes early intervention, support, and appropriate mental health care (Venkataraman et al., 2019). According to the International Federation of Red Cross and Red Crescent Societies (IRFC, 2009), psychosocial services are the provision of interventions that address the psychological needs of individuals and communities and integrates psychological, social, and cultural dimensions of well-being. Simply stated, psychosocial services aim to meet individuals' ongoing psychological and social needs (Australian Institute of Health and Welfare, 2014). According to the IRFC (2009), psychosocial services can be preventive and curative simultaneously. Preventive care minimises the risks of developing mental health problems, whereas curative care helps individuals address and overcome psychosocial problems.

2.9.2 Psychosocial Services Available in Schools

While the literature clearly supports the need to offer school-based mental health and psychosocial support services, there appears to be a widening gap between learners' increasing mental health needs and access to such services (Splett et al., 2011). In the South African context, Muribwathoho (2015) pointed out that the differences in wealth,

access to resources, and social class give some South African schools an advantage over other schools in accessing psychosocial support services. This author stated that in most poorly resourced schools that serve Black learners, there is a lack of school counsellors, and schools do not have trauma and counselling services. Moreover, public schools usually cannot employ school social workers because the school cannot afford their services (Masilo, 2018). Muribwathoho (2015) reported that South African educators often provide counselling services to learners out of their sense of responsibility despite inadequate resources.

There are significant variations between mental health services and the criteria used to determine a learner's eligibility for mental health interventions and outcomes (Fazel et al., 2014). From this perspective, the same learners might be interpreted differently by different people; thus, a learner with depression may be regarded as failing academically, disinterested, or cognitively impaired, or perceived as lacking motivation or low self-esteem (Fazel et al., 2014). Additionally, educators may harshly punish learners or send them out of the classroom, increasing the risk of deviant behaviour and aggressiveness (Shung-King et al., 2019). WHO (2003b) stipulates that harsh punishment of learners may lead to increased mental health problems and substance abuse later in adulthood.

2.9.3 The Value of Psychosocial Services in Schools

Child and adolescent mental health services are essential to prevent mental health problems and mental disorders, and enhance the mental well-being of children and adolescents (Mokitimi et al., 2018). More specifically, school-based interventions can be a turning point for many learners who come from adverse environments (Weare & Nind, 2011). Research suggests that the delivery of school mental health care promotes school attendance, improves academic achievement, reduces suicide-related behaviours, and decreases juvenile arrests (Splett et al., 2011). Mental health professionals can also use mental health care in schools as a way to enable educators to follow up on learners' therapy in the classroom (Heller, 2015).

Finally, learners may perceive the educational setting as more familiar and less threatening for seeking and receiving mental health care (Swick & Powers, 2018). For this reason, learners who need mental health support are more likely to seek mental health services at school than at a mental health facility within the community (Heller, 2015; King-White, 2019; National Academies of Sciences, Engineering, and Medicine, 2019). School-based mental health services improve access to mental health services for learners and are recommended to increase access to evidence-based treatment methods for mental health (Gronholm et al., 2018).

2.9.4 The Importance of Inclusive Education and School-based Support Teams

According to the Department of Education (DoE, 2001), providing more intense and specialised support may be necessary for learners to develop to their full potential. Learners may experience difficulties learning effectively or may be excluded from the learning system altogether when their different learning needs are not met (DoE, 2001). Many learners experience learning challenges or drop out of school because the education system cannot recognise and address diverse learning and because of inaccessible educational facilities, curriculums, assessments, learning resources, and learning strategies. This is why the DoE established an inclusive education and training system framework. The DoE 2001 White Paper 6 on Special Needs Education: Building an Inclusive Education and Training System outlined a model for inclusive education. It was designed to provide institutions and structures of support and to ensure that all learners receive a high-quality education (DoE, 2001).

The White Paper 6 objectives were to achieve equity and reduce exclusionary pressures in schools by promoting access to the curriculum and facilitating the inclusion and participation of diverse learners with disabilities in school and other learning environments (Masango, 2013). According to the DoE (2001), an inclusive education and training system provides learners with various types and levels of support. First, inclusive education acknowledges and respects the differences among learners while embracing their

similarities. Second, it comprehensively supports all learners, educators, and the education system to ensure that various learning needs are met, with an emphasis on developing effective teaching practices that will benefit all learners. Last, it aims to address barriers to the education system that impede the system from serving the entire spectrum of learning requirements. It addresses these barriers by highlighting the adaptability and support systems that are accessible in classrooms.

Another critical point according to the DBE (2014), is that support services at the school level are primarily delivered by the School-based Support Team (SBST). SBSTs are established by schools primarily to provide school-based support services to schools, learners, and educators (DBE, 2014). The SBST is comprised of educators from various levels of education and plays a vital role in identifying barriers in the educational system and ensuring that the needs of all learners are addressed (DBE, 2014; Nong, 2020). As part of their responsibilities, the SBST interacts with their District-based Support Teams (DBST), which provide integrated and specialised services as needed (Nong, 2020). The DBSTs are multifunctional and interdisciplinary groups of professionals from the department. These groups are responsible for promoting inclusive education for training, delivering curriculum, resource distribution, and identifying, assessing, and addressing learning barriers (DBE, 2014). In light of this, the DBSTs should empower educators to address education barriers (Nong, 2020). The DBSTs, assist SBSTs through collaborative consultations (Amod, 2018).

2.10 Barriers to Seeking and Accessing Psychosocial Services in Schools

2.10.1 Barriers Associated with Seeking Psychosocial Services

Multiple barriers may prevent learners from seeking school-based mental health services. Barriers to mental health help-seeking minimise the probability of individuals seeking mental health services (Vidourek et al., 2014; Radez et al., 2020). These barriers are discussed below.

2.10.1.1 Stigma. Stigma is the most prominent barrier to seeking mental health services among adolescents (Loreto, 2017; Velasco et al., 2020). Stigma refers to negative

attitudes and beliefs that result in society fearing, rejecting, avoiding, or discriminating against individuals with mental health problems (Kutcher & Wei, 2017). For example, Zartaloudi and Madianos (2010) maintained that stigma involves negative labels and separation, and that stigma comprises distinct constructs such as stereotypes, prejudice, and discrimination. The most common form of stigma is the perceived negative attitudes, such as believing that individuals with mental health problems are weak, incompetent, less intelligent, and incapable. These negative attitudes might increase discriminatory behaviour, alienation, and social isolation against individuals with mental health problems (Ke et al., 2014; Vidourek et al., 2014). Individuals often feel ashamed and embarrassed to seek psychological services because of the fear of being stigmatised and discriminated against (Ganasen et al., 2008; Radez et al., 2019; Swick & Powers, 2018). This is why individuals may seek help from family and friends, and only lastly from professionals (Zartaloudi & Madianos, 2010; Radez et al., 2020).

Engelhardt (2016) articulated that stigma may also exist because society associates mental health with mental illness. As a result, adolescents with mental health problems face stigma, which inhibits help-seeking behaviour (UN, 2014; Radez et al., 2020). Mental health stigma might result in individuals' denial of mental health problems and the reluctance to seek mental health services (Owens et al., 2002; Watson et al., 2004). Consequently, stigma and discrimination against individuals with mental disorders increase the burden of mental disorders among children and adolescents (Kleintjies et al., 2010).

2.10.1.2 Cultural Perceptions. Cultural perceptions is another obstacle to help-seeking behaviours among adolescents (Loreto, 2017). The UN (2014) stated that cultural factors directly impact individuals' help-seeking behaviour and, to some extent, account for the differences across countries in help-seeking and using mental health services. Furthermore, cultural perceptions influence the reaction and response to mental illness and the attitudes and beliefs of individuals regarding mental health services, and help-seeking behaviour (Loreto, 2017). Previous research also shows that internalised stigma, and other

demographic factors influence individuals' willingness to seek mental health interventions (Morris, 2018). Combined with erroneous beliefs about mental health problems (Brooks et al., 2021), mental health stigma contributes further to delays in accessing effective mental health treatment (Brooks et al., 2021; Simkiss, 2020). In some ethnic groups, for example, the expression of emotions is discouraged and restricted, which inhibits adolescents from seeking help for mental health problems (Loreto, 2017).

2.10.1.3 Family Perceptions. The beliefs of the adolescents' family regarding mental health services and treatment (Velasco et al., 2020), adverse reactions from family and friends, social stigmatisation (Zartaloudi & Madianos, 2010), family expectations, and societal norms and attitudes are some of the barriers to addressing the mental health needs of adolescents (Heller, 2015). The adolescents' family perceptions associated with a lack of cultural sensitivity, miscommunication, lack of trust in mental health professionals, past negative experiences with mental health care professionals, and lack of confidence in the treatment are obstacles to help-seeking behaviours in adolescents (Velasco et al., 2020). Additionally, these cultural differences may include adolescent and caregiver perceptions regarding mental health problems, the stigma associated with the mental health problem, or the seeking of mental health care (UN, 2014).

2.10.1.4 Poor Mental Health Literacy. Poor mental health literacy is another significant help-seeking barrier (Johnson et al., 2020; Velasco et al., 2020). Bonabi et al. (2016), Brooks et al. (2021), and Loreto (2017) described mental health literacy as knowledge and attitudes about recognising, managing, and preventing mental disorders. Mental health literacy is about being aware of different mental illnesses, biopsychosocial factors contributing to the onset of mental illnesses, the stigma surrounding mental health, and the importance of early mental health interventions (Loreto, 2017).

Poor mental health literacy also leads to young people's inability to perceive their problems as mental health-related, uncertainty about whether or not their problems are severe enough to require mental health services, being unsure of where to seek help, and

the refusal to seek help due to the desire to manage their problems independently (Radez et al., 2019; Vidourek et al., 2014). Adolescents often feel inclined to cope with mental health problems on their own; however, when they seek support, it is usually in the form of more informal service systems such as friends and family before consulting a mental health professional (Radez et al., 2020; UN, 2014). Consequently, insufficient knowledge about mental health care in society and among professionals such as educators can contribute to the stigma associated with mental health problems (Fukuda et al., 2016).

2.10.1.5 Confidentiality. The CMHA (n.d.) maintained that the issues of privacy and confidentiality breaches may hinder learners from seeking help. Furthermore, learners may be reluctant to seek psychosocial services because they are concerned about confidentiality (Meyer et al., 2019; Muribwathoho, 2015; Radez et al., 2020; Smit, 2015), perceptions of learned helplessness, and cultural differences (Muribwathoho, 2015; Smit, 2015).

2.10.1.6 Mental Health Treatment. The fear of mental health treatments and adverse medication effects are barriers that inhibit help-seeking behaviour (Johnson et al., 2020). Furthermore, previous negative experiences with mental health services may also prevent individuals from re-seeking mental health services (Smit, 2015; Swick & Powers, 2018). Adolescents under mental health management for depression (which can include prescribed treatments and activities for adolescents and their parents, which facilitate the adolescents' recovery from depression) are fearful that they may relapse into depression. This fear consequently interferes with their sense of identity and self-perception (Chukwuere et al., 2022). Moreover, Chukwuere et al. (2022) affirmed that adolescents who suffer from depression, regardless of mental health management, tend to self-alienate, which also negatively impacts their family and friends.

2.10.2 Barriers Associated with Accessing Psychosocial Services

A number of barriers may hinder access to school-based mental health services.

Owens et al. (2002) identified three barriers to accessing mental health services in schools. The first is the structural barrier, which includes a lack of resources and long

waitlists. The second barrier is associated with perceptions about mental health problems. This barrier relates to educators, healthcare providers, and parents' inability to identify learners' mental health needs. It also relates to their deniability of the seriousness of the mental health problem. Finally, the third barrier is inextricably linked with perceptions about mental health services. For example, it may be learners' lack of desire to receive mental health care, negative experiences with mental health professionals, or stigma associated with receiving mental health services.

Additionally, stigma inhibits individuals from participating in mental health services (Ganasen et al., 2008; Martin, 2010; Smit, 2015; Swick & Powers, 2018; Thorley, 2016). Moreover, Zartaloudi and Madianos (2010) pointed out that stigma is associated with the denial of treatment for mental illness and a lack of recognition and autonomy regarding addressing personal challenges. Vidourek et al. (2014) proposed that the perception of ineffective mental health services and the difficulty of accessing mental health care could undermine the ability to access mental health services.

2.10.3 Addressing Psychosocial Services Barriers

There is no straightforward strategy to eliminate the stigma barrier associated with mental health problems (Kutcher & Wei, 2017). However, increased mental health literacy and awareness of mental health conditions may reduce the perceived stigma associated with seeking mental health care and disclosing symptoms to professionals and adults in positions to assist (UN, 2014). The main facilitators of help-seeking behaviour include emotional competence, mental health literacy, and past positive experiences with mental health care professionals (Velasco et al., 2020).

Bonabi et al. (2016) maintained that the perceived need for mental health services and positive attitudes about mental health services enhances help-seeking behaviours. Here, schools can play a crucial role in addressing mental health problems in society as a whole by breaking down the mental health stigma (Engelhardt, 2016). The preceding author pointed out that schools can provide mental health literacy programmes that incorporate

mental health concepts. These programmes can be delivered by educators in a manner that is familiar and comprehensible for the learners. Engelhardt (2016) also maintained that educational programmes on mental health are crucial for two reasons. First, to enlighten learners, educators, and parents on mental health challenges. Second, to provide strategies and skills to help reduce and address mental health problems among learners before they negatively affect learners' academic performance.

Effective and appropriate mental health interventions that promote help-seeking behaviour can enhance mental health knowledge and early mental health interventions (Velasco et al., 2020). Thus, mental health services offered in schools can normalise help-seeking behaviour, facilitate access to mental health services, and reduce stigma around mental illnesses (Gronholm et al., 2018).

2.11 Theoretical Framework

The term *theoretical framework* refers to a specific perspective used by a researcher to underpin a study (Green, 2014; Imenda, 2014). Thus, a theoretical framework involves the application of a theory to explore, explain, or interpret the phenomenon under study (Imenda, 2014). Green (2014) articulated that a theoretical framework guides a researcher in formulating a rationale, research question, and literature review. Simply stated, Merriam (2001, p. 45) asserted that a theoretical framework is “the structure, the scaffolding, the framework of your study”. The two theories that underpinned the present study are the psychosocial development theory in relation to understanding identity development in adolescent mental health and the ecological systems theory.

2.11.1 The Psychosocial Development Theory: Understanding Identity Development in Adolescent Mental Health

Erik Erikson proposed eight psychosocial stages of development, each characterised by a psychosocial crisis (Kroger & Marcia, 2011; Meyer et al., 2008; Weiten, 2013). Adolescence is the fifth psychosocial stage (Gillbrand et al., 2016; Louw & Louw, 2014; Weiten, 2013, 2017). Distinctly, forming a stable identity is one of the significant

developmental tasks during adolescence (Bornstein & Putnick, 2018; Branje et al., 2021; Jung et al., 2013; Ragelienė, 2016; Sharifi, 2015; Sokol, 2009). At the same time, identity versus role confusion is the psychosocial crisis that occurs during adolescence (Kroger & Marcia, 2011; Louw & Louw, 2014; Weiten, 2013, 2017). Meyer et al. (2008) defined identity as an individual's self-image and unique sense of self and that their self-image is consistent with the perceptions of others regarding the individual's self-image. In plain terms, identity is a unique combination of personality traits and the social style through which individuals define themselves and are characterised by others (Branje et al., 2021; Tsang et al., 2012).

Identity versus role confusion is resolved when adolescents attain an identity by understanding who they are as unique individuals and thoroughly evaluating, accepting, and rejecting specific goals and values (Block, 2011; Upeti, 2017). Kroger and Marcia (2011) maintained that the absence or presence of identity could not be observed; however, elicited behaviour resulting from an identity that has or has not been formed can be observed and measured. In the absence of a strong identity during adolescence, a shared identity cannot be developed, which could result in instability in many areas as an adult (Upeti, 2017).

The psychosocial task of forming a stable identity requires adolescents to integrate their childhood identities in their own unique way to establish a mutual relationship with their society and maintain a sense of continuity within themselves (Kroger & Marcia, 2011; National Academies of Sciences, Engineering, and Medicine, 2019). Erikson (1962) articulated that identity formation is associated with developing mental health problems. With this in mind, forming a firm sense of identity is associated with better mental health, psychological well-being, improved emotional adjustment, emotional stability, and reduced anxiety, depression, and suicidal behaviours (Ragelienė, 2016).

The identity search process during adolescence often results in discrepancies. These discrepancies can either be between the adolescents' ideal, authentic, and self-perceived selves, and how others perceive them or between their social and personal identities. Both discrepancies make them more susceptible to psychosocial risks (Tsang et al., 2012).

Additionally, the association between self-image, negative thoughts, and mental health problems is prominent among adolescents (Leve, 2015). Self- discrepancies can trigger negative emotions such as resentment, distress, agitation, frustration, and even adverse psychological outcomes (Rickwood & Ferry, 2018).

Demir et al. (2010) maintained that identity confusion occurs when adolescents fail to develop a sense of self, solve role confusion, and experience challenges in establishing values. Erikson (1970) stated that adolescents undergoing identity confusion are prone to developing mental health problems. Consequently, mental health problems adversely affect adolescents' development, quality of life, socioeconomic integration, and their relationships with parents, peers, romantic partners and educators, (UN, 2014). If the identity versus role confusion crisis is not resolved, adolescents might experience confusion and struggle to figure out their plans in adulthood, especially concerning roles and responsibilities (Upeti, 2017).

Positive peer relationships are crucial for adolescents' social development, enhanced well-being, self-esteem, and identity development (Mental Health Foundation, 2016). Although relationships with parents are still crucial for adolescents, healthy peer relationships have been associated with better mental health, low social anxiety, and depression during adolescence (Ragelienė. 2016). From this perspective, the Mental Health Foundation (2016) highlighted that peer exclusion or rejection can negatively impact self-esteem and sense of worth. Furthermore, social rejection, social withdrawal, and isolation during adolescence have been associated with mental health problems such as depression, anxiety disorders, and eating disorders, which interrupt adolescents' social development. Adolescents with mental health problems struggle to form and sustain healthy and supportive relationships and manage conflict in relationships (UN, 2014).

As noted before, Erikson (1968) concluded that the main and most important developmental tasks during adolescence are to resolve the identity crisis, establish a sense of inner identity, and develop meaningful relationships. With this in mind, forming a healthy

and coherent identity is enhanced when adolescents successfully resolve the psychosocial crisis in this stage (Treiber & Booysen, 2021; Tsang et al., 2012). Erikson (1968) also articulated that although the end of adolescence is marked by achieving a firm sense of identity, identity continues to develop throughout the lifespan.

Figure 1 depicts a graphic representation of Erikson's eight stages of psychosocial development (Gillbrand et al., 2016; Weiten, 2013, 2017), through which individuals develop throughout their lifespan. Each psychosocial developmental stage, such as adolescence, is characterised by a psychosocial crisis (identity versus role confusion) that involves contemplating the fundamental question such as, 'Who am I and where am I going?'. The psychosocial developmental process is enhanced when the psychosocial crisis in each stage is resolved.

Figure 1

Erikson's Eight Stages of Psychosocial Development



Note. Adapted From Gillbrand et al. (2016) and Weiten (2013, 2017)

2.11.2 The Ecological Systems Theory

Positive mental health is embedded in an individual's historical, cultural, socioeconomic, and political settings (WHO, 2005). For instance, the mental health system of an individual is influenced by the interaction between the individual and broader settings such as family, peers, school, and community (WHO, 2005). Mental health and mental

illness are determined by the interaction between individual and societal factors (Eriksson et al., 2018). Therefore, to prevent mental illnesses and promote mental health, mental health needs should be addressed from a psychosocial perspective (Eriksson et al., 2018). Burns et al. (2015) articulated that the ecological systems model could be implemented and used as a framework to address the individual needs of learners and ensure the environment no longer supports previous problem behaviours. The ecosystems theory, therefore, was able to provide an additional structure for the present study.

The ecosystems theory (Bronfenbrenner, 1975, 1977, 1986, 1994/1993) highlights the interrelation between an individual and the systems in their environment. Bronfenbrenner (1975, p. 439) defined ecology as the “fit between the organism and its environment”. The survival and development of an organism depend on its close fit with its environment (Bronfenbrenner, 1975). Therefore, both change and continuity are essential for the development of the individual (Bronfenbrenner, 1975; Bronfenbrenner, 1978, 1979, as cited in Rosa & Tudge, 2013). Moreover, *development* implies a gradual structural and functional change in the relationship between the developing individual and the environment, resulting in the continuity of the organism and the environment (Bronfenbrenner, 1975).

Meyer et al. (2008, p. 475) maintained that an individual is a “subsystem within a hierarchy of larger systems” with specific subsystems of their own; and the individual is centrally within the systems. The four significant systems surrounding the developing individual are the microsystem, mesosystem, exosystem, and macrosystem (Bronfenbrenner, 1979, as cited in Hertler et al., 2018).

Bronfenbrenner (1977, 1994/1993) described the microsystem as a system that has an immediate influence on a child’s development. A child’s microsystem might, therefore, include their family, peer group, school, and the community. The child, in turn, also affects the systems (Sigelman & Rider, 2018).

The mesosystem involves the interconnections between two or more microsystem structures, such as the relations between the child’s parents and educators (Bronfenbrenner,

1977, 1986, 1994/1993; Donald et al., 2020). To state it more simply, a mesosystem consists of two or more microsystems (Bronfenbrenner, 1994/1993).

The exosystem consists of the interaction between the larger system and the microsystem (Bronfenbrenner, 1977, 1986, 1994/1993). Although the individual does not have a direct connection with the larger system, the system still influences their development (Donald et al., 2020; Sigelman & Rider, 2018). For instance, parents' experiences at work might influence the child's experience at home (Bronfenbrenner, 1994/1993; Donald et al., 2020; Sigelman & Rider, 2018).

The macrosystem involves the overarching cultural and societal patterns that influence the development of the individual. This system level incorporates the cultures and customs of the micro-, meso-, and exosystems (Bronfenbrenner, 1977, 1994/1993). For instance, the macrosystem includes the society's cultural values, customs, norms, laws, socio-political systems, and institutions (Sigelman & Rider, 2018).

In addition to the four major systems, Bronfenbrenner introduced the chronosystem into the ecological systems model (Eriksson et al., 2018; Sigelman & Rider, 2018). The chronosystem consists of the changes that occur over time in the developing individual and their environment (Bronfenbrenner, 1986, 1994/1993; Donald et al., 2020). The chronosystem also incorporates the changes in the relationship between the individual and their environment over time (Sigelman & Rider, 2018). The simplest form of a chronosystem emphasises the life transitions that occur throughout an individual's lifespan (Bronfenbrenner, 1986).

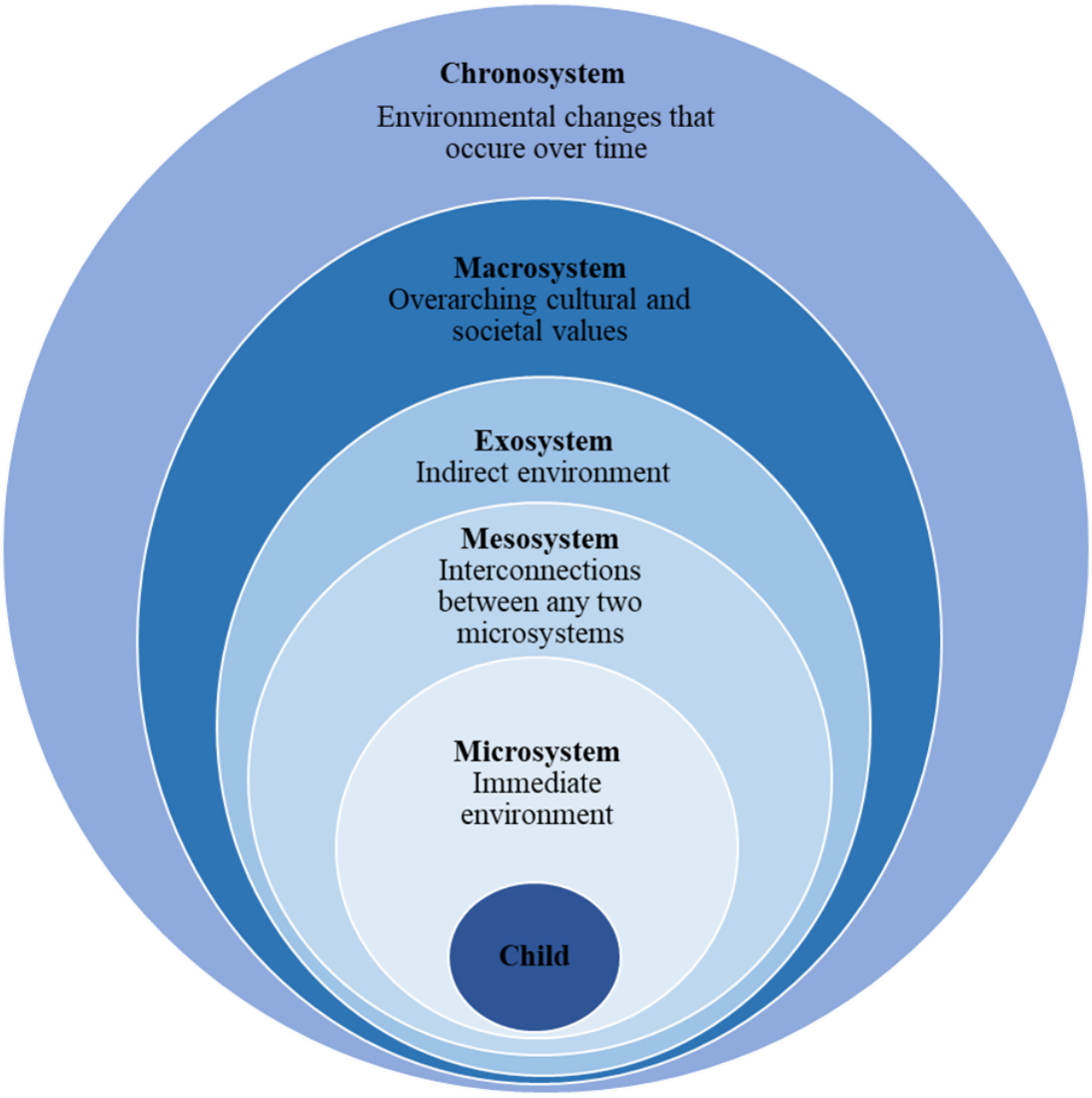
Notably, the family is the first environment a child has contact with, and family is the fundamental element of human society, which influences a child's development and inculcates good habits and values in a child (Vij & Sharma, 2014). Thus, instability in family living conditions has been associated with anxiety among adolescents (Bronfenbrenner, 1986). Family and school instability also disrupts a child's development (Bronfenbrenner, 1986). In essence, an ecological system perspective is an integral approach for organising,

evaluating, and promoting mental health interventions because the perspective offers a way of understanding the development of an individual (Eriksson et al., 2018).

Figure 2 is a graphical illustration of Bronfenbrenner's ecological systems model through which a child develops as an individual shaped by their interaction with the environment. The child is at the core of the ecological model in which the five systems surrounding the child are embedded in the larger system.

Figure 2

Bronfenbrenner's Ecological Systems Model



Note. Adapted From Bronfenbrenner (1977, 1994/1993); Donald et al. (2020), Eriksson et al. (2018), and Sigelman & Rider (2018)

2.12 Conclusion

Chapter 2 was a review of the literature on school mental health and specifically on the mental health needs of high school learners. Chapter 3 outlines the research design and methods used in the present study. In addition, details are provided on the applied research paradigm and data collection and analysis.

Chapter Three

Methods

3.1 Introduction

In the previous chapter, literature pertaining to the mental health needs of high school learners was examined. The purpose of Chapter 3 is to provide an overview of the research approach and design, the research paradigm, and the quality criteria for validating research within the interpretivist paradigm. The chapter also provides a comprehensive description of the study context, sample, sampling techniques, data collection method, and the role of the researcher and reflexivity. A detailed account of data collection procedures, data analysis procedures, ethical considerations adhered to within the current study, data management, and the dissemination of research results is also provided.

3.2 Research Design and Research Methodology

The term research design refers to a set of strategies that specify the procedures in a research study (Creswell & Creswell, 2018). Similarly, research methodology refers to a research strategy that incorporates ontology and epistemological principles that guide the steps taken to conduct research. The research methodology also defines the principles and procedures that guide the research (Antwi & Hamza, 2015).

The present study undertook a qualitative research approach and adopted an exploratory and descriptive research design. Qualitative research emphasises the verbal narratives of participants derived from data collection techniques. At the time of data analysis, these verbal narratives are categorised into themes (Kumar, 2011). Qualitative research seeks to extract the meaning people attribute to symbols, rituals, social roles, and social structures, as well as their circumstances and experiences (Maree, 2016).

In the research process, research questions and procedures are developed, data are usually collected in the participant's environment, and data analysis is conducted inductively by creating specific to broad themes and interpreting the findings (Creswell & Creswell, 2018).

Research designs can be categorised into exploratory, descriptive, and explanatory research designs, with each design achieving a distinct end purpose (Boru, 2018). For the purpose of this study, the pertinent research design was both exploratory and descriptive, and answered the ‘what’ question of the research questions. An exploratory research design is commonly used in qualitative studies (Maree, 2016), where the main focus is to explore and gain a better understanding of a phenomenon that a researcher knows very little about (Bless et al., 2016; Maree, 2016). On the other hand, a descriptive research design focuses on describing the characteristics of the phenomenon under study (Bless et al., 2016). This research study therefore had the dual focus of gaining a better understanding of and then describing the experiences of the mental health needs of learners through the lens of educator experiences.

A qualitative research approach was suited to this exploratory and descriptive study, which focussed on gaining educators’ experiences related to the mental health needs of high school learners. The study, therefore, used an interpretive research stance to explore and understand the topic under study. The next section provides further rationale for selecting an interpretive research stance.

3.3 Research Paradigm

A research paradigm refers to a researcher's ontology, epistemology, and methodology that guide a research study (Denzin & Lincoln, 2005). Paradigms assist researchers in organising their experiences and interpretations of the world, which are informed by their beliefs and assumptions about the world, societal values, and reality (de Vos, 2005). Interpretive research is directed by a researcher's beliefs and perceptions about the world and how they believe it should be studied (Levers, 2013).

The interpretivist paradigm's ontological foundation is based on the idea that reality is socially constructed (Guba & Lincoln, 1994). Moreover, ontology illustrates that existing realities are categorised into multiple and intangible constructed realities based on experiences in local and specific contexts and are shaped by the individuals who hold those constructed realities (Guba & Lincoln, 1994). According to Denzin and Lincoln (2005),

researchers and participants can construct meanings independently and together within this paradigm. Furthermore, in interpretivism, epistemology is transactional and subjective (Guba & Lincoln, 1994). The transactional and subjective epistemology have merged into one entity, which indicates that the world does not exist in isolation to the participants' and researchers' understanding of it. It also indicates that the interpretation and participation of individuals impact the observed phenomenon (Shah & Al-Bargi, 2013). The assumption of subjective epistemology is that the researcher interprets data through a cognitive and reflective process informed by researcher-participant interactions (Kivunja & Kuyini, 2015).

In like manner, the concept of authenticity has a distinctive characteristic in qualitative research (Shannon & Hambacher, 2014). The preceding authors stated that authenticity entails evaluating the significance and meaningfulness of the interactive inquiry methods and the processes that result in societal development. With this in mind, the researcher chose the interpretivist paradigm to explore, understand, and describe educators' experiences of the mental health needs of high school learners.

An interpretivist paradigm provides a deeper understanding of a social phenomenon from participants’ perspectives about their personal experiences (Antwi & Hamza, 2015). That is to say, applying context-sensitive data collection methods facilitates detailed and comprehensive descriptions of a social phenomenon. This is possible because participants can express themselves freely about a phenomenon they experienced, thus enabling the researcher to gain substantial insight (Antwi & Hamza, 2015). Applying the inquiry paradigm, therefore, allowed the researcher to understand the educators' experiences of the mental health of learners. In addition, the researcher reflected on her assumptions, biases, and beliefs that might have influenced how the data was interpreted. For instance, the researcher was mindful of her role as a researcher and that her positionality could influence how she made sense of and interpreted the data. In this regard, the researcher kept a reflective journal to ensure that the research findings were the experiences and perceptions of educators and not the researcher's preferences. This practice helped ensure that the data were not biased.

3.4 Quality Criteria for Validating Research within the Interpretivist Paradigm

The most important quality criteria for qualitative research reports is trustworthiness (Lincoln & Guba, 1985). Trustworthiness is essential for establishing methodological rigour; thus, the interpretivist paradigm establishes its methodological rigour by evaluating trustworthiness and authenticity (Enworo, 2023; Shannon & Hambacher, 2014). In the interpretivist paradigm, the positivist criteria of internal validity, external validity, reliability, and objectivity should be substituted with the four criteria of trustworthiness (Guba, 1981; Guba & Lincoln, 1982; Lincoln & Guba, 1985).

The four components of trustworthiness are credibility, transferability, dependability, and confirmability (Enworo, 2023; Guba & Lincoln, 1994; Lincoln & Guba, 1985; Korstjens & Moser, 2018; Nowell et al., 2017; Ryan et al., 2007; Shenton, 2004). Lincoln and Guba (1985) articulated that trustworthiness cannot be achieved without credibility. Ryan et al. (2007) stated that credibility is the quality of describing the phenomenon under study. It refers to the extent to which the participants' perspectives and the researcher's representation of those viewpoints correlate (Enworo, 2023; Guba & Lincoln, 1982; Korstjens & Moser, 2018; Nowell et al., 2017; Ryan et al., 2007; Shenton, 2004).

The researcher applied numerous approaches to ensure the trustworthiness of this qualitative study. As proposed by Guba (1981) and supported by Shenton (2004), the researcher enhanced credibility by building a rapport with participants before working through the participation information sheet, informed consent, and proceeding with the semi-structured interview. The researcher kept and used a reflective journal to reflect on her positionality within the study and documented how her personal views or biases influenced the research findings. Finally, the researcher had regular collaborative sessions with her supervisor throughout this study.

Ryan et al. (2007) asserted that rigour describes the credibility of the steps in qualitative research and that rigour can be achieved when a reader can trace the steps in the research process. Dependability is a significant aspect of rigour as it includes the researcher ensuring the reader has sufficient data to make informed decisions about the trustworthiness of the

researcher and study (Ryan et al., 2007; Shenton, 2004). Dependability also allows for the replication of the study by future researchers (Enworo, 2023; Forero et al., 2018; Guion, 2002; Kivunja & Kuyini, 2015). To achieve dependability, the researcher clearly described the data collection method used in this study.

Transferability is the extent to which researchers try to provide their readers with sufficient information about the research (Enworo, 2023; Kivunja & Kuyini, 2015; Nowell et al., 2017) so that readers can apply research findings to other situations or settings (Enworo, 2023; Forero et al., 2018; Merriam, 1998; Korstjens & Moser, 2018; Nowell et al., 2017; Ryan et al., 2007) and find them meaningful (Merriam, 1998; Ryan et al., 2007). Readers will be enabled to make an informed decision on the transference of the findings based on the information about the sample, sampling technique, data collection methods, data collection procedures, and data analysis procedures.

Confirmability requires a researcher to describe how conclusions and interpretations were made clearly (Enworo, 2023; Hadi & José Closs, 2015; Nowell et al., 2017; Ryan et al., 2007). Confirmability is the degree to which the researcher is aware of their biases (Miles & Huberman, 1994) to prevent the contamination of research findings (Kivunja & Kuyini, 2015). Confirmability is obtained when credibility, dependability, and transferability are established (Nowell et al., 2017; Ryan et al., 2007). Guba (1981) Nowell et al. (2017) and Shenton (2004) asserted that researchers should document and describe the research process in detail. With that knowledge in mind, the researcher adhered to the abovementioned components to ensure the study's trustworthiness.

Likewise, the process of authenticating the research involves ensuring the research findings are within the context of participants' experiences and involves research that contributes to the well-being of society in a significant way (Shannon & Hambacher, 2014). In view of this, when writing up the research report, the researcher provided a justification for the methods used, how data was interpreted, and how conclusions were reached.

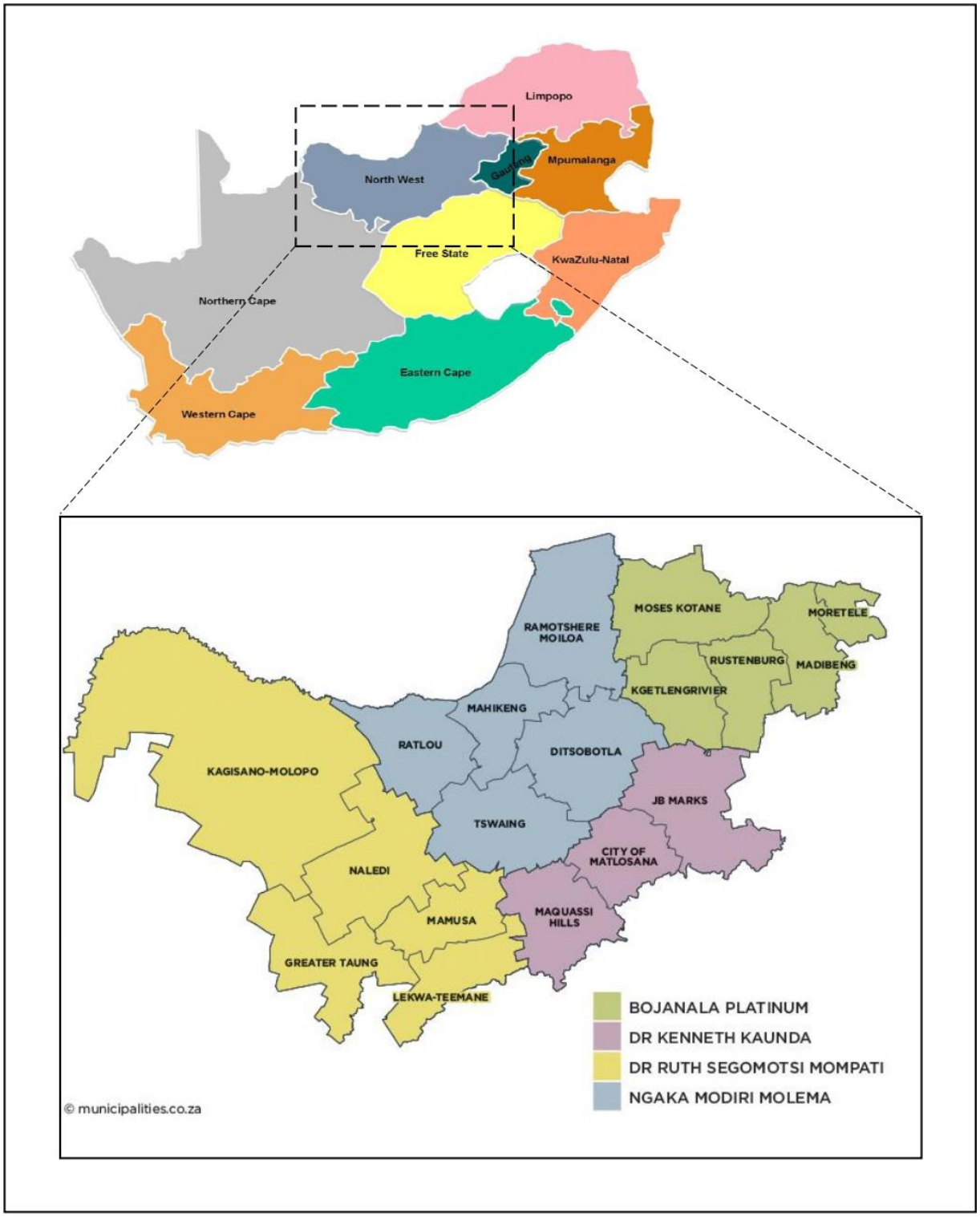
3.5 Study Context

The North West covers approximately 9.5% of South Africa's total area (116 320 km^2), thus making it the sixth largest province (Palamuleni, 2015). Based on the 2016 municipal boundaries, North West has four districts and 18 local municipalities. The 2016 provincial profile survey indicated that South Africa's population size increased to 55.6 million in 2016, of which the North West population size was 3,748,435 million. According to Stats SA (2018a), the 2016 statistics on the demographic profile of adolescents in South Africa showed that adolescents constituted 18.5% of South Africa's total population. Moreover, the findings indicated that North West was one of the three provinces that showed a gradual increase in the adolescent population. The majority population in the North West is Black Africans, and the most commonly spoken language is Setswana (Stats SA, 2018c).

As for adolescents' mental health, North West has an estimated 7.45% and 18.6% depression prevalence rate among adolescents in rural and urban areas, respectively (Chukwuere et al., 2021). Furthermore, in the Stats SA (2018b) report on children's education and well-being in South Africa, compared to other provinces, North West was one of the three provinces with the lowest percentage of adolescents aged 14 to 17 years attending school.

Figure 3

A Map of South Africa indicating the Location of Provinces and the Location of the Districts and Local Municipalities within North West



Note. Yes Media, 2022

Figure 2 shows a map of South Africa indicating the location of the nine provinces. The magnified section shows the location of the North West municipal boundaries. The North West has four districts and 18 local municipalities.

3.6 Sample

A sample refers to a subset of the population thought to be representative and to be investigated to gain information about the entire population (Bless et al., 2016). The sample in this study consisted of high school educators in the North West province of South Africa.

Adolescents' mental health is crucial because, in LMICs, including South Africa, adolescent well-being significantly impacts socioeconomic development (Sorsdahl et al., 2021). Untreated mental health problems during adolescence are associated with school drop-out, delinquent behaviour (Simkiss et al., 2020), and adverse life outcomes, such as developing psychopathology or physical comorbidities in later life (Sorsdahl et al., 2021).

Notably, the study included high school educators from schools that service Black learners, as one often finds that such schools have inadequate psychosocial resources to support learners' mental health. Educators inevitably provide emotional support to their learners in addition to addressing their learning and academic functioning. According to Muribwathoho (2015), despite limited resources, South African educators frequently provide counselling services to learners out of a sense of duty. Therefore, high school educators were selected as the researcher believed that educators could, based on their experiences as educators, provide in-depth, contextual, and rich perspectives about the mental health needs of high school learners.

The inclusion criteria of the sample was that participants should be high school educators between the ages of 25 and 65 years with at least 2 years of teaching experience. Additionally, the study participants in this research had to have a University Diploma in Education Secondary (UDES), Bachelor’s degree in Education (BEd), or Postgraduate Certificate in Education (PGCE). High school educators with the abovementioned qualifications were not chosen because of their qualifications but for their experience and

knowledge relevant to the study. Twenty-four educators were approached to participate in the study. Some potential participants cited a lack of mental health knowledge and time constraints as reasons for their non-participation. The final number of participants who voluntarily participated in the study was eleven. Additionally, the sample comprised representatives from a total of six schools.

Further participant recruitment was unnecessary as data saturation was reached. Data saturation indicates that no additional information could contribute to the already collected data (Fusch & Ness, 2015; Saunders et al., 2017). The background information about educator participants is presented below:

Table 1 *Background Details of the Sample*

	Age group category	**Previous and current grades taught**	**Years of teaching experience**	**Job description**
Educator A	40-49	Grade 8, 10, 11, and 12	25 years	Head of Department (HOD): Department of Geography
Educator B	30-39	Grade 10, 11, and 12	9 years	Educator
Educator C	40-49	Grade 8 to 12	6 years	Educator
Educator D	25-29	Grade 8 to 12	2 years	Post-level one educator
Educator E	60-65	Grade 6 and 7 Grade 8 to 12	27 years	Principal
Educator F	50-59	Grade 10 to 12	18 years	Educator
Educator G	50-59	Grade 10 to 12	30 years	Principal
Educator H	50-59	Grade 1 to 12 Grade 11 and 12	32 years	HOD: Department of English
Educator I	50-59	Grade 4 to 12 Grade 11 and 12	35 years	HOD: Department of English
Educator J	40-49	Grade 11 and 12	18 years	Deputy Principal
Educator K	25-29	Grade 8 to 11	3 years	Educator

Table 1 shows the background details of the educator participants, indicating their age group, previous and current grades taught, years of teaching experience, and job description. The majority of participants were in the 50 to 59 age range and had approximately 18 to 35 years of teaching experience each. Educators occupied several different positions, ranging from subject educator to principal. In addition, some of the educator participants had both primary and high school teaching experience.

3.7 Sampling Techniques

Multiple sampling techniques were used to recruit participants for this study, these being, non-probability: purposive, convenience, and snowball sampling-strategies. Non-probability sampling is a sampling strategy where not every member of the community has a fair chance of being included in a sample (Bless et al., 2016; Kumar, 2011). This sampling strategy allowed the researcher to select the sample based on her own judgment in order to achieve the study's research aim.

Purposive sampling is commonly used in qualitative research (Kumar, 2011), where the researcher selects participants who meet the specific criteria for the sample (Bless et al., 2016). Purposive sampling was used to recruit participants who met the inclusion criteria as they could provide the best information to achieve the study's research aim.

On the other hand, convenience sampling is used to select a sample that is easily and conveniently available to the researcher (Maree, 2016) with regard to time and money (Bless et al., 2016). Selecting high school educators to participate in the study did not require the researcher to follow the research protocols and processes provided by the DBE regarding conducting research in schools. Thus the sample of educators was convenient and easier to recruit. The implementation of this sampling strategy was cost-effective.

Finally, snowball sampling is a sophisticated technique (Bless et al., 2016) used to recruit participants through networks (Bless et al., 2016; Kumar, 2011). Participants in this study were asked to nominate other potential participants who might become part of the sample.

3.8 Data Collection Method

Data were collected using semi-structured interviews to explore the educators' experiences of the mental health needs of high school learners. Dearnley (2005) maintained that a semi-structured interview technique is used due to its flexibility where participants can share their experiences through open-ended questions. The individual interviews lasted between 30 to 60 minutes and were audio-recorded. The interviews were conducted telephonically due to the COVID-19 Level 5 lockdown regulations.

The researcher ensured that the interview questions were aligned with the research questions and met the research aim and objectives. The researcher used a semi-structured interview schedule to guide the interviews. The interview schedule consisted of five sections, these being Section A: Background information; Section B: Educators' experiences of the mental health needs of high school learners; Section C: Learners' needs for school psychosocial services; Section D: Availability of school psychosocial services; and Section E: Barriers to seeking and accessing psychosocial services in school (see Appendix C).

The first three interviews were pilot interviews, and modifications were made to the questions in the interview schedule to improve the quality of the interview schedule. Some questions were rephrased and sequentially aligned, and probes were added. Examples of the probing questions are: 'What do you think are some of the factors that could potentially affect the mental health of learners?'; 'How do you think the abovementioned issues affect the mental health of learners?' and 'How confident are you in identifying and addressing the mental health problems of learners?'

3.9 The Role of the Researcher and Reflexivity

The role of the researcher is to be theoretically sensitive, which implies having insight and understanding as well as the capability to differentiate between crucial and unimportant information, recognise bias, and perceive situations holistically (Gray, 2018). Reflexivity is the researcher's process of having continual conversations with self and critically evaluating their positioning, self-knowledge, and awareness of how their positioning could influence the research process and outcomes (Berger, 2015; Korstjens & Moser, 2018).

Being a Master's student in Social and Psychological Research (SPR), the topic interested the researcher. The researcher's perceptions of mental health have been shaped by her academic and community service-learning experiences. The researcher has obtained a Bachelor of Social Sciences in Human and Societal Dynamics degree and a Bachelor of Psychology Honours degree by the time the current study was conducted. The researcher engaged in practical opportunities and service-learning activities as part of the Psychology Honours Programme requirements. Additionally, as part of a collaborative community service-learning opportunity, the researcher worked with high school learners from a township school in Bloemfontein. The researcher's academic and community service-learning experiences and role as a researcher in the present study enhanced her awareness, knowledge, and sensitivity about the context of the mental health needs of high school learners.

The researcher was aware that she may have perceptions, biases, and beliefs about the mental health needs of learners, neglected mental health of learners, and the lack of school psychosocial services, especially in township schools. She was mindful that these may affect how she might comprehend and interpret information acquired from the semi-structured interviews. Thus, the researcher rigorously monitored her perceptions, biases, and beliefs during all research steps to ensure objectivity. Additionally, when collecting and analysing data, the researcher ensured that participants' experiences were captured fully during the interpretation of the data. Finally, the researcher also made a deliberate effort to conduct a methodical thematic analysis to yield meaningful results.

3.10 Data Collection Procedures

Potential participants were recruited using social media platforms such as Facebook and WhatsApp. The researcher contacted all potential participants and emailed them a copy of the participation information sheet (see Appendix A), the informed consent (see Appendix B) , and the interview schedule. The participation information sheet outlined the criteria for participation. In addition, the researcher worked through the participation information sheet and informed consent with the participants to ensure that they understood that participation

was voluntary and that they would not be advantaged or disadvantaged in any way for participating in the study or not.

The researcher phoned potential participants within two days of sending them the participation information sheet, informed consent, and the interview schedule. This phone call to each participant was to determine if they would be willing to participate in the research. The telephone interviews were scheduled for participants interested in participating in the study. The interviews were conducted at a convenient time for the participants. Data were collected from July 2020 to August 2021. Interviews were conducted in English; however, participants were allowed to respond in English or their native language, Setswana. Finally, permission was obtained from participants to record the telephone interviews using a call recording application to ensure accuracy when transcribing the interviews.

3.11 Data Analysis Procedures

An inductive data analysis approach was followed in this study. Inductive data analysis entails organising data into abstract information units, resulting from constructing patterns and categories from the bottom up and alternating between themes until a comprehensive set of themes is constructed (Creswell & Creswell, 2018). This approach helped the researcher establish patterns, consistencies, and meaning from the data gathered from this study.

Interview transcripts were analysed using thematic analysis (TA) through ATLAS.ti 9, a qualitative data analysis software package. TA is “a method for identifying, analysing, and reporting patterns (themes) within the data” (Braun & Clark, 2006, p.79; Nowell et al., 2017, p. 1) and is a commonly used method of analysis in qualitative research (Braun & Clark, 2006). TA can be used as an essentialist method to report participants’ experiences and reality, as it allows for flexibility and the collection of rich data (Braun & Clark, 2006; Nowell et al., 2017). In this regard, TA was used to reflect educators’ experiences of the mental health needs of learners in high school.

Transcribing the interview recordings was the first step in data analysis. Some interviews were translated from Setswana (the source language) into English (the target language). Interviews were translated clean verbatim.

Braun and Clark's (2006, 2021) six thematic analysis phases guided the present study's analysis. The six steps of the process are:

1. Become familiar with all aspects of the data.
2. Produce initial codes from the entire data set.
3. Generate potential themes from different codes.
4. Revise themes.
5. Describe and label themes.
6. Write up a scholarly report.

First, all the interview transcriptions were coded independently by the researcher. Subsequently, codes were organised into themes.

3.12 Ethical Considerations

3.12.1 Ethical Clearance

Before the commencement to conduct research, ethical clearance was obtained from the University of the Witwatersrand's Human Research Ethics Committee (HREC non-medical). The ethics clearance certificate (protocol number: MASPR/20/08) is included as Appendix D of this research report.

Research participants were treated as per two sets of ethical guidelines. The first set of guidelines followed was the University of the Witwatersrand's Research Office guidelines. The second set being the Health Professions Council of South Africa (HPCSA, 2016) ethical guidelines for good practice in health care professions, as stipulated in the general ethical guidelines for health researchers (Booklet 13).

3.12.2 Voluntary Participation and the Right to Withdraw

Participation in research must be voluntary, with no coercion (Silverman, 2013). Therefore, the researcher emphasised to participants that study participation was voluntary

and that they could refrain from answering questions they would prefer not to respond to. The researcher also informed the participants about their right not to participate or to withdraw from the study at any time during or after the interview without being penalised or expected to explain their discontinuation. Furthermore, the researcher informed the participants whom (and how) they could contact if they had questions regarding the research.

3.12.3 Protection of Research Participants' Privacy and Confidentiality

It is imperative that participants' identities are protected and that participants' information is kept confidential (Silverman, 2013). Anonymity could not be assured because the researcher made personal contact with the participants. However, pseudonyms (e.g., Educator B) were used to represent the participants in the final research report to maintain their anonymity and confidentiality. Participants were informed that direct quotes might be used and that pseudonyms would be used to represent them in the write-up of the final research report and any other publications and presentations that might arise from the research report. The participants were informed that no one else would be present in the room while the researcher conducted the telephone interviews. This was another way to maintain privacy. As for confidentiality, only the researcher and her supervisor could access raw recordings and transcribed interviews.

3.12.4 Obtaining Informed Consent of Participants

Informed consent is achieved when participants receive sufficient and readily available information about the research so that they can make an informed decision about whether to participate in the study (Gray, 2018). Correspondingly, Silverman (2013) asserted that, for the study to be valid, consent should be given voluntarily. Due to the COVID-19 Level 5 lockdown regulations, consent was obtained from participants verbally or in writing. Written consent was non-contact. Participants either sent the researcher completed and signed informed consent forms via email or Whatsapp. In an instance where participants could not complete, sign, and email the informed consent form back to the researcher, the

researcher obtained verbal consent from the participants. A verbal agreement was recorded at the beginning of the telephone interview. The researcher concisely explained the purpose of the study to participants and informed them what was required of them and approximately how long the telephone interview would be. The researcher also informed the participants about the risks and benefits involved in the study and how confidentiality would be maintained.

The researcher obtained permission from the participants to record the interviews to ensure accuracy during transcription.

3.12.5 Potential Study Risks and Benefits for Participants

Researchers must take precautions to avoid causing harm to participants (Silverman, 2013). Although harm to participants could not be prevented in this study, the researcher could commit to minimising harm. Participants were informed that they were exposed to a 'low risk' by participating in the study. 'Low risk' means that discomfort was the only foreseeable risk in the research (National Health and Medical Research Council, 2018). Discomfort may included anxiety caused by participating in a research interview (Northern Adelaide Local Health Network Inc. [NALHN], 2019). Participants might have felt distressed and overwhelmed by the mental health needs of their learners. There was a potential that the interviews might have caused participants discomfort, as the experience might have evoked repressed emotions about the mental health needs of learners or caused participants to relive a traumatic experience if they knew a learner with mental health problems or had lost a learner to suicide. For this reason, in the participation information sheet, the researcher included the contact details of two non-profit organisations in South Africa that offer free counselling services. These organisations were SADAG and LifeLine Johannesburg. Additionally, participants were informed that there were no benefits to participating in the study.

3.13 Data Management

Electronic data (audio recordings of interviews) and transcribed interviews were stored on a password-encrypted laptop. The final research report will be available online through the university library website. The data will be kept indefinitely for research purposes on a password-encrypted laptop.

3.14 Dissemination of Research Results

Apart from this research report, the research results may also be published as a journal article or a book chapter. It might also be presented at a conference. Participants have been informed that, should they be interested, they may receive a summary of the research results by contacting the researcher after March 2023.

3.15 Conclusion

Chapter 3 provided the research method employed and justifications for adopting an interpretivist paradigm. A qualitative, exploratory, and descriptive approach was deemed the most appropriate research method. The chapter also included the rationale for selecting high school educators as study participants and the study context was provided. Semi-structured interviews were used as a data collection method. Moreover, a detailed description of data analysis through thematic analysis was provided. Additionally, strategies to ensure the trustworthiness of the study and ethical considerations within the study were described. The subsequent chapter is a presentation of findings that emerged through an inductive and thematic analysis process.

Chapter Four

Presentation of Findings

4.1 Introduction

Chapter 4 presents themes and sub-themes that emerged from the analysis of the individual semi-structured interviews. Each educator shared their unique experiences of the mental health needs of high school learners. Consistencies in the codes identified in the data allowed for themes to emerge.

Themes and sub-themes were also identified through inductive data analysis. The findings were conceptually organised under the following categories:

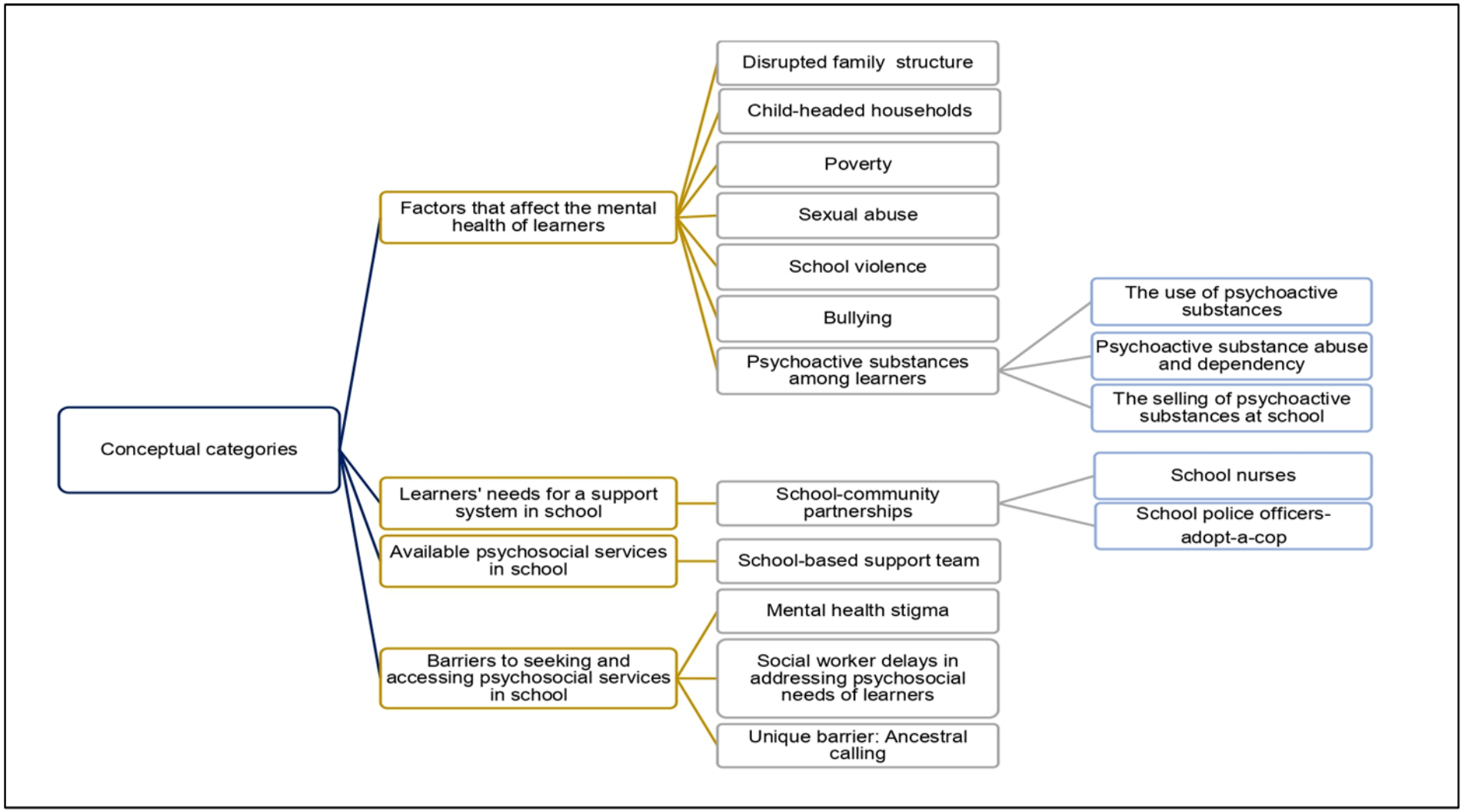
1. Factors that affect the mental health of learners.
2. Learners' needs for a support system in schools.
3. Available psychosocial services in schools.
4. Barriers to seeking and accessing psychosocial services in schools.

The educators' verbatim quotations were used to illustrate the identified themes and sub-themes. Participating educators were assigned pseudonyms, that is, Educator A to Educator K in order to comply with the study's ethical guidelines. The themes and sub-themes in this study were presented under the abovementioned conceptual categories.

4.2 Findings of the Study

Figure 3 represents the themes and sub-themes identified through thematic analysis of the data. Themes and sub-themes were organised into four conceptual categories.

Figure 4 *A Diagrammatic Representation of Themes and Sub-themes*



4.2.1 Factors that Affect the Mental Health of Learners

Based on the findings of this study, seven themes and three sub-themes related to the factors that affect the mental health of high school learners emerged in the analysis of the study. The seven themes that emerged were disrupted family structure, child-headed households, poverty, sexual abuse, school violence, bullying, and psychoactive substances among learners. The three sub-themes were (a) the use of psychoactive substances, (b) psychoactive substance abuse, and (c) dependency, and the selling of psychoactive substances at school. These themes will now be unpacked.

4.2.1.1 Disrupted Family Structure. Educators supported the notion that a disrupted family structure has long-term effects on learners' mental health. A family transition, such as the breakdown of parental relationships, may negatively impact the development of learners and may result in poor mental health outcomes for learners. Educator B supported this statement:

> ‘I believe a lot of it comes from the environment and home, social problems, and then a lot stems from home; it might be broken families. Of course, such units that are broken ultimately produce broken children as well’ (Educator B)

Educator E added that challenges in the home environment, such as divorce and conflict, can result in learners experiencing loneliness, which in severe instances can give learners suicidal ideation. The following statement supported this:

> ‘Learners go through various challenges in their lives…the divorce, the conflict in the home environment . . . they bring the type of behaviour of loneliness to learners, and learners tend to be very quiet most of the time. And there are very severe incidents where learners can even think of killing themselves’. (Educator E)

Domestic violence seems to be another factor that affects learners' mental health. Educator F narrated a ‘sad’ incident of how one of their learners was exposed to violence at home. In an effort to try to protect their family from being physically assaulted by their sister's said boyfriend, the learner fought with the sister's said boyfriend. The fight ultimately resulted

in criminal charges being laid against the learner. The learner was absent from school and did not want people to know about his situation at home. The following excerpt supported this statement:

> 'I was asking the other learner in the Grade 12 class where the other learner is, she said, "Sir, it's private and confidential, may I please tell you outside." Okay, I allowed that child, that girl, to tell me what is happening. "This guy's sister has a boyfriend, and the boyfriend is a prison warder. The boyfriend physically abuses the girlfriend and the girlfriend's mother. This boy, as a boy child, when he fought, a case was opened against him, the sister wanted to protect the boyfriend, and say the boyfriend didn't do that"'. (Educator F)

4.2.1.2 Child-headed Households. A child-headed household is another factor that affects the mental health of learners. A child living in a child-headed household may not have parental guidance and support, thus placing them in a position where they do not make healthy decisions on their own.

Educator C emphasised how poverty in a child-headed household can result in older men taking advantage of learners' vulnerabilities.

> 'We have what we call "vulnerable learners", who are learners coming from households whereby children are actually in child-headed households. So, let's say the parents are deceased . . . You find that the elder one is having to be the father or mother to the younger ones . . . In the process, this causes problems where poverty comes in, and the issue of what do we call them, uhm, "sugar daddies", who then come to take advantage of the situation of these poor kids, especially girl learners'. (Educator C)

Within the educational context, growing up in a child-headed family can adversely affect learners' academic performances. The following excerpt supported this:

> ‘The learners, most of them are child-headed households or households where the parents have substance abuse problems, and they cannot focus on school’. (Educator K)

4.2.1.3 Poverty. Educators identified poverty as another factor affecting learners’ mental health adversely. The following comments supported this:

> ‘So, the biggest . . . issue that contributes to or affects mental health is . . . poverty’. (Educator K)

Poverty due to both parents being unemployed resulted in a learner living in hunger, consequently making the learner irritable and impatient. This learner’s behaviour was shown in the following extract:

> ‘I’ve just mentioned poverty in the home environment, where you find that a father is not working, the mother is not working, so, most of the time, this particular learner lives in hunger, he becomes very irritable, he becomes very impatient . . . that is how it affects them’. (Educator E)

Learners who live in severe poverty may consequently experience hygiene poverty. Hygiene poverty can affect learners' self-worth, confidence, and dignity, which might result in them being isolated from their peers. Educator J and Educator A narrated the effects of hygiene poverty on learners' mental health with the following statements:

> ‘Even if there's financial pressure at home, it affects the child mentally . . . there are kids who come from homes with severe poverty. So, I've tried to get a little sort of foundation going, where I make sure they’ve got the essentials when it comes to their sanitary products and also personal hygiene things, so they can at least come to school not feeling that they’re dirty’. (Educator J)

> ‘We have identified that the learner comes from a poverty-stricken home, thinks a lot, and is isolated . . . there was a Grade 11 learner who had a terrible body odour and was isolated by other learners. We [educators] started buying toiletry, deodorant that [they] needed. We [educators] then noticed that child began to be at ease, was able

to speak freely . . . You start to see the child being more positive, engaging with other learners'. (Educator A)

4.2.1.4 Sexual Abuse. The data indicated that sexual abuse was another factor that affected learners' mental health. Educators highlighted the traumatic sexual experiences learners experienced. The following comments supported this:

'So, the biggest issue that contributes to or affects mental health is sexual assault. Sexual assault in the way of learners that were raped, learners that were molested by family members, and as such other things. Even sexual acts done to them indirectly. Like, exhibitionism, where adults make these kids watch, so these kids obviously come to school quite traumatised'. (Educator K)

Two educators narrated that some parents of the learners raped by family members covered up the rape and insisted on not involving law enforcement officials or other people. These excerpts substantiated this:

'There was this issue of a learner who was being raped . . . when I tried to intervene as an educator, the parents did not want charges opened because they said it was a family matter, it will be resolved by the family . . . they are thinking about the reputation of the family'. (Educator C)

'Problems at home at times you get that the mother has a boyfriend, the mother tries to satisfy the needs of the boyfriend over the child's. So, if the boyfriend wants to do this and this to a child, the mother will just ask the child to keep quiet, don't involve other people; it's a family matter. So, some of these things disturb children, some of the girls are raped by their stepfathers because of the mother'. (Educator F)

4.2.1.5 School Violence. School violence among learners was another factor that affected the mental health of learners. The following excerpt provided an example of this:

'The learner would be under pressure . . . they start to fight, or they plan to fight after school. One learner was not intended to fight would always, the mind will always be

disturbed, the state of mind won't be good, there'll be disorder in the mind'. (Educator G)

Sometimes, community violence is carried into the school environment, shaping the context of school violence among learners. The following excerpt corroborated this:

'There is too much fighting that is also there, it is in the village here and some of these things that learners come to do here, these fights originate from the village and then extend up to school'. (Educator E)

4.2.1.6 Bullying. Educator participants expressed that bullying affected the mental health of bullied learners. Educator K reported that absenteeism could indicate that a bullied learner has mental health problems. Therefore, chronic bullying could result in learner absenteeism, consequently affecting their self-worth. This notion was captured in the following excerpt:

'A learner who will skip class, absenteeism is actually the biggest indicator of a learner with mental health issues. Because for example, a child will stay away from school because they've been continually bullied, and that leads to the fact that then their confidence, their self-esteem becomes etched away at, as the days go by, interacting with this bully'. (Educator K)

Two educators affirmed that bullied learners might resort to suicide. Educator I added that learners who were attracted to individuals of the same gender also experienced bullying and were teased by their classmates; the succeeding excerpts corroborated this:

'Bullying also, when they're being bullied because now bullying is also suicidal'. (Educator H)

'Bullying has become- especially those kids that are homosexual and lesbians. When they come into my class the whole class starts whistling . . . they start talking. They laugh; they're rude'. (Educator I)

4.2.1.7 Psychoactive Substances among Learners. Psychoactive substances were another factor that educators identified as affecting the mental health of learners.

4.2.1.7.1 The Use of Psychoactive Substances. Some problems learners experience at home were brought into the school environment, resulting in learners bringing alcohol to school. Consequently, this affected their mental health and concentration in class. This statement was captured in the following excerpt:

> ‘And some of them bring liquor at school because of the problems that they have at home. So, some of these things destroy the children mentally, so their minds are not here’. (Educator F)

An educator affirmed marijuana use can affect concentration in the classroom environment, resulting in learners dropping out of school. Using drugs can also result in a continual cycle of mental health problems, drug use, and poverty. The succeeding excerpt supported this:

> ‘There was a time where my student did not come to class, and he smelled of cannabis or smelled of cigarettes and something else. Most of them, by Grade 11, will have dropped out, especially boy children, will have dropped out due to drug use, they obviously cannot even focus, they can't even stay awake standing up. So, the learner then cannot even focus in class . . . So, it affects their mental health because they cannot even facilitate growth within themselves. They can't force themselves to sit in a classroom environment and focus for the betterment or the growth of the minds academically. So, it affects them by creating a perpetual cycle of either mental illness, drug use, and poverty or of abuse in an environment’. (Educator K)

Educators indicated that some learners not only use but experiment with psychoactive substances. This was corroborated by the subsequent excerpts:

> ‘Where I’m staying, especially dagga is, they are experimenting with dagga these young boys. It’s available, somewhere it showed in the village, so it’s accessible for them’. (Educator G)

> ‘Learners are smoking dagga . . . Recently, they are just taking, I forgot what this is, eh, these drugs that they combine glue with what and so on’. (Educator E)

***4.2.1.7.2 Psychoactive Substance Abuse and Dependency*.** The frequent use of psychoactive substances among learners may result in psychoactive substance abuse or dependency. The following excerpts corroborated this statement:

> ‘One of the boys said to me that he cannot live without marijuana . . . he said that it makes him going’. (Educator I)
>
> ‘We’re seeing such a big increase in drug and alcohol dependency among teenagers’. (Educator J)
>
> ‘This one of drug abuse is so fashionable’. (Educator H)

4.2.1.7.3 The Selling of Psychoactive Substances at School. It was also evident that marijuana was being sold among learners. The following excerpts supported this statement:

> ‘We discovered that learners are smoking dagga, and they are even selling it in school’. (Educator E)

Educator F and Educator K narrated that learners who sold marijuana at school usually placed it in the cases they use to carry their stationery or Mathematical instruments. Educator F added that some learners did not attend lessons because they wanted to sell marijuana and would only return to class once they had sold the marijuana. This behaviour negatively affected these learners’ mental health and schoolwork. Educator F further reported that a learner financially supported his parents with the money earned from selling marijuana. Educator K also added that a Grade 8 learner caught selling marijuana at school sold it on behalf of her gangster boyfriend. These statements were verified by the subsequent excerpts:

> ‘This one of marijuana, selling drugs at school, it too, is something that is problematic . . . there are these 19-year-old boys in Grade 9 who are selling marijuana at school. They sell to other people, the boys wrap the marijuana and put it in pencil cases or instrumental sets [Mathematical instrument set], so the child leaves his books in class. When the marijuana isn’t sold out, he doesn’t sit in class, of which it affects

him, and on the other hand, he loses a certain period because he is outside. The mother doesn't work, the father doesn't work, but they do piece jobs, so he sees to it to bring in a certain income by selling marijuana to someone. So, those are some of the things that end up affecting them mentally'. (Educator F)

'There was a Grade 8 female learner caught with cannabis and a knife in her pencil case because she was selling drugs on her boyfriend's behalf. She was dating a gangster'. (Educator K)

4.2.2 Learners' Needs for a Support System in Schools

Based on the study findings, there was one theme and two sub-themes related to the learners' need for a support system within schools. The theme that emerged was about school-community partnerships. The two sub-themes identified were (a) school nurses and (b) school police officers (adopt-a-cop).

4.2.2.1 School-Community Partnerships. Educators narrated the importance of partnerships with various stakeholders to address the various psychosocial and mental health needs of learners within the education system. The following excerpts corroborated this notion:

'Actually, the needs- we at school have what is called QLTC [Quality Learning and Teaching Campaign]. Whereby if an- there has to be different stakeholders that must be there to support. Because that something that is supportive to the learners, we say, "Ngwana sejo oa tlhakanelwa [A child belongs to the mother, the family, and the community at large]" in Setswana. So, we need to take care of a child. We have what we call QLTC, which involves the police, social workers, and psychologists, and the community at large'. (Educator F)

'There is also the other thing that compiles of different stakeholders that was formed by the principal, where individual professionals are identified in the area, and they are encouraged to form a group. You may find that we have people who come from the

> Social Development, from Health, from Police, these people assist with these problems that learners encounter'. (Educator E)

4.2.2.1.1 School Nurses. The North West DoH assigned a school nurse to schools to address challenges learners might have, provide counselling and address drug-related issues. The succeeding excerpted support this:

> 'We are having the nurse of the school to address learners, maybe with learner problems'. (Educator H)
>
> 'We do invite nurses also to come and address about drugs, not only dagga'. (Educator G)

Another educator emphasised the importance of involving a school nurse in discussions and counselling with learners before any disciplinary action is taken against the learner for misconduct. The following excerpt captured this sentiment:

> 'If a child, let me say, has a certain problem of drugs and other things, before we can overrule everything, we have to call, let me say, if a nurse is needed, we have to call all these people. The child has to receive enough counselling before they [learner] can be expelled or before the child is suspended. So, we need to give these learners enough counselling before we can go through disciplinary measures'. (Educator F)

4.2.2.1.2 School Police Officers (Adopt-a-Cop). Educators indicated that police officers were assigned to schools by the South African Police Service (SAPS) through the Adopt-a-Cop programme. Police officers assigned to the school assist educators in addressing psychosocial problems that affect learners. The following excerpt corroborated this statement:

> 'The school has a police, "adopt-a-cop", we just call, and somebody will just come and help to address the issues that affect the learners'. (Educator G)

Educator F added that the police officers also help to promote school safety. The following excerpt supports this:

> ‘There’s people who enter the school premises, so I need to make sure that there’s nothing wrong; when something is not in order, I must inform the police. Because there is adopt-a-cop at schools’. (Educator F)

Bullying is another challenge that the designated police officers address. The following excerpt supported this statement:

> ‘We also have what we call an “adopted-a-cop”, which is a police officer who is based at a certain school, then he comes from time to time, and is someone I’m also working with, where there are challenges of bullying, he also assists’. (Educator C)

The police officer also addresses drug-related activities at school. The following excerpt corroborated this statement:

> ‘Fortunately, we have “adopt-a-cop” here, who is very active, so we refer to him these problems so that he can assist. If a learner is suspected to be dealing drugs, this guy is called, and he deals with this particular learner’. (Educator E)

4.2.3 Available Psychosocial Services in Schools

The study findings highlighted one theme related to the psychosocial services currently available in the schools. These services were being provided by the school-based support team (SBST).

4.2.3.1 School-based Support Team (SBST). Educator H narrated that the SBST provides learners with counselling. Educators also receive support from the SBST on how they can support and refer learners to receive counselling services from the SBST. The following excerpt supported this:

> ‘The SBST, school-based support team providing counselling to learners. If a learner is encountering problems in your class, you’ll have to take the learner maybe to the school-based support team so that they record the learner’s problems and so on. And then teach educators to know how to provide support to learners as they seek help’. (Educator H)

According to Educator A, the SBST collaborated with external stakeholders with diverse expertise to assist in addressing the problems of learners. This comment was captured in the following excerpt:

> ‘We have SBST, a school-based support group associated with the Department of Health and the South African Police Service; we put our heads together and discuss problems. Sometimes you don't know what the issue of the child is when they act in a particular manner, but sometimes they know certain things about the child, and then they can help’. (Educator A)

4.2.4 Barriers to Seeking and Accessing Psychosocial Services in Schools

Educators described the factors that impeded learners from seeking the available psychosocial support. They also reported on factors that hampered the provision of these services. Based on the findings of this study, the three themes that emerged in the analysis of the study were mental health stigma, social worker delays in addressing the psychosocial needs of learners, and a unique barrier related to an ancestral calling.’

4.2.4.1 Mental Health Stigma. Mental health stigma can lead to individuals having fears about being stigmatised or discriminated against for their mental health problems. Another obstacle to seeking mental health treatment identified by the educators was the fear of being vulnerable, judged or perceived as weak. The following excerpts supported this statement:

> ‘I think also feeling exposed, the fact that they’re forced to realise that, nothing, no matter where you come from, no matter who you are, or what your grades, everybody is exposed to problems, nobody is exempt from them, and that makes them feel vulnerable to come and speak and to seek help, and again, the fact that society has this idea of it being a weakness or a disease or anything like that, you haven’t got a backbone’. (Educator J)

In light of the data, parental or societal attitudes about mental health and mental health services can influence learners' decisions to seek mental health treatment in school. This statement was captured in the subsequent excerpts:

> 'Because it's not really practiced in our society. So, it doesn't motivate learners to go into that route. It's not something that is even practiced from our own homes. So, I don't think it would be easier for a kid to do it in school. A certain portion of a child's life is embedded and is rooted at home. So, it's not a subject that is freely discussed or a service that is freely accessed or talked about in our society. Therefore, people have attached, I would say, negative stigmas and self-connotations towards it'. (Educator B)

Educator C emphasised that a lack of mental health literacy contributes to stigmatisation and discrimination against people with mental health problems, resulting in suicide due to a lack of mental health support. This statement was captured in the following excerpt:

> 'When it comes to our African families . . . We, as Africans, we tend to label people with names, so this brings about stigmatisation, which then becomes a problem in itself on top of people having medical issues . . . So, what we need is a lot of information regarding the matter, rather than labelling, stigmatising people, calling them names, and making them feel as if they are inferior, and to some extent, I will imagine this may turn into people even committing suicide because there is no help out there'. (Educator C)

Educator K indicated that stigma and lack of knowledge about mental health might result in learners opting to consult with traditional healers for treatment. The following excerpt supported this:

> 'Learners that feel there is a stigma to mental health. Someone will say, "no, I'd rather take the traditional route because I'm not depressed"'. (Educator K)

4.2.4.2 Social Worker Delays in Addressing Psychosocial Needs of Learners.

Social workers are external stakeholders to schools who collaborate with educators to address the psychosocial needs and promote the mental health of learners. Although this is the intention, it is evident from the subsequent narratives that the social workers are delayed in addressing the psychosocial needs of learners. The delays become a barrier to learners accessing psychosocial services at their schools. A social worker who, because of being allocated to too many schools, could only come to one particular school once a quarter to address the psychosocial problems of learners. The result was a delayed intervention in addressing learners' psychosocial problems. The following excerpt concurred with this statement:

> 'There's this social worker that we invite to the school . . . this social worker was allocated to our school to assist with problems that we raised. The only problem here is that the number of schools that the social worker is doing; she does many schools…So, when she comes to address educators how to assist learners on their conduct, it's only once in a quarter, and these learners have serious challenges'. (Educator E)

Despite the educators' efforts to involve the schools' allocated social workers, the delayed response from social workers in addressing the learners' psychosocial needs discouraged the help-seeking behaviour of the learners. These excerpts concurred with this statement:

> 'Other issues could be that there is no response from the social department . . . I think issues really need to be resolved as soon as they happen. But unfortunately, at times, an issue really take time, which I feel really works against what one is trying to do. So, this can be a barrier and even discourage them and others to come forward when they experience the same issues'. (Educator C)

> ‘The social workers from the Social Development are sometimes not alarmed by the circumstances we see, they take a long time to respond, and sometimes they don’t come at all while the child is waiting for them’. (Educator A)

4.2.4.3 Unique Barrier: Ancestral Calling. An additional barrier was substantiated by two educators. Educator J and Educator I identified that some parents lacked mental health literacy and also associated their child’s mental health problems with an ancestral calling. These are both barriers to accessing mental health treatment. The following are excerpts that elaborate on the participants’ views:

> ‘One of the things that I've, I think you would maybe know this more in-depth than I would, is sort of what I call ancestral interference, where the parents believe if it's not panic attacks, then the ancestors are calling them to, you know, traditional things, to be a sangoma or a traditional healer, a sangoma, witch doctor, or whatever that they believe they've been called to do. So, they are very uneducated on this, the idea that you know what, “my child has got a problem with anxiety or the behaviour of my child's abnormal”. Their parents want them to go to school to become a sangoma or whatever. Parents are ignorant towards the needs the emotional and mental needs of their kids’. (Educator J)

> ‘There was one girl that had anxiety attacks; I remember, I phoned her mother . . . But sometimes even the parents do not know what to do with their children. So, they would say it's like a forefather thing, forefathers calling them spiritual, the spirit, forefather spirit. Even the parents don’t have wisdom to deal with kids with anxiety or depression or have a mental issue’. (Educator I)

4.3 Conclusion

Chapter 4 provided an overview of the themes and sub-themes that emerged from the semi-structured interviews, and these were supported by verbatim quotations from the educators. The next chapter presents the research results in relation to the background literature and empirical research.

Chapter Five

Discussion of Findings

5.1 Introduction

In Chapter 5, the results of the study are examined in relation to the research questions that guided the study. The findings are also discussed with reference to the related literature review and the theoretical framework underpinning the study.

5.2 Factors that Affect the Mental Health of Learners

5.2.1 Disrupted Family Structure

Educators in this study reported that a disrupted family structure due to conflict within the family or a breakdown of parental relationships, might adversely impact on learners' mental health. A disrupted family structure may also result in feelings of loneliness and, in severe instances, might result in suicide ideation. It was further reported that exposure to domestic violence could negatively affect learners' mental health.

In line with the findings of this study, adolescents from broken families are at a greater risk of developing mental health problems (Chaulagain et al., 2019; DoH, n.d). Additionally, the findings of this study are consistent with literature that demonstrates the significant long-term effects of parental divorce on adolescents' mental health. Similarly, Tullius et al. (2021) reported that adolescents' mental health problems significantly increased post-parental divorce. Not only that, but adolescents’ mental health problems increased and expanded over time compared to adolescents who did not experience parental divorce.

A study by Obeid et al. (2021) confirmed that parental divorce was linked to poor mental health, such as depression, in adolescents. Likewise, consistent with the findings of this study, Mrug and Windle (2010) found that exposure to domestic violence was a more robust predictor of mental health problems such as anxiety and aggression in adolescents than exposure to community violence. Zona and Milan (2011) reported that exposure to violence significantly predicted the symptomology of mental health problems. In essence, exposure to violence is associated with poor mental health in adolescents (DoH, n.d.).

5.2.2 Child-headed Households

The findings of this study revealed that living in a child-headed household is another factor that affects learners' mental health. Within an academic context, educators reported that living in a child-headed household might also affect learners' academic performance.

According to Hall (2019), there is a paucity of robust data on child-headed households in South Africa. Thus, Hall (2019) stated that caution should be exercised when interpreting the figures in the General Household Survey, as child-headed households comprise a very small portion of the entire General Household Survey. In line with the findings of the study, as stated by Sebola et al. (2019), children in child-headed households are much more vulnerable to economic hardships, food insecurity, and interruptions to education.

The findings of this study further showed that learners in a child-headed household may not have parental guidance and support and might be vulnerable, resulting in them being romantically involved with older men. This study seemed to contradict the research by Hoss and Blokland et al. (2018), who stated that in young girls' interactions with older men, their roles cannot always be reduced to that of a victim who is manipulated regardless of the unbalanced power dynamics. These authors asserted that it is crucial to consider both the aspects of young girls' vulnerability as well as their agency.

5.2.3 Poverty

Educators in this study identified poverty as another factor affecting learners' mental health. For example, it was reported that learners might live in hunger due to poverty. Educators reported that learners living in severe poverty might also experience hygiene-related issues, which can affect their mental health, self-worth, confidence, and dignity, consequently resulting in peer isolation.

The DoH (2013) maintained that living in poverty exacerbates the risk of an individual developing mental ill-health. A South African study by Tsegay and Rusare (2014) highlighted that childhood stunting in the country has increased to 26.5% due to the limited access to

quality and nutritious food in South Africa. In line with the results of this study, people living in poverty are at greater risk of hunger (Tsagay & Rusare, 2014; UNICEF, 2019), which is significant because hunger can prevent quality and effective learning even if children have access to education (Tsagay & Rusare, 2014).

Consistent with the findings of this study, adolescents who live in poverty are at high risk for developing mental health problems (Bøe et al., 2017; Chaulagain et al., 2019; Hanandita & Tampubolon, 2014). Similarly, in a study by Skinner et al. (2019), educators considered poor living conditions to be direct contributors to poor mental health. Furthermore, previous research has shown a relationship between low socioeconomic status and mental health problems (Reiss, 2013; Reiss et al., 2019).

Hygiene poverty is described as the lack of access to essential products individuals require to stay clean, safe, and healthy (The Hygiene Bank, 2020). In line with the findings of this study, the authors of the above source stated that hygiene poverty can have a detrimental impact on individuals' confidence, leaving them feeling lonely, ostracised, stigmatised, bullied, and humiliated, resulting in poor mental health. Although the current study did not explore the consequences of hygiene poverty for learners, the Hygiene Bank authors stated that a lack of access to hygiene products may prevent individuals from participating and contributing to society.

Moreover, having a low-income limits individuals' purchasing options, forcing them to choose between, for example, purchasing electricity or food, paying rent or maintaining their hygiene (The Hygiene Bank, 2020). For instance, an individual who cannot replace a toothbrush, might be forced to share one. If they cannot purchase deodorant, they might have body odour. Or, for lack of resources, an individual might be confined to home because they cannot afford to purchase sanity towels and instead needs to use rolled-up toilet paper or socks for period protection (The Hygiene Bank, 2020). And therefore, the study showed a direct link between the consequences of poverty and the mental health of learners.

5.2.4 Sexual Abuse

The educators in this study reported that some learners experienced sexual abuse in the form of rape or molestation, which consequently adversely impacted their mental health. Educators further reported that families of some learners who experienced intrafamilial rape insisted that the learner not disclose the abuse but keep it secret.

Similar to the findings of this study, Fontes et al. (2017) affirmed that sexual abuse has significant adverse effects on learners' mental health and that most of the sexual violations are committed by people known to the learner, such as family members. According to the UN (2020), sexual violence is associated with inverse mental health outcomes such as depression, PTSD, suicide risk, psychoactive substance use, and poor academic results.

The results of this study corroborate the findings of Tener (2017), who affirmed that a significant barrier to intrafamilial child sexual abuse was the family's behaviour. The family used several sophisticated strategies to avoid disclosure or continue to conceal the intrafamilial child sexual abuse even after it had been disclosed to them. A study by Katz et al. (2020) highlighted that non-disclosure is one of the survival strategies developed by survivors of intrafamilial child sexual abuse. Yet, secrecy has been associated with shame, rejection, and disclosure anxiety (Tener, 2017), which could have adverse consequences on the mental health of learners.

5.2.5 School Violence

The findings of this study revealed that school violence affects learners' mental health. In addition, it was reported that community violence was carried into the school environment, indicating that in the school, physical fights among learners could also be influenced by fights in the community or village.

Studies by Fraga et al. (2011), Hussin et al. (2014), and Omer et al. (2020) revealed that some learners had been involved in physical fights in the 12 months before being surveyed. Physical fights among learners frequently occur at schools (Fraga et al., 2011),

and those involved in physical fights were primarily victims of bullying (Omer et al., 2020). With this in mind, the findings of this study concur with those of Mrug and Windle (2010), who found that exposure to school violence is associated with mental health problems such as anxiety and depression. Finally, the findings of this study have demonstrated that, at times, violence occurred outside the school environment and was brought into the school premises (Sibisi, 2016).

5.2.6 Bullying

Educators in this study reported bullying as a factor affecting the mental health of bullied learners. It was also reported that bullying might result in bullied learners having low self-esteem, increased school absenteeism, or even committing suicide.

Consistent with the findings of this study, Halabi et al. (2018) reported a correlation between being a victim of bullying and mental health problems among adolescents. Likewise, similar to the findings of this study, van Geel et al. (2014) and Owusu et al. (2022) reported positive associations between being a victim of bullying and suicidal ideation or suicide attempts. Furthermore, Moore et al. (2017) articulated that there is an independent temporal relationship between bullying, victimisation, and poor mental health outcomes. Finally, although not explored in this study, Man et al. (2022) articulated that the frequency and type of bullying had a more significant detrimental impact on the mental health of adolescents younger than the age of 15.

According to the UN (2020), bullying puts adolescents at risk of poor academic outcomes and mental health problems such as anxiety, depression, self-harm, suicide ideation, suicide, and violent behaviour, which may persist into adulthood. Consistent with previous findings, Dunne et al. (2013) and Owusu et al. (2022) articulated that bullying among high school learners is associated with school absenteeism. The findings of this study concur with the results of earlier studies, which indicated that frequent exposure to bullying is detrimental to the psychological well-being of learners and is a predictor of

depression and low esteem among victimised learners (Mungala & Nabuzoka, 2020), and is associated with poor academic achievement and school absenteeism (Feldman et al., 2014).

5.2.7 Psychoactive Substances among Learners

5.2.7.1 The Use of Psychoactive Substances. Another factor that educators considered as one affecting the mental health of learners was the use of psychoactive substances such as alcohol and marijuana. This substance use consequently affects the learners' mental health and educational progress. It was also reported that the use of marijuana among learners might result in learners dropping out of school and causes a vicious cycle of mental health problems, drug use, and poverty.

The findings of this study corroborate the studies conducted in South Africa by Magidson et al. (2017), Mohale and Mokwena (2020), Mokwena and Setshego (2021), and Taukoor et al. (2017), which highlighted the substance use among adolescents. In line with the results of this study, Mohale and Mokwena (2020) highlighted a high prevalence of psychoactive substance use among high school learners. Due to alcohol being socially acceptable and easily accessible, it may explain its apparent prevalence among adolescents (Mohale & Mokwena, 2020; Taukoor et al., 2017). Skinner et al. (2019), in their study conducted in South Africa, also remarked that multiple drug-related behaviours were observed among learners by educators, including the use of alcohol and marijuana.

Brownlie et al. (2019) affirmed that psychoactive substance use was a risk factor for poor mental health during early adolescence. Findings have demonstrated a positive correlation between substance use and concentration problems (Skinner et al., 2019). A study by Sorsdahl et al. (2021) evaluated the mental health needs of adolescents in South African communities and revealed that in the Western Cape province, alcohol use and depression were significant concerns among adolescents. A study by Johannessen et al. (2017) demonstrated that early alcohol use is associated with high levels of depressive symptoms among adolescents.

Moreover, in South Africa, the prevalence of marijuana use among adolescent learners is related to age, peers, affordability, and easy access to the drug (Sedibe & Hendricks, 2021). In most cases, learners reported that they could easily acquire illicit psychoactive substances in their communities or villages (Tshitangano & Tosin, 2016).

5.2.7.2 Psychoactive Substance Abuse and Dependency. This study also found that educators articulated that the mental health and behaviour of learners were further affected by psychoactive substance abuse and dependency. This study supports evidence from previous research studies. For example, Maritz and Chibaya's (2016) findings highlighted the transition from psychoactive substance use to psychoactive substance abuse among high school learners, resulting in normal brain function disruptions, personality and behavioural changes, and social dysfunction. Mfidi (2017) evaluated high school adolescents' mental health issues. The results of this South African study revealed that psychoactive substance abuse was one of the highly prevalent risky behaviours adolescents engaged in, which affected their mental health and consequently resulted in problems associated with poor academic performance and dropping out of school. Mohale and Mokwena (2020) articulated that the high prevalence of psychoactive substance abuse among learners is a public health concern because psychoactive substance use and abuse pose significant health and academic risks for learners.

5.2.7.3 The Selling of Psychoactive Substances at School. This study revealed that marijuana was one of the psychoactive substances that learners sold on the school premises, negatively impacting their academic performance and mental health. It is important to note that limited research has been conducted on the association between selling psychoactive substances at school and mental health. However, Steinman (2005) evaluated drug selling among high school learners and revealed that drug selling is a widespread behaviour among adolescent learners and that selling drugs was strongly associated with other risky behaviours such as delinquency, violence, and the use of marijuana. Consistent with the finding of this study, a South African study by Sibisi (2016)

revealed that high school learners sell psychoactive substances on the school premises during school hours. The substances are provided to them by community members or older gang members (Sibisi, 2016). Additionally, these learners left their classrooms to engage in drug dealings.

5.3. Learners' Needs for a Support System in School

5.3.1 School-Community Partnerships

The findings of this study revealed that school-community partnerships between various stakeholders, such as the DBE, Department of Social Development, DoH, and the SAPS, contribute to the well-being of learners and address the psychosocial challenges that learners experience at school. This study corroborates evidence from previous studies. For example, Shapiro et al. (2010) stated that, because the systems that contribute to adolescents' mental health development are interconnected and complex, it is essential to develop school-community partnerships to efficiently and effectively address the mental health needs of learners. Hertz and Barrios (2020) highlighted that identifying learners who need mental health support cannot be done by schools alone. They point out that school-community partnerships are vital to assist schools in providing appropriate, affordable, and convenient mental health services to learners or appropriately referring to adolescent-oriented mental health professionals.

5.3.1.1 School Nurses. Educators in this study indicated the importance of the appointment of school nurses. School nurses assist in identifying and addressing various problems learners might have, including drug-related problems.

In schools, nurses are the frontline providers of care for learners (Cowell, 2013; Ramos et al., 2013). Similar to the findings of this current study, Patestos et al. (2014) articulated that school nurses have multiple roles to play, including that of a liaison and referral person. As outlined by Patestos et al. (2014), the primary responsibility of school nurses is health education and promotion; thus, substance abuse prevention education should be provided throughout the health continuum at the earliest grades possible. The

abovementioned authors further reported that in cases of substance abuse prevention, school nurses play a crucial role in bridging the gap between the school, family, and community.

5.3.1.2 School Police Officers (Adopt-a-Cop). The findings of this study revealed that *adopt-a-cop* are police officers assigned to a school to essentially promote school safety. These assigned officers address issues that affect learners, such as bullying and drug-related concerns. Adopt-a-cop is one of the programmes initiated by the SAPS to prevent crimes against children and promote school safety (SAHRC, 2006). In line with the results of this study, the SAPS endeavour to create and maintain their presence at the schools and speak out against bullying and violence during school assemblies (SAHRC, 2006).

Choi et al. (2021), Muller et al. (2020), and Whitaker et al. (2020) found data to be scarce about the presence of police officers in schools related to the issue of the mental health of learners. Muller et al. (2020) affirmed that it is, however, difficult to quantify the mental health needs of learners as their mental health needs may manifest as aggressive or disruptive behaviour, violence, or psychoactive substance use, making it somewhat challenging for school-based police officers to identify the mental health needs of learners.

From this perspective, contrary to the findings of the current study, the presence of police officers in schools was not found to contribute to school safety consistently. The Whitaker et al. (2020) study indicated that police officers in schools do not contribute to creating a safe and drug-free school environment and need to be qualified and trained to work with learners. This implies that police officers are trained to enforce law and order, which sometimes results in detainment and arrests, consequently creating a hostile learning environment for learners. Choi et al. (2021) and Whitaker et al. (2020) concluded that police officers' involvement with adolescent learners could have negative associations with learners' mental health and academic well-being.

5.4 Available Psychosocial Services in Schools

5.4.1 School-based Support Team (SBST)

Educator participants in this study reported that the SBST played an essential role in providing learners with psychosocial services and supporting educators in addressing the learners' psychosocial needs. Similar to the findings of this study, Skinner et al. (2019) found that SBST is a programme run at schools where educators refer learners to receive assistance. However, the current study findings somewhat contrast with the results of Skinner et al. (2019) in that their study demonstrated that the focus of the SBST is limited to educational assistance rather than the provision of psychosocial services as in this current study. Still, Bowers et al. (2013) pointed out that there is generally limited availability of school-based mental health services in schools.

5.5 Barriers to Seeking or Accessing Psychosocial Services in Schools

5.5.1 Mental Health Stigma

Educators in this study narrated that mental health stigma results in learners with mental health problems having fears of being stigmatised and discriminated against for their mental health problems, thus impeding help-seeking behaviour. Furthermore, the findings of this study revealed that negative family and societal perceptions of mental health and mental health services could be a barrier to learners seeking mental health treatment at school. The lack of mental health literacy also contributes to mental health stigma.

Consistent with the findings of this study, a Rwandan study by Muhorakeye and Biracyaza (2021) found that the fear of stigmatisation was one of the most common barriers to seeking and accessing mental health services. This is because stigmatisation results in mental health labels, and individuals feeling neglected, shameful, and discriminated against. Bowers et al. (2013) also evaluated stigma in school-based mental health. Their study revealed that stigma was the most common barrier to accessing school-based mental health services. Bracke et al. (2019) also indicated that personal and dominant cultural stigma beliefs are barriers to seeking mental health care. Stigma may be experienced differently

depending on cultural differences (Gallego et al., 2020; Telesia et al., 2020). Moreover, a systematic review on improving mental health literacy in adolescents by Seedakat et al. (2020) revealed that mental health literacy improves mental health attitudes and reduces mental health stigma.

5.5.2 Social Worker Delays in Addressing Psychosocial Needs of Learners

Educators in this study reported social workers are allocated to multiple schools and, therefore, only come to each school once a quarter causing a delay in addressing the psychosocial needs of learners. Delayed interventions in addressing the psychosocial needs of learners discouraged help-seeking behaviours in learners.

The findings of this study support evidence from previous studies. For example, Skinner et al. (2019) remarked that educators perceived additional mental health resources to be severely limited, resulting in many learners having to wait for long periods to access interventions, indicating a delay in the referral process. Studies by Babatunde et al. (2020) and Mokitimi et al. (2019) further highlighted the lack of child and adolescent mental health resources and poor priority for child and adolescent mental health services. Sometimes, learners waited for years to receive mental health services and, at times, were refused referrals because they were no longer age-eligible for those services (Skinner et al., 2019).

A study by Reyneke (2018) indicated that the DBE rarely employs social workers to provide psychosocial services. This being despite the fact that the need for social services for learners was being discussed by diverse stakeholders and in various policy documents and court findings (Reyneke, 2018). The possible reason for this could include limited financial resources (Masilo, 2018; Reyneke, 2018). Furthermore, Masilo (2018) articulated that private schools in South Africa with the financial means to pay social workers, are usually the ones that employ school social workers to provide counselling services. Therefore, Babatunde et al. (2020) concluded that insufficient child and adolescent mental health resources, and low priority for child and adolescent mental health services negatively

affect child and adolescent mental health states and serve as a barrier to accessing and receiving child and adolescent mental health services in the district.

5.5.3 Unique Barrier: Ancestral Calling

The findings of this study revealed that due to limited mental health literacy, parents might believe the mental health problems of their children to be an ancestral calling to become a sangoma or traditional healer. This may consequently inhibit mental health treatment-seeking behaviour. Additionally, a lack of mental health literacy may result in seeking alternative mental health treatment from a traditional healer. Notably, few studies have examined the interrelation between mental health and an ancestral calling.

The findings of this study are consistent with those of Flisher et al. (2012), who stated that, in several African traditional beliefs, mental health problems are associated with spiritual entities, including ancestors. Similarly, in line with the results of this study, a Nigerian study by Wada and Anjorin (2022) highlighted that the cause of mental illnesses is often attributed to ancestral spirits, resulting in individuals seeking mental health services from traditional healers. A study by van der Zeijs et al. (2020) revealed that ancestral calling-related hallucinations are often preceded by other symptoms of mental health problems such as anxiety, confusion, dementophobia, and sleep problems, which may result in distress and impaired functioning. Simply stated, symptoms of mental health problems may be interpreted as a sign of becoming a traditional healer (van der Zeijs et al., 2020).

Audet et al. (2017) conducted a study on traditional healers' treatment of mental disorders in rural South Africa. The study highlighted that, even though there is limited information regarding the treatment of mental illnesses by South African traditional healers, some traditional healers reported having the ability to treat mental illnesses (Audet et al., 2017).

5.6 Review of Findings from Multiple Theoretical Perspectives

In addition to confirming or contradicting numerous previous studies, the findings of this study bolster the propositions of the two theories that underpinned it.

5.6.1 The Psychosocial Development Theory: Understanding Identity Development in Adolescent Mental Health

First, the results of this study align with the developmental task of the fifth stage of psychosocial development. Erikson's (1968) guiding principle is that mental health problems may result when adolescents do not resolve their psychosocial crisis in this stage and form a stable identity. Adolescence is a period of identity formation often accompanied by depression and anxiety (Potterton et al., 2022). A narrative synthesis by the preceding authors revealed a bidirectional association between identity confusion and symptoms of depression and anxiety.

From this perspective, adolescent learners from a disrupted family structure, a child-headed household, or those who experienced sexual abuse may adopt roles to meet the expectations of others. This may result in role confusion. If the identity versus role confusion crisis is not resolved, adolescents may also struggle to understand their roles and responsibilities (Upeti, 2017). With reference to the importance of peer relationships in the development of adolescents' identity, bullied learners may find it challenging to establish peer relationships as they often experience isolation and social exclusion. With this in mind, peer relationships positively influence the development of adolescents' identity (Ragelienė, 2016). Similar to the results of this study, a study by Skarstein et al. (2020) investigating social exclusion and bullying among adolescents revealed that bullied learners were socially excluded and bullied by peers, often resulting in learners describing emotional experiences of sadness, loneliness, and depression.

Adolescent learners who use, abuse, are dependent on, or sell psychoactive substances may also fail to build healthy peer and family relationships. Louw and Louw (2014) posited that adolescents who abuse psychoactive substances and do not conform to the societal views, norms, and values that are regarded as normal and acceptable, usually have a negative identity. Similarly, de Moor et al. (2022) articulated that adolescents who have strong identities may be less likely to use psychoactive substances. A study on the

links between identity and substance use by de Moor et al. (2022) highlighted that consistent with previous cross-sectional research, they found a negative association between psychoactive substances (such as alcohol, marijuana, and cigarettes) and identity commitment. Additionally, the use of psychoactive substances was associated with reconsidering one's identity commitment, thus highlighting that psychoactive substance use may be associated with poor adjustments in adolescents.

5.6.2 The Ecological Systems Theory

This research report highlighted some critical aspects that contribute to identifying and addressing the mental health needs of learners. Notably, a single system within the ecosystems model might not incorporate all the mental health needs of learners. The findings of this study indicated that the systems within the ecological system often overlap with each other and influence the development of the learners, as well as shape the interaction between the learners and the systems.

The ecological perspective aligns with the mental health needs of learners, at various levels of the ecological systems. The guiding principle of the ecological theory is that the learner interacts with their environmental contexts such as home, school, and community that. These contexts influence learner development and mental health.

5.6.2.1 Microsystem. Martinello (2020) articulated that family is an integral component of a child's microsystem, as family shapes how the child learns, is raised, and is integrated into the community. Perpetrators of sexual abuse are also a component of a child's microsystem, as they directly impact the child's sexual development (Martinello, 2020). Donald et al. (2020) articulated that sexual abuse mostly occurs within the home environment. Furthermore, Martinello (2020) articulated that the cultural perceptions concerning sexual abuse may influence the response to child sexual abuse by society, which may result in mistrust and a lack of support provision, impacting the child's well-being and recovery. At times, learners often do not have a supportive family environment, which consequently affects their development and progress. A disrupted family structure, living in a

child-headed house, poverty, sexual abuse, school violence, bullying, and psychoactive substances among learners are some factors that should be considered to affect learners' mental health. This is because these factors directly and negatively influence the development of the learners.

5.6.2.2 Mesosystem. The mesosystem involves continuous interactions between microsystems, highlighting that the changes and influences within one microsystem influence how the child responds to other microsystems (Donald et al., 2020). For example, on a mesosystem level, educators interact with families of the learners who survived intrafamilial sexual abuse to address the adverse childhood experience.

Previous research has indicated that often, child intrafamilial sexual abuse is kept secret by mothers and family members of the children who survive such abuse. From the participants' narratives, it was clear that some mothers and family members tried to conceal intrafamilial sexual abuse even when the learner had disclosed the abuse to educators, which consequently affected the learners' mental health.

5.6.2.3 Exosystem. The exosystem encompasses other systems that the child is not directly part of but has a profound impact on the child's development and the individuals in the child's microsystem (Donald et al., 2020). Collectively, individuals within the exosystem surrounding the learner played an important role in supporting learners' mental health and addressing their psychosocial needs. School-community partnerships and the SBST may provide a support structure readily available in schools. It was evident, however, that certain factors in this level could have an adverse impact on learners' mental health. Educators tried to obtain psychosocial interventions for learners from social workers assigned to the school. Delays in social workers addressing the psychosocial needs of learners had a detrimental effect on the mental health of learners and impeded help-seeking behaviour.

5.6.2.4 Macrosystem. The macrosystem involves social and cultural beliefs, practices, and values that may influence other systems and interactions within microsystems and the whole mesosystem (Donald et al., 2020). For example, mental health stigma and

ancestral calling were barriers to seeking and accessing psychosocial services at school. These barriers may not directly influence learners' development and mental health. However, mental health stigma and ancestral callings encompass social and cultural elements, and such elements significantly influence learners' beliefs on mental health and interpretations of their life events. This influence over beliefs and interpretations may consequently inhibit help-seeking and accessing behaviour. In addition, these barriers might shape how learners interact with other systems.

5.6.2.5 Chronosystem. Changes that occur over time influence the interaction between systems and the child's development (Donald et al., 2020). Many environmental events and significant life transitions occur throughout an adolescent's life, shaping their development and mental health. According to this research, for example, factors such as a disrupted family structure, child-headed households, and sexual abuse are major life events that may occur over time and may influence learners' development and mental health. Within the chronosystem, for example, experiences of child sexual abuse may affect the child's interaction within and between subsystems over time (Martinello, 2020).

5.7 Conclusion

In this chapter, the results of the study were considered in relation to the research questions which guided the study. First, the study findings were discussed with regard to the literature review about factors that affect the mental health of learners, learners' needs for a support system in schools, available psychosocial services in schools, and barriers to seeking and accessing psychosocial services within schools. Next, the findings were discussed according to the psychosocial development theory in relation to understanding identity development in adolescent mental health and the ecological systems theory. Finally, an overview and conclusion of the study are provided in the next and final chapter of this research report.

Chapter Six

Conclusion, Significance of the Study, and Recommendations

6.1 Introduction

Chapter 6 provides a brief overview of the study and presents the researcher's recommendations based on the implications of the finding. The limitations of the study are also considered, and recommendations are made for future research.

6.2 Overview and Conclusion of the Study

In this study, a qualitative research design approach using an interpretivist paradigm was used to gain insight into educators' experiences of the mental health needs of high school learners in North West. The research objectives of this study were to:

1. Describe educator's experiences as they relate to factors that affect the mental health of their learners
2. Describe their learners' needs for support services.
3. Reflect on the availability of psychosocial services in schools.
4. Describe the barriers that learners might face in seeking and accessing psychosocial services in schools.

Thematic analysis was used to analyse the results. Analysis of the results revealed factors that affect the mental health of learners. These factors are a disrupted family structure, child-headed households, poverty, sexual abuse, school violence, bullying, and psychoactive substances among learners. Results showed a need for systemic intervention through school-community partnerships. The SBSTs are the primary source of psychosocial services available within schools. The findings of the study reflected the main barriers to seeking or accessing psychosocial services at school to be mental health stigma, social worker delays in addressing the psychosocial needs of learners, and ancestral calling.

6.3 Significance and Possible Contributions of the Study

The study findings contribute to existing research in the field of adolescent mental health in schools, as there needs to be more published work in this area, particularly within

the African and South African contexts. In addition, school administrators and governing bodies can use the results to build research-based motivation for the provision of psychosocial services and mental health support structures within schools to address learners' needs.

This study reflects that collaborative teamwork and networking with other professionals and stakeholders such as health care workers, social service providers, and other relevant community members is essential to optimally meet learners' needs for support within the school system. In view of this, collaborative teamwork would also provide support to SBSTs and complement and extend the assistance that they must provide in schools. In addition, parent involvement and participation are also essential to promote mental health programmes and reduce barriers to seeking or accessing psychosocial support services in schools.

The study findings may have implications for various level-specific stakeholders involved in the mental health promotion and policy development for children and adolescents, such as the National Department of Health (NDoH), the Department of Basic Education (DBE) and school leadership and management teams. The NDoH and DBE may need to lobby support using practical experiences in schools and research findings such as the current study to improve and further develop age-specific policies and programmes. These programmes can help ensure that mental health promotion and care within schools are prioritised to meet the holistic needs of all learners. While the study may emphasise the need for national mental health policies and legislations for children and adolescents, more research with a larger, more diverse sample is required to increase generalisability of the findings and support particular policy initiatives. With this in mind, the findings of this study may be considered as preliminary data on a complex issue that warrants further investigation.

The NDoH, DBE, and school leadership and management teams can use the information to understand what needs to be done to improve mental health and address the

mental health needs of learners. The information can be used to enhance the provision of psychosocial services in schools, meet learners' needs for a support system, and develop strategies to reduce barriers to seeking or accessing psychosocial services at school. In addition, the information provided in this study can contribute to the great paucity of research on the mental health needs of adolescents and the limited research on educators' perceptions of the mental health needs of learners. This research can contribute to the development of mental health policies and legislation for children and adolescents at the national level, highlighting the need to develop promotive, preventive, curative, and rehabilitative interventions to promote the mental health of all learners. Implementing these mental health policies and legislations for children and adolescents can be delegated at the provincial level.

6.4 Recommendations

It is recommended that the government allocate a higher budget to the DBE, of which some funds can be used to develop and implement school policies and guidelines that promote mental health awareness of learners, teach life skills, curb school violence, and promote school safety. These outcomes can be achieved through incorporating such policies and guidelines into the curriculum. From this perspective, integrating mental health services into the school system can result in a continuum of integrative interventions that improve learners' mental health and academic success (Fazel et al., 2014).

Some education funding can be used to employ school nurses and social workers. Based on the findings of this study, the DBE needs to consider the mental health of learners and not only promote school safety, and should weigh the risks and benefits of appointing police officers to schools. In this light, the DBE Districts, Sub-Districts, and schools should be encouraged to develop school-community partnerships. Donald et al. (2020) articulated that crime and violence can be prevented in schools by developing positive relationships between schools and communities. Thus, positive school-community relationships may

contribute to the holistic development of learners and provide a healthy and safe learning environment.

Employing school nurses and school social workers to be part of the SBST will promote the mental health and psychosocial development of learners. These employments can also reduce the delay in addressing the mental health and psychosocial needs of learners, also encouraging a multidisciplinary and interdisciplinary team approach when addressing the mental health and psychosocial problems of learners. Additionally, school nurses and school social workers can make appropriate referrals for learners in need. For instance, sexual abuse cases of learners can be reported to the SAPS, and learners addicted to or dependent on psychoactive substances can be referred to drug and alcohol counselling or rehabilitation centres.

The school nurses and school social workers can also collaborate with and provide training programmes to the appointed school police officers to enhance their ability to intervene appropriately and contribute positively within the macrosystem. With this in mind, school nurses and school social workers can also provide expertise and knowledge on mental health, early identification of mental health concerns, appropriate interventions, and effective strategies for supporting the mental health and well-being of learners. Adopting a multidisciplinary approach will encourage a collaboration between the school, school nurses, school social workers, appointed school police officers, and other relevant professionals ensuring a holistic approach when addressing the mental health needs of learners.

The DBE needs to continue developing and implementing in-service professional development programmes, skills training, and support for school mental health for educators. Schools need to be equipped with skills for the early detection of mental health problems among learners and strategies to effectively enhance their mental health and the well-being of their families and the community.

6.5 Public Health Implications

Finally, numerous studies have highlighted the detrimental effects of poverty on mental health. Some public schools have a National School Nutrition Programme (NSNP), which is a government programme that provides learners with one nutritious meal. Yet food is not the only need. For example, educators in this study reported that the confidence and self-esteem of learners were affected by the challenge they experienced in meeting their self-care and hygiene needs. Therefore, in addition to the nutrition programme, the DBE also needs to consider allocating funds to schools to provide learners from underprivileged families with hygiene kits (soap, toothbrush, toothpaste, deodorant, body lotion, and sanitary towels).

6.6 Limitations of the Study

While the findings of this study provide valuable information on the mental health needs of learners in high school, there were limitations related to the study which need to be acknowledged. First, the researcher allowed educator participants to respond in English or Setswana. The Setswana to English-translated transcripts might have lost meaning because the researcher may have constricted the essential meaning of educators' contextual and rich experiences and perspectives. Second, the findings of this study were derived from a small sample of high school educators in North West. The findings may, therefore, not apply to other locations and social contexts, thus, the findings should be interpreted with caution. However, the results provide in-depth contextual rich accounts of educators' experiences on the mental health needs of learners in high school. In this light, some of the themes and sub-themes that emerged from the study may reflect the mental health needs of high school learners in similar settings in South Africa and other LMICs.

6.7 Suggestions for Future Research

This research raises several interesting research possibilities. For instance, it would be interesting to obtain in-depth contextual rich accounts from learners about their mental health needs and how the presence of police officers in schools influences their mental

health. Additionally, further research could investigate learners' experiences of psychosocial services in schools and how traditional events such as ancestral callings affect their development and mental health. It would be valuable to conduct a research study using a more significant number of representatives from different school settings in South Africa. Moreover, conducting a quantitative or mixed-methods study investigating the mental health needs of learners might also have enormous significance. Findings from such an investigation might help identify more complex and varied challenges than those identified in the present study, as well as possible solutions to address the mental health needs of learners.

The findings of this research have highlighted that a holistic and comprehensive approach needs to be taken to promote mental health literacy, promote mental health, and prevent, identify and address existing or potential mental health problems of learners.

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Appendices

Appendix A

Participation Information Sheet

An exploratory study on educators' experiences of the mental health needs of high school learners in the North West Province

Good day

My name is Boitumelo Mziwakhe, and I am a Master's student in the Department of Psychology in the School of Human and Community Development at the University of the Witwatersrand. As part of my studies, I am required to undertake a research project and do an exploratory study on educators' experiences of the mental health needs of high school learners in the North West Province. This will be done under the supervision of Professor Zaytoon Amod.

An invitation to participate

You are invited to participate in this research study. Before you decide on whether you would like to participate or not, it is important for you to understand what the purpose of this research is, what is expected of you as a participant, as well as the risks and benefits of the study. Please take time to read the information below and decide whether or not you would like to participate in this research. Within the next two days, I will call you to find out if you would be interested in participating in the study. Should you be interested and meet the criteria for participation in the research, I will make an appointment to conduct a telephone interview.

Participation in the study

You have been invited to participate in the study because you are a high school educator in North West. The criteria for participation in this study is high school educators between the ages of 25 and 65 years with at least two years of teaching experience. In addition, educators must have a University Diploma in Education Secondary (UDES), Bachelor's Degree in Education (BEd), or Postgraduate Certificate in Education (PGCE). As a participant, you will form part of the 10- 12 participants who will participate in the study. If you are interested in participating, I will re-check that you do meet the criteria in order to re-clarify the details of the Participation Information Sheet if necessary.

Participation in this study will involve taking part in a telephone interview at a time that is convenient for you. The interview will last for approximately 30- 60 minutes, and I will ask questions about the mental health needs of learners. With your permission, the call will be recorded for the duration of the interview, and the interview will be recorded using a call recorder to ensure accuracy. No one else will be present in the room while I conduct the interview. You will not be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. Participation in this study is completely voluntary. You may refrain from answering any questions you would prefer not to, and you may choose to withdraw from the study at any point during or after the interview without consequence. All of your responses will be kept confidential, and no information that could identify you will be included in the research report. In the final research report, you will be referred to by a pseudonym (e.g., Educator B). Only my supervisor and I will have access to the raw recordings and transcribed interviews.

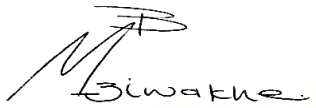
Moreover, direct quotes might be used; however, data will not be associated with your name or any other identifiers when writing up findings in the final research report and/ or any other publications/ presentations that might arise from the research report, as pseudonyms will be used. To maintain confidentiality, electronic and transcribed data will be stored in a password-encrypted laptop. Furthermore, electronic and transcribed data will be kept indefinitely for research purposes. This study will be written up in a research report which will be available online through the university library website. The research results may also be published in the form of a journal article or a book chapter. It might also be presented at a conference. Should you be interested in receiving a summary of the research results, you can contact me via email in April 2022.

Possible risks of participating

It is possible that the interview might cause you discomfort, as it might evoke repressed emotions about the mental health needs of learners or relive a traumatic experience concerning the mental health of your learners. Should this happen, please call The South African Depression and Anxiety Group (SADAG) on 0800 456 789 or LifeLine Johannesburg on 0861 322 322 to receive free emotional and psychological support.

If you choose to participate in the study, please complete the form below. If you have any queries about the research, feel free to contact me on the details listed below. Alternatively, you can contact my research supervisor. Should you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone on +27 (0) 11 717 1408, email Shaun.Schoeman@wits.ac.za

Yours sincerely,



Boitumelo Mziwakhe,

Student

Master of Arts in Social and Psychological Research

email: 2134255@students.wits.ac.za or call 073 686 6885

Sign 

Professor Zaytoon Amod

Supervisor

Educational and Clinical Psychologist,

email: Zaytoon.Amod@wits.ac.za or call 011 717 8326

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Appendix B

Participant Consent Form (Telephone interview)

An exploratory study on educators' experiences of the mental health needs of high school learners in the North West Province

I _____ consent to be interviewed telephonically by _____ for the above-titled study. I understand that:

a) My participation in this study is completely voluntary.
b) Participating in this study might make me uncomfortable, and it might evoke repressed emotions about the mental health needs of learners.
c) There are no benefits in choosing to participate in this study.
d) I may refuse to answer any questions I would prefer not to.
e) I may withdraw from this study at any time during or after the interview without being penalised.
f) No information that might identify me will be included in the research report, and my responses will remain confidential.
g) Electronic and transcribed data will be kept in a password-encrypted laptop.
h) Electronic and transcribed data will be kept indefinitely for the purpose of research.

_____ _____

Signature Date

I _____ consent to the call with _____ to be recorded to ensure accuracy. I understand that:

a) Only the researcher and her supervisor will have access to the raw recordings and transcribed interviews.
b) All interview recordings will be kept indefinitely.
c) No identifying information will be used in the transcripts, research report, or other forms of publication. I will be referred to by a pseudonym in the research final research report and/or any publications or presentations that may arise from this study.
d) The researcher might use direct quotations in the research report provided that the data is not obviously associated with your name or any other identifiers.

_____ _____

Signature Date

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Appendix C:

Semi-Structured Interview Schedule

Section A: Background Information

1) How long have you been teaching?
2) What grades do you teach and have taught before?
3) What is your age group category? (25- 29; 30- 39; 40- 49; 50- 59; 60- 65)
4) What is your position at the school?

Section B: Educators' experiences of mental health needs of high school learners

5) What is your understanding of mental health?
6) What is your understanding of the mental health needs of learners?
7) What do you think are some of the mental health needs of learners?
8) How would you identify learners with mental health needs?
9) What do you think are some of the factors that could potentially affect the mental health of learners?
10) How do you think the above-mentioned issues affect the mental health of learners?
11) How can you promote the mental health needs of learners as an educator?
12) How can the school promote the mental health needs of learners?
13) Could you tell me what resources and/ or programmes you have at your school that assist you to improve your knowledge of the mental health needs of learners?
14) What resources and/ or programmes outside your school that you are aware of which could help you to improve your knowledge of the mental health needs of learners?
15) How confident are you in identifying and addressing the mental health problems of learners?

Section C: Learners' needs for school psychosocial services

16) What is your understanding of school psychosocial services?
17) What do you think are the benefits of school psychosocial services?

Section D: Availability of School Psychosocial Services

18) Does the school offer psychosocial services?
19) Does the school have a school counsellor?
20) Does the school have a social worker?
21) What additional services does the school offer that may positively contribute to the mental well-being of learners?
22) Does the school have a curriculum or programmes to educate learners on mental health?
23) Does the school have an anti-violence (anti-bullying) policy?
24) Does the school have a substance abuse prevention policy?

Section E: Barriers to seeking and accessing psychosocial services in school

25) What barriers may prevent learners from seeking and accessing school psychosocial services?
26) What do you think can be done by the school to address these barriers?
27) Are there any other comments you would like to add regarding the mental health of learners in schools?

Thank you very much for taking the time to participate in the study.

Appendix D

Ethical Clearance Certificate

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SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:	**PROTOCOL NUMBER: MASPR/20/08**
PROJECT TITLE:	An exploratory study on teachers' experiences of the mental health needs of high school learners in Itsoseng in the North West Province
INVESTIGATOR	Mziwakhe Boitumelo (2134255)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	12 June 2020
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Low Risk
EXPIRY DATE	31 December 2022

ISSUE DATE OF CERTIFICATE 21 June 2020 **CHAIRPERSON** _____
(Dr Sahba Besharati)

cc: Prof. Zaytoon Amod (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

Mziwakhe
Signature

29/06/2020
Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix E

Turnitin Report

An Exploratory Study on Educators Experiences of the Mental Health Needs of High School Learners in the North West Province1.docx

ORIGINALITY REPORT

13%	9%	10%	2%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	hdl.handle.net Internet Source	1%
2	Submitted to University of Witwatersrand Student Paper	1%
3	www.science.gov Internet Source	1%
4	Cohen, Ariella. "Learners', Parents' and Teachers' Perceptions of Homework and Mental Health of Learners in the Foundation Phase", University of Johannesburg (South Africa), 2022 Publication	<1%
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