Primary School Teachers and Child Mental Health: Developing Knowledge and Understanding

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A Thesis Submitted to Cardiff University's School of Psychology

Doctorate in Educational Psychology

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Abstract

Research estimates that around ten per cent of children in the UK between 5 and 16 years of age are diagnosed with a mental health disorder (MHD) (Green et al., 2005). The review of the literature suggests that teachers are not receiving specific training about child mental health (CMH) and lack confidence in their ability to respond to children's mental health needs effectively (Trudgen and Lawn, 2011; Rothi, Leavey and Best, 2008). The reduced capacity of Child and Adolescent Mental Health Services (CAMHS) and increasing focus on early intervention has shifted government attention from clinical to community settings, such as schools (Stallard et al., 2012). Therefore, teachers are identified as ideally placed to promote CMH from an early stage and identify and respond appropriately to early indications of mental health issues (MHIs) (DfE, 2014b).

This mixed methods study aimed to extend the research literature by exploring primary school teachers' (PSTs') current understanding of child mental health issues (CMHIs); their awareness and previous use of MH resources; and their perceptions of how they could best be supported to develop their knowledge. A questionnaire and semi-structured interview were designed to collect quantitative and qualitative data, which were analysed using descriptive statistics and thematic analysis. The findings indicate that the majority of PSTs had not received specific training about CMH and reported general uncertainty and confusion about the concept. The PSTs' awareness and previous use of professional agencies were higher than their awareness and previous use of digital and literary resources. They requested opportunities for context-specific learning and 'expert' support, similar to mentoring and coaching models, in order to learn about CMH. The strengths, limitations and implications for educational psychology are discussed.

Summary

This thesis contains three main parts: the literature review; the empirical study; and a critical reflective account. The literature review seeks to define the broad concept of 'mental health' (MH) before describing the current context of child mental health (CMH) in the UK. The rationale for a focus on school-based MH services is provided. This is followed by an outline of the positive effects of specific MH interventions on mental wellbeing (MWB) and academic outcomes. The fundamental role of teachers in promoting CMH is presented, before a critical discussion of the literature exploring their knowledge of child mental health issues (CMHIs). Next, the resources and services in place to enable teachers to support children's MH needs are discussed. This is followed by an analysis of the theoretical significance of constructivist approaches to learning and the available evidence concerning teachers' perceptions of current professional development programmes. Specific attention is given to primary school teachers (PSTs) due to the government's growing interest and investment in early intervention. Subsequently, the review explains how the development of PSTs' understanding in CMH is relevant to the role of educational psychologists. Part 1 concludes with an overview of the present study and identifies four key areas of exploration.

The review of the literature leads to a journal article which provides a detailed account of a mixed methods research study. Qualitative methodology was employed to facilitate an in-depth exploration of PSTs' views with regards to the four research aims. Quantitative data was collected to gain an initial insight into PSTs' awareness and previous use of the available resources which could support their learning in CMH. The findings, strengths, limitations and implications for educational psychology are discussed.

Finally, a critical reflective account of the research is presented, including the study's contribution to knowledge and an overview of the research process from inception to completion.

Acknowledgements

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Abbreviations

ADHD .... Attention Deficit Hyperactivity Disorder

APA ....American Psychiatric Association

APPG ....All‑Party Parliamentary Group

BESD ....Behaviour Emotional Social Disorder

BPS ....British Psychological Society

CAMHS ....Child and Adolescent Mental Health Service

CBCL ....Child Behaviour Checklist

CMH ....Child Mental Health

CMHI ....Child Mental Health Issues

CPD ....Continued Professional Development

CYP ....Children and Young People

DfE ....Department for Education

DfES ....Department for Education and Skills

DoH ....Department of Health

DSM ....Diagnostic Statistical Manual

EP ....Educational Psychologist

GP ....General Practitioner

INSET ....In‑service Training

JCPMH ....Joint Commissioning Panel for Mental Health

MH ....Mental Health

MHD ....Mental Health Disorder

MHI ....Mental Health Issue

MWB ....Mental Wellbeing

NCB ....National Children's Bureau

NCTL ....National College of Teaching and Leadership

NG ....Nurture Groups

NICE ....National Institute of Clinical Excellence

NSPCC ....National Society for the Prevention of Cruelty to Children

NQT ....Newly Qualified Teacher

OFSTED .... The Office for Standards in Education, Children's Services and Skills

PLC ....Professional Learning Community

PST ....Primary School Teacher

SDQ ....Strengths and Difficulties Questionnaire

SEAL ....Social and Emotional Aspects of Learning

SST ....Secondary School Teacher

TA ....Thematic Analysis

TaMHS ....Targeting Mental Health in Schools

WHO ....World Health Organisation

ZPD ....Zone of Proximal Development

ZPTD ....Zone of Proximal Teacher Development

PART 1: THE LITERATURE REVIEW

1. Introduction

Research suggests that ten per cent of children and adolescents are diagnosed with a 'mental health issue (MHI)' in the UK (Green et al., 2005) and recent statistics indicate a rise in prevalence (National Institute of Clinical Excellence [NICE], 2013; National Society for the Prevention of Cruelty to Children [NSPCC], 2015). Despite the government's growing interest and investment in child mental health (CMH) in recent years, "seriously and deeply ingrained problems" continue to exist at each level of Child and Adolescent Mental Health Services (CAMHS) and preventative mental health (MH) support has been restricted (Health Committee, 2014, p.3) However, early intervention has proven to be effective in both improving CMH and reducing long-term costs, and remains a key government priority (Evers et al., 2007; Brown and Taylor, 2008). The reduced capacity of CAMHS and the focus on early intervention has shifted government attention from clinical to community settings, such as schools (Stallard et al., 2012).

The Department for Education (DfE, 2014b) emphasises the key role of teachers in promoting MH for all children and identifying emerging MH needs. However, the literature suggests that, although some teachers are willing to accept this role, they lack sufficient training and confidence in their capacity to respond effectively (Rothi, Leavey and Best, 2008; Trudgen and Lawn, 2011). Authors report uncertainty among teachers with regards to the point at which their concerns should be referred to MH professionals, with some basing their decisions on intuition (Trudgen and Lawn, 2011). However, the literature relating to the knowledge of British primary school teachers (PSTs) is limited and, therefore, warrants further study.

The DfE (2014b) have compiled a selection of resources and services in order to enable teachers to fulfil their MH responsibilities. However, Ernest (1996) raises concerns about the government's tendency to "transmit" such policies and the expectation that teachers will "passively absorb and then implement them in 'delivering the curriculum'" (p. 74). Furthermore, The Health Committee (2014) stresses that "within a sea of competing priorities, it may

be difficult to ensure that all schools and teachers use these tools" (p.6). However, to date, there is no evidence to demonstrate teachers' awareness and use of resources to develop their knowledge of child mental health issues (CMHIs).

Some authors assert that the drive towards raising academic standards has resulted in the swift delivery of "one-size-fits-all professional development" (Stover et al., 2011, p.499), leaving teachers lacking interest in the issues at hand. Furthermore, the content of MH training is reported by some teachers to be clinical and inappropriate for the school setting (Rothi, Leavey and Best, 2008).

Constructivists note the difference between transferring information and effective professional learning for teachers (Pedder and Opfer, 2013). Fox (1996) argues that knowledge must be actively constructed through on-going interactions between individuals and the external world. According to this view, success in learning depends on individuals' capacity to maintain an appropriate balance between reflection on existing knowledge and active exploration of new constructs (Pedder and Opfer, 2013). Some constructivists suggest that the social and cultural elements of collaborative working can contribute to the development of teachers' knowledge (Sorenson, 2014). However, there is currently no research to suggest that British PSTs are engaging in reflective and active learning processes in order to develop their knowledge of CMHIs.

Educational psychologists (EPs) have an important role in preventing CMHIs at various levels of service delivery (Allen and Hardy, 2013; Roffey, 2013). While schools stress the value of EP involvement at targeted levels, their distinctive contribution to wider school objectives, such as raising staff expertise, is also reported (Farrell, 2006). Furthermore, EPs can develop effective lines of communication between education and health professionals (Wolpert et al., 2011) and use their knowledge and skills to facilitate the implementation of evidence-based MH interventions within complex school environments (Kelly, 2012).

PSTs have been selected as the focus for the present study, as research estimates that early indications of MHIs can be recognised in children as young as 8 years of age (Mukolo, Heflinger and Wallston, 2010). Therefore, PSTs are best placed to prevent MHIs from arising, first and foremost, by promoting MH for all children. The majority of the relevant literature explores teachers' capacity to recognise MHIs and refer their concerns to MH professionals (Loades and Mastroyannopoulou, 2010; Trudgen and Lawn, 2011). However, in light of the recent restrictions to specialist MH services, the current study aimed to investigate the ways in which PSTs could be empowered to support the MH needs within their classrooms.

The current study aimed to explore four key areas. Firstly, this research aimed to contribute to the existing literature around teachers' knowledge of MHIs by obtaining detailed and up-to-date accounts of PSTs' understanding of CMHIs. The second and third aims of the study intended to gain an initial insight into PSTs' awareness and previous use of the various resources available to develop their knowledge of CMH. The final purpose of the research involved an in-depth investigation of PSTs' perceptions of how they could best be supported to develop their understanding of CMHIs effectively. These areas of study were chosen in order to gain an insight into PSTs' current capacity to prevent CMHIs in schools and the ways in which EPs could contribute to the development of their expertise in this area.

1.1 Overview of the Literature Review

The literature review begins with a discussion involving the complications surrounding the definition of MH and the use of various labels within the literature to refer to MHIs. For the purpose of this paper, CMHIs refers to those identified by Green et al. (2005) as the most common in the UK: emotional, hyperkinetic and conduct disorders (sic). The terms 'mental wellbeing' (MWB) and 'MHIs' will be used throughout this paper to describe both ends of the 'MH continuum'. This is followed by a brief description of the data which estimates the prevalence of CMHIs in Britain, the associated outcomes of such issues, and some indications of a rise in

prevalence in recent years. Subsequently, the review provides an outline of the government's stance on school-based MH support and the current framework of CAMHS in the UK. Teachers' key role in promoting children's MWB and preventing CMHIs is introduced before a critical discussion of the literature relating to their knowledge of CMHIs. Next, attention is given to the MH resources that are currently available to support teachers. The theoretical significance of constructivism, in terms of the development of teachers' knowledge of CMH, is discussed. Thought is subsequently given to the relevance of this area in relation to educational psychology and the role of the educational psychologist. Finally, the findings from key papers are outlined and the present study is introduced.

1.2. Description of Key Sources

The literature included in the review is considered to be most relevant to the topic. Due to the higher prevalence of MHIs in adolescence, the majority of available studies explored secondary school teachers' knowledge of MHIs. Furthermore, much of the research had been carried out overseas, particularly in America and Australia. Due to the government focus on preventative strategies, this research aimed to focus on PSTs' knowledge of CMH. However, due to the lack of available evidence exploring British PSTs' knowledge of CMHIs, research involving secondary school teachers has also been included in this review. There were a number of articles which investigated a range of approaches to teachers' professional development, however, very few studies focused specifically on the development of their understanding of CMH. Therefore, some of the papers included in the review were derived from a wider search, as shown below.

The electronic sources utilised included PsychInfo, British Education Index (BEI), Science Direct and Google Scholar. Search items included: 'primary school teachers child mental health'; 'teachers mental health knowledge'; 'child mental health'; 'teacher learning'; 'constructivism'; 'constructivist approaches learning'; and 'school mental health interventions'.

2. Mental Health

2.1   Defining Mental Health

The ambiguous concept of 'mental health' (MH) continues to raise considerable debate within academic literature and national policy (Adi et al., 2007; Bentall, 2003; Bilton and Cooper, 2013; Cole, 2015; Ekornes, 2015; Greenberg, 2011, Leader, 2011). The Diagnostic and Statistical Manuals (DSMs) I-V published by the American Psychiatric Association (APA), demonstrate the on-going attempts to organise human behaviours and experiences into distinct categories since 1952.

Whilst these manuals have established a common diagnostic language for the MH profession they have been criticised for clouding the boundaries between typical psychological phenomena (e.g., intense sadness following the death of a family member) and mental health issues (MHIs) (Horwitz and Wakefield, 2009; Stein et al., 2010). Concerns have also been raised about the increasing number of diagnoses included within each successive edition of the DSMs (Stein et al., 2010). For example, 'Binge Eating Disorder' 'Pica' 'Rumination' and 'Avoidant/Restrictive Food Intake Disorder' were integrated as distinct subcategories of eating disorders in the most recent DSM (V) and 'Internet Gaming Disorder' was proposed as a diagnosis meriting further investigation.

Appignanesi (2008) suggests that increasing numbers of classified disorders might not signify a growing number of conditions; rather, contemporary society has "begun to count things we hadn't counted before" (p.3). She also recognises that diagnoses, such as anorexia, depression and Attention Deficit Hyperactivity Disorder (ADHD), appear to reflect the culture and time period in which they are classified. For example, on the subject of ADHD, she argues that, "It is perhaps no surprise that an age in which the sum of information available in any given minute is larger than it has ever been in history should find a condition in which attention is at a deficit" (p.5). However, she emphasises that individuals with MHIs experience great distress and suffering, regardless of the labels used to describe them.

Other authors propose a shift from the DSM mindset, as they believe that the diagnostic process overlooks a number of key factors which contribute to a holistic understanding of an individual's psychological experiences (e.g., social circumstances, strengths, relationship changes etc.) (Bentall, 2003; Johnstone, 2007). They argue for a formulation process which empowers individuals to make sense of their personal experiences rather than reduce them to a list of symptoms (Bentall, 2003; Johnstone, 2007).

There has been great controversy with regards to the labels and medical language used to refer to non-physical concerns such as 'mental disorder' (Bilton and Cooper, 2013; Bringewatt, 2013; Greenberg, 2011; Link and Phelan, 2010). Some authors have expressed concerns about the negative psychological effects of labelling, whilst others highlight that with improved categorisation comes improved levels of understanding and communication between professionals (Bringewatt, 2013). Cole (2015) argues that the use of the term 'mental disorder' is a descriptor of a collection of features, and should not indicate that the issues exist entirely within the individual. Link and Phelan (2010) acknowledge that labelling has both helpful and unhelpful consequences and emphasise the need to distinguish between labelling the MHI and labelling the person.

More recently, the complex interaction between mental and physical health has been increasingly recognised in medical research and both are believed to be affected by biological, environmental and experiential factors (Murphey, Barry and Vaughn, 2013). Cole (2015) urges professionals to use a definition of 'good MH' to avoid confusion and reduce the risk of stigmatisation. Therefore, the definition of children with good MH assumed in this paper, is that of the World Health Organisation (WHO):

"Children and adolescents with good MH are able to achieve and maintain optimal psychological and social functioning and wellbeing. They have a sense of identity and self-worth sound family and peer relationships, an ability to be productive and to learn and a capacity to tackle developmental challenges and use cultural resources to maximize growth" (WHO, 2005, p.2).

In these terms, MHIs can hinder children's psychological wellbeing, social functioning and ability to reach their full potential. For the remainder of this paper the term 'mental wellbeing' (MWB) will be used as an alternative to 'good MH'.

2.2   The Mental Health Continuum

Authors suggest that rather than attempting to make clear distinctions between MWB and MHIs, both should exist on opposite ends of a continuum (Bentall, 2003; Ekornes, 2015; Leader, 2011; Keyes, Dhingra and Simoes, 2010; Murphey, and Vaughn, 2013). For example, Ekornes (2015) argues that the promotion of MWB should also include the prevention of MHIs. However, researchers emphasise the complexities of both concepts, arguing that many individuals without MHIs appear to lack MWB and those with MHIs may have a number of features associated with MWB (Adi et al., 2007; Murphey, Barry and Vaughn, 2013). Murphey, Barry and Vaughn (2013) argue that, "Just as the absence of disease does not adequately define physical health, mental health consists of more than the absence of mental disorders" (p.1). Regrettably, it is beyond the scope of this paper to explore this issue further. Therefore, for the purposes of this review, 'promoting MWB' and 'preventing CMHIs' describe movements along the MH continuum towards optimal MWB. Figure 1 provides a diagram to demonstrate this concept.

Figure 1: The Mental Health Continuum
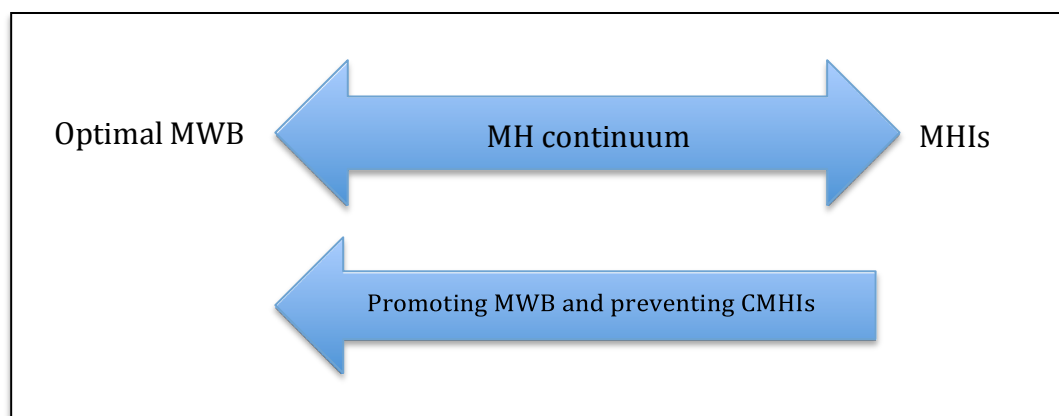
The following section provides an overview of the prevalence of MHIs in childhood and adolescence and the outcomes which are associated with them.

3. Mental Health Issues in Childhood and Adolescence

3.1 The Prevalence of Mental Health Issues in Childhood and Adolescence

Twenty five per cent of the British population is likely to experience a MHI and around fifty per cent of those with lifelong MHIs are believed to experience the first signs during childhood and early adolescence (The Department of Health [DoH], 2011). The DoH (2011) estimates the cost of MHIs at around 105 billion pounds and expects this to double by 2035. Figures from the Office of National Statistics (ONS) estimate that, in 2004, around ten percent of children between 5 and 16 years of age were diagnosed with a mental health disorder (MHD) (sic) (Green et al., 2005), which equates to between 2-3 children in the average British classroom. The MHDs were categorised into the following subgroups:

- emotional disorders, such as anxiety and depression (4%);
- hyperkinetic disorders, such as ADHD (2%);
- conduct disorders (6%); and,
- less common disorders (e.g., eating disorders) (1%)

Although these are the most comprehensive and up-to-date statistics estimating the prevalence of CMHIs, several authors have highlighted some issues with the reliability of these findings. Firstly, Cole (2015) argues that while Green et al. (2005) recruited a considerable number of families from every postcode in the UK (8000), the sample represented only 0.1% of school-age children in 2004 and, therefore, cannot be generalised across the country. Furthermore, Cole (2015) highlights that 95% of Green et al.'s (2005) parent sample were mothers and were, therefore, not representative of the parent population. According to Action for Children (2015), mothers have been found more likely to identify and worry about CMHIs than fathers. This suggests that an equal sample of mothers and fathers could have resulted in fewer reports of CMHIs. On the other hand, Stallard et al. (2012) stress that the official data collected by Green et al. (2005) do not provide a true picture of the number of children affected by MHIs, as they do not

account for those who do not meet the full criteria for a MH diagnosis.

Some authors emphasise that children with silent and internalising issues (e.g., depression) are more likely to be under-identified and unsupported than those whose MHIs are more visible and disruptive to the daily running of the classroom (Bayer and Beatson, 2013; Loades and Mastroyannopoulou, 2010; Pescosolido et al., 2008; Rothi, Leavey and Best, 2008; Trudgen and Lawn, 2011). This could explain the higher numbers of conduct issues and lower numbers of emotional issues recorded by Green et al. (2005). The following subsection provides a brief description of the most common CMHIs and their associated outcomes.

3.2 The Outcomes Associated with Child and Adolescent Mental Health Issues

Research shows that, although emotional issues are not the most predominant in childhood (Adi et al., 2007), they have the highest lifetime prevalence of all CMHIs (Kessler et al., 2007a). Anxiety and depression are known to negatively affect several aspects of children's lives (e.g., social, educational and family experiences) and are shown to predict MHIs, substance misuse and suicide later in life (Brown et al., 2008; Creswell, Waite and Cooper, 2014; James et al., 2013; Saavedra et al., 2010). Hyperkinetic issues usually arise within the first 5 years of a child's life and are characterised by attention difficulties, unpredictability and impulsivity (Laufer, Denhoff and Solomons, 2011). As a result, these children are believed to experience considerable challenges in the school environment (Laufer, Denhoff and Solomons, 2011). Hyperkinetic issues have been associated with harmful long-term outcomes such as drug use and antisocial behaviour (Shaw et al., 2012). Conduct issues account for the majority of referrals made to Child and Adolescent Mental Health Services (CAMHS) and around one third of general practitioner (GP) child consultations (National Institute of Clinical Excellence [NICE], 2013). Children identified as having conduct issues are more likely than their peers to: struggle both academically and socially and to experience unemployment, substance use, and crime in adult life (Cole, 2015; Farrington et al., 2006). Despite limited up-to-date evidence of the current numbers of children experiencing

MHIs, some recent findings indicate a rise in prevalence. These are discussed below.

3.3 Rising Concerns about Child and Adolescent Mental Health

The Children's Society (2013) reports a decline in children's MWB since 2008 and estimates that around ten per cent of children and young people (CYP) rated poorly on MWB scores (The Children's Society, 2013). Furthermore, The Department of Health (2013) speculated that increasing rates of hospital admissions for self-harming and calls to helplines suggest a rise in CMHIs in recent years. Moreover, evidence from the latest ChildLine annual review calculated:

- 3.2 million website visits between 2014 and 2015: demonstrating a 5% increase since the previous year (NSPCC, 2015);
- a 116% increase in ChildLine counselling sessions concerning suicide since 2011, with a total number of 34,517 between 2013 and 2014 (NSPCC, 2014); and
- 37,000 visits to suicide information websites between 2013 and 2014, compared to 18,000 in the previous year (NSPCC, 2014).

Although these figures do not show the true extent of CMHIs in the UK, they demonstrate an increasing demand for information and support relating to CMH. Furthermore, the dramatic increase in suicide specific data cannot be overlooked.

Several attempts have been made to explain this potential rise in prevalence. For example, the Director of Campaigns for Young Minds, Lucie Russell, asserts that "Modern childhood has become really stressful: there are family breakdowns, increasing pressure from school with testing from a very early age and then the really significant factor in recent years is social media" (Donnelly, 2013, para. 7). According to the Marriage Foundation, up to 1.8 million children are believed to experience family breakdown in England and Wales, which is an increase of 44% since 1980 (The Marriage Foundation, 2015). Family breakdown has been linked to poor outcomes for children, including poverty and MHIs (Pryor and Rodgers, 2009; Joint Commissioning Panel for Mental Health [JCPMH], 2012; Porche, Costello and Rosen-Reynoso, 2016). However, despite this association, these

findings do not provide evidence of a direct causality between family breakdown and MHIs.

Crilly (2015) notes the potential impact of the recent economic downturn on children's MWB, due to increasing pressures on parents to work full time. She claims that parents' absence from the family home leaves CYP "crying out for quality time and attention." (p.42). There is some evidence to suggest that psychosocial factors such as, the availability of relational support, both at home and at school, are fundamental to the development of children's MWB (Gubhaju et al., 2015). Therefore, family pressures of any kind (e.g., financial constraints, job security) could negatively affect parents' wellbeing and, in turn, have similar consequences for children (Welsh et al., 2015).

Between 2012 and 2013, the number of young people engaging in social media for up to three hours per day was estimated at around 56% (Booker, Sacker and Kelly, 2015). Best, Manktelow and Taylor (2014) argue that, although social media provides CYP with an alternative means to connect with others, social networking sites can also provide a platform for social comparison and cyber bullying.

Chanfreau (2013) stresses the adverse impact of negative social interactions and bullying (both bullying others and being bullied) on CYPs' MWB. Therefore, there is some evidence to suggest that increased use of social media could contribute to a rise in prevalence of CMHIs. Furthermore, participation in prolonged periods of screen time (e.g., TV, video games, computers etc.) has been associated with higher levels of emotional distress among CYP (Holder, Coleman and Sehn, 2009; Chanfreau, 2013), particularly those engaging in such activities for over four hours per day (Page et al., 2010; Yang et al., 2013). The following chapter provides an overview of the MH services which are currently in place for children in Britain.

4. Child and Adolescent Mental Health Services (CAMHS)

CAMHS are responsible for the assessment and support of CYP with social, emotional and MHIs. The four-tier strategic framework for CAMHS is generally accepted as the basis for providing CMH services in the UK. Figure 2 below shows the 4 tiers of intervention, which are available for CYP from preventative (Tier 1) to specialist levels (Tier 4), and specifies the professionals responsible for implementing services within each tier.

Figure 2:The Four-tier Strategic Framework for CAMHS – Retrieved from http://www.brightonandhoveccg.nhs.uk/your-services/mental-health-services (Selected due to clarity, not due to relevance of geographical area).
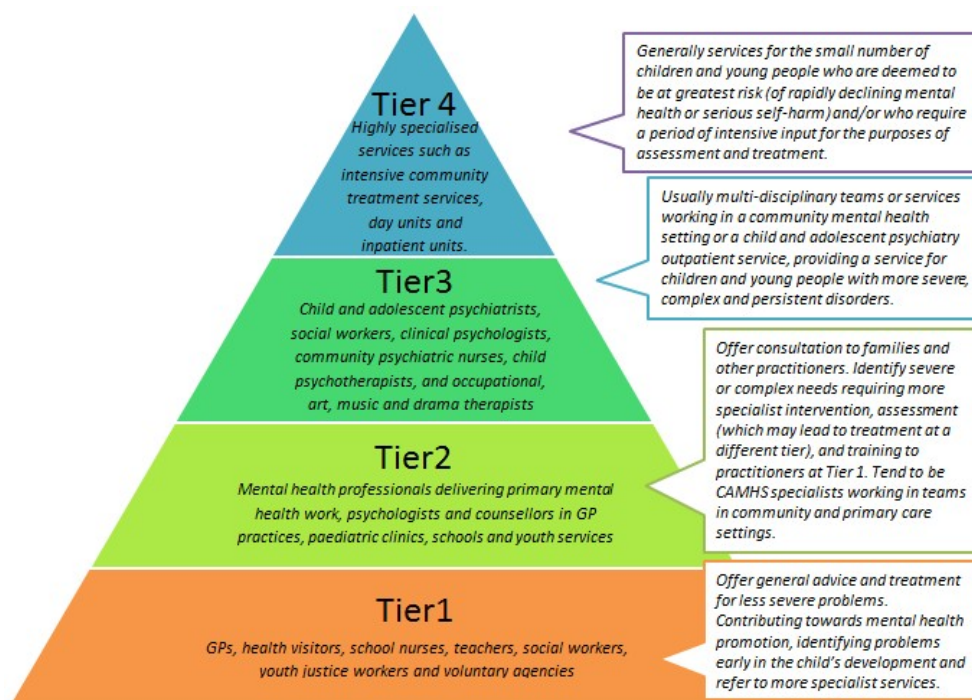
As shown in the diagram, professionals such as teachers and voluntary agencies, are expected to provide Tier 1 services and are considered to be non-specialist CAMHS practitioners. Mental health professionals at Tier 2 (e.g., psychologists and GP practices) are responsible for facilitating assessments and consultations for children presenting with MHIs. The support provided at Tiers 3 and 4 is increasingly specialised and intensive. The four-tier framework has been criticised for providing fragmented support for CYP due to the barriers that are inadvertently formed between services (DoH, 2015). However, although particular roles are clearly specified within each tier, the framework is not

intended to deliver rigid, step-by-step support (National Archives, 2010). Flexibility of services is encouraged and practitioners are advised that children, professionals and services can fit into more than one tier at any given time (National Archives, 2010).

Despite growing interest and investment in MH in recent years, "seriously and deeply ingrained problems" continue to exist at each level of CAMHS (Health Committee, 2014, p.3). The Health Committee (2014) stress that, while there is significant evidence to show the benefits of investing in preventative approaches, funding for early intervention budgets are limited in several areas of the UK.

Recent research carried out by Young Minds (2015) revealed that a substantial number of MH budgets were cut or frozen between 2013 and 2015, including:

- 75% of MH Trusts;
- 67% of Clinical Commissioning Groups (CCGs) (groups established to organise the delivery of NHS services in England); and
- 65% of local authorities (LAs).

Financial restrictions to preventative services have resulted in increasing numbers of CYP requiring specialist support, demonstrated by a 40% rise in Tier 3 referrals between 2003 and 2009-2010 (Health Committee, 2014). Thus, cuts to early intervention services can prolong the distress experienced by children and families and increase public spending in the long term (DoH, 2014a). Layard and Clark (2015) highlight the discrepancy between the government's assertions and actions with regards to CMH claiming that, "Nowhere is the gap between rhetoric and performance greater than in how we treat child mental health" (p.213). The reduced capacity of CAMHS and the focus on early intervention has shifted government attention from clinical to community settings, such as schools (Stallard et al., 2012). The following section provides an outline of the government initiatives developed to promote CMH in schools.

5. Governmental Stance on Child Mental Health

The Every Child Matters (ECM) agenda (Department for Education and Skills [DfES], 2003) and The Children's Act (2004) initiated a growing interest in collaborative and holistic services for children and families. Professionals working with CYP were encouraged to consider five key outcomes including: to be healthy; to stay safe; to enjoy and achieve; to make a positive contribution; and to achieve economic wellbeing. The association between social and emotional skills and academic achievement was increasingly acknowledged and programmes aiming to promote child MWB, (e.g., 'The National Healthy Schools Programme', 'Social and Emotional Aspects of Learning' [SEAL]) were implemented in schools across the UK. The SEAL curriculum encompassed seven key themes including: 'New beginnings'; 'Getting on and falling out'; 'Say no to bullying'; 'Going for goals'; 'Good to me'; 'Relationships'; and 'Changes'. SEAL was executed at varying degrees in around 90% of English primary schools by 2010 (Humphrey, Lendrum and Wigelsworth, 2010) and was found to have a significant impact on children's social and emotional skills at individual and group level (Cheney et al.'s, 2014). The Targeting Mental Health in Schools (TaMHS) project was implemented between 2008 and 2011 to provide targeted school-based MH support for children (aged 5-13) and families across England. The schools described several positive outcomes as a result, including fewer incidents relating to emotional issues (Weare, 2014).

The Coalition Government claimed to be the first to prioritise physical and mental health equally and acknowledged that MH was central to "quality of life", "economic success" and "improving education, training and employment outcomes" (DoH, 2011 p.2). 'Mental Health and Behaviour in Schools' (Department for Education [DfE], 2014b) outlines this government's expectations for schools in terms of CMH promotion. The key points within this document are detailed below.

---   To support children to be resilient and mentally healthy.
---   To identify and respond to early signs of MHIs.
---   To use appropriate resources to assess MH needs (e.g.,

Strengths and Difficulties Questionnaires).
- To access online educational resources (e.g., MindEd).
- To seek information and support from national and local MH organisations (both professional and voluntary).

A list of national services are specified within the document, including ChildLine, the Education Endowment Foundation, MindEd, NICE and Place2Be in order to offer support to children, families and professionals. Some brief descriptions of preventative school-based MH interventions, such as bully boxes, reflective classroom activities (e.g., 'thought of the day') and circle time are also provided.

'Future in Mind' (DoH, 2015) outlines the findings from the Children and Young People's Mental Health and Well Being Taskforce. This multi-disciplinary group (education, health, care, voluntary etc.) was organised to identify 25 priorities in order to improve access to CYP's MH services. The themes bearing particular relevance to schools include "promoting resilience, prevention and early intervention" (DoH, 2015, p.33) and "developing the workforce" (e.g., school staff) to recognise and support children with emerging MHIs (DoH, 2015, p.63).

Therefore, schools and teachers have a responsibility to ensure that they are fully prepared to fulfill these responsibilities. The following section provides the rationale for implementing CMH interventions in schools and describes how this support can be facilitated from whole school to individual level.

6. Promoting Mental Wellbeing in Schools

Stallard (2013) argues that, although developing children's academic skills remains a key priority for schools, they are also ideal settings in which to provide MH services. He uses the terms below to describe school-based MH interventions at three levels.

- Universal level: preventative, whole-school interventions to promote

MWB for all children.

-- Selective level: targeted interventions for groups of children believed to be at greater risk of developing MHIs.

-- Indicated level: targeted interventions for children who are already experiencing early signs of MHIs.

Authors stress the convenience of offering MH support in schools, as they offer central points of contact for children and families (Bringewatt and Gershoff, 2010; DfE, 2014b; DoH, 2014a; Ekornes, 2015; Pereira et al., 2015). Additionally, the implementation of school---based interventions reduces some of the barriers involved in accessing MH services elsewhere (e.g., cost and transportation) (Bringewatt and Gershoff, 2010; Masia-Warner et al., 2006). Furthermore, children can also access specialist MH support at school from school counsellors and primary MH workers when necessary (Bringewatt and Gershoff, 2010).

6.1 Universal Interventions

Schools are advised to implement whole-school interventions to promote the MWB of all children (NICE, 2008; DoH, 2015). The DfE (2014c) urges schools to prioritise universal strategies above all else, emphasising that targeted and individual support "cannot compensate for a lack of good quality teaching" (p.99). Preventative educational approaches (e.g., whole school anti-bullying interventions) can significantly improve children's MWB (Evers et al., 2007) and reduce the long-term costs by around £50,000 per child (Brown and Taylor, 2008). Therefore, these interventions can improve outcomes for both the individual and the provider. Furthermore, Higgins and O'Sullivan (2015) stress that around 64-75% of children who are diagnosed with MHIs do not access specialist services. Consequently, whole-school approaches are the only way to ensure that these children receive MH support.

Roffey (2013) argues that "conscious and sustained school development on wellbeing, respect and inclusion" help CYP to feel welcome, acknowledged and valued in their learning environments (p.46). The positive impact of effective whole-school MH interventions on academic performance has also been supported within the literature (Cheney et al., 2014; Dix, Slee, Lawson and

Keeves, 2012; Khan, Parsonage and Stubbs, 2015). For example, there is a wealth of evidence which indicates a direct causality between social and emotional skill development and psychological and academic outcomes (Gutman and Schoon, 2013). Other research suggests that interventions based on cognitive behavioural therapy (CBT) principles, such as FRIENDS for Life, are also effective in supporting children to recognise and manage their emotions (Higgins and O'Sullivan, 2015).

The development of non-cognitive skills, such as resilience, is believed to be a key component in increasing psychological and academic outcomes (All-Party Parliamentary Group [APPG], 2014; DfE, 2014b; DoH, 2015). The APPG (2014) calls for a holistic approach, which appreciates the "mutually reinforcing process" of cognitive and non-cognitive skill development (otherwise known as 'hard skills' and 'soft skills' respectively), to maximise children's learning (p.12). The DfE (2014b) stresses the key role of schools in developing children's resilience, particularly for children who are believed to be at risk of experiencing MHIs. They advise schools to foster sufficient protective factors within the school environment (e.g., positive behaviour management, inclusive approaches) in order to counterbalance the risk factors (e.g., bullying, relationship breakdown within the family etc.) (DfE, 2014b). A number of schools claim to give equal priority to these so-called 'soft skills' (e.g., resilience, coping skills etc.) by increasing extra-curricular opportunities and incorporating classes in leadership and debate (APPG, 2014). One study found that improved coping skills were positively associated with MWB and academic achievement (Garcia, 2010; Rosen et al., 2010). Besides this study, there is a lack of causal evidence demonstrating the impact of soft skills on MWB and academic achievement (Gutman and Schoon, 2013).

Stallard (2013) notes that promoting MWB at whole-school level limits the number of children requiring targeted services and, therefore, reduces stigmatisation. On the other hand, he argues that universal approaches are not the most effective of the three levels and questions the implementation of MH interventions for children who are generally psychologically healthy.

6.2 Selective and Indicated Mental Health interventions

Selective and indicated MH interventions aim to support fewer numbers of children who are believed to be at risk, or showing early signs, of MHIs (Stallard, 2013). TaMHS is one such programme which has been found to provide effective school---based MH support for children (DfE, 2010). Positive outcomes associated with TaMHS include:

- effective support for behavioural issues among primary school children (DfE, 2010; Cane and Oland, 2015);
- improvements in children's resilience, emotional expression and relationships with peers (Cane and Oland, 2015); and
- improvements in children's confidence and increased help-seeking behaviour (Cane and Oland, 2015).

It is worth noting that, these findings were derived from focus groups, comprising of school professionals who were directly involved with the programme. The positive outcomes reported in this study are based on the participants' perceptions of the impact of TaMHS, rather than the actual impact and could be biased. Furthermore, consideration must be given to the potential of a power imbalance within focus groups, as some participants could be more likely to dominate the discussions than others (Millward, 2012).

The Nurture Group (NG) intervention was specifically designed to support children with social and emotional issues. For this provision, a teacher and a teaching assistant facilitate nurturing experiences for 6-12 children, according to their developmental stage (Taylor and Gulliford, 2011). NGs are underpinned by attachment theory, which suggests that children who have developed insecure attachments are more likely to experience emotional issues in later life (Cooper and Tiknaz, 2007). Therefore, NGs aim to improve children's attachments with others by developing a range of skills, including emotional literacy, self-esteem and social skills. A systematic review of 13 studies investigating the impact of NGs concluded that, in the short term, NGs were effective in developing social and emotional skills (Hughes and Schlosser, 2014). However, Hughes and Schlosser (2014) note that further research is required to determine the long-term impact

of NGs. Furthermore, as the fundamental nurture principles are promoted at whole school level, separating the wider impact of the universal element from the effects of the group intervention would be impossible (Hughes and Schlosser, 2014).

Stallard (2013) emphasises that the practicalities of providing successful targeted approaches in schools are complex and the effectiveness of these interventions relies on teachers' ability to accurately identify and support children with difficulties. The following chapter outlines the key role of teachers in providing MH support to children at all three levels of intervention.

7. The Key Role of Teachers in Child Mental Health

The responsibility of teachers in the promotion of children's MWB in schools is clearly stated within governmental policy and academic literature (DfE, 2014b and c; Trudgen and Lawn, 2011). Teachers are considered to be ideally placed to recognise early indications of CMHIs, stressing that they "see their children day in day out, they know them well and are well placed to spot changes in behaviour that might indicate a problem" (p.9). Additionally, teachers are often expected to facilitate targeted MH interventions (Cheney et al., 2014) and have been found, in some cases, to be the sole providers of such support (Franklin et al., 2012). Therefore, teachers' awareness of, and capacity to implement, evidence-based interventions appear to be significant in providing effective targeted MH support for children. Teachers are also expected to support the children in their classrooms to transfer the skills acquired during selective interventions (Diekstra, 2008). Furthermore, some authors argue that teachers are better placed than MH professionals to reinforce such skills, due to their on-going interactions with children throughout the school year (Adi et al. 2007).

At indicated levels, relationship building is fundamental to MH prevention and teachers can integrate a range of techniques for individual work with children (e.g., mindfulness, CBT etc.) (Cole, 2015). Nevertheless, schools are unlikely to have the capacity to meet the MH needs of all pupils (Bringewatt and Gershoff,

2010) and, as children rarely refer themselves for support (Loades and Mastroyannapulou, 2010; Pereira et al., 2015), teachers are also responsible for referring their concerns to specialist MH professionals (Ekornes, 2015; Pescosolido et al. 2008; Trudgen and Lawn, 2011).

The DfE (2014b) emphasises that developing high quality teacher expertise (e.g., differentiation, positive behaviour management, nurturing social and emotional skills etc.) is central to the promotion of CMH in schools (DfE, 2014c; DoH, 2015; Weare, 2014). Additionally, Gutman and Schoon (2013) argue that, "The most important consideration, in the implementation of any intervention programme, is its execution. Well-executed programmes conducted by high quality staff will have greater effect than those with implementation problems" (p.42). Therefore, teachers' knowledge and understanding of CMH is central to successful execution of MH interventions at multiple levels.

8. Teachers' Knowledge of Child Mental Health

According to the literature, teachers are not receiving sufficient opportunities to learn about emotional and MH issues during their initial training or continued professional development (CPD) (Rothi, Leavey and Best, 2008; Trudgen and Lawn, 2011; Walter, Gouze and Lim, 2006).

Trudgen and Lawn's (2011) study explored teachers' ability to identify emotional issues (e.g., depression and anxiety) among their students and report their concerns to MH professionals. Twenty secondary school teachers (SSTs) were interviewed to explore the following key areas: how teachers had been informed about MHIs; teachers' capacity to recognise a student with anxiety or depression; their thresholds for referring their concerns to MH professionals; teachers' awareness of the professionals in place to respond to their concerns; and their perceptions of the obstacles involved in recognising and reporting MHIs. The findings demonstrated that, although the teachers had attended a wide range of CPD courses, they had not received specific training about MH. This is consistent with Rothi, Leavey and Best's (2008) study, in which teachers

reported feeling inadequately prepared to support the MH needs within their classrooms.

Trudgen and Lawn (2011) found that, in the absence of MH training, teachers were informed about MHIs through informal means, including the media and personal experiences. Only one of Trudgen and Lawn's (2011) twenty participants referred to the national public website which was designed to provide MH-related information and advice to CYP, families and professionals. Consequently, the teachers in this study were more likely to rely on their intuition than factual information about MH. These findings are consistent with Stover et al. (2011), who claimed that participants' knowledge of typical child development was based on intuition rather than particular knowledge.

Teachers' reliance on their intuition resulted in varying thresholds for identifying MHIs and referring their concerns to specialists. These ranged from "an intuitive feeling or knowing that something was not right" to more severe signs, such as school avoidance and self-harm (Trudgen and Lawn, 2011, p.136). Furthermore, the teachers felt uncertain about the point at which typical adolescent experiences should be considered to be serious MHIs.

Several other authors have also reported this confusion among teachers (Ekornes, 2015; Kidger et al., 2010; Rothi, Best and Leavey, 2008). For example, although Rothi, Leavey and Best's (2008) participants were confident in their ability to recognise behaviours that were out of the ordinary for the children's developmental stages, they were aware that individual children experienced MHIs in different ways. Therefore, behaviour that could be considered typical for some children might not be for others. For example, one participant stressed, "I mean a child could be quiet, but they could be quiet because they are normally quiet and children exhibit different behaviours and different behaviours mean different things" (Rothi, Leavey and Best, 2008, p.1226).

While the literature reveals some valuable insights with regards to teachers' knowledge of MHIs, there are some methodological limitations to consider. Firstly, Trudgen and Lawn's (2011) study was carried out in one region of

Australia and included a sample of 20 teachers and, therefore, the findings are limited and cannot be generalised to the wider population. Furthermore, Cheney et al., (2014) argue that American and Australian evidence surrounding CMH cannot be generalised to the UK, due to several contextual differences, including the ways in which MHIs are conceptualised and the organisation of the education systems.

Although Rothi, Leavey and Best's (2008) study provides an insight into British teachers' knowledge of CMH, their sample was also small and the findings are now out of date. The National College of Teaching and Leadership (NCTL, 2015) survey provides a more recent account of 3429 newly qualified teachers' (NQTs') perceptions of their training opportunities with regards to CMH. For example, 'teaching pupils with special educational needs (SEN)' was one of the lowest rated aspects of primary teacher training with only 64% of the NQTs rating 'good' or 'very good' (NCTL, 2015). Unfortunately, the survey does not refer specifically to CMH needs. However, SEN might include CMHIs following the recent addition of the new broad category of SEN, 'social, emotional and mental health' to the Special Educational Needs and Disability (SEND) Code of Practice (DfE, 2014c).

The absence of a specific focus on CMH is also evident in the most recent National Standards for Qualified Teacher Status (NCTL, 2011). For example, while the NCTL expects newly qualified teachers (NQTs) to, "demonstrate an awareness of the physical, social intellectual development of children", the document does not refer to teachers' awareness of children's mental or emotional development. Thus, there appears to be a discrepancy between the increasing responsibilities placed on teachers, with regards to CMH promotion, and the frameworks which are organised to ensure that they are able to fulfill them. Further research is required in order to explore British teachers' current understanding of CMH.

9. Mental Health Resources for Teachers

Teachers are expected to remain aware of the resources in place, both nationally and locally, which offer information and guidance about CMH (e.g., government policies, voluntary services etc.) (DoH, 2015). The DoH (2015) states that, "Only

by working in partnership, sharing expertise and making best use of finite resources can we achieve the improvements in MH outcomes that we want to see" (p.5).

Therefore, DfE (2014b) encourages teachers to make use of the available resources to enable them to support children's MH needs effectively (DfE, 2014b). These resources include:

- assessment tools (e.g., the Strengths and Difficulties Questionnaire [SDQ]);
- official documents (e.g., government policy, research papers);
- professional services (e.g., educational psychologists, primary mental health workers);
- voluntary organisations (e.g., Young Minds); and
- digital services (e.g., MindEd)

The DfE (2014b) recommends the SDQ as a means to assist teachers in "taking an overview and making a judgment about whether the pupil is likely to be suffering from a mental health problem" (p.16). The SDQ is a questionnaire used to screen CYP's positive and negative attributes within 5 scales (e.g., emotional symptoms (sic); conduct problems; hyperactivity/inattention; peer relationship problems; and prosocial behaviour). The DfE (2014b) states that an "abnormal" (sic) score indicates that a CYP is experiencing "high levels of psychological difficulties" (p.16) and advise teachers to seek support from specialist professionals (e.g., CAMHS). However, this advice is not accompanied by the necessary caveats required to ensure fair and ethical use of assessments. For example, Achenbach (1991), the founder of the Child Behaviour Checklist (CBCL), emphasises that, "No single score precisely indicates a child's status. Instead a child's score on a syndrome scale should be considered an approximation of the child's status as seen by a particular informant at the time the informant completes (it)" (p.45). The British Psychological Society (BPS, 2014) urges professionals to use these methods with caution, alongside other methods (e.g., classroom observations) to ensure accurate and holistic assessments of children. Furthermore, as mentioned previously, the restrictions within CMH services limit the availability of specialist MH workers to respond to the needs identified by the SDQ.

The Health Committee (2014) states that the launch of public initiatives, such as MindEd, are "welcome steps" in developing effective preventative CMH services (p.6). However, Ernest (1996) raised concerns about providing information to schools in this way, stating that, "Many government driven curriculum reforms, in Britain and elsewhere, assume that the central powers can simply transmit their plans and structures to teachers who will passively absorb and then implement them in 'delivering the curriculum'" (p. 74). As teachers report that they lack time (Rothi, Leavey and Best, 2008), perhaps merely pointing them in the direction of these resources is not adequate to ensure that meaningful learning takes place. The Health Committee emphasises the current pressures on schools, arguing that, "the onus is on the individual schools and teachers to find time to prioritise this (CMH) and within a sea of competing priorities, it may be difficult to ensure that all schools and teachers use these tools" (Health Committee, 2014, p.6). Therefore, teachers' awareness and use of these resources warrant further investigation.

10. An Introduction to Constructivism

Constructivism provides the theoretical basis for this research in order to explore the complex elements involved in developing teachers' knowledge and understanding of CMHs. The constructivist paradigm was established as an alternative to the dominant empiricist view of Western society in the nineteenth century, which suggested that, "knowledge should represent a real world that is thought of as existing, separate and independent of the knower" (von Glasersfeld, 1995, p.6).

Piaget, a key theorist in constructivism, claimed that knowledge enabled individuals to continuously adapt to their ever-changing surroundings and was, therefore, fundamental to human survival (Piaget, 1971). According to Piaget (1971), learners absorb new information that corresponds with their current ideas (assimilation) and accommodate information that does not match their

current understanding (accommodation). Consequently, learning is a process of change which is activated by the apprehension that a current situation does not correspond with the knowledge that has already been acquired; otherwise known as 'disequilibrium' (von Glasersfeld, 1995). Fox (1996) emphasises that knowledge must be actively constructed through the ongoing interaction between individuals and their external world: "Learning is both a matter of adapting our experience of the world to our ideas and theories and also adapting our ideas and theories to the nature of the world" (p.35). Therefore, equilibrium is achieved and maintained as knowledge is continuously reconstructed (Scott, 2011).

Vygotsky and Feuerstein extended Piagetian ideas by emphasising the social and cultural elements involved in learning, particularly with regards to the support and mediation provided by the more capable other (Burden, 1996; Harvard, 1996).
Vygotsky (1978) posited that this mediation or scaffolding assisted learners through 'The Zone of Proximal Development' (ZPD), a level of understanding that learners were incapable of reaching independently.

Constructivist learning theories have mostly been developed in relation to children (von Glasersfeld, 1995) and have been applied to classroom practice in order to encourage pupils to become active and autonomous learners (Drew and Mackie, 2011; Scott, 2011). Several authors have applied constructivist theories to attempt to understand the facilitators and barriers involved in adult learning processes (Pedder and Opfer, 2013; Fani and Ghaemi, 2011). For example, Fani and Ghaemi (2011) extended Vygotsky's theory of the zone of proximal development by applying it to teacher education. They argued that Vygotsky's original theory did not account for the sources which could be used independently by adults (e.g., books) before a capable other was required. This notion will be described in more detail later.

 The following section critically discusses the available literature that explores teachers' perceptions of the structures in place to enable them to develop their knowledge of CMH. Other recent attempts to apply constructivist theories to facilitate meaningful learning for teachers have also been critically analysed.

11. Developing Teachers' Knowledge of Child Mental Health

11.1 Active and Sustained Learning

In order to build teachers' capacity to support the MH needs within their classrooms, Trudgen and Lawn (2011) advise training providers and schools to incorporate MH modules into initial teacher training and CPD programmes. However, some teachers claim that including an additional module for MH to the already congested initial teacher training course might not be possible (Rothi, Leavey and Best, 2008). As an alternative, they expressed a preference for implementing MH modules into in-service training (INSET) and CPD days. Conversely, some participants stressed that, due to the increasing pressures on schools to raise standards, CPD around increasing academic attainment was likely to take precedence over CMH (Rothi, Leavey and Best, 2008).

In the wider literature around teacher learning, some authors assert that practical restrictions (e.g., time, finances etc.) frequently result in the delivery of one-off CPD events, which are often arranged to support teachers to reach academic targets (Avalos, 2011; Pedder and Opfer, 2013; Stover et al., 2011). Stover et al. (2011) argue that this kind of "top-down distribution of one-size-fits-all professional development.....leaves teachers with little interest or ownership in the areas being addressed" (p.499). Authors note the difference between distributing information and professional learning and advise that transferring information from trainer to learner is unlikely to have a lasting impact on teachers' expertise (Avalos, 2011; Pedder and Opfer, 2013; Stover et al. 2011). Although there is no evidence to suggest that this is the case for teacher education in MH, teachers have been found more likely to apply the knowledge learned from several professional development sessions over an extended period of time, than information gathered during isolated training events (Day and Leitch, 2007).

11.2 Reflective Learning

Constructivists highlight that teachers' ability to learn depends on their existing knowledge of the subject matter (Avalos, 2011; Fani and Ghaemi; 2011). According to this theory, teachers must reflect on their existing conceptual structures before meaningful learning can take place (Hase and Kenyon, 2007).

For example, strategies such as writing autobiographies (Knowles, 1992) and keeping journals (Fani and Ghaemi, 2011; Taylor, 2015) have been found to support teachers to reflect on their practice. Zigmont, Kappus and Sudikoff (2011) suggest that guided reflection can be used as a means to dislodge fixed 'mental models' and encourage learners to consider each individual situation, rather than basing their decisions on previous experiences. Pedder and Opfer (2013) argue that teachers must be empowered to maintain an essential balance between reflection on existing knowledge and practices and active exploration of new concepts. By doing so, teachers can develop a collection of skills and responses to the needs in their classrooms. Von Glasfersfeld (1995) used the term "compendium of concepts and actions" to refer to this ongoing and adaptive learning process (p.5).

Rothi, Leavey and Best's (2008) found that some teachers felt they did not have adequate time to reflect on their practice and requested further opportunities to do so. However, their sample of primary, secondary and special school teachers (n=30) included only 8 PSTs, therefore the findings from this study cannot be generalised to all PSTs. Furthermore, although the research aimed to explore the perceptions of teachers "on the frontline" (p.1217), almost a quarter of their sample (n=7) were members of senior leadership and some of the remaining participants were designated SEN and pastoral support staff. Consequently, there is a possibility that these teachers were not working with children as often as main grade teachers and the insufficient reflection time reported by them could be due to their additional responsibilities. However, evidence is required to support this.

11.3 Self-directed Learning

Teachers report that they lack awareness of the available resources within their schools, which could enable them to provide effective support for children with MH needs (Rothi, Leavey and Best, 2008). Their awareness and use of relevant resources, professional organisations and voluntary services outside school was not discussed. Trudgen and Lawn (2011) explored teachers' awareness of the MH professionals that could respond to their concerns, although, other useful MH resources such as articles and websites were not covered.

Fani and Ghaemi (2011) argue that Vygotsky's original definition of ZPD does not account for the ways in which literary sources, such as books, articles and worksheets, serve to scaffold the learning process. Therefore, they adapted Vygotsky's original model to include a level at which teachers are able to learn independently, 'The Zone of Professional Teacher Development" (ZPTD). Fani and Ghaemi's (2011) ZPTD model includes a self-scaffolding stage during which teachers direct and regulate their own learning experiences. ZPTD posits that literate adults can engage in independent, self-directed and self-regulated learning before mediation from a more capable other is required (Fani and Ghaemi, 2011; Ohta, 2005). This theory has not yet been applied to the development of teachers' knowledge of CMH.

Authors claim that information technology can provide a reliable source of scaffolding and mediation for teacher learning (Fani and Ghaemi, 2011; Pereira et al. 2015). Pereira et al.'s (2015) randomised controlled trial found that interactive web-based programmes could be employed as an effective means to develop and sustain teachers' knowledge of CMH. They found that teachers using web-based programmes were more likely to recall information than those using video and text-based programmes. Moreover, Pereira et al. (2015) concluded that rates of recall were highest among the participants who were involved in the discussion forum than those using only the web-based programme. This suggests that, although MindEd does not have a discussion forum, this web-based initiative could also be effective in developing teachers' knowledge of CMH. However, there is currently no evidence to show whether teachers are aware of or using resources such as MindEd.

11.4 Collaborative Learning

Constructivist theories suggest that the social and cultural elements of collaborative working could enhance teachers' learning experiences (Sorensen, 2014). This is in line with Vygotsky's theory, which suggests that learning takes place through social interactions and discourse with others (Vygotsky, 1987). Allensworth (2012) asserts that, by developing positive professional relationships with colleagues, teachers can gain insight into better approaches for practice. For

example, Fani and Ghaemi (2011) stress that collaboration facilitates valuable opportunities to exchange positive and negative feedback about teachers' classroom practices. Collaborative problem solving structures have been found to provide school staff with a deeper understanding of individual children's learning and behaviour (Bozic and Carter, 2002; Jackson, 2005; Wilson and Newton, 2006). Other authors highlight the emotional benefits of co-working (e.g., mutual support) (Pedder and Opfer, 2013; Taylor, 2015). Teachers are reported to use a range of collaborative methods to learn including, consultation, mentoring, coaching, peer-observation and professional learning communities (PLCs) (Adams, 2016; Cole, 2015; Pedder and Opfer, 2013; Taylor, 2015).

Consultation is an indirect model of service delivery which is often applied in schools to empower teachers to solve problems with a range of professionals. Conoley and Conoley (1990) describe the consultation process as a means to provide "new knowledge, new skills, a greater sense of self-efficacy and a more perfectly developed level of objectivity in consultees" (p.85). Therefore, during consultation teachers can learn with and from professionals who have relevant knowledge to improve their situations. Within Vygotsky's theory of the zone of proximal development, these professionals could be considered as the scaffolding that supports teachers to develop their skills in specific areas (e.g., mental health). However, it seems important to mention that the consultants are not deemed 'more capable' as posited by Vygotsky, as consultation is a collaborative and empowering process within which all participants are equal.

Professional Learning Communities (PLCs) are used to provide teachers with regular opportunities to share expertise and develop their teaching skills (Pedder and Opfer, 2013). Pedder and Opfer (2013) found that teachers who were actively involved in a PLC were more likely to develop their skills as a result of being able to explore issues together and co-construct possible ways forward. Some authors suggest peer observations as a means to provide mentoring pairs with real life examples which are situated in the classroom context (Cole, 2015) Hallam and Castle (1999) also emphasise that staff knowledge and expertise might best be developed in the classroom with the assistance of outside professionals (e.g., educational psychologists).

OFSTED (2006) state that strategies such as team teaching and mentoring show evidence of improving school professionals' ability to respond to children with behavioural, emotional and social difficulties (BESD). However, there is no evidence to suggest that these approaches are utilised to develop teachers' knowledge of CMH.

12. A Focus on Primary School Teachers

Childhood years are crucial for the development of emotional and mental capabilities (Welsh et al., 2015). Key factors, such as secure attachments with significant others and nurturing learning environments, are believed to support CMH development (WHO and Calouste Gulbenkian Foundation, 2014). It is widely accepted that early intervention prevents unhelpful patterns (e.g., thinking, feeling and behaviour) from becoming embedded and reduces the number of children requiring higher levels of support (Bringewatt and Gershoff, 2010; Bayer and Beatson, 2013; DoH, 2014a, 2014b; DfE, 2014b, Health Committee, 2014). As stated previously, preventative strategies can reduce the duration and severity of psychological distress (DoH, 2014a, 2014b; DfE, 2014b) and are, therefore, considered the best and most cost-effective approaches for improving MH outcomes across Britain (DoH, 2014a, 2014b; DfE, 2014b; DoH, 2015).

Due to the slightly higher prevalence of MHIs in adolescence, much of the research exploring teachers' understanding of MHIs focuses on SSTs (Collins and Holmshaw, 2008; Jorm et al., 2010; Trudgen and Lawn, 2011). However, although SSTs' understanding of MHIs is key to improving school-based MH services for adolescents, developing teachers' knowledge at this stage of CYP's education is less likely to have an impact than educating PSTs. Research shows that the majority of adults with MHIs are first diagnosed between 11 and 15 years of age (Fraser and Blishen, 2007), suggesting that young people of secondary school age are at a higher risk of experiencing MHIs. However, while the majority of CYP between 11 and 15 are of secondary school age, primary school children are also included within this bracket. Furthermore, Fraser and Blishen's (2007) study

does not account for the children without MH diagnoses who are experiencing early indications of MHIs. These findings suggest that children could experience emerging MHIs before the age of 11.

Another study concluded that teachers' assessments of 8-year-old children predicted MHIs in adolescence (Mukolo, Heflinger and Wallston, 2010); for example, emotional issues in childhood were predictive of withdrawal and social issues in adolescence. This demonstrates that early indications of MHIs (e.g., emotional issues) can be identified at primary school age. Therefore, it is imperative that PSTs have sufficient knowledge and understanding to provide effective, preventative MH support for children.

13. The Role of the Educational Psychologist

Allen and Hardy (2013) emphasise that educational psychologists (EPs) should prepare for growing CMH concerns in educational settings and advise them to step into realms which used to be the sole responsibility of CAMHS specialists. EPs are well placed to promote CMH at a universal level by developing school policies and staff expertise (Farrell et al., 2006). For example, EPs can apply their knowledge of systems to encourage teachers to reflect on their ability to provide effective MH services for children. They can also contribute to the promotion of CMH at Tier 1 by supporting PSTs to foster positive and supportive relationships with their pupils (Roffey, 2013). Schools report that EPs have a "distinctive contribution" to the development of teachers' capacity to respond to children's needs (Farrell et al., 2006, p.50). Examples of capacity building within this research included: organising school staff workshops; developing and delivering training events with key professionals (e.g., CAMHS); and providing ongoing support packages for teachers (Farrel et al., 2006). Furthermore, Baxter and Frederickson (2005) argue that focusing EP practice at staff level can support greater numbers of children.

EPs also have an important role in assisting teachers in the delivery of MH interventions (Allen and Hardy, 2013). Allen and Hardy (2013) stress that

"evidence-base is the zeitgeist of this decade, with politicians and senior managers insisting that they focus funding on 'what works'" (p.144). EPs can apply their knowledge of the evidence-base to guide teachers to select the most effective MH programmes. EPs' experience in delivering interventions in schools (Kelly, 2012) can also be applied to inform teachers of the facilitators and barriers that are likely to be involved in implementing evidence-based programmes within complex school environments.

Although teachers are advised to seek MH training from MH specialists (Ekornes, 2015), some authors stress the potential barriers in establishing effective lines of communication between education and health care professionals (Rothi, Leavey and Best, 2008; Wolpert, 2011). Teachers have reported confusion around the terminology used by MH specialists and claim that MH professionals lack adequate understanding of the educational environment (Rothi, Leavey and Best, 2008). Wolpert (2011) argues that EPs have a key role in supporting the development of a common language between schools and CAMHS specialists. Therefore, EPs are ideally placed to support children's MH needs by developing PSTs' knowledge and understanding of CMH.

14. The Present Study

The majority of literature surrounding teachers' knowledge of MH is American or Australian in origin and can, therefore, not be reliably generalised to the UK (Cheney et al., 2011). Furthermore, Rothi, Leavey and Best's (2008) findings, involving British teachers' knowledge of MH, might not provide an accurate reflection of PSTs' current understanding of MH. Due to the current financial restrictions to public services across the country, it is imperative that existing resources are harnessed and utilised in order to provide effective MH support for children. Additionally, very few studies have explored teachers' perceptions of effective learning methods, particularly with regards to CMH. This research aims to explore PSTs':

··· current understanding of CMHIs;

--- awareness of MH resources;

--- previous use of MH resources; and

--- perceptions of how they could best be supported to develop their knowledge of CMHIs.

These areas of study were chosen in order to gain an insight into PSTs' current capacity to prevent CMHIs in schools and the ways in which educational psychologists (EPs) can contribute to the development of their expertise in this area.

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PART 2: THE EMPIRICAL STUDY

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1. Abstract

Research estimates that around ten percent of children in the UK between 5 and 16 years of age are diagnosed with a mental health disorder (MHD) (Green et al., 2005). The review of the literature suggests that teachers are not receiving specific training about child mental health (CMH) and lack confidence in their ability to respond to CMH needs effectively. The reduced capacity of Child and Adolescent Mental Health Services (CAMHS) and the focus on early intervention has shifted government attention from clinical to community settings, such as schools (Stallard et al., 2012). Therefore, teachers are ideally placed to promote CMH from an early stage and identify and respond appropriately to early indications of child mental health issues (CMHIs) (Department for Education [DfE], 2014b). This mixed methods study aimed to extend the research literature by exploring primary school teachers' (PSTs') current understanding of CMHIs; their awareness and previous use of mental health (MH) resources; and their perceptions of how they could best be supported to develop their knowledge of MH. The mixed methods design was implemented in order to collect both quantitative and qualitative data from questionnaires and semi-structured interviews. Both strands of data were analysed separately with descriptive statistics and thematic analysis. The findings indicate that the majority of PSTs in this sample had not received specific training about CMH and reported general uncertainty and confusion about the concept. The PSTs' awareness and previous involvement with professional agencies were higher than digital and literary resources. The participants requested detailed case studies and opportunities for context-specific learning with 'experts', similar to mentoring and coaching models, in order to learn about CMH. The strengths, limitations and implications for educational psychology are discussed.

2. Introduction

2.1   Defining Mental Health

The ambiguous concept of 'mental health' (MH) continues to raise considerable debate within academic literature and national policy (Adi et al., 2007; Bentall, 2003; Bilton and Cooper, 2013; Cole, 2015; Ekornes, 2015; Greenberg, 2011, Leader, 2011). The Diagnostic and Statistical Manuals (DSMs) I-V, published by the American Psychiatric Association (APA), and International Classification of Diseases (ICD 10), published by the World Health Organisation, demonstrate the ongoing attempts to organise human experiences into distinct categories since 1952. Although these manuals have established a common diagnostic language for the MH profession, they have been criticised for clouding the boundaries between typical psychological phenomena (e.g., intense sadness following the death of a family member) and mental health issues (MHIs) (Horwitz and Wakefield, 2009; Stein et al., 2010). Rather than attempting to make clear distinctions between 'mental health issues' (MHIs) and 'mental wellbeing' (MWB), the present study assumes that both exist on the opposite ends of a continuum (Ekornes, 2015; Murphey, and Vaughn, 2013). Therefore, the terms 'promoting MWB' and 'preventing MHIs' will be used interchangeably throughout this paper.

2.2   Mental Health in Childhood and Adolescence

Research estimates that around ten percent of children in the UK between 5 and 16 years of age are diagnosed with a mental health disorder (MHD) (Green et al., 2005). Some authors suggest that these statistics do not reveal the true extent of child mental health issues (CMHIs), as many children do not meet the full criteria for a diagnosis (Stallard et al., 2012). Furthermore, increasing rates of hospital admissions for self-harming and ChildLine calls relating to suicide suggest a rise in CMHIs in recent years (DoH, 2013; NSPCC, 2014).

2.3   Child and Adolescent Mental Health Services (CAMHS)

The four-tier strategic framework is generally accepted as the basis for providing CAMHS in the UK. Figure 2 below shows the 4 Tiers that are available to support children and young people (CYP) from preventative (Tier 1) to specialist level (Tier 4).

Figure 3: The Four-tier Strategic Framework for CAMHS – (Retrieved from http://www.brightonandhoveccg.nhs.uk/your-services/mental-health-services (Selected due to clarity, not due to relevance of geographical area)).

Tier 4
Highly specialised services such as intensive community treatment services, day units and inpatient units.

Generally services for the small number of children and young people who are deemed to be at greatest risk (of rapidly declining mental health or serious self-harm) and/or who require a period of intensive input for the purposes of assessment and treatment.

Tier3
Child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, and occupational, art, music and drama therapists

Usually multi-disciplinary teams or services working in a community mental health setting or a child and adolescent psychiatry outpatient service, providing a service for children and young people with more severe, complex and persistent disorders.

Tier2
Mental health professionals delivering primary mental health work, psychologists and counsellors in GP practices, paediatric clinics, schools and youth services

Offer consultation to families and other practitioners. Identify severe or complex needs requiring more specialist intervention, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1. Tend to be CAMHS specialists working in teams in community and primary care settings.

Tier1
GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies

Offer general advice and treatment for less severe problems. Contributing towards mental health promotion, identifying problems early in the child's development and refer to more specialist services.

Despite the government's growing interest and investment in MH prevention in recent years, "seriously and deeply ingrained problems" continue to exist at each level of CAMHS (Health Committee, 2014, p.3). Recent research discovered that a substantial number of MH budgets were cut or frozen between 2013 and 2015, particularly those which funded preventative services (Young Minds, 2015). The reduced capacity of CAMHS and the focus on early intervention has shifted government attention from clinical to community settings, such as schools (Stallard et al., 2012).

2.4   The Key Role of Schools and Teachers

Schools are ideal settings in which to provide child mental health (CMH) services, as they are convenient and accessible for children and families (Bringewatt and Gershoff, 2010; DfE, 2014b; DoH, 2014a). The DfE (2014b) advises schools to promote MH and resilience for all children and to utilise appropriate resources in order to identify and respond to CMHIs promptly. There is a wealth of evidence which demonstrates direct causality between social and emotional skills and psychological and academic outcomes (Gutman and Schoon, 2013). Therefore,

universal programmes such as Social and Emotional Aspects for Learning (SEAL) have been implemented in schools to promote MWB (Humphrey et al., 2010). The research indicates that preventative strategies such as SEAL are the most cost-effective way of improving MH outcomes (Brown and Taylor, 2008). Selective interventions such as Nurture Groups (Hughes and Schlosser, 2014) have also been found to develop children's social and emotional skills.

The DfE (2014b) emphasises that teachers "see their children day in day out, they know them well and are well placed to spot changes in behaviour that might indicate a problem" (DfE, 2014b, p.9). Additionally, Gutman and Schoon (2013) argue that, "The most important consideration, in the implementation of any intervention programme, is its execution" (p.42). Therefore, teachers' knowledge of CMHIs is fundamental to the provision of effective school-based MH interventions.

Research suggests that children could experience emotional distress before the age of 11 (Fraser and Blishen, 2007), demonstrating that early indications of MHIs (e.g., emotional issues) could be identified at primary school age. Therefore, it is imperative that PSTs have sufficient knowledge and understanding of CMH in order to provide effective preventative school-based support.

2.5   Teachers' Knowledge of Child Mental Health

Research suggests that teachers lack sufficient MH training in order to respond to CMH needs effectively (Rothi, Leavey and Best, 2008; Trudgen and Lawn, 2011; Walter, Gouze and Lim, 2006). Trudgen and Lawn's (2011) findings show that teachers were informed by a range of informal means (e.g., media and personal experiences) and their responses to CYP's needs were based primarily on their intuition. This resulted in a range of thresholds for identifying MHIs and referring their concerns to MH specialists. These teachers also reported uncertainty around the point at which typical psychological experiences should be considered as MHIs (Trudgen and Lawn, 2011). Trudgen and Lawn (2011) advised training providers and schools to integrate MH modules into initial teacher training and continued professional development (CPD) courses. However, teachers in Rothi, Leavey and Best's (2008) study stated that initial teacher training programmes

were already congested and training around raising academic achievement was likely to take precedence over MH.

2.6   Mental Health Resources for Teachers

Professionals working with CYP are advised to make use of the available resources and services to inform them about CMH. For example, the DfE (2014b) directs teachers towards Place2Be, ChildLine and MindEd, a free online resource which was developed to provide adults with information about CMH. The evidence suggests that teachers who use web-based programmes to develop their understanding of MH are more likely to recall information than those using video and text-based programmes (Pereira, 2015). Although, there is no research to show teachers' current awareness and use of such resources, nor those specifically advised by the DfE (2014b). The Health Committee argue that, "the onus is on the individual schools and teachers to find time to prioritise this (CMH) and within a sea of competing priorities, it may be difficult to ensure that all schools and teachers use these tools" (p.6).

2.7   Constructivism: Professional Development for Teachers

Constructivism provides the theoretical basis for this research in order to explore the complex elements which are involved in developing teachers' knowledge of CMHIs. Constructivists propose that learning is activated by the apprehension that a current situation does not correspond with existing knowledge (disequilibrium) (Cobb, Wood and Yackel, 1990; von Glasersfeld, 1995). Fox (1996) emphasises that knowledge must be actively constructed through the ongoing interaction between individual learners and their external worlds.

Some authors propose that reflective methods, such as writing autobiographies and journals, can enhance teachers' professional development (Avalos, 2011; Knowles, 1992; Fani and Ghaemi, 2011). Social and cultural elements of collaborative working have also been found to improve learning experiences for teachers (Sorensen, 2014; Pedder and Opfer, 2013). Avalos (2011) discusses an approach to professional development called "workplace learning" (p.12), in which knowledge is constructed, both formally and informally, within specific contexts. Some authors have advised schools to facilitate such situated learning

approaches (e.g., peer observations) in order to provide teachers with real-life examples (Hallam and Castle, 1999; Cole, 2015). Teachers have requested adequate time to reflect on their practice and further opportunities for context-specific training from MH professionals, to develop their knowledge and capacity to support the MH needs in their classrooms (Rothi, Leavey and Best, 2008). However, there is no evidence to demonstrate teachers' current perceptions of how they could best be supported to develop their knowledge of CMH.

2.8 The Role of the Educational Psychologist

Authors report the value of EPs' wider roles in developing school policies and staff expertise (Farrell et al., 2006; Baxter and Frederickson, 2005). EPs also have an important role in assisting teachers to implement evidence-based MH interventions within complex school environments (Allen and Hardy, 2012; Kelly, 2012). Furthermore, Wolpert (2011) emphasises that EPs are ideally placed to develop a common language between schools and CAMHS specialists, as they have sufficient understanding of both MH and educational settings.

2.9 The Present Study

The majority of the literature surrounding teachers' knowledge of MH is American or Australian in origin and can, therefore, not be reliably generalised to the UK (Cheney et al., 2011). Furthermore, Rothi, Leavey and Best's (2008) findings, involving British teachers' knowledge of CMH, might not provide an accurate reflection of PSTs' current understanding. There is no evidence to demonstrate teachers' awareness and use of the available MH resources and very few studies have explored teachers' perceptions of effective learning methods, particularly with regards to CMH. Due to continuing financial restrictions to public services across the country, it is important to harness existing resources and empower teachers to provide effective preventative MH support for children. Therefore, this research aims to explore PSTs':

1)   current understanding of CMHIs
2)   awareness of MH resources

3) previous use of MH resources

4) perception of how PSTs could best be supported to develop their knowledge of CMHIs

3. Method

3.1 Design

Creswell (2013) proposes the mixed methods design as an effective way to understand real-life contextual situations. This approach combines the strengths and weaknesses of both quantitative and qualitative methods "to obtain different but complementary data on the same topic" (Morse, 1991, p.122). This approach allowed both:

1. the collection of data to determine PSTs awareness and previous use of various MH resources; and

2. an in-depth contextual investigation to obtain PSTs' views, with regards to all four research aims.

A convergent, parallel, mixed methods design was chosen as both quantitative and qualitative methods were prioritised equally. The current study is underpinned by a constructivist epistemology, which posits that learning is an active and dynamic process in which individuals continually construct and re-construct their knowledge by responding to the world around them (Scott, 2011).

3.2 Participants

A full list of mainstream Local Education Authority (LEA) maintained primary schools within one English county was obtained from the Educational Psychology Service (EPS). A gatekeeper letter (Appendix 1), information sheet (Appendix 2) and consent form for both parts of the study (Appendix 3 and 4)

were sent to the head teachers via email in order to introduce the research and invite main grade PSTs to participate in the study. Six schools agreed to participate and the average number of PSTs in each school was twelve. The response rates for the questionnaires ranged between 0% and 100%. 1-2 PSTs from each school were interviewed. The total number of participants recruited for each part of the study was:

--- 31 PSTs for the questionnaire; and

--- 8 PSTs for the interviews.

3.3   Materials

3.3.1 Questionnaires

A questionnaire (Appendix 5) was designed specifically for this study in order to gather quantitative and qualitative data. Seventeen items were carefully considered to ensure that the aims of the research were addressed. Eleven of the items were devised to gather quantitative information about PSTs' awareness and previous use of MH resources. PSTs were required to write the title of the resource (e.g., MindEd) in order for it to be counted. This approach was intended, rather than providing options for PSTs to select, to reduce the risk of obtaining socially desirable responses (Mathie and Wakeling, 2011).

PSTs were also required to asterisk the resources that they had used. The six remaining items were designed to gather qualitative data, which was combined with the interview data during the interpretation phase. The questionnaire took approximately twenty minutes to complete.

3.3.2 Semi-structured interviews

Semi-structured interviews (Appendix 6) were chosen to collect in-depth data from 8 participants. This method was specifically selected to ensure that the issues that were relevant to the research aims were fully explored, whilst providing suitable flexibility for the participants to express their views in greater detail (Smith and Osborn, 2008). The interview schedule consisted of four open questions and a selection of organised prompts.

3.4   Procedure

3.4.1   Pilot study

Three teachers were recruited to take part in a pilot study to ensure that both parts of the research were clear. The pilot participants were asked to comment on the suitability of the language, the structure of the questions and the accuracy of the estimated time frame. The feedback from the participants was mostly positive, however, some definitions appeared to be quite similar to those used by mental health organisations/websites. Therefore, a caveat was included in the research introduction to ensure that PSTs provided their own views.

3.4.2   The Main Study: Quantitative Data Collection

School visits were arranged to take place during routine staff meetings to introduce the research to the PSTs. Following a brief overview, PSTs were provided with packs including: two blank envelopes; an information sheet; a questionnaire; and a consent form for each part of the study. A sealed post box was placed in the staff room for 1-2 weeks to give the teachers plenty of time to complete and enclose the consent form/s in the blank envelopes and return them to the box. The box was collected from each school at the end of the agreed time

frame.

3.4.3   Main Study: Qualitative Data Collection

The contact details provided on the interview consent forms were used to arrange the semi-structured interviews. The interviews were carried out at each school after working hours. The interview schedule was followed flexibly and prompts were used where appropriate. The qualitative data was transcribed at least two weeks after the interviews.

3.5   Data Analysis

3.5.1 Descriptive Statistics

The information provided in the questionnaires was transferred to   number data. For example, PSTs demonstrated their awareness of an official document by writing its title and asterisked the title to show that they had used it. The participants did not accumulate scores for each resource: only one resource was necessary to be counted. The participants' questionnaire responses are included in Appendix 9. Descriptive statistics were used to calculate the number of PSTs who were aware of the types of resources specified and the number of PSTs who had used each resource type.

3.5.2 Thematic Analysis

Thematic Analysis (TA) was chosen to analyse the interview responses in order to "provide a rich and detailed, yet complex, account of the data" (Braun and Clarke, 2006, p.78). Although the flexibility of TA can be beneficial for recognising and recording patterns within qualitative data, this advantage can also be perceived as a disadvantage (Braun and Clarke, 2006). TA has been criticised for its

subjectivity and vulnerability to researchers with preferred outcomes (Braun and Clarke, 2006). To avoid this, the current study followed the guidance of Braun and Clarke (2006) who emphasise the importance of an explicit epistemological position and a detailed explanation of how the analysis was carried out. An independent researcher was recruited to cross-examine the strategies and interpretations of the data.

The transcriptions were read several times before patterns were highlighted within the data. The patterns were coded and post-it notes were used to construct the initial themes and subthemes. As this research explored a relatively new area, the thematic analysis was carried out at a semantic level in order to capture the explicit meanings of the teachers' views. Before the themes were finalised, a meeting was held with the independent coder to compare and discuss the initial thematic map. The themes were loosely agreed during the first meeting before re-reading and coding the entire data set. A second meeting was arranged to compare the transcripts and assemble the final thematic map. The themes represent the analysis of the entire set of data and only brief anonymous illustrative quotes have been included. An example of one of the coded transcripts has been provided in Appendix 10.

3.6 Ethical considerations

Detailed information was provided to the PSTs during the staff meetings in both verbal and written form. The participants were encouraged to take time to consider their participation and to ask questions during or following the meeting. They were reminded of their rights not to participate, to decline to answer any of

the questions and to withdraw from the study without giving a reason. Particular emphasis was placed during the explanation on participants' inability to withdraw from the quantitative part of the study once they had posted their anonymous questionnaires into the sealed box. The participants were encouraged to take the questionnaires away and complete them independently at a convenient time. A large sign was created to remind the teachers to collect a debriefing sheet (Appendix 7) from the pile beside the post box.
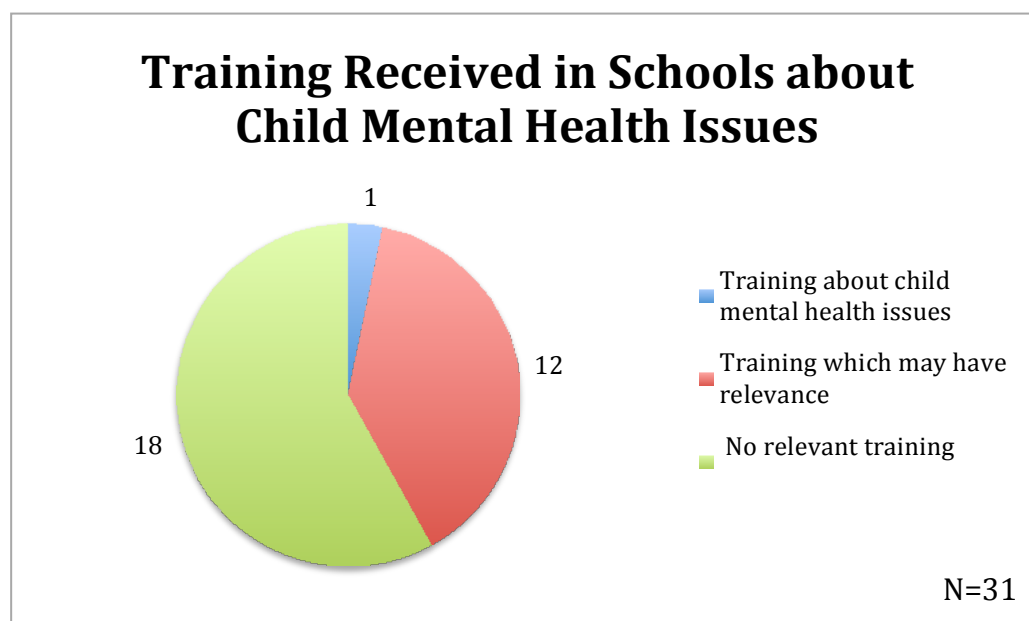
A private and quiet space was organised at each school to carry out the semi-structured interviews and the purpose, process and participation rights involved in the second part of the study were repeated. The participants were reminded of their rights to request for their data to be deleted at any stage before the interviews were transcribed and anonymised. Debriefing sheets (Appendix 8) were provided including contact details for use in the event of any issues. The participants were not referred to by name during the interviews and the recordings were held confidentially and securely on a password protected computer. The recordings were permanently deleted once the interviews had been transcribed and anonymised. The participants were informed that the independent researcher would have access to the anonymised transcripts and a summary of the results from both parts of the study would be shared with them. The data was retained indefinitely by Cardiff University.

4. Results

Questionnaire items 1, 2 and 14-17 were designed to collect qualitative data and were, therefore, combined with the data derived from the semi-structured interviews for the TA. The descriptive statistics from Items 3-13 have been presented in the pie and bar charts below.

4.1 Descriptive Statistics

Figure 4: Item 3

Training Received in Schools about Child Mental Health Issues

- Training about child mental health issues
- Training which may have relevance
- No relevant training

1
12
18

N=31

The pie chart above shows that 1 PST reported receiving training about CMHIs in school and 12 had attended training which may have had relevance to CMHIs. The majority of participants had not attended any relevant training around CMHIs.

Figure 5: Item 4

Training Received Outside Schools about Child Mental Health Issues

- Training about child mental health issues
- Training which may have relevance
- No relevant training

3
8
20

N=31
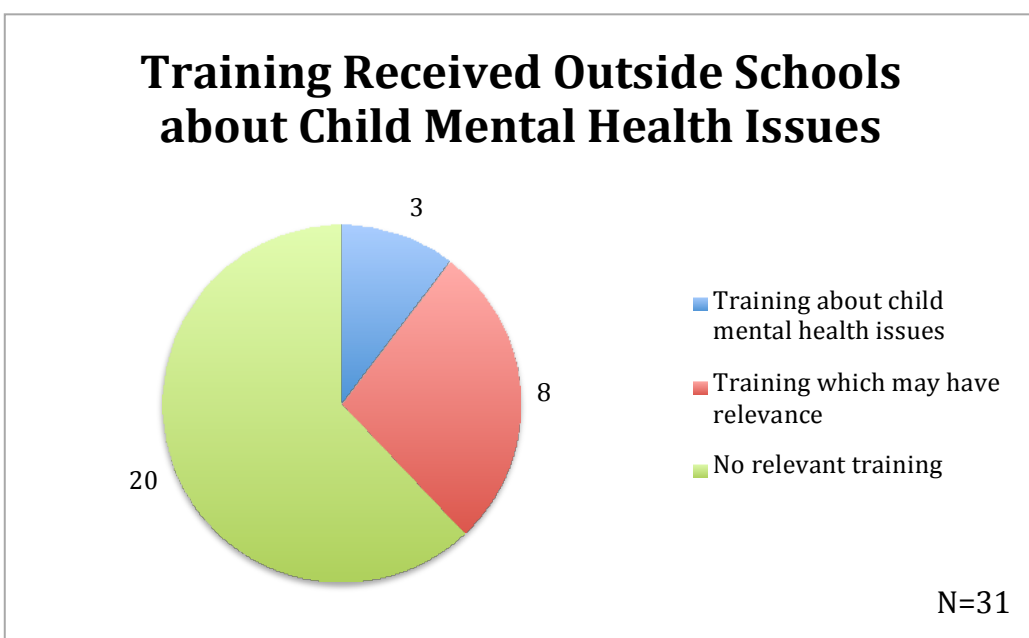
The pie chart above shows that 3 PSTs had received training about CMHIs outside school and 8 had attended training which, they believed, may have had relevance to CMHIs. Almost two thirds of the participants had not attended any relevant training about CMHIs.

Figure 6: Items 5 – 12: PSTs' awareness and use of resources
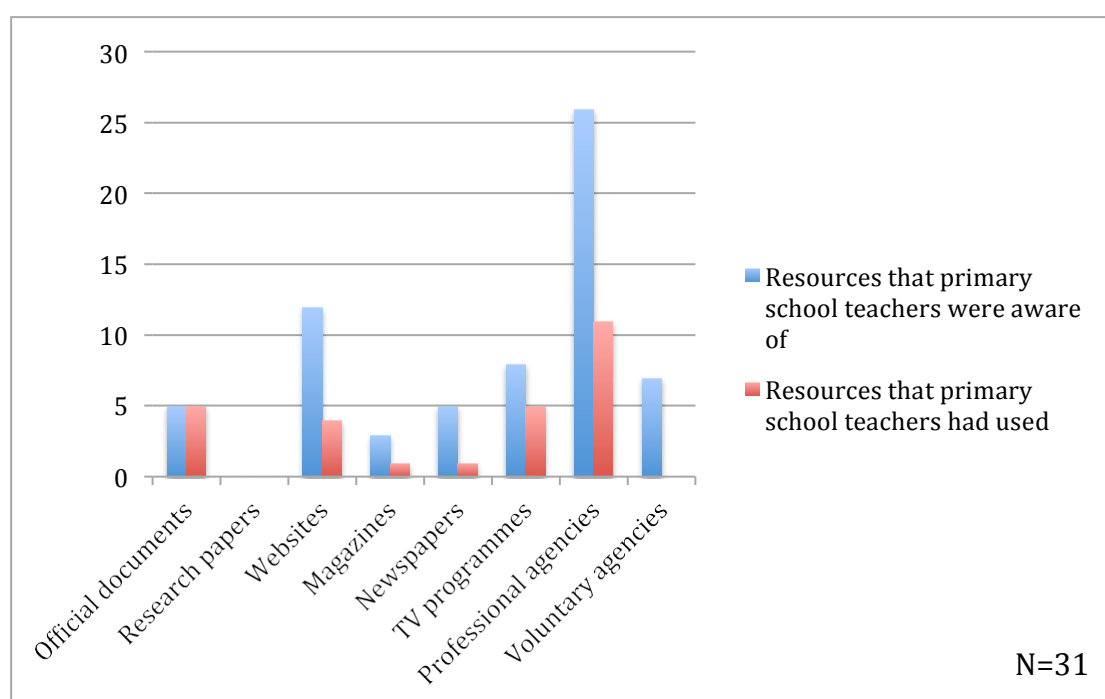
The number of PSTs who were aware of each type of MH resources and those who had used each category are demonstrated in the bar graph above. None of the PSTs were aware of any research papers about CMHIs and had, therefore, not used this type of resource. The 5 PSTs who were aware of official documents had used them to learn about CMHIs. However, none of the PSTs reported any awareness of the 'Mental Health and Behaviour in Schools' document (DfE, 2014b). Three times as many PSTs were aware of CMH-related websites compared to those who had used them and none of the participants were aware of the free web-based information resource, MindEd. PSTs were more likely to watch TV programmes about CMHIs than they were to read

magazines and newspapers about them. They were most aware of the available professional agencies and 11 had been directly involved with them. 7 PSTs were aware of relevant voluntary agencies (e.g., Mind, NSPCC), although none had accessed these services.

Item 13: Please list below any other approaches that you have explored

All PSTs (n=31) left this item blank.

4.2 Thematic Analysis

The data from the semi-structured interviews and responses to items 1, 2 and 14-17 in the questionnaires were combined and analysed using TA. The TA resulted in six main themes which have been presented in the blue circles in Figure 4 below.

The pink rectangles demonstrate the subthemes within Theme 3.

Figure 7: Six main themes
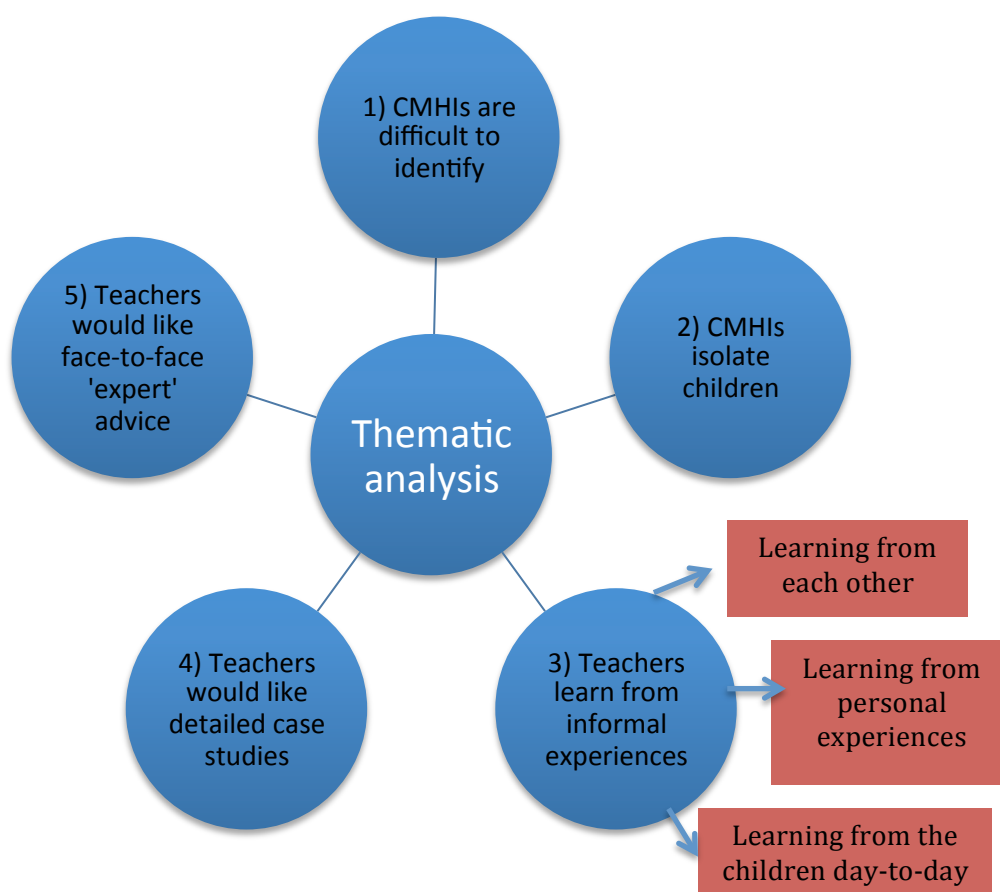
4.2.1. Theme 1: Child Mental Health Issues are Difficult to Identify

PSTs used the terms 'foggy', 'vague' and 'grey area' to describe the concept of MH. They were uncertain about how to distinguish between CMHIs and typical psychological experiences: *"...are children just, sort of, struggling a bit with life or do they have something else?"* (Participant 3). As a result, PSTs were unsure about how they should respond to different children: *"You know, is it you just need to get on with it and get a grip or is there an actual, you know, medical illness that needs to be, you know, where's that line?"* (Participant 1).

4.2.2. Theme 2: Child Mental Health Issues Isolate Children

PSTs felt that children with MHIs were isolated from the rest of the class. For example, some children were quiet, withdrawn and found it difficult to connect with others: *"Sometimes children don't, like, can feel quite alone, like, they don't always share how they're feeling"* (Participant 3). *"They can't really form friendships with other children or adults, um, kind of isolate themselves, not very trusting of adults"* (Participant 8). PSTs reported that children's social, emotional and behavioural issues interfered with their ability to progress with the rest of the class.

4.2.3. Theme 3: Learning from Informal Experiences Subtheme 1: Learning from Personal Experiences

PSTs recognised that their knowledge of MHIs had been gathered from personal experiences: *"I think it's very personal to the experiences we've had"* (Participant 6). On the whole, participants used their friends' and families' MHIs as frames of reference to attempt to identify children with similar needs in their classrooms: *"I have friends that have MHIs and, you know, there are certain behaviours that you*

could…you can spot perhaps in somebody and think, 'well that's similar to that', 'could that be connected?' or 'could that be an issue?'" (Participant 1). PSTs were concerned that this approach was subjective and could lead them to make assumptions about the children's experiences: *"I might be projecting that or assuming things about the child and how they're feeling when actually they might feel completely different"* (Participant 2)*.*

Subtheme 2: Learning from Each Other

PSTs appreciated having informal conversations with fellow members of staff in their schools (e.g., teachers, SENCos, behaviour support staff) and speaking to teachers from other settings during training events: *"I think just talking to other people is really helpful because it's good having, like, the training from people coming in but I think just being able to talk to other people and just those informal conversations are good"* (Participant 8). PSTs also reported observing each other's lessons to learn new strategies: *"I went to observe another teacher who had a child who was fairly similar in their class so, like, learning through watching, like, peer observation, that kind of thing"* (Participant 3).

Subtheme 3: Learning from the Children Day‑to‑day

PSTs' understanding of CMHIs appeared to depend on the children in their classes each year: *"I think we learn predominantly through who comes into our class"* (Participant 3).

4.2.4. Theme 4: Teachers Would Like Detailed Case Studies

PSTs requested opportunities to learn about MHIs from specific examples, particularly from those who had experienced them. They felt that children's views could be communicated through video clips, recordings and creative activities (e.g., drawing): *"maybe a recording or extracts from things children have said to, kind of, help paint a picture of what is going through their minds"* (Participant 2). PSTs frequently requested detailed case studies in order to fully understand children's individual experiences of MHIs before it was possible to respond effectively: *"A whole case study of the child and how the child might be feeling, so what you could do to, kind of, alleviate those things"* (Participant 4). PSTs felt that ideas from case studies of other children could be carefully selected and applied to the children in their classrooms: *"Even though each child is completely individual, it's sort of magpieing those ideas so that you feel like you've got an understanding of what you're dealing with"* (Participant 5).

4.2.5. Theme 5: Teachers Would Like Face‑to‑face, 'Expert' Advice

PSTs requested classroom observations with 'experts' in order to learn how to develop new skills, particularly in recognising emerging MHIs: *"I think that you need support from the experts coming in, observing with you"* (Participant 6). They felt that advice from an 'expert' was more reliable than surmising from the information provided by other sources: *"if I know of somebody who comes in who's got experience and is knowledgeable in a subject then I would listen to them rather than, sort of, reading things and thinking, 'Oh, that could be right'"* (Participant 1). The language used to describe MH-related issues was reported to be complex and difficult to understand without support: *"I think reading anything on the Internet or in books can sometimes take quite a long time to digest it 'cause you're not*

familiar with the language" (Participant 1).

5. Discussion

Both strands of analysis are discussed and combined below each research aim
in the following subsections.

5.1. Research Aim 1: Primary School Teachers' Current Understanding of Child Mental Health Issues

The quantitative data shows that the majority of the participants had not received
specific training about CMHIs. However, more than a third had received training
which may have been relevant to CMHIs (e.g., attachment training). The
qualitative data demonstrates the confusion experienced by the PSTs with
regards to the broad concept of MH and 'the line' at which children should be
considered to have a MHI. Teachers tended to refer to friends' and family
members' experiences in order to understand, and respond appropriately, to the
CMH needs in their classrooms. They perceived children with MHIs to be
withdrawn and isolated from the rest of the class.

These findings reflect the issues faced by authors who have attempted to define
the concept of 'mental health' (Adi et al., 2007; Murphey, Barry and Vaughn,
2013) and previous evidence of teachers' uncertainty around the point at which
children's psychological experiences should be considered to be MHIs (Ekornes,
2015; Kidger et al., 2010; Rothi, Leavey and Best, 2008; Trudgen and Lawn,
2011). Teachers' lack of specific MH training and use of personal experiences to
inform

their decisions in the classroom have also been found in other studies

(Rothi, Leavey and Best, 2008; Trudgen and Lawn, 2011).

However, it is important to note that the teachers' lack of specific MH training

does not necessarily indicate that they do not have sufficient understanding or

skills to support children's MH needs effectively. On the other hand, their reports

of confusion and concerns about making assumptions about children's needs

suggest that an improved understanding could lead to greater clarity and

confidence among these teachers. The findings also suggest that these PSTs could

have benefited from some additional advice around developing the social and

emotional skills within their classrooms, particularly for children who were

withdrawn and isolated.

5.2. Research Aim 2: Primary School Teachers' Awareness of Mental Health Resources

The quantitative data shows that PSTs were more likely to be aware of

professional agencies (e.g., CAMHS, EPS) than any other resource type. PSTs'

awareness of various professional agencies was also clearly communicated

during the interviews. These findings suggest that this sample of PSTs could

benefit from acquiring a greater awareness of the available MH-related resources,

particularly those that have been specifically advised by the DfE (2014b) (e.g.,

MindEd). These results indicate that greater efforts might be required by those

disseminating MH-related resources to ensure that this information reaches

teachers.

5.3. Research Aim 3: Primary School Teachers' Previous Use of Mental Health Resources

Aside from the official documents, the 'use' scores were lower than the 'awareness' scores for all resource types. This suggests that, although the teachers were aware of some of the available MH resources, they had not utilised them. One possibility could be that teachers have insufficient time to develop their knowledge of CMH (Rothi, Leavey and Best, 2008). However, there are several other possibilities; for example, PSTs might be unable to access some of the relevant research papers which could inform them about CMH. Future studies might consider exploring this area in more detail in order to reveal some of the potential barriers that prevent PSTs from using these resources.

Teachers reported seeking support from professional agencies (e.g., EPS, CAMHS, and social services) more than any other resource type and reports of using literary resources were low in both parts of the study. This could partly be due to the complexity of these resources and the time required for PSTs to read, understand and apply them to their practice (Theme 5). However, further evidence is required to explore this in greater detail.

PSTs reported using their everyday teaching experiences to learn about CMH. These included peer observations, informal conversations with teachers and learning as they worked with the children. This provides some additional evidence to suggest that teachers are using a combination of experiential, collaborative and context-specific methods to learn about CMH (Pedder and Opfer, 2013; Rothi, Leavey and Best, 2008; Sorenson, 2014; Stover et al. 2011). While these findings

show that PSTs are using these approaches, further evidence is required to explore whether they are effective in developing teachers' knowledge of CMHIs.

5.4 Research Aim 4: Primary School Teachers' Perceptions of How They Could Best Be Supported to Develop Their Knowledge of Child Mental Health Issues

PSTs' wish to fully understand the experiences of children with MHIs was particularly prominent within the data. They recognised that individual children experienced MHIs in different ways and, therefore, required a different approach from their teachers. PSTs requested activities which could help them to understand the experiences of children with MHIs in school. In order to achieve this, they suggested detailed case studies and specific real-life examples presented by videos and audio recordings.

PSTs also requested time to observe children with 'expert' professionals in order to develop skills in recognising signs of CMHIs and discuss potential strategies which could be individually tailored to support particular children effectively. This suggests a preference among these PSTs for supportive and situated methods of learning, such as mentoring and coaching.

5.5. Implications for Educational Psychology

While the findings from this study have been collected from a small sample, several practical suggestions can be made.

--- The information from this study could be used as a framework to negotiate potential professional learning arrangements for teachers and schools in relation to MH.

- These findings could also inform the development of effective professional learning events for teachers, which integrate a wide range of teaching approaches.

- EPs should remain well-informed of the available resources and services, both locally and nationally, which provide advice and support around CMH and communicate changes to families and settings.

- EPs should continue to consult directly with PSTs and share their thoughts following classroom observations.

- EPs also have an important role in preparing PSTs for the children who arrive in their classrooms each year, particularly for those transferring from early years settings. EPs could support transition by providing detailed descriptions of children's strengths and needs (e.g., one page profiles) within plenty of time to ensure that teachers are adequately prepared to support them.

- Policy makers could also be advised to reduce the amount and complexity of the information which is directed towards teachers in order to ensure that they have time to read the information and apply it to their settings. Advice could also be provided to those disseminating this information to ensure that it is advertised appropriately for teachers (e.g., sending information to schools by post/email, Twitter).

5.6. Strengths, Limitations and Future Directions

Due to the recent shift in government attention from clinical to community settings (Stallard et al., 2012), mainstream PSTs are increasingly expected to promote CMH,

identify emerging CMHIs and provide timely support (DfE, 2014b). The prevalence of CMHIs in the UK appears to be rising and it is, therefore, vital to ensure that PSTs are adequately prepared to provide the best possible MH support for children. This study gleans an initial insight into teachers' awareness and previous use of MH resources and their preferred approaches of developing their understanding in this area.

Despite the mixed methods design, the study was small in scale and the findings cannot be reliably generalised to the PST population. The questionnaire was designed for the purpose of this research and had, therefore, not been tested for validity. A small pilot study was carried out to test the reliability of the questionnaire, however, the number of blank spaces within those returned suggested that there were some issues with the instrument. Very few participants completed the last 2-3 questions which could suggest, for example, that they found the questions difficult to answer within the estimated time frame. Therefore, future studies might consider using a questionnaire that has been tested for validity and reliability.

Despite every effort to maximise participation (e.g., sending reminders to schools, extending questionnaire completion time etc.), the questionnaire response rate was low. The high demands already experienced by teachers (Rothi, Leavey and Best, 2008) and the unfortunate timing of the data collection process (e.g., amidst end of year reports/exams/productions/sports days etc.) could have contributed to the low response rate. Therefore, collecting data at a quieter time of year or extending the time for PSTs to complete their questionnaires might increase participants' responses in future studies.

The open-ended questions were also likely to have reduced the return rate, as PSTs were required to take time to write their own responses rather than ticking selected answers. However, providing a list of all conceivable MH-related resources would have been impossible and identifying particular resources from which PSTs could select would restrict the responses to those that the researcher deemed to be of relevance to MH (Neuman, 2000). The open-ended items raised further complications with regards to the data analysis, as

participants' responses were required to be converted into numbers. By doing so, all participants' responses were counted and details of the resources were provided in the appendices. Therefore, the quantitative data simply demonstrates the number of PSTs who responded to each of the items and the relevance of the resources, in relation to their capacity to aid the development of MH knowledge, is subject to the reader's interpretation.

Both parts of the study included self-report measures, which do not necessarily provide a reliable measure of reality (Alshenqeeti, 2014). For semi-structured interviews in particular, Alshenqeeti (2014) forewarns that the interviewer's ability to obtain the interviewees' true perceptions depends on the participants' willingness to share them. The flexibility of the semi-structured interviews facilitated the in-depth exploration of the research aims and provided opportunities to investigate areas of particular interest. However, the flexible element of this method could have reduced the internal validity of the research by increasing the risk of researcher bias. Nevertheless, the interview plan was thoroughly analysed to ensure the absence of leading questions and the prompts provided interviewees with opportunities to clarify their views (Creswell, 2012). The design of the questions was also highlighted as a key area of focus during the pilot studies for both parts of the research.

Whilst teacher knowledge and understanding is a crucial factor in mental health promotion in schools, researchers have also explored young people's views in this area, particularly with regards to the ways in which schools can be organised to support them (Aston, 2014; DfE, 2011; Oliver et al., 2007; Woolfson, Mooney and Bryce, 2007). According to the young people in these studies, key features of mental health promotion included: safe areas for supportive conversations with peers and staff (DfE, 2011); interventions for behaviour management and bullying; (DfE, 2011); receiving information about a range of mental health issues (Woolfson, Mooney and Bryce, 2007); feeling listened to and understood by others (Olivers et al., 2007); and learning a variety of coping strategies, such as expressing feelings through music, dance and sport (Oliver et al., 2007). Aston (2014) stresses the risks involved in relying solely on the opinions of professionals and other adults and argues for further research to be carried out to explore young people's views around mental health provision in schools. She

emphasises that young people's participation in systemic change empowers them to have their say on matters that affect them and has the potential to enhance mental health provision in schools. Additional research of this kind could develop teachers' understanding of children and young people's needs in this area and inform their practices.

Future researchers might also consider focusing on a latent approach to thematic analysis to explore PSTs' thoughts surrounding mental health at a deeper level.

6. Concluding Comments

This study is consistent with the existing literature which suggests that teachers require additional support to develop their knowledge of CMH. It extends previous research by suggesting that PSTs could benefit from greater awareness of the available MH resources. However, these findings should be considered with caution in light of the methodological limitations. The PSTs in this study also revealed a preference for detailed case studies of children with MHIs, individually tailored 'expert' advice and context-specific learning approaches such as coaching. Future researchers might consider executing a similar study with a larger sample of participants.

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PART 3: MAJOR CRITICAL APPRAISAL

1.Introduction

The purpose of the major research critical appraisal is to provide an account of the researcher's reflections and decisions at each stage of the research process. This critical appraisal consists of two main parts. These include a critical account of:

- the contribution made by this research to educational psychology and the role of the educational psychologist; and

---   the research process from inception to completion.

2.Contribution to Knowledge

2.1 A Summary of the Gaps in the Literature

I began my literature search by attempting to confirm that teachers' understanding of child mental health issues (CMHIs) was a relevant area of study (e.g., researching recent statistics, reading governmental policy). It was immediately clear to me that CMH was a very topical area, as there were several recent newspaper articles discussing the challenges for mental health (MH) services and the government initiatives aiming to improve MH outcomes in Britain. The 'Mental Health and Behaviour in Schools' document (DfE, 2014b) seemed to place a great deal of responsibility on teachers to recognise signs of child mental health issues (CMHIs). Having worked as a teacher myself, I was aware of the high level of responsibility and pressure that they face on a daily basis and I was keen to explore how educational psychologists could contribute to their support.

2.1.1 Teachers' Knowledge of Child Mental Health
The first article of interest was an Australian paper by Trudgen and Lawn (2011), which explored secondary school teachers' ability to recognise 'internalising' MHIs (e.g., anxiety and depression) and refer their concerns to MH professionals. Trudgen and Lawn (2011) focused on emotional issues such as anxiety and depression as they claimed that the silent and internalising symptoms (sic) were more likely to go unnoticed and unsupported. I assumed that their

concept of externalising MHIs might include conduct issues, as discussed at length by Cole (2015).

Having read Cole's (2015) document, I felt that although externalising MHIs may well be easier to identify, this did not necessarily mean that teachers would be able to recognise them as MHIs and, therefore, understand them as such. As a result, I decided to keep my research focus fairly broad by considering MHIs in general. I thought that, by doing so, teachers would be able to share what they perceived MHIs to be. As Trudgen and Lawn's (2011) study could not be generalised to the UK (Cheney et al., 2011), I attempted to search for British papers that explored teachers' knowledge of MHIs.

Rothi, Leavey and Best's (2008) study provided a second key source for the literature review, as this study explored British teachers' perceptions of their capacity to support the mental health (MH) needs in their classrooms and their views on current professional development programmes (CPD). These findings were consistent with the findings in Trudgen and Lawn's (2011) study, as the teachers reported that they lacked confidence in their ability to support CMH needs effectively. Furthermore, although CPD around CMH would have been helpful to them, they were concerned that these programmes were more likely to be focused towards raising academic standards (Rothi, Leavey and Best, 2008). On the other hand, I was aware that initial teacher training programmes and CPD arrangements were likely to have changed since 2008, particularly due to the government's interest in MH and emotional and social skills over the past few decades (Cole, 2015).

Due to the focus on early intervention and the growing body of evidence that supports preventative approaches for CMH (Cheney et al., 2014), I thought that building capacity at primary school level would be more likely to improve MH outcomes in Britain than focusing on secondary school teachers. Therefore, I felt that it was necessary to obtain an up-to-date understanding of PSTs' knowledge of CMHIs.

2.1.2. Available Resources

The Department for Education (DfE) (2014b) lists a number of resources for teachers to use to develop their understanding of MH and their capacity to support children and young people's (CYP) MH needs. However, a number of authors have expressed concerns about providing information to teachers in this way (The Health Committee, 2014; Ernest, 1996), particularly due to the pressures that they are already experiencing to reach academic targets. Due to the financial restrictions to public services throughout the country, I thought that it would be advisable for schools and teachers to be aware, and make use, of the MH resources which are available to them. However, there was no evidence to indicate that PSTs were currently aware of, or using, this information and support. Therefore, I decided that this area warranted further investigation.

2.1.3. Developing Teachers' Knowledge of Mental Health

As very few studies have explored professional learning for teachers around MH (e.g., Pereira et al., 2015), I decided to broaden my search to include papers which researched general approaches to teachers' professional learning. Avalos' (2011) 10-year review provided a great deal of interesting information about a range of teacher learning approaches which had been implemented to develop teachers' knowledge and skills including, reflective, collaborative and situated learning methods. Although this paper demonstrated a number of interesting findings with regards to the effectiveness of these approaches, I realised that my study was not necessarily concerned with 'what worked'. My intention was merely to gain an initial insight into the approaches that were currently being used by teachers and explore the methods which might help them to learn about MH in the future.

Furthermore, only 7 of the 111 studies in Avalos' (2011) review were British and some of them were carried out over a decade ago. Therefore, I decided to explore PSTs' current perceptions of how they might best be supported to develop their understanding of CMHIs.

2.2. Methods Used to Explore Teachers' Understanding of Child Mental Health Issues

2.2.1 The Questionnaires

I designed a questionnaire, which comprised of 17 open-ended items, in order to gather quantitative and qualitative data. The first few items on the questionnaire were constructed to collect qualitative information and were combined with the interview data during the interpretation phase. I was pleased that I had a little extra information to feed into the first aim, as this one was particularly broad. I spent quite some time exploring the possible avenues for collecting the quantitative information before deciding on an open-ended style questionnaire. These questions were constructed to allow the participants to write the resources which they felt were relevant to the items (e.g., websites, official documents, etc.). Creswell (2012) advises open-ended items for researchers who "may want to probe a little deeper and explore the main possibilities that participants might create for a question" (p.386). He also states that these types of questions are suitable for researchers who do not know all of the possible answers to the questions that they would like to ask. This confirmed to me that an open-ended questionnaire was the most suitable approach for the quantitative part of the study.

2.2.2 The Semi-structured Interviews

I was already fairly familiar with the process of collecting and analysing qualitative data, as I had carried out semi-structured interviews on a few previous occasions. I decided that semi-structured interviews would be the most appropriate method for this study for several reasons. Firstly, this approach would ensure that the questions relating to the research aims were fully explored. Secondly, the flexibility of the semi-structured interviews would allow for particular points of interest to be investigated further (Alshenqeeti, 2014). Thirdly, I thought that the unstructured interviews would be too flexible and I was aware that this type of approach was associated with a higher level of researcher bias. Finally, as I was less confident with the quantitative part of the study, I thought it best to use a familiar method for the qualitative part.

When the participants were asked about their understanding of CMHIs, they spoke about every possible emotion, both internalising and externalising, and I was concerned that there might not be any clear themes for the first research aim. Though, the 'CMHIs are isolating' theme worked very well, as PSTs spoke about children being separate, detached and withdrawn from the rest of the class. This did not necessarily mean that the children were quiet. According to the teachers, the children were just as likely to experience 'internalising' MHIs as they were to experience those which were 'externalising'. The participants shared some very interesting ideas about CMH and I thoroughly enjoyed this stage of the research process.

2.3 Contribution to Knowledge

2.3.1 Research Aim 1: PSTs' Current Understanding of Child Mental Health Issues

The findings from this study revealed a small sample of British primary school teachers' understanding of CMHIs; their awareness and previous use of MH resources and their perceptions of how they could best be support to learn about CMHIs. Although other researchers have previously studied teachers' knowledge of MH, this study provides an up-to-date insight into British primary school teachers' understanding of CMHIs. The uncertainty and confusion experienced by the participants in this sample demonstrated that they could benefit from some training around MH. This training might include information around developing social and emotional skills in the classroom, particularly in order to support the children who were described as 'withdrawn' and 'isolated'. However, further research is required to extend this finding due to the small sample of participants.

2.3.2 Research Aim 2 and 3: Primary School Teachers' Awareness and Use of Mental Health Resources

This research also showed that these PSTs were not aware of, or using, some of the available MH resources which could be used to develop their understanding of CMHIs (e.g., MindEd, Mental Health and Behaviour in Schools). They were more likely to be aware of and seek support from professional agencies such as

educational psychologists (EPs) and Child and Adolescent Mental Health Service (CAMHS) specialists than any other resource, however, some PSTs also reported using digital services (e.g., websites). Very few numbers of PSTs had used literary resources (e.g., magazines, books, articles etc.) to learn about CMH, despite reporting some awareness of them. These results provide an initial insight into PSTs' awareness and use of MH resources, however, due to the low response rate the findings cannot be reliably generalised to the wider population. Future studies could consider exploring similar areas of interest with a larger sample of participants.

2.3.3. Research Aim 4: Primary School Teachers' Perceptions of how they could best be supported to develop their Knowledge of Child Mental Health Issues

The findings show that teachers wished to spend time working alongside 'experts' to learn about MH, particularly during classroom observations. Teachers believed that this approach would be particularly helpful to learn how to recognise signs of CMHIs and understand the ways in which support could be individually tailored to meet the needs of specific children. The teachers requested support to develop a holistic view of the child before considering the best ways forward. However, like any other research study, the findings appear to raise more questions than answers. For example, are these findings specific to CMHIs or would these preferences for learning approaches be the same if the teachers were learning about other children (e.g., children with other additional learning needs)?

2.4 Limitations and Future Directions

Despite attempting to gather quantitative data via the mixed methods design, I was only able to recruit a small number of participants. Therefore, the study was smaller in scale than I had intended and the findings can, therefore, not be generalised to the PST population. The questionnaires had not been tested for reliability and validity (Creswell, 2012) and the open questions made it difficult for participants to respond. The open format also caused a few complications with regards to data analysis, as I was required to transfer the words into number data. Unfortunately, this meant that the participants' responses had to be included on a

separate sheet in the appendices. The extent of the blank spaces towards the end of the questionnaires indicated that there were some issues with the instrument that I had designed, despite the positive feedback from the pilot participants.

Future researchers could consider:
- using a questionnaire which has been tested for validity and reliability;
- designing a questionnaire with closed questions;
- extending the time period for PSTs to complete their questionnaires; and
- inviting participants to take part in the study at a different time of year.

I asked a SENCo at one of the schools whether it would have been wise for me to collect the data at a different time of year. Although I could not have changed anything by that point, I thought that this information might be helpful in the future. Executing the research during the time of year that s/he suggested (February) would have been impossible, as I would not have received consent from the ethics committee by that time. The SENCo went on to say that there was no good time of year for teachers to take part in research.

I believe that the open ended items in the questionnaires discouraged the PSTs from taking part in the study. As mentioned above, they were already under a considerable amount of pressure so it might have been easier for them to complete questionnaires which comprised of only closed questions. However, providing a list of all conceivable answers to each of the questions would have been impossible and would have restricted the responses to the resources which I believed to be useful and relevant to MH (Neuman, 2000).

Unfortunately, the data that I was able to collect was not completely reliable as both the questionnaires and semi-structured interviews were both self-report measures (Alshenqeeti, 2014). Alshenqeeti (2014) emphasises that interviewees will only share what they are willing to share with the interviewer and, therefore, might decide not to reveal their true feelings about the topic in question. On the other hand, the ethical issues had been considered with great care and all participants were fully informed of these considerations in verbal and written form. The participants were not named during the interviews and, although the

results were shared with the schools, the teachers were only referred to by number. Therefore, I hoped that the participants would feel comfortable enough to share their views openly.

2.5 Contribution to Knowledge of the Research Practitioner

I have learned a great deal during this research process, particularly with regards to my role in directing teachers to useful information. Although I was previously aware of this part of my role, I did not fully appreciate its importance. During my short time as a trainee educational psychologist, the amount of available information within my new area of work has been quite overwhelming and I have been lucky enough to have some time to reflect on it and apply it to my practice. During my time as a teacher, I did not have any time to reflect on my practice and I was not aware of the information or resources that I am aware of now. Part of my support to teachers in the future might involve condensing key documents in a similar way to a one-page profile so that they can be stored electronically and retrieved when necessary. The teachers' perceptions around effective learning approaches will also inform my forthcoming discussions with schools with regards teachers' professional development needs.

The most valuable finding from this research was the level of concern among PSTs' about feeling capable to take on their roles and tier 1 mental health staff. They appeared to experience a great deal of uncertainty and questioned their ability to support children with such issues effectively, particularly in light of limited resources and austerity. Their requests for 'hands-on', individually tailored support from professionals reflects this insecurity and, according to Vygotsky's zone of proximal development theory, demonstrates their needs a 'more capable other' for guidance. For example, the more uncomfortable the teachers feel about supporting children's mental health, the more they will need someone to support them and validate their experiences.

3. Critical Account of the Research Practitioner

3.1 Initial Reflections Around the Research Topic

My initial thoughts around this research topic stemmed from various sources. Firstly, mental health was selected as a broad research area due to my personal interest and reading around the subject. I was particularly interested in the ways in which mental health (MH) had been constructed over time and the impact of these constructions on society's responses to people with mental health issues (MHIs) (e.g., medication, abuse, exclusion etc.) (Appignanesi, 2007). This prompted me to think about how knowledge and understanding of a concept can influence individuals' responses to it (Leader, 2011). For example, I was aware that my personal interest in MH would have contributed to my level of understanding and this had, in turn, structured my responses to children with MHIs. I could not remember receiving any training in mental health during my Post Graduate Certificate in Education (PCGE) and received very little around additional learning needs in general (ALN). I was therefore interested to find out how other teachers had been informed about CMH.

Secondly, as part of my placement responsibilities, I was asked to develop and co-deliver some training events around MH for schools. I suspected this was due to the introduction of the new broad category of special educational needs (SEN), 'social emotional and mental health', in the Special Educational Needs and Disability Code of Practice (SEND) (Department for Education [DfE], 2014c). Whilst preparing for this training, I came across the DfE's 'Mental Health and Behaviour in Schools' document (2014b), which provided a framework for the training. When I referred to the document and its contents during the training, the teachers all appeared to be unfamiliar with it. As a result, I began to wonder whether this might be the case for many teachers across the UK and, if so, whether they were unaware of the support that was available to them in relation to MH.

Brown and Henderson's (2012) article about Solution Circles was another source of inspiration, due to its focus on providing practical and emotional support for teachers. Like many other ideas and materials that have been discussed during the Doctorate in Educational Psychology, this was a framework that I would have

valued during my own teaching practice. Therefore, this research topic was chosen in order to develop effective structures of support for teachers and enable them to provide the best possible MH support for children.

3.2 Ethical Issues

I was generally very pleased with this aspect of my research project. Through supervision and referral to the British Psychological Code of Research Ethics (2010), I took great care in considering the potential ethical issues at each stage of the research and was able to take the necessary steps to protect my participants. For example, at first I decided to leave two separate boxes in each staff room; one for the questionnaire envelopes and another for the interview consent forms. This initial procedure was proposed to ensure that I could collect the interview consent forms separately and leave the questionnaire box for as long as possible. However, after considering the practicalities of this decision, I realised that the teachers wishing to take part in the interview would be required to return their consent forms to the staff room and place them in a designated interview consent form box for all to see. As this would compromise their anonymity, I decided to leave only one box behind and request for the interview envelopes and questionnaire envelopes to be placed in the same box.

Participants were reminded that, as the questionnaires were completely anonymous, they would be unable to withdraw from this part of the study once they had been posted. As the research focus of 'mental health' was of a sensitive nature, I placed great emphasis on the participants' rights at the beginning of the staff meetings. These included, their rights not to participate, to decline to answer any of the questions and to withdraw from the study at any point without giving a reason. The rights were also included in the information sheets alongside the consent forms and questionnaires.

Although I am pleased that I described my research study and the ethical issues relating to it in great detail, I might have benefited from attempting to provide the same information to the participants in a more condensed form. I think this might have increased the participants level of motivation and enthusiasm to take part and, therefore, increased my return rate slightly.

3.3 Research paradigm

I sought a research paradigm that would allow me to explore the broad areas of study, 'mental health' and 'knowledge'. Ryan's (2006) discussion around post---positivist approaches confirmed that these types of approach would allow me to obtain an overview of the research aims according to the teachers. Attempting to observe and measure teachers' knowledge of a concept, which was so ambiguous that MH professionals struggled to define it, would have been impossible. More importantly, I felt that an in-depth exploration of teachers' perceptions of MH and their knowledge around professional development methods would be much more informative.

Ryan's (2006) chapter also encouraged me to reflect on my own beliefs as a researcher and their potential impact on the research process. For example, I recognised that my own experiences as a teacher could influence my approach to the research, as I might assume that the participants' experiences were similar to my own. This risk would be particularly high during the interviews, as my opinions could be unintentionally communicated to the participants and influence their responses (Alshenqeeti, 2014). Therefore, I decided to reflect on some of my own opinions around the research area before I progressed further.

Following a great deal of reading and thought, I decided that a constructivist epistemology would be the most appropriate for this study, as this stance posits that meaning is actively and internally constructed by individuals as they adapt to the world around them (Fox, 1996). I was aiming to explore the teachers' individual, internally constructed and reconstructed understanding of MH rather than attempting to critique or alter them in any way (Guba and Lincoln, 1994).

3.4 Methodology

3.4.1 Designing the Questionnaire

The questionnaires were my first attempt at using quantitative methods. I knew from the beginning that quite an original design would be required in order to capture the participants' perceptions of the MH resources that were available to

them. Designing a questionnaire with closed-ended questions would have restricted the data collection to the resources and approaches which I thought were relevant to developing the teachers' knowledge of MH. I was concerned about the potential consequences of designing my own questionnaire with regards to reliability and validity, especially as I wished to include open-ended items. Therefore, I tried to follow Creswell's (2012) guidance on questionnaire construction as closely as possible (e.g., avoiding jargon and wordy items).

Overall, I believe that my questions were clear and fairly concise. However, in hindsight, perhaps a different order for the questions would have increased the participants' responses. For example, the first question 'What do you understand by the term 'child mental health issues'?' is quite an open and challenging question to place at the beginning of a questionnaire. The time taken to think of an appropriate response to such a question could have affected the teachers' willingness to continue with the questionnaire. This might explain some of the blank spaces towards the end of the surveys. However, using an open-ended question format was a risk regardless of the order of the questions. If I could begin the research process again, I would design a questionnaire with pre-selected answers and include a space underneath for participants to add any resources which they felt were relevant to the study.

3.4.2 The Pilot Studies

I carried out a pilot study to test the reliability of both parts of the research. The participants felt that the questionnaire was clear and the approximate completion time was accurate. However, I suspected that two of the participants' responses to the first question (e.g., 'What do you understand by the term 'child mental health issues'?) had been transferred from a website or other source. Therefore, I decided to add a caveat during the preamble of the staff meetings to request that the teachers provided their own perceptions of CMHIs.

The semi-structured interview appeared to be the most appropriate method to obtain an in-depth account of teachers' views whilst providing the necessary structure to meet the research aims (Alshenqeeti, 2014). I was relatively familiar with this method of data collection and felt confident in my ability to carry it out.

Again, the feedback from the interviews was positive, however, the non-verbal responses from one of the participants suggested otherwise. This teacher shared that she was inexperienced, particularly with regards to CMHIs and stated this clearly on a number of occasions. I wondered whether she was concerned about being unable to provide the 'right answer' to the questions. The level of discomfort appeared to increase slightly after my prompts (e.g., could you tell me any more about that please?). As a result, I decided to terminate the interview and spend some time debriefing with the teacher. I reassured her that there were no right answers to the questions I was asking and that her responses would not be revealed to anyone else. I did not make any adjustments to the questions, as they all seemed to understand what was being asked. However, I began each interview in the main study by emphasising that there were no right answers to the questions and that I was interested to hear their views and their views only. The remainder of the interviews appeared to run smoothly.

3.5 Participant Recruitment

I was able to send the first round of emails to the head teachers towards the end of May, following approval from the ethics committee. The majority of the head teachers that replied to the emails took at least one week to do so and the visits were organised according to their usual staff meetings. As a result I was quite pressed for time. I was very strict with the inclusion criteria and so, unfortunately, I had to refuse a number of kind offers from Special Educational Needs Coordinators (SENCos). This had quite an impact on my response rate, however, I am pleased that I followed the procedures to the letter.

3.6 Data Collection

3.6.1 Low Response Rate

Collecting the quantitative data from teachers during the summer term was the most challenging aspect of the research process. I was aware that there were a number of extra-curricular activities taking place around the school and the teachers all appeared to be tired. Although I was under a lot of pressure to collect as many questionnaires as possible in a restricted period of time, I did not make this known to the participants, as I did not want them to feel pressured to take part in the study.

As some of the schools requested to keep their boxes for longer than the agreed 1-2 week period I was required to travel back to the local authority on a number of occasions following the completion of my placement. Despite this, some of the boxes were empty. I could not have been more organised or motivated to make a success of this part of the study. However, my level of preparation and persistence is, regrettably, not reflected in the response rate. I did not wish to add to the pressures that the teachers were already experiencing so I decided to leave with the number of questionnaires that the schools had provided.

I considered collecting more quantitative data whilst on my third year placement. However, this placement was due to take place in Wales and the government policy that I had focused on during my literature review would not have been as relevant. Additionally, the schools in my new catchment were all very small, with some including only one main grade teacher. Therefore, if I had managed to obtain a 100% return rate in all of my schools, I could have collected between 6-10 questionnaires. Given the time that it would have taken to go through all of the ethical steps (e.g., obtaining consent from the gatekeeper, meeting with the teachers to explain the research etc.) to collect data in the new schools and the limited numbers of questionnaires that would be obtained as a result, I decided that this would not be worth the while. Adding another 6-10 questionnaires to my 31 would not have had any impact on the generalisability of the findings and I was already behind with my data analysis.

3.6.2 Face‑to‑face or electronic

A great deal of paper and time was used in order to provide participants with the necessary information, consent forms and questionnaires. Following the low response rate I began to regret distributing paper copies of the questionnaires to the schools. Whilst writing my ethics proposal, I had considered distributing the questionnaires via survey monkey, however, I decided against this approach, as I thought that face-to-face contact would have more of an impact on my response rates. This was partly due to the influence of a book that I had been reading at the time called 'The Village Effect: Why Face-to-Face Contact Matters' (Pinker, 2014). I thought that my enthusiasm for the project was more likely to be communicated

in person through a lively presentation and introduction of the research. Furthermore, I knew that the teachers would already be receiving several emails on a daily basis and I was concerned that an email from an unfamiliar researcher might not have proved successful. For future research endeavors, I might combine these two approaches by presenting the research study in person and then sending the questionnaires and other supporting documents by email.

3.7 Data Analysis

I experienced some difficulty whilst attempting to transfer the words within the questionnaires to number data. Items 3 and 4 instructed the participants to provide details of any training that they had received from their schools to develop their understanding of MHIs. I was uncertain about some of the responses such as 'bereavement training' and 'attachment training' with regards to their relevance to MH. I attempted to organise the responses into two columns (relevant and irrelevant), however, following supervision I realised that this approach went against the epistemological stance of the research and would have biased the results. Alternatively, I decided to include the detail of the participants' interesting responses in the appendices. A new column was added to the questionnaire response table (training which may have relevance).

The Thematic Analysis was extremely time consuming however I thoroughly enjoyed this part of the process. I began transcribing the recordings as soon as the two-week period following the interviews had come to an end. During the initial coding phase, I noticed myself being drawn in by various interesting ideas before realising that they did not correspond with my research aims. For example, some teachers spoke about the difficulties they sometimes face whilst supporting the mental health of children from different cultures, due the parents' reluctance to discuss such issues. Although this information was considered interesting and important within the area of mental health promotion and intervention in schools, it did not answer the questions which I had set out to ask. Therefore, this information was not included in the interpretation phase. Great care and patience was required to ensure that my coding was accurate and relevant to the study.

The concept of 'mental health' was such a broad area that I wondered whether it was possible to identify any themes from the data, regardless of the participants recruited and the time available to interview them. Despite this, the first draft of the thematic map was composed and a meeting was arranged with the independent coder to cross-examine our interpretations. I was delighted to find that, despite the slightly different language used to describe the themes and the procedures used to reveal them, our thematic maps were very similar indeed. This part of the process was extremely beneficial for both of us, as it provided us with the reassurance that we needed to be confident about our findings. We met on one more occasion to refine the details (e.g., theme names etc.).

3.8 Summary

Initially, I was quite daunted by the prospect of this research process. However, I have learned a great deal from the opportunity and I would like to continue to develop my skills in the future. I believe that I have acquired a good understanding of the strengths and limitations of various approaches and feel fairly confident in my ability to critically analyse the methodology in other research studies.

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Primary School Teachers and Child Mental Health Issues: Developing

Knowledge and Understanding

School address

……………………………...

…………………………..

…………………….

……………. Date:

Dear ……

I am a trainee educational psychologist (TEP) on the Doctorate in Educational

Psychology (DEdPsy) Programme at Cardiff University. I am approaching

primary schools to request teachers' participation in a piece of research for my

thesis.

I am interested in carrying out a study involving both questionnaires and

interviews to explore the four key areas listed below.

1)   Primary school teachers' current understanding of child mental

health issues.

2)   The resources that primary school teachers are currently aware

of, both inside and outside school, which could be used to develop their

understanding of child mental health issues.

3)   The resources that primary school teachers are currently using, both inside and outside school, to develop their understanding of child mental health issues.

4)   Primary school teachers' perceptions of how they can be supported to develop their knowledge of child mental health issues in a meaningful way.

The first part of this research will include a questionnaire which has been constructed to explore primary teachers' understanding of child mental health issues and their awareness and use of various resources that are in place to support them to develop this knowledge. The second part of the research will include an interview which has been designed to collect detailed information about primary school teachers' current understanding of child mental health and their perceptions of how they could be supported to develop their knowledge in a meaningful way. I am writing to enquire whether you would be willing for me to visit your school to collect data for my research project.

 With your permission, I would like to meet with the teachers during a staff meeting to fully inform them about the purpose of the research and the ethical procedures relating to it. Two blank envelopes, detailed information sheets, consent forms and questionnaires will be distributed for all participants to read carefully, to consider their participation and to ask any questions they might have. The teachers will be reminded of their right not to participate, to decline to answer any of the questions and to withdraw from the study without giving a reason. They will also be reminded that, as the consent forms and questionnaires are completely

anonymous, it will be impossible to withdraw from the first part of the study once their consent forms and questionnaires have been returned. Participants will be encouraged to complete their consent forms and questionnaires independently to ensure anonymity. They will be asked to enclose their consent forms and questionnaires into the blank envelope and seal it before placing it in the post box in the staff room. A pack of debriefing sheets for the questionnaire participants will be placed next to the box. I will attach a large sign to the front of the box to remind the teachers to collect a debriefing sheet each. I would like to arrange a convenient date with you to collect the box from your school between 1-2 weeks after the data collection date.

Once the box has been collected, I will contact 2-3 teachers from each school who gave their consent to participate in the interviews to arrange a convenient time and place to meet them. I will return to your school at the arranged times to carry out the interviews in a private and quiet space.

Prior to the interview, I will remind the participants of the purpose of the interview, their right not to participate, to decline to answer any questions, to withdraw from the study without giving a reason and to ask for their data to be deleted at any stage up until it is transcribed and anonymised two weeks after the interview. I will ask the questions one by one and use some available prompts if necessary. All teachers will receive debriefing sheets at the end of their interviews. The participants will not be referred to by name during the interviews and the recordings will be held confidentially and securely on my password-protected computer. The information from the interviews will be transcribed exactly two weeks

after the interviews and saved securely on the same computer. The recordings will be permanently destroyed once the data has been typed up. An independent researcher will be recruited to cross-examine my strategies and interpretations of the data. We will be the only people able to access the transcriptions.

The anonymised information from both parts of the study will be included in a Thesis written as part of the DEdPsy Programme. I will look for patterns in the in-depth data collected from questions 1 and 2 of the questionnaire. An appropriate statistical method will be used to obtain descriptive statistics for the remainder of the participants' responses. The in-depth data from the interviews will represent the student researcher's analysis of the entire set of data and only brief anonymous illustrative quotes will be included. It will be impossible to relate any information gathered from the questionnaires to the interviews. All participants will be reminded via the information sheet that a summary of the results outlined in the report will be shared with them and the school. The anonymised transcriptions will be retained indefinitely by Cardiff University.

I will be closely supervised throughout this process by Gillian Rhydderch, the Academic Director of the DEdPsy Programme at Cardiff University.
Ethical approval for this research has been received from the School Research Ethics Committee. Any complaints can be made to the School Research Ethics Committee or Dr S. Claridge, Research Director of the DEdPsy Programme at Cardiff University. Their contact details can be found below.

Many thanks in advance for your consideration of this project. Participants can contact the research supervisor or myself if further information is required. My contact details and those of my research supervisor are included below.

Kind regards,

Catrin Harrap Student

Researcher

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Information Sheet

Primary School teachers and Child Mental Health Issues: Developing

Knowledge and Understanding

You are being invited to take part in a research project. Before you decide

whether or not to participate it is important for you to understand why the

research is being carried out and what it will involve. Please take time to read

the following information carefully and feel free to ask me any questions.

What is the purpose of the study?

I am interested in carrying out a study involving both questionnaires and

interviews to explore the four key areas listed below.

1)   Primary school teachers' current understanding of child

mental health issues.

2)   The resources that primary school teachers are currently aware

of, both inside and outside school, which could be used to develop their

understanding of child mental health issues.

3)   The resources that primary school teachers are currently

using, both inside and outside school, to develop their understanding of child

mental health issues.

4)   Primary school teachers' perceptions of how they can be

supported to develop their knowledge of child mental health issues in a

meaningful way. The first part of this research will include a questionnaire which

has been constructed to explore your understanding of child mental health issues

and your awareness and use of various resources that are in place to support teachers to develop their understanding. The second part of this research will include an interview which has been designed to collect detailed information about your current understanding of child mental health and your perceptions of how you could be supported to develop this knowledge in a meaningful way.

Who are the researchers?

My name is Catrin Harrap and I will be the primary student researcher for this project. An independent researcher will be recruited to cross-examine my strategies and interpretations of the data. This study is part of my Doctorate in Educational and Child Psychology and Gillian Rhydderch, the Academic Director of the course at Cardiff University, is my supervisor for this research. The research has been approved by the School of Psychology Ethics Committee at Cardiff University.

Why have I been chosen?

I am inviting main grade primary school teachers to participate in this study, as they have been identified as best placed to recognise and support children with mental health difficulties (D for E, 2014). Furthermore, the British Household Panel and Understanding Society Survey (2011-2012) found that the peak onset of mental health difficulties could be as early as 8 years of age. It is therefore important to explore your understanding of child mental health issues, your current awareness and use of resources in place to support and develop your knowledge of child mental health issues

and your perceptions of how you could be supported to develop this knowledge further in a meaningful way.

What do I have to do?

Once you have read this information sheet and had time to ask any questions, I will invite you to participate in the first part of the study (the questionnaire). The consent form, which will be attached to the front of the questionnaire, will remind you of your right not to participate, to decline to answer any of the questions and to withdraw from either or both parts of the study without giving a reason. Please take both documents away with you and consider carefully whether you would like to participate. If you are happy to take part, you will be required to tick the appropriate boxes on the consent form and complete the questionnaire within one week from today. The questionnaires should take no more than 20 minutes of your time. Please use the blank envelope provided to enclose the completed questionnaire and consent forms and return it anonymously to the post box in the staff room. As all questionnaires will be anonymous, it will be impossible to trace your questionnaire back to you once you have handed it in. Therefore, once your questionnaire has been returned, you will be unable to withdraw from this part of the research. A pack of debriefing sheets will be placed next to the questionnaire box, which will include further information about the project and some sources of support. Please remember to take one!

If you would like to take part in the second part of this project, please fill in the interview consent form and seal it in the other blank envelope. Once I have collected the box at the end of the one-week period, I may contact

you to arrange a convenient time and place for an interview. I will only need to interview 2-3 participants from each school. Prior to the interview, I will remind you of the purpose of the interview, your right to decline to answer any questions, to withdraw from the study without giving a reason and to ask for your data to be deleted at any stage up until it is transcribed and anonymised two weeks after the interview. I will ask the questions

one by one and use some prompts if necessary. The interviews will take around 45 minutes of your time either during or after school hours. You will receive a debriefing sheet at the end of the interview.

What will happen to the information that I give?

I will look for patterns in the in-depth data collected from questions 1, 2 and 14-17 of the questionnaire. An appropriate statistical method will be used to obtain descriptive statistics for the remainder of the responses. All interviews will be recorded on my password-protected computer. I will begin to transcribe the data exactly two weeks after the interviews and you will be reminded of the timescale for making any request for your data to be removed from the analysis. The transcribed information will be saved securely on the same computer. I will look for patterns in the in-depth data collected from the interviews. I will be the only person able to access the transcriptions and the recordings will be permanently destroyed once the data has been typed up. The anonymised transcriptions will be retained indefinitely by Cardiff University. The anonymised information from both parts of the study will be included in the thesis written as part of the DEdPsy Programme. The report will

represent my analysis of the entire set of data and a summary report will be shared with the school following completion.

Will my taking part be confidential?

During both the questionnaire and the interviews, you can give as much or as little information as you wish. Nobody involved in the study will be named or identifiable in any way in the thesis or the summary report. It will be impossible to relate any information gathered from the questionnaire to the interviews.

Consent

If you are happy to take part in this research please read the consent forms carefully before completing either or both of them. Please enclose the completed form/s in the blank envelope provided. If you provide consent to take part in the interviews, I may contact you within two weeks' time.

Contact Information

If you would like further information about the study or have any questions at all please do not hesitate to contact me at the following:

Catrin Harrap

Telephone: 02920847007 Email:

harrapce@cardiff.ac.uk

If you have any complaints about the research please contact the School Research Ethics Committee (SREC) or Dr. S Claridge at Cardiff University using the details below.

School Research Ethics Committee: psychethics@cf.ac.uk Dr S. Claridge: 02920874007

Consent Form for the Questionnaire

Primary School teachers and Child Mental Health Issues: Developing

Knowledge and Understanding

Please tick the boxes below to demonstrate your understanding of what is being

requested and your consent to participate in this research.

I understand that my participation in this project will involve completing a

questionnaire that will investigate my understanding of child mental health

issues and how I am currently informed about these issues.

I understand that I am free to ask any questions at any time and discuss my

concerns with Catrin Harrap (student researcher) or Gillian Rhydderch

(Research Supervisor and Academic Director of the DEdPsy Programme).

I understand that participation in this project is entirely voluntary and that

I have the right not to participate, to decline to answer any questions or

withdraw from the study without giving a reason.

I understand that once the questionnaire has been handed in I will be

unable to withdraw from this part of the research, as it will be impossible to

trace the information back to me individually.

I understand that the information provided by me via the questionnaire will

be collected and combined with other teachers' data and presented using

descriptive statistics.

I understand that the Thesis will be submitted as part of the DEdPsy Programme

and a summary report will be shared with my school.

I understand that I will be provided with additional information about the

project and some sources of further information.

I confirm that I have read the information sheet for the above project. I have

had the opportunity to consider the information and ask questions and I have

had these answered satisfactorily.

I agree to the points above and consent to participate in the research

conducted by Catrin Harrap, DEdPsy student researcher in the School of

Psychology, Cardiff University with the supervision of Gillian Rhydderch

Consent Form for the Interview

Primary School teachers and Child Mental Health Issues: Developing

Knowledge and Understanding

- I understand that my participation in this project will involve taking part in a 45-minute interview to share my understanding of child mental health issues and the approaches I might consider to become more informed about them.

- I understand that I am free to ask any questions at any time and discuss my concerns with Catrin Harrap (student researcher) or Gillian Rhydderch (Research Supervisor and Academic Director of the DEdPsyProgramme).

- I understand that participation in this project is entirely voluntary and that I have the right not to participate, to decline to answer any questions or withdraw from the interview without giving a reason.

- I understand that the information provided by me will be recorded and stored securely and confidentially until it is transcribed and anonymised.

- I understand that I have two weeks after the date of the interview in which to ask for my data to be deleted before it is transcribed and anonymised.

- I understand that once the data has been transcribed it will be impossible to trace the information back to me individually.

- I understand that the anonymised information from the interviews will be used to derive themes, based on the researcher's analysis of the entire set of data, and will be included in a thesis.

- I understand that the report will be submitted as part of the DEdPsy Programme and a summary of the report will be shared with me and my school.

- I understand that at the end of the interview I will be provided with additional information about the project and some sources of support.

- I confirm that I have read the information sheet for the above research. I have had the opportunity to consider the information and ask questions and I have had these answered satisfactorily.

- I,＿＿＿＿＿＿＿＿(NAME) agree to the points above and consent to participate in the study conducted by Catrin Harrap, DEdPsy student researcher in the School of Psychology, Cardiff University with the supervision of Gillian Rhydderch.

  Please leave some contact details here so that we can arrange a convenient time and place for your interview:

  ＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

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Contact Information

If you would like further information about the study or have any questions at all

please do not hesitate to contact me at the following:

Catrin Harrap

Telephone: 02920847007 Email:

harrapce@cardiff.ac.uk

If you have any complaints about the research please contact the School Research

Ethics Committee (SREC) or Dr. S Claridge at Cardiff University using the details

below.

School Research Ethics Committee email address: psychethics@cf.ac.uk Dr

S. Claridge: 02920874007

Signed: _____

Date: _____

Questionnaire

Primary School teachers and Child Mental Health Issues: Developing

Knowledge and Understanding

This questionnaire has been designed to answer the key points below.

1)   Primary school teachers' current understanding of child

mental health issues.

2)   The resources that primary school teachers are currently aware

of, both inside and outside school, which could be used to develop their

understanding of child mental health issues.

3)   The resources that primary school teachers are currently

using, both inside and outside school, to develop their understanding of child

mental health issues.

4)   Primary school teachers' perceptions of how they can be

supported to develop their knowledge of child mental health issues in a

meaningful way.

This questionnaire is completely anonymous so nobody will be able to trace

your responses back to you individually. Please remember that you have the

right to decline to answer any of the questions and withdraw from the study

without giving a reason. However, due to the anonymity of the questionnaire, it

will be impossible for you to withdraw from this part of the study once you have

handed in your questionnaire. Please ensure that you answer each question as

honestly as possible. This research does not link in any way to evaluation of

performance or appraisal. Please read each request carefully and list your

responses below.

Child Mental Health Definition

"Children and adolescents with good mental health are able to achieve and maintain optimal psychological and social functioning and well---being. They have a sense of identity and self---worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth."

(Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans, World Health Organisation, 2005, p.2)

1. What do you understand by the term 'child mental health issues'?

    _____

    _____

    _____

    _____

    _____

    _____

    _____

2. Please list some thoughts/feelings/behaviours that might be experienced by a child with mental health issues.

    _____

    _____

    _____

    _____

    _____

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_____

_____

3. Please list below any training that you have received from your school about child mental health issues.

_____

_____

_____

_____

_____

_____

4. Please list below any training that you have received from outside of your school about child mental health issues.

_____

_____

_____

_____

_____

_____

5. Please list below any official documents (e.g. government papers) that you are aware of which could inform your understanding of child mental health issues. Please asterisk the documents that you have read.

_____

_____

_____

_____

6. Please list below any research papers that you are aware of which could inform your understanding of child mental health issues. Please asterisk the papers that you have read.

_____

_____

_____

_____

7. Please list below any websites that you are aware of which could inform your understanding of child mental health issues. Please asterisk the websites that you have explored.

_____

_____

_____

8. Please list below any magazines that you are aware of which could inform your understanding of child mental health issues. Please asterisk the magazines that you have read.

_____

_____

9. Please list below any newspapers that you are aware ofwhich could inform your understanding of child mental health issues. Please asterisk the newspapers that you have read.

_____

_____

_____

_____

10. Please list below any TV programmes that you are aware of which could inform your understanding of child mental health issues. Please asterisk the programmes that you have watched.

_____

_____

_____

_____

11. Please list below any local professional agencies that you are aware of which could inform your understanding of child mental health issues. Please asterisk the ones that you have been directly involved with.

_____

_____

_____

_____

12. Please list below any local voluntary agencies that you are aware of which could inform your understanding of child mental health issues. Please asterisk the ones that you have been directly involved with.

_____

_____

_____

_____

13. Please list below any other approaches that you have explored to inform your understanding of child mental health issues.

_____

_____

_____

_____

14. Which approaches have been most useful?

_____

_____

_____

_____

15. Which approaches have been least useful?

_____

_____

_____

_____

16. Which approaches would you like to explore more often?

_____

_____

_____

_____

17. What prevents you from using these approaches more often?

_____

_____

_____

_____

Thank you very much for taking time to participate in this part of the study!

Please remember to enclose your completed consent form and questionnaire in the blank envelope provided before placing it in the post box located in the staff room. Please also remember to take a debriefing sheet with you!

Appendix 6

Semi‑Structured Interview

Primary School teachers and Child Mental Health Issues: Developing

Knowledge and Understanding

Thank you so much for making time to take part in this interview today. If you

completed the questionnaire, there will be no link between your questionnaire

responses and your responses to the interview questions as the questionnaires

are completely anonymous. These questions have been devised to gather in-depth

information about your current understanding of child mental health issues. They

have also been designed to explore your thoughts on how you can be supported

to develop knowledge about child mental health further in a meaningful way.

The recordings of all interviews will be held confidentially and securely on my

password-protected computer. Please remember that you have the right to

decline to answer any questions, to withdraw from the interview without giving a

reason and to ask for data to be deleted at any stage up until the data is

transcribed and anonymised. I will begin to transcribe the data in exactly two

weeks' time so that you can have plenty of time to change your mind if you wish.

The transcribed information will be saved securely on my password-protected

computer. The independent researcher, recruited to cross-examine the strategies

and interpretations of the data, will be the only other person, apart from myself,

who able to access the transcriptions and the recordings will be permanently

destroyed once the data has been typed up. The anonymised information

from the interviews will be analysed and the analysis included in the Thesis written as part of the DEdPsy Programme. It will not be possible to identify any individual from the thesis. The analysis will represent my interpretation of the entire set of data and only short illustrative quotes from participants will be included, anonymously. A summary report will be shared with each participant and the school following completion. The anonymised transcriptions will be retained indefinitely at Cardiff University.

Do you have any questions before we start?

Child Mental Health Definition

"Children and adolescents with good mental health are able to achieve and maintain optimal psychological and social functioning and well-being.

They have a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth."

(Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans, World Health Organisation, 2005, p.2)

1. What is your current understanding of child mental health issues?

   ---   What impact might mental health issues have on the child?

   ---   What impact might mental health issues have on your class?

   ---   What impact might mental health issues have on your school as a whole?

2. What has informed your understanding of child mental health issues?

---   Have you received any formal training?

---   Have you learned through informal experiences?

3. What approaches have been used during these training sessions to support you to develop your understanding of child mental health issues?

4. How could primary school teachers be supported to learn about child mental health issues in a meaningful way?

---   Can you tell me any more about that?

---   Why do you think that would be a useful approach for teachers?

--- Who might be well placed to support primary teachers to learn about child mental health issues?

Thank you very much for your time!

Debrief Sheet for the Questionnaires

Thank you so much for making time to take part in this study. I am very grateful for your help, as I know you must be very busy. I hope that you have found it interesting! Please feel free to ask me any questions you have about what happened today. You can either do this in person or by contacting me on another day using the details provided on the left-hand side of this page.

What was the purpose of this study?

I was interested in exploring teachers' understanding of child mental health issues and their perceptions of how they could be supported to develop this knowledge. This part of the study consisted of a questionnaire which was used to investigate your current understanding of child mental health issues and the resources that you are currently aware of and using to learn about child mental health issues.

If you have any questions after today, please contact the university reception using the number below and ask them to email me.

02920874007

If you are dissatisfied after discussing your concerns, please contact the School of Ethics Committee directly using the email address below.

psychethics@cf.ac.uk

What will happen to the information that I have provided?

The information from the questionnaires will be collected and combined with other primary school teachers' data and presented using thematic analysis and descriptive statistics. Once the information has been collected the questionnaires will be destroyed. The anonymised information from both parts of the study will be included in a report written as part of the DEdPsy Programme. The thematic analysis in the report will represent my analysis of the entire set of data and a summary report will be shared with the school following completion.

Why is this research important?

In Britain it is estimated that around 8% of children aged 5 – 10 years are diagnosed with a mental health disorder (Green et al., 2005).

Early identification and intervention is progressively recognised as an effective approach to improve many social problems (Allen, 2011).

There is increasing interest in the ways in which teachers and schools can respond to child mental health difficulties (DfE, 2014).

It is important to explore what teachers already know about child mental health and the resources available to help them before plans can be put in place to support them to develop their knowledge.

<p style="text-align: center;">Appendix 8</p>

<p style="text-align: center;">Debriefing Sheet for the Semi-structured Interviews</p>

Thank you so much for making time to take part in this study. I am very grateful for your help, as I know you must be very busy. I hope that you have found it interesting! Please feel free to ask me any questions you have about what happened today. You can either do this in person or by contacting me on another day using the details provided on the left-hand side of this page.

What was the purpose of this study?

This part of the study consisted of an interview which was used to collect rich detailed information about your current understanding of child mental health and your perceptions about how you could be supported to develop your knowledge further.

If you have any questions after today, please contact the university reception using the number below and ask them to email me.

<div style="text-align: right;">02920874007</div>

If you are dissatisfied after discussing your concerns, please contact the School of Ethics Committee directly using the email address below.
psychethics@cf.ac.uk

What will happen to the information that I have provided?

All interviews will be recorded and stored on my password-protected computer. I will begin to transcribe the data exactly two weeks after the interviews and you will be reminded of the timescale for making any request for your data to be removed from the analysis. The transcribed information will be saved securely on a password-protected computer. The transcriptions and the recordings will be permanently destroyed once the data has been typed up. The anonymised transcriptions will be retained indefinitely and stored in a locked cupboard. The anonymised information from both parts of the study will be included in the report written as part of the DEdPsy Programme. The thematic analysis in the

report will represent my analysis of the entire set of data and a summary report will be shared with the school following completion.

Why is this research important?

In Britain it is estimated that around 8% of children aged 5 – 10 years are diagnosed with a mental health disorder (Green et al., 2005).

Early identification and intervention is progressively recognised as an effective approach to improve many social problems (Allen, 2011).

There is increasing interest in the ways in which teachers and schools can respond to child mental health difficulties (DfE, 2014).

It is important to explore what teachers already know about child mental health and the resources available to help them develop their knowledge before plans can be put in place to support them.

Questionnaire Responses: Item 3-12

Item 3: Training received in schools about CMHIs

Yes	Yes (General SEN)	No relevant training
Mental health training	Thrive Special educational needs, Attention deficit hyperactivity disorder Attachment issues	None N/A Left blank

Item 4: Training received outside schools about CMHIs

Yes	Yes (General SEN)	No relevant training
Mental health training (e.g. university courses, placement in mental health unit)	Attachment issues Bereavement Special educational needs Behaviour management Emotional and behavioural difficulties Child protection	None N/A, Left blank

Item 5a: Official documents that PSTs were aware of

Official documents	No relevant official documents
Special Educational Needs and Disability Code of Practice Child Protection Act Every Child Matters Keeping Children Safe in Education	None Left blank N/A

Item 6a: Research papers that PSTs were aware of

Research papers	No relevant research papers
	None N/A Left blank

Item 6b: Research papers that PSTs had read (same as above)

Item 7a: Websites that PSTs were aware of

Websites	No relevant websites
NHS CAMHS ASD support Mind ChildLine Samaritans Time to Change Barnardos NSPCC Winston's Wish Local provider (confidential) Young Minds	None N/A Left blank

Item 7b: Websites that PSTs had explored

Websites	No relevant websites
NHS ChildLine Time to Change NSPCC Winston's Wish Local provider (confidential) Young Minds	None N/A Left blank

Item 8a: Magazines that PSTs were aware of

Magazines	No relevant magazines
Times Educational Supplement (TES) Association of Teachers and Lecturers (ATL) National Association of Schoolmasters Union of Women Teachers (NASUWT) Psychology Today Primary Resources	None Left blank N/A

Item 8b: Magazines that PSTs had read

Magazines	No relevant magazines
Psychology Today	None N/A Left blank

Item 9a: Newspapers that PSTs were aware of

Newspapers	No relevant newspapers
The Guardian Times Educational Supplement (TES)	None N/A Left blank

Item 9b: Newspapers that PSTs had read

Newspapers	No relevant newspapers
The Guardian	None N/A Left blank

Item: 10a: TV programmes that PSTs were aware of

TV programmes	No relevant TV programmes
The Unteachables Too Tough to Teach Child of our Time Born Naughty My Angry Child Channel 4 News Crimes That Shook Britain Tourettes	None Left blank N/A

Item 10b: TV programmes that PSTs had watched

TV programmes	No relevant TV programmes
The Unteachables Too Tough to Teach Child of our Time My Angry Child Channel 4 News Crimes that Shook Britain Tourettes	None N/A Left blank

Item 11a: Professional agencies that PSTs were aware of

Professional agencies	No relevant professional agencies
CAMHS EPS Behaviour Support NHS Be Safe Social Services Council Counselling Services Local agency (confidential) GP Family Support	None N/A Left blank

Item 11b: Professional agencies that PSTs had been directly involved with

Professional agencies	No relevant professional agencies
CAMHS EPS NHS Be Safe Catchpoint Social Services Counselling Services Local agency (confidential) GP Family Support	None N/A Left blank

Item 12a: Voluntary agencies that PSTs were aware of

Voluntary agencies	No relevant voluntary agencies
Mind ChildLine Samaritans NSPCC Mencap Barnardos	None N/A Left blank

Item 12b: Voluntary agencies that PSTs had been directly involved with

Voluntary agencies	No relevant voluntary agencies
	None N/A Left blank

Participant 1

Student researcher (SR): Ok, so, um, what is your current understanding of child mental health issues?

Participant (P): Um…just that…um, a child who has mental health issues could be a child who's, um, come from a background where something's happened that's affected…affected them or perhaps been…come down from a parent 'cause it can be hereditary I think, can't it, mental health? But, um, but I don't really know very much more than that. I didn't…I don't know how much because of development and brain development…I don't know how much a child could be affected by mental health…how much they… I don't know very much at all I'm afraid. ①

SR: Ok, that's great. What impact do you think, um, mental health issues might have on a child?

P: Um, I think it could impact their confidence, their ability to mix with other children, ② their educational ethic and, you know, any of their levels or anything like that because of their ability to concentrate and focus, um, their own, you know, how they feel ② amongst the other children, their own, you know…… ②

SR: Yeah, that's great. Um, what about the impact mental health issues might have on the class as a whole?

P: Um, I think depending on, sort of, how severe they were I think it could have quite a big impact with especially friendship groups and things like that on how the child will ② interact with other children which could have quite an impact on the class and on the ② learning in general, so……

SR: Anything else? Any other impact that it might have on the class?

P: Um………I'm not sure.

SR: That's great, thank you. Um, what impact might mental health issues have on your school as a whole, do you think?

P: I think if...if there are children throughout the school and we don't know how to manage and we don't know how to support the children, I think it could have quite a big impact because I think just, you know, like we were saying just in the class there is definitely going to be learning implications there. I think also siblings and, you know, other relationships within the school, I think it would be quite hard if there is an issue and we don't know how to fix or support the issue then there could be quite a big impact.

SR: And what would the impact be do you think? What would happen?

P: Breakdown of, um, sort of, communication between children and staff members, um, learning implications.

SR: Yeah, that's great, thank you. Um...what has informed your understanding of child mental health issues?

P: Um, I think the only thing, 'cause I've not had any training, um, but I obviously...I have friends that have had mental health issues and, you know, there are certain behaviours that you could...you can spot perhaps in somebody and think, 'well that's similar to that', 'could that be connected?' or 'could that be an issue?', 'could that be something that's similar to something that's happening in their lives to, you know, somebody else I might know?' but it's only presumed, it's not...it's not factual, I don't know anything, it's just information that I think, well, you know, put two and two together and could that be something that's....that's happening? I don't know, could that...could mental health be affecting...affecting the child? But again, it's just...it's just presumed, I don't know.

SR: Yeah...ok...so you're kind of informed by your friends' experiences?

P: Yeah, through my own experience and just through friends that have had mental health problems and things that I've seen, sort of, in my own life experiences, yeah.

SR: Yeah. That's good. So you haven't received any formal training, um, and you've learned through your own experiences.

P: Yeah.

SR: Yeah. So....I was going to ask what kind of approaches might have been used in the training sessions you'd attended but....

P: Yeah 'cause we didn't have any. I qualified two years ago, um, and I did a PGCE so it was a yearlong course and there was nothing at all in the whole PGCE about mental health. Nothing. We had, um, we had lots of stuff about...well, maybe not lots of stuff...we had the bare minimum about children with special educational needs but mental health wasn't covered at all. There's a lot to learn but I think in reflection to my own course, I think that some things could have been...you could have been given more experience with some things than you did.

SR: Ok. So, how could primary school teachers be supported to learn about child mental health issues in a meaningful way?

P: I think anybody that could come in and explain behaviours noticed, like, in the children and approaches to help the children would be really helpful. So I think somebody coming in to talk to you because we get a lot of things sent through email about dyslexia or whatever and it's a very difficult schedule that we have, it's very difficult to make time to sit down and read through something and then actually apply it to what you're doing but actually having somebody coming in, even if it was for an hour, and just explain, you know, what they know, what to look out for and how to approach it would be very helpful I think...

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SR: Ok so...is there...if you were given, say, an opportunity to learn about child mental health, how do you feel you learn best?

P: I'm quite a visual learner. I learn visually. I...practical so...doing and experiencing it really. That's how I learn best.

SR: Ok, so maybe something a bit more practical as well might be...

P: Yeah. Yeah. But even something, like doing, you know, if somebody came in and said, uh, "This is...this is what we know, this is...these are the things to be looking out for" then you could always be, like, "Well hold on a minute, I've got a child that ticks that box and that box and that box", you know, and would come up and then perhaps an observation or something with somebody to support you, to say, "Right ok, well, they're showing signs of..." But then I suppose it's difficult 'cause you can't really delve into family history and stuff too much because of...you're not really allowed are you?

SR: Um...we can always have a chat about that after the interview if you like. So you think that an observation...an observation as in....what kind of observation do you mean?

P: Perhaps somebody, um, observing the child in class and seeing if they agree with what...'cause I think sometimes it's easy to...if you know a child very well, as you do when you teach them every day, it's sometimes...it's quite nice to have somebody come in from an outside perspective and...because the other thing I would worry about with mental health issues as well...'cause it is such a, sort of, a glossy...it's glossed over really isn't it, mental health, in general I think and it's a bit of a foggy area so I think it could be quite easy to label incorrectly, label children incorrectly and I think to have somebody come in from an outside perspective that doesn't know the child and just say, "Actually, yeah, do you know what that is highlighting? That's a worry. That's something we need to address", that would be quite helpful I think.

SR: Yeah. I think I know what you mean by 'glossed over' and 'foggy' but could you please tell me a little more about that?

P: It's a grey area I think isn't it.

SR: So it's....

P: It's......unclear. Yeah. 'Cause I know, like, I know from friends that I've had with mental health issues is that it...it's almost a taboo subject, mental health, and it's...depending on how you've been brought up and what your beliefs are, you know, is it, you just need to get on with it and get a grip or is there an actual, you know, medical illness that needs to be, you know, where's that line? But I think, you know, I teach year one so my children are very little but, I mean, I don't really know when it's something, I don't know, when would mental health be...like what age do they start to...? I suppose...I suppose even from when they are tiny, you know, they can develop mental health issues but I know that I've got a child in my class at the moment who has had a very tough up-.... like, start to life and I'm certain that he would have mental health issues already. He's only, um, he's only five so...and when you don't know...you know, when you don't know what to do or you don't know what's helpful, it's quite difficult to...to feel like you're doing anything I suppose.

SR: Mhm. Ok. Um, the way that you said about primary school teachers being able to learn in a meaningful way, um, so with an observation, with support from somebody else from outside the school, why do you think that would be useful for teachers? Why do you think that would be a good approach for them to learn about child mental health?

P: Um, because it would just give you some knowledge that you didn't have. I think that would be, um, I just think that...for me that... that's how I learn things the best and I know that if I know if somebody who comes in who's got experience and is knowledgeable in a subject then I would listen to them rather than, sort of, reading things and thinking, 'Oh, that could be right', like, somebody could say, "Actually this is

something and this is what you do about it", that would be more helpful than just reading something that, you know, you don't really know...so...that's true.

SR: Um, so, who might be well placed to support you to learn about child mental health issues, do you think?

P: Um, a mental health specialist. Somebody who's trained and has understanding of mental health issues I think.

SR: Yeah? Anybody else?

P: Um, perhaps the parents as well. Maybe doctors, I don't know, just...professionals...

SR: Has there been anything else that's informed your understanding of child mental health issues? Anything at all?

P: Um probably things that I've watched actually. I...not necessarily about children but about mental health. I don't think I've watched anything specifically about child mental health. Not that I can remember anyway. Um...and...I suppose just conversations that you have with other teachers and observations that you make but, yeah, nothing specifically I think has informed me it's just bits and pieces I've picked up along the way and I don't know if they're right or wrong.

SR: Mm. Would you know where to look if you wanted to find out more about it?

P: I think my first port would be to go to my SENCo because she would be the person who would have access, I suppose, to any information and if I hadn't had any luck there I'd just be researching it myself with, you know, sort of, Internet. But again, it's like I say, it's having time because in my...in my two years of teaching I've learnt very quickly that there, there's a, you know, there's a pressure on you to do a job and to get these children where you need to get them and then there's a list, almost a prioritised list of what comes first and that would probably not be on the top of the

list unfortunately, depending on the child obviously. But it's just finding the time... finding the time to sit down and read something and...because, also, from studying, aside from doing a PGCE, I think reading anything on the Internet or in books can sometimes take quite a long time to digest it 'cause you're not familiar with the language, you know, it takes time to, you know, really understand what you're reading so I think that would make things hard as well, like, 'I'm gonna have to sit down and have a look at that'. It's very nice, I think, to, like, you know, ideally say, "Well yes, you know, I could do that or I could do that" but if I would do it honestly...it... finding the time would be a...it would be my own time that I would need to use to find out more information.

SR: Ok. Yeah. That's it. Is there anything else that you would like to say that I haven't asked about?

P: No, I don't think so.....I think that's everything. Thank you.

SR: No, thank you. Thank you very much.