A PROPOSED MODEL FOR PREDICTING THE WILLINGNESS OF MAINSTREAM SECONDARY TEACHERS TO SUPPORT THE MENTAL HEALTH NEEDS OF PUPILS.

by

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A Thesis Submitted to Cardiff University's School of Psychology

in Partial Fulfilment of the

Requirements for the degree of

DOCTOR OF EDUCATIONAL PSYCHOLOGY

Cardiff University School of Psychology,
Cardiff
June, 2012

ABSTRACT

Recent research has suggested that ten percent of school aged children and young people within the UK experience a clinically diagnosable mental health problem (Green et al., 2005). Schools, teachers and educational psychology services are increasingly required to help with the prevention, early recognition and management of mental health difficulties. In particular, teachers have been identified as important supporters of pupil mental health needs as tier one mental health workers and providers of universal mental health services (DfCSF & DH, 2008; Ofsted, 2005). However, a comprehensive review of both government and academic literature indicated that the feasibility of this expectation is largely unexplored, particularly within the UK context. Therefore, this thesis sought to investigate the perspectives of mainstream secondary school teachers regarding pupil mental health needs in order to develop a predictive model of their willingness. The rationale for focusing on willingness was that psychological theory indicates that willingness is an important determinant of actual behaviour (e.g. Ajzen, 2005). A model was developed based upon the theory of planned behaviour (TPB), but which included other relevant elements identified within the literature. The model was tested using a questionnaire developed for the purpose of the study, which was found to have both internal reliability and validity. Teachers from 14 schools within 9 South Wales LEAs completed the questionnaire (n=217). Regression analysis provided support for the proposed model, indicating that teacher age, level of personal experience and attitude towards the role were particularly strong predictors of teacher willingness. This research has many implications in terms of developing the capacity of schools to support the mental health needs of their pupils, for example, in providing an understanding of some of the social-cognitive processes which may influence teacher willingness. Additionally, the research has identified an important role for educational psychologists in terms of supporting schools to develop teacher willingness, for example, through tailored training.

ACKNOWLEDGMENTS

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ABBREVIATIONS

ADHD.. Attention Deficit Hyper-Activity Disorder
ASD.. Autistic Spectrum Disorder
BMA... British Medical Association
CAMHS... Children & Adolescent Mental Health Service
DfCSF... Department for Children, Schools and Families
DfE...Department for Education
DfEE.. Department for Education & Employment
DfES.. Department for Education & Skills
DH... Department of Health
EP... Educational Psychologist
EPS.. Educational Psychology Service
LEA... Local Education Authority
NCSS.. National CAMHS Support Service
NHS.. National Health Service
NICE.. National Institute of Clinical Excellence
ODD.. Oppositional Defiance Disorder
PBC.. Perceived Behavioural Control
SEAL... Social & Emotional Aspects of Learning
SEN... Special Educational Needs
SENCo... Special Educational Needs Co-ordinator
SPSS... Statistical Package for Social Scientists
TACT... Target, Action, Context, Time
TaMHS...Targeted Mental Health in Schools
TPB.. Theory of Planned Behaviour
WAG...Welsh Assembly Government
WAO..Welsh Audit Office
WHO... World Health Organisation

1. INTRODUCTION

This research sought to ascertain the views of mainstream secondary school teachers in relation to supporting the mental health needs of their pupils, with particular attention to exploring factors which might moderate their willingness in order to construct a predicative model of teacher willingness.

The overarching aim of this introductory chapter is to set the scene in terms of the national context, so as to highlight the relevance and motivations of the current study. Firstly, the status quo of mental health amongst children and young people is outlined with reference to relevant statistical information and governmental policy. This is followed by a discussion regarding the perceived roles of educational settings in terms of child and adolescent mental health as outlined within governmental literature. This is essential in order to appreciate the expectations placed upon schools in terms of mental health promotion. Next, some of the tensions and difficulties experienced by schools in meeting the mental health needs of their pupils are discussed before exploring how relevant parties recommend schools could/should develop their capacity to meet the wellbeing agenda. Following this, the theoretical importance of 'willingness' in terms of the change process, that is, enabling teachers to adopt an inclusive approach with regards to supporting the mental health of their pupils, is examined. Finally, thought is given as to how this topic bears relevance at various levels to the practice of educational psychologists (EPs). The chapter concludes by summarising governmental findings and their relevance to the current study.

1.1   The current context of mental health in Britain

> Mental health and mental wellbeing are fundamental to the quality of life and productivity of individuals, families, communities and nations, enabling people to experience life as meaningful and to be creative and active citizens.
>
> (World Health Organisation, 2005, p. 1)

The World Health Organisation (WHO, 2004) defined mental health as a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In these terms, childhood mental health difficulties can prevent a young person from reaching his or her full potential by disrupting normal development. Thus the prevention, detection, and treatment of these problems are important not only to alleviate distress for children and young people, but also to improve adult functioning and prevent the escalation of disadvantage into the next generation.

It is widely accepted that good social, emotional and psychological health helps protect children and young people against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol (National Institute for Health and Clinical Excellence [NICE], 2009), and in turn reduces the multiple detrimental health and social outcomes with which mental health problems are associated, such as self-harm, suicide, educational underachievement, unemployment and long term psychiatric disorders (Kidger, Donovan, Biddle, Campbell & Gunnell, 2009). Research had indicated that a high proportion of adults with mental health problems are first diagnosed between 11 and 15 years of age (Fraser & Blishen, 2007), with the majority of severe and enduring mental illnesses being diagnosed by the age of 18 (Kessler et al, 2003). In terms of the mental health of children and young people in today's Britain, there is evidence to suggest that overall prevalence has increased since

the 1970s and is set to continue rising (Collishaw, Maughan, Goodman & Pickles, 2004; DH, 2004)

A study carried out for the Office for National Statistics, reported that in 2004 ten percent of children in Britain aged 5 to 16 had a clinically significant mental health difficulty that was associated with considerable distress and substantial interference with personal functions such as family and social relationships and learning (Green, McGinnity, Meltzer, Ford & Goodman, 2005). These included: emotional disorders (4 %), conduct disorders (6%), hyperkinetic disorders (2%) and less common disorders including autism, tics and mutism (1%). These mental health concerns were found to be more common in children of secondary school age in comparison to those of primary age (12% and 8% respectively). There is also a significant concern regarding young people post 16. For example, McManus, Melzer, Brugha, Bebbington and Jenkins (2009) reported that at any one time, 17 percent of young adults aged 16-24 will have a mental health disorder that meets the threshold for clinical diagnosis. However, it should be emphasised that the figures outlined above do not provide a comprehensive picture regarding the extent of mental health difficulties within Britain, as those children and young people experiencing subclinical mental health issues (those just below the criteria for psychiatric diagnosis) are not accounted for. The prevalence of subclinical mental health difficulties is an area which is unrepresented within the literature.

1.2   Emotional wellbeing, learning and achievement

There is no separation of mind and emotions; emotions, thinking, and learning are all linked.

(Jensen, 1998, p.71)

It is widely accepted that good social, emotional and psychological health can help young people to learn and achieve academically (e.g. Jensen, 1998; Weare, 2000, 2004; Goleman, 1996; Roeser, Eccles & Strobel, 1998), and thus can potentially improve their long-term social and economic wellbeing outcomes. Conversely, poor mental health has

been associated with poor educational attainment, absence from school, exclusion and lack of friendship networks (Department for Schools, Children & Families [DfSCF] & Department of Health [DH], 2008). Indeed, recent research has found support for a link between the implementation of quality whole-school mental health promotion and academic performance (Dix, Slee, Lawson & Keeves, 2012). Due to rationales such as these, the construct that a child or young person's mental health and wellbeing can affect their ability to learn and achieve has received extensive interest over the past decade or so, forming the foundation of much governmental guidance, policy and intervention.

1.3   Governmental stance

> Supporting children and young people's emotional wellbeing and mental health is a critical issue for public health. Effective services in this area will not only make children's lives better, but also prevent individuals experiencing mental health problems later in life, bringing benefits for their health, education, employment and relationships.
>
> (DfCSF & DH, 2010, p. 3)

The UK government is a signatory to the United Nations Convention on the Rights of the Child. This provides a commitment to ensuring that the best interests of children are promoted and applies in particular to budget, policy and law makers. According to the Convention, all children have the right to good quality health care and to education which develops each child's personality, talents and abilities to the fullest (see www.unicef.org). The implications of the Convention are profound: children and young people's mental health issues cannot be ignored, and must be addressed and managed effectively.

Government policy over the past decade reflects the growing concern regarding child and adolescent mental health in the UK and the developing understanding around the impact mental health and emotional wellbeing can have on the lives of individuals and their families. *Every Child Matters* (Department for Education and Skills [DfES], 2004),

which is supported in legislation by the Children Act 2004, set out the government's agenda for the reform of children's services to improve outcomes for children and young people in five key areas: being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic wellbeing. Similarly, in Wales, *Children and Young People: Rights to Action* (Welsh Assembly Government [WAG], 2004) set out seven core aims, including to 'enjoy the best possible health' and 'to be free from abuse, victimisation and exploitation'. Within these respective agendas, emphasis is placed on multiagency working between health, education and social care.

In 2004, the *Children's National Service Framework* was published (DfES & DH, 2004) which set out a 10-year programme to raise standards, including a specific focus on the mental health and wellbeing of children and young people. Within Standard 9 of the framework, it was specified that all staff working with children and young people should be able to make a contribution to mental health promotion and early intervention, providing appropriate interventions and specialist referral when problems are identified. Further to this, in 2006 the Education and Inspection Act was passed, which placed a duty on schools to promote wellbeing.

1.4   Children and Adolescent Mental Health Services (CAMHS)

Anyone in contact with a child has an impact on that child's mental health and psychological well‑being. The challenge for all of us is to remember that and to be able to respond if things start to go wrong.

(DfCSF & DH, 2008, p.6)

Whereas mental health may once have been perceived as something that should be dealt with by a particular set of professionals within clinical settings, there is now a clear message that child and adolescent mental health is everybody's business. For example, the CAMHS Review (DfSCF & DH, 2008, p. 27) stated that everybody has a responsibility to ensure children and young people have good mental health and psychological wellbeing as they grow up and that anyone working directly with children

and families need to ask themselves regularly "What can I do to improve the mental health and wellbeing of this child"? Similar views are also expressed in many Welsh Governmental publications (e.g. WAG, 2001; WAG, 2010a).

The notion that child and adolescent mental health is everybody's business could be seen to have its origins in the influential *Together We Stand* document (NHS Advisory Service, 1995) which placed an emphasis on inter-agency working and introduced the idea of primary mental health workers and the four-tier CAMHS framework, whereby those who are not necessarily mental health specialists have notable responsibilities for the mental health of children and young people within tier one (see Figure 1.1).

Figure 1.1: The CAMHS Framework (DfCSF & DH, 2008)

Tier 1: Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers), who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2: Services provided by specialists working in community and primary care settings in a uni-disciplinary way (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3: Services usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community settings. They offer a specialised service for those with more severe, complex and persistent disorders.

Tier 4: Services for children and young people with the most serious problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

Much emphasis has been placed on awareness raising and development of prevention and early intervention at tier one. Initiatives have included the 'tier one' online training package *Everybody's Business* (http://learning.camhs.org.uk).

More recently, a three tiered model of CAMHS was proposed (DfES, 2004), which focuses more on the actual service 'being' delivered, rather than on 'who' is delivering it, as with the four-tiered model. The three-tiered model comprises of: universal services (promoting emotional wellbeing), targeted services (early intervention for vulnerable children and young people), and specialist services (high-quality mental health provision).

Despite the differences between these two models, the message is essentially the same – child and adolescent mental health is the responsibility of all those who work with them. Furthermore, the role of schools and teachers exists within both models: as a provider at tier one within the four-tiered model, and as a provider of a universal service within the three-tiered model. Additionally, schools and specific personnel within them such as school-based counsellors, primary mental health workers and EPs are also seen as professionals who should be providing targeted services or working within tier two.

1.5   The role of schools in supporting child and adolescent mental health

> Schools play a vital role in promoting the health and wellbeing of their pupils, through the environment that they create, the support and opportunities they provide and the expectations and aspirations they have for each of their pupils.
>
> (National CAMHS Support Service [NCSS], 2011, p. 41)

Schools are increasingly being recognised within both academic and governmental literature as services which can help support the mental health of children and young people. Taking an ecological systems theory perspective (e.g. Bronfrenbrenner, 1979), the important mediating role schools can play in the social, emotional and educational development of children and young people can be appreciated. Children and young people in Britain generally spend 25 hours per week in school for 39 weeks of the year,

which equates to 16 percent of their waking childhood lives (based on having eight hours sleep per night). Thus, after family, schools are the most important system in the lives of the vast majority of children and young people, having a significant impact on the development of their mental health and psychological wellbeing, particularly as they become older. This view is supported by research which indicates that schools are seen by many agencies as central stakeholders in efforts to promote the mental health and psychological wellbeing of today's youth (DfCSF & DH, 2008).

There is evidence that schools, colleges and other organisations can enhance children and young people's emotional wellbeing, for example by reducing risk taking behaviours, building self-esteem and supporting the development of social and emotional skills (NCSS, 2011). It is also the position of the UK government that universal services, such as schools, children's centres and GPs, play a pivotal role in promotion, prevention and early detection of emotional wellbeing and mental health issues, bringing in other professionals as appropriate (DfCSF & DH, 2010). Similarly, WAG (2001) stated in their strategy document *Child and Adolescent Mental Health Services: Everybody's Business* that the role of those working at tier one included: identification of mental health problems early in their development; providing general advice and intervention with less severe problems; and pursuing opportunities for mental health promotion and problem prevention.

The Office for Standards in Education, Children's Services and Skills (Ofsted, 2005) reported that for many pupils and parents, the notion of mental health difficulties carries a considerable stigma, and together with the need to attend a clinic, created difficulties for CAMHS in engaging with young people and their parents. For example, some pupils did not want to attend a CAMHS clinic for fear of being labelled 'mentally ill'. Similarly, WAG (2001) argued that inappropriate referrals to tier two, tier three or tier four owing to gaps at tier one can lead to a risk of otherwise avoidable stigmatisation. This further emphasises the important role schools play in supporting the mental health of children and young people, within the community context.

The 2010 White Paper for schools (Department for Education [DfE], 2010) does not place any legislative requirements on schools with regard to health and wellbeing. However, it anticipated that schools would continue to support children and young people's health and wellbeing due to an understanding from headteachers that pupils struggle to learn if they experience adversity. This is supported by the *Pupil and Parent Guarantees* DfCSF (2010), which declared that every pupil would go to a school that would promote their health and wellbeing.

In conjunction with the focus in government literature on the mental health and wellbeing of children and young people, a number of initiatives have been disseminated to schools with the common aim of promoting wellbeing. Such initiatives have included the *National Healthy Schools Programme* (DfCSF & DH, 1999), the *Behaviour and Attendance National Strategy* (DfES, 2005a), the *Extended Schools Policy* (DfES, 2005b), the *Social, Emotional Aspects of Learning (SEAL) Programme* (DfCSF, 2005, 2007), and the *Targeted Mental Health in Schools (TaMHS) Programme* (DfCSF, 2008). Additionally, in 2001, a revised *Special Educational Needs (SEN) Code of Practice* was published (DfES, 2001) which aimed to ensure equality of opportunity and high achievement for all children and young people. The code stresses the importance of preventative work to ensure that the needs of children and young people are identified quickly and that early action is taken to meet them.

Schools are now also assessed by Ofsted for the effectiveness of promoting both learning and wellbeing (www.ofsted.gov.uk). Similarly, one of the key inspection questions for the Education and Training Inspectorate for Wales, Estyn, is how well learners are cared for, guided and supported (www.estyn.gov.uk). Such a criterion illustrates the growing emphasis within the education system that is being placed on the emotional wellbeing of children and young people, inferring a clear acknowledgement that emotional wellbeing and learning are intrinsically linked.

1.5.1 Successful promotion of mental health within schools

There is evidence that children with mental health needs are supported most effectively when there is universal provision which promotes the mental health of all pupils, reinforced by targeted support for those with particular needs (Weare and Markham, 2005). In developing coping and social skills, and by creating a positive, safe environment that fosters a sense of inclusion, identity and connectedness among pupils, universal interventions can result in: improved adjustment to school; enhanced competence, self-esteem, increased control and problem-solving skills; improved school achievement; and decreased loneliness, learning problems, bullying, aggression, depression, and anxiety (Pollett, 2007). Similarly, Ofsted (2005) and the CAMHS Review (DfCSF & DH, 2008) were in agreement that whole-school, universal approaches were most effective in terms of supporting pupil mental health. In particular, the CAMHS Review noted that successful initiatives valued the importance of adult-child interactions, supporting staff to develop better ways of engaging with pupils. It was also advocated that children and young people should have access to information and advice in school relating to services which can support their wellbeing, and feel able to share worries with trusted adults without the fear of stigma. Ofsted reported that other effective approaches can involve pupils' self-referral, peer support and flexible approaches by schools to modifying the curriculum and timetables.

1.5.2 Shortfalls, tensions and difficulties

Despite the sound rationale, and accompanying policy, guidance and initiatives provided for schools to actively support the mental health of children and young people, there appear to remain a number of shortfalls. For example, a recent review carried out for WAG (Welsh Audit Office [WAO], 2009) stated that although many schools were part of the Healthy Schools Programme, the focus of activities was generally found to be on physical rather than emotional health. Similarly, Ofsted (2005) found that few schools were using the national guidance (Department for Education and Employment [DfEE], 2001) to plan and provide support for pupils' emotional wellbeing and mental health. They also found that relevant staff training in over a third of schools surveyed was unsatisfactory. Furthermore, Ofsted reported that schools were under-identifying pupils

with mental health difficulties and therefore were not providing the necessary and appropriate services and interventions for some of their most vulnerable pupils. Additionally, the CAMHS Review (DfCSF & DH, 2008) concluded that variations in the approach and attitudes of schools towards the mental health needs of children and young people pose ongoing barriers to progress.

It should be noted that these shortcomings are not necessarily evenly dispersed across different types of schools. For example, Ofsted (2005) reported that primary and special schools were more successful than secondary schools in supporting mental health and emotional wellbeing. It was noted that in particular, secondary schools found it more difficult to prioritise arrangements for multiagency working and rarely took the lead in improving this aspect of their work. It is likely that such findings are due to the nature of the secondary school context, a setting where inclusive initiatives are more difficult to implement and execute due to complex and sometimes inflexible systems.

There also appears to be evidence that staff awareness, training and support offered for different types of mental health difficulties vary. For example, Ofsted (2005) reported that most staff training tended to focus on strategies to manage pupils' behaviour rather than on promoting a positive approach to relationships and conflict resolution. This was supported by WAO (2009) who identified that although school staff had undertaken a range of training, the topics covered were inconsistent, and training in key areas such as recognising, advising and/or supporting pupils with emotional and mental health problems was not always provided. A concern here is that, although training for staff in this area seemed to be more orientated towards behaviour management rather than recognising or supporting the mental health needs of pupils (WAO, 2009; Ofsted, 2005), the pupils who were reportedly least mentally well in schools were those who were withdrawn or depressed and who were underachieving as a result (Ofsted, 2005). Furthermore, it was reported that these vulnerable pupils presented few challenges to teachers, and consequently their problems were frequently not followed up and addressed. This issue was highlighted by Armbruster, Gerstein and Fallon (1997) who commented that often mental health issues which are characterised by difficult and

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sometimes problematic externalised behaviours (such as attention deficit hyperactivity disorder [ADHD] or oppositional defiance disorder [ODD]) were more commonly recognised and the subject of intervention from teachers than those where the pupil internalised their issues and thus presented as less of a challenge within the school environment.

1.5.3 *Building capacity through a focus on teachers.*

Many examples of good practice in supporting the mental health needs of pupils hold teaching staff as central stakeholders in whole-school, universal approaches—the Holy Grail of mental health promotion within schools. From this perspective, if teachers are not ready, willing and/or able to support the mental health needs of their pupils, the adoption of whole-school approaches would simply not be possible.

Recently, WAO (2009) advocated that school staff have the potential to undertake an important role in identifying risk factors and emotional problems at an early stage, given their regular contact with children and young people. However, the need for more effective training initiatives to develop their capacity to do so is well documented. For example, the CAMHS Review concluded that staff in universal services, which include teachers, need a better understanding of their role in mental health promotion, prevention and early intervention; training to improve their skills and confidence; information and advice on what is available; and awareness of the systems in place to access specialist support (DfCSF & DH, 2008). WAG (2001) also advocated that all staff in schools need access to continuing opportunities for professional development in the area of child and adolescent mental health, to build on skills acquired during initial training.

The CAMHS Review (DfCSF & DH, 2008) stated that in order for universal services to successfully support the mental health and emotional needs of children and young people, there needs to be a cultural change. In particular, those within the relevant services need to take greater 'ownership' of mental health and psychological wellbeing issues and become more responsive to the needs of all children, young people and their families. This echoes WAG's strategy document (2001) which advocated work on

organisation, culture and roles in order to develop capacity to meet the mental health needs of children and young people.

One cultural change that seems to be relevant for school staff is their willingness to support the mental health needs of their pupils. This issue was highlighted by the WAO in their review of child and adolescent mental health services in Wales (2009). They stated that many local education departments felt the willingness of their school staff to play their part in supporting children with emotional and mental health problems varied considerably (WAO, 2009). Similarly, the CAMHS Review implied that one of the main barriers to improving the mental health of children and young people was the significant variance in the approach and attitude of schools (DfCSF & DH, 2008).

Theoretically, willingness, or intention, is a pre-requisite for carrying out most types of behaviours or actions (e.g. Ajzen, 2005). Therefore, theory would indicate that in order for school staff to actually engage in supporting the mental health needs of their pupils, they need to have some level of intention to do so first. Many factors may potentially affect a teacher's willingness in this sense, and these are discussed further within the next chapter.

1.6   Role of the educational psychologist

Although the identification of an explicit role for schools in the promotion of mental health and wellbeing is relatively recent, work to support the mental health of children and young people through schools has a comparatively long history. From its formative years, educational psychology has acknowledged the complexity of social, emotional and behavioural factors that influence developmental outcomes in children and learning outcomes in schools.

EPs are widely depicted as a group of professionals who hold the necessary skills, knowledge and experience to help implement the wellbeing agenda within schools at multiple levels. At the individual pupil level, EPs exist within tier two of the CAMHS framework and can provide targeted intervention and guidance for pupils and school.

Similarly, Appleby, Shribman & Eisenstadt (2006) noted that often EPs are seconded to CAMHS outreach teams, practising and delivering training alongside primary mental health workers. However, EPs can also support schools at tier one in the provision of universal services. For example, in their child and adolescent mental health strategy document, WAG (2001) advocated that educational psychology services (EPSs) should assist schools in establishing systems and procedures to benefit the mental health of children and young people. More recently, the government published the SEN and Disability Green Paper (DfE, 2011a) which stated that EPs should help to develop the skills of teachers and other professionals working with pupils with SEN, which would include those with mental health difficulties. Such views are shared by those within the health sector, who suggest that EPs are amongst those who can enable education establishments to adopt organisation-wide approaches to promoting the social and emotional wellbeing of children and young people, helping them to develop the necessary organisational capacity, specialist skills and resources, as well as offering advice and support (NICE, 2009).

1.7   Summary

This introduction has provided a summary of the extent of concern, government policy and the role of schools in relation to child and adolescent mental health. It has also outlined the clear link between the role of the EP and mental health promotion in schools at different levels.

Based on the findings of three recent governmental reviews carried out in England and Wales (DfCSF & DH, 2008; Ofsted, 2005; WAO, 2009), it would seem that, although some progress has been made, there is room for improvement in terms of how schools can support the mental health needs of their pupils. This appears to be particularly relevant for secondary schools and also in relation to more internalised mental health concerns, where there is a risk that pupils will slip beneath the schools' radar. There is also an evident need to expand the capacities of schools in order for them to successfully adopt truly whole school approaches. It is suggested that this needs to include not just senior management, but all members of staff, including classroom teachers (Ofsted,

2005). Nevertheless, in order to become more proactive, teachers must first be willing. However, it has been reported that the willingness and attitude of school staff towards supporting the mental health needs of their pupils vary considerably (WAO, 2009; DfCSF & DH, 2008).

1.8   The Current Study

The focus of the current study is on building the capacity of mainstream secondary school teachers to support the mental health needs of their pupils. This bears much relevance to the role of the EP, as EPs are in a unique position to apply psychological theory at a systemic level within the education system, in order to promote positive change at an individual level for children and young people.

In terms of 'mental health problems', the current research focuses primarily on the internalised mental health issues most commonly experienced by young people (e.g. mood disorders, eating disorders, anxiety disorders, suicidal thoughts, self-harm, psychosis). Ofsted (2005) state that such mental health issues are frequently not followed up within the school context as they pose few challenges to staff. This issue is discussed further within the next chapter.

As well as exploring the perceptions of mainstream secondary school teachers, the current study seeks to employ a quantitative methodology in order to test a theoretical model which, hypothetically, has the potential to account for the variance of willingness displayed by teachers to support the mental health needs of their pupils. Such a model would be of particular use and relevance at a strategic level in maximising willingness when planning and implementing interventions for mainstream teachers, such as training.

1.9   Overview of thesis

The thesis begins with a review of the literature that is relevant to this area of enquiry, followed by the research question and related hypotheses. Next, the methodology and

procedures used to test the research hypotheses are described. Following this, the research findings are critically discussed in relation to each of the research hypotheses and the reliability of the current study is subjected to critical consideration. Finally, the results are critically discussed with reference to the literature, before highlighting the implications of the findings and raising possible directions for future research. The thesis concludes by drawing together the research outcomes and discussing the practical and theoretical significance of the study.

2. LITERATURE REVIEW

The introductory chapter outlined the status quo of child and adolescent mental health within the UK, the respective role expected of schools and the motivation within the current study for a focus on how to increase teachers' capacity to support the mental health needs of their pupils. This chapter seeks to provide a thorough and critical review of the literature regarding teachers' capacity to support the mental health needs of pupils, with a particular focus on what factors might have a moderating role on their willingness to do so.

After summarising the techniques used to perform the literature search, the review begins with a discussion of the terminology around 'mental health' and its use within the current study. This is followed by an exploration of the literature regarding the role of schools in mental health work and sustainable implementation, before more specifically focusing on the importance of mainstream secondary school teachers in this. Next, relevant theoretical literature is discussed, with a particular focus on how the theory of planned behaviour (TPB) (Ajzen, 1985; 1991) can help in better understanding the underlying social-cognitive processes that may lead to teachers adopting active roles in supporting the mental health needs of pupils. Following this, how the TPB can be amalgamated with the research literature regarding teachers and pupil mental health is explored. Relevant factors from the research literature which are not applicable to the TPB are then discussed separately. The chapter concludes by providing a proposed model for predicting teachers' willingness to support the mental health needs of pupils. Finally, the present study is introduced along with the research question to be explored and related research hypotheses.

2.1 The literature search

A number of sources were used in the search for literature which was relevant to this study. These included the computerised databases: PSYCH info, Google Scholar and Web of Science. Key descriptor words for searches within these databases included the terms: 'school' or 'teacher' and 'mental health', 'emotional wellbeing', 'emotional

health' or 'psychological wellbeing'. Only literature published within the past 15 years was reviewed. Unpublished papers were not included, unless they bore significant and direct reference to the study. A further literature search using the same computerised databases and criteria was run to identify relevant studies employing the TPB in the field of education using the key descriptor words 'teacher', 'school', 'education' and 'planned behaviour'.

2.2 Mental health

Terminology associated with mental health and wellbeing can be very convoluted, since terms are constructed differently by people and within different contexts. This section hopes to provide some clarity regarding these terms, particularly with respect to the current study.

The terms 'emotional wellbeing', 'psychological wellbeing' and 'mental health' are frequently used interchangeably (WAG, 2001; DfCSF & DH, 2008). Similarly, different professionals may use different terminology to describe observable behaviours dependent on professional training and/or theoretical orientation. For example, a child psychiatrist might categorise certain symptoms in a child as 'conduct disorder', whereas an EP seeing the same symptoms in a child within the classroom may describe them primarily as 'social, emotional and behavioural difficulties'. Terms such as 'mental illness' and 'mental health disorders' are commonly used within more medical contexts, whereas the term 'social, emotional and behavioural difficulties' is often used within education. However, the term 'mental health' is broadly used and is generally recognised across all health, social care and educational contexts. For example, Gott (2003) notes that although the term 'mental health' is not always employed within educational contexts, it helps raise an awareness of needs in a much broader contextual frame rather than being purely academic. Thus, for the purpose of this study the term 'mental health' is adopted to ensure clarity and consistency. Nevertheless, mental health in itself is a complex concept and is constructed in many different ways.

Traditionally, mental health has been viewed as a spectrum ranging from positive to negative (The Health Development Agency, 2004). However, research has now indicated a need to differentiate between positive and negative mental health as the two are suggested to be independent of one another and not at polar ends of a spectrum (Keyes 2002; 2005; Huppert & Whittington 2003). The Health Development Agency (2004) suggests it is helpful to consider mental health as operating along two continua: one for mental health and one for mental ill health, both of which can be experienced simultaneously. This would mean that a person's location on the mental illness continuum does not necessarily predict where they fall on the separate mental health continuum.

2.2.1   Mental health continuum (Positive mental health)

Good mental health can be described as a 'holistic, subjective state which is present when a range of feelings, among them energy, confidence, openness, enjoyment, happiness, calm, and caring, are combined and balanced' (WAG, 2010a, p. 7). Good mental health is thought to be promoted by concepts such as emotional intelligence and emotional literacy. Consequently, in recent years many schools and local authorities have invested considerable resources in promoting these concepts in recognition of their positive impact on mental health and raising standards.

As aforementioned, good mental health does not necessarily mean the absence of mental illness. For example, a child with a clinically diagnosable disorder such as ADHD, which would exist along the mental ill health continuum, could also experience good mental health along the mental health continuum. Guidance indicates that a mentally healthy child or young person should have the ability to:

- develop psychologically, emotionally, socially, creatively and spiritually;
- initiate, develop and sustain mutually satisfying relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;

- develop a sense of right and wrong; and

- face and resolve problems and setbacks satisfactorily and learn from them.

(Alexander, 2002)

However, although positive and negative mental health are seen as representing two separate continua, universal initiatives aimed at promoting good mental health in all also have the potential to help prevent individuals from experiencing mental ill health (WHO, 2002). Equally, promoting positive mental health can also significantly improve the mental ill health of individuals who are already experiencing specific conditions (The Health Development Agency, 2004).

2.2.2 *Mental ill health continuum (negative mental health)*

Terms such as mental 'illness', 'problem', 'disorder' and 'issue' are often used to describe mental ill health or negative mental health outcomes. The term mental health problem is generally used to encompass both sub-clinical 'mental health problems' and more clinically recognised 'mental health disorders'. WAG (2001), in attempting to establish a widely applied and understood definition of the term 'mental health problem', set out the following definition:

> Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning, development of the concepts of right and wrong, and in distress and maladaptive behaviour. They may arise from any number or combination of congenital, constitutional, environmental family or illness factors. 'Mental health problems' describes a very broad range of emotional or behavioural difficulties that may cause concern or distress. They are relatively common, may or may not be transient, but encompass mental disorders, which are more severe and/or persistent. (WAG, 2001, p.14).

It follows that if a mental health 'problem' becomes persistent, more severe and associated with other problems, it may meet the criteria for clinical diagnosis and be referred to as a 'disorder'. For instance, in their study for the Office of National Statistics, Green et al. (2005, p. 8) used the term 'mental health disorders' as implying "a clinically recognised set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal function".

The British Medical Association (BMA, 2006) provided guidance for distinguishing between different levels of severity of mental ill health in children and young people.

- Mental health problems: relatively minor conditions such as sleep disorders or excessive temper tantrums.
- Mental health disorders: a marked deviation from normality, together with impaired personal functioning or development, and significant suffering.
- Mental illness: severe forms of psychiatric disorder, particularly of the kind also found in adulthood, for example, schizophrenia, depressive disorders and obsessive disorders.

2.2.3 Types of mental health problems

The BMA have stated that there are seven prevailing mental health problems experienced by children and young people: emotional disorders, self-harm and suicide, eating disorders, psychotic disorders, conduct disorders, hyperkinetic disorders and autistic spectrum disorders (BMA, 2006). The BMA, in accordance with The Royal College of Psychiatrists (2004), do not acknowledge learning disabilities as a mental health problem. Nevertheless, it should be noted that children and young people with learning disabilities are a particularly vulnerable group, with approximately 40 per cent reported to experience a significant mental health problem at some point (Green et al., 2005).

2.2.4 Terminology within the current study

The current research is concerned with the concept of negative mental health or the mental ill health continuum. That is, the research aims to explore teachers' willingness to

support the mental health needs of pupils who are presenting with mental health problems – both clinical and subclinical. Throughout this thesis, the term mental health problem is used generically to include mental health illnesses and disorders, unless otherwise specified. Additionally, where reference is made to the 'mental health needs of children and young people', it should be assumed that the 'needs' are an outcome of a child or young person experiencing a mental health problem.

2.3   Supporting mental health needs in schools

There is growing concern about the rise in mental health problems in children, long waiting lists for specialist mental health intervention and the use of school exclusion for pupils with certain mental health difficulties (World Federation for Mental Health, 2003; Baxtor, 2002; Lines, 2002; Capey, 1997). It is also recognised that out of those children and adolescents who experience a diagnosable mental health problem, only a small percentage actually access specialist services (Naylor, Cowie, Walters, Talamelli & Dawkins, 2009; Ford, Goodman & Melzer, 2003).

Over a decade ago, in their influential document *Bright Futures*, the Mental Health Foundation (1999, p. 31) stated: "...it is our firm belief that if we want to change things, school has to be the place to do it". Since this time, the notion of mental health promotion in schools has thrived and received widespread attention and backing from government (DfES, 2001; DfES, 2004; DfCSF & DH, 2008; DfCSF & DH, 2010; WAG, 2001; WAG, 2010a; Education & Inspections Act, 2006).With respect to supporting pupil mental health needs, perspectives regarding the roles of schools vary but tend to include: identification of mental health problems early in their development; providing general advice and intervention with less severe problems; and pursuing opportunities for mental health promotion and problem prevention (WAG, 2001; DfCSF & DH, 2008; NICE, 2009).

Schools are seen as important agents in providing caring and supportive environments and trusting relationships for all children and young people, which can be particularly helpful in meeting the needs of those children experiencing mental health problems. This

is supported by Roeser (2001) who advised that supportive educational environments continue to be one of the most viable 'treatments' that can be delivered in schools, given funding and service-provision constraints. Factors which foster a feeling of wellbeing, a sense of belonging and facilitate learning – which may in turn have a positive effect on pupils experiencing a mental health problem – are seen to be within the control of all schools (Gott, 2003). Specific strategies to help in meeting the needs of individual pupils with mental health problems, as agreed in consultation with CAMHS and/or EPs should further complement, but not replace, fundamental action taken by the whole-school to create a supportive and caring environment.

Generally, both academic literature (Weare, 2000; Weare & Murray, 2004; Wells, Barton & Stewart-Brown, 2003; Dix et al., 2012) and government literature (DfCSF & DH, 2008; WAO, 2009) advocate whole-school approaches to mental health promotion. The general emphasis is on schools promoting positive mental health (i.e. through SEAL). However, this may not wholly recognise or meet the needs of those pupils who exist on the negative mental health continuum, that is, those experiencing mental health problems. For example, with recent statistics suggesting that 10 percent of children and adolescents experience a mental health disorder at any one time (Green et al, 2005), it is feasible to estimate that on average this constitutes two or three pupils in every classroom. More worryingly, this statistic does not account for pupils who may be experiencing a subclinical mental health problem that does not quite reach the threshold for clinical diagnosis, but who may be experiencing distress or impairment in functioning as a consequence. For these reasons, it is imperative that schools are able to play their part in meeting the needs of this vulnerable population, in addition to promoting positive mental health for all.

The basic notion of the CAMHS four tier framework is that much relevant and useful advice can be offered on a simple, pragmatic basis by people working in schools to pupils with mental health problems, without the need to move to higher tiers of involvement and the stigmatisation that that may carry. Despite this, it is suggested that some schools rarely see 'mental health' per se as among their list of priorities, with

mental health agendas being perceived as diverting attention away from the core business of schools (Gott, 2003; Rowling, 2007; Weare, 2004). This is supported by Frederickson and Dunsmuir (2011) who commented that a considerable difficulty for some schools in adopting mental health work is a narrow focus on teaching and learning, which leads to important aspects of a child or young person's development being overlooked or ignored. Furthermore, often mental health problems are seen by school personnel as medical issues requiring the careful attention of an 'expert', despite research and guidance clearly indicating that a holistic approach, encompassing social, health and educational aspects, is most beneficial in meeting the needs of these children and young people (Rowling, 2007). Another difficulty noted within the literature is that pupil populations are characterised by numerous problems which can undermine the motivations and collective efficacy of staff (Roeser, 2001), for example through feeling overwhelmed.

It is important to consider carefully the attitudes and responses of school personnel when implementing school-based mental health initiatives, as fundamentally the question of whether or not schools are ready, willing and able to take on such a role will inevitably affect the degree of success that the initiative has. In other words, if schools do not take ownership of their intended responsibilities as outlined the government (e.g. DfES, 2001; DfCSF & DH, 2010; WAG, 2001), the mission will be futile.

2.3.1   Sustainable implementation of mental health initiatives

As has already been alluded to, the sustainability of mental health work in schools is a complex yet important challenge, the success of which is very dependent upon careful preparation (Weare and Murray, 2004). Barry and Jenkins (2007) acknowledged that in order to ensure sustainability, the implementation of school-based mental health initiatives should be grounded in a strong research base, creative and effective practice, government policy and public preparation. With respect to this, it would seem that the 'public preparation' aspect is somewhat lacking (e.g. Ofsted, 2005; Rothi, Leavey & Best, 2008). Furthermore, although there exists a solid research base with regards to how and why schools should be adopting these roles, research determining the willingness and capabilities of schools in adopting these responsibilities is also lacking (Greenburg

et al., 2003; Gowers, Thomas & Deeley, 2004; Rowling, 2007). The inclusion of this element is imperative in supporting any school change effort. However, it is particularly crucial for supporting the longevity of mental health work in schools given the entrenched disciplinary silos which are seen to exist between education and mental health services (Paternite & Johnston, 2005; Weist & Murray, 2007; Greenburg et al, 2003). Consequently, it has been advocated that further research concerning the obstacles to dissemination of school-based mental health initiatives is required (Weist & Evans, 2005).

In terms of successful capacity building and engagement, it is reported that there is little evidence as to what components of a programme work when educating adults about mental health (Kelly, Jorm and Wright, 2007). However, there is a great amount that can be learned from the general mental health promotion literature. For example, a review undertaken by Noar (2006, p. 25) identified some important components of successful mental health programmes, which included:

- to conduct formative research with the target audience to clearly understand the behaviour and the problem area;
- to pre-test messages with target audience to be sure they are both appropriate and effective;
- to use theory as a conceptual foundation to the programme development, as this will provide important determinants around which to develop messages, and will help ensure that campaign messages guide individuals through the process of attitude and/or behaviour change;
- to segment audiences into meaningful subgroups based on important characteristics
  such as demographic variables, risk characteristics, experience with the
  behaviour, personality characteristics; and
- to carry out evaluation of training to ensure that the messages are reaching the target audience, and if they are not, rethink the approach and try something different.

However, it is reported that in terms of general mental health training little formative research is ever carried out with the target populations and very rarely do the developed programmes have theoretical underpinnings (Kelly et al., 2007). This situation appears to be reflected within the educational context.

The literature points out that EPs can play a fundamental role in integrating mental health initiatives into schools (Levitt, Saka, Hunter-Romanelli & Hoagwood, 2007). Not only do EPs have the relevant knowledge and skills regarding both mental health problems and educational contexts which could help in terms of training, they are also in a unique position to work at a systemic level to unpack the underlying processes and systems that may influence the adoption of inclusive and supportive practices by schools and their staff teams.

2.4   A focus on mainstream teachers

The views, attitudes and abilities of mainstream class teachers relating to supporting pupil mental health needs appear to be largely absent from the academic literature. The predominant focus is on those with a pastoral care designation such as special educational needs coordinators (SENCo), pastoral care heads or specialist teachers (e.g. Rothi et al., 2008; Kidger, Gunnel, Biddle, Campbell & Donovan, 2010). It could be considered that the views, attitudes and abilities of such school personnel are biased. For example, having chosen to take up a position which innately encompasses a responsibility for supporting pupils who may be experiencing mental health problems, they are more likely to have the necessary motivation and preparation (Kidger et al., 2010). A counter argument to this may be that these personnel are more likely to be supporting these pupils and therefore, their views are more relevant. Not only would such a rebuttal be contrary to the notion of a whole-school approach as best practice, it may also be seen as short-sighted given the theoretical and research literature available which paints a picture of mainstream class teachers as being central agents in supporting the mental health needs of children and young people.

2.4.1 Do mainstream teachers have a role to play?

The considerable proportion of children and young people who are experiencing mental health problems means that almost all teachers will have daily contact with this population (Gott, 2003). Furthermore, it was reported in the SEN and Disability Green Paper (DfE, 2011a) that nearly 50 percent of children with a diagnosable mental health problem do not have an additional SEN. It is therefore possible that almost half of those pupils with mental health needs are not known to their school's SEN department, and thus are reliant on the wider school in terms of initial identification and support. However, these needs should be considered in conjunction with the "decline in the pastoral role of teachers because of the constraints imposed by the National Curriculum, SATS and resulting pressures of work" (Baginsky, 2004, p. 4). Thus, it should be appreciated that successful whole-school adoption of approaches to meet the mental health needs of pupils is likely to be diluted by competing objectives.

The importance of mainstream class teachers in supporting the mental health needs of pupils is discussed below in terms of prevention, identification and management of mental health problems, in line with expectations from the government (DfCSF & DH, 2010).

A role in prevention. Receiving good support from a teacher is emphasised within the literature as a protective factor in supporting the growth and development of children and young people (Rutter, 1990; Bowen & Bowen, 1998; Bowen, Richman, Brewster & Bowen, 1998). Similarly, school connectedness – whereby pupils feel accepted, valued, respected and included – has been associated with better mental health outcomes amongst adolescents (Bond, Butler, Thomas, Carlin, Glover, Bowes & Patton, 2007; Shochet, Dadds, Ham & Roslyn, 2006). This is reflected by government guidance that states that "many teachers have a lasting impact on children and families, helping them to build resilience, work through problems and access extra support where necessary" (DfCSF & DH, 2008 p. 38). Additionally, it is noted that if a child or young person is experiencing adversity, they are more likely to tell someone if they have an open and trusting relationship with an adult, for example a teacher (DfCSF & DH, 2010).

Furthermore, a study by Cohall et al. (2007) found that many secondary school teachers overheard pupil conversations regarding health related issues including mental health. They also reported that 70 percent of teachers involved in their survey were approached by pupils regarding a health concern at least once each term. This indicates the level to which school teachers are in a position to identify and intervene if necessary. Similarly, a recent American study found that 58 percent of high school teachers reported that at least one pupil had disclosed suicidal thoughts or behaviour to them (Freedenthal & Breslin, 2010). However, research indicates that within the primary setting, teachers rank fairly low down in pupils' ratings of who they might turn to if they needed help (Kniveton, 2004). This perhaps indicates that teachers become a more important source of support for pupils as they become older.

A recent study by Suldo et al. (2009) sought the perceptions of pupils regarding how teachers could best help in the prevention of mental health problems. Major themes in this respect were: to connect with pupils on an emotional level; to provide diverse teaching strategies; to acknowledge and boost academic success; to demonstrate fairness in classroom interactions; and to foster a classroom where questions are encouraged. Similarly, research seeking the perspectives of both pupils and teachers regarding how best to support pupils 'at risk' of experiencing mental health problems found several ways in which mainstream teachers could help (Johnson, 2008, p. 395). These included: making themselves available and accessible; engaging pupils by actively listening to concerns; displaying empathy with and understanding their tough circumstances yet providing positive strategies; advocating for pupils by mobilising existing support provisions; identifying and opposing bullying and harassment; and remembering the 'human touches' to promote bonding between teacher and pupil. However, research indicates that, despite a desire to support, care for and relate to pupils, teachers find trying to maintain this level of care and attention difficult when work place factors interfere (Ridge, Sheehan, Marshall, Maher & Carlise, 2003; Cooper, 2004).

Based on research, it is stressed that teachers generally need to be more attuned to the contextual and relational factors which help promote school connectedness and resilience amongst pupils experiencing adversity (Johnson, 2008).

A role in identification. It is suggested that apart from parents, those in the best position to identify children who have mental health difficulties are teachers (Layard & Dunn, 2009; Herbert, Crittenden & Dalrymple, 2004; Collins & Holmshaw, 2008). This is supported by Roeser and Midgely (1997) who, based on teachers' ratings and pupils' self-reports, concluded that 'regular' teachers are good informants of which pupils would benefit from mental health services. However, findings regarding the efficacy of teachers in identifying certain mental health problems are generally mixed (e.g. Ozabaci, 2010; Wyman et al., 2008; Dwyer, Nicholson & Battistutta, 2006; Collins & Holmshaw, 2008). It is suggested that the effective identification of pupils with mental health problems is affected by uncertainty amongst teachers regarding the legitimacy of taking action outside specialised services and ambiguity regarding their role (WAG, 2001).

A role in management. It is argued that unless schools address pupils' experience of the whole-school environment, targeted interventions (e.g. school-based counselling) are likely to have little impact (Cole, Sellman, Daniels & Visser, 2002; Spratt, Shucksmith, Philip & Watson, 2006). That is, there is little benefit in providing specialist interventions for those pupils experiencing mental health problems if the progress made is not supported, or is even undermined, by the wider school environment. It is not expected that teachers become therapists, but that teachers develop practices that can meaningfully engage and manage vulnerable pupils (Le Cornu & Collins, 2004; Spratt et al, 2006). This notion is supported by research carried out by Kidger et al. (2009) who noted that both pupils and teachers emphasised the need to consider the whole-school environment in order to address sources of distress, such as teacher-pupil relationships.

Research has found that teachers believe they can support pupils with high mental health needs by: providing multiple points of contact; facilitating friendships and relationships; finding a 'hook' to help tune in with them; finding activities that can 'close the gap'

between staff and pupils; helping them feel 'normal'; providing extra support and structure to help them succeed; promoting a sense of school as a second home and family; being upfront about confidentiality; and being prepared to persist (Anderson, Kerr-Roubicek & Rowling, 2006). However, research had indicated that support for those experiencing distress varies, with pupils expressing a desire for increased school-based support sources that were sympathetic (Kidger et al, 2009). Similarly, Ofsted (2005) reported that during their review, children and young people had commented that school staff need to be more aware of mental health problems, especially in order to help remove the stigma surrounding such issues.

2.4.2   The importance of mainstream teachers in successful implementation

A number of researchers argue that any school change must involve and potentially even begin with teachers as they are the key change agents (Burke & Paternite, 2007; Weare & Murray, 2004; Burke, 2008, Fullan, 2007; Paternite, 2007). Thus, the general consensus is that teachers should be included in the policy development and implementation of school mental health initiatives (Weist & Evans, 2005; Gowers et al., 2004; Gott, 2003; Weist & Murray, 2007; Lever et al, 2003). For example, Lynn, McKernan McKay and Atkins (2003, p. 197) stated that essentially the influences that schools have on the mental health needs of pupils are mediated by the teachers' role and thus collaboration with teachers is the "centrepiece for change at the school, classroom, and individual teacher levels". Moreover, it is suggested that there are priorities that need to be considered and addressed even before the development and implementation of initiatives occur such as: increasing collegiality between teachers; ongoing focused professional development; and embracing and implementing change at school level (St Leger, 2000). Although this may be perceived by some as time-consuming, the extensive literature on managing the change process indicates that success depends very much on participants "having a clear grasp of the vision, a good understanding of their role and a genuine willingness to contribute to the process" (Weare & Murray, 2004, p. 58). This is supported by Burack, Root & Zigler (1997) who stressed that teachers play a crucial role in the success of integration programmes, with the two specific criteria for success being their willingness and the provision of appropriate preparation. In adopting such

participative approaches to change, it is claimed there is a greater possibility of genuine ownership by all (Mullins, 1999) which tends to be enduring (Hersey & Blanchard, 1988). However, despite this consensus, there appears to be an absence of research literature encompassing the views and perspectives of school personnel, particularly in relation to their willingness to take on this role, a factor noted as integral to the success and sustainability of any change process (Weare & Murray, 2004; Paternite & Johnston, 2005; Weist & Murray, 2007; Greenburg et al., 2003). This absence is acknowledged by Rothi et al. (2008) who called for more research into good practice and teacher training models and a wider survey of teachers' perceived roles and responsibilities. Therefore, as powerful change agents in school reform, an improved understanding of teachers' willingness to support pupils' mental health needs is essential. This could contribute to providing more effective models of teacher training as well as ascertaining information regarding how teachers perceive this role.

2.5   Willingness and organisational change

Systems theory (e.g. Campbell, Coldicott & Kinsella; 1994; Dowling & Osborne, 1994) can help in understanding the complex processes involved in change. In particular, when an individual is confronted with change, they may seek a balance between change and stability, referred to within systems theory as homeostasis. This can manifest itself as a resistance within the system to adapt to change. Causes of resistance might lie in the perception of a threat to the status quo, leading to reduced levels of well-being, motivation and satisfaction; this is especially relevant when the change in consideration is perceived to conflict with the objectives and responsibilities associated with specific work roles (Metselaar, 1997).

As such, much of the literature regarding organisational change has focused on the concept of 'resistance' (e.g. Watson, 1973; Bovey & Hede, 2001; Oreg, 2006; Evans, 2001). However, the concept of resistance carries with it negative connotations which are problem focused. Solution orientated models of change are proposed to be more helpful in identifying what is working and building upon it in order to facilitate positive change (Rees, 2008). As an alternative to resistance, the concept of 'willingness':

defined within the English language as a "freedom from reluctance; disposition to consent or comply; disposition to do what is required; readiness to be of service" (www.oed.com), is more solution orientated and thus can serve as a useful concept in relation to the change process regarding teachers more actively supporting the mental health needs of their pupils, particularly in identifying what factors might contribute to success. In terms of organisational change, willingness has been described as "a positive behavioural intention towards the implementation of modifications" (Metselaar, 1997). From this perspective, the question arises as to which theories can help define and understand this construct.

Many behavioural theorists have proposed models of behavioural change based on concepts such as reinforcement (e.g. Skinner, 1953, 1969; Azrin & Holz, 1966). This could be translated into the context of the current study with the example of teachers being paid more for adopting desirable practices such as supporting the mental health needs of pupils. However, such forms of motivation rely, at least initially, on extrinsic motivation and do not account for the complexity of certain behaviours or the impact of social factors. Furthermore, from a political stance, the current economic climate is likely to make such a system financially impracticable.

Social and cognitive learning theorists would argue that behaviour modification is more than a process of the individual forming associations (e.g. Vroom, 1964, 1968; Locke, 1975). Indeed, most would argue that it involves cognitive processes to understand associations between behaviour and response, and make decisions about how they will act. Vroom's expectancy theory (1964) suggested that behaviour results from conscious choices between alternatives, and these choices are systematically related to psychological processes such as perception and the formation of beliefs and attitudes. Vroom asserted that an individual's motivation is determined by the affective position he or she holds with regard to outcomes (valence), the anticipation that these outcomes will lead to other outcomes (instrumentality) and his or her beliefs about whether a particular outcome is possible (expectancy). Although expectancy theory provides a framework for understanding the cognitive processes involved in the formation of willingness, it has

been criticised for not considering the influences of 'climate' (Metselaar, 1997). The impact of organisational climate has been pointed out by many researchers as relevant in supporting change and innovative behaviour (Abbey & Dickson, 1983; Amabile & Gryskiewicz, 1989; Scott & Bruce 1994). Organisational climate in these terms represents the messages which individuals receive from others concerning expectations for behaviour and potential outcomes of behaviour (Scott and Bruce, 1994).

From a social constructionist perspective (Burr, 2003; Gergen, 1999), organisations are seen as socially constructed realities. From this perspective, the willingness to perform certain behaviours develops during the course of social interactions. Thus, the development of willingness might be founded in socially constructed group norms as much as in the socially constructed attitudes and beliefs of individual employees. The constructionist model of informed and reasoned action (COMOIRA, Gameson & Rhydderch, 2008, p. 105) is a framework for EP practice to guide the process of change. The framework places social constructionism at its core to help practitioners make sense of what is going on and the ways in which people might be "choosing to think, feel and act within their local, specific and unique contexts". As such, COMOIRA places emphasis on appreciating how individuals or groups of individuals choose to frame certain situations, and the implications these constructions have on the change process. The framework also acknowledges the role that constructions of willingness have in the change process.

A model for explaining social behaviour that can accommodate an individual's socially constructed beliefs, attitudes and norms is Ajzen's TPB (e.g. Ajzen, 1985, 1991, 2005). The model posits that behavioural intention is a direct antecedent to behaviour. It has been used to predict the likelihood of behavioural intention and actual behaviour in a variety of contexts. It can therefore be argued that the model has the potential for establishing the antecedents of positive behavioural intention (i.e. willingness). The following section takes a closer look at the TPB in conjunction with relevant research literature.

2.6 The theory of planned behaviour

The TPB model is based on the notion that several motivational factors underlie a person's behavioural intentions (Figure 2.1).

Figure 2.1: The theory of planned behaviour (based on Fishbein & Ajzen, 2010)
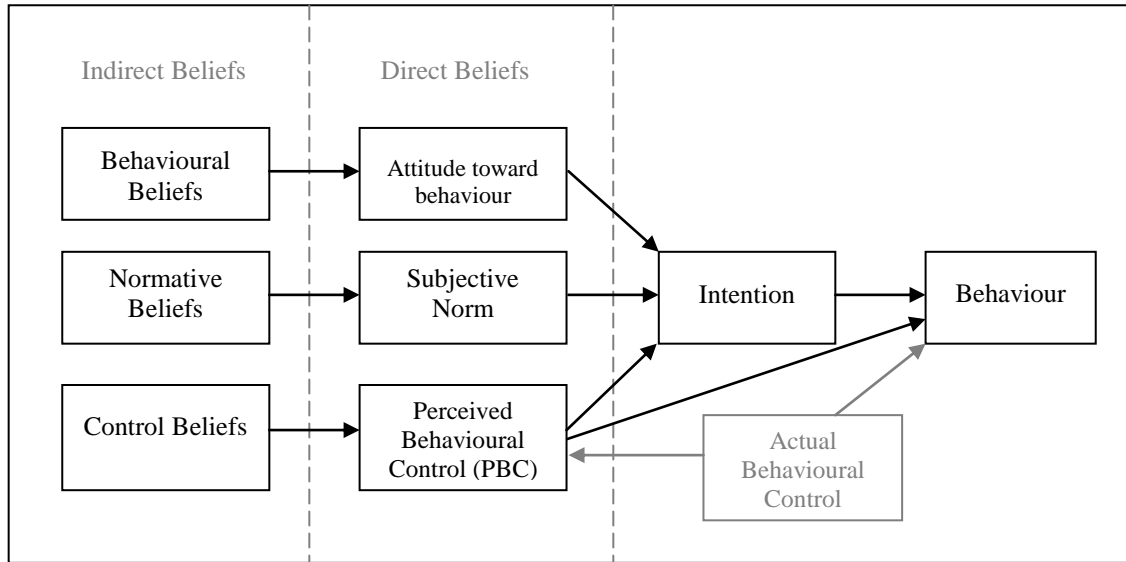
According to the theory, human behaviour is guided by three kinds of constructions: beliefs about the likely outcomes of the behaviour (behavioural beliefs), beliefs about the general expectations of others (normative beliefs), and beliefs about the presence of factors that may facilitate or hinder performance of the behaviour (control beliefs). These are known as indirect beliefs.

In their respective aggregates, behavioural beliefs produce a favourable or unfavourable attitude toward the behaviour; normative beliefs result in perceived social pressure or subjective norm; and control beliefs contribute to perceived behavioural control (PBC). Attitude toward behaviour, subjective norm, and PBC, also known as direct beliefs, in turn lead to the formation of a behavioural intention. The theory implies that the more favourable the direct beliefs, the stronger the person's intention will be to perform the behaviour in question. It follows that, given a sufficient degree of actual control over the behaviour in question, for example physical resources, people are expected to carry out their intentions when the opportunity arises. Intention is thus assumed to be an

immediate precursor to behaviour. The theory also posits that where there are constraints on volitional control, PBC alone can account for variance in behaviour. Therefore, within the model, PBC is seen to contribute to behaviour both directly and indirectly in conjunction with intention.

The TPB has received considerable attention within the academic field. Although there is criticism that many of the concepts within the theory are ill defined (Sutton, 1997; Ajzen, 1991), the theory has received substantial support in terms of its ability to predict intention and subsequent behaviour (Armitage & Conner, 2001; Godin & Kok, 1996). For example, Armitage and Conner (2001) carried out a comprehensive meta-analysis of 185 independent studies of TPB and found that the model accounted for 27% and 39% of the variance in behaviour and intention respectively. Furthermore, it was found that the PBC construct in particular accounted for significant amounts of variance. However, the subjective norm construct has been found to be a weak predictor of intentions (Armitage & Conner, 2001; Godin & Kok, 1996), to the extent that some researchers have left it out of their research altogether. Armitage and Conner attributed this weakness to a combination of poor measurement and the need for further expansion of the normative component (i.e. to include moral or descriptive norms). However, it could also be hypothesised that for many of the studies included within the meta-analysis, subjective norms may not have been as salient a factor as others. That is, many of the studies analysed looked at the adoption of health related behaviours, for instance losing weight or stopping smoking. In these situations the views of others might not be as pervasive as individual attitude or perceived control. Whereas, in organisational change it could be argued that the influence of normative beliefs may be more pervasive, such as the perceived pressure from management, colleagues and service users. This suggestion is somewhat supported by Azjen (1991) who states that the relative importance of attitude, subjective norm, and PBC in the prediction of intention is expected to vary across behaviours and situations.

2.6.1   The use of TPB within the educational context

Although applications of the TPB have predominantly been linked to health-related behaviours, there have been a number of successful applications of the model within the educational context to predict the intentions of teachers (Ballone & Czemiak, 2001; Lee, Cerreto & Lee, 2010; Haney, Czerniak & Lumpe, 1996; Sugar, Crawley & Fine, 2005; Zint, 2002; Kudlaeek, Valkova, Sherrill, Myers & French, 2002; Kersaint, Lewis, Potter & Meisels, 2007). It would seem that amongst these studies, the attitudinal component of the model tends to be the strongest predictor of teacher intention. It should be noted that not all of these applications have employed the whole model of TPB, that is, they have explored the direct components only. This may be seen as a missed opportunity, as by understanding what specific indirect beliefs predict direct factors, one has the potential to improve favourable intentions. For instance, Sugar et al. (2005, p. 331) concluded that the theory offers researchers "fruitful avenues in examining teachers' decision making processes". This is something also recognised by Ajzen (2002) who notes, with regards to general applications of the TPB, that the vast majority of studies only utilise the direct factors, even though belief-based measures have the additional benefit of providing insight into the cognitive foundations underlying them.

Ballone and Czerniak (2001) used the TPB to examine the influences of teacher beliefs on their intent to implement a variety of instructional strategies to meet the needs of different learning styles in the science classroom. Their results indicated that attitude towards the behaviour, PBC and subjective norm all influenced teacher intention, with attitude towards behaviour bearing the greatest influence. Overall, the model accounted for 62 percent of the variance of teacher intent. More recently, Lee et al. (2010) used the TPB to explore teachers' decisions regarding the use of educational technology. Results revealed that attitude towards behaviour, subjective norm and PBC were all significant predictors of teacher intention, predicting 69 percent of the variance. However, similar to the aforementioned study, attitude towards the behaviour had twice the influence of subjective norm and three times that of PBC, suggesting that teachers must have positive attitudes in order to carry out the target behaviour and are less concerned about what others think, and far less concerned by internal or external constraints.

One study has compared three types of attitude-behaviour theories (TPB, theory of reasoned action and theory of trying) in order to predict teachers' intentions in relation to incorporating certain factors within their lessons (Zint, 2002). Out of the three theories, it was concluded that the TPB provided the best attitude-behaviour model to predict teacher intention.

Many of these school-based studies report that the TPB would be helpful in guiding training and interventions amongst staff (Lee et al, 2010; Ballone & Czerniak, 2001; Sugar et al., 2005). Despite this, many studies utilising the TPB have been criticised for using the model to measure pre- to post-intervention change, without actually using it to inform and develop the intervention itself (Hardeman et al., 2002). There is support for this notion in the form of a randomised control study undertaken outside of the educational context (Casper, 2007). The study sought the effects of a training session for mental health professionals regarding a particular mental health assessment tool on their intention to integrate the tool into their practices. Within this study, one group of participants received general training and one group received training developed and guided by the TPB. Findings indicated that the session guided by the TPB significantly and substantially increased participants' intentions to use the instrument in comparison with the control group who received standard training. Furthermore, significantly more participants in the theory-guided session than in the control group had used the instrument at three month follow-up (74% versus 42%). Moreover, among those participants who had implemented the assessment tool within their practice, those who attended the TPB-guided session had implemented it considerably more. Hence it was concluded that the TPB has the potential to guide the development and improve the effectiveness of continuing professional development training. Therefore, not only would it seem that the TPB could be useful in aiding the exploration of teacher constructions regarding supporting the mental health needs of their pupils, if proved applicable, it could also help in the design and development of interventions which foster positive intentions amongst teachers, in this case willingness.

2.7 A framework for the exploring teacher willingness

This section examines how the TPB could be used as a framework for understanding the willingness of teachers to support the mental health needs of pupils. In doing this, it is hoped that clarity will be provided regarding each of the constructs within the model and, with reference to the academic literature, their relevance to the current study. Many of the studies yielded from the literature search have identified and/or explored certain factors in isolation without a strong or comprehensive theoretical basis. However, most of these are relevant in terms of the individual components of the TPB, and thus can help inform a comprehensive theoretical model that may be helpful in understanding the underlying social-cognitive processes that influence teachers' willingness to support pupil mental health.

2.7.1 Attitude towards role

Although formal definitions of attitude vary, there is a general consensus amongst modern social psychologists that its main feature is its evaluative nature i.e. positive-negative (Ajzen, 2005). The notion that attitude can help predict behaviour is widely supported within the social psychological field and is well supported in research (e.g. Kraus, 1995, Ajzen & Fishbein, 1977). However, there also exists much debate over the strength of its predictive value when considered in isolation (Tittle & Hill, 1967).

Amidst this debate, there exist a number of reasons why findings exploring attitude-behaviour relationships are mixed. For example, Ajzen (2005) has emphasised the importance of distinguishing between two types of attitude when predicting intention and behaviour. The first type are general attitudes toward physical objects; racial, ethnic or other groups; institutions; events; or other general targets (e.g. mental health problems), which can often be broad and multi-dimensional in nature. The second type are attitudes toward performing specific behaviours with respect to an object or target (e.g. supporting pupils with mental health problems). These latter attitudes are those which feature in the TPB. It is also suggested that where individuals are certain about their attitude toward something, its predictive value is higher (Sample & Warland, 1973). This implies that where ambivalent attitudes are held, their power to predict

intention and behaviour may be reduced. Furthermore, there is also discussion within the literature that the predictive power of attitudes may be affected by response bias, especially the tendency amongst research participants to give socially desirable responses that do not accurately reflect their true attitude (Ajzen & Fishbein, 2005). It has been proposed that a way of avoiding such social desirability bias is to ensure that the purpose of the instrument measuring attitudes is not apparent to the respondent (Waly & Cook, 1965; cited in Ajzen & Fishbein, 2005).

In terms of relevance to mental health work in schools, as mentioned within the introductory chapter, the CAMHS Review (DfCSF & DH, 2008) reported that varying attitudes held by schools towards child and adolescent mental health were seen as a particular barrier to progress. In other words, it has been identified that a variety of attitudes are held by schools regarding their role in supporting the mental health needs of pupils and, in accordance with the TPB, these have the potential to facilitate or hinder willingness. Nevertheless, there is indication that many of the attitudes held by school staff are generally favourable in terms of supporting pupil mental health needs. However many of these studies: focus on attitudes amongst teachers in primary settings and thus do not account for the complexities of the secondary school context (e.g. Walter, Gouze & Lim, 2006; Reinke, Stormont, Herman, Puri & Goel, 2011; Roeser & Midgely, 1997; Gowers et al., 2004); ascertain the attitudes of school staff from outside of the UK context and thus do not necessarily represent attitudes formed within the UK, where policy, guidance, education systems and practice are fundamentally different (e.g. Walter et al., 2006; Lam & Hui, 2010; Reinke et al., 2011; Roeser & Midgely, 1997; King, Price, Telljohan & Wahl, 1999); or tend to focus on the attitudes of senior management (e.g. headteachers) or those with a specific pastoral care designation (e.g. SENCo, pastoral care coordinator) and these attitudes are generally favourable in terms of supporting pupil mental health needs (Moor et al., 2007; Rothi et al., 2008; Kidger et al., 2010). Therefore, it would seem that there is a lack of research concerning the attitudes of mainstream secondary school teachers within the UK. Nevertheless, this is an essential area for further exploration as those limited findings which are available indicate somewhat negative attitudes towards supporting the mental health needs of

pupils (e.g. McGregor & Campbell, 2001). One example of mainstream secondary school teachers constructing their role in supporting pupil mental health needs in negative terms is presented in an American study which reported that over a third (38%) of high school teachers commented that schools were unsuitable places for recognising depression amongst pupils (Ozabaci, 2010).

Behavioural beliefs. Most contemporary social psychologists take a cognitive or information-processing approach to attitude formation (Ajzen, 1991). Likewise, the TPB dictates that attitudes towards specific behaviours are influenced by other beliefs held by individuals regarding the outcomes of performing the behaviour in question. These are referred to within the model as behavioural beliefs. There are a number of factors that appear within the literature which have the potential to influence the attitudes of teachers in supporting the mental health needs of pupils. Factors that may be particularly pertinent are beliefs that such practices:

- conflict with academic priorities (Roeser & Midegly, 1997; Cooper, 2004; Lam & Hui, 2010; King et al, 1999; Koller & Bertel, 2006, DfCSF & DH, 2008; Connelly et al., 2008; Ecclestone & Hayes, 2009; Ridge et al., 2003; Rothi et al., 2008; Rowling, 2007);
- are of benefit or are of burden to teachers (Reinke et al., 2011; Finney, 2006; Lam & Hui, 2010, Roeser & Midgely, 1997; Connelly et al., 2008; Han & Weiss, 2005; St Leger, 2000; Ringeisen, Henderson & Hoagwood, 2003; Weare & Murray, 2004); and
- are of benefit to pupils' learning outcomes (Kidger et al., 2010; Weare & Murray, 2004; Han & Weiss, 2005; Lohrmann, Forman, Martin & Palmieri, 2008; Roeser & Midgely, 1997).

Weare and Murray (2004, p. 54) postulated that in order for schools to adopt inclusive mental health practices, they have to be demonstrated as relevant to the priorities of the school, such as:

> ...the learning of all pupils, supporting the professional development of teachers, helping with the management of commonplace but difficult behaviours in a wide range of pupils such as lack of attention, aggression, bullying, depression and withdrawal, and tackling widespread underachievement.

However, in line with the TPB, it is recognised within the literature that attitude alone is not enough for teachers to support pupil mental health needs (Reinke et al., 2011). It is suggested that a positive attitude towards the role is required in conjunction with the appropriate knowledge and skills acquired through training.

2.7.2   Subjective norm

Psychological theory would indicate that the perceived expectations of others can act as a motivator for compliance. Within social psychology, the concept of social influence (e.g. Kelman, 1958) can help us to appreciate some of the mechanisms by which teachers may be socially motivated to support the mental health needs of pupils. In terms of the TPB, the subjective norm is the perceived social pressure to engage or not to engage in a behaviour. Therefore, in relation to supporting pupil mental health needs, a supportive subjective norm would be "I am expected to support the mental health needs of pupils". However, findings relating to this would indicate a mixture of subjective norms are held by teachers (Connelly et al., 2008; Walter et al., 2006, Lohrmann et al., 2008; Roeser & Midgely, 1997; Lam & Hui, 2010; Collins & Holmshaw, 2008; Reinke et al., 2011; King et al., 1999; Ozabaci, 2010), with some teachers perceiving supporting the mental health of pupils to be part of their role, some perceiving it to be the role of more specialist school staff such as pastoral care co-ordinators, and some perceiving it to be the role of external 'experts' such as EPs and psychiatrists. Out of those limited studies based within the UK, findings indicate that teachers remain uncertain about the role they are expected to play in supporting the mental health needs of pupils (Conelly et

al., 2008; Collins & Holmshaw, 2008). Similarly, in 2001, the Welsh Government reported that the capacity of front line staff, such as teachers, to undertake the role of tier one mental health workers is hindered by "uncertainty about the legitimacy of taking action outside more specialised services" and "uncertainties about their role, which needs to be clarified and developed" (WAG, 2001, p. 19). Despite this acknowledgement, several years later a review carried out by the WAO (2009) reported that only 6 of the 18 Welsh local education departments who responded to their survey had made school staff aware of the role envisaged for them in the strategy document '*Child and Adolescent Mental Health Services: Everybody's Business*' (WAG, 2001). It was also reported that there is no consensus between local education departments on the role of school staff. For example, some do not expect school staff to promote resilience of families, to assess children who may have problems, or provide advice and interventions. Weare and Murray (2004) allude to the importance of social norms in successful school mental health work, stating that it is essential that there is widespread consensus at all levels regarding the current reality, that is, that teachers are expected to play a role in supporting the mental health needs of pupils. It could therefore be postulated that such mixed messages may result in ambivalent subjective norms which may have negative or neutral implications for teachers' willingness to engage in mental health work.

Normative beliefs. Within the TPB, it is assumed that the prevailing subjective norm is determined by a set of normative beliefs concerning the expectations of important referents. This is supported by the aforementioned concept of 'organisation climate' (e.g. Scott & Bruce, 1994) and also the notion of socially constructed realities where some dialogues are perceived as more powerful than others (e.g. Burr, 2003; Gergen, 1999). There are no studies per se which have explored what referents might influence teachers' subjective norm regarding supporting the mental health needs of pupils. However, Fishbein & Ajzen (1975) stated that referents can constitute individuals and groups and are generally dependent on the population, context and behaviour in question. Therefore, within the school context, these sources of social influence may come from government, senior management, colleagues or even pupils. This notion is supported by Weare and

Murray (2004, p. 57) pointed out the importance of identifying agents of change who can "spread ripples of awareness" amongst those who are reticent and waiting for encouragement and clear opportunities before becoming involved in school mental health work.

2.7.3 Perceived behavioural control (PBC)

In the TPB, PBC refers to one's perceptions of ability to perform a given behaviour. It is assumed that PBC is determined by a set of control beliefs (beliefs about the presence of factors that may facilitate or impede performance of the behaviour). There is much debate over the distinction between PBC and self-efficacy, with only weak evidence to support this distinction (Armitage & Conner, 2001). However, Ajzen (2002) distinguishes between the two by emphasising that within the TPB the PBC component encompasses both self-efficacy (dealing largely with the ease or difficulty of performing a behaviour) and controllability (the capacity the individual has to perform the behaviour), adding that dependent on the context and behaviour in question, one may be more powerful than another. Nevertheless, the debate continues, with many researchers questioning the concept.

Self-efficacy is formally defined as a person's judgments of their capabilities "to organize and execute courses of action required to attain designated types of performances" (Bandura, 1986, p.391). In other words, self-efficacy is a person's belief in their ability to succeed in specific situations, something which Bandura (1997) describes as fundamental in a generative system of human competence. As such, theoretically, a teacher's sense of self-efficacy can play an integral role in how they approach goals, tasks, and challenges, such as adopting a supportive role in meeting the mental health needs of pupils.

Generally, the research literature indicates that many school staff feel unprepared or ill-equipped and are thus unable to support the mental health needs of pupils (Ozabaci, 2010; Rothi et al., 2008; Adelman & Taylor, 2000; King et al., 1999; Walter et al., 2006; Kidger et al., 2010; Cooper, 2004). It would seem that this exists to a greater extent in

terms of mental health than other health related issues such as substance misuse, sex and pregnancy, nutrition and physical activity and general medical issues (Cohall et al., 2007). For instance, an American study carried out by Ozabaci (2010) found that over half of the high school teachers participating in his study (56%) were lacking confidence in their ability to recognise depressive symptoms in pupils. Likewise, within the UK, Rothi and colleagues (2008) found that amongst a sample of school staff consisting of those undertaking pastoral care duties, there was a widespread perception that teachers feel inadequately prepared to manage pupils with mental health needs. However, no research has been carried out within the UK that aims to ascertain the self-efficacy of mainstream teachers who do not have designated pastoral care responsibilities.

The TPB indicates that PBC is not only an important determinant of willingness, but is also an important factor in actually carrying out the behaviour in question. Thus, it is particularly worrying that the evidence suggests that generally teachers do not feel able to support the mental health needs of pupils.

Control beliefs. According to the TPB, control beliefs are the perceived presence of factors that may facilitate or impede performance of a behaviour. These may constitute both internal and external factors. In relation to the role of teachers in supporting the mental health of pupils, this is where the majority of research seems to be directed. That is, many studies have focused on interrelations between factors such as training, knowledge, skills and self-efficacy. The remainder of this section will be discussed in terms of factors which may impact on self-efficacy and factors which may impact on perceived controllability, in line with guidance from Ajzen (2002).

Self-efficacy. In relation to self-efficacy, the predominant relevant themes within the literature are the impacts of:

- perceived knowledge (e.g. Ozabaci, 2010; Walter et al., 2006, Langeveld et al., 2011; Moor et al., 2007; Herbert et al., 2004; Sciutto, Terjesen & Bender Frank, 2000; Wyman et al., 2008; Gowers et al., 2004);

- perceived skill (e.g. Lam & Hui, 2010; Reinke et al., 2011; McGregor & Campbell, 2001; Moor et al., 2007); and

- perceived level of experience of pupils with mental health problems (e.g. Walter et al., 2006; McGregor & Campbell, 2001; Ittzes, Tomcsányi, Szabó, Midling & Török, 2011; King et al., 2010; Gowers et al., 2004).

Generally, research implies that many teachers feel they lack the knowledge, skills and experience to support the mental health needs of pupils. This is supported by the CAMHS Review which reported a shortfall in the number of staff with the skills and confidence to deal with mental health issues (DfCSF & DH, 2008).

Perceived controllability. There are three main factors noted within the research literature which are relevant to the concept of perceived controllability of teachers to support the mental health needs of their pupils. These are:

- perceived time limitations (Connelly et al., 2008; Walter et al., 2006; Ringeisen et al., 2003; Ridge et al., 2003, Cooper, 2004);

- teacher stress (Wehby, Maggin, Moore Partin & Robinson, 2012; Lam & Hui, 2010; Hui, Jiangyu & Wenquan, 2001; Han & Weiss, 2005; Koller & Bertel, 2006; Hastings & Bham, 2003; Kidger et al., 2010; Ridge et al., 2003); and

- level of training (Langeveld et al, 2011, Moor et al., 2007; Jorm, Kitchener, Sawyer, Scales & Cvetkovski, 2010; Wyman et al., 2008; Gowers et al., 2004; Lam & Hui, 2010).

For example, a main finding of a recent qualitative UK study which sought the views of secondary pastoral care staff was that teachers' own emotional health needs are neglected, leaving them unable or unwilling to consider those of pupils (Kidger et al., 2010). Another UK study (Connelly et al., 2008) used survey methods to seek the views of school staff regarding their frustrations in supporting the mental health needs of pupils (including both primary and secondary settings, senior management and teachers).

Findings indicated that time limitations were a major barrier and source of frustration, in addition to inadequate levels of training.

A further factor which might be of relevance in terms of the perceived controllability is the aetiological beliefs held by teachers about mental health problems. For example, in terms of attribution theory, it would be feasible to suggest that strongly held beliefs as to whether mental health problems are attributed to biological causes or a product of environment influences, and thus whether they need to be 'treated' within a clinical setting, with medication, and/or by specialists, could have an effect on the perceived control of teachers in meeting these needs. This is supported by Mukolo and Heflinger (2011, p. 288) who report that the quality of response to mental health problems if often "determined by the perceived controllability of the illness experience". Furthermore they purport that the general public are more likely to attribute mental health problems amongst children and young people to genetic and biological causes, than they are for adults. Research has indicated a link between perceiving mental health problems as being caused by genetics and a tendency to recommend harsh forms of management such as medical interventions (Phelan, Yang & Cruz-Rojas, 2006). Although no research has been carried out in this area with respect to the teaching population, it is something that is recognised by Gott (2003), who points out that teachers can feel frustrated and disempowered by causal factors which they perceived to be out of their control. Correspondingly, Sciutto et al. (2000) claimed that misconceptions held by teachers regarding mental health problems may have important implications for the success of educational interventions. Furthermore, Moor et al. (2007) suggested that some teachers may hold attitudes which are apathetic to medicalised perspectives of mental health. Thus, it is argued that the perceived acceptability of interventions in terms of their ability to 'treat' the mental health problems of children and young people is an important consideration in school mental health promotion (Han and Weiss, 2005); that is, teachers need to know exactly why and how they can help.

There appears to be a preoccupation within the literature that increasing training levels will provide a solution, which is understandable in light of findings such as those from

Ofsted (2005), who reported that very often the provision of training for teachers on mental health was insufficient. Within the UK, one study has indicated that perceived knowledge, perceived skill and confidence amongst teachers in relation to recognising depressed pupils can increase with appropriate training (Moor et al., 2007). However, in accordance with the TPB, there appears to be an acknowledgement within the literature that training, with the aim of raising knowledge and skill, is insufficient in itself for teachers to feel able to take action (St Leger, 2000; Ringeisen et al., 2003; Kos, Richdale & Jackson, 2004; Barry & Jenkins, 2007; Han & Weiss, 2005). For example, Kos et al. (2004) noted that ratings of perceived knowledge about pupil mental health amongst teachers were much lower than their actual knowledge, indicating a lack of belief in their own abilities. Similarly, St Leger (2000) reported that teachers' level of satisfaction with their own skill and knowledge levels were low, even after undertaking professional development activities. St Leger attributed this to teachers (more so than some other professionals) setting themselves very high goals and often not being satisfied with their own individual efforts. One element that could help, yet is hard to control for, is the provision of relevant experience. For instance, McGregor and Campbell (2001) found that mainstream teachers who had experience of children with autism were more confident in managing them than those without. For reasons such as this, some researchers advocate that experiential learning should feature as part of mental health training programmes (Kelly et al., 2007; Kos et al., 2004). Therefore, it could be proposed that relevant previous experience may impact upon controllability beliefs and thus PBC.

2.8   Other factors which may affect willingness

Although the TPB can provide a framework for exploring how certain elements noted within the literature might piece together to influence a teacher's willingness to support the mental health needs of pupils, there are a number of factors which feature within the literature that the TPB does not accommodate. In particular, it does not explicitly allow for the impact of variables such as background factors (age, years of practice and personal experience) or awareness of support and supervision opportunities. Similarly, the model does not accommodate the potential impact of preferred social distance which

may well be relevant given the potential for stigmatised attitudes around mental health problems. However, since the TPB was first published, research has shown that, not only are there significant relationships between the theory's constructs, but that it is also possible to include other factors in the theory on an 'as needed' basis (Ajzen, 1991).

2.8.1   Background factors

Age. Age may be a relevant mediating factor to consider when exploring teacher willingness to support the mental health needs of their pupils. For example, it could by hypothesised that with age comes years of life and work experience, and thus confidence, expertise and skill with dealing with sensitive and difficult scenarios. Equally, it might be hypothesised that age paves the way to pessimism, disillusionment or exhaustion. Kos and colleagues (2004) found that in relation to ADHD, the age of teachers correlated significantly with continuing professional development opportunities, years of practice and experience of teaching pupils with ADHD, although no relationships were found between age and knowledge. Similarly, another study regarding teachers' knowledge of ADHD found no association between teacher age and knowledge (Sciutto et al., 2000). Furthermore, research exploring teachers' knowledge in relation to a variety of mental health problems, found no association with age (White et al., 2011). However, there has been no research to date looking at the association between teacher age and attitudinal beliefs relating to mental health.

Years of teaching practice. In a similar vein to age, years of teaching practice may be an important mediating factor in the willingness of teachers to support the mental health needs of pupils. Years of practice have been positively associated with perceived knowledge of ADHD (Sciutto et al., 2000). However, a similar study found no support for a relationship of this kind (Kos et al., 2004). Years of practice have also, as would be anticipated, been associated with experience of ADHD (Kos et al., 2004). However, in terms of general mental health problems, there is research which indicates no association between years of practice amongst primary school teachers and experience, knowledge, attitudes or self-efficacy in relation to pupil mental health (Walter et al., 2006; Collins & Holmshaw, 2008; Roeser & Midgely, 1997). However, there is some research which

indicates comfort level in dealing with mental health problems increases with years of practice (Cohall et al., 2007).

Personal experience. An area that remains unexplored is the effect of personal experience on teachers' engagement in mental health work in schools. That is, if teachers themselves, or someone they are close to, have experienced a mental health problem they may have an insight which impacts upon factors such as their awareness, attitude, empathy and confidence in terms of supporting the mental health of their pupils. This is alluded to by Bell, Long, Garvan and Bussing (2011) who comment that personal experiences relating to mental health problems may influence individual teacher's responses regarding pupil mental health. Outside of the educational context, it is well documented that 'contact with' or personal experience of mental health problems is a strong predictor of reduced stigmatisation (Smith, 2004). Furthermore, a UK study has reported that those members of the public who do not have any personal experience of mental health problems are less likely to take note of mental health awareness raising efforts (Braunholtz, Davidson & King, 2004). Therefore, it could well be postulated that a teacher's personal experience of mental health problems is likely to affect his or her willingness to engage with school mental health promotion efforts and support pupil mental health needs.

2.8.2   Support and supervision

It was a recommendation of WAG (2001) that people who are not specialist mental health workers but whose work brings them into contact with young people must have easy and structured access to specialist staff within their own and other agencies when this support is needed. This is further supported by Wehby et al. (2012), who found that in terms of the implementation of a mental health intervention, teacher-coach alliances had the largest impact in comparison to factors such as teacher burnout. This research implies that ongoing support from a 'coach' can help empower and motivate teachers.

However, in contrast to mental health clinicians who have an entitlement to supervision of practice, which allows for a healthy reflection on their working practices, teachers are

not necessarily provided with such supervisory opportunities (Finney, 2006). Nevertheless, Barry and Jenkins (2007) argue that, in addition to the provision of relevant training for teaching staff, support mechanisms are fundamental to ensure high quality implementation and sustainability of mental health work in schools. However, evidence has generally indicated that teachers are uncertain of the support structures available (Koller & Bertel, 2006; Cohall et al., 2007; Collins & Holmshaw, 2008) and feel that they do not have adequate supervisory opportunities (King et al., 2010, Kidger et al., 2010; Ringeisen et al., 2003). Teacher awareness of relevant pastoral care support structures has been linked with higher levels of self-efficacy (King et al., 1999), as has the provision of support and supervision (Kruger, 1997). Furthermore, findings from Gamman (2003) indicated that effective support for pupils experiencing mental health problems is likely to come when teachers feel they themselves have access to good support networks, can be open about the challenges they face and can be helped to develop more collaborative cultures. This is supported by St Leger (2000), who also proposed support for teachers when undertaking mental health work does not necessarily have to come from senior staff members, but can take the form of collaborative support communities (i.e. peer support). Based on the literature, it would seem that both an awareness of the pastoral care support structures and supervisory opportunities could help in promoting willingness amongst teachers in supporting the mental health needs of pupils.

2.8.3   *Preferred social distance*

As mentioned previously, Ajzen (2005) emphasised that it is attitude towards a behaviour that constitutes the attitudinal component of the TPB and not general attitudes. In these terms, stigmatic attitudes about mental health problems would be deemed as a general attitude and thus would not form part of the TPB. Nevertheless, stigmatic attitudes held by teachers may lead to a preference for social distance from those pupils who are experiencing mental health problems, which in turn has the potential to impact upon the inclusive practices of teachers and their willingness to support them. For example, Cohall and colleagues (2007) found that teachers feel most uncomfortable dealing with mental health problems when compared to other forms of difficulties

experienced by pupils, perhaps indicating the level of stigma associated with mental health. Furthermore, an American study carried out by Ozabaci (2010) identified that over half of those teachers participating (52%) felt that their school could not cope with depressed pupils. Such findings would indicate that some teachers may hold attitudes which are non-inclusive and could be attributable to stigmatic attitudes. There is no research available, however, that specifically explores stigmatic attitudes held by teachers regarding pupil mental health. Stigmatic attitudes are generally measured by gaining preference for social distance (Mukolo & Heflinger, 2011). Within the general population, preference for social distance from people with mental health problems has been seen to reduce with mental health literacy or mental health first aid training (e.g. Kitchener & Jorm, 2006; Kelly et al., 2007). Therefore, in light of the evidence which indicates limited training amongst teachers on mental health problems, it seems important to explore levels of preferred social distance amongst teachers as a determinant of their willingness to support the mental health needs of pupils. This is supported by Bell et al. (2011), who warn that stigmatic perceptions held by teachers can lead them to being pessimistic about teaching pupils experiencing mental health problems and affect their interactions with such pupils.

One strategy used to reduce preference for social distance in anti-stigma programs, is contact with a 'consumer-educator'. That is, part of the training is delivered by someone who has or is experiencing a mental health issue. However, in reviewing the "active ingredients" of anti-stigma programs, Jorm and Wright (2007, cited in Kelly et al, 2007) found that, although adult participants claimed contact with a consumer–educator had the greatest impact on them in terms of the content of the training, no actual difference was found between those who did and did not have such contact. Nevertheless, no research has been carried out as to the effects of a consumer-educator on teachers' attitudes and beliefs.

2.9   A proposed model

Although research has explored variables relating to mental health work in schools in isolation, research on them together as they interrelate and impact on teachers is limited (Roeser & Midgely, 1997). This view was supported by Reinke and colleagues (2011), who called for future research to examine connections between teacher characteristics such as training level and perceptions of school mental health initiatives.

The need to better understand the complexities surrounding the implementation of school mental health initiatives under real-world conditions in order to increase their sustainability was acknowledged by Han & Weiss (2005), who proposed a sequential model of successful programme implementation. Although this model is based on findings from the research literature, it was not theoretically driven, and furthermore did not consider social-cognitive factors, focusing more on training and the development of skills. Furthermore, this model has not been tested through research and thus remains hypothetical in nature.

Therefore, the current study proposes a predicative model of teacher willingness to support pupil mental health needs derived from both the TPB and academic literature (Figure 2.2).

Figure 2.2: A predictive model of teacher willingness to support pupil mental health needs
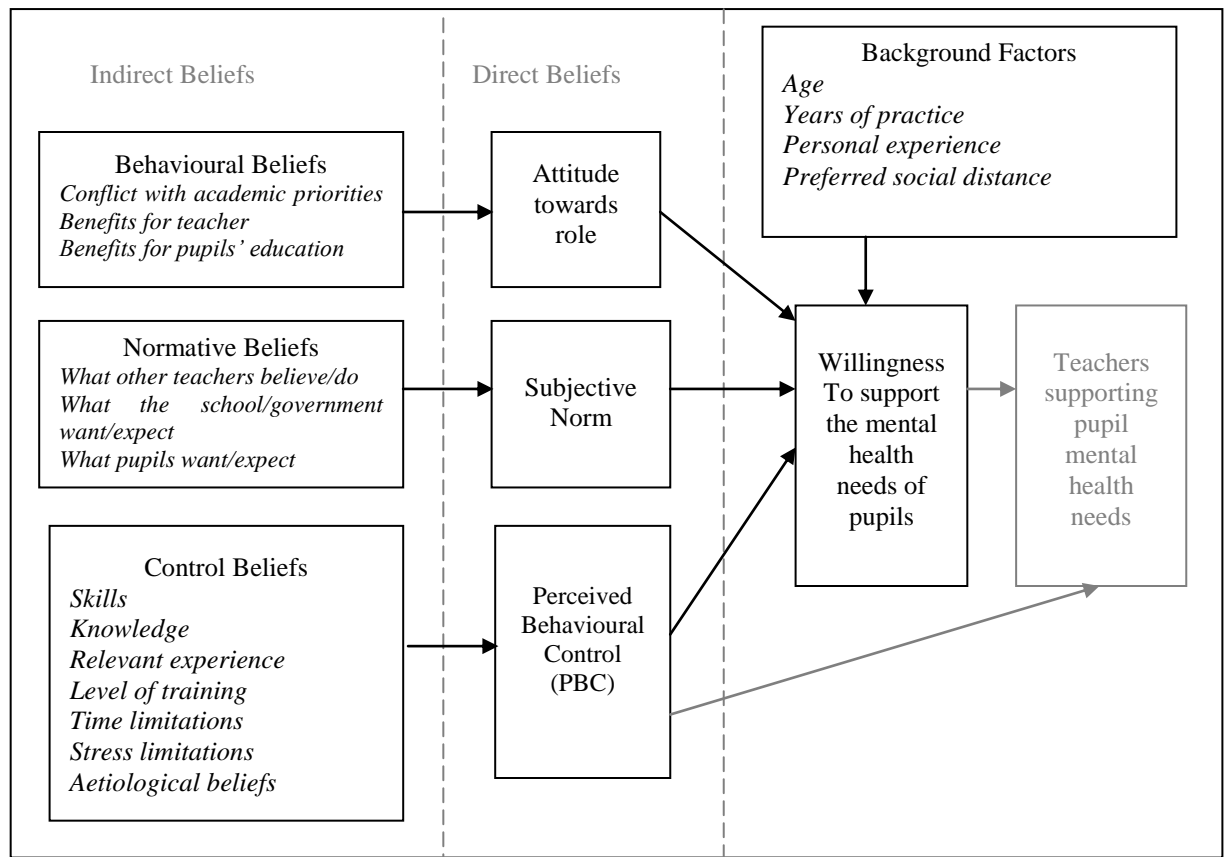
2.10 Internalised and externalised mental health problems

Referring back to the earlier section on mental health terminology, although a variety of issues and disorders exist under the same broad umbrella term 'mental health problems', there is an apparent need to appreciate that each of these 'problems' carries vastly different implications for inclusion within an educational setting due to their differing nature. Some problems may result in the individual internalising their difficulties and/or becoming very withdrawn (e.g. emotional disorders, eating disorders, self-harm and psychotic disorders), whilst other problems may result in very noticeable externalised behaviours which can be perceived as challenging or difficult to manage within the educational setting (e.g. hyperkinetic, conduct and autistic spectrum disorders).

It is acknowledged that schools and teachers are more likely to express concern, or seek help on a child's behalf, if a child is experiencing an externalising mental health problem

(Adelman and Taylor, 1999; Armbruster, Gerstein & Fallon, 1997; Herbert et al., 2004; Dwyer et al., 2006). Furthermore, in their inspection report, Ofsted (2005) expressed concern that the pupils who are least mentally well were those who are withdrawn or depressed. However, Ofsted also reported that such pupils present few challenges to teachers and consequently their problems are often not followed up, with few schools viewing non-attendance, lateness or falling behind in coursework and homework as indicative of deeper emotional problems. This is supported by Loades & Mastroyannopoulou (2010), who found that although teachers are good at recognising whether a pupil presents with a problem, their problem recognition is affected by both the gender of the child and the type of symptomatology being displayed, that is, emotional versus behavioural.

It is feasible to suggest that the predominance of training on conduct issues, as reported by both Ofsted (2005) and the DfCSF & DH (2008), could be attributed to the disruptive and somewhat inconvenient challenges posed by such issues within the educational setting (Adelman & Taylor, 1999; Walter et al., 2006). It could also be suggested that awareness and knowledge regarding different mental health disorders vary amongst school staff. For example, due to the high profile of autistic spectrum and hyperkinetic disorders, it is possible that many teachers are more familiar with the symptoms, characteristics and needs of young people experiencing these difficulties than, say, an anxiety disorder (e.g. Herbert et al., 2004). Therefore, it seems that there is a need to differentiate between externalised and internalised mental health problems when exploring them within the educational context. Furthermore, given the complex nature of the term mental health, for example the mental health and mental ill health continua, there is certainly a need to ensure clarity in terminology when researching this area, as these subtle differences in language are likely to translate into vastly different implications within the school context.

Although some studies exploring the views of school staff look at specific areas such as ADHD (e.g. Kos et al., 2004), autism (e.g. McGregor & Campbell, 2001), depression (e.g. Ozabaci, 2010) or suicide (e.g. King et al., 1999), many studies seek staff views on

'mental health' generically. Of those studies carried out within the UK seeking the perspectives of school staff in relation to their role in supporting the pupil mental health needs, few appear to make explicit to participants what is meant by mental health and/or to differentiate between internalised and externalised mental health problems. For example, Kidger and colleagues (2010, p. 923) opted to employ the term "emotional health and wellbeing" to explore staff views regarding undertaking "any school-based activities or lessons that focus on mental or emotional health", however failed to differentiate between mental health and mental ill health, or internalised and externalised mental health problems. Similarly, in their paper entitled "*On the front-line: Teachers as active observers of pupils' mental health"*, Rothi et al. (2008) sought the perspectives of school staff regarding their role in relation to pupil mental health. Although Rothi et al. distinguished between the mental ill health and mental health continua in their research, they did not differentiate between internalised and externalised mental health problems, rather the term was used generically to encompass all. Thus, in both cases, the fundamental concept of the research, mental health, was open to subjective interpretation by the participants, hence were unlikely to represent all mental health problems. For example, a participant whose predominant experience of mental health problems per se has been with pupils experiencing ADHD or conduct disorders may provide responses that are biased towards externalised mental health problems. Similarly, a staff member who has had involvement in the SEAL initiative may construct the term mental health as concerning the mental health continuum and not mental ill health.

2.11 A focus on secondary school teachers

When exploring the role of teachers in supporting the mental health needs of pupils, the differences between the roles of the secondary school and the primary school teacher must be appreciated. For instance, Ofsted (2005) reported that secondary schools were less successful than primary schools in taking on this role, and also less coordinated in terms of liaison with external agencies. One reason for this could be that the systems which exist within secondary schools are very different from those in primary settings. For example, primary teachers spend much more of their time with the same pupils than do secondary teachers, and thus they have more opportunities to get to know their pupils

and notice any concerning differences in affect or behaviour. This is supported by King et al. (2010), who argued that the set-up of the secondary school day and the different roles and responsibilities of staff can provide limited opportunities and time for exploration, dialogue and reflection in terms of pupil mental health. Additionally, secondary school teachers are often more subject-orientated than primary teachers (Roeser & Midgely, 1997). Furthermore, it is suggested that the higher likelihood of secondary schools having counsellors on site can contribute to increased attitudes amongst staff that mental health problems are 'somebody else's business' (Roeser & Midgely, 1997, p. 130). Another reason for this difference may be that the prevalence of mental health problems is slightly higher, and of a different nature, amongst young people of secondary school age (Green et al. 2005). Consequently, there seems a particular need to improve the capacity of secondary school teachers to support the mental health needs of pupils.

Despite this need, there is a dearth of studies within the UK which explore the views of secondary school staff with respect to supporting pupil mental health needs, and those few which do only seek the perspectives of staff who have a designated pastoral care role or who are part of their school's senior management team (Moor et al., 2007; Rothi et al., 2008; Kidger et al., 2010).

2.12 The current study

Although government guidance and policy regarding the implementation of the wellbeing agenda within educational settings have a sound philosophical grounding, there has been a lack of consideration with regards to relevant theory in terms of its implementation. Furthermore, there is a notable shortage of research with respect to general mainstream school teachers who do not have a designated pastoral care responsibility within their schools. These teachers are arguably on the 'front-line' when it comes to supporting the mental health needs of all pupils. Nevertheless, within the UK there exists only a handful of studies which seek the perceptions of school staff regarding their role in supporting pupil mental health, and none of these seek the perceptions of mainstream secondary school teachers who are not formally engaged in

pastoral care activities. Secondary schools are made up of notoriously complex systems, and consequently a whole-school approach to mental health is innately difficult to implement. Therefore, there is a need to explore the underlying processes that contribute to the willingness of secondary mainstream school teachers who do not have a designated pastoral care role in supporting the mental health needs of pupils. There also appears to be a particular need to explore this in relation to internalised mental health problems.

Therefore, the present study sought to test a proposed model of teacher willingness in supporting the mental health needs of pupils, derived from the TPB and factors drawn from the research literature. It is hoped that by synthesising factors from the research literature with the TPB, the willingness of teachers to support the mental health needs of their pupils can be better predicted, thus providing a unique and important contribution to the field. Such a contribution has the potential to inform school mental health promotion initiatives, policy making and training.

2.12.1 Hypotheses

There were four main research hypotheses, which are listed below. Each of the hypotheses is supported by an individual model, each of which is a component of the model illustrated in figure 2.2.

H1: Direct factors will be predicted by their respective indirect factors (H1a, H1b, H1c).

H1a: Behavioural beliefs held by mainstream secondary school teachers about supporting the mental health needs of pupils such as conflicts with academic priorities, benefits for teachers, and benefits for pupils' education will predict the attitude they hold towards the role (Figure 2.3).

Figure 2.3: Model illustrating H1a
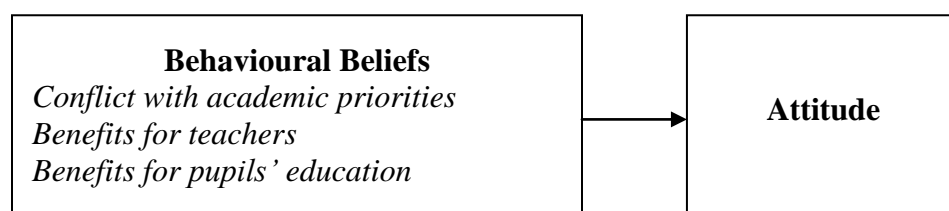
H1b: Normative beliefs held by mainstream secondary school teachers regarding what other teachers believe/do and what their school, pupils and the government want/expect from teachers in relation to supporting pupil mental health will predict the subjective norms they hold towards the role (Figure 2.4).

Figure 2.4: Model illustrating H1b
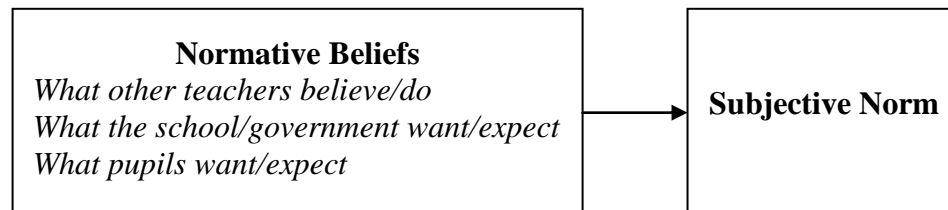
H1c: Control beliefs held by mainstream secondary school teachers about supporting the mental health needs of pupils such as their perceived levels of skill, knowledge, relevant experience, training, time limitations, stress limitations and aetiological beliefs will predict their perceived behavioural control in terms of performing the role (Figure 2.5).

Figure 2.5: Model illustrating H1c
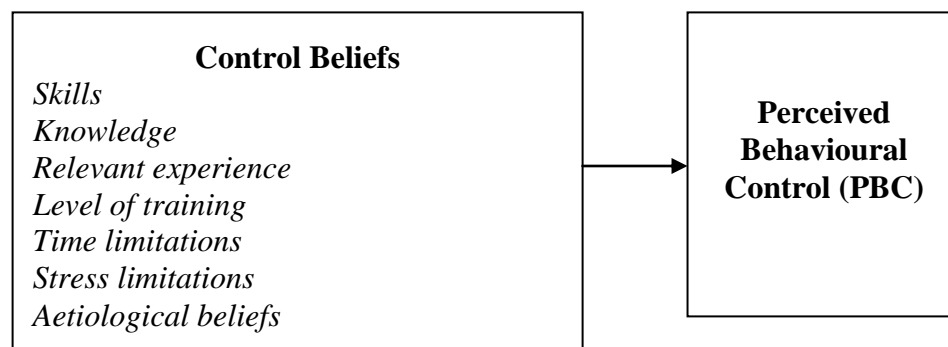
H2: Direct factors from the TPB such as attitude, subjective norm and perceived behavioural control will predict mainstream secondary school teachers' willingness to support the mental health needs of pupils (Figure 2.6).

Figure 2.6: Model illustrating H2

```
┌─────────────────────┐
│     Attitude         │────────┐
└─────────────────────┘        │
                               ▼
┌─────────────────────┐   ┌──────────────┐
│  Subjective Norm     │──▶│  Willingness │
└─────────────────────┘   └──────────────┘
                               ▲
┌─────────────────────┐        │
│ Perceived Behavioural│────────┘
│    Control (PCB)     │
└─────────────────────┘
```
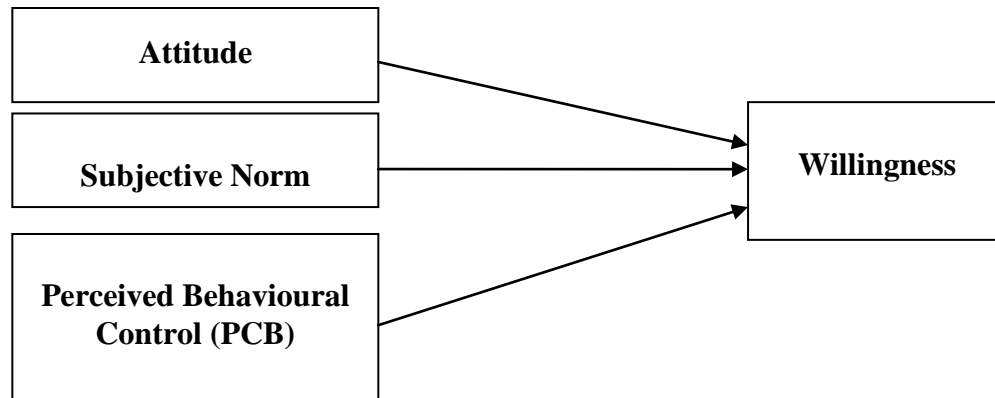
H3: A model containing background factors (such as age, perceptions of personal experience and years of practice), awareness of pastoral support structure, supervisory opportunities and preferred social distance regarding mental health will predict mainstream secondary school teachers' willingness to support the mental health needs of pupils (Figure 2.7).

Figure 2.7: Model illustrating H3

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┌─────────────────────────┐
│         Age             │───┐
├─────────────────────────┤   │
│   Personal experience    │──┐│
├─────────────────────────┤  ││
│    Years of practice     │─┐││
├─────────────────────────┤ │││
│ Awareness of pastoral    │ │││   ┌──────────────┐
│   support structure      │─┼┼┼──▶│  Willingness │
├─────────────────────────┤ │││   └──────────────┘
│     Supervisory          │─┘││
│    opportunities         │  ││
├─────────────────────────┤  ││
│   Preferred social       │──┘│
│      distance            │───┘
└─────────────────────────┘
```
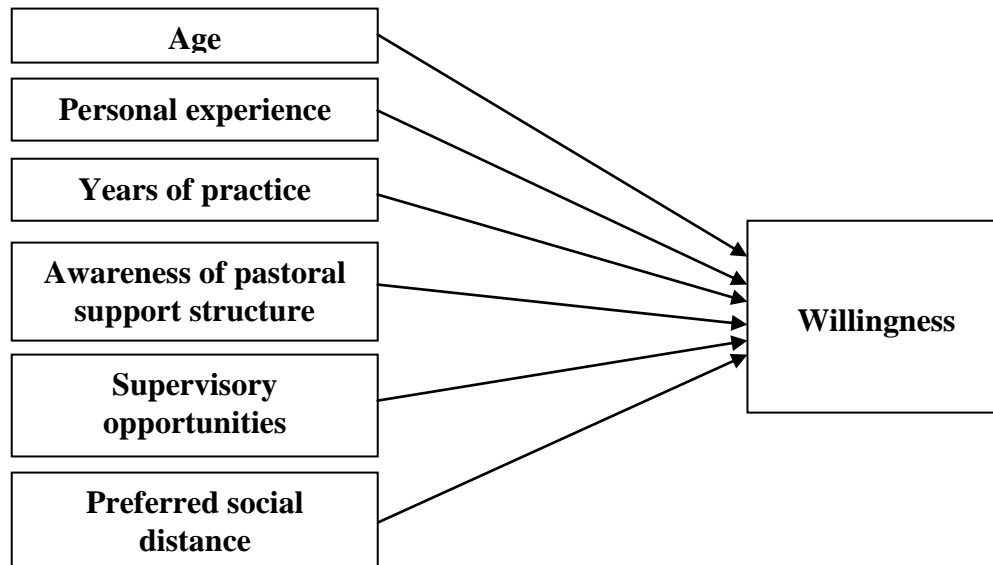
H4: A model including direct factors from the TPB (attitude, subjective norm and perceived behavioural control) and background factors (such as age, perceptions of personal experience and years of practice), awareness of pastoral support structure, supervisory opportunities and preferred social distance will best predict mainstream secondary school teachers' willingness to support the mental health needs of pupils (Figure 2.8).

Figure 2.8: Model illustrating H4
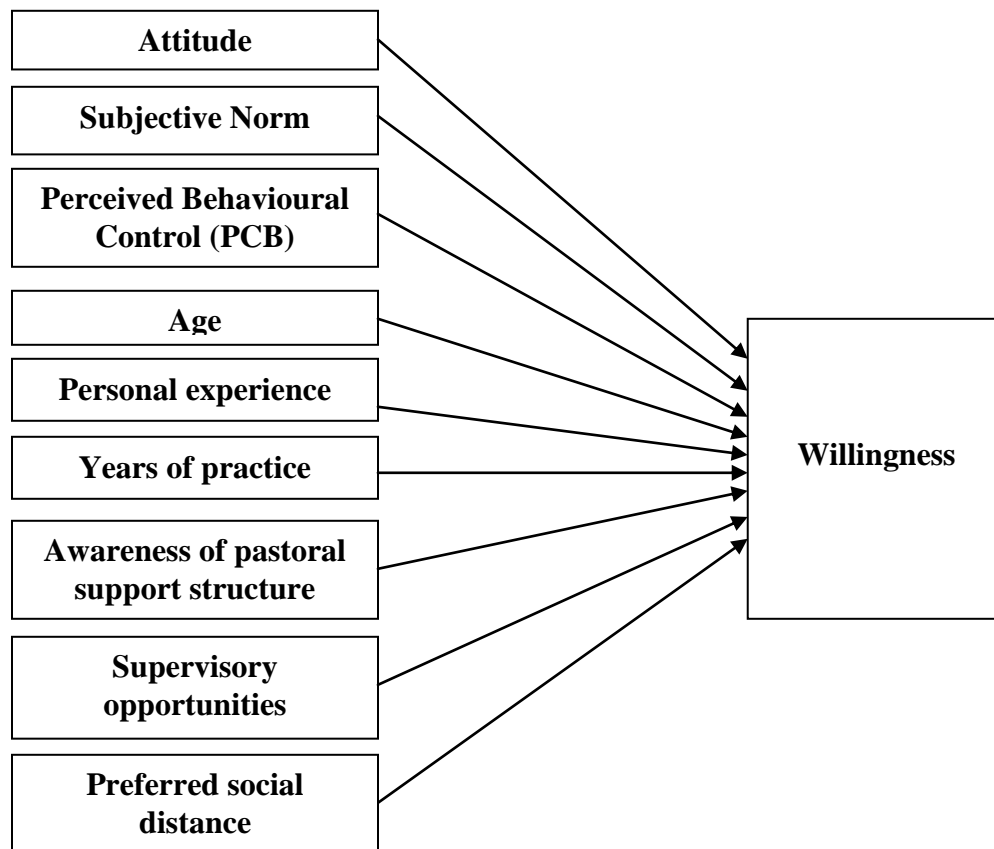
3. METHODOLOGY

3.1   Overview

This section describes the methodology used in this study to test the research hypotheses. The chapter begins by discussing the chosen research paradigm. This is followed by details of the participant sample and information regarding the development of the measurement instrument used. This includes details of the procedures adopted and the ethical considerations given. This section concludes with a description of the chosen methods employed to analyse the research findings.

3.2   Research Paradigm

Studies aiming to test applications of TPB have generally implemented quantitative methodologies (Ajzen, 1991; Armitage & Conner, 2001). Bryman (1988) advocates that quantitative methodologies should be adopted when research is concerned with the testing of hypotheses, the prediction of variance, assessments of validity and questions related to generalisability. The current study can be seen to fit within these parameters in terms of its focus on the testing of hypotheses related to the relationship between a set of variables. The research also fits with Bryman's parameters for quantitative research in its concern with exploring the value of models and theories developed in organisational settings, when applied to the school context.

The practical and ethical constraints involved in adopting experimental approaches for research concerned with teachers' perceptions and behaviours (i.e. the research was concerned with a very busy and thus possibly hard to engage population and their perceptions and attitudes regarding a very vulnerable population of young people), led to a decision to avoid an experimental research design. Alternatively, survey methods were employed to assess participants' ratings of the variables in question. There are some obvious drawbacks of using self-report methods such as response bias. However, steps were taken in the current study to account for such drawbacks and these are discussed in greater detail later on.

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In congruence with the main body of research literature concerning the application of the TPB to real world situations, the relationships amongst the variables in the current study were assessed using multivariate analysis (Fishbein & Ajzen, 2010; Armitage & Conner, 2001). Cohen and Cohen (1983) suggest that methodology of this sort provides a consistent approach for quantitative analysis that does not rely on passive observations of a phenomenon, but enables useful insights into associations among a number of variables to be made. The use of multivariate analyses is also supported by Tabachnick and Fidell (2001) who state that methodology of this kind has the benefit of providing a flexible analysis for complicated real-world problems that cannot be meaningfully reduced to experimental research in laboratory settings.

3.3   Research Design

The study employed survey methods to test the research hypotheses. Survey methods are used to collect quantitative information from certain populations - the population in the current study being mainstream secondary school teachers. Creswell (2008) asserts that such methods are widely used within the educational context and are helpful in identifying the beliefs, opinions and attitudes held by individuals. Fishbein and Ajzen (2010), the creators of the TPB, advocate the use of questionnaires in testing applications of the TPB and this is reflected in the main body of associated research literature (Armitage & Conner, 2001). In light of this, the current study opted for the use of questionnaires over interviews. This was in congruence with Fishbein and Ajzen's guidance and also had the additional benefits of helping to access a large sample, accommodating the needs of the target population (the time limitations of mainstream secondary school teachers) and allowing for anonymity (helping to prevent social desirability bias).

3.4   Sample

3.4.1   Participants

Participants consisted of 215 mainstream secondary school teachers who did not have any additional role that may potentially include pastoral care responsibilities (i.e. head of

year, pastoral care co-ordinator, SENCo, or other member of senior management). This sample size, with 16 proposed independent variables, is well above the minimum recommended requirement of 178 (N ≥ 50 + 8m; where the value of m is the number of independent variables) for testing individual predictors in standard multiple regression analysis (Tabachnick & Fidell, 2001).

3.4.2 Schools

Participants within the sample taught at 14 state maintained secondary schools situated within nine local education authorities (LEA) within South Wales. The current study was limited to secondary schools, primarily for the reasons outlined within the literature review (i.e. secondary schools are less successful than primary or special schools in tackling emotional health and well-being through whole-school initiatives, Ofsted, 2005). Additionally, mental health issues are more pervasive in children and young people of secondary school age than those of primary school age, (Green et al., 2005). However, focusing solely upon secondary establishments had the additional benefit of controlling for organisational structure. The selection of participants from different school settings and within different LEAs also attempted to avoid the potential biases that may have resulted if participants were drawn from one school and/or LEA. Creswell (2008) purports that this type of approach helps to increase the generalisability of research findings.

School sizes ranged from 548 to 1239 pupils on roll, with a mean school size of 904 pupils. Eight schools within the sample had sixth form facilities and thus catered for children and young people aged 11-18. The remaining six schools catered for children and young people aged 11-16. The majority of schools within the sample were English medium, co-educational settings with the exception of two single-sex schools (one boys, one girls), two faith schools (namely Roman Catholic) and one Welsh medium school. All of the participating schools had been inspected at least once since 2006 by the Education and Training Inspectorate for Wales, Estyn. All participating schools had been

awarded with a Grade 2, 3 or 4[1] for Estyn's Key Question 1: how well do learners achieve, and Grade 1, 2 or 3 for Key Question 4: how well are learners cared for, guided and supported (information accessed from http://www.estyn.gov.uk). Therefore, the schools within the sample could be seen to represent a wide range of school standards. Finally, collectively the participating schools had broad catchments in relation to the socio-economic status of pupils. Please see table 3.1 for further details of participating schools.

Table 3.1: Details regarding participating schools

LEA	School	Intake	Pupils on role	Estyn KQ1	Estyn KQ4
LEA 1	School 1	11-18, Mixed	783 (89 sixth form)	Grade 2	Grade 1
	School 2	11-18, Boys	1006 (118 sixth form)	Grade 2	Grade 1
	School 3	11-18, Mixed	787 (95 in sixth form)	Grade 3	Grade 2
	School 4	11-16, Mixed	965	Grade 2	Grade 1
LEA 2	School 5	11-16, Mixed	625	Grade 2	Grade 1
	School 6	11-18, Mixed (Faith School)	1108 (220 in sixth form)	Grade 2	Grade 1
	School 7	11-16, Mixed	553	Grade 2	Grade 1
LEA 3	School 8	11-18, Girls	1261 (211 in sixth form)	Grade 2	Grade 2
LEA 4	School 9	11-16, Mixed	1054	Grade 2	Grade 1
LEA 5	School 10	11-18, Mixed	1200 (189 in sixth form)	Grade 3	Grade 2
LEA 6	School 11	11-16, Mixed	571	Grade 3	Grade 1
LEA 7	School 12	11-16, Mixed (Faith School)	548	Grade 4	Grade 3
LEA 8	School 13	11-18, Mixed	1239 (202 in sixth form)	Grade 3	Grade 2
LEA 9	School 14	11-18, Mixed (Welsh Medium)	960 (127 in sixth form)	Grade 2	Grade 2

Note: KQ = Estyn Key Question as outlined on previous page.

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[1] ***Estyn Judgement Grades:*** *Grade 1 - good with outstanding features; Grade 2 - good features and no important shortcomings; Grade 3 - good features outweigh shortcomings; Grade 4 - some good features, but shortcomings in important areas; Grade 5 - many important shortcomings.*

3.5   Questionnaire Development

The five page questionnaire (Appendix 1) administered to teachers was developed with reference to guidance provided by Fishbein and Ajzen (2010) and Francis et al. (2004), both of whom set out frameworks for developing questionnaires based on the TPB.

At the outset of the questionnaire, a definition of 'mental health' was given for the purpose of participation. In addition to questions regarding various background factors (age range, gender, teaching qualification, years of teaching practice and attendance at relevant training) the questionnaire contained 64 items which constituted a total of 2 single-item Likehurt scales (perceived level of personal experience and perceived level of training) and 12 multi-item Likehurt scales (aetiological beliefs, preferred social distance, awareness of support and supervisory opportunities, behavioural beliefs, normative beliefs, perceived skills, perceived knowledge, perceived time and stress limitations, attitude towards the role, subjective norm, perceived behavioural control, and willingness). In line with guidance provided by Fishbein and Ajzen (2010) each of these items had a five point scale in order for participants to record their responses.

3.5.1   A definition of 'mental health'

A definition of 'mental health' was provided for the purpose of participation to help control for varying pre-conceptions. The definition provided was developed through examination of the literature as detailed previously within the literature review. As aforementioned, the definition developed was concerned with mental health problems and closely related to those problems highlighted by the BMA (2006) as being most prevalent amongst children and young people. As the study was not concerned with externalised mental health problems (due to their differing nature and implications for education to internalising mental health problems), these were explicitly excluded from the definition.

For the purpose of the questionnaire, the term 'mental health issue' was adopted to replace the terms 'mental health disorder' or 'mental health problem'. This was purely as the word 'issue' was felt to be less clinically loaded and within-child focused than the

word 'disorder' or 'problem' and thus would help reduce influence over participant responses. The definition provided within the questionnaire is provided in figure 3.1.

Figure 3.1: Definition of mental health as provided in questionnaire

Please keep the following definition of 'mental health' in mind when completing this questionnaire:

"Someone who may be at risk of developing or who is experiencing a mental health issue such as the following; a mood disorder (e.g. depression), psychosis (e.g. schizophrenia), an eating disorder (e.g. anorexia), an anxiety disorder (e.g. obsessive compulsive disorder, social anxiety disorder), suicidal thoughts, or self-harm".

*Please note, this definition of mental health purposely excludes developmental disorders (e.g. autistic spectrum disorder [ASD]), conduct disorders (e.g. oppositional-defiance disorder [ODD]) and hyperkinetic disorders (e.g. attention-deficit/hyperactivity disorder [ADHD]).

3.5.2   Background factors

Demographic information was requested regarding age range, gender and teaching qualification. These items were presented as multiple-choice response questions for ease of completion. Participants were also asked to state how many years of teaching practice they had. A multiple-choice item was included which required participants to indicate what types of relevant training they had attended, either as part of their pre-service training or as part of their continuing professional development. Participants were also asked to provide an estimate of how many pupils with mental health issues they believe themselves to have experience of.

3.5.3   Defining the target behaviour

In their guidance, Francis et al. (2004) stated that prior to constructing a questionnaire based on the TPB, it is important to clearly define the target 'behaviour' in question in terms of its Target, Action, Context and Time (TACT). In the current study, the target behaviour was for mainstream secondary school teachers 'to help identify and support the mental health needs of their pupils'. The target was pupils, the action was to help

identify and support mental health needs, and the context and time (implicitly) were within the school context/day.

3.5.4 Willingness to help identify and support pupil mental health needs

This scale provided a definition of the word 'willing' and consisted of two items: 'I am willing to support the mental health needs of my pupils' and 'I am willing to help identify pupils with mental health needs and refer pupils to the relevant parties'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.5 Perceived level of personal experience

A single-item scale was employed to explore perceptions of personal experience of mental health. Participants were asked 'How much personal experience of mental health issues do you have (e.g. yourself, family or friends)?'. Participants rated their perceived level of personal experience on a five-point scale (*1 = none, 5 = a lot*).

3.5.6 Aetiological beliefs

This multi-item Likehurt scale was concerned with what participants perceived as the causes and respective treatments for mental health issues. The scale consisted of four statements: 'People with mental health issues are born with a genetic predisposition to experience such issues'; 'Mental health issues ultimately need to be treated in a clinical/medical setting (e.g. with a psychiatrist)'; 'Mental health issues do not generally have a biological or genetic cause'; and 'Medication is not usually the main treatment for people with mental health issues'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.7 Preferred social distance

This multi-item Likehurt scale was comprised of three statements: 'I think sometimes it is best if pupils with mental health needs are not placed in mainstream classes'; 'If I am honest, I sometimes avoid talking to pupils with mental health needs'; and 'I do not have a problem with having pupils with mental health needs in my classes'. This scale aimed to ascertain the preferred social distance of teachers in relation to pupils with mental

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health needs as a measure of stigmatic attitudes. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.8   *Awareness of support structures and supervisory opportunities*

This multi-item Likehurt scale consisted of six statements concerning the participant's awareness of relevant support structures within their school and opportunities for supervision. These were: 'I know who to contact should I feel a pupil has a mental health concern'; 'I am confident that I am aware of the relevant support structures in place in my school should I suspect a pupil of having a mental health need'; 'I am able to seek supervision and feedback from my seniors if I have concerns about supporting the mental health needs of a pupil'; 'I discuss how to best support the mental health needs of pupils with my colleagues and seniors'; 'I don't know much about the pastoral care system in my school'; and 'I have no supervision opportunities in relation to supporting the specific mental health needs of pupils'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.9   *Attitude towards target behaviour*

Attitude towards the target behaviour was measured using a multi-item Likehurt scale consisting of four statements: 'As a subject teacher, I should not be expected to support the mental health needs of pupils when there are others who are better placed to do so'; 'As a subject teacher, I am well positioned to support the mental health needs of pupils'; 'I feel it is part of my role to support the mental health needs of my pupils'; and 'Supporting the mental health needs of pupils should not be my responsibility'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.10   *Subjective norm*

Subjective norm regarding the target behaviour was measured using a multi-item Likehurt scale consisting of three statements: 'Teachers are expected to support the mental health needs of pupils'; 'I think that supporting the mental health needs of pupils is an integral part of being any teacher'; and 'Generally, I am not expected to support the

mental health needs of my pupils'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.11 Perceived behavioural control (PBC)

Participants' PBC over the target behaviour was measured using a multi-item Likehurt scale consisting of eight statements: 'I do not feel confident in my ability to support the mental health needs of pupils'; 'I feel I am able to help pupils by supporting their mental health needs'; 'I am well equipped to support the mental health needs of my pupils'; 'Even if I supported the mental health needs of my pupils, I don't think it would make a difference'; 'I believe I am quite capable of supporting the mental health needs of pupils'; 'I am able to recognise the mental health needs of pupils'; 'I am able to support the mental health needs of pupils'; and 'I have been able to directly support the mental health needs of my pupils on a number of occasions'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.12 Behavioural beliefs

The multi-item Likehurt scale for behavioural beliefs was concerned with three areas of belief regarding supporting pupil mental health needs; perceived conflicts with academic priorities, perceived benefits for pupils' educational outcomes, perceived benefits for the teaching role. The scale consisted of nine statements: 'For me, supporting the mental health needs of pupils is difficult when also trying to meet curriculum demands'; 'For me, supporting the mental health needs of pupils is just as important as teaching the curriculum'; 'Learning is a school's main priority. This may be diluted by expecting subject teachers to actively play a role in supporting the mental health needs of pupils'; 'I think supporting the mental health needs of a pupil would give me job satisfaction'; 'Subject teachers do not really gain any benefits from supporting the mental health needs of their pupils'; 'In some situations, being able to support the mental health needs of pupils can make the work of a teacher easier'; 'If teachers take a holistic approach, which includes supporting pupil's mental health, it can help increase positive academic outcomes for pupils'; 'Supporting the mental health needs of pupils can help improve their academic achievement'; and 'Even if subject teachers are willing and able to

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support the mental health needs of their pupils, I doubt that it would have an impact on pupil achievement'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.13 Normative beliefs

The multi-item Likehurt scale for normative beliefs was concerned with three areas: the perceived expectations of pupils; the perceived expectations of the school and government; and perceived beliefs held by colleagues. The scale consisted of ten items: 'Other subject teachers in my school feel that supporting the mental health needs of pupils is part of the teacher role'; 'I do not think my colleagues are very open to supporting the mental health needs of pupils'; 'Many of my colleagues display a willingness to support the mental health needs of pupils'; 'Other subject teachers in my school would probably argue that they should not be expected to support the mental health needs of pupils'; 'The government do not advocate that subject teachers should support the mental health needs of pupils as there are others better placed to do it'; 'The senior management team of my school do not put pressure on subject teachers to directly support pupil mental health'; 'As a subject teacher, I am expected by senior management to support the mental health needs of pupils'; 'Pupils would not want to seek support from a subject teacher'; 'Pupils would not expect subject teachers to support their mental health needs'; and 'Pupils are likely to want subject teachers, in addition to pastoral staff, to support their mental health needs'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.5.14 Control beliefs - Perceived skills, Perceived knowledge, Perceived level of training and Perceived time and stress limitations

As the factors constituting the control beliefs construct were intrinsically diverse, it was deemed appropriate to have individual scales to represent each, which would then allow for individual analysis.

Perceived skill was measured using a multi-item Likehurt scale consisting of three statements: 'I feel I have the necessary skills to appropriately support the mental health needs of my pupils'; 'I don't think I am skilful enough to support the mental health

needs of pupils'; and 'I worry that I am not skilful enough to intervene if a pupil has a mental health issue'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

Perceived knowledge was measured using a multi-item Likehurt scale consisting of four statements: 'I think I know enough about mental health to effectively support the needs of pupils who are of concern'; 'I don't know much about mental health'; 'The knowledge I have regarding mental health is not sufficient to help support the mental health needs of pupil'; and 'I feel my mental health knowledge is adequate'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

Perceived level of training was a single-item scale which asked participants 'How would you rate the amount of training you have received in the area of mental health?'. Participants rated their perceived level of training on a five-point scale (*1 = none, 5 = a lot*).

Perceived time and stress limitations were measured using a multi-item Likehurt scale consisting of six statements: 'Generally, I do not get very stressed'; 'I find I experience a high level of stress in my job'; 'I sometimes feel too stressed with my own life and work pressures to address pupil mental health'; 'I do not have the time to incorporate supporting the mental health needs of pupils into my role'; 'I am usually able to find the time to meet the mental health needs of pupils'; and 'There is not enough time in the school day to support pupil mental health'. Participants rated their level of agreement on a five-point scale (*1 = strongly disagree, 5 = strongly agree*).

3.6 Reliability of Instrument

Reliability refers to the extent to which constructs are free from error and therefore yield consistent results. In order to compensate for acquiescence bias, where feasible, the multi-item Likehurt scales were made up of both positively and negatively weighted

items. To compensate for social desirability bias, participants were reminded at the start of the questionnaire:

> Please answer all questions as honestly as possible. Be assured that all your responses are anonymous and cannot be traced back to you. The identity of your school will also remain confidential.

Cronbach's alpha was used to measure the internal consistency of the multi-item Likehurt scales used in this study. If any scale was below the normal acceptable level (Cronbach's $\alpha = 0.6$; Nunnally, 1978), it was deleted. Furthermore, individual items were deleted if they led to a significant increase in the alpha value. Consequently, the scales used provided a statistically reliable and consistent measure of the intended constructs.

To further increase reliability, items within the questionnaire were randomly presented rather than grouped by construct. Goodhue and Loiacono (2002) purport that although Cronbach's alpha becomes inflated when questions are placed adjacent to each other and labelled by construct, this is artificial. However, they reported that intermixing questions leads to systematic improvement in actual reliability. Although this format has the potential to cause a "confusion bias" in terms of the participant having to shift from construct to construct and back again, Goodhue and Loiacono concluded that this does not have a significant effect on results.

Scales were also tested for multicollinearity. Field (2009) posits that this is important in order to ensure that the scales used are not effectively measuring the same construct.

3.7   Instrument Validity

Validity is defined as the extent to which any measuring instrument measures what it is intended to measure (Carmines & Zeller, 1979). In this study, the instrument was examined for content validity. Content validity implies that all aspects of the construct being measured are considered by the instrument. According to Nunnally (1978),

evaluating content validity is basically a question of judgement. To ensure content validity, a thorough examination was made of the relevant literature, and consultation with a panel of EPs, Trainee EPs and research psychologists was undertaken during the development of the questionnaire. Questions were reworded to improve their readability. The questionnaire was also tested through a pilot study, the results of which suggested that the instructions and questions were clear enough. Thus, the content validity of the questionnaire was accounted for in this study.

3.8   Pilot Study

A sample of 20 mainstream secondary school teachers were approached (via professional contacts) for the purpose of piloting the questionnaire, of which there was a response rate of n=13. Questionnaires were administered along with a 'Pilot Feedback Form' which allowed participants to provide details on how long it took them to complete the questionnaire and any concerns or queries they had. Generally feedback was positive and as mentioned above, the pilot study indicated that the questionnaire was fit for purpose and did not pose any methodological or ethical concerns.

3.9   Procedure

As the research required a large sample from a specific and very time restricted target population (mainstream secondary school teachers without a dedicated pastoral care role), it was appropriate to use convenience sampling. Convenience sampling can be very useful for situations where you need to reach a targeted sample quickly and conveniently and where sampling for proportionality is not the primary concern. The sample was acquired directly through schools rather than through alternative means such as internet questionnaires via online forums etc. It was felt this would help ensure that the target sample criteria were adhered to and would help to ensure a better response rate.

3.9.1   Consent for participation

Gatekeeper permission was sought from each headteacher prior to requesting teachers within their schools to participate. The headteachers of 125 secondary schools in South

Wales were contacted via email (these constituted all of the state maintained secondary schools within South Wales). Emails contained a brief introduction and an attached letter outlining the research proposal and an explanation of how ethical issues would be dealt with (Appendix 2). Five schools out of those contacted responded to this initial email, and these were contacted via telephone by the researcher immediately. A second round of emails were sent out a fortnight later seeking for any further interest, a further four schools responded and were contacted immediately via telephone. In addition to those schools who were recruited via email, a further five schools were recruited separately by the researcher through professional contacts.

Teacher consent was sought immediately prior to questionnaire completion. The 'opt in style' consent form (Appendix 3), which allowed for anonymity, constituted the front page of the questionnaire. The consent form outlined the nature and professional affiliations of the research, right to withdraw and anonymity procedures. Due to anonymity procedures, participants were informed that once they had submitted the questionnaire they could not request for it to be omitted from the study as it would be impossible to identify. Teachers were required to tick two check boxes in order for their questionnaire to be included within the study, these were: "I understand that this questionnaire is to be completed only by secondary school teachers who do not have a designated role within their schools core pastoral care system (e.g. head of year, SENCo, pastoral care co-ordinator)" and "I understand that by completing the questionnaire and handing it in to the researcher, I am aware of the points made above and I am consenting to my participation in the research". This served the dual purpose of gaining informed consent and ensuring eligibility for participation.

Debriefing forms were provided after questionnaire completion (Appendix 4). These provided further details regarding the aims of the research and relevant references for the participant's information. In line with the British Psychological Society's Code of Conduct (BPS, 2006), details of the researcher's professional affiliates were provided.

3.9.2   Data collection

Data were collected during the second half of the school summer term, 2011. Dependent on the wishes of the gatekeeper, data collection took one of three forms: administration by the researcher during a staff meeting organised by the school (n=1); administration by a member of school personnel during a staff meeting organised by school (i.e. deputy headteacher, SENCo, teacher) (n=10), opportunistic administration by the researcher to staff within the school's staffroom (n=3). Table 3.2 provides details of methods and collections and response rates within respective schools. As can be seen, responses from individual schools ranged from 4 to 33.

Table 3.2: Methods of data collection and response rates for individual schools

	Method of Data Collection	Response Rate	Response Percentage (%)
School 1	Researcher in staff room	16	7
School 2	Deputy head during staff meeting	27	13
School 3	Researcher in staff room	4	2
School 4	Deputy head during staff meeting	33	16
School 5	Teacher during staff meeting	16	7
School 6	Headteacher during staff meeting	21	10
School 7	Researcher in staff room	16	7
School 8	Deputy head during staff meeting	20	9
School 9	Teacher during staff meeting	11	5
School 10	Teacher during staff meeting	8	4
School 11	Deputy Head during staff meeting	12	5
School 12	Researcher during staff meeting	10	5
School 13	Teacher during staff meeting	5	2
School 14	Teacher during staff meeting	18	8
Total		**217**	**100**

If the gatekeeper's preference was to administer the questionnaire themselves (or via an appointed member of staff), the researcher visited them beforehand to discuss the principles of the research, anonymity procedures and to answer any questions. The researcher then arranged a date to collect the completed questionnaires from the school.

Questionnaires were numbered purely to keep track of response rates from individual schools. Questionnaires were administered to participants with a blank envelope attached so that they could be returned anonymously. Sealed envelopes were returned to either the appointed member of school personnel or the researcher, dependent on the method of data collection, and debrief forms provided. Completion of the questionnaire took approximately ten minutes.

3.9.3   Ethical issues

Prior to commencing research, it is necessary to evaluate the benefits of the study (such as advances in theory or increased understanding) against any possible negative consequences incurred in undertaking the research such as exposing individuals to unnecessary stress or diminished self-esteem (Cohen, Manion & Morrison, 2005). Therefore ethical issues raised by the current research were given careful consideration prior to commencing.

Approval was sought and gained from the Cardiff University School of Psychology Ethics Committee before any element of the research was carried out (Appendices 5, 6 & 7). Particular focus was given to confidentiality and anonymity procedures which are important factors in gaining reliable responses when ascertaining opinions regarding socially or professionally sensitive topics (Paulhus, 1991). It was decided that questionnaires, consent forms, and therefore the identity of participants would remain completely anonymous. Furthermore, participating schools were assigned a number and anonymised once data collection was complete: until this point schools' participation was confidential.

3.10   Data Analysis

With reference to Field (2009) data were entered into SPSS (Statistical Package for Social Scientists) and screened to check for accuracy of data entry, missing values and fit between the distributions of data and the assumptions of multivariate analysis. Following this a series of Pearson's correlation analyses were conducted to measure the degree of association between the variables and to check for multicollinearity.

After carrying out a number of descriptive analyses, four multiple regressions and two single regression analyses were conducted to test the research hypotheses. An advantage of this form of analysis, as opposed to carrying out several bivariate correlations, is that regression analysis corrects for correlations among the predictor variables (Brace, Kemp & Snelgar, 2006). This helps to examine the unique contribution of predictor variables in accounting for variance in each outcome variable. An alpha level of $\leq .05$ was employed for these analyses, consistent with convention in psychological research (Tabachnick & Fidell, 2001).

4. RESULTS

4.1 Descriptive Statistics

A total of 217 participants completed the questionnaire. It was unclear as to whether two of the participants were eligible to partake (the box confirming eligibility was not ticked and there was no indication of the participant holding an appropriate teaching qualification). Therefore the respective questionnaires were omitted from the study leaving a final sample size of n = 215. Out of these participants, just over a third were male (36%); the median age range was 26-35 years old (39%); and on average participants had been teaching for 15 years ($SD = 22.98$). The majority of participants held a postgraduate teaching qualification (77%).

Demographically, the sample within the current study was closely representative of teaching populations in both England and Wales[2] in terms of both age and gender distributions (DfE, 2011b; WAG, 2010b; General Teaching Council for Wales [GTCW], 2011; see Figures 4.1 and 4.2).

Figure 4.1: Teacher age comparisons

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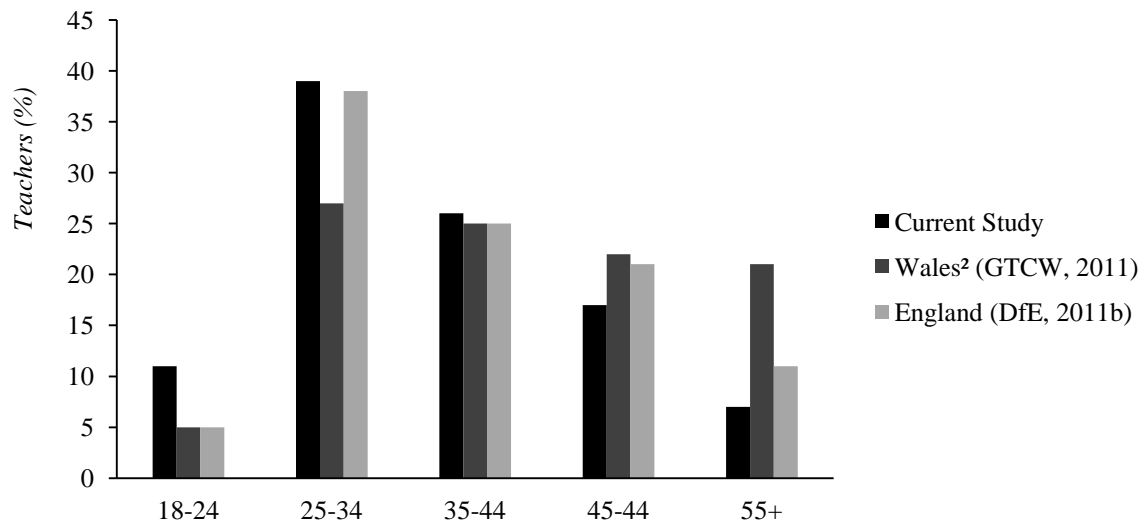
[2] *Demographic comparisons are representative of secondary school teacher populations apart from data representing teacher age distributions in Wales, which were only available for all registered teachers, and thus does not differentiate between primary and secondary.*

Figure 4.2: Teacher gender comparisons
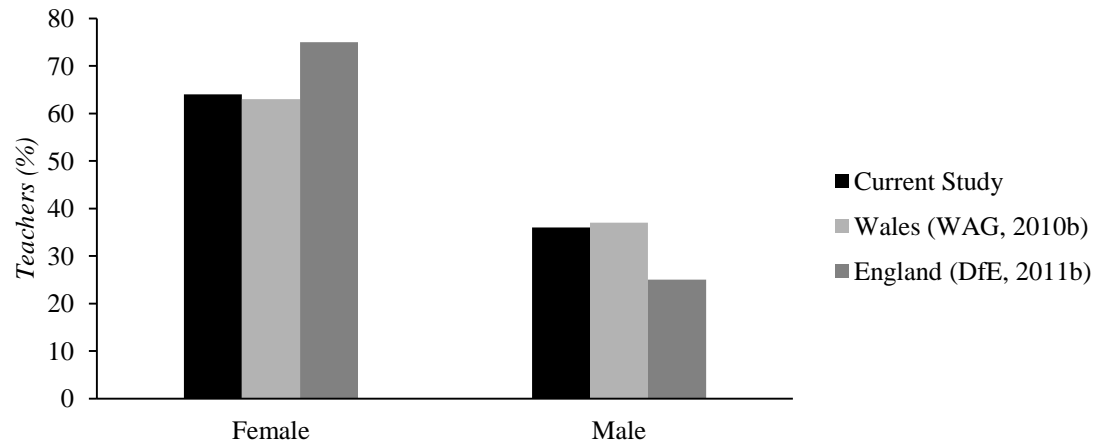
Generally, teachers rated themselves as willing to support pupil mental health needs ($M = 4.3$ out of 5) with the majority of teachers rating their willingness at four or five out of five (80%). However, teachers on average did not feel very able and confident in their abilities to do this ($M = 2.77$ out of 5) with a vast proportion rating their PBC less than three out of five (57%). Furthermore, most teachers rated their level of relevant training to be low ($M = 1.73$) with the majority rating it less than two out of five (85%). The most commonly reported training was regarding eating disorders (20%), followed by anxiety disorders (16%) and self-harm (15%). The types of mental health training received are represented in Figure 4.3, however the majority of respondents did not select any training option (63%), suggesting no training had been received. A full account of the descriptive statistics is presented in Table 4.1.

Figure 4.3: Types of mental health training received
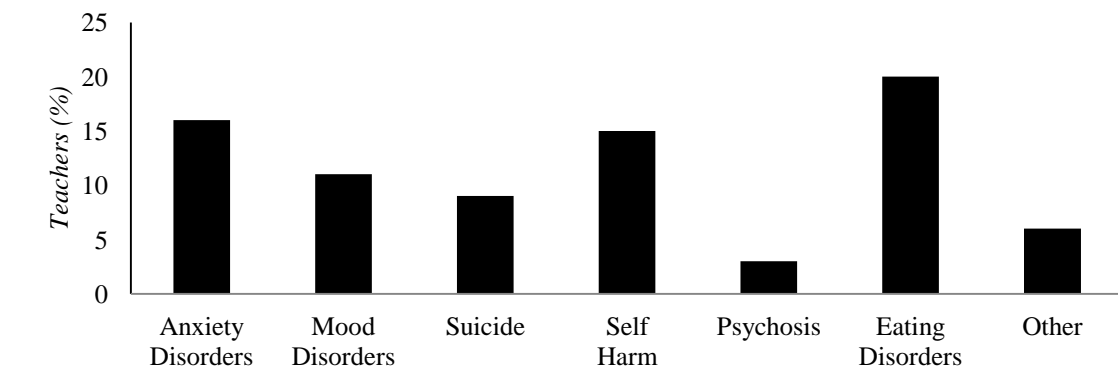
4.2 Measures of reliability

Prior to analysis, the data were examined using SPSS for accuracy of data entry, missing values and fit between their distributions, and the assumptions of multivariate analysis (Tabachnick & Fidell, 2001). Field (2009) reported that where the necessary assumptions of a regression are met, the model produced can be applied to the population of interest with more confidence.

4.2.1 Missing data

Missing data were entered into SPSS with reference to Field (2009) and generally these were relatively low. Where less than 10 percent of data were missing for a variable, the mean value was imputed. The variable 'Pupil Experience' was missing data from nearly a quarter of the sample (23%) and therefore this variable was omitted from multivariate analysis.

4.2.2 Assumption 1: Variables are measured without error (reliably)

Cronbach's alpha was used to measure the internal consistency of the multi-item scales used in this study. These analyses revealed most of the scales met the minimum requirement for reliability, $\alpha = .60$, as suggested by Nunnally (1978)[3]. Table 4.1 presents the outcomes of these initial analyses, in addition to the mean and standard deviation for each of the multi-item scales used. Unfortunately, the necessary level of reliability for the variables 'Preferred Social Distance' ($\alpha = .49$) and 'Aetiological Beliefs' ($\alpha = .48$) were not met and thus these scales were excluded from multivariate analysis.

4.2.3 Assumption 2: Variables are normally distributed

It was necessary to correct for skewness on five variables prior to further analysis[4]. For 'Willingness' an inverse correction was performed. For 'Awareness of Support and Supervisory Opportunities', 'Perceived Level of Training' and 'Perceived Level of Personal Experience' logistical transformations were performed. For 'Age' a square root

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[3] *Individual items were deleted if they led to a significant increase in the alpha value. Details of which items constituted the final scales can be found in Appendix 8.*
[4] *Details of transformations for skewness can be found in appendix 9.*

transformation was performed. It was not possible to correct for skewness for the variable 'Years of Practice' and thus this item was excluded from multivariate analysis.

Table 4.1: Alpha coefficients of reliability and descriptive statistics

Variable	α	Mean	SD
Willingness	.76	4.30	.88
Attitude	.75	3.37	.82
Subjective Norm	.60	3.49	.86
Perceived Behavioural Control	.84	2.77	.69
Behavioural Beliefs	.80	3.64	.60
Normative Beliefs	.71	3.32	.57
Perceived Level of Knowledge	.76	2.49	.81
Perceived Level Skill	.66	2.61	.85
Perceived Time & Stress Limitations	.69	3.11	.72
Perceived Level of Training	n/a	1.73	.82
Awareness of Support Structure and Supervisory Opportunities	.70	4.00	.82
Perceived Level of Personal Experience	n/a	2.56	1.26
Age*	n/a	26-35	1
Years of Practice**	n/a	15.16	22.98

Note: α = Cronbach's alpha of reliability, SD = Standard Deviation, n/a = Cronbach alpha non-applicable to single item scales. All responses apart from where indicated are out of five (*where 5 = a lot/strongly agree*). * For age, the median age group is presented, results indicated a standard deviation from the mean of one age group (10 years). ** For years of practice, figures indicate number of actual years.

4.2.4 Assumption 3: There are linear relationships between the predictor and outcome variable(s)

To test for linear relationships between the predictor and outcome variables, a number of scatter plots were produced and visually scrutinised, indicating no concerns. A number of Pearson's correlations were also conducted, as illustrated in Table 4.2. In addition to confirming the significant linear relationships between predictor and outcome variables necessary for multivariate analysis, the correlations indicated there were no concerns regarding multicollinearity, thereby justifying the treatment of all variables as distinct constructs for analysis.

Table 4.2: Pearson's correlations among variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Willingness	-												
2. Attitude	.41**	-											
3. Subjective Norm	.33**	.61**	-										
4. Perceived Behavioural Control	.30**	.55**	.37**	-									
5. Behavioural Beliefs	.35**	.59**	.50**	.32**	-								
6. Normative Beliefs	.28**	.57**	.56**	.36**	.45**	-							
7. Perceived level of knowledge	.16*	.31**	.22**	.67**	.31**	.22**	-						
8. Perceived level of skill	.11	.36**	.24**	.59**	.26**	.25**	.71**	-					
9. Perceived time and stress limitations	.20**	.47**	.32**	.38**	.46**	.39**	.34**	.40**	-				
10. Perceived level of training	.10	.13	.15*	.39**	.08	.16*	.37**	.34**	.25**	-			
11. Awareness of support structure and supervisory opportunities	.22**	.11	.19**	.24**	.16*	.15*	.21**	.20**	.24**	.20**	-		
12. Age	-.21**	-.08	-.11	.01	-.05	-.08	-.00	.03	-.15*	-.12	.03	-	
13. Perceived level of personal experience	.16*	.15*	.09	.19**	.23**	.00	.28**	.08	.04	.09	-.17*	.07	-
14. Years of Practice	-.10	-.10	-.05	.06	.02	-.06	-.06	-.05	-.02	-.12	-.07	.40**	-.06

* Correlation is significant at $p < .05$ level (2-tailed), ** Correlation is significant at $p < .01$ level (2-tailed).

4.2.5 Assumption 4: Homoscedasticity

Tabachhnick and Fidell (2001) advised that the assumption of homoscedasticity can be checked by visual examination of a plot of the standardised residuals (the errors) by the regression standardised predicted value. Therefore in order to check the data for homoscedasticity, a plot was produced for each regression analysis carried out. Visual examination of these plots indicated no concerns with regards to homoscedasticity.

4.3 Regression Analysis

In order to test the research hypotheses, four multiple regressions and two single regression analyses were conducted. These are presented on the following pages in terms of the individual hypotheses. The SPSS outputs for the regression analyses are included in Appendix 10.

4.3.1 Hypotheses 1

In line with the TPB, three separate regression models were used to explore the predictive values of the indirect variables (behavioural beliefs, normative beliefs and control beliefs) in terms of their respective direct variable counterparts (attitude, subjective norm, PBC) as illustrated in Figure 4.4.

Figure 4.4: Regression analysis of indirect factors and respective direct factors (H1)

H1a

| Behavioural Beliefs | — .59*** → | Attitude ($R^2 = .35$) |

H1b

| Normative Beliefs | — .56*** → | Subjective Norm ($R^2 = .32$) |

H1c

| Perceived Knowledge |
| Perceived Skill | .45*** |
| Perceived Level of Training | .19** | Perceived Behavioural Control (PBC) ($R^2 = .50$) |
| .13** |
| Perceived Time & Stress Limitations | .12* |
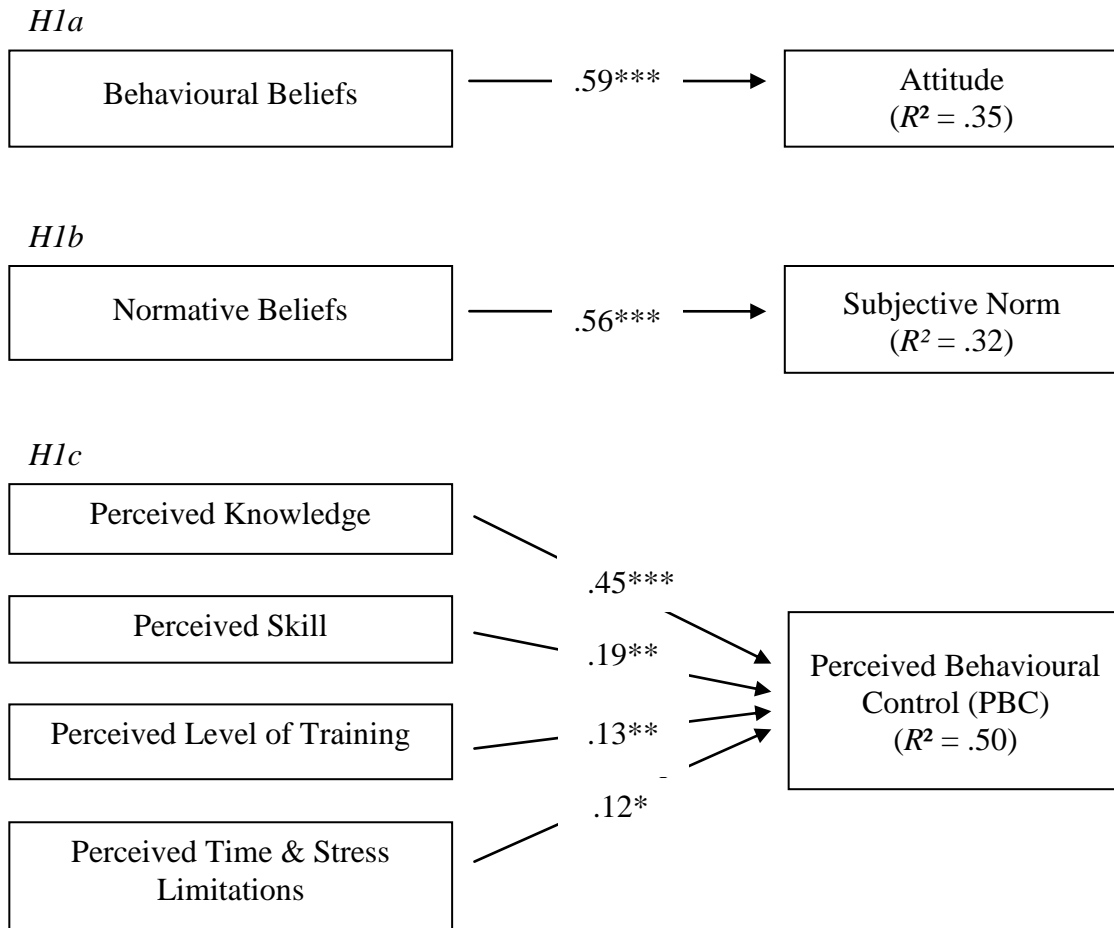
Note: * Significant at $p < .05$ level, ** Significant at $p < .01$ level, *** Significant at $p < .001$, R^2 Proportion of variance in the outcome variable accounted for by model.

H1a – Attitude. Behavioural beliefs significantly predicted attitude ratings ($\beta = .59$, $p <$ .001). Behavioural beliefs also explained 35 percent of the variance in attitude ratings, $R^2 = .35$, $F(1,213) = 115.69$, $p < .001$.

H1b – Subjective norm. Normative beliefs significantly predicted subjective norm ratings ($\beta = .56$, $p < .001$) and predicted 32 percent of the variance in subjective norm, $R^2 = .32$, $F(1,213) = 99.13$, $p < .001$.

H1c - PBC. The model containing perceived knowledge, perceived skill, perceived level of training and perceived time and stress limitations explained 50 percent of the variance for PBC, $R^2 = .50$, $F(4, 210) = 52.94$, $p < .001$. Results indicated that perceived knowledge ($\beta = .45$, $p < .001$), perceived skill ($\beta = 19$, $p < .01$), perceived level of training ($\beta = .13$, $p < .01$) and perceived time and stress limitations ($\beta = .12$, $p < .05$) were all significant positive predictors of teachers' PBC in relation to supporting pupil mental health needs.

Overall, these findings are in support of hypothesis one, which predicted that behavioural beliefs, normative beliefs and control beliefs (perceptions of knowledge, skill, level of training, and time and stress limitations) would predict teachers' attitude, subjective norm and PBC, respectively, in terms of supporting pupils' mental health.

4.3.2   Hypothesis 2

As Figure 4.3 illustrates, the model containing attitude, subjective norm and PBC explained 21 percent of the variance for teachers' willingness to support pupil mental health needs, $R^2 = .21$, $F(3, 211) = 18.77$, $p < .001$.
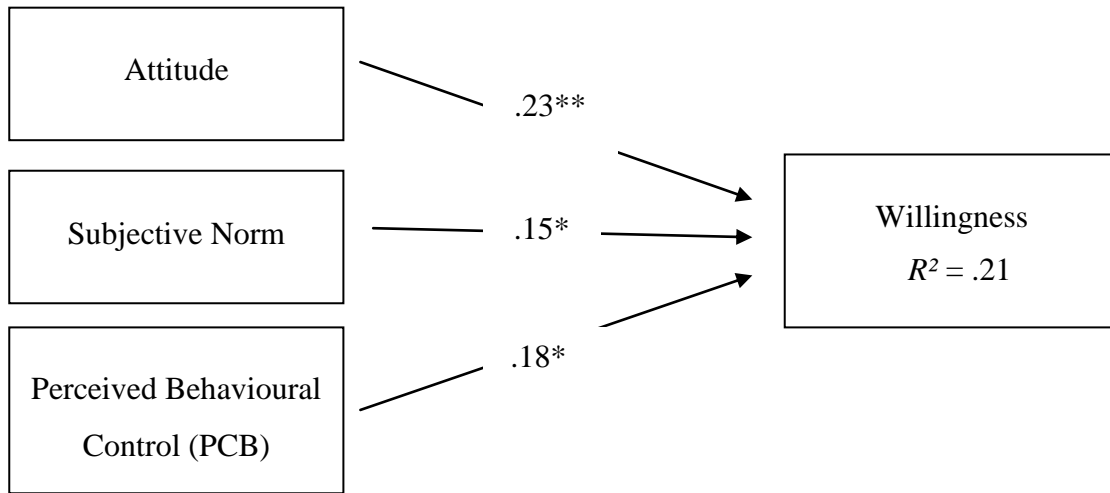
Note: * Significant at $p < .05$ level, ** Significant at $p < .01$ level, R² Proportion of variance in the outcome variable accounted for by model.

Results indicated that attitude ($\beta = .23$, $p < .01$), subjective norm ($\beta = 15$, $p < .05$) and PBC ($\beta = .18$, $p < .05$) were all significant positive predictors of teachers' willingness to support pupils' mental health needs.

These findings are in support of hypothesis two, which predicted that the direct variables within TPB could help predict teachers' willingness to support pupils' mental health needs.

4.3.3   Hypothesis 3

The third hypothesis was tested using a model containing three relevant background factors: age, awareness of support structure and supervisory opportunities, and perceived level of personal experience as illustrated in Figure 4.4.

Figure 4.6: Regression analysis of relevant background factors and teacher willingness to support pupils' mental health (H3)

Note: * Significant at $p < .05$ level, ** Significant at $p < .01$ level, *** Significant at $p < .001$ level, R² Proportion of variance in the outcome variable accounted for by model.

The model explained 17 percent of the variance of willingness ($R^2 = 17$, $F(3,211) = 13.77$, $p < .001$). The results indicated that awareness of support structure and supervisory opportunities ($\beta = .25$, $p < .001$) and perceived level of personal expereince ($\beta = .29$, $p < .001$) were both significant positive predictors of willingness, whilst age was a significant negative predictor of willingness ($\beta = -.22$, $p < .001$). That is, the results indicated that on average the older the teacher the less willing they were to support pupil mental health needs.

These findings are in support of hypothesis three which purported that background variables such as age, awareness of support structure and supervisory opportunities, and perceived level of training would predict variability in teachers' willingness to support pupil mental health needs. Furthermore, associations are in the predicted directions. However, the proportion of variance predicted by the model was relatively low.

Hypothesis four postulated that a model containing both direct variables from the TPB (attitude, subjective norm and PBC) and background variables would help predict a higher proportion of variance in terms of willingness, than models containing either direct variables or background factors.

Figure 4.7: Regression analysis of direct variables and relevant background factors, and teacher willingness to support pupils' mental health needs (H4)

Note: * Significant at $p < .05$ level, ** Significant at $p < .01$ level, ***Significant $p < .001$ level, [a] Marginally Significant at $p < .10$ level, [NS] Not Significant, R^2 Proportion of variance in the outcome variable accounted for by model.
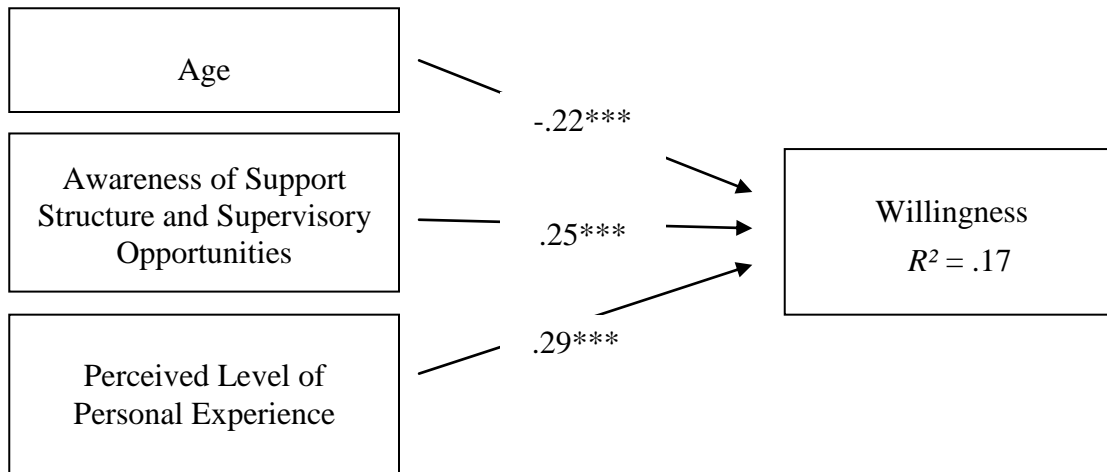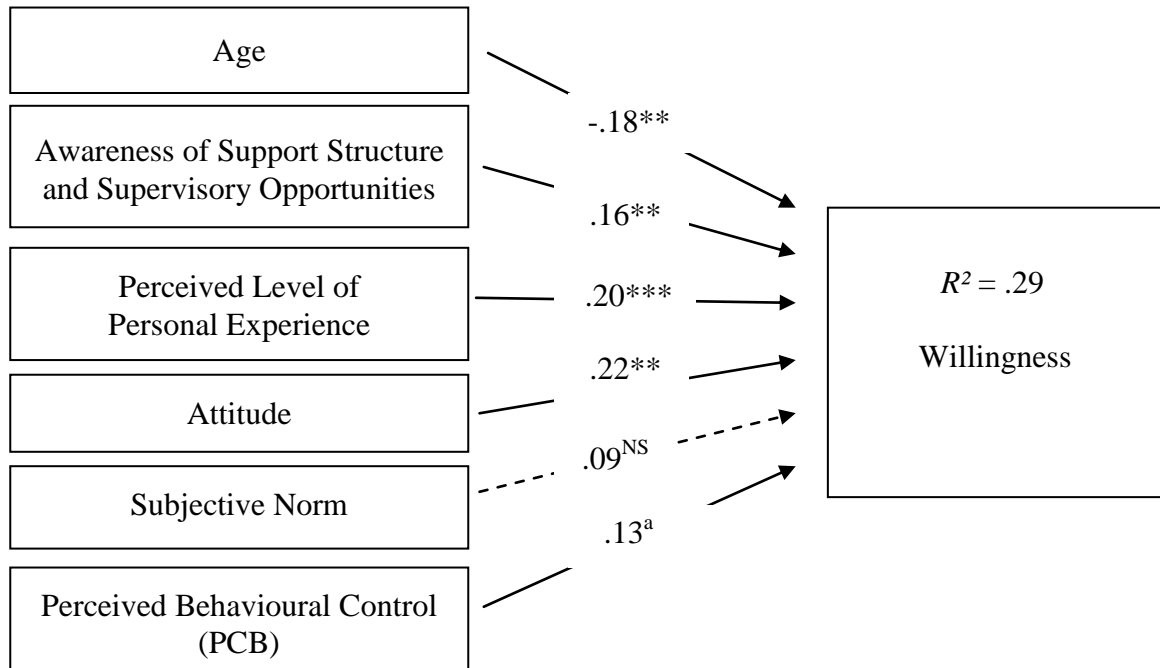
As Figure 4.5 illustrates, the model containing attitude, subjective norm, PBC, age, awareness of support structure and supervisory opportunities, and perceived level of personal experience accounted for 29 percent of the variance for teachers' willingness to support pupil mental health needs, $R^2 = .29$, $F(6, 208) = 14.122$, $p < .001$. Results indicated that awareness of support structure and supervisory opportunities ($\beta = .16$, $p < .01$), perceived level of personal experience ($\beta = .20$, $p < .001$) and attitude ($\beta = .22$, $p < .01$) were all significant positive predictors of willingness, whilst age was a significant negative predictor of willingness ($\beta = -.18$, $p < .01$). Inspection of the coefficients also

indicated that PBC was a marginally significant positive predictor of willingness ($\beta =$ .13, $p < .10$).   No significant relationship was found between subjective norm and willingness ($\beta = .09$, $p < .22$). However the results are consistent with a trend in the hypothesised direction.

These findings support hypothesis four, that is, a higher proportion of variance in terms of teacher willingness to support pupils' mental health needs can be accounted for by using a model that contains both direct TPB variables and relevant background variables.

5. DISCUSSION

The purpose of the this study was to examine the perspectives of mainstream secondary school teachers in relation to supporting the mental health needs of pupils, particularly focusing on internalised emotional mental health problems. In doing this, the study aimed to develop a predictive model which can account for variance in teacher willingness, that has strong theoretical and research underpinnings. It was proposed that a better understanding of what factors might impact upon teacher willingness to support pupil mental health needs could better inform the implementation of school mental health initiatives, training and support for teachers.

The developed model was tested by way of four research hypotheses, all of which were supported by analyses to some extent. The hypotheses predicted that, in line with the TPB, behavioural beliefs would predict attitude towards the behaviour; normative beliefs would predict subjective norm; control beliefs would predict PBC; and attitude towards the behaviour, subjective norm and PBC would collectively predict willingness. It was also hypothesised that age, years of practice, personal experience and preferred social distance would predict willingness; and furthermore, a model combining the direct TPB components – attitude towards the behaviour, subjective norm and PBC – along with age, years of practice, personal experience and preferred social distance would predict the highest variance of willingness.

This chapter firstly discusses the descriptive findings from the study and their relevance in terms of previous research. The findings are then discussed in terms of each of the research hypotheses with critical consideration to previous research and theory in this domain. The next section discusses the theoretical and practical implications of the research findings. The chapter ends by discussing the possible limitations of research and how these might be overcome, followed by highlighting the strengths of the research.

5.1 Descriptive findings

The sample population was closely representative of teaching populations within England and Wales. This would indicate that the study has strong grounds for generalisability within the UK context. Furthermore, the data met the necessary assumptions for multivariate analysis and thus the findings of the current study can be applied to the wider population of mainstream secondary school teachers with increased confidence (Field, 2009).

A number of Pearson correlation analyses were run in order to test for multicollinearity amongst variables, but also to highlight any linear relationships (see Table 4.2). The relevant relationships identified are discussed below along with other descriptive findings, with reference to the literature.

5.1.1 Training and support

Generally, participants perceived their level of mental health training to be low to non-existent; with the most common training, amongst the minority of teachers who have received it, focusing on eating disorders, anxiety and self-harm. These findings concur with the small number of relevant UK studies available, which indicate that levels of training regarding internalised mental health problems amongst teachers are insufficient (Ofsted, 2005) and consequently teachers feel undertrained (Rothi et al., 2008; Collins & Holmshaw, 2008; Connelly et al., 2008; Gowers et al., 2004; Kidger et al., 2010).

The literature indicates that not only is training important in order to give teachers the knowledge, skills and confidence they need to support the mental health needs of pupils (Hui et al., 2001; Langeveld et al., 2011; Jorm et al., 2010; White et al, 2011; Kelly et al, 2007; Moor et al., 2007; Wyman et al., 2008; King et al., 1999; Kos et al., 2004), but it is also important in terms of them adopting favourable beliefs and attitudes about undertaking this role (Kidger et al., 2010; Moor et al., 2007; Bell et al., 2011; Kitchener & Jorm, 2006) and in raising awareness of policy and guidance (Jorm et al., 2010). The findings of the current study support this in part, with strong positive correlations observed between perceived level of training and PBC, perceptions of knowledge,

perceptions of skill, subjective norm, normative beliefs and awareness of support structure and supervisory opportunities. However no relationships were found with respect to perceived level of training and behavioural beliefs or attitudes towards the behaviour. Although no causal relationships can be drawn from this, based on the current findings it could be suggested that, in line with previous findings, higher levels of training increase teacher perceptions of knowledge, skill and confidence in ability. It may also be suggested that levels of training increase awareness amongst teachers of: the support structures available; expectations from others; and appreciation of what other colleagues are doing. The lack of association between teachers' perceived level of training and both behavioural beliefs and attitude towards the behaviour may be explained in terms of training not being made relevant to the educational context. For example, training efforts making explicit how supporting the mental health needs of pupils can help with learning and achievement and how tackling mental health issues can also have positive implications for a teacher's work in terms of managing difficult and worrying behaviours. This is something that was alluded to by pastoral care staff in Rothi et al. (2008, p. 1229) who expressed concern that "training should be focused on mental health within the educational environment rather than mental health in general".

In contrast to level of training, participants generally rated their awareness of pastoral support structures and supervisory opportunities relatively highly. This suggests that participants were content with who to refer to or who to talk to should they have concerns about a pupil. Although this is a benefit in terms of teachers feeling well supported and onward referral of concern, when considered in conjunction with the low levels of PBC observed, it may also indicate that teachers are to some degree absolving responsibility to more senior 'specialist' staff members rather than playing an active role in supporting pupil mental health themselves. This interpretation is reflective of Roeser and Midgely (1997, p.130), who suggested that the higher likelihood in secondary schools of having 'specialist' staff on site, can contribute to increased attitudes amongst staff that mental health problems are 'somebody else's business'. Such practices would not be in keeping with whole-school, inclusive approaches as advocated by many. Rowling (2007) highlighted this as a prominent issue in school mental health promotion

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and noted that addressing power balance between staff is a critical factor in promoting school mental health. Connelly and colleagues (2008, p. 15) stated that for teachers a "source of related frustration is the feeling of powerlessness which results from the belief that one's direct knowledge of the young person may carry less weight than the opinions of others". Therefore, it could be suggested that interventions are required to empower those on the front-line into feeling able to support the mental health needs of pupils, with support from appropriate, more experienced, staff members.

5.1.2 *Teacher willingness, attitude towards and ability to support pupil mental health needs.*

In concordance with previous findings, although teachers in the current study felt generally willing to support the mental health needs of pupils, they very much felt unable and lacked the confidence to do so (Rothi et al., 2008; Kidger et al., 2010; Adelman & Taylor, 2000; King et al, 1999; Walter et al., 2006). This dichotomy is concerning as it implies that although many teachers are willing to adopt a role in supporting pupil mental health, they are unlikely to act with such low feelings of self-efficacy and control. This assumption would be supported by the TPB which would indicate that PBC not only influences intention, but also has a direct effect on actually carrying out the behaviour (Ajzen, 1991).

Interestingly, although willingness amongst the sample was relatively high, ratings for attitude towards supporting pupil mental health was somewhat lower perhaps indicating a dissonance between these two factors. From a methodological standpoint, this might be because the attitude scale included both negatively and positively weighted items and thus might have encouraged more open and evenly distributed responses. From a theoretical perspective, this could be attributed to teachers feeling willing, yet holding ambivalent beliefs as to whether or not they should or are best placed to take on this role. These findings may indeed reflect the conclusions of the CAMHS review that the attitudes held by school staff towards child and adolescent mental health vary considerably (DfCSF & DH, 2008). As the current study found no association between behavioural beliefs or attitude towards supporting pupil mental health and level of training, it could be postulated that, as previously suggested, the training undertaken has

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not focused on developing favourable attitudes which are relevant to the educational context.

5.1.3   Subjective norm and normative beliefs

Generally, teachers' ratings in relation to their subjective norm and normative beliefs regarding their role in supporting pupil mental health were relatively neutral, neither strongly agreeing nor disagreeing that it was something expected of them. This would perhaps indicate that the message that teachers should and can be playing an active role in supporting pupil mental health needs has not fully penetrated. It may be that policy has not been well disseminated or indeed messages about what teachers are expected to do are ambivalent or unclear. This would be in congruence with previous findings which collectively imply a mixture of subjective norms are held by teachers (e.g. Connelly et al., 2008; Walter et al., 2006; Reinke et al., 2011; Ozabaci, 2010; Collins & Holmshaw, 2008). This would also be supported by recent Welsh Government findings (WOA, 2009) which indicate that communication regarding the role envisaged for teachers as tier one workers (as outlined in WAG, 2001) is inconsistently disseminated to them by local education departments, with no consensus between these departments as to what teachers should or should not be doing. The findings of the current study may also be seen as supportive of Ofsted (2005) who reported that few schools were aware of or using the guidance set out for them by the government (DfEE, 2001) to plan and provide support for pupils mental health needs. Therefore, it would seem that clearer messages disseminated consistently at all levels are required for a widespread consensus to be reached, in order for mainstream teachers to be encouraged to adopt participative roles in supporting pupil mental health needs. Indeed, this is also something that is advocated by Weare and Murray (2004).

5.1.4   Perceptions of knowledge and skill

In accordance with previous findings, the current study found that teachers generally perceived their levels of relevant skills and knowledge to be low (e.g. Herbert et al., 2004; Ozabaci, 2010; Jorm et al., 2010; Walter et al., 2006; Wyman et al., 2008; Gowers et al., 2004; Connelly et al., 2008; Rothi et al., 2008; Kidger et al., 2010). Although, this

is likely to be true when considered in conjunction with the low levels of training, it may also be that teachers set very high standards for themselves in terms of what knowledge and skills they should have, something noted by Kos et al. (2004) as a characteristic of the teaching profession. Kos and colleagues also reported that teacher ratings of perceived knowledge were generally much lower than their actual knowledge. Due to the disciplinary silos between health and education (Weist and Murray, 2007), it may be that teachers feel that they need a particular set of clinical or specialist skills in order to support the mental health needs of pupils, when in reality the principle of tier one support is that much relevant and useful advice can be offered on a simple, pragmatic basis by teachers to pupils with mental health problems, without the need to move to higher tiers of involvement, and the stigmatisation that that may carry (Gott, 2003). Again, such schemas could be challenged through training that has a strong focus on mental health in the educational context, as also suggested by Rothi et al. (2008).

5.1.5   *Perceived time and stress limitations*

Overall, ratings of perceived time and stress limitations amongst the current sample were relatively neutral. This is interesting given that previous studies have found levels of time and stress to be a barrier to supporting pupil mental health (Wehby et al., 2012; Connelly et al., 2008; Walter et al., 2006; Ringeisen et al., 2003; Ridge et al., 2003; Lam & Hui, 2010; Hui et al., 2001; Kidger et al., 2010). Nevertheless, lower levels of perceived stress and time limitations were indeed associated with more favourable beliefs, attitudes and perceptions towards supporting pupil mental health needs. This implies that levels of perceived time and stress limitations amongst teachers may have the potential to act as a barrier.

5.1.6   *Omitted scales*

It was necessary to omit a number of scales from further multivariate analysis as they did not meet the necessary assumptions for inferential statistical analysis. Information regarding the stigmatic beliefs held by teachers is an area that is unrepresented in the literature, yet has the potential to increase understanding and inform intervention.

Unfortunately, the scales for both aetiological beliefs and preferred social distance did not meet the alpha threshold required and therefore could not be considered as reliable.

Aetiological beliefs. In terms of aetiological beliefs, the inconsistency of responses, which led to the low level of reliability, could be attributed to a lack of concrete beliefs held by teachers regarding whether mental health problems are biological or environmental in nature. This should not be construed as a negative, as it could imply that teachers are open to a holistic view of mental health problems, incorporating both environmental and biological factors, which is preferable. Nonetheless, examination of the individual item responses provided insight into the beliefs of teachers with respect to the causes and treatments for mental health problems (Appendix 11). Indeed, it would seem that the majority of teachers held neutral beliefs regarding mental health causes and treatments implying either an uncertainty or as suggested above, an appreciation that problems can manifest as a result of both environmental and biological factors and can be treated holistically. However, over a third of the participants agreed to some extent that *"People with mental health issues are born with a genetic predisposition to experience such issues"* and similarly over a third of participants agreed to some extent that *"Mental health issues ultimately need to be treated in a clinical/medical setting"*. This would indicate that a large proportion of participants see mental health problems from a medical model perspective. In line with what the literature suggests, such beliefs may have implications for willingness or perceived ability to support pupils experiencing mental health problems (Gott, 2003; Sciutto et al., 2000; Moor et al., 2007).

Preferred social distance. In terms of preferred social distance, the inconsistency of teacher responses could be attributed to undecided beliefs about whether or not they feel comfortable with this vulnerable population. Examination of the individual items supports this (Appendix 12), as although over half of the participants disagreed with the statement "*I think sometimes it is best if pupils with mental health needs are not placed in mainstream classes*", over two thirds also disagreed with the statement "*I do not have a problem with having pupils with mental health needs in my classes*". This would perhaps indicate that although many teachers agree with the overall concept of the

inclusion of pupils with mental health problems, on a personal level they have some reservations. This is perhaps explained to some degree by an American study which found that although high school teachers agreed schools were an important venue for discussing and providing health messages, student mental health was an area of health promotion that they felt least comfortable in dealing with (Cohall et al., 2007).

5.2 Hypothesis 1

Hypothesis 1 postulated that, in line with the TPB, direct factors would be predicted by their respective indirect factors. This hypothesis was divided into three parts: a) behavioural beliefs would predict attitude towards behaviour; b) normative beliefs would predict subjective norm; and c) control beliefs would predict PBC. These are discussed individually below.

5.2.1 Hypothesis 1a

Regression analysis provided support for the hypothesis that the behavioural beliefs held by mainstream secondary school teachers about supporting the mental health needs of pupils—such as conflicts with academic priorities, benefits for teachers and benefits for pupils' education—will predict the attitude they hold towards the role. A relationship was observed between behavioural beliefs and attitude towards the behaviour, with behavioural beliefs predicting over a third of the variance for the attitude measure. This finding would indicate that a teacher is more likely to hold a positive attitude towards supporting the mental health needs of their pupils if they believe it does not conflict with academic priorities, and has benefits for the pupil in terms of learning and also the teacher in terms of job satisfaction and workload. This finding provides support for the literature which emphasises a need to share with teachers why they should be supporting pupil mental health needs and how it is relevant to the priorities of the school as a whole (Weare & Murray, 2004; Lohrmann et al., 2008; Ringeisen et al., 2003). Furthermore, these findings provide empirical support for the qualitative findings of Kidger et al. (2010) who reported that the pastoral care staff in their study felt strongly that the reluctant attitudes of mainstream staff could be challenged through training which included raising awareness of the link between mental health and academic performance

and also the ways in which different activities throughout the school can link to mental health.

Theoretically, this finding concurs with other applications of the TPB where the average variance of attitude predicted by behavioural beliefs is 25 percent (Armitage & Conner, 2001). Indeed, the scales used in the current study exceeded this, accounting for 35 percent of the variance. Therefore, this finding supports the TPB and suggests that beliefs relating to academic priorities, learning outcomes, and benefits for teachers are good predictors of a teacher's attitude towards supporting pupil mental health needs.

5.2.2   Hypothesis 1b

Regression analysis provided support for the hypothesis that normative beliefs held by mainstream secondary school teachers—regarding what other teachers believe and do and what their school, pupils and the government want or expect from them in terms of supporting pupil mental health—would predict the subjective norms they hold towards the role. A relationship was observed between normative beliefs and subjective norm, with normative beliefs predicting nearly a third of the variance for the subjective norm measure. This finding indicates that if a teacher believes that their colleagues are supportive of pupil mental health needs, and that the expectations of their school, pupils and government is that they should take an active role in supporting pupil mental health, they are more likely to hold a more favourable subjective norm. There is no research exploring this area, however this finding somewhat supports Weare and Murray's (2004) proposal that other members of the school community can act as agents of change in spreading awareness with regards to mental health. It also supports the theoretical literature regarding social constructionism which would stress the importance of social interactions in developing subjective beliefs (e.g. Gergen, 1999).

Theoretically, this finding is in concordance with other applications of the TPB where the average variance of subjective norm predicted by normative beliefs is 25 percent (Armitage & Conner, 2001). Once again, the scale used in the current study surpassed this, accounting for 32 percent of the variance. Therefore, this finding supports the TPB

and suggests that, in terms of the subjective norms held by teachers regarding supporting the mental health needs of pupils, beliefs about what their colleagues do or believe, and what their schools, pupils and government want and/or expect are good predictors.

5.2.3   *Hypothesis 1c*

Regression analysis provided support for the hypothesis that the control beliefs held by teachers about supporting the mental health needs of pupils—such as perceptions, knowledge, skill, training, level of experience with pupils with mental health problems, time and stress limitations and aetiological beliefs—will predict their PBC in carrying out the role. Although the aetiological beliefs and previous pupil experience variables had to be omitted from the model as they failed to meet the assumptions of multivariate analysis, a strong relationship was observed between the remaining control beliefs and PBC, with the proposed control beliefs predicting half of the variance for the PBC measure. These findings would indicate that if a teacher has confidence in their level of knowledge, skill, and training and perceives their time and stress limitations to be low, they are more likely to view themselves as able to support the mental health needs of pupils. These findings are very much in concordance with previous research in this area which has found that teachers who have higher perceptions of knowledge, skills and attendance at training have increased confidence in their ability to support the mental health needs of pupils (e.g. Moor et al., 2007; Jorm et al., 2010; Kitchener & Jorm, 2006; Herbert et al., 2004; Langeveld et al., 2011, Wyman et al., 2008; Lam & Hui, 2010; Bell et al., 2011). Similarly, the literature suggests that perceived time limitations (Connelly et al., 2008; Walter et al., 2006; Cooper, 2004; Ringeisen et al., 2003; Ridge et al., 2003), and stress limitations (Wehby et al., 2012; Lam & Hui, 2010; Hui et al., 2001; Han & Weiss, 2005; Koller & Bertel, 2006; Kidger et al., 2010; Ridge et al., 2003) are associated with perceptions amongst school staff of being unable to take on the role.

Theoretically, the findings are in line with other applications of the TPB where the average variance of PBC predicted by control beliefs is 27 percent (Armitage & Conner, 2001). However, the control belief scales used in the current study substantially improve upon this, accounting for 50 percent of the variance. Therefore, the findings in the

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current study support the TPB and suggest that in terms of teachers' PBC in supporting the mental health needs of pupils, beliefs about their perceived level of knowledge, skill, training and perceived time and stress limitations are good predictors.

It should be noted that this study is concerned with perceptions of as oppose to actual levels of knowledge, skill and training. As previously mentioned, teachers have a tendency to set themselves high standards and perceive their abilities to be lower than they actually are (Kos et al., 2004). The current study provides support for the notion that teachers' PBC increases with perceptions of skill, knowledge and training, and thus it is important that teachers believe in their abilities. Therefore, in addition to providing training for teachers, feedback and affirmation are likely to help to encourage a realistic appreciation of their actual knowledge and skills (as suggested by Rothi et al., 2008; Ringeisen et al., 2003; King et al., 2010).

5.3   Hypothesis 2

Hypothesis 2 postulated that, in line with the TPB, the willingness of mainstream secondary school teachers to support the mental health needs of their pupils would be predicted by their attitude towards the role, subjective norm and PBC. Multiple regression analysis of the variables provides support for this hypothesis, with relationships observed between willingness and attitude, willingness and subjective norm, and willingness and PBC, and the three predictor variables collectively accounting for nearly a quarter of the variance for the willingness measure. In concordance with previous applications of the TPB within the educational context, the attitude measure in particular displayed a strong association with willingness (Ballone & Czerniak, 2001; Lee et al., 2010; Haney et al., 1996).

The model brings together and provides empirical support for those factors alluded to within the literature as having the potential to hinder or facilitate mental health work in schools. That is, the impact of teachers' attitude (DfCSF & DH, 2008; Kidger et al., 2010; Roeser & Midgely et al., 1997), perceptions of social pressure (Murray & Weare, 2004; Ofsted, 2005; WAO, 2009), and perceptions of ability (Kidger et al., 2010; Rothi

et al., 2008; Jorm et al., 2010). Therefore, the model provides evidence for the importance of these factors in terms of teacher willingness to support the mental health needs of pupils.

5.4 Hypothesis 3

Hypothesis 3 predicted that the willingness of teachers to support the mental health needs of their pupils will be predicted by age, personal experience of mental health problems, years of practice, awareness of pastoral support structure and supervisory opportunities, and preferred social distance. Although the preferred social distance and years of practice variables were omitted as they did not meet the assumptions for multivariate analysis, multiple regression analysis of the remaining variables provided support for this hypothesis. Strong relationships were observed between willingness and age, willingness and awareness of pastoral support structure and supervisory opportunities, and willingness and perceived level of personal experience.

5.4.1   A negative association between age and willingness

Regression analysis implied that age was negatively associated with willingness. It may be that pre-service training paradigms have altered over the course of the decades to place greater emphasis on the wellbeing of children and young people, and thus older participants displayed less willingness as a consequence.

Additionally, when this finding is considered in conjunction with previous findings which have positively associated age with years of practice and experience of pupil mental health issues (Kos et al., 2004), it is feasible to assume that teachers may experience disillusionment or higher levels of stress and burnout with age which affects their willingness to support pupil mental health. This suggestion would be further supported by the other correlates of age within the current study (Table 4.2), such as perceived time and stress limitations, level of personal experience and years of practice. Examination of the years of practice correlates indicated that they were in the same direction as age, although they were not statistically significant. However, age and years of practice were strongly associated, thus implying that age could be a proxy variable of

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years of practice in terms of teacher willingness. This would mean that the strong negative relationship between age and willingness observed within this regression model could be reflective of the impact of years of practice on willingness. Unfortunately, it was not possible to confirm this with multivariate analysis as the years of practice variable was too highly skewed.

5.4.2   An association between personal experience and willingness

As anticipated, perceived level of personal experience was a strong predictor of willingness to support pupil mental health needs, supporting the proposal of Bell et al. (2011) that personal experience may influence individual teachers' responses regarding pupil mental health.

The research literature in this area is focused outside of the educational domain, but has indicated that personal experience is a strong predictor of reduced stigmatisation (Smith, 2004) and awareness of mental health promotion efforts (Braunholtz et al., 2004). This would suggest that the teachers in the current study may be more willing if they have had personal experience due to its effects on lowering stigmatic attitudes and increasing awareness of role. Unfortunately, it was not possible to explore the relationship between personal experience and preferred social distance (the stigmatic attitude measurement) in the current study[5]. Nevertheless, examination of the correlates available (Table 4.2) highlighted that higher levels of personal experience were associated with more positive attitudes and behavioural beliefs about supporting pupil mental health. Furthermore, personal experience was also positively associated with PBC and perceived knowledge, possibly indicating that personal experience can help teachers feel more confident in their ability to support pupil mental health. This would be somewhat in keeping with the literature that indicates that experience of pupils with mental health problems can help increase confidence and knowledge (e.g. Walter et al., 2006; McGregor & Campbell, 2001). Many general mental health programmes recognise the value of individuals having 'contact' with someone who has had or is experiencing a mental health problem

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[5] *The preferred social distance scale was omitted due to insufficient reliability.*

and often courses are delivered in part by a consumer-educator in order to achieve this (Kelly et al., 2007).

5.4.3 An association between awareness of support structures and supervisory opportunities, and willingness

Finally, in accordance with what the literature indicates (e.g. King et al., 1999; Kruger, 1997), awareness of support structure and supervisory opportunities was a strong predictor of willingness. This would therefore imply that teachers who feel they have an awareness of the pastoral care support structures within their school and who can access supervisory opportunities if they are concerned about supporting the mental health needs of a pupil, are more willing to do so.

5.5 Hypothesis 4

Hypothesis 4 proposed that the willingness of teachers to support the mental health needs of their pupils would be best predicted by a model which combines those predictor variables from both hypothesis 2 and hypothesis 3. Indeed, multivariate analysis supported this, with the predictor variables accounting for nearly a third of the variance of the teacher willingness measure. Furthermore, relationships were observed between willingness and age, willingness and awareness of support structure and supervisory opportunities, willingness and perceived level of personal experience, and willingness and attitude towards role. When controlling for the effects of all of the predictor variables in the model, PBC was only marginally associated with willingness and subjective norm was no longer associated. Therefore, it may be that the relationships observed between subjective norm and willingness and PBC and willingness, as seen in the hypothesis 2 model, are less important relative to age, personal experience and awareness of support structure and supervisory opportunities.

These findings indicate that an augmented model of the TPB that includes background factors such as age, personal experience and also awareness of support structure and supervisory opportunities is the best predictor of teachers' willingness to support the mental health needs of pupils, at least within the current study. This would support the

view of Barry and Jenkins (2007), who argued that teacher training needs to be accompanied by effective support mechanisms within the school. Furthermore, the findings are in keeping with King et al. (2010) whose qualitative findings suggested that the development of skills and knowledge, which would help improve self-efficacious beliefs, depend on natural learning opportunities and support. The model would also support Noar (2006) who recommends that interventions to improve mental health promoting behaviours should take demographic factors into consideration (i.e. age).

Finally, the results show that, with respect to the TPB components, attitude towards supporting pupil mental health remains a strong predictor of willingness, even when controlling for the effects of other variables.

5.6   Summary of findings

In summary, the current study found that, although mainstream secondary school teachers reported they were fairly willing to support the mental health needs of pupils, they do not feel confident in their ability to do so. Additionally, interpretation of the subjective norm data indicates that no strong beliefs are held by teachers as to what is expected of them in relation to school mental health work. A positive finding was that teachers tended to agree that they were aware of the pastoral care support structures in their respective schools and also that they had a senior member of staff to turn to should they be concerned about the wellbeing of a pupil. However, this may also be construed in terms of teachers absolving responsibility and perceiving the role of supporting pupil mental health as the responsibility of the pastoral care team. Unfortunately, due to low levels of internal consistency within the aetiological beliefs and preferred social distance scales they could not be subject to further analysis. However, examination of the individual items indicated that teachers held mixed beliefs regarding their preferred social distance from pupils experiencing mental health problems.

In terms of the research hypotheses, as predicted the model containing the direct components from the TPB as well as age, personal experience and awareness of support

structure and supervisory opportunities accounted for the highest variance of teacher willingness.

5.7   Implications of findings

The current study provides some useful and novel insights into the views of mainstream secondary teachers within the UK. The findings have several implications, both in terms of practice and theory.

5.7.1   Improving confidence in ability

The findings provide support for the growing argument that teachers are not confident in their ability to support the mental health needs of pupils, particularly in terms of having received sufficient training or having the necessary skills and knowledge. Indeed this seems to be more of a barrier than time and stress limitations. Therefore, the current study indicates a substantial need for professional development if teachers are to feel able to adopt this role. The TPB would imply that improving levels of PBC is important not only to increase teacher willingness, but also in terms of them actually undertaking the role (Figure 2.1; Fishbein & Ajzen, 2010).

5.7.2   Policy and bespoke interventions utilising the TPB

The results indicated that the TPB indeed predicts a certain degree of willingness to support pupil mental health needs. The considerable findings regarding what beliefs might influence a teacher's attitude towards the role, their subjective norm and their PBC provides insight into the cognitive-social processes which might facilitate or hinder their adoption of school mental health work. This has implications in terms of policy and training for teachers. For example, the findings could be used in tailoring teacher training packages that would help build both intention to support pupil mental health and, in terms of PBC, actual performance. Attitude in particular appears to be a strong predictor of willingness, regardless of factors which are less controllable such as age or personal experience of mental health problems, and thus teacher training could exploit this by focusing on fostering favourable behavioural beliefs such as those explored in the current study.

5.7.3 Clearer communication

The findings could be interpreted as indicating that messages regarding the anticipated roles for teachers as tier one workers are not penetrating the profession at a grassroots level. Teachers' responses in the current study implied uncertain or ambivalent subjective norms and thus there appears to be a need to emphasise what is expected from mainstream teachers.

5.7.4 Increasing experience

Fourthly, personal experience in particular was strongly associated with willingness. It could be postulated that those teachers who have personal experience are more aware, sensitive and empathetic towards the needs of pupils with mental health problems. Unfortunately, personal experience of mental health problems is a difficult factor to control for and hence cannot really be used to develop general teacher willingness to support pupil mental health needs. However, a substitute for this might be in the form of a consumer-educator as used in many general mental health literacy training programmes (Kelly et al., 2007). This may translate into the educational context by means of adults who experienced mental health problems when they were in school retrospectively talking about their experiences or even video recordings of young people talking about their difficulties within the school context.

Although the impact of experience with pupils with mental health needs on teacher willingness could not be explored within the current study, the literature implies that experience of this kind can have a positive effect (e.g. Walter et al., 2006; McGreggor & Campbell, 2001). Therefore, it is likely that providing teachers with relevant experience of pupils with mental health needs, for example during their pre-service training, may be beneficial. The current study was concerned with internalised mental health problems, and experience of this kind may be difficult to control for within the school environment. However, relevant experience may consist of, for example, visiting a CAMHS clinic as part of a teacher training course to observe, talk to staff, and meet with children, young people and their families who are attending. Alternatively, it could involve attending a

hospital education provision. However, obviously these suggestions are not without practical and ethical limitations.

5.7.5 *Collaboration and consultation between specialist and teaching staff*

Awareness of support structure and supervisory opportunities were also associated with teacher willingness to support pupil mental health needs. The items within this scale would indicate that if a teacher feels he or she has a good grasp of the pastoral support structures within his or her school and can turn to a senior member of staff should he or she have concerns, he or she is more likely to be willing. However, the current study suggests that this may also be due to teachers 'passing the buck', rather than supporting pupils themselves. This would mean that an intervention that empowers mainstream teachers in adopting this role is required. This may be in the form of training for teachers, but could also include encouraging and training up pastoral care staff to consult with and empower teaching staff when they express concerns, in order to adopt more collaborative approaches. This would be supported by Wehby and colleagues (2012) who found that the greatest association with mental health intervention implementation was teacher-coach alliance.

5.7.6 *Overcoming teacher age and stress as a barrier to willingness*

Age was found to be a strong predictor of willingness and it has been suggested within this study that this association could be interpreted in terms of years of practice effecting willingness. Although ultimately, within the educational context it is difficult to control for teacher age and years of practice, it may indicate a need to continually focus on improving staff willingness through continual professional development. Furthermore, the negative relationship observed between age and perceptions of time and stress limitations may also indicate a need to focus on continually addressing the emotional wellbeing of staff as a prerequisite to them feeling willing to support the mental health needs of their pupils. This suggestion is reflective of Kidger et al. (2010) who noted within their qualitative study that teacher's own emotional needs tend to be neglected, leaving them unwilling to consider those of their pupils. Furthermore, Wehby et al.

(2012) provided empirical evidence of this, noting that teacher burnout can negatively impact upon the implementation of mental health interventions.

5.8   Strengths and limitations of the current study

Although the current study has many strengths, it is not without both methodological and theoretical limitations. These are discussed below.

5.8.1   Methodological limitations

Whilst undertaking the research, a few participants commented on the length of the questionnaire, stating that it was repetitive and confusing. Due to the number of variables being measured and the need for multiple-item scales to ensure internal reliability, the questionnaire had a total of 76 items. Furthermore, to reduce demand characteristics, items were randomised as opposed to being presented as individual scales. Although these factors increased reliability, they may have also increased the likelihood of fatigue effects, something which is noted by Cape (2010) as having the potential to reduce data quality. Nevertheless, the final scales used for analysis had internal reliability. Furthermore, several items were removed during reliability testing, thus reducing the length of the questionnaire for future use.

Although participation was completely anonymous, it was impossible to completely account for all social desirability biases. The exploration of perceptions regarding a sensitive—and perhaps somewhat contentious—area such as child and adolescent mental health will inevitably be effected to some degree by levels of discomfort or unease in terms of providing answers that are not socially desirable within a given context. The current study utilised a 'pen and paper' survey method, however, future research could utilise online survey techniques, which may make participants feel even more anonymous in order to encourage more open and honest answers.

The current study looked at willingness, as it is seen as a positive behavioural intention and thus more solution focused than exploring resistance. However, in only exploring positive intention, it may be that the level of variance was limited. That is, in looking at

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intention as an alternative to willingness, ranging from no intent to very intent, data collection may have elicited a broader spectrum of responses from participants.

The current study could also be criticised for using an overly broad target behaviour (supporting pupil mental health needs). This is something highlighted by Lee et al. (2010) as a common flaw of research exploring applications of the TPB with teachers, and proposed that the use of overly broad target behaviours can yield inconsistent results. In developing questionnaires based on the TPB, it is suggested that the target behaviour should be clearly defined in terms of its targets, action, context and time (Francis et al., 2004). Although this was considered during questionnaire development, the questionnaire may have produced more accurate results if the research had used a more tangible and specific scenario as its target behaviour. Future research could consider using a vignette in order to provide a definitive and clear target behaviour.

It was necessary to omit three scales as they did not meet assumptions for multivariate statistical analysis. The questionnaire in the current study requested participants to state the approximate number of pupils with mental health difficulties which they had experience of. In hindsight, this was a very difficult question for participants to respond to, and is the likely reason that nearly a quarter of participants left the item blank thus leading to the scale being excluded from the study. The questionnaire may be improved by asking participants to rate their *'level of perceived experience of pupils with mental health difficulties'* on a five point scale. Both the aetiological belief and desired social distance scales had to be omitted due to a low internal reliability. Internal reliability in relation to the aetiological belief scale may be improved by simplifying it. Based on the findings of the current study, teachers appear to hold undecided or uncommitted beliefs regarding whether mental health problems are biological or environmental in nature. However, Mukolo and Heflinger (2011) identified that adults were more likely to attribute the mental health problems of children and young people to biological/genetic causes, and Phelan et al. (2006) found a link between perceiving mental health problems as being caused by genetics or biology and a tendency to recommend 'harsh' forms of interventions such as medical intervention. Such perceptions may lead to teachers

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feeling powerless in terms of supporting pupil mental health. Therefore, rather than using a generic aetiological beliefs scale, which includes both environmentally and biologically weighted items, it might be better to have a more specific biological/genetic aetiological belief scale, which focuses purely on eliciting the degree to which a teacher believes that mental health problems are biological/genetic in nature, and should be treated using medical/clinical intervention. In terms of improving the internal reliability of the preferred social distance scale, having an exact scenario (e.g. a vignette) may help in controlling for the consistency of item interpretation and response.

Although the current study presents many interesting associations between the variables, it is important to appreciate that causal relationships cannot be inferred with confidence. For instance, there is no telling whether the teachers in the current study were more willing because of their personal experience of mental health, or whether they were more aware of mental health problems within their personal domain because of a willingness and interest in the area.

The current study could be criticised for not exploring the mediating effects amongst variables. Although this may have proved insightful, unfortunately it was beyond the scope of this thesis. Furthermore, the research did not ascertain longitudinal data, which are most appropriate for meaningful and rigorous analyses of mediational models (Cole & Maxwell, 2003).

5.8.2 Theoretical limitations

Although the current research found extensive support for the proposed model in terms of willingness, the research did not explore the relationship between willingness and actual behaviour or PBC and actual behaviour. Actual behaviour within the current study would have been hard to measure, as unless carrying out observations, measures would have to rely on self report methods. Nevertheless, it has been proposed that one of the most important contributions of the TPB model, in comparison with previous models of the attitude-behaviour, is the observation that behavioural-intention can be used as a proximal measure of behaviour (Francis et al., 2004). This has been supported through

two meta-analyses of the TPB (Armitage & Conner, 2001; Godin & Gok; 1996) which reported that the model generally predicts up to a third of the variance of actual behaviour.

The hypothetical model accounting for the highest level of variance within the current study (hypothesis 4), accounted for 29 percent of willingness. Although this is statistically relevant and can help in understanding and perhaps increasing teacher willingness, it is important to consider what this means in the real world context. That is, what factors are influencing the other 71 percent? Many of these factors may be difficult to control, such as teacher mood when completing the questionnaire. Although the variables comprising the proposed model in this study were informed by a comprehensive audit of the relevant literature and based upon psychological theory, undertaking formative qualitative research—either in the form of focus groups or individual interviews—may have helped in further informing the model in preparation for quantitative testing. Indeed, the use of elicitation studies to inform questionnaire development is something that is suggested within the literature (Lee et al., 2010).

5.8.3 Practical limitations

The current study has identified many factors which may influence a teacher's willingness to support pupil mental health needs. Consequently, several implications of the research have been offered, including a need to improve teacher's confidence in their ability to support pupil mental health needs through tailored training, providing increased opportunities for relevant experiences, encouraging collaboration and consultation between more specialist and teaching staff to empower those on the front-line, and a focus on overcoming age and burnout as a barrier to willingness. Although all of these implications are supported by the current study, their feasibility given the current economic climate, in terms of restricted budgets and resources, is questionable. Conversely, it could be argued that it is imperative for policy makers to consider findings such as these if whole school mental health initiatives are to be successful.

5.8.4 Strengths of the research

This study has many strengths in terms of its methodology. Firstly, the proposed model of teacher willingness is driven by both theory and previous research findings and further supported by empirical testing. Secondly, the questionnaire developed demonstrated good internal validity. Thirdly, the study operationalises the term 'mental health' so as to differentiate between internal and external mental health problems and also mental health and mental ill health continua, this is something that has been overlooked in previous research of a similar nature (e.g. Rothi et al., 2008; Kidger et al., 2010). Finally, the study sought the perceptions of a large—and demographically representative—sample and thus provides grounds for the generalisation of the findings.

This study explores the views of mainstream teachers within the secondary school context. In terms of mental health work in schools, the views of this population have been under represented within the literature, and have not been explored at all within the UK context. However, these views are arguably imperative in order to inform successful and long lasting initiatives and to promote change (Weist & Evans, 2005; Gowers et al., 2004; Gott, 2003; Weist & Murray, 2007; Lever et al., 2003). Therefore, the current study provides a novel and important contribution to the research literature. In doing so, the findings have provided some useful insights into the social-cognitive processes of teachers regarding supporting the mental health needs of their pupils, which could prove helpful in informing the development of teacher training packages and whole-school mental health initiatives. The research can help in meeting many of the requirements outlined by Noar (2006) as important during the initial steps of mental health programme development. For example: conducting formative research with the target audience to clearly understand the behaviour and the problem area; using theory as a conceptual foundation in order to provide important determinants around which key messages can be developed, to ensure that intended messages guide individuals through the process of attitude and/or behaviour change; and considering demographic variables, risk characteristics and experience (e.g. age, burnout, personal experience).

This thesis has also unveiled an important role for EPs, particularly in terms of helping to develop the capacity and skills of mainstream teachers to support the mental health needs of their pupils. This is in keeping with the role envisaged for EPs by the government (DfE, 2011), who stated that they should be involved in developing the skills of teachers. The findings are also in line with views held by the health sector, that EPs are amongst those who can enable education establishments to adopt organisation-wide approaches to promoting the social and emotional wellbeing of children and young people, helping them to develop the necessary organisational capacity, specialist skills and resources, as well as offering advice and support (NICE, 2009). The significance of the findings for the EP profession is discussed further within the next chapter.

6. CONCLUSION

This study was concerned with the perceptions and beliefs of mainstream secondary school teachers regarding their role in supporting internalised mental health issues that are experienced by pupils, with a particular focus on exploring teacher willingness. It was proposed that a teacher's willingness to support pupil mental health needs could be seen as a prerequisite for them undertaking the role. Thus, understanding the underlying factors that may contribute to teacher willingness could help in improving their actual engagement in school mental health work. Therefore, a predicative model of teacher willingness in terms of supporting pupil mental health needs was developed utilising both theory and past research (Figure 2.2). The model was tested by means of four research hypotheses. The results obtained provided comprehensive empirical support for all four hypotheses, and thus supported the proposed model of teacher willingness.

Mental health problems are a rising concern not only in the UK, but around the world. Within the UK, there is evidence to suggest that the prevalence of childhood mental health problems is gradually increasing (Collishaw et al., 2004; DH, 2004). With this increase comes a need to effectively meet the needs of this vulnerable population, not only to reduce the levels of distress experienced, but also in order to help all children and young people reach their full potential (WHO, 2004).

Schools have been identified as important agents in helping to prevent, identify and manage the mental health needs of children and young people as providers of universal services at tier one within the CAMHS framework (DfCSF & DH, 2008; DfES & DH, 2004; NCSS, 2011; Ofsted, 2005). It is suggested that much relevant and useful advice can be offered, on a simple, pragmatic basis by people working in schools to pupils with mental health problems, without the need to move to higher tiers of involvement (DfCSF & DH, 2008). In terms of undertaking this role, whole-school approaches are generally advocated as most effective (Ofsted, 2005; DfCSF & DH, 2008). However, there has been little research to explore the perceptions of mainstream secondary teachers regarding the undertaking of this role. Exploring the views of this group of professionals is particularly important as it has been reported that secondary schools are least

successful in meeting the mental health needs of pupils (Ofsted, 2005). Furthermore, the prevalence of mental health difficulties is generally higher for those young people of secondary school age than of primary school age (Green et al., 2005), thus it is imperative that secondary schools are equipped to deal with this demand.

This is the first study of its kind which aims to comprehensively and collaboratively explore factors which might affect teachers' willingness to support the mental health needs of pupils, utilising psychological theory in exploring attitude development. Moreover, it is the first study within the UK which seeks the perspectives of mainstream secondary school teachers who do not have a designated pastoral care role. It is also the only study of its kind within the UK which operationalises the term 'mental health', differentiating between internalised and externalised mental health problems to ensure greater control over participant response.

6.1 Future directions

Based on this study, there are three main future directions that would be helpful in understanding and exploring this area further. Firstly, developing more effective scales to measure factors which had to be omitted, secondly, accounting for a greater level of variance in teacher willingness, and thirdly, testing the effectiveness of the model in real terms.

6.1.1 Omitted scales

Unfortunately, the current study was unable to explore the impacts on willingness of years of practice, previous experience of pupils with mental health difficulties, preferred social distance, and aetiological beliefs due to the scales being omitted due to methodological flaws. Some suggestions as to how these scales could be improved were proposed within the limitations section of the previous chapter. As the literature implies that these factors may affect teacher willingness to support the mental health needs of pupils—directly and/or indirectly—it is important that future research investigates them.

6.1.2 Predicting a greater level of variance

It may be interesting to repeat a similar study to this one which utilises vignettes in order to ensure that the target behaviour is more specific and measurable. This may increase consistency of results, which may in turn increase the level of variance accounted for. Additionally, rather than looking at willingness, future studies could explore behavioural intention, which may encourage a broader range of responses from teachers and thus provide a more normally distributed outcome variable. Moreover, as mentioned within the discussion section, carrying out formative qualitative research with mainstream secondary school teachers may be useful in terms of eliciting factors which have not been identified within the body of research literature to date. This would help in expanding the proposed predictive model of teacher willingness, in an attempt to account for a greater percentage of variance. Qualitative research could take the form of open-ended questionnaires, interviews or focus groups.

Triangulation is a method of enquiry that is stated to increase the accuracy of findings through the process of corroboration (Creswell, 2008). Therefore, an additional direction may be to ascertain the views of a number of stakeholders including teachers, pupils, parents, senior/specialist staff and/or other relevant professionals as to what they feel may affect the willingness of teachers to support the mental health needs of pupils. This has the potential to provide triangulation of the factors noted within the model, and even identify additional ones.

6.1.3 Testing effectiveness

The effectiveness of the model could be further explored and tested by developing training and support packages which are informed by it. This could take the form of a randomised control trial (such as that undertaken by Ballone & Czerniak, 2001), whereby teachers are randomly allocated to either a control group—where they are provided with a standard training package—or an intervention group, where the training package provided is informed by the predictive model. Pre, post and follow-up measures could be taken which would enable not only the exploration of effects on willingness, but also on actual behaviour (e.g. asking at follow-up *"have you supported a pupil with*

mental health needs over the past month"). In turn, this would allow for the exploration of the interaction between intention and actual behaviour and also PBC and actual behaviour. If successful, research of this kind would provide robust evidence for the efficacy of the model. Collecting longitudinal data in this way would also allow for the analysis of mediating effects.

6.2   The wider inclusion agenda and related initiatives

The current study has provided a predictive model in terms of teacher willingness to support the mental health needs of pupils. However, as the model is based on psychological theory, it might be that the model could be adapted and applied to the wider inclusion agenda, for example, supporting pupils with learning difficulties, supporting pupils with ASD or supporting pupils with physical needs. The model may also be relevant in terms of predicting the willingness of teachers to implement specific initiatives, for example, certain strategies for differentiating work for pupils with speech and language difficulties. Nevertheless, this would require further research to explore the model's applicability within different domains. Implications for EPs

6.3   Implications for EPs

In order for schools to effectively meet the mental health needs of their pupils, this study indicates a need for training and support for teachers which aims to develop more favourable attitudes and beliefs regarding their role in supporting child and adolescent mental health. The findings also imply a need to skill up more specialist school staff to consult with and empower mainstream teachers who do not have a designated pastoral care role. Furthermore, in line with previous qualitative findings, there appears to be a need to focus on promoting the mental health of teachers, in order for them to feel willing and able to support that of their pupils.

It has been stated that collaboration between school- and community-employed professionals is critical to the success of school mental health work (Weist, Mellin, Chambers, Lever , Haber & Blaber , 2012). However, it has also been noted that in many health sector interactions with education; there is little or no recognition of the dynamic

nature of schools, the extensive research on school change and innovation, and the well-developed expertise of teachers (Rowling & Jeffries, 2006; cited in Rowling 2007). Here lies a clear role for EPs in bridging the gap between health and educational contexts. EPs are familiar with the complexities of change processes within educational contexts and also theories of attitude development, in addition to having a comprehensive knowledge of child and adolescent mental health informed by theory, research and experience. Thus, EPs can effectively support in the delivering of mental health training, making it relevant for teachers, a factor which—based on the findings of this study—appears to be important in terms of attitudinal change. Furthermore, EPs are in a position to provide ongoing support for teachers, for example through group consultations or drop-in surgeries. They would also be in a position to support more senior staff in developing effective mechanisms for consulting with and empowering teaching staff when issues arise. Mainstream secondary teachers could even be invited to take part in relevant consultations with EPs and pastoral care staff as part of their continual professional development opportunities. Finally, EPs are in a position to help schools in developing policies and initiatives to help support the mental health of teachers so that they are able to practice more effectively.

The current study provides an example of how EPs can utilise psychological theory to inform practice and change at a systemic level. This is an important implication for the profession in terms of promoting the unique contribution EPs can have in supporting the achievement and development of children and young people.

6.4   Summary

An improved understanding of the willingness of teachers to support the mental health needs of their pupils has the potential to improve mental health outcomes for children and young people. Effective school mental health approaches are becoming increasingly essential in providing children and young people with access to quality mental health services and promoting overall mental wellbeing. Currently, schools serve as the "de facto mental health care system for children" (Hoagwood & Erwin, 1997, p.438), and this is reflected in government policy (e.g. DfCSF & DH, 2008).

In addition to ascertaining the views of mainstream secondary school teachers regarding pupil mental health needs, this study has developed, tested and provided empirical evidence for a predictive model of teacher willingness to support pupil mental health needs. In doing so, the study has developed a model that provides insights not only into what direct factors may increase willingness, but also what types of belief systems may influence those factors to begin with.

One of the main findings of this study is that, although teachers are generally willing to support the mental health needs of their pupils, they do not feel they have the ability or control to do so—conceptualised within this study as PCB. Although findings from this study indicate that this is not a strong contributory factor of willingness, in terms of the TPB and theories of self-efficacy, confidence in own ability is likely to impact directly upon the likelihood of a teacher actually undertaking the role, separately and in addition to their level of willingness. Therefore, improving low levels of PBC amongst mainstream teachers is likely to be an important factor in order to successfully achieve the wellbeing agenda in schools. This study has identified a number of control beliefs which contribute considerably to PBC, thus providing a framework to work with in terms of improving PBC.

This study illustrates that in order to further increase levels of willingness amongst teachers, it is critical that their attitudes, beliefs and own mental wellbeing are addressed. In light of the current findings, there is a need for future research that aims to measure the effectiveness of teacher training and support packages which are developed with reference to those factors evidenced within this study as bearing relevance to teacher willingness.

7. REFERENCES

Abbey, A., & Dickson, J. (1983). R & D work climate and innovation in semiconductors. *Academy of Management Journal, 26*, 362-368.

Adelman, H. S., & Taylor, L. (1999). Mental health in schools and system restructuring. *Clinical Psychology Review, 19*(2), 137-163.

Adelman, H. S., & Taylor, L. (2000). Promoting mental health in schools in the midst of school reform. *Journal of School Health, 70*, 171-178.

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl & J. Beckmann (Eds.), *Action control: From cognition to behavior* (pp. 11-39). New York: Springer-Verlag.

Ajzen, I. (1991). 'The theory of planned behavior', organizational behavior and human. *Decision Processes, 50*(2), 179-211.

Ajzen, I. (2002). Perceived behavioral control, self-efficacy, locus of control, and the theory of planned behavior. *Journal of Applied Social Psychology, 32*, 665-683.

Ajzen, I. (2005). *Attitudes, personality and behavior* (2nd ed.). Berkshire: McGraw-Hill International.

Ajzen, I., & Fishbein, M. (1977). Attitude-behavior relations: A theoretical analysis and review of empirical research. *Psychological Bulletin, 84*(5), 888-918.

Ajzen, I., & Fishbein, M. (2005). The influence of attitudes on behavior. In D. Albarracin, B. T. Johnson & M. P. Zanna (Eds.), *The handbook of attitudes.* New York: Lawrence Erlbaum Associates Inc.

Alexander, T. (2002). *A bright future for all: Promoting mental health in education*. London: The Mental Health Foundation.

Amabile, T., & Gryskiewicz, S. (1989). The creative environment scales: The work environment inventory. *Creativity Research Journal, 2*, 231-254.

Anderson, S., Kerr-Roubicek, H., & Rowling, L. (2006). Staff voices: What helps students with high mental health support needs connect to school? *Australian Journal of Guidance & Counselling, 16*(1), 1-13.

Appleby, L., Shribman, S., & Eisenstadt, N. (2006). *Report on the implementation of standard 9 of the National Service Framework for children, young people and maternity services – promoting the mental health and psychological well-being of children and young people*. London: Department for Education and Skills/Department of Health.

Armbruster, P., Gerstein, S. H., & Fallon, T. (1997). Bridging the gap between service need and service utilization: A school-based mental health program. *Community Mental Health Journal, 33*(3), 199-211.

Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behaviour: A meta-analytic review. *British Journal Social Psychology, 40*, 471-499.

Azrin, N. H., & Holz, W. C. (1966). Punishment. In W. K. Honig (Ed.), *Operant behavior: Areas of research and application*. Michigan: Appleton Century-Crofts.

Baginsky, W. (2004). *School counselling in England, Wales and Northern Ireland: A review*. NSPCC and Keel University.

Ballone, L. M., & Czerniak, C. M. (2001). Teachers' beliefs about accommodating students' learning styles in science classes. *Electronic Journal of Science Education, 6*(2).

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice Hall.

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York: W.H. Freeman and Company.

Barry, M., & Jenkins, R. (2007). *Implementing mental health promotion.* Oxford: Elsevier.

Baxtor, J. (2002). Creative partnerships: Public and voluntary services working together. *Educational Psychology in Practice, 18*(1), 63-72.

Bell, L., Long, S., Garvan, C., & Bussing, R. (2011). The impact of teacher credentials on ADHD stigma perceptions. *Psychology in the Schools, 48*(2), 184-197

Bond, L., Butler, H., Thomas, L., Carlin, J., Glover, S., Bowes, G., & Patton, G. (2007). Social and school connectedness in early secondary school as predictors of late teenage substance use, mental health, and academic outcomes. *Journal of Adolescent Health, 40*(4).

Bovey, W. H., & Hede, A. (2001). Resistance to organizational change: the role of cognitive and affective processes. *Leadership & Organization Development Journal, 22*(8), 372–382.

Bowen, G., L, Richman, J., M, Brewster, A., & Bowen, N. (1998). Sense of school coherence, perceptions of danger at school, and teacher support among youth at risk of school failure. *Child & Adolescent Social Work Journal, 15*, 273-286.

Bowen, N., & Bowen, G. (1998). The effects of home microsystem risk factors and school microsystem protective factors on student academic performance and affective investment in schooling. *Children & Schools, 20*(4), 219-231.

Brace, N., Kemp, R., & Snelgar, R. (2006). *SPSS for Psychologists* (3 ed.). London: Palgrave.

Braunholtz, S., Davidson, S., & King, S. (2004). *Well What do you think the second national Scottish survey of public attitudes to mental health, mental well-*

being and mental health problems. Edinburgh: Scottish Executive and MORI Scotland.

The British Medical Association (BMA) (2006). *Child and adolescent mental health: A guide for healthcare professionals*. London: British Medical Association.

British Psychological Society (BPS) (2006). *Code of ethics and conduct*. Leicester: BPS

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Bryman, A. (1988). *Quantity and quality in social research*. New York: Routledge.

Burack, A., Root, A. R., & Zigler, E. (1997). Inclusive education for students with autism: Reviewing ideological, empirical, and community considerations. In D. J. D.J. Cohen & F. R. Volkmar (Eds.), *Handbook of autism and pervasive developmental disorders* (2 ed., pp. 796–807). New York: Wiley & Sons.

Burke, R. W. (2008). Contextual features of public schools in the United States as settings for mental health promotion. *Advances in School Mental Health Promotion, 1*(Inaugural Issue), 52-56.

Burke, R. W., & Paternite, C. E. (2007). Teacher engagement in expanded school mental health. In S. W. Evans, M. D. Weist & Z. N. Serpell (Eds.), *Advances in school-based mental health interventions: Best practices and program models* (Vol. 2, pp. 1-15). Kingston: Civic Research Institute.

Burr, V. (2003). *Social constructionism*. London: Routledge.

Campbell, D., Coldicott, T., & Kinsella, K. (1994). *Systemic work with organizations: A new model for managers and change agents*. London: Karnac Books.

Cape, P. (2010). Questionnaire length, fatigue effects and response quality revisited. Paper presented at the at Advertising Research Foundation Re:think 2010 convention, New York.

Capey, M. (1997). *Counselling for pupils and young adults: Examples of what LEA and schools provide*. Slough: Education management Information Exchange NFER.

Carmines, E. G., & Zeller, R. A. (1979). *Reliability and validity assessment*. Newbury Park, CA: Sage Publications.

Casper, E. (2007). The theory of planned behavior applied to continuing education for mental health professionals. *Psychiatric Services, 58*(10), 1324-1329.

The Children Act 2004. London: The Stationary Office (TSO)

Cohall, A. T., Cohall, R., Dye, B., Dini, S., Vaughan, R. D., & Coots, S. (2007). Overheard in the halls: What adolescents are saying, and what teachers are hearing, about health issues. *Journal of School Health, 77*(7), 344-350.

Cohen, J., & Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioral sciences* (2 ed.). Hillsdale, N. J: L. Erlbaum Associates.

Cohen, L., Manion, L., & Morrison, K. R. (2005). *Research methods in education*. London: Routledge Falmer.

Cole, B. E., Sellman, E. M., Daniels, H. R. J., & Visser, J. G. (2002). *The mental health needs of young people with emotional and behavioral difficulties.* London: Mental health foundation.

Cole, D. A., & Maxwell, S. E. (2003). Testing mediational models with longitudinal data: Questions and tips in the use of structural equation modelling. *Journal of Abnormal Psychology, 112*(4)*,* 558-577.

Collins, A., & Holmshaw, J. (2008). Early detection: a survey of secondary school teachers' knowledge about psychosis. *Early Intervention in Psychiatry, 2*(2), 90-97.

Collishaw, S., Maughan, B., Goodman, R., & Pickles, A. (2004). Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry, 45*(8), 1350–1362.

Connelly, G., Lockhart, E., Wilson, P., Furnivall, J., Bryce, G., Barbour, R., & Phin, L. (2008). Teachers' responses to the emotional needs of children and young people. Results from the Scottish Needs Assessment Programme. *Emotional and Behavioural Difficulties, 13*(1), 7 - 19.

Cooper, B. (2004). Empathy, interaction and caring: teachers' roles in a constrained environment. *Pastoral Care in Education: An International Journal of Personal, Social and Emotional Development, 22*(3), 12-21.

Creswell, J. W. (2008). *Research design: qualitative, quantitative, and mixed methods approaches* (3 ed.). London: Sage.

Department for Children, Schools and Families (DfCSF). (2005). *Primary national strategy excellence and enjoyment: Social and emotional aspects of learning (SEAL) guidance - curriculum and standards*. London: The Stationary Office (TSO).

Department for Children, Schools and Families (DfCSF). (2007). *Secondary national strategy for school improvement: Social and emotional aspects of learning for secondary schools (SEAL) guidance - curriculum and standards*. London: The Stationary Office (TSO).

Department for Children, Schools and Families (DfCSF). (2008). Targeted mental health in schools grant project (TaMHS) - Evidence-based guidance booklet. London: The Stationary Office (TSO).

124

Department for Children, Schools and Families (DfCSF). (2010). *The pupil and parent guarantees*. London: The Stationary Office (TSO).

Department for Children, Schools and Families (DfCSF), & Department of Health (DH). (1999). *National healthy schools programme*. London: The Stationary Office (TSO).

Department for Children, Schools and Families (DfCSF). & Department of Health (DH). (2008). *Children and young people in mind: The final report of the National CAMHS Review* Nottingham: The Stationary Office (TSO)..

Department for Children, Schools and Families (DfCSF), & Department of Health (DH). (2010). *Keeping children and young people in mind – Full government response to the CAMHS Review*. Nottingham: The Stationary Office (TSO).

Department for Education (DfE). (2010). *The importance of teaching - The schools white paper 2010*. London : The Stationary Office (TSO).

Department for Education (DfE). (2011a). *Support and aspiration: A new approach to special educational needs and disability - a consultation*. London: The Stationary Office (TSO).

Department for Education (DfE). (2011b). *School Workforce in England November 2010 (Provisional)*. London: The Stationary Office (TSO).

Department for Education and Employment (DfEE). (2001). *Promoting children 's mental health within early years and school settings - Guidance*. London: The Stationary Office (TSO).

Department for Education and Skills (DfES). (2001). *Special education needs: Code of practice*. London: The Stationary Office (TSO).

Department for Education and Skills (DfES). (2004). *Every child matters: Change for children*. Nottingham: The Stationary Office (TSO).

Department for Education and Skills (DfES). (2005a). *Key Stage 3 National Strategy. Developing emotional health and well-being: a whole-school approach to improving behaviour and attendance*. London: The Stationary Office (TSO).

Department for Education and Skills (DfES). (2005b). *Extended schools: access to opportunities and services for all*. London: The Stationary Office (TSO).

Department for Education and Skills (DfES). & Department of Health (DH). (2004). *National service framework for children, young people and maternity services*. London: The Stationary Office (TSO).

Department of Health (DH). (2004). Choosing health. Making healthy choices easier. London: DH.

Dix, K. L., Slee, P. T., Lawson, M. J., & Keeves, J., P. (2012). Implementation quality of whole-school mental health promotion and students' academic performance. *Child and Adolescent Mental Health, 17*(1), 45-51.

Dowling, E., & Osborne, E. (1994). *The family and the school: A joint systems approach to problems with children.* London: Routledge.

Dwyer, S. B., Nicholson, J. M., & Battistutta, D. (2006). Parent and teacher identification of children at risk of developing internalizing or externalizing mental health problems: A comparison of screening methods. [References]. *Prevention Science, 7*(4), 343-357.

Ecclestone, K., & Hayes, D. (2009). Changing the subject: the educational implications of developing emotional well-being. *Oxford Review of Education, 35*(3), 371 - 389.

The Education and Inspections Act 2006. London : The Stationary Office (TSO).

Evans, R. (2001). *The human side of school change: Reform, resistance, and the real-life problems of innovation*. New York: Jossey-Bass.

126

Field, A. (2009). *Discovering statistics using SPSS: (and sex and drugs and rock 'n' roll)*. London: Sage.

Finney, D. (2006). Stretching the boundaries: Schools as therapeutic agents in mental health. Is it a realistic proposition? *Pastoral Care in Education, 24*(3), 22-27.

Fishbein, M., & Ajzen, I. (1975). *Belief, attitude, intention, and behavior: An introduction to theory and research*. Reading, MA: Addison-Wesley.

Fishbein, M., & Ajzen, I. (2010). *Predicting and changing behaviour: The reasoned action approach*. New York: Psychology Press (Taylor & Francis).

Ford, T., Goodman, R., & Meltzer, M. (2003). Service use over 18 months among a nationally representative sample of British children with psychiatric disorder. *Clinical Child Psychology and Psychiatry, 8*, 37-51.

Francis, J. J., Eccles, M. P., Johnston, M., Walker, A., Grimshaw, J., Foy, R., . . . Bonetti, D. (2004). *Constructing questionnaires based on the theory of planned behaviour: A manual for health services researchers*. Newcastle University Centre for Health Services Research.

Fraser, M., & Blishen, S. (2007). *Supporting young people's mental health: eight points for action: a policy briefing from the Mental Health Foundation*. London: Mental Health Foundation

Frederickson, N., & Dunsmuir, S. (2011). *Measures of children's mental health and psychological wellbeing: Introduction*. London: GL Assessment.

Freedenthal, S., & Breslin, L. (2010). High school teachers' experiences with suicidal students: A descriptive study. *Journal of Loss and Trauma: International Perspectives on Stress & Coping, 15*(2), 83-92.

Fullan, M. (2007). *The new meaning of educational change* (4 ed.). New York: Teachers College.

Gameson, J., & Rhydderch, G. (2008). The constructionist model of informed and reasoned action (COMOIRA) In B. Kelly, L. Woolfson & J. Boyle (Eds.), *Frameworks for Practice in Educational Psychology.* London: Jessica Kingsley.

Gamman, R. (2003). *Promoting young people's wellbeing: A review of research on emotional health.* The SCRE Centre, University of Glasgow.

General Teaching Council for Wales (GTCW). (2011). *Annual Statistics Digest March 2011*. Cardiff: GTCW

Gergen, K. J. (1999). *An invitation to social constructionism*. London: Sage.

Godin, G., & Kok, G. (1996). The theory of planned behavior: A review of its applications to health-related behaviours. *American Journal of Health Promotion, 11*, 87–98.

Goleman, D. (1996). *Emotional intelligence: Why it can matter more than IQ*. London: Bloomsbury Publishing.

Goodhue, D. L., & Loiacono, E. T. (2002). *Randomizing survey question order vs. grouping questions by construct: An empirical test of the impact on apparent reliabilities and links to related constructs.* Paper presented at the Proceedings of the 35th Hawaii International Conference on System Sciences, Hawaii.

Gott, J. (2003). The school: The front line of mental health development? *Pastoral Care in Education: An International Journal of Personal, Social and Emotional Development, 21*(4), 5-13.

Gowers, S., Thomas, S., & Deeley, S. (2004). Can primary schools contribute effectively to tier I Child Mental Health Services? *Clinical Child Psychology and Psychiatry, 9*(3), 419-425.

Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain, 2004*. Hampshire: Palgrave McMillan.

Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredericks, L., Resnik, H., & Elias, M. J. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist, 58*(6-7), 466-474.

Han, S. S., & Weiss, B. (2005). Sustainability of teacher implementation of school-based mental health programs. *Journal of Abnormal Child Psychology, 33*(6), 665-679.

Haney, J. J., Czerniak, C. M., & Lumpe, A. T. (1996). Teacher beliefs and intentions regarding the implementation of science education reform strands. *Journal of Research in Science Teaching, 33*, 971-993.

Hardeman, W., Johnston, M., Johnston, D. W., Bonetti, D., Wareman, N. J., & Kinmonth, A. L. (2002). Application of the theory of planned behaviours in behaviour change interventions: A systematic review. *Psychological Health, 17*, 123–158.

Hastings, R. P., & Bham, M. S. (2003). The relationship between student behaviour patterns and teacher burnout. *School Psychology International, 24*(1), 115-127.

The Heath Development Agency. (2004). *Promoting emotional health and wellbeing through the National Healthy School Standard*. Yorkshire: The Health Development Agency.

Herbert, J. D., Crittenden, K., & Dalrymple, K. L. (2004). Knowledge of social anxiety disorder relative to attention deficit hyperactivity disorder among educational professionals. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 366–372.

Hersey, P., & Blanchard, K. (1988). *Management of organizational behaviour* (5 ed.). New Jersey: Prentice Hall.

Hui, L., Jiangyu, S., & Wenquan, L. (2001). Enhancing primary school teachers' consciousness and abilities to care for pupils' mental health. *Chinese Mental Health Journal, 4*, Abstract only.

Huppert, F., A, & Whittington, J., E. (2003). Evidence for the independence of positive and negative wellbeing: implications for quality of life assessment. *British Journal of Health Psychology 8*, 107-122.

Hoagwood, K., & Erwin, H. (1997). Effectiveness of School-Based Mental Health Services for Children: A 10-Year Research Review. *Journal of Child and Family Studies, 6*(4), 435-451.

Ian M. Shochet, I., M, Dadds, M., R, Ham, D., & Montague, R. (2006). School connectedness is an underemphasized parameter in adolescent mental health: Results of a community prediction study. *Journal of Clinical Child & Adolescent Psychology, 35*(2), 170-179.

Ittzés, A., Tomcsányi, T., Szabó, T., Midling, A., & Török, P. (2011). Recent findings in the effectiveness testing of an interdisciplinary training program in mental health promotion. *Community Mental Health Journal, 47*(5), 498-505.

Jensen, E. (1998). *Teaching with the brain in mind*. Alexandria, VA: Association for Supervision and Curriculum Development.

Johnson, B. (2008). Teacher-student relationships which promote resilience at school: a micro-level analysis of students' views. *British Journal of Guidance and Counselling, 36*(2), 385-398.

Jorm, A. F., Kitchener, B. A., Sawyer, M. G., Scales, H., & Cvetkovski, S. (2010). Mental health first aid training for high school teachers: A cluster randomized trial. *BMC Psychiatry, 10*, 51-63.

Kelly, C., Jorm, A., & Wright, A. (2007). Improving mental health literacy as a strategy
to facilitate early intervention for mental disorders. *Medical Journal of
Austrailia, 187*(7), 26-30.

Kelman, H. C. (1958). Compliance, identification, and internalization: three processes of
attitude change. *Journal of Conflict Resolution, 2*(1), 51-60.

Kersaint, G., Lewis, J., Potter, R., & Meisels, G. (2007). Why teachers leave: Factors
that influence retention and resignation. *Teaching and Teacher Education, 23*(6),
775-794.

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B.
(2003). Age of onset of mental disorders: A review of recent literature. *Current
Opinion in Psychiatry, 20*(4), 359-364.

Keyes, C., L. (2002). The mental health continuum: from languishing to flourishing in
life. *Journal of Health and Social Research, 43*, 207-222.

Keyes, C., L. (2005). Mental illness and/or mental health? Investigating axioms of
the complete state model of health. *Journal of Consulting and Clinical
Psychology 73*, 539-548.

Kidger, J., Donovan, J., Biddle, L., Campbell, R., & Gunnell, D. (2009). Supporting
adolescent emotional health in schools: a mixed methods study of student and
staff views in England. *BMC Public Health, 9*(1), 403.

Kidger, J., Gunnell, D., Biddle, L., Campbell, R., & Donovan, J. (2010). Part and parcel
of teaching? Secondary school staff's views on supporting student emotional
health and well-being. *British Educational Research Journal, 36*(6), 919 - 935.

King, G., Specht, J., Bartlett, D., Servais, M., Petersen, P., Brown, H., . . . Stewart, S.
(2010). A qualitative study of workplace factors influencing expertise in the
delivery of children's education and mental health services. *Journal of Research
in Interprofessional Practice and Education, 1*(3), 265-283.

King, K. A., Price, J. H., Telljohann, S. K., & Wahl, J. (1999). High school health teachers' perceived self-efficacy in identifying students at risk for suicide. *Journal of School Health, 69*(5), 202-207.

Kitchener, B. A., & Jorm, A. F. (2006). Mental Health First Aid training: review of evaluation studies. *Australian and New Zealand Journal of Psychiatry, 40*, 6-8.

Kniveton, B., H. (2004). Adolescent perceptions of the importance of teachers as a therapeutic support in coping with their problems. *Emotional and Behavioural Difficulties, 9*(4), 239-248.

Koller, J., & Bertel, J. (2006). Responding to today's mental health needs of children, families and schools: Revisiting the preservice training and preparation of school-based personnel. *Education and Treatment of Children, 29*(2), 197-217.

Kos, J. M., Richdale, A. L., & Jackson, M. S. (2004). Knowledge about attention-deficit/hyperactivity disorder: A comparison of in-service and preservice teachers. *Psychology in the Schools, 41*(5), 517-526.

Kraus, S. J. (1995). Attitudes and the prediction of behavior: A meta-analysis of the empirical literature. *Personality and Social Psychology Bulletin, 21*(1), 58-75.

Kruger, L. J. (1997). Social support and self-efficacy in problem solving among teacher assistance teams and school staff. *Journal of Educational Research, 90*(3), 164-168.

Kudlaeek, M., Valkova, H., Sherrill, C., Myers, B., & French, R. (2002). An inclusion instrument based on planned behavior theory for prospective physical educators. *Adapted Physical Activity Quarterly 19*(3), 280-299.

Lam, S., & Hui, E. (2010). Factors affecting the involvement of teachers in guidance and counselling as a whole-school approach. *British Journal of Guidance and Counselling, 38*(2), 219-234.

Langeveld, J., Joa, I., Larsen, T. K., Rennan, J. A., Cosmovici, E., & Johannessen, J. O. (2011). Teachers' awareness for psychotic symptoms in secondary school: The effects of an early detection programme and information campaign. *Early Intervention in Psychiatry, 5*(2), 115–121.

Layard, R., & Dunn, J. (2009). *A good childhood. Searching for values in a competitive age: The landmark report for the Children's Society*. London: The Children's Society.

Le Cornu, R., & Collins, J. (2004). Re-emphasising the role of affect in learning and teaching. *Pastoral Care in Education, 22*(4), 27-33.

Lee, J., Cerreto, F. A., & Lee, J. (2010). Theory of planned behavior and teachers' decisions regarding use of educational technology. *Educational Technology & Society, 13*(1), 152–164.

Lever, N. A., Adelsheim, S., Prodente, C. A., Christodulu, K. V., Ambrose, M. G., Schlitt, J., & Weist, M. D. (2003). System, agency and stakeholder collaboration to advance mental health programs in schools. In M. D. Weist, S. W. Evans & N. A. Level (Eds.), *Handbook of school mental health: Advancing practice and research*. New York: Springer.

Levitt, J., Saka, N., Hunter-Romanelli, L., & Hoagwood, K. (2007). Early identification of mental health problems in schools: The status of instrumentation.. *Journal of School Psychology, 45*, 163–191.

Lines, D. (2002). *Brief counselling in schools*. London: Sage.

Loades, M., E, & Mastroyannopoulou, K. (2010). Teachers' recognition of children's mental health problems. *Child and Adolescent Mental Health, 15*(3), 150–156.

Locke, E. A. (1975). Personal Attitudes and Motivation. *Annual Review of Psychology, 26*, 457-480.

Lohrmann, S., Forman, S., Martin, S., & Palmieri, M. (2008). Understanding
school personnel's resistance to adopting schoolwide positive behavior support
at a universal level of intervention. *Journal of Positive Behavior Interventions,
10*(256-269.

Lynn, C., McKernan McKay, M., & Atkins, M. (2003). School social work: meeting the
mental health needs of students through collaboration with teachers. *Children
and Schools, 25*, 197-209.

McGregor, E., & Campbell, E. (2001). The attitudes of teachers in Scotland to the
integration of children with autism into mainstream schools. *Autism, 5*(2), 189-
207.

McManus, S., Meltzer, H., Brugha, T., Bebbington, P., & Jenkins, R. (2009). *Adult
psychiatric morbidity in England, 2007: Results of a household survey*. London:
The NHS Information Centre for Health and Social Care.

Mental Health Foundation (1999). *Bright futures: promoting children and young
people's mental health*. England: Mental Health Foundation.

Metselaar, E. E. (1997). *Assessing the willingness to change*. Amsterdam:
Free University.

Moor, S., Maguire, A., McQueen, H., Wells, E. J., Elton, R., Wrate, R., & Blair, R.
(2007). Improving the recognition of depression in adolescence: Can we teach
the teachers? *Journal of Adolescence, 30*(1), 81-95.

Mukolo, A., & Heflinger, C. (2011). Factors associated with attributions about child
health conditions and social distance preference. *Community Mental Health
Journal, 47*(3), 286-299. doi: 10.1007/s10597-010-9325-1

Mullins, L. J. (1999). *Management and organisational behaviour* (5 ed.). London:
Pitman.

National CAMHS Support Service (NCSS) (2011). *Better mental health outcomes for children and young people.* London: NCSS.

Naylor, P., B, Cowie, H., A, Walters, S., J, Talamelli, L., & Dawkins, J. (2009). Impact of a mental health teaching programme on adolescents. *The British Journal of Psychiatry 194*, 365-370.

NICE. (2009). Social and emotional wellbeing in secondary education *Quick reference guide*. London: National Institution of Clinical Excellence.

NHS Health Advisory Service (1995). *Together we stand: Commissioning, role and management of child and adolescent mental health services.* London: HMSO.

Noar, S., M. (2006). A 10-year retrospective of research in health mass media campaigns: where do we go from here? *Journal of Health Communication, 11*(1), 21-42.

Nunnally, J. C. (1978). *Psychometric Theory* (2 ed.). New York: McGraw-Hill.

Ofsted. (2005). *Healthy Minds: Promoting Emotional Health and Well-Being in Schools.* London: The Stationary Office (TSO).

Oreg, S. (2006). Personality, context, and resistance to organizational change. *European Journal of Work and Organizational Psychology, 15*(1), 73-101.

ÖzabacI, N. (2010). The effectiveness of teachers to recognize the symptoms of depression for their depressive students. *Procedia - Social and Behavioral Sciences, 2*(2), 2371-2376.

Paternite, C. E. (2007). Involving educators in school-based mental health programs. In K. E. Robinson (Ed.), *Advances in school-based mental health interventions: Best practices and program models* Kingston, NJ: Civic Research Institute.

Paternite, C. E., & Johnston, T. C. (2005). Rationale and strategies for central involvement of educators in effective school-based mental health programs. *Journal of Youth and Adolescence, 34*(1), 41-49.

Paulhus, D. L. (1991). Measurement and control of response biases. In J. P. Robinson, P. R. Shaver & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (Vol. 1). San Diego: Academic Press.

Phelan, J. C., Yang, L. H., & Cruz-Rojas, R. (2006). Effects of attributing serious mental health illness to genetic causes on orientations of treatment. *Psychiatric Services, 57*, 382-387.

Pollett, H. (2007). *Mental health promotion: A literature review.* Canada: Canadian Mental Health Association.

Rees, I. (2008). A systemic solution-orientated model. In B. Kelly, L. Woolfson & J. Boyle (Eds.), *Frameworks for practice in educational psychology: A textbook for trainees and practitioners* (pp. 162-182). London: Jessica Kingsley.

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1-13.

Ridge, D. T., Sheehan, M., Marshall, B., Maher, S., & Carlisle, R. (2003). Being there: How teachers of students facing adversity promote positive relationships. *Qualitative Research Journal, 3*(2), 5-21.

Ringeisen, H., Henderson, K., & Hoagwood, K. (2003). Context matters: Schools and the "research to practice gap" in children's mental health. *School Psychology Review, 32*(2), 153-168.

Roeser, R. (2001). To cultivate the positive: Introduction to the special issue on schooling and mental health issues. *Journal of School Psychology, 39*(2), 99–110.

Roeser, R. W., Eccles, J. S., & Strobel, K. R. (1998). Linking the study of schooling and mental health: Selected issues and empirical illustrations. *Educational Psychologist, 33*(4), 153 - 176.

Roeser, R. W., & Midgley, C. (1997). Teachers' views of issues involving students' mental health. *Elementary School Journal, 98*(2), 115-133.

Rothì, D. M., Leavey, G., & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education, 24*(5), 1217-1231.

Rowling, L. (2007). School mental health: Politics, power and practice. *Advances in School Mental Health Promotion, 1*, 23-31.

Royal College of Psychiatrists (2004). *Mental health and growing up (3e). Factsheets for parents, teachers and young people.* London: Gaskell.

Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In J. Rolf, A. Masten, S, D. Cicchetti, K. Nuechterlein, H & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology*. Cambridge University Press.

Sample, J., & Warland, R. (1973). Attitude and prediction of behaviour. *Social Forces, 51*(3), 292-304.

Sciutto, M. J., Terjesen, M. D., & Bender Frank, A. S. B. (2000). Teachers' knowledge and misperceptions of attention-deficit hyperactivity disorder. *Psychology in the Schools, 37*(2), 115-122.

Scott, S. G., & Bruce, R. A. (1994). Determinants of innovative behaviour: A path model of individual innovation in the work place. *Academy of Management Journal, 37*, 580-607.

Skinner, B. F. (1953). *Science and human behaviour*. New York: McMillan.

Skinner, B. F. (1969). *Contingencies of reinforcement: A theoretical analysis.* New York: Appleton Century-Crofts.

Smith, M. (2004). What do surveys of public attitudes to mental health problems really mean (and do we mean what we say)? *Journal of Public Mental Health, 3*(4), 40-48.

Spratt, J., Shucksmith, J., Philip, K., & Watson, C. (2006). 'Part of who we are as a school should include responsibility for well-being': Links between the school environment, mental health and behaviour. *Pastoral Care in Education: An International Journal of Personal, Social and Emotional Development, 24*(3), 14-21.

St Leger, L. (2000). Reducing the barriers to the expansion of health-promoting schools by focusing on teachers. *Health Education, 100*(2), 81-87.

Sugar, W., Crawley, F., & Fine, B. (2005). Critiquing theory of planned behaviour as a method to assess teachers' technology integration attitudes. *British Journal of Educational Technology 36*(2), 331-334.

Suldo, S., M, Friedrich, A., A, White, T., Farmer, J., Minch, D., & Michalowski, J. (2009). Teacher support and adolescents' subjective well-being: A mixed-methods investigation. *School Psychology Review, 38*(1), 67-85.

Sutton, S. (1997). Theory of planned behaviour. In Baum A, Newman S, Weinman J, West R & M. C (Eds.), *Cambridge handbook of psychology, health and medicine* (pp. 177–179). Cambridge University Press.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate analysis* (4 ed.). Boston: Allyn and Bacon.

Tittle, C. R., & Hill, R. J. (1967). Attitude measurement and prediction of behavior: An evaluation of conditions and measurement techniques. *Sociometry, 30*(2), 199-213.

Vroom, V. H. (1964). *Work and motivation*. New York: Wiley.

Vroom, V. H. (1968). Methods of Organizational Research. Pittsburgh, PA: University of Pittsburgh Press.

Walter, H. J., Gouze, K., & Lim, K. G. (2006). Teachers' beliefs about mental health needs in inner city elementary schools. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(1), 61-68.

Watson, G. (1973). Resistance to change. In G. Zaltman (Ed.), *Processes and phenomena of social change*. New York: Wiley.

Weare, K. (2000). *Promoting mental, emotional, and social health: A whole school approach.* London: Psychology Press.

Weare, K. (2004). *Developing the emotional literate school*. London: Paul Chapman Publishing.

Weare, K., & Markham, W. (2005). What do we know about promoting mental health through schools? *Promotion and Education, 12*(3-4), 118-122.

Weare, K., & Murray, M. (2004). Building a sustainable approach to mental health work in schools. *The International Journal of Mental Health Promotion, 6*(2), 53-59.

Wehby, J. H., Maggin, D. M., Moore Partin, T. C., & Robertson, R. (2012). The impact of working alliance, social validity, and teacher burnout on implementation fidelity of the Good Behavior Game. *School Mental Health, 4*(1), 22-33

Weist, M., D, & Murray, M. (2007). Advancing school mental health promotion globally. *Advances in School Mental Health Promotion, 1*(1), 2-12.

Weist, M. D., & Evans, S. W. (2005). Expanded school mental health: Challenges and opportunities in an emerging field. *Journal of Youth and Adolescence, 34*(1), 3-6.

Wells, J., Barton, J., & Stewart Brown, S. (2003). A systematic review of universal
approaches to mental health promotion in schools. *Health Education, 103*(4),
197-220.

Welsh Assembly Government (WAG). (2001). *Child and adolescent mental health
services: Everybody's business.* Cardiff: WAG.

Welsh Assembly Government (WAG). (2004). *Children and young people: Rights to
action*. Cardiff: WAG.

Welsh Assembly Government (WAG). (2010a). *Thinking positively: Emotional health
and well-being in schools and early years settings*. Cardiff: WAG.

Welash Assembly Government (WAG). (2010b). *Schools' Census 2010: Final results.*
Cardiff: WAG.

Welsh Audit Office (WAO). (2009). *Services for children and young people with
emotional and mental health needs.* Cardiff: WAO.

White, S., Sukhodolsky, D., Rains, A., Foster, D., McGuire, J., & Scahill, L. (2011).
Elementary school teachers' knowledge of tourette syndrome, obsessive-
compulsive disorder, & attention-deficit/hyperactivity disorder: Effects of
teacher training. *Journal of Developmental and Physical Disabilities, 23*(1), 5-
14.

World Federation for Mental Health. (2003). *World Mental Health Day: emotional and
behavioural disorders of children and adolescents*. USA: World Federation for
Mental Health.

World Health Organisation (WHO) (2002). *Prevention and Promotion in Mental
Health.* Geneva: WHO

World Health Organisation (WHO) (2004). *Promoting mental health:
Concepts, emerging evidence, practice. A report from the World Health*

Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. Geneva: WHO.

World Health Organisation (WHO) (2005). Mental Health declaration for Europe facing the challenges, building solutions. *WHO European Ministerial Conference on Mental Health.* Helsinki: WHO.

Wyman, P. A., Inman, J., Guo, J., Brown, C. H., Cross, W., & Schmeelk-Cone, K (2008). Randomized trial of a gatekeeper program for suicide prevention: 1-year impact on secondary school staff. *Journal of Consulting and Clinical Psychology, 76*, 104–115.

Zint, M. (2002). Comparing three attitude-behavior theories for predicting science teachers' intentions. *Journal of Research in Science Teaching, 39*(9), 819-844.

Appendix 1: Teacher questionnaire

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD

School of Psychology

▶ **1. Please provide the following background information** *(Please tick one option for each section).*

Age	18-25 ❑	26-35 ❑	36-45❑	46-55❑	56-65❑	66+❑

Gender	Male ❑	Female ❑

Teaching Qualification	Degree ❑	PGCE ❑	Other ❑ *(please specify)*_____

How many years of teaching practice do you have? *(Please note in box)*	_____

★ Please keep the following definition of 'mental health' in mind when completing this questionnaire:

"Someone who may be at risk of developing or who is experiencing a mental health issue such as the following; a mood disorder (e.g. depression), psychosis (e.g. schizophrenia), an eating disorder (e.g. anorexia), an anxiety disorder (e.g. obsessive compulsive disorder, social anxiety disorder), suicidal thoughts, or self-harm".

*Please note, this definition of mental health <u>purposely excludes</u> developmental disorders (e.g. autistic spectrum disorder [ASD]), conduct disorders (e.g. oppositional-defiance disorder [ODD]) and hyperkinetic disorders (e.g. attention-deficit/hyperactivity disorder [ADHD]).

▶ **2. How would you rate the amount of training you have received in the area of mental health?** *(Please circle the appropriate number. 1=None, 5=A lot).*

1	2	3	4	5
None				A lot

▶ **3. Have you experienced any training (prior to, or after qualifying as a teacher) in any of the areas of mental health specified below** *(please tick as many boxes as necessary)*

Anxiety disorders *(Such as social anxiety disorder, obsessive compulsive disorder, phobias)*	❑	**Non-Suicidal Self-harm**	❑
		Psychosis *(such as schizophrenia)*	❑
Mood disorder *(Such as depression, bipolar disorder)*	❑	**Eating Disorder** *(such as bulimia, anorexia)*	❑
		Other *(please specify)*	❑
Suicidal Thoughts	❑		

▶ **4. How much personal experience of mental health issues do you have (e.g. yourself, family or friends)?** *(Please circle the appropriate number. 1=None, 5=A lot).*
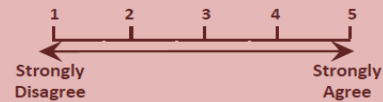
1	2	3	4	5
None				A lot

Please continue overleaf

▸ **5. Approximately, how many pupils with mental health needs have you think you have had experience of?** *(Please write estimate in box).*

▸ **6.**

Please rate the extent to which you agree with the following statements *(Please circle the appropriate number – please do not circle between numbers).*	1 (Strongly Disagree)	2	3	4	5 (Strongly Agree)
a. People with mental health issues are born with a genetic predisposition to experience such issues.	1	2	3	4	5
b. Mental health issues ultimately need to be treated in a clinical/medical setting (e.g. with a psychiatrist).	1	2	3	4	5
c. Mental health issues do not generally have a biological or genetic cause.	1	2	3	4	5
d. Medication is not usually the main treatment for people with mental health issues.	1	2	3	4	5

▸ **7.**

Please rate the extent to which you agree with the following statements *(Please circle the appropriate number – please do not circle between numbers).*	1 (Strongly Disagree)	2	3	4	5 (Strongly Agree)
★ For the next two items, the term **'willing'** is defined as being ready, eager, and/or prepared to do something.					
a. I am **willing** to support the mental health needs of my pupils.	1	2	3	4	5
b. I am **willing** to help identify pupils with mental health needs and refer pupils to the relevant parties.	1	2	3	4	5
★ For the next three items, the term **'able'** is defined as the possession of the necessary means/ resources or skills to do something.					
c. I am **able** to recognise the mental health needs of pupils.	1	2	3	4	5
d. I am **able** to support the mental health needs of pupils.	1	2	3	4	5
e. I have been **able** to directly support the mental needs of my pupils on a number of occasions	1	2	3	4	5

Please continue on the next page

Please rate the extent to which you agree with the following statements *(Please circle the appropriate number – please do not circle between numbers).*	1 Strongly Disagree	2	3	4	5 Strongly Agree
a. I do not feel confident in my ability to support the mental health needs of pupils.	1	2	3	4	5
b. Teachers are expected to support the mental health needs of pupils.	1	2	3	4	5
c. As a subject teacher, I should not be expected to support the mental health needs of pupils when there are others who are better placed to do so.	1	2	3	4	5
d. I feel I am able to help pupils by supporting their mental health needs.	1	2	3	4	5
e. I think that supporting the mental health needs of pupils is an integral part of being any teacher.	1	2	3	4	5
f. As a subject teacher, I am well positioned to support the mental health needs of pupils.	1	2	3	4	5
g. I am well equipped to support the mental health needs of my pupils.	1	2	3	4	5
h. Generally, I am not expected to support the mental health needs of my pupils.	1	2	3	4	5
i. Even if I supported the mental health needs of my pupils, I don't think it would make a difference.	1	2	3	4	5
j. I feel it is part of my role to support the mental health needs of my pupils.	1	2	3	4	5
k. I believe I am quite capable of supporting the mental health needs of pupils.	1	2	3	4	5
l. Supporting the mental health needs of pupils should not be my responsibility.	1	2	3	4	5
m. Other subject teachers in my school feel that supporting the mental health needs of pupils is part of the teacher role	1	2	3	4	5
n. The senior management team of my school do not put pressure on subject teachers to directly support pupil mental health.	1	2	3	4	5
o. Pupils would not want to seek support from a subject teacher.	1	2	3	4	5
p. I do not think my colleagues are very open to supporting the mental health needs of pupils	1	2	3	4	5
q. The government do not advocate that subject teachers should support the mental health needs of pupils as there are others better placed to do it.	1	2	3	4	5
r. Pupils would not expect subject teachers to support their mental health needs.	1	2	3	4	5
s. Other subject teachers in my school would probably argue that they should not be expected to support the mental health needs of pupils.	1	2	3	4	5
t. As a subject teacher, I am expected by senior management to support the mental health needs of pupils.	1	2	3	4	5
u. Pupils are likely to want subject teachers, in addition to pastoral staff, to support their mental health needs.	1	2	3	4	5
v. Many of my colleagues display a willingness to support the mental health needs of pupils.	1	2	3	4	5

Please continue overleaf

Please rate the extent to which you agree with the following statements (Please circle the appropriate number – please do not circle between numbers).	1 2 3 4 5 ← ——————————— → Strongly Disagree Strongly Agree
a. For me, supporting the mental health needs of pupils is difficult when also trying to meet curriculum demands.	1 2 3 4 5
b. I think supporting the mental health needs of a pupil would give me job satisfaction.	1 2 3 4 5
c. If teachers take a holistic approach, which includes supporting pupil's mental health, it can help increase positive academic outcomes for pupils.	1 2 3 4 5
d. I think sometimes it is best if pupils with mental health needs are not placed in mainstream classes.	1 2 3 4 5
e. For me, supporting the mental health needs of pupils is just as important as teaching the curriculum.	1 2 3 4 5
f. Subject teachers do not really gain any benefits from supporting the mental health needs of their pupils.	1 2 3 4 5
g. Supporting the mental health needs of pupils can help improve their academic achievement.	1 2 3 4 5
h. If I am honest, I sometimes avoid talking to pupils with mental health needs.	1 2 3 4 5
i. Learning is a schools main priority. This may be diluted by expecting subject teachers to actively play a role in supporting the mental health needs of pupils.	1 2 3 4 5
j. In some situations, being able to support the mental health needs of pupils can make the work of a teacher easier.	1 2 3 4 5
k. Even if subject teachers are willing and able to support the mental health needs of their pupils, I doubt that it would have an impact on pupil achievement.	1 2 3 4 5
l. I do not have a problem with having pupils with mental health needs in my classes.	1 2 3 4 5

Please continue on next page

Please rate the extent to which you agree with the following statements *(Please circle the appropriate number – please do not circle between numbers).*	1 Strongly Disagree	2	3	4	5 Strongly Agree
a. Generally, I do not get very stressed.	1	2	3	4	5
b. I do not have the time to incorporate supporting the mental health needs of pupils into my role.	1	2	3	4	5
c. I think I know enough about mental health to effectively support the needs of pupils who are of concern.	1	2	3	4	5
d. I feel I have the necessary skills to appropriately support the mental health needs of my pupils.	1	2	3	4	5
e. I don't know much about the pastoral care system in my school.	1	2	3	4	5
f. I discuss how to best support the mental health needs of pupils with my colleagues and/or seniors.	1	2	3	4	5
g. I am usually able to find the time to meet the mental health needs of pupils.	1	2	3	4	5
h. I don't think I am skilful enough to support the mental health needs of pupils.	1	2	3	4	5
i. I find I experience a high level of stress in my job.	1	2	3	4	5
j. I don't know much about mental health.	1	2	3	4	5
k. I know who to contact should I feel a pupil has a mental health concern.	1	2	3	4	5
l. I am able to seek supervision and feedback from my seniors if I have concerns about supporting the mental health needs of pupil.	1	2	3	4	5
m. There is not enough time in the school day to support pupil mental health.	1	2	3	4	5
n. I worry that I am not skilful enough to intervene if a pupil has a mental health issue.	1	2	3	4	5
o. I sometimes feel too stressed with my own life and work pressures to address pupil mental health.	1	2	3	4	5
p. The knowledge I have regarding mental health is not sufficient enough to help support the mental health needs of pupils.	1	2	3	4	5
q. I am confident that I am aware of the relevant support structures in place in my school should I suspect a pupil of having a mental health need.	1	2	3	4	5
r. I have no supervision opportunities in relation to supporting the specific mental health needs of pupils.	1	2	3	4	5
s. I feel my mental health knowledge is adequate.	1	2	3	4	5

Many thanks for taking the time to complete this questionnaire – please now ensure you have completed all pages.

Appendix 2: Headteacher letter

Dear Head Teacher,

Thank you for taking the time to read this email. My name is Amy Hamilton-Roberts and I am a Trainee Educational Psychologist currently completing my doctoral training at Cardiff University.

I am approaching secondary schools to take part in a piece of research for my thesis. The main aim of this research is to explore secondary school teacher views regarding pupil mental health issues.

Your participation in the research would be greatly appreciated and would simply involve me visiting your school and asking teachers if they are willing to complete a brief questionnaire (for example, this could be done in the staff room or as part of a teacher training day – whatever is most convenient for you). Teacher participation will obviously be completely voluntary and in the case that a teacher agrees to participate, the questionnaire itself should take no longer than 10 minutes of their time to complete. I am hoping to come out to schools during June and July of this academic year.

I would like to assure you that school participation would be completely anonymous, as would be the questionnaire responses of teachers.

If you are interested in participating, please reply to this email to let me know (sapah4@cf.ac.uk) to make further arrangements. If you wish to receive more information regarding the research before registering your interest please also email me and I will be happy to answer any of your questions or speak with you on the telephone whenever it is convenient for you.

Again, participation from your staff would be greatly appreciated and extremely helpful.
Thanking you in anticipation of your interest,

Amy Hamilton-Roberts
Trainee Educational Psychologist (Cardiff DEdPsy Programme)

Appendix 3: Teacher consent

School of Psychology, Cardiff University
Consent Form

I understand that my participation in this pilot study will involve completing questionnaire about my views regarding supporting the mental health needs of pupils. This should take no longer than 15 minutes of my time.

I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason. I am also aware that, although I should try to answer all the items in the questionnaire, I am free to omit answering any item if I feel it necessary.

I understand that I am free to ask any questions at any time. I am also free to withdraw or discuss my concerns with Dr. Simon Griffey, Cardiff University research supervisor.

I understand that the information provided by me will be held anonymously, so that it is impossible to trace this information back to me individually. I understand that this information may be retained indefinitely. I also understand that once I have handed in the questionnaire to the researcher, I cannot ask for it to be omitted from the study as the questionnaire itself will be impossible to identify.

Finally, I understand that after completion of the questionnaire, I will be provided with additional information and feedback sheet about the purpose of the study.

Please ensure you have read the statements below and ticked the boxes to show your understanding before completing the questionnaire: *(please tick as appropriate)* ****

I understand that this questionnaire is to be completed only by secondary school teachers who do not have a designated role within their schools core pastoral care system (e.g. Head of Year, SENCo, Pastoral Care Co-ordinator).

I understand that by completing the questionnaire and handing it in to the researcher, I am aware of the points made above and I am consenting to my participation in the research.

Many thanks for taking the time to fill out this questionnaire, it should take no longer than 15 minutes of your time. Please try your best to provide an answer for every question. Please be as honest as possible, be assured your responses are completely anonymous.
Once you have finished, please put the questionnaire in the blank envelope provided give to the researcher.

Please turn the page to start.

Appendix 4: Teacher debriefing form

School of Psychology, Cardiff University

Teacher Debrief Form

Are secondary school teachers ready, willing and able to support the mental health needs of pupils?

Many thanks for taking the time to complete this questionnaire.

The research project aims to seek the views of secondary school teachers who do not have a designated role within a schools core pastoral care team. The research is concerned with factors that may influence a teacher's willingness and/or ability to support the mental health needs of their pupils (e.g. level of training).

It is hypothesised that there could be a number of factors that may affect a teachers willingness/ability to support the mental health needs of their pupils and these factors are what the questionnaire aims to explore. The factors include self-efficacy, training, experience, capacity, and systemic support - amongst others.

Please be assured that the responses you have given are anonymous and cannot be traced back to you. However, this also means that you are now unable to withdraw from the study, as the data you have provided is non-identifiable.

If you wish to find out more about the role of the teacher in supporting the mental health needs of pupils, the following documents are easily accessible and may be of some use:

- Department for Children, Schools and Families (2007b) *Whole-school approach to the national healthy schools programme* (Nottingham, DCSF Publications).
- Department for Education and Employment (2001) *Promoting children's mental health within early years and school settings* (Nottingham, DfES Publications).
- Welsh Assembly Government (2001). *Child and Adolescent Mental Health Services: Everybody's Business* (Cardiff, WAG)
- Welsh Assembly Government (2010). *Thinking Positively: Emotional Health and Well-being in Schools and Early Years settings* (Cardiff, WAG).
- Welsh Audit Office, et al. (2009). *Services for children and young people with emotional and mental health needs.* (Wales, WAO).

If you have any queries regarding the study, please contact either my Research Supervisor or me. Alternatively, if you have any concerns regarding the study, you are free to contact the universities Ethics Committiee directly. Contact details are provided below:

Amy Hamilton-Roberts	**Dr. Simon Griffey**	**Psychology Ethics Committee**
Trainee Educational Psychologist	Research Supervisor	School of Psychology
School of Psychology	School of Psychology	Cardiff University
Cardiff University	Cardiff University	Tower Building, Park Place
Tower Building, Park Place	Tower Building, Park Place	Cardiff.
Cardiff.	Cardiff.	CF10 3AT
CF10 3AT	CF10 3AT	psychethics@cf.ac.uk
sapah4@cf.ac.uk	sapsjg1@cf.ac.uk	

Many thanks for your time and support,

Amy Hamilton-Roberts

(Cardiff DEdPsy Professional Training Programme)

Appendix 5: Ethics proforma

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

SCHOOL OF PSYCHOLOGY, CARDIFF UNIVERSITY ETHICS PROFORMA

School of Psychology

Form version 1.2

Guidelines for completing this form

1) You should save this document with the following type of Filename: **SAPXXX_Title.xls** where **SAPXXX** refers to the 1st Researcher's university username and **Title** refers to the project title.
2) All sections marked YELLOW should be completed.
3) Click on the blue and white questionmark symbol for more info on an adjacent section ❓
4) All supporting attachments should be either Word or PDF format. Please combine multiple documents of the same format into one. ❓
5) When completed, this document and any supporting material should be emailed to **psychethics@cardiff.ac.uk** by the **permanent member of staff** associated with the project.

Project Type

Select one option:
- ○ Staff Project
- ◉ Postgraduate Project
- ○ Undergraduate Project

Submission Type ❓

Select if submission is for:
- ◉ Standard
- ○ Level 2 Practical
- ○ Generic

NB. Undergraduate projects MUST be Standard Submission Type

If project comes under supervisor's generic approval, please provide the EC reference number

| 12.34.56.789 | ❓

Submission date

| 03 ▼ | May ▼ | 2011 ▼ |

Title of Project

Are secondary teachers ready, willing and able to support the mental health needs of pupils?

Applicant's Email Address

sapah4@cf.ac.uk ❓

Name of researcher(s) (Please list all researchers on separate   Status (e.g. staff,
line with the applicant first)   student, external RA)

Page 2 of 4 Ethics proforma

1	Amy Hamilton-Roberts	Student
2		
3		
4		
5		
6		
7		
8		
9		
10		

Name of supervisor (for student research)
Dr. Simon Griffey

Name of permanent member of staff associated with the project
Dr. Simon Griffey

		YES	NO	NOT APPLICABLE
1	I will describe the main experimental procedures to participants in advance, so that they are informed about what to expect.	○ YES	○ NO	◉ N/A
2	I will tell participants that their participation is voluntary and that they may withdraw from the research at any time and for any reason.	◉ YES	○ NO	○ N/A
3	I will obtain written consent for participation (this includes consent to be observed in observational studies).	◉ YES	○ NO	○ N/A
4	The data are to be stored anonymously (i.e. the identity of the person IS NOT linked directly or indirectly with their data).	◉ YES	○ NO	○ N/A
5	I will debrief participants at the end of their participation (i.e. give them a brief explanation of the study)	◉ YES	○ NO	○ N/A
6	With questionnaires, I will give participants the option of omitting questions they do not want to answer.	◉ YES	○ NO	○ N/A

Note: If you have ticked **No** to any of Q1-6 please give an explanation as to why in separate word document and submit with this form.

		YES	NO	NOT APPLICABLE
7	The research is observational without consent and/or involves any covert recording.	○ YES	◉ NO	○ N/A
8	The research involves deliberately misleading participants.	○ YES	◉ NO	○ N/A

9   Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines, and tick box B below.

Note that you may also need to obtain satisfactory Criminal Records Bureau clearance (or equivalent for overseas students).

a	People on premises other than Cardiff University? (if yes, please include letter asking permission to recruit from relevant authority).	● YES	○ NO	○ N/A
b	Children (under 18 years of age).	○ YES	● NO	○ N/A
c	People with learning or communication difficulties.	○ YES	● NO	○ N/A
d	Patients (NHS ethical approval will be required).	○ YES	● NO	○ N/A
e	People in custody.	○ YES	● NO	○ N/A
f	People engaged in illegal activities, for example drug taking.	○ YES	● NO	○ N/A

Note: If you have ticked Yes to 7, 8 or 9(a-f) you should normally tick box B overleaf; if not, please give a full explanation on a separate sheet.

There is an obligation on the lead researcher to bring to the attention of the School Research Ethics Committee any issues with ethical implications not clearly covered by the above checklist.

PLEASE SELECT **EITHER BOX A** OR **BOX B** BELOW AND PROVIDE THE DETAILS REQUIRED IN SUPPORT OF YOUR APPLICATION THEN SIGN THE FORM.

A. I consider that this project has no significant ethical implications to be brought before the School Research Ethics Committee.	● Check to confirm

Give a brief description of the experiment (approximately 200 words). Include study rationale and theoretical constructs as well as brief information about: participants (e.g. number, age, sex, recruitment method, group assignment), apparatus and materials (e.g., stimuli, names of questionnaire) and procedure (e.g., what will happen to participants). Any exclusions must be scientifically justified.
Tip: To insert line breaks within a cell use Alt+Enter on a PC and Cmd+Option+Return on a Mac.

Please see attached research proposal.

B	I consider that this project may have ethical implications that should be brought before the School Research Ethics Committee, and/or it will be carried out with children or other vulnerable populations.	○ Check to confirm

If you have checked BOX B, please provide all the further information listed below in a separate attachment. Please number the pages.

i   Title of project
ii   Purpose of project and its academic rationale.
iii   Brief description of methods and measurements.
iv   Participants: recruitment methods, number, age, gender, exclusion/inclusion criteria.
v   Consent and participant information arrangements, debriefing.
vi   A clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them.
vii   Estimated start date and duration of project.
     This form should be submitted to the School Research Ethics Committee for consideration.

If any of the above information is missing, your application will be returned to you.

10	I confirm that the relevant health and safety measures, in accordance with University policy and School requirements, have been taken into account for the proposed research.	☑ Check to confirm	❓
11	I confirm that the relevant equality and diversity considerations, in accordance with University policy and School requirements, have been taken into account for the proposed research.	☑ Check to confirm	❓
12	I confirm that the relevant Human Tissue Act considerations, in accordance with University policy and School requirements, have been taken into account for the proposed research.	☑ Check to confirm	❓
13	I confirm that, where appropriate, the University's Safeguarding Children and Vulnerable Adults Policy 2010 has been read and understood.	☑ Check to confirm	❓
14	I am familiar with the BPS Guidelines for ethical practices in psychological research (and have discussed them with the other researchers involved in the project).	☑ Check to confirm	❓

❓

INFORMATION FOR PERMANENT MEMBER OF STAFF ONLY

I confirm as the permanent member of staff, by forwarding this documentation to the Ethics Committee, I have read this application and consider it suitable for ethical review.

Appendix 6: Research proposal

Thesis Proposal

Prepared by Amy Hamilton-Roberts

Submitted as part of the Doctorate of Educational Psychology Professional Training Programme, Cardiff University

Thesis title:

Are secondary teachers ready, willing and able to support the mental health needs of pupils?

Positioning of the research:

In 2004, Green et al. (2005) carried out research concerning the mental health of children and young people in Britain. Findings indicated that one in ten children and young people aged five to 16 suffer from a diagnosable mental health disorder, which is around three children in every class. Furthermore, research from 2003 indicated that 45% of children in looked after care have a mental health disorder (Meltzer et al., 2003). Despite the abundance of mental health issues within schools, there is evidence that schools are failing children and young people through a lack of awareness, knowledge and identification (OFSTED, 2005; Welsh Audit Office et al., 2009). These failings have been reported to be greater within secondary school as opposed to primary schools(OFSTED, 2005).

The need for schools to support the mental health needs of children and young people is increasingly the focus of government policy, guidance and initiative (e.g. Department for Education and Employment, 2001; Welsh Assembly Government, 2001; National Institute for Clinical Excellence, 2009; Welsh Audit Office et al., 2009; Welsh Assembly Government, 2010).

There is also a modest amount of academic research investigating the potential of using the school environment to nurture, support and intervene with the mental health of children and young people (e.g. Gowers, Thomas, & Deeley, 2004; Cohall et al., 2007; Moor, et al.., 2007) . However, it should be noted that the many of these studies have been conducted in North America.

Many studies have aimed to gain the views of pastoral care staff (e.g. Kidger et al., 2009; King et al., 1999; Kidger et al, 2010), primary school staff (e.g. Gowers et al., 2004; Roeser & Midgely, 1997; Walter,

Gouze, & Lim, 2006); special education teachers (Westling, 2010) and SENCOs (e.g. Gowers et al., 2004). However, there is a scarcity of research exploring the views of general teachers regarding this noticeable expansion of their role (Kidger et al., 2010); in particular the views of general subject teachers within mainstream secondary schools.

The importance of evidence based intervention and practice in relation to mental health promotion within schools is well recited within the literature (Kelly, Jorm, & Wright, 2007; Han & Weiss, 2005). For example, Han and Weiss (2005) argue that it is important to identify and understand the complexities of the mental health initiative implementation within schools under real-world conditions. In light of this, and considering that whole-school approaches are widely advocated in both government agenda (e.g. Department of Health, 2005; Department for Children, Schools and Families, 2007) and academic literature (e.g. Kidger et al., 2009; Wells et al., 2003; Roeser , 2008) in order to meet the mental health needs of children and young people, there appears to be a lack of research exploring the most effective ways of engaging and empowering secondary school teachers to fulfil this role.

Various studies within the field have noted factors which may potentially mediate the effectiveness of mental health promotion within schools including: teacher knowledge of mental health (Roeser & Midgely, 1997; Cohall & al, 2007; Jorm et al., 2010; Walter et al., 2006); perceived relevance to teaching role (Gowers et al., 2004, Roeser & Midgely, 1997; Cohall et al., 2007; Kidger et al., 2010); mental health training (Gowers, Thomas, & Deeley, 2004, Cohall et al., 2007, Roeser & Midgely, 1997; Koller & Bertell, 2006; Westling, 2010; Walter et al., 2006); teacher efficacy (Roeser & Midgely, 1997; Jorm et al., 2010; Walter et al., 2006; Han & Weiss, 2005; Alvarez, 2007; King et al., 1999; Kidger et al., 2010); teacher well-being (Westling, 2010; Han & Weiss, 2005; Alvarez, 2007; Kidger et al., 2010); school/systemic support (Han & Weiss, 2005; Kidger et al., 2010); type of mental illness (Moor, et al.., 2007, Kos et al., 2004; White et al., 2011); stage in teacher training process (Kos, 2004; Koller et al. 2004); burden/capacity (Roeser & Midgely, 1997; Kidger et al., 2010) and stigma (Jorm et al., 2010). There are also many interplays between these various factors noted within the academic literature.

Few studies have, however, focused on the perspectives of mainstream secondary school teachers in relation to these factors, particularly within the UK. In light of the expanding teacher role, it could be argued that gaining the views and constructions of these teachers is imperative to inform both teacher training programmes and government legislation. This view is supported by Kelly and colleagues (2007) who recommended that in relation to school-based mental health initiatives:

> *"It is necessary to carry out preliminary research with the audience to whom the message will be directed"* (Kelly et al., 2007, p29)*.*

and Alvarez (2007) who concluded:

> *"Given the many stressful conditions present in today's schools, there is a clear value in continuing to investigate ways to support the professional effectiveness and personal wellbeing of teachers"* (Alvarez, 2007)

Therefore the current research will seek the views of mainstream secondary school teachers in relation to possible factors affecting their ability and willingness to support the mental health needs of pupils. Rowling (2006; 2007) argues that there are limitations to linear thinking regarding school mental health practice and thus a systems theory perspective is necessary. Therefore this research will additionally seek to explore any relationships between variables (e.g. training and efficacy).

Main aims of research

The current research aims to investigate secondary school teacher perspectives regarding several factors that have been highlighted within the literature as potentially effecting a teacher's ability and willingness to support the mental health of their pupils (please see appendix 1 for details). These factors can be underpinned by psychological theories of motivation (e.g. self-efficacy, attribution, locus of control, hierarchy of needs). Furthermore, by utilising principles of systems theory (e.g. Burden 1981; Gameson & Rydderch, 2008), the research aims to explore how interpersonal, intrapersonal and organisational factors may interact to increase or decrease a teacher's willingness and ability to support the mental health needs of their pupils.

Aim One →To seek teacher's perspectives regarding various factors potentially affecting their willingness and ability to support pupil mental health needs (descriptive analysis)
Aim Two → To explore how these factors may relate to each other (statistical analysis)

It is hoped that the production of a model, illustrating factors which may influence a teacher's ability and willingness to support the mental health needs of their pupils, will be possible.

Method of investigation

The study will employ quantitative methods in order to gain access to a large sample and thus gain the perspectives of a large number of teachers within different authorities.

Participants required

Participants will be secondary school teachers from the South Wales area, who do not have an additional responsibility within their school's core pastoral care system.

The research will target two randomly selected schools within each of the 11 South Wales authorities, amounting to a total of 22 schools. It is hoped that a minimum of 400 teachers will participate (with a maximum sample population size of approximately 1500).

Request for approval from the School's Ethics Committee

Please see attached ethics pro-forma for details of ethical considerations in line with Cardiff University's School of Psychology's requirements.

Methodology

The study will be a relatively large-scale study utilising quantitative measures to gain a breadth of perspectives across different local authority settings.

Research Tools

A questionnaire will be developed which will aims to capture information on a number of variables related to a teacher's potential willingness and ability to support the mental health needs of their pupils as well as general demographic information regarding age, gender, years of practice, teacher training course and subject taught. Cohen et al. (2008) provide guidance on devising questionnaires. The questionnaire will mainly use Likert scales to gather teacher's views. Advice regarding the quantitative nature of this research will be sought from the relevant persons within the university both prior to questionnaire development and during analysis (please see appendix 2 for a sample of questionnaire items, it should be noted these may be modified as appropriate during the questionnaire design stage).

Pilot

The questionnaire will be piloted on a sample of 10-15 teacher volunteers. Any amendments required to the questionnaire will be made at this stage.

Recruitment of participants

To maximise participation and response rate the following recruitment procedure will be followed:

1. Brief email (appendix 3) sent to head-teachers of all secondary schools within South Wales out lining research and seeking interest in participation. Follow up telephone call if necessary.

2. Random selection of two schools from each of the 11 local authorities that have displayed an interest in participating.

3. Email prompt and Gatekeeper letter to head-teachers requesting formal consent to approach staff (appendix 4). Followed up by telephone call and/or visit where necessary. (If no consent granted, seek alternative randomly selected school within the authority).

4. Researcher to arrange with head-teacher to visit school in order to administer questionnaires to staff and collect in person. There are two potential ways of doing this:

    i. Agree to administer questionnaires during staff development/teacher training days.

    ii. Agree for the researcher to approach staff within the staff room of the school on a particular day (will require researcher to spend the day on site).

5. Questionnaires to be pre-coded (this information will remain confidential but will help to how many participants there were at a particular school).

6. Questionnaires to be administered to staff on an individual or small group basis. Rather than a consent form, the front page of the questionnaire (appendix 5) will have information regarding the study, participation and anonymity. It will state that if the individual completes the questionnaire and returns it in they are effectively consenting to their participation within the research. It will also state that filling out the questionnaire is voluntary and that, although completing the whole questionnaire is desirable, they are free to omit particular items if they wish.

7. The final page of the questionnaire will have a 'tear-off' debrief outlining the purpose of the study and anonymity procedures (appendix 6).

8. Questionnaires handed in immediately after completion by teachers in blank envelope.

9. Thank schools for their participation and provide debrief information (appendix 7) to head teacher.

Participation in the research will be anonymous and procedures to ensure this are outlined above. Informed consent will be gained from both the head-teacher of the school participating and the teachers who complete the questionnaires. This will inform them of their right to withdraw and to anonymity.

Method of Analysis

Appropriate statistical analysis of the data will be conducted using the statistical package SPSS. Descriptive statistics will also be used where appropriate (advice sought from relevant person within school of psychology).

Proposed structure of Dissertation

Abstract	→Brief overview of rationale, methodology, results and discussion.
Section 1: Introduction	→ Overview of argument for research
Section 2: Literature Review	→ Set context – Review of relevant statistics, governmental literature and academic literature. → Discussion and critique of term 'mental health' → Discussion of different factors (e.g. efficacy) in relation to research and theory → Theoretical underpinnings e.g. systems theory, motivation, theory of planned Behaviour → Model of factors/ relationships based on research literature → Research aims → Research hypothesis/questions
Section3: Methodology	→Methodological approach (and justification in terms of appropriateness/relevance to aims) →Participants (setting and participant details) →Measures used – Questionnaire, validity/reliability details, analysis and reference to relevant appendices. → Procedures and ethical practices/issues → Method of analysis
Section 4: Results	→ Discussion of findings in relation to the main aims utilising both descriptive and inferential statistics → Proposed model of factors/relationships based on research findings
Section 5: Discussion	→ How do findings relate to previous research/comparison of models → What are the limitations of this research
Section 6: Conclusions	→ What do the findings show → How could this inform policy and practice → Future research directions

Proposed work schedule

Date	Activity
January/ February 2011	Apply for ethical approval – possibly audit
February 2011	Comprehensively map out all factors and relationships noted within the literature
February/March2011	Liaise with Lee Shepherd re qualitative research
March 2011	Design questionnaire
March 2011	Pilot questionnaire → amend if necessary
April 2011	Contact head-teachers seeking interest
April/May 2011	Begin work on literature review
May 2011	Contact randomly selected school seeking consent/make arrangements to visit.
June 2011	Meet with Simon Griffey for tutorial re questionnaire, sample size, data collection, and analysis.
June – July 2011	Begin data collection, making use of thesis days and reading weeks (maximum of 22 days required).
August 2011	Write up methodology
July – September 2011	Data analysis
September 2011 – January 2012	Write up of results, discussion and conclusions
January 2012	Submission of draft thesis
April 2012	Completion and submission of thesis

Signed   _(signature)_   **Date 18/01/11**

(Amy Hamilton-Roberts, DEdPsy Trainee 2009-2012)

Appendix 7: Ethical approval (via email)

Hi Amy

I am now happy with the ethics of your research proposal and consider this 'audit' and so you may proceed with the research now.

Best wishes

Simon

Dr. Simon Griffey

Director, Post-Qualification DEdPsy

Research Director, DEdPsy

School of Psychology

Cardiff University

Tower Building

Cardiff CF10 3AT

Tel: +44 (0)2920 874568 (DEdPsy Administrator)

    +44 (0)2920 870366 (direct)

Fax: +44 (0)2920 874858

Appendix 8: Items constituting final variables

Willingness (2 items)	Willingness7a	I am willing to support the mental health needs of my pupils.
	Willingness7b	I am willing to help identify pupils with mental health needs and refer pupils to the relevant parties

Perceived Behavioural Control (8 items)	PBC8a (negative)	I do not feel confident in my ability to support the mental health needs of pupils
	PBC8d	I feel I am able to help pupils by supporting their mental health needs
	PBC8g	I am well equipped to support the mental health needs of my pupils
	PBC8i (negative)	Even if I supported the mental health needs of my pupils, I don't think it would make a difference
	PBC8k	I believe I am quite capable of supporting the mental health needs of pupils
	Able7c	I am able to recognise the mental health needs of pupils.
	Able7d	I am able to support the mental health needs of pupils.
	Able7e	I have been able to directly support the mental needs of my pupils on a number of occasions

Social norm (2 items)	SN8b	Teachers are expected to support the mental health needs of pupils
	SN8e	I think that supporting the mental health needs of pupils is an integral part of being any teacher

Attitude Towards Role (4 items)	Attitude8c (negative)	As a subject teacher, I should not be expected to support the mental health needs of pupils when there are others who are better placed to do so
	Attitude8f	As a subject teacher, I am well positioned to support the mental health needs of pupils
	Attitude8j	I feel it is part of my role to support the mental health needs of my pupils
	Attitude8i (negative)	Supporting the mental health needs of pupils should not be my responsibility

| Normative Beliefs (8 items)	Colleague8m	Other subject teachers in my school feel that supporting the mental health needs of pupils is part of the teacher role
	Colleague8p (negative)	I do not think my colleagues are very open to supporting the mental health needs of pupils
	Colleague8v	Many of my colleagues display a willingness to support the mental health needs of pupils
	SchGov8q (negative)	The government do not advocate that subject teachers should support the mental health needs of pupils as there are others better placed to do it
	SchGov8t	As a subject teacher, I am expected by senior management to support the mental health needs of pupils
	Pupils8o	*Pupils would not want to seek support from a subject teacher*
	Pupils8r (negative)	Pupils would not expect subject teachers to support their mental health needs
	Pupils8u	Pupils are likely to want subject teachers, in addition to pastoral staff, to support their mental health needs

Behavioural Beliefs (9 items)	AcCon9a (negative)	For me, supporting the mental health needs of pupils is difficult when also trying to meet curriculum demands
	AcCon9e	For me, supporting the mental health needs of pupils is just as important as teaching the curriculum
	AcCon9i (negative)	Learning is a schools main priority. This may be diluted by expecting subject teachers to actively play a role in supporting the mental health needs of pupils
	TBelief9b	I think supporting the mental health needs of a pupil would give me job satisfaction
	TBelief9f (negative)	Subject teachers do not really gain any benefits from supporting the mental health needs of their pupils
	TBelief9j	In some situations, being able to support the mental health needs of pupils can make the work of a teacher easier
	EdBelief9c	If teachers take a holistic approach, which includes supporting pupil's mental health, it can help increase positive academic outcomes for pupils
	EdBelief9g	Supporting the mental health needs of pupils can help improve their academic achievement
	EdBelief9k (negative)	Even if subject teachers are willing and able to support the mental health needs of their pupils, I doubt that it would have an impact on pupil achievement

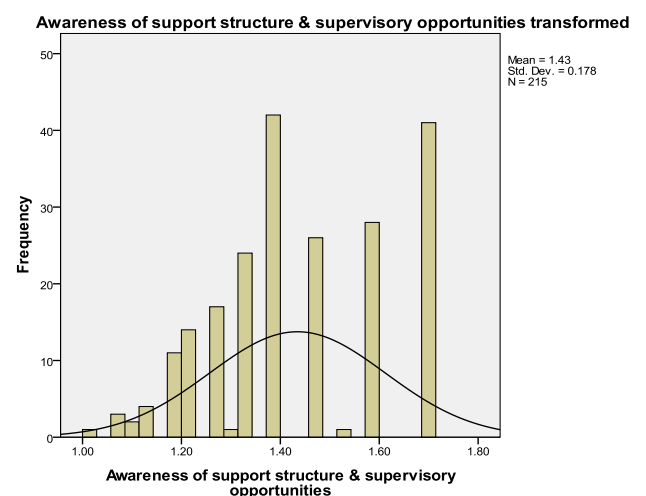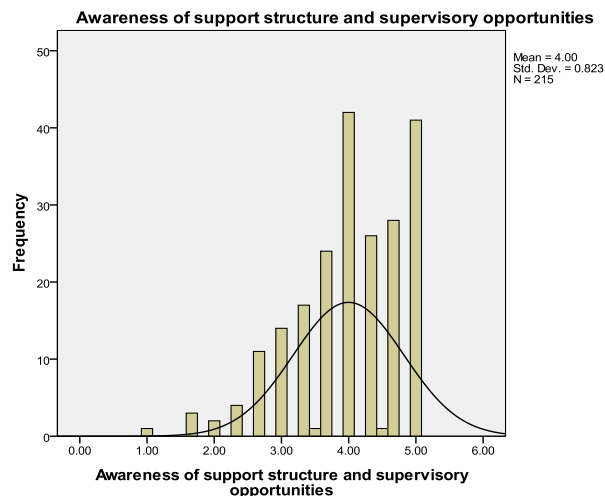|			
Control Beliefs	**Stress/Time (6 items)**	Stress10a	Generally, I do not get very stressed.
		Stress10i (negative)	I find I experience a high level of stress in my job
		Stress10o (negative)	I sometimes feel too stressed with my own life and work pressures to address pupil mental health
		Time10b (negative)	I do not have the time to incorporate supporting the mental health needs of pupils into my role
		Time10g	I am usually able to find the time to meet the mental health needs of pupils
		Time10m (negative)	There is not enough time in the school day to support pupil mental health
	Awareness of Support & Supervision Opportunities (3 items)	Support10k	I know who to contact should I feel a pupil has a mental health concern
		Support10q	I am confident that I am aware of the relevant support structures in place in my school should I suspect a pupil of having a mental health need
		Super10l	I am able to seek supervision and feedback from my seniors if I have concerns about supporting the mental health needs of pupil
	Perceived Knowledge (4 items)	PKnow10c	I think I know enough about mental health to effectively support the needs of pupils who are of concern
		PKnow10j (negative)	I don't know much about mental health
		PKnow10p (negative)	The knowledge I have regarding mental health is not sufficient enough to help support the mental health needs of pupils
		PKnow10s	I feel my mental health knowledge is adequate
	Perceived Skill (3 items)	PSkill10d	I feel I have the necessary skills to appropriately support the mental health needs of my pupils
		PSkill10h (negative)	I don't think I am skilful enough to support the mental health needs of pupils
		PSkill10n (negatve)	I worry that I am not skilful enough to intervene if a pupil has a mental health issue

Appendix 9: Transformations for skewness

1. Willingness (inverse correction)

	Willingness	Willingness Transformed
N Valid	215	215
Skewness	-1.269	-.263
Std. Error of Skewness	.166	.166

Willingness

Mean = 4.30
Std. Dev. = 0.882
N = 215

Willingness Transformed

Mean = 0.73
Std. Dev. = 0.285
N = 215
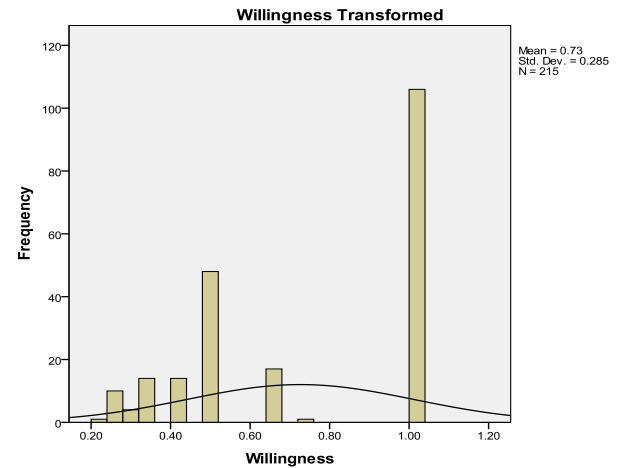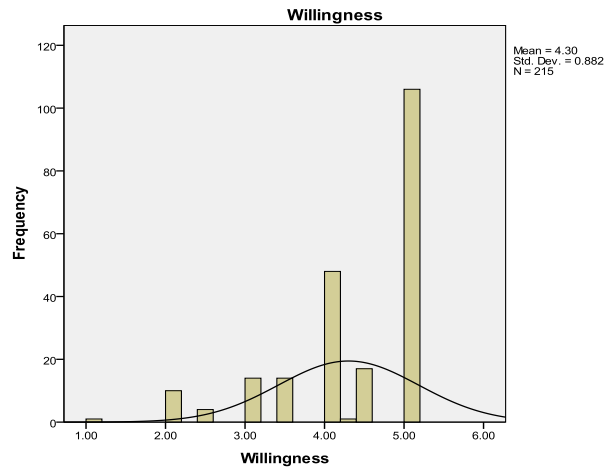
2. Awareness of support structures and supervisory opportunities (logistical transformation)

	Awareness of support/supervision	Awareness of support/supervision Transformed
N Valid	215	215
Skewness	-.800	.006
Std. Error of Skewness	.166	.166

Awareness of support structure and supervisory opportunities

Mean = 4.00
Std. Dev. = 0.823
N = 215

Awareness of support structure & supervisory opportunities transformed

Mean = 1.43
Std. Dev. = 0.178
N = 215

165

3. Perceived level of training (logistical regression)

	Perceived level of training	Perceived level of training transformed
N Valid	215	215
Skewness	1.099	.340
Std. Error of Skewness	.166	.166
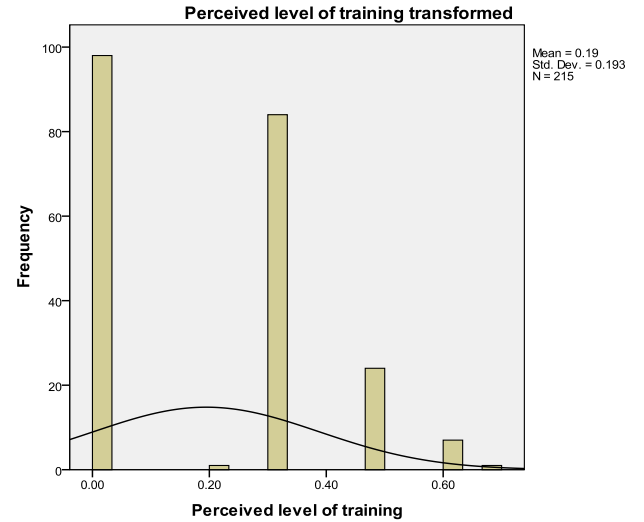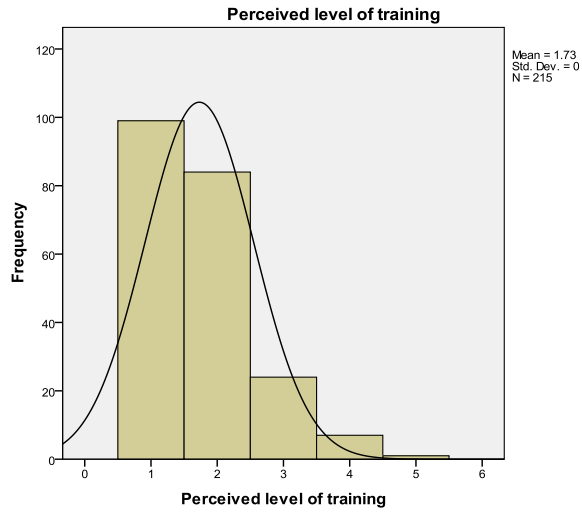
4. Perceived level of personal experience (logical transformation)

	Perceived level of personal experience	Perceived level of personal experience transformed
N Valid	215	215
Skewness	.580	-.191
Std. Error of Skewness	.166	.166

166
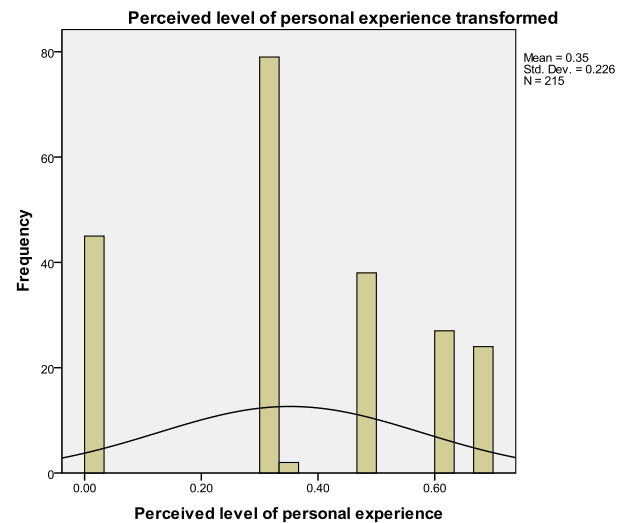
5. Age (square root transformation)

	Age	Age transformed
N Valid	215	215
Skewness	.504	.050
Std. Error of Skewness	.166	.166

Age

Mean = 2.6
Std. Dev. =
N = 215

Age transformed

Mean = 1.60
Std. Dev. = 0.337
N = 215
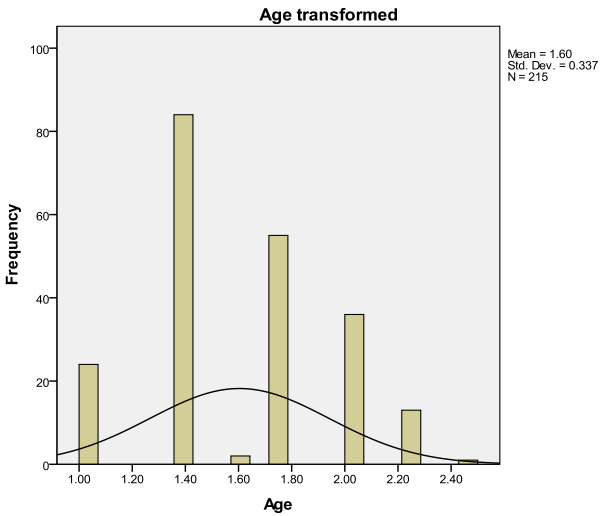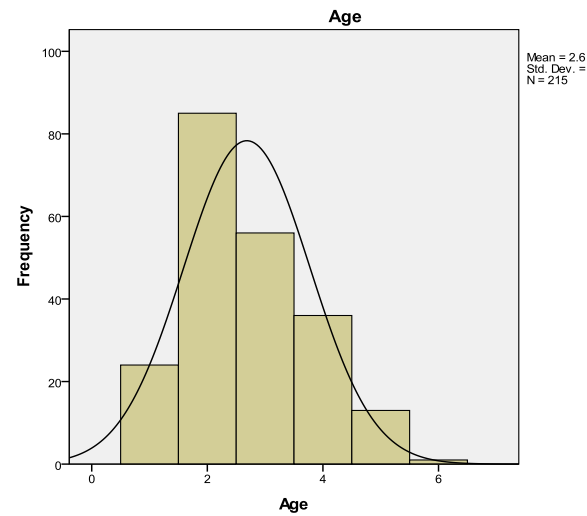
Appendix 10: Regression analyses (SPSS output)

Hypothesis 1a

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT Attitude
  /METHOD=ENTER BehaviouralBeliefs.
```

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	Behavioural Beliefs[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: Attitude

Model Summary

Model	R	R Square	Adjusted R Square	the Estimate
1	.593[a]	.352	.349	.66097

a. Predictors: (Constant), Behavioural Beliefs

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	50.538	1	50.538	115.678	.000[a]
	Residual	93.057	213	.437		
	Total	143.595	214			

a. Predictors: (Constant), Behavioural Beliefs

b. Dependent Variable: Attitude

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.432	.277		1.560	.120
	Behavioural Beliefs	.808	.075	.593	10.755	.000

a. Dependent Variable: Attitude

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Hypothesis 1b

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT SubjNorm
  /METHOD=ENTER NormativeBeliefs.
```

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	Normative Beliefs[a]		Enter

a. All requested variables entered.

b. Dependent Variable: Subjective Norm

Model Summary

Model	R	R Square	Adjusted R Square	the Estimate
1	.564[a]	.318	.314	.71475

a. Predictors: (Constant), Normative Beliefs

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	50.643	1	50.643	99.130	.000[a]
	Residual	108.816	213	.511		
	Total	159.458	214			

a. Predictors: (Constant), Normative Beliefs

b. Dependent Variable: Subjective Norm

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	.652	.289		2.257	.025
	Normative Beliefs	.853	.086	.564	9.956	.000

a. Dependent Variable: Subjective Norm

Hypothesis 1c

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT PerBehCon
  /METHOD=ENTER TimeStress Knowledge Skill TTraining.
```

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	Perceived level of training, Peceived time and stress limitations, Perceived level of knowledge, Perceived level of skill[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: Perceived Behavioural Control

Model Summary

Model	R	R Square	Adjusted R Square	the Estimate
1	.709[a]	.502	.493	.49450

a. Predictors: (Constant), Perceived level of training, Peceived time and stress limitations, Perceived level of knc

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	51.782	4	12.946	52.939	.000[a]
	Residual	51.352	210	.245		
	Total	103.134	214			

a. Predictors: (Constant), Perceived level of training, Peceived time and stress limitations, Perceived level of knowledge, Perc

b. Dependent Variable: Perceived Behavioural Control

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.973	.163		5.971	.000
	Peceived time and stress limitations	.113	.052	.117	2.167	.031
	Knowledge	.384	.061	.445	6.344	.000
	Skill	.154	.058	.189	2.664	.008
	Training	.481	.188	.134	2.554	.011

a. Dependent Variable: Perceived Behavioural Control

Hypothesis 2

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT TWillingness
  /METHOD=ENTER Attitude SubjNorm PerBehCon.
```

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	Perceived Behavioural Control, Subjective Norm, Attitude[a]	.	Enter

a. All requested variables entered.

b. Dependent Variable: Willingness

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.459[a]	.211	.199	.25538

a. Predictors: (Constant), Perceived Behavioural Control, Subjective Norm, Attitude

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3.673	3	1.224	18.773	.000[a]
	Residual	13.761	211	.065		
	Total	17.434	214			

a. Predictors: (Constant), Perceived Behavioural Control, Subjective Norm, Attitude

b. Dependent Variable: Willingness

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.085	.088		.967	.334
	Attitude	.079	.030	.227	2.638	.009
	Sub Norm	.049	.026	.149	1.913	.054
	PBC	.073	.030	.178	2.434	.016

a. Dependent Variable: Willingness

Hypothesis 3

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT TWillingness
  /METHOD=ENTER TAge TPersonal TSupport.
```

Variables Entered/Removed[b]

Model	Variables Entered	Variables Removed	Method
1	Awareness of support structure & supervisory opportunities , Age, Perceived level of personal experience[a]	.	Enter

a. All requested variables entered.   b. Dependent Variable: Willingness

Model Summary

Model	R	R Square	Adjusted R Square	the Estimate
1	.405[a]	.167	.152	.26287

a. Predictors: (Constant), Awareness of support structure & supervisory opportunities , Age, Perceived level of p

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2.854	3	.951	13.767	.000[a]
	Residual	14.580	211	.069		
	Total	17.434	214			

a. Predictors: (Constant), Awareness of support structure & supervisory opportunities , Age, Perceived level of personal expe

b. Dependent Variable: Willingness

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	.317	.172		1.842	.067
	Age	-.184	.053	-.217	-3.439	.001
	Personal experience	.359	.080	.285	4.477	.000
	Awareness support & supervisory ops	.403	.102	.252	3.955	.000

a. Dependent Variable: Willingness

Hypothesis 4

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT TWillingness
  /METHOD=ENTER TAge TPersonal TSupport Attitude SubjNorm PerBehCon.
```

Variables Entered/Removed[b]

| Model	Variables Entered	Variables Removed	Method
1	Perceived Behavioural Control, Age, Perceived level of personal experience, Awareness of support structure & supervisory opportunities , Subjective Norm, Attitude[a]	.	Enter

a. All requested variables entered.   b. Dependent Variable: Willingness

Model Summary

Model	R	R Square	Adjusted R Square	the Estimate
1	.538[a]	.289	.269	.24404

a. Predictors: (Constant), Perceived Behavioural Control, Age, Perceived level of personal experience, Awarene:

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5.046	6	.841	14.122	.000[a]
	Residual	12.388	208	.060		
	Total	17.434	214			

a. Predictors: (Constant), Perceived Behavioural Control, Age, Perceived level of personal experience, Awareness of support
b. Dependent Variable: Willingness

Coefficients[a]

| Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-.004	.169		-.025	.980
	Age	-.155	.050	-.183	-3.094	.002
	Personal experience	.254	.077	.201	3.294	.001
	Awareness of support & supervisory	.263	.099	.164	2.643	.009
	Attitude	.078	.029	.223	2.695	.008
	Subjective Norm	.031	.025	.092	1.223	.223
	Perceived Behavioural Control	.052	.030	.127	1.755	.081

a. Dependent Variable: Willingness

**Appendix 11: Aetiological beliefs (individual items)**

People with mental health issues are born with a genetic predisposition to experience such issues (1=Strongly disagree, 5=Strongly agree).
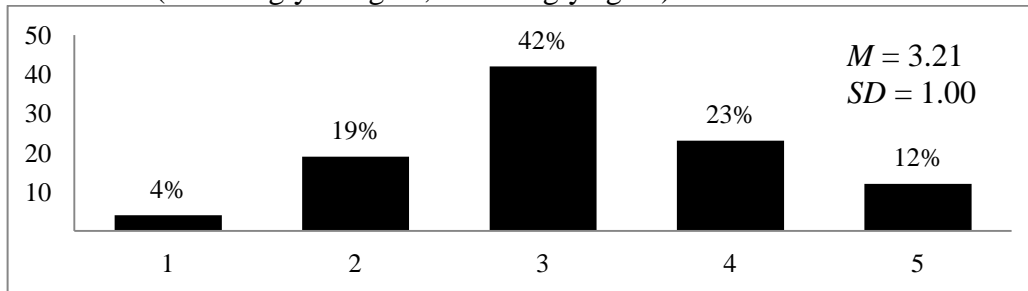

Mental health issues do not generally have a biological or genetic cause (1=Strongly disagree, 5=Strongly agree).
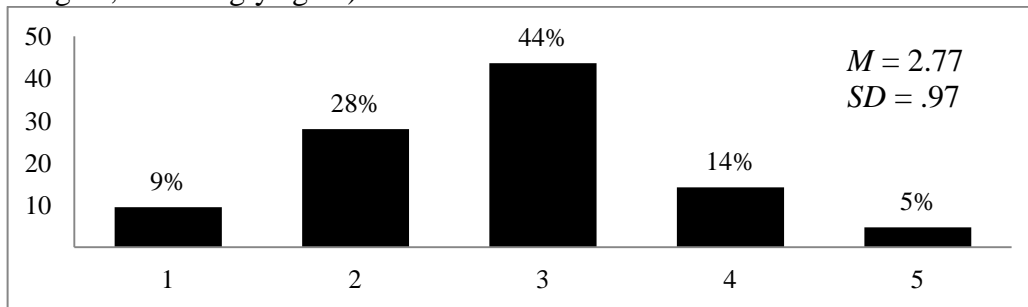
Mental health issues ultimately need to be treated in a clinical/medical setting (e.g. with a psychiatrist) (1=Strongly disagree, 5=Strongly agree).
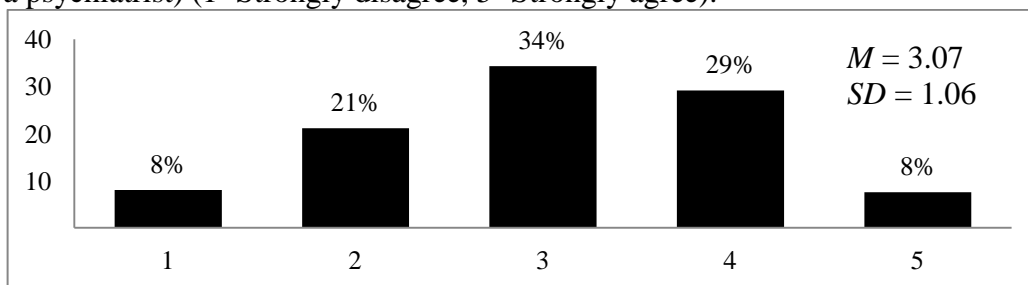

Medication is not usually the main treatment for people with mental health issues (1=Strongly disagree, 5=Strongly agree).
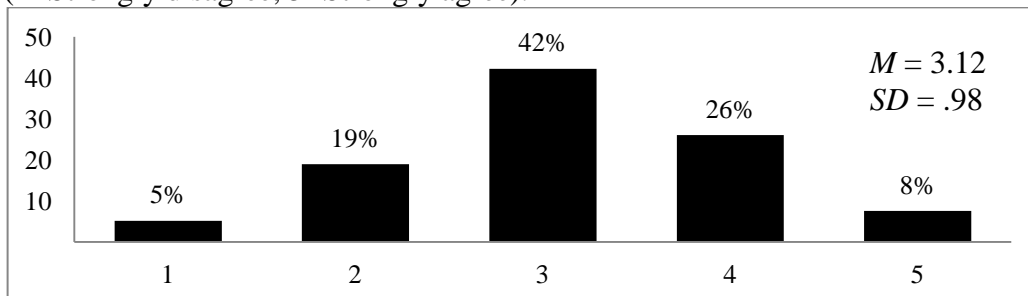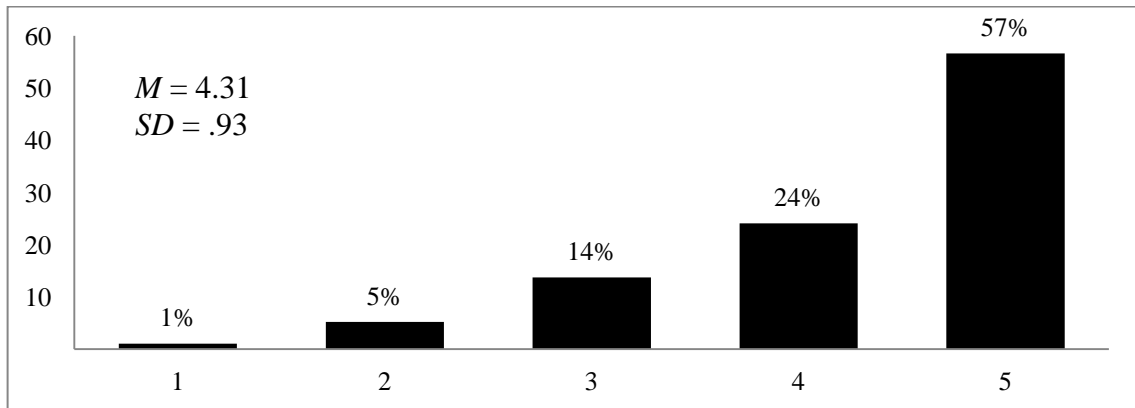

Note: M = Mean, SD = Standard deviation from the mean

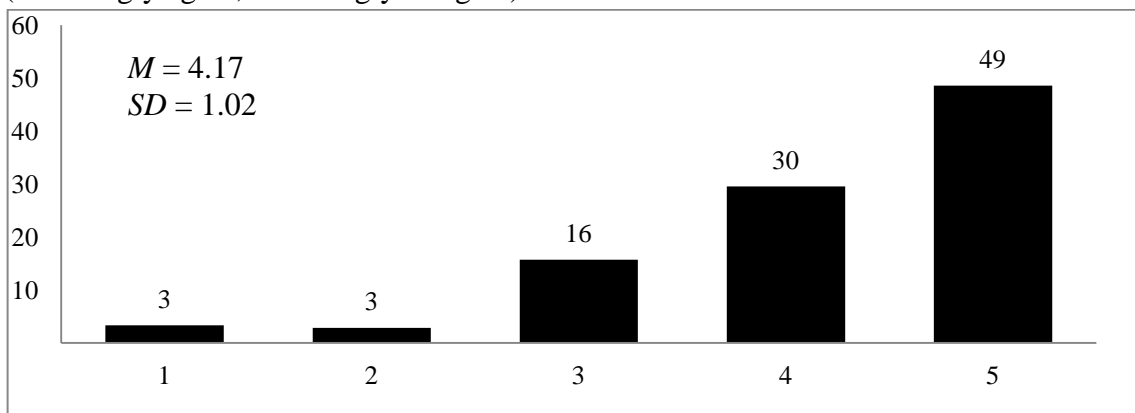**Appendix 12: Preferred social distance (individual items)**

I think sometimes it is best if pupils with mental health needs are not placed in mainstream classes (1=Strongly agree, 5=Strongly disagree).

$M = 3.62$
$SD = 1.3$
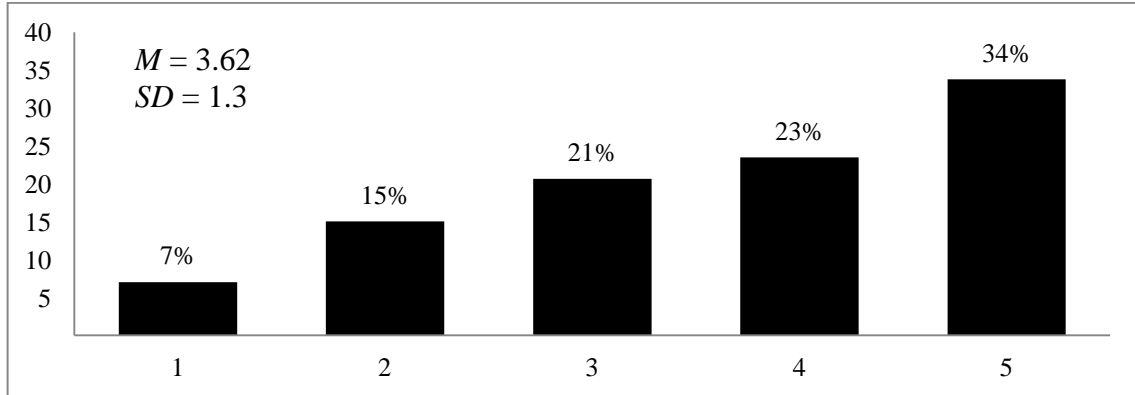
If I am honest, I sometimes avoid talking to pupils with mental health needs (1=Strongly agree, 5=Strongly disagree).

$M = 4.31$
$SD = .93$

I do not have a problem with having pupils with mental health needs in my classes (1=Strongly agree, 5=Strongly disagree).

$M = 4.17$
$SD = 1.02$

Note: M = Mean, SD = Standard deviation from mean