



# Australian and Maltese teachers' perspectives about their capabilities for mental health promotion in school settings



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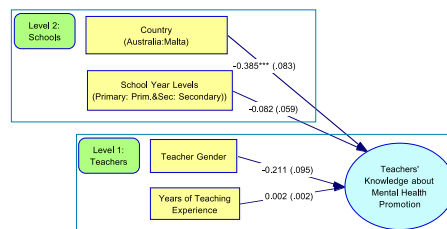
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## HIGHLIGHTS

- Schools are strategic settings for mental health promotion.
- Teachers from both Australia and Malta support mental health promotion in schools.
- Some teachers did not strongly endorse their capabilities to enact mental health promotion.
- Country, Gender, Year level, but not Years of Experience influenced outcomes.
- Teachers' need professional education to support mental health promotion.

## GRAPHICAL ABSTRACT



Two level hierarchical linear model for Teachers' Knowledge about Mental Health Promotion with path coefficients (robust standard errors). \*\*\*  $p < .001$

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## ABSTRACT

Policy makers identify schools as settings for promoting students' positive mental health. However, mental health promotion is not typically addressed in pre- or in-service teacher education. This paper reports 1029 Australian and Maltese teachers' perspectives about their capabilities for mental health promotion. Although participants reported favourable attitudes, many indicated concerns about capabilities such as Knowledge, Parenting Support and Self-efficacy. Multilevel modelling showed differences between country, gender and year level, but not between years of teaching experience. Curriculum initiatives for mental health promotion require opportunities for teachers to build their capabilities in this relatively new domain of school and teacher responsibility.

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## 1. Introduction

Each year, Oct 10th is World Mental Health Day: A day for global mental health education, awareness and advocacy (WFMH, 2007). This public profile of mental health promotion demonstrates that there is international concern about the prevalence

and severity of mental health difficulties and the impact such difficulties have upon individuals, families, communities and societies.

In everyday usage, the term 'mental health' can be ambiguous, as in some quarters this term has come to mean mental ill-health. This paper adopts the World Health Organisation (WHO) definition, which highlights that mental health is a positive state:

Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the

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normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in WHO's definition of health as contained in its constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (WHO, 2013a, p.1)

Policy makers identify schools as strategic settings for promoting students' positive mental health, such as through the explicit teaching of social and emotional skills. Promoting students' mental health requires teachers to possess particular types of subject-matter knowledge, pedagogical knowledge, and knowledge of learners and their characteristics. However, mental health promotion is not typically addressed in pre- or in-service teacher education, thus raising questions about teachers' capabilities to enact policy directives for mental health promotion in schools. In this emerging curriculum domain, little is known about teachers' knowledge and confidence for mental health promotion. Policy makers, curriculum designers and school leaders need information about what can be reasonably expected from the teachers who will eventually become responsible for enacting mental health promotion initiatives.

Furthermore, as concerns about mental health cross international boundaries, information from international contexts has the potential to be more enlightening than information from one context only. Cross-cultural research is useful for the development of theories that can be applied more generally across different contexts. This contributes to the diffusion of global knowledge. It also helps policy makers, researchers and educators to evaluate their own policies and practices in comparison to those in different cultures, identify strengths and weaknesses, and use the knowledge gained from other contexts to improve local policies and practices. On the other hand, cross-cultural research also draws attention to the need for cultural sensitivity when importing frameworks and practices from different cultures without first exploring the needs of particular contexts. Recognising the value of cross-cultural research, this paper reports an investigation into Australian and Maltese teachers' perspectives about their capabilities for mental health promotion. The purpose of this paper is to contribute evidence from key players in the delivery of mental health promotion initiatives in educational settings, namely teachers, with a view to better understanding facilitators and barriers to program implementation.

## 2. Mental health is an issue of contemporary international concern

There is strong evidence that resources do need to be directed towards mental health promotion. The WHO (2013a) reported that around 20% of the world's children and adolescents are estimated to have mental disorders or problems, with about half of mental disorders beginning before the age of 14, and with similar types of disorders being reported across cultures. In 1999 the US Surgeon General released the department's first ever report on the topic of mental health and mental illness, explicitly acknowledging that mental health is fundamental to health (DHHS, 1999). The report documented that mental disorders in the US collectively accounted for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer. Furthermore, some estimates suggested that up to 70% of young people who had mental health support needs did not access mental health services (DHHS, 1999). According to the recent 2013 report by the US Centre for Disease Control and Prevention (CDC) (Perou et al., 2013), the prevalence of mental health difficulties in

children and young people has been increasing in the last twenty five years, with 13–20% of American children and teenagers suffering from mental health difficulties in a given year. Statistics from the CDC for the period 2005–2011 indicate that attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioural or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), autism spectrum disorders (1.1%), and Tourette syndrome (0.2% among children aged 6–17 years). Approximately 8% of adolescents aged 12–17 years reported 14 or more mentally unhealthy days in the preceding month. During the same period as the CRC surveillance, Merikangas et al. (2010) reported results from the administration of the National Comorbidity Survey–Adolescent Supplement NCS-A, which is a nationally representative face-to-face survey of 10,123 adolescents aged 13 to 18. Participants' mental health was assessed using a modified version of the fully structured WHO Composite International Diagnostic Interview. Merikangas et al. found that anxiety disorders were the most common condition (31.9%), followed by behaviour disorders (19.1%), mood disorders (14.3%), and substance use disorders (11.4%), with approximately 40% of participants with one class of disorder also meeting criteria for another class of lifetime disorder. The overall prevalence of disorders with severe impairment and/or distress was 22.2% (11.2% with mood disorders, 8.3% with anxiety disorders, and 9.6% behaviour disorders). The median age of onset for disorder classes was earliest for anxiety (6 years), followed by 11 years for behaviour, 13 years for mood, and 15 years for substance use disorders. The study indicates that approximately one in every four to five youth in the US meets criteria for a mental disorder (with severe impairment) across their lifetime. Merikangas et al. observed that the likelihood that common mental disorders in adults first emerge in childhood and adolescence highlights the need for a transition from the common focus on treatment to that of prevention and early intervention. An estimate of the annual economic cost of mental illness in young people in the US is \$247 billion (O'Connell, Boat, & Warner, 2009; Perou et al., 2013).

In this paper we report a study undertaken in Australia and Malta, where the prevalence of mental health difficulties shows similarity with reports from the US. For example, Slade et al. (2009) reported results from the 2007 National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics. The survey was designed to estimate the prevalence of common mental disorders defined according to clinical diagnostic criteria, as directed by both the International Classification of Diseases 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). The results showed that one in five Australians experienced mental illness in the 12 months preceding the surveys, and that almost half of the population experienced a mental disorder at some point in their lifetime. The highest reported prevalence of mental health difficulties in the Australian sample, just over one in four (26.4%), was in the age group 16–24 years.

Sawyer, Miller-Lewis, and Clark (2007) reported the child and adolescent component of that national Australian study, focussing upon mental disorders in children and youth aged 4–17 years. Parents completed the Diagnostic Interview Schedule for Children Version IV, the Child Behaviour Checklist, and standard questionnaires to assess health-related quality of life and service use. The Youth Risk Behaviour Questionnaire was completed by adolescents. Sawyer et al. found that 14% of children and adolescents were identified as having mental health problems. Many of those with mental health problems had problems in other areas of their lives and were at increased risk for suicidal behaviour. Only 25% of children and youth with mental health problems had attended a professional service during the six months prior to the survey.

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