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**Time to Talk in Initial Teacher Training; staff and students' perspectives on mental health**

**A thesis submitted by Julie Dalton**

**To the School of Education University of Sheffield**

**In part fulfilment of the award of**

**Doctor of Education**

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## **Glossary of Terms**

ADD	Attention Deficit Disorder
ADHD	Attention Deficit and Hyperactivity Disorder
BDD	Behavioural Deficit Disorder
BERA	British Educational Research Association
CAMHS	Children and Adolescents Mental Health Services
CPD	Continuing Professional Development
CYPP	Children and Young People's Plans
DoH	Department of Health
ECM	Every Child Matters
FdA	Foundation Degree
FE	Further Education
GP	General Practitioner
HE	Higher Education
HEI	Higher Education Institution
ITT	Initial Teacher Training
JSNA	Joint Strategic Needs Assessments
LGBT	Lesbian, Gay, Bisexual and Transsexual
MHF	Mental Health Foundation
NI	National Indicators
OFSTED	Office for Standards in Education
ONS	Office of National Statistics
PGCE	Post/ Professional Graduate Certificate of Education
PHSE	Personal, Health and Social Education
PTSD	Post Traumatic Stress Disorder
SAD	Seasonal Affective Disorder
SEN	Special Educational Needs
SENDA	Special Educational Needs and Disability Act
TA	Teaching Assistant
TAMHS	Targeted Mental Health in Schools
WHO	World Health Organisation

## **Chapter 1. Mental Health in Initial Teacher Training: Context and background.**

This thesis investigates the awareness of Initial Teacher Training (ITT) students and teachers around the topic of mental health and how mental health issues can impact on teaching and learning. All teaching staff and support staff are named in the '*National Service Framework for Mental Health children, young people and maternity services: The mental health and psychological wellbeing of children and young people*' (2004) as Tier 1 professionals. The 4 tier framework illustrates how staff from each tier can interact with professionals from other tiers to ensure smooth and consistent care for children and young people who are experiencing mental health issues. Tier 1 staff include any front line professionals who meet and deal with children and young people on a regular basis and education has been highlighted as an opportune activity: for promoting positive wellbeing; for preventing mental health issues from escalating and for ensuring that referrals are made promptly to other services and staff in the incrementally more specialised tiers 2, 3 and 4. The thesis focuses on awareness of mental health issues as a potential barrier to learning and whether staff and students engaged in Initial Teacher Training (ITT) programmes are aware of and feel ready and confident to meet their Tier 1 responsibilities. The thesis pivots on a balance between my subjective view that anyone working with children and young people needs to be aware of mental health issues and how they affect teaching and learning and the views and voices of a cohort of PGCE teacher trainees and the staff delivering their programmes which may provide an alternative viewpoint.

The initial spark that led, ultimately to this study was a critical incident from many years ago in my time as a curriculum manager when a young, newly qualified member of staff accused me of putting her in danger because one of the learners in her class had mental health issues. She was truly frightened and it made me reflect on the need for awareness-raising which was specifically targeted to staff in education. It was not necessary for her to know the name of the condition which this learner presented with or his medication regime and his support for living arrangements. It was however necessary to know what behaviour might be manifest in class, how to manage it and how his learning could be best supported to give him equality of opportunity to access the curriculum. It was also necessary to challenge

the stereotypes, myths and misconceptions around mental health issues with this teacher to ensure that she felt confident and aware, rather than frightened.

This chapter positions the study in the field of education; considering its interdisciplinary aspect and acknowledging that there are obviously links to health, but arguing for awareness- raising which is firmly rooted in the social model of disability and appropriate for those involved specifically in education. The chapter firstly fully identifies the context and interest which led to the development of the research question which this thesis investigates. This is followed by a rationale which clearly states the aim and objectives of the study and which follows Creswell's (2007) design pattern by stating the problem and the purpose of the study before linking the question persuasively to a particular qualitative approach.

One of the unique approaches in this thesis is my proposal that awareness for teachers needs to exist in three separate but complimentary strands. This overview has been developed from practice in:

1. noting the increasing range of conditions and diagnosis of younger children with mental health issues
2. having been challenged myself at a conference about mental health to consider the effect of the actual processes of my practice on my own mental health and that of my learners
3. seeing student teachers worry over their own mental health during and post qualifying.

Chapter 2 is presented in three sections so that these three separate facets of the literature can be evaluated:

- i) Sources which consider the statistical evidence surrounding the mental health needs of children and young people.
- ii) Literature around mental health promotion and management in schools and
- iii) Literature around the stressful nature of teaching as a profession and the need for staff to be aware of their own wellbeing and to develop coping strategies. A concluding section considers the stigma surrounding mental health issues.



Chapter 3 discusses and justifies the methodology of the study including: the philosophical underpinning of the piece; discussion of the definitions of research applied to the study and the demographics of the sample utilised, my positionality, ethical considerations, data collection and analysis.

Chapter 4 contains the findings from the three phases of research which include initial questionnaires, staff interviews and student model making focus groups. Each section is evaluated and considered in Chapter 5 before any conclusions and recommendations are reported in Chapter 6.

The study reported in this thesis stands apart from other research that considers mental health awareness for teachers as my study is focused on the voices of both students and staff and from those engaged in primary, secondary and FE teacher training. It asks whether targeted and specific awareness-raising based on the needs of teachers is required and postulates three separate arguments for awareness of mental health issues.

### **Starting point**

Charlie Taylor, the Chief Executive of the National College for Teaching and Leadership, (Department for Education 2012) put the problem into context when he said in a speech to the Academies Show that,

In our society when a child becomes ill we reach out to them, we instinctively keep them close and look after them. This response is sadly not always the case when children become emotionally distressed...Rather than being helped, children in difficulty are often pushed away and ignored. (2012, p.1)

This investigation starts by considering the specialised nature of ITT courses which prepare students through an intense year of post graduate study to enter the classroom and teach children such as those Taylor is describing. It asks the question: **What are ITT staff and students' perspectives on mental health as a barrier to teaching and learning?** Within ITT programmes students are introduced to pedagogical, psychological and sociological theories which enable them to make sense of their practice. They also consider education policy and how that impacts on practice. This thesis examines one aspect of policy and considers whether students and their tutors are managing to incorporate this particular requirement within their programmes. More widely it considers whether ITT students and staff recognise a

need for mental health awareness- raising. This sets the research apart from other studies and the thesis attempts to fill a gap in the literature which was highlighted by Bostock, Kitt and Kitt (2010).

There are many barriers to learning and it is open to question as to whether student teachers could, or should, be made aware of, and learn how to deal with, every potential barrier before they go into practice. In order to create a positive learning experience however, and to embed inclusion into their practice, student teachers will need to be open to learning about issues which affect teaching and learning and the study reported in this thesis is based around the issue of one of those possible barriers; mental health. Positive mental wellbeing is an aspect of the positive learning experience that practitioners are charged with creating and negative issues around mental health will definitely have an impact on the classroom environment and on learning in general. This study will accordingly, consider the views of trainee teachers who are presently managing the demands of an ITT programme alongside their own development into qualified professionals and also the opinions of their tutors who are preparing them for practice.

Since 1999 and the creation of the first National Service Framework for mental health in the U.K. the issue has been given policy status. In the additional 2004 document, ' The mental health and wellbeing of children and young people', teachers are classed as Tier 1 professionals in a 4 tier system and the other tiers are made up of more specialised services including mental health professionals. In Tier 1 the teacher's role is to notice mental health issues and to refer pupils to practitioners in the higher tiers but also to promote positive mental health for all learners. The thesis argues that the issue of referral could tempt teachers into thinking of this as a medical issue rather than focusing on the promotion of wellbeing which fits within the classroom and teaching and learning activities.

My commitment to personalised learning and to achieving 100% satisfaction rates from my students means that I approach practice expecting and intending to get to know each individual very well and to support them to break down whatever barriers they may bring with them. Mental health issues have been a barrier for many that I have taught over a 20 year teaching career. I have taught in FE colleges teaching and managing general education (English and philosophy) and learning support

before moving into managing skills for life and most recently moving into H.E. In all those roles and in every class I have supported, and continue to support, learners who have been managing mental health issues. I find it interesting to talk to fellow practitioners and to trainees who have been out on placement who report having never experienced learners with mental health issues in their classes. The explanation for the different experiences is a source of interest and leads me to wonder whether this is merely a matter of a lack of awareness or is it awareness of what to look for combined with a keen attention to individual learners? It has to be noted that my work was based geographically in areas of deprivation and often I have taught non-traditional learners which may mean that I was more likely to find higher levels of mental health issues. Often I have taught learners dealing with poverty, those with learning difficulties, learners with behavioural issues and those being educated within the criminal justice system who again would be more likely statistically to be dealing with mental health issues. This is not a satisfactory explanation for the difference though as I have spoken to colleagues and trainees who are working in the same geographical area and with students exhibiting similar levels of risk factor. I feel that it is possible that creating a learning environment where it is acceptable, and where students are even encouraged, to talk about mental health issues may lead to increased disclosures.

I consider mental health awareness to be the key to breaking down this particular barrier to learning because if teachers are aware they are likely to be more confident in their approach. It was from this premise that I began the study reported in the thesis to seek a deeper exploration of the current state of awareness within three Higher Education Institutions (HEIs) and to lead to some conclusions about whether changes were necessary. This is not an action research project as it is possible that no change will be instigated from the recommendations; however the study will lead to the production of a pack of informative materials which can be accessed online and which will be offered to all participants for more general dissemination if appropriate. The research question and the methods adopted for the enquiry were selected after an initial trawl of the literature which revealed a gap in research aimed specifically at those on ITT courses for all key stages and this element of the thesis is unique in suggesting that there are three distinct reasons why teachers should be aware of mental health issues in education. The study was planned to investigate

the overall awareness of both staff and trainee teachers around mental health issues which are presented in class. Following this staff interviews were conducted to explore the needs of the trainees versus the demands of the curriculum. Finally focus groups were conducted where trainee teachers; through the protective medium of model making discussed their feelings and opinions around this particular barrier to learning; enabling them, in a safe environment, to discover their own thinking about the mental health needs of their learners and themselves.

### **Aim and objectives**

The overall aim of the study is to discover whether teacher trainees and their tutors are aware of their responsibilities towards their pupils in terms of promoting positive mental health, negating the damaging effects of teaching and learning processes and providing support and referrals for pupils, colleagues and themselves to maintain wellbeing. The specific outcomes are to:

- 1) Critically evaluate participants' views around their current awareness of mental health
- 2) Explore the tensions within the ITT curriculum between trainees' need for awareness of mental health issues and the input needed to produce competent practitioners.
- 3) Analyse the feelings and opinions of participants towards mental health issues.

### **Putting the research into context.**

Following instances when mental health awareness had enhanced my own teaching I further developed interest in this topic from my work mentoring PGCE students in FE and my current practice teaching PGCE students and students on the Foundation Degree for Learning Support( who are support staff planning to progress into teaching) in HE. The work brought together two facets of my career path and offered an opportunity to explore the need for mental health awareness- raising to be embedded into programmes for any practitioners working within the children's workforce and especially for those preparing to teach. A link to policy was initially drawn from the National Service Framework for Mental Health: The Mental Health of children and Young People (2004) which categorised all professionals working with

children into 4 distinct tiers. Tier 1 includes teachers and their specific responsibilities as front line staff are to: assess and diagnose, to give advice, to promote mental health and to prevent mental health problems. . The research was conducted in my home HEI and two other institutions; one in the North West and one in the midlands. Two of the HEIs were general University centres and one was a teacher training specific university college. One of the general HEIs hosts a centre for excellence in teacher training for its consortium partnership. The three phases were structured to allow data from **Phase 1** questionnaires to have an impact on the semi- structured interviews carried out with staff in **Phase 2** and the model making focus groups for teacher trainees in **Phase 3**.

The starting point for this particular piece of research was to consider how well trainees on PGCE programmes were prepared for their Tier 1 responsibility and to try to measure their readiness and confidence to deal with mental health issues in all aspects of their practice. Drawing on the literature and my own experience I identified three distinct facets of awareness to consider. 1. Firstly trainees need to be aware of the mental health issues that will be presented to them in practice by their learners and which will have an effect on the delivery of teaching and the ability to learn. The work of the Mental Health Foundation (2004, 2006), Young Minds (1996) and most recently MindFull (2013) are backed up by statistical evidence from the Office for National Statistics (2003) and in section 2.1 of the literature review the case is made for being aware of the levels of incidence and the types of condition being experienced by children and young people. From experience of supporting learners with: anxiety and depression, phobias, Obsessive Compulsive Disorder, OCD, Attention Deficit Hyperactivity Disorder ADHD, eating disorders and self-harm; awareness around incidence of conditions and typical symptoms has been a useful tool.

2. Trainees are also in a position to harm the wellbeing of their learners and to cause damage to existing conditions or even create new mental health issues by means of their practice as teaching and learning include stressful activities. This is evidenced by the work of Weare (2000, 2004). Rothi *et al*(2008), Graham *et al*(2011) and Atkinson and Hornby(2002) who all present the perspective that teachers need to be aware of the role of the school in dealing with mental health issues for children and young people. Chapter 2.2 looks in depth at studies both home and abroad about

how school can be a positive environment for dealing with mental health issues. In my practice awareness of this issue has been advantageous in managing the environment and building in positive management techniques to allow learners to succeed and attain without damaging their wellbeing. An example of this in practice was when I was a curriculum manager in Skills for Life when the Adult Literacy and Numeracy tests were introduced; this was a management challenge as the non-traditional learners in these classes often had negative associations with testing and assessing based on their experiences in school, so to introduce a stress inducing method of assessment to them as adults was not without difficulty.

3. Thirdly, and perhaps of greatest concern to the trainees to start with, is that they need to maintain positive mental health for themselves despite working in an intensely pressurised environment and profession. Holmes (2005), Weare (2000, 2004) and Garner (2010) have studied the effects of a stressful profession on staff and estimated the impact on burnout and numbers of young teachers leaving the profession early. In all my teaching roles I have supported colleagues and covered for absent members of staff because people have struggled to deal with the intensity of the demands of the profession. Working in a target driven environment with an inspection regime which is linked to future funding can lead to difficulty and attrition.

I was therefore interested to firstly attempt to roughly measure awareness around mental health issues which would form the baseline for current trainees and tutors to be able to establish how much movement from the baseline would be needed, if any, to enable teacher trainees and their university tutors to be prepared to meet their National Framework responsibilities. My initial notion was that if trainees were introduced to the three strands of awareness around mental health issues then they would be better equipped to: meet the needs of their learners; to promote positive mental health through practice and to protect their own mental health and that of their colleagues.

## Policy context 1:1

This chapter contains a short retrospective section on policy to consider the various documents that have had an impact on practice so far within education in specific relation to mental health. It is necessary to note that the first set of initiatives listed here, were introduced under the last administration and that since 2010 the Coalition Government's policies have changed in several pertinent areas. What has not changed is the commitment to initiatives to measure wellbeing and to continue the work of Children and Adolescents Mental Health Services (CAMHS) teams. The National Framework also has not been altered and is referred to in the *No Health without Mental Health* (DoH 2011) document.

The previous government's initiative; *Every Child Matters* (Boateng 2003) introduced the 'one stop shop' idea of schools as buildings where any and all issues affecting teaching and learning could be dealt with by a multi- agency team. This was originally an American initiative and in Britain the process was not fully completed across the country and the realities of multi- agency working proved difficult as workloads, timetables and staffing issues meant that physically getting teams together from various agencies was challenging. There are doubtless areas where the initiative is more firmly embedded than others and also many aspects of change to practice which are still being implemented have roots in the policy. It encapsulated five outcomes and there was a direct link to mental health in the *Be Healthy* outcome which said that children should be, 'enjoying *good physical and mental health and living a healthy lifestyle.*' The current coalition government are not maintaining ECM as policy but as an alternative have introduced *No Health without Mental Health* (DoH 2011); a policy which summarises their aims to reduce inequality of opportunity by focusing on the mental health of all groups

*The Children's Act 2004* underpinned the setting up of children's trusts and the initiation of the *Joint Strategic Needs Assessments* (JSNA). The first *Children and Young People's plans* (CYPPs) were published and services were served for the first time from pooled budgets. In 2004 too, the *National Framework for Children, Young People and maternity services* was introduced and 9 out of the 11 standards set the standard for mental health services and led to the development of *Children and Adolescent Mental Health Services* (CAMHS) in 2006.

The development of CAMHS across the country has not led to a standardised approach to training or awareness- raising for staff in schools. Some authorities have trained named people from specific schools and others have provided CAMHS support in house to work with parents and pupils who need to access CAMHS services.

Following the comprehensive spending review in 2007 National Indicators were created: to monitor the effectiveness of CAMHS (N.I. 51); to check on the emotional health of children and young people (N.I.50) and to look particularly at the emotional and behavioural health of looked after children. (NI 58)

In the *Children's Plan* of 2008 the document summarised the role of the 21<sup>st</sup> Century School, as a place to be held accountable for and having a new duty to promote wellbeing. Also in 2008 the *Think Family* Agenda extended the logic from ECM to include families as a way of starting to break down the generational cycle of various issues which can so easily occur in families who are excluded. The *Foresight Report* was also released in 2008 and this advised government that policies should lead to children, 'flourishing' and they emphasised 4 points for future policies;

1. Addressing the risk factors associated with mental disorders
2. Diagnosing early and treating promptly
3. Addressing important mediating factors including stigma
4. Targeting high risk groups including looked after children and young offenders.

Another report produced in 2008 was the *Children and Young People in Mind* report which reviewed CAMHS and led to a response called *Keeping Children and Young People in Mind* published in 2010. This indicated acceptance by the government of the business case made for investing in children's mental health as early as possible to save money in NHS and other support budgets in the long term.

In 2011 the Department of Health published *No Health without Mental Health the Mental Health Strategy for England* which led to *Making Mental Health Services more Effective and Accessible* released in 2013 again by the Department of Health. This report is important because it called for mental health to be part of a new national measure of wellbeing.



As policy is changing around what the current government requires from ITT programmes the study reported in this thesis could be limited in any application because of its link to current ITT courses. Whilst the outcomes around raising current awareness and consideration of the curriculum requirements could stand for any delivery pattern, it may be that more creative and innovative methods of raising awareness amongst trainee teachers will have to be developed to fit in with the models of Teach First and School Direct.

Lee Miller, from Young Minds, considered that:

Teacher training doesn't cover mental health awareness in any depth at present and Young Minds believes that there should be more modules on the topic in PGCE courses. (in Tickle 2006, p.6)

The current PGCE programme may not have currency for much longer but the need for awareness is definitely recognised by the current coalition government, who, in, '*No Health without Mental Health*' state clearly that:

The government is committed to ensuring that front line staff are knowledgeable, motivated and supported. (D of H 2011, p.36; 4.30)

Therefore if this research can suggest sustainable methods to increase awareness then it could fit into current policy and also be part of an on-going strategy for future practice.

This chapter so far has introduced the research question and put it into context in terms of practice and policy. The next section will present a rationale for the study and explain the thinking behind the plan for the research presented in the thesis.

## **Rationale 1:2**

This study began with my concern for the need to raise awareness around mental health issues experienced by young people in schools.

City and Guilds (2010) produced a briefing note, in which they suggest:

Learners may also experience difficulties expressing themselves and asking for help, and practitioners might lack knowledge about mental illnesses and the symptoms which could allow them to recognise the signs... The implications for the whole classroom or environment are serious (2010, p.2)

This study considers the implications of the above for ITT providers and students. As outlined on page 6 some literature leads to the proposition that there are three

separate strands of awareness that newly qualified teachers need to have input on before they begin in practice. The literature will thus be organised to reflect these three components:

1. Mental health issues which learners present with in class;
2. Mental health issues caused or exacerbated by the process of education and finally,
3. Mental health issues as experienced by staff themselves in a stressful occupation.

These three areas of study are linked and there are elements of crossover. The stigma attached to mental health as a topic and possible reluctance to disclose and talk about the subject needs consideration and the final section of chapter 2 looks at some of the challenges for staff and students.

In *No Health without Mental Health* (2011) the Department of Health guidelines for school aged children surmise that:

Early interventions particularly with vulnerable children and young people can improve lifetime health and wellbeing. (2011, p.9 1:15)

Maddern (2010) summarised the notion of *The Targeted Mental Health in Schools programme* TAMHS (2009) as:

Services for pupils with mental health issues will be based in primaries and secondaries and teachers trained to spot symptoms in a bid to improve children's treatment. (TES online)

TAMHS is the most recent school based intervention programme for children aged 5-13. The staff incorporated into schools were front line Tier 1 staff who worked 1:1, in small groups or with parents. *Achieving Equity and Excellence for Children* (Dept. of Health) discussed plans for new online services to provide guidance and training on mental health for teachers, police personnel, health professionals and others working with children.

Statistical evidence from the Office for National Statistics (ONS 2005) shows that the numbers of children and young people experiencing distress and dealing with less than positive mental health are growing. The ONS in 2005 published the results of, "*Mental Health of Children and Young People in Great Britain 2004*" The survey recorded just under 10% of pupils aged between 5 and 15 as experiencing a mental

health disorder. The World Health Organisation (WHO) took a global view in 2001 and estimated that 1.5million of the world's youth (15 years and under) suffer from mild to severe disorders and a large number of these young people remain untreated. The City and Guilds report (2010) states that:

The inadequate support for children with problems affects the wellbeing and performance of all pupils and this applies equally across other educational settings. (2010, p.2)

It is important to note here that these figures are based on children and young people who have been diagnosed and as there is no screening for mental health issues in schools or in the National Health Service then the figures could be under representative of the actual number of children affected. This is reinforced by the fact that statistics for the adult population suggest that 25% of adults will develop a mental health issue at some point in their lives. In the '*No Health without Mental Health*' (DoH 2011) report Andrew Lansley, the then *Secretary of State for Health*, stated that:

Around half the people with lifetime mental health problems experience their first symptoms by the age of 14. (2011, p.2)

Worryingly, Ford *et al.* (2003) found that only 18% of children and young people in the U.K. diagnosed with anxiety disorders had any contact at all with Children and Adolescent Mental Health Services CAMHS. At least half of this group had no contact with any service at all.

MindFull's founder Emma-Jane Cross (2013) said that:

Poor mental health among young people was one of the last great medical taboos in the UK today. (2013, p.1)

The charity produced a report which calls for:

the awareness of the importance of mental health to be integrated into every aspect of young people's development particularly in schools and health services. (anon 2013)

Having worked across a number of Further Education colleges in lecturing and management roles I have had the opportunity to mentor and teach PGCE students and in general I have found that mental health issues presented by students in class have caused concern and even fearful reactions whilst trainees are on placement.

Another strand of experience suggests that teaching and learning activities are in themselves detrimental to the positive mental health of learners unless managed effectively and the third and final strand of my concern is that teacher trainees are entering a profession which also can test or damage resilience and positive mental wellbeing. Weare (2001) considers the overall difficulty of this topic for trainees when she postulates that:

Those in education have tended to view what happens in the black box of mental health as at best mysterious and medical and at worst rather frightening and off putting. (p.34)

The topic of fear and its link to stigma will be a thread running through the research and will be considered when planning the content of the awareness raising pack of materials which will be shared with all participants following the completion of the thesis. Rothi *et al.* (2008) consider that:

Teachers tend to avoid using psychiatric language for a variety of reasons including teaching tradition, ethos and boundaries. They also view psychiatric terminology as stigmatising and harmful. (2008, p.1223)

This is an important aspect of awareness raising as it is not necessary for teachers to be able to diagnose specific mental ill health conditions and it could be argued that it is necessary to consider mental ill health as being no different to physical ill health which in most cases has little or no stigma attached. It is necessary in awareness raising to guard against the danger of teachers simply seeing the topic as one to be referred to outside agencies rather than being dealt with in class through simple, common sense strategies.

It is possible therefore to consider that a lack of training about issues to be faced in practice could be detrimental to trainee teachers and to the students that they are supporting. Rothi *et al.* (2008) postulate that:

As a consequence of the changing school pupil population there is a need for innovation in teacher training that encompasses the spectrum of abilities and needs among pupils. (2008, p.1228)

In my role in HE for the last 8 years I have been involved in delivery to BA primary and PGCE FE teacher trainees and I have had sole responsibility for a Learning Support BA which recruits support staff from across the primary and secondary key stages; although not directly an ITT course most learners progress into teaching

roles post -graduation. Across all this provision there are no modules which deal specifically with mental health. This does not mean that opportunities to embed awareness are not taken. In class discussion, setting of assessment tasks and lesson observations it is possible that staff are noticing and recording commitment to improving mental health by their trainees. Also as many assignments allow trainees to choose topics to write about, mental health may be represented as a valid topic through student interest. It is also possible to infer that in all modules which deal with inclusion or special educational needs, that mental health might be included in the syllabus. These inferences and possibilities however cannot be assumed and the lack of knowledge and evidence of embedding makes the topic for this research pertinent.

## **Chapter 2.**

### **Literature Review: Introduction**

The purpose of this chapter is to locate the study reported in this thesis to other published research in the field. Although covering a cross- disciplinary topic all the literature cited here has a direct application to the work of teachers and schools/ colleges. This study offers an investigation around whether pre- service teacher trainees and their tutors perceive a need for awareness raising around mental health issues during their training by employing specific and targeted materials to prepare them for their Tier 1 responsibilities under the National Framework.

Thematic divisions have been applied and the chapter is organised to investigate:

**2.1 Studies which have considered the statistical evidence of mental health issues for young people and children.** This section will attempt to provide a measure of the incidence of learners presenting in class with diagnosable conditions. The literature around statistics is dated in the UK as the last full survey was published in 2005 around data collected up to 2004. There are smaller studies which focus on e.g. self- harm which suggest an increase over time and other studies which suggest that British children report being less happy than children in other countries which might suggest that mental health issues are statistically rising.

**2.2 Literature around the needs of teachers in service which could be used with pre service trainees.** These look at how schools manage the emotional wellbeing of pupils and some are intended for use as CPD for existing teachers. This section will include some elements of international perspective from the US, Australia, France , Germany and America which show how staff are being supported with a range of materials which may increase the possibility of a whole school approach to mental health which is an approach championed by Weare in the UK

## 2.3

**Literature around teacher wellbeing and stress management.** This is an important element because it could be argued that teachers who don't have resilience and strategies for maintaining positive mental wellbeing for themselves would not be in a position to promote mental wellbeing in their learners.

## 2.4

**Stigma** is an overarching issue which links the three other themes. This is discussed separately however, it is not another, distinct reason for awareness raising as in 2.1, 2.2 and 2.3 but literature around stigma is directly linked to awareness as it can affect all aspects of teaching and learning for staff and students.

### **Aims of the chapter**

The chapter aims to:

1. Introduce relevant literature around 3 reasons to be aware as stated in Chapter 1.
2. To consider arguments put forward in the literature which link to the study reported in this thesis.
3. To illustrate how stigma is an issue which is linked to mental ill health and which overarches the three named sections and must be tackled in order to improve the educational experience of teachers and learners.

Figure 2.1) shows a visual representation of this chapter to emphasise the overlapping and interdependent nature of the discussion and the equal importance of each section. The overarching issue of stigma which impacts on each section runs through the centre of the figure 2. 1)

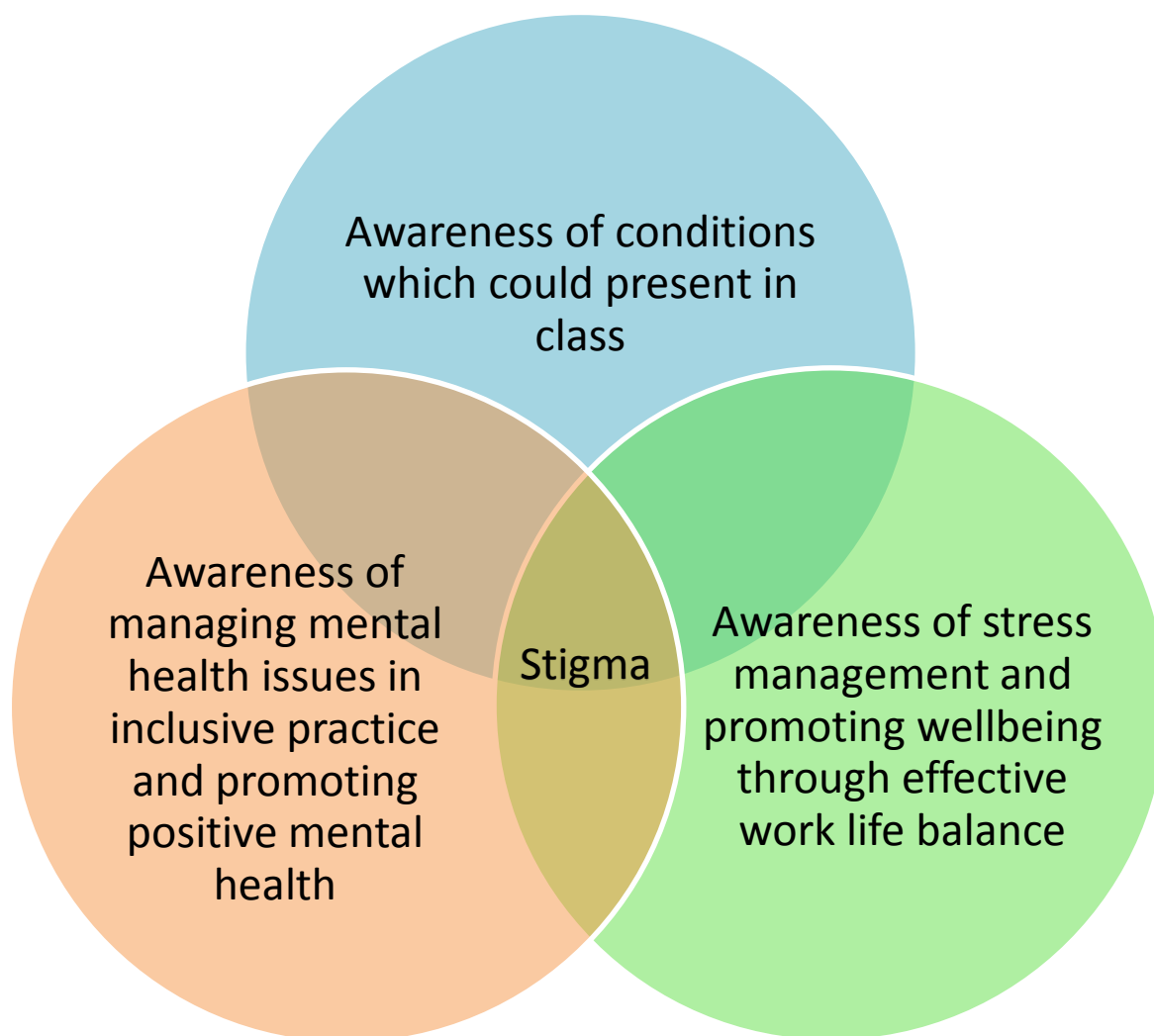


Figure 2.1) A graphical representation of the literature review.

This chapter will begin with a discussion of the statistical studies in the UK which suggest that issues around mental health and teaching and learning are growing and will continue to have an effect on those entering the profession, those already qualified and their learners.

## **2.1 Statistical evidence of mental health conditions in the school aged population and how these conditions affect teaching and learning.**

This section considers that mental health issues affect a significant proportion of pupils in mainstream primary, secondary and FE provision. In the introduction it was postulated that teacher trainees and the staff teaching/ mentoring them need an awareness of mental health issues and how to meet the requirements of the Tier 1



statement of the National Framework. The literature reviewed here is all relevant to this need. According to the Office for National Statistics (2005) one in ten children between the ages of 5 and 15 has a mental health disorder. The Mental Health Foundation (2006) estimates that 20% of children have a mental health problem in any given year, and around 10% at any one time. These statistics are likely to be under representative of the actual levels of distress as they are all based on diagnosed conditions. In many cases children and young people are considered to have emotional or behavioural issues but have no definite mental health diagnosis. As children and young people are placed on school action based on the concerns of teachers and parents then often this is the only record of them dealing with any issues of 'difference'. If teachers are aware of the range of possible mental health issues then the move to school action plus and the referral to CAMHS or other external services could be made earlier and treatment solutions put into place in a timely manner. This will have a positive effect on the learning environment with less disruption for all learners and on the particular learning of the individual as they are able to develop strategies to break down their barriers to learning.

The next subsection deals with the statistical information produced through research over the last decade which suggests that a significant proportion of children and young people are experiencing mental health issues which the study has used to infer that teachers and teacher trainers need to have awareness of.

### **2.1a) General statistics on mental health**

The last published statistics by the Office of National Statistics in the UK (2005) refer to levels of mental health disorder in young people aged between 5 and 15 in 2004. This survey measured learners presenting with conditions that had already been diagnosed. The study categorised the disorders into three main groups: emotional disorders, conduct disorders and hyperactivity disorders. An average of all types of disorders showed that 10% of children had been diagnosed. The figure was slightly higher for boys aged 11 -15 and considerably lower for girls aged between 5 and 10. In 2005 the Royal College of Psychiatrists estimated that depression affects two to three of every one hundred teenagers and around 1 in every 200 children under 12 but this is a contested statistic as until recently only adults were diagnosed with depression and many GPs still lack specific mental health training. Young people

therefore are more likely to be recorded with an emotional disorder or a behavioural concern. Jane-Llopis and Braddick (2008), claim that around 10-20% of children are identified as having mental health problems in Europe.

Truth Hurts (Mental Health Foundation 2006) was a summary of the findings of a national enquiry into self-harm. The survey concluded that 10% of young people aged between 15 and 16 had deliberately hurt themselves and as many as 24,000 under 18 year olds are treated for self-harm annually in Accident and Emergency departments. The report reminded readers that hospital admission or presentation was unlikely to be a valid measure of the scale of the problem. The work summarised three large scale community based surveys (Green *et al.* 2005, Hawton *et al.* 2000 and Meltzer *et al.* 2001); all three pieces of research concluded that many young people treated their injuries themselves or were treated at home by parents/carers so they were confident that the figures were an under-representation of the actual scale of the issue. Young Minds (2011) published a statement claiming that by 2020 100,000 children and young people could be hospitalised each year because of self-harm. This prediction is based on statistics which show that over the last 10 years inpatient admissions for young people have risen by 68%. Amongst females under 25 there has been a 77% increase over the last 10 years. Hall *et al.* (2010) postulate that the most recognisable form of self-harm, which is cutting, affects 10% of young people. It is important for teachers to know and recognise a range of harming behaviours though, as biting, burning and hair pulling are less common but need also to be looked out for. It is unlikely that the harm itself will be visible in school as it is an intensely private and hidden activity but all staff and other students should be vigilant for the signs of harm and ready to step in and offer help and comfort to young people who are affected. It is also necessary to challenge the stereotype that self-harming is an attention seeking activity as an appreciation of the lengths people go to, in order to hide this activity would enhance awareness and ensure that people pay attention to less obvious changes in behaviour which might mask the actual issue. Lucie Russell (2012) claims that:

Young people's mental health is under pressure like never before. (p1)

She cites the WHO which predicts that by 2030 more people will be affected by depression than any other health problem (WHO) Russell (2012) questions the

spending by governments on mental health prevention and positive promotion in light of these statistics. Awareness- raising for teachers therefore could become an even more important aspect in the support of children and young people who need referrals to specialist services. Delays in seeking appropriate treatments and support for depression can lead to an increase in self harm and even suicide. If young people are under increased pressure then it seems increasingly likely that they will make disclosures to adults who are close to them and teachers and teaching assistants are in this group. All such staff need awareness of the possible conditions which young people present with and also the support mechanisms in place to refer them on to for appropriate help and support.

The next section discusses particularly vulnerable groups and considers some aspects of teachers' and learners' experience/demographics/ socio economic status which puts them at additional risk of developing mental health issues which will negatively impact on their teaching and learning.

### **2.1b) Specific factors**

Socio economic factors negatively impact on the prevalence of mental health issues in children and young people. Erin Wright is a Young Minds; Very Important Kids (VIK) London Regional Support Worker and she concludes that due to the pressure of life in the capital,

With 3 children in every classroom having a diagnosable mental health condition and 1 in 12 young people self- harming there has never been a more critical time for London to prioritise the mental health and wellbeing of children and young people. (Wright 2012)

I would argue however that children and young people all over the country are just as in need of such a prioritisation. There are a range of socio- economic factors such as the financial crisis, levels of child poverty, relationship breakdowns, shortage of affordable housing and levels of ill health and substance abuse which are not purely inner city issues and which we can infer will negatively impact on the physical and mental health of teachers and learners who are affected

The Children and Young People's Mental Health Coalition record that in an average classroom 10 young people will have witnessed their parents separate; 1 will have experienced the death of a parent and 7 will have been bullied. (Faulkner 2011)

The NSPCC (2011) report based on findings from research in 2009 recorded that 1 in 17 children under 11 had experienced severe maltreatment; this rose to 1 in 5 aged 11-17. The important link to the current study is the conclusion that:

The strong association between maltreatment and poorer emotional wellbeing including self-harm and suicidal thoughts demonstrate the need for prevention and earlier intervention (2011, p.14)

Green *et al.* (2005) surveyed 7977 children with emotional, conduct and emotional disorders. They found that the incidence of self-harm within these groups was statistically higher than the general population. 28% of children with emotional disorders, 21% with conduct disorders and 18% with hyperkinetic disorders had self-harmed which suggested that their difficulties were causing them to feel out of control and under increased pressure. One of the other findings of this report was that children with emotional difficulties were three times more likely to have a specific literacy problem. This means that within schools where these disorders are being managed, ineffective provision and support can have a detrimental effect on teaching and learning.

The Prince's Trust (2012) stated that: 'Almost half of young people with fewer than 5 GCSEs graded A\* to C said they 'always' or 'often' feel down or depressed compared with 30% of young people who are more qualified. As teachers and teaching assistants are tasked with improving achievement for all then awareness of mental health issues is needed to tackle their low self-esteem and to work towards an improvement.

Other significant risk factors include: LGBT issues; having a specific learning difficulty, being a young carer, having a sensory disability, belonging to a minority ethnicity group and being a looked after child. The Children and Young People's Mental Health Coalition records that 60% of looked after children have a mental health disorder (NICE 2010). The report also includes Emerson and Hatton (2007) who claim that 30% of children and young people with learning disabilities will have a mental health problem, compared with 8% of non-disabled children. Guasp (2012) found that 2 in 5 gay young people who experience homophobic bullying deliberately harm themselves as a direct consequence of being bullied. Awareness of these statistics would surely benefit staff supporting pupils in these vulnerable groups.

Prever (2006) records that suicide is the third leading cause of death in young people after illness and accidents. This is a dramatic statement and at present the effect of cyber bullying leading to suicide is prominent in the press and has been the subject of research by among others; Hinduja and Patchin (2010) and Kowalski *et al.* (2012) Bullying policies and support systems in schools need to be proactive and reflexive rather than reactive following a crisis. In associated work Prever( 2004) found that as many as 10% of school aged girls experienced eating distress and some of those will then develop into an eating disorder. This is again linked to bullying and to promoting a positive and realistic body image within school practices and through PHSE and similar curriculum input.

It should be emphasised here that this is not just an issue for adolescents, although the rates of mental health problems increase as children reach adolescence. One major difference in the (Bostock, Kitt and Kitt 2010) paper was that the team from another Northern HEI considered the problem to be one for PGCE secondary ITT only. There are less studies with young children but a pilot into Early Years mental health for children with behavioural problems in pre-school ( Upshur et al 2009) found that: ‘ intervening at an early stage has been emphasised by a broad array of mental health and childcare professionals.’ (2009, p.29) This report summarises that in the US in the last decade studies conducted report a prevalence rate among 3-5 year olds, based on teacher ratings that range between 14 and 52% (Qi and Kalser 2003 p.29). Cole et al. (2008, p.141) refer to a published study which:

indicated that approximately 6-7% of Danish toddlers qualified for a psychiatric diagnosis of emotional, behavioural, or attentional disorders on the basis of two recognised classification systems.

In the UK the Mental Health Foundation (2007) published; *The Fundamental Facts*, which found that between the ages of 5 and 10 the prevalence of mental health conditions, was 10.4% for boys and 5.9% for girls. These figures altered to 12.8% of boys aged 11-15 and rose to 9.5% of girls at the same age. This was reinforced by a National Statistics online (2004) publication entitled; *Mental disorders more common in boys*. The mental health foundation report, ‘ *Lifetime impacts; childhood and adolescent mental health* concluded that children from single parent families, are twice as likely to have a mental health issue than those from two parent families. Also children from large families; children from poor families and children living in

social housing are statistically more likely to be affected. (2004, p.6) Other important factors are that looked after children are five times more likely than their peers to have a mental disorder. 40% of young offenders have been found to have a diagnosable condition. (DoH 2004) Children as young as five are being treated for anxiety and depression and NHS Solent Clinical Psychologist Barbara Inkson reported in 2012 that:

Mental health workers in Sussex are working with about 330 under 11s with anxiety and depression. (2012, p.5)

The Mental Health Foundation (2011) produce online statistics and point to some growing statistics which have a direct impact on teaching and learning. E.g. the UK has one of the highest rates of self-harm in Europe at 400 per 100,000 of the population. People with current mental health problems are 20 times more likely to report having harmed themselves in the past. These particular UK examples suggest that there is a need for awareness of mental health issues for teachers across the key stages and into adult education.

Night Terrors are estimated at between 1 and 6 per cent in children in the Diagnostic and Statistical Manual of Mental Disorders. An estimated 10-50% of children suffer from nightmare disorder and sleepwalking affects around 5 % of children but certain episodes affect up to 30% of children. Linked to Maslow (1943) it is possible to consider the effects of sleep disturbances on teaching and learning and these conditions are obviously also linked to anxiety.

Other conditions which are of growing concern are ADHD which according to the *Rethink Mental Illness factsheet* affects 3-9% of school aged children and young people in the UK and about 2% of adults worldwide. Panic disorders are estimated to affect seven out of every 1000 people and prevalence among all age groups and across gender is roughly the same. (counselling directory online) Phobias are an irrational fear of an object or situation and ONS postulate that 1.9% of adults in Britain experience a phobia and women are twice as likely as men to be affected.

The next section will consider current literature around mental health issues in schools and how using a whole school approach has been beneficial in managing issues and supporting learning.

## 2.2 The management of mental health issues in schools

It is necessary to consider that this investigation crosses the boundary between health and education. There has been a recognition of the need for a multi- agency approach to topics which have medical roots but also impact on teaching and learning. The wider notions of disability and inclusion have taken the approach of schools being visited by peripatetic experts to offer guidance and support to both staff and pupils across a wide range of issues .Greenberg *et al.* (2005) evaluated a range of interventions in American schools and concluded that:

..for school age children the school ecology and climate should be a central focus of intervention. (2005, p.12)

Dave Finney (2006) manager of Calderdale's CAMHS, explained that in Britain seeing schools as therapeutic agents and as an ideal place for interventions is probably overstretching the boundaries of the school's role .He points out that:

The school as a site for mental health work appears to be an enlightened rather than a radical proposition yet there are often cultural and systemic barriers to implementation. (2006, p.6)

This thesis is advocating awareness- raising which is specific and targeted towards teachers and other educational professionals and para- professionals. It is not taking the position that teachers and others need to become part of the treatment programme for children and young people but is postulating that awareness will lead to confidence in recognising, supporting, developing classroom strategies and referring on to appropriate CAMHS colleagues.

This section of the literature review looks, in light of this premise, at studies which have considered the management of wellbeing within a school environment. The chapter considers international perspectives and advice and guidance available to schools in the UK. The starting point could be to consider that there is no global policy on CAMHS (2004) and Shatkin, Myron and Belfer (2004) propose that,

Child and adolescent mental health policy in developing and developed countries is essential for the rational development of systems of care for children. (2004, p. 104)

It is useful therefore in this chapter to look at developments and policy from other countries and to critically analyse the current UK policy of No Health without Mental

Health.( DoH 2011) Moving from an international perspective, down to a national perspective and then to the management of wellbeing within individual schools and systems will meet the second of the proposed reasons for ITT staff and students to be aware of mental health issues and that is that teaching and learning has an affective element and a direct impact on the wellbeing of children and young people. Therefore to maintain and / or promote positive wellbeing the school and teachers in Tier 1 of the national framework need to be aware of strategies and practical applications which are proven and tested. This section will start with an international perspective. Felver –Grant and Levi (2011) review an American publication about school based mental health services. They begin from the premise that childhood and adolescence is a time of difficulty and far greater rates of mental health issues will be noticed during these transitions. They therefore postulate:

Professionals who provide services for children and adolescents are in need of evidence based interventions to address this growing problem. (p.1)

And that:

Given their access and reach school districts have the unique opportunity to identify, prevent and provide interventions for children and adolescents. (2011, p.1)

The premise of this thesis links with other researchers who have also concluded that staff working in schools need specialist input about mental health. Rothi *et al.* (2008) consider that schoolteachers need to see their role as a holistic enterprise and to consider the 'whole person'. They conclude that to help all pupils, including those in distress they will need specialist intervention.

*Truth Hurts; a Mental Health Foundation report* (2006, p.7) concludes that:

A strong theme in the evidence presented to the report was the need for school staff and others working with young people to have a much better awareness and understanding of self-harm.

*The Mental Health Handbook for Schools* (Atkinson and Hornby 2002) also considers there to be a need for help for teachers in this area. In its preface they consider that:

in addition our experiences in the early days of our teaching careers led us to believe that many mainstream teachers lacked awareness of children's mental health problems and at times, even experienced teachers felt out of their depth when confronted with pupils with such problems.( 2001,p.1)



In the findings section this view will be discussed in light of pertinent interview and questionnaire data.

Ofsted (2005) cited in Rothi *et al.* (2008) notes that,

a large number of schools in the survey were not working towards the standard,'(p8) ' training for staff on mental health difficulties was found to be needed in three quarters of the schools;' 'multi-agency working was unsatisfactory in a quarter of schools.( 2008,p.1)

Prever (2006, p.xii) concurs and he suggests that:

Many professionals working in schools will recognise that they feel helpless and deskilled when confronted with young people who are self-harming, socially isolated, withdrawn or behaving in a way that causes distress at home and in school.

The above three quotations add weight to the argument at the heart of this thesis that specific and targeted mental health awareness would benefit those working in the children's workforce and lead to teachers feeling empowered to manage conditions rather than just refer pupils. This is backed up by Green *et al.* (2005) in a paper entitled; *Promoting the Social and Emotional Health of Primary school- aged children* which suggests that:

Whole school approaches to the promotion of social and emotional health implemented over years appear to be more effective than brief class based programmes aimed at preventing mental health problems. A whole school approach aims to include all relevant stake- holders including teachers, administrators, parents and community members in addition to setting out to change the environment and culture of the school. (2005, p.34)

Also in 2005 Weare and Markham identified 9 elements of a whole school approach:

1. A holistic model of health
2. Concerned with several aspects of the school
3. Consider environmental determinants
4. Works with all relevant parties and at all levels
5. Includes the caregivers( teachers and parents) as well as students
6. Exhibits congruence between the various parts
7. Promotes coherence, teamwork , 'joined up thinking' and multi-professional work
8. Focuses on processes as well as content and outcome
9. Facilitates the acquisition of different types of skills. ( Cited in Rowling 2009, p. 360)

There are several reports which suggest that the whole school approach needs to be lead from the top. Durlak and DuPre (2008) propose that:

to implement this approach, heads and senior staff need to be effective leaders and champion emotional and emotional wellbeing within the school. (2008, p.340)

Frabutt and Speach (2012) cite Skalsi and Smith (2006, p.15) who sum up the role of the head teacher as being able to:

listen to the pulse of the school, pay attention to the things that do not 'feel right' and build the capacity of staff members to react to specific situations in a calm, caring manner.

In direct contrast to this in 2009 the previous Labour government introduced the *Healthy Schools Agenda* which meant that training had to be made available to just one designated member of staff per institution. In some authorities this training has been made available through CAMHS but this is not commonplace and as Morgan (2007, p.6.2) points out:

for PHSE and emotional and social skills to be delivered effectively a whole school approach is required. These should never be seen as an individual teacher's responsibility.

Morgan's conclusion is that all staff need awareness raising and specific training rather than one named individual being nominally responsible for diagnosing, guiding and referring pupils appropriately across the school. If class teachers do not recognise and refer to the designated member of staff delays could cause the young person further distress. Powers (2011) postulated that a lack of specific training for classroom teachers on how to recognise symptoms of mental health issues was a barrier to allowing mental health issues to be dealt with effectively in schools. Rowling (2009) looks at this from a different perspective; that of teachers' mental health. She claims that, 'teaching morale is a mental health issue' and suggests that:

Acknowledging the wellbeing of staff along with the mental health and wellbeing of students creates a synergistic process in the school environment (2008, p.364)

This was a factor in constructing the semi structured interviews and the model making phase of this thesis and specific literature around staff wellbeing is considered in 2.3

Graham et al. (2011) conducted a pertinent study into the views of teachers about supporting mental health in schools. They suggest that:

The paradox seems to be that whilst accredited pre-service programmes are intended to prepare graduates for working with a diversity of children and young people in a range of contexts, an increasingly narrow curriculum focus in teacher education limits the scope of what can be achieved. Teachers often begin their careers then feeling somewhat ill equipped for the complex realities of contemporary classrooms. (2011, p.481)

This is directly linked with the current study which is also suggesting awareness-raising for all trainees and not just for those who have a leaning towards pastoral elements of the curriculum.

Bostock, Kitt and Kitt (2010) go to the heart of this issue by suggesting that it is while PGCE students are still studying and learning about the facets of their role that they are best placed to undergo mental health awareness training. The researchers found that teachers in schools were more resistant to the notion of Tier 1 responsibilities than the PGCE students were. They also surveyed the previous year's cohort who were undertaking their probationary year and found that increased confidence around the issue after the training was maintained even after a year of leaving the university. Bostock, Kitt and Kitt (2010) summarise that:

The findings present strong arguments in favour of incorporating mental health training into the PGCE curriculum. The need to prepare PGCE students for this role (Tier 1 CAMHS) and the longer term impact of such training on levels of confidence were also demonstrated. (2010, p.1)

Sweeney (2003) studied the effects of mental health on teaching and learning in an FE setting. She concludes that:

an inclusive learning environment for learners with mental health problems needs to be developed, monitored and maintained.

She continues by suggesting that the way to achieve this aim could be summarised by the:

... need to ensure that its (the institution's) staff development programmes offer awareness raising for all staff (managers, tutors, administrators) regarding effective strategies in dealing with learners with mental health problems. (2003, p.40)

The Children and Young People's mental health coalition concur and suggest that:

Supporting staff's emotional health and wellbeing can lead to reduced sick leave, increased motivation and staff retention.

In the Mind Matters; Whole School Matters (2010) report from Australia, which is a world leader in this work, the introduction aligns with Sweeney when it considers that:

In a school setting the mental health and wellbeing of individuals and the whole school community are both important. (2010, p.7)

This report links sections 2.2 and 2.3 of the current study in its summary that,

Increasing staff understanding of mental health and wellbeing helps to build staff wellbeing within schools. Expanding staff capacity increases staff ethos, understanding and empathy for students. (2010, p.10)

In the WHO model (1995) (see appendix 8) the starting point for a, 'creative environment conducive to promoting psycho-social competence and wellbeing' (p.12) is shown to need whole school involvement. The second stage of the model proposes that all students and teachers are involved in mental health education-knowledge, attitudes and behaviour. This may seem an idealistic approach but for the 20-30% of students who then need additional help and especially for the 3-12% of students who need professional treatment, it is imperative that a whole school approach is adopted. Students could choose any member of staff to make their disclosure to and in the Truth Hurts (2006) study many participants recorded that the response from staff to disclosures was often negative and that feelings of rejection and not being understood were common. Nind and Weare (2011, p. 8) sum up the importance of teaching staff being most effective when they claim, 'we want interventions to get to the heart of the school process...' in their review of Mental Health. Specialist staff are seen as less effective so this suggests that all teachers ought to be equipped to carry out interventions and ought to be prepared to be the first point of disclosure.

I agree with Daniels (2006) who argues that a:

radical culture shift is needed among professionals so that more sophisticated models of working, which can assist holistic multi agency assessment and intervention, are provided. (P.149 cited in Hackett *et al.* 2010)

The current thesis may record data which refutes this claim if awareness is already in place and students and staff on ITT programmes are prepared to work with professionals in the other tiers of the national framework.

Daniels' work is cited in a paper which considers the greater incidence of mental health issues amongst pupils who have additional social, emotional and behavioural needs. Rose et al. (2009) highlighted the particular difficulties for staff in separating out the mental health issue from other diagnosed conditions e.g. ADHD and they found that:

teachers felt ill prepared and anxious about how best to identify and meet the mental health needs of this population. (2009, p148)

It could however be argued that the culture shift that Daniels is calling for might be easier to achieve in specialist provision where individual learning plans are routinely used rather than in mainstream where all additional needs have to be met in the busy classroom with class sizes of 30+. It also seems possible that there will be a difference in approach from staff in primary settings to that of staff in secondary settings.

Paulus (2009) published *Mental Health- backbone of the soul*, which I found highly influential in guiding my thinking around this chapter. He considers that:

results show that mental health and achievement in schools affect each other positively and that it is therefore worthwhile investing in maintaining and promoting positive mental health. (2009, p.292)

He postulates that:

for children, mental health means having the ability to come to terms actively and successfully with the age and socio cultural typical conditions in which they find themselves, (2009,p.290)

Summarising what this means for schools, Paulus (2009) suggests that:

Mentally healthy school children can deal constructively with the regular cognitive challenges posed them by the curriculum in the classroom. They understand what the lesson is about, what they are being asked to do. They are able to make their ideas heard in the classroom and feel they have a contribution to make. (2009, p.290)

These definitions of mental health in such a positive light could be instrumental in preparing student teachers for the needs of all the pupils in their classrooms. This

definition could be added to the curriculum for PGCE and be linked to classroom management and planning, to assessment for learning strategies and to behaviour management theory. Obviously to achieve this, 'Mentally healthy' status for all pupils, schools will have to be aware of mental health needs and to ensure that the learning environment is able to meet them. Paulus (2008, p.4) postulated that the way to create a 'good, healthy school' was to produce schools that used 'health related interventions' to improve quality. All staff, including teachers would have to be involved in whole school initiatives therefore if the positive view of mental health linked to achievement is to be attained. However Garner (2010) considered the difficulty of this:

The idea of teachers as agents of emotional socialisation has received limited research attention. (2010, p.310)

Hargreaves (2000) emphasised that, 'School is an environment where the arousal of strong emotions occurs'. He continues...

Like parents, teachers experience a range of emotions in response to their students' performance and behaviour; including worry, disappointment, hope, enthusiasm and pride. (cited in Garner 2010, p. 310)

It seems possible then from these statements which urge a realistic consideration of the evidence, that we could infer that even with mental health awareness training teachers may be held back from promoting positive mental health and supporting those with mental health issues by a range of negative emotions and fears. The issue of stigma will be considered at the end of this chapter as an additional factor which might have a negative effect on teaching and learning.

Nind and Weare (2011) are proponents of the whole school approach to mental health and believe that active promotion is the way forward for schools. They consider 'the school is a unique resource for mental health promotion in children and adolescents.' (p.2) Discussing mental health promotion and prevention in schools across Europe they reiterate that:

The characteristics of more effective interventions included focusing on positive mental health, balancing universal and targeted approaches, starting early with the youngest children and continuing with the older ones... whole school approach combining social skills development, curriculum, teacher training.... (2011, p.4)

Obviously the inclusion of teacher training links directly to the purpose of this thesis.

Best (2007, p.249) is in agreement with Weare and feels that the key to success involves the pastoral care element of schooling through which, 'schools should not limit their activities to the transmission of knowledge but should educate the whole child.'

This also has direct implications for the question being asked in this work as to whether teacher trainees need awareness of mental health issues.

A further view on the role of pastoral support is provided by Sarah Teather, (former Minister for Children and Families) who is reported by the Children and Young People's Mental Health Coalition to have said that:

Emotional wellbeing lays the foundation for adulthood, and ensures young people are able to participate fully as adults. It is vital that schools feel confident to play their part in both pastoral support and early intervention activities. (p.2)

This section has considered the positive implications for practice of having a whole school approach to positive mental health. The international and UK studies concur that if all staff and pupils are part of a cross organisational approach to the issue then it is more likely that the school will succeed in meeting the needs of individual learners and supporting staff. The link between this positive intervention and attainment may provide a necessary incentive for encouraging the inclusion of mental health awareness raising and on-going training within the profession. The following section is related to the ITT trainees and their tutors as perhaps the most pressing of the three reasons that I have put forward to be aware.

### **2.3 Stress within the teaching profession.**

This section discusses policy and research related to the stress experienced by teachers and other educational professionals and considers the third suggested strand of awareness raising; teachers need to be aware of their own wellbeing and promotion of positive mental health amongst ITT students and staff towards a positive impact on practice for themselves, their learners and their colleagues.

Bowers (2004) concludes his report into *Stress Teaching and Teacher Health* by stating that:

The educational context is a key trigger for mental health and promoting wellbeing requires action to address the systematic causes of stress and poor mental health. (2004, p.79)

This has implications for ITT courses and the preparation of trainees for practice.

Another important conclusion from Bowers which has direct impact on this thesis is his consideration that:

The acute pressures arising from the school accountability regime and school inspection has a profound impact on teachers' work and on the quality of their working lives. Teachers who have experienced mental health problems at work commonly experience a psychological conflict between their preferred role identity and their values as a teacher, and the narrow and conflicting requirements of the job, (2004,p.78)

We are preparing student teachers to enter a profession which will have a negative impact on their wellbeing at certain times and during certain processes. This thesis suggests that we need to give student teachers specific and targeted awareness raising opportunities to better prepare them to enter and remain within the field.

This chapter will consider stress as an issue for teachers and investigate the links between stress and teacher burnout. An important starting point in considering the implications of the profession for the mental health of teachers is the work of Holmes (2005) who considers that:

Those who are not on top of who they are emotionally, what affects their emotional wellbeing and how to move themselves towards rebalancing their emotional life are clearly not equipped to help others to do the same. (2006, p.11)

This is an important consideration for this thesis and for the roles of teachers in relation to the national framework as it creates a direct link between the wellbeing of staff and their impact on the wellbeing of pupils. Holmes is suggesting and I agree that the emotional wellbeing of teachers is thus necessary to ensure that they can work with pupils who are experiencing problems. Weare (2005) sums up this consideration;

The... need to focus on mental health is not simply to add another demand to a teacher's already impossible workload: effective social and affective education is directly beneficial to academic attainment and can therefore help teachers to be more effective. (2006, p. 6)

This links directly to a facet of the current thesis as one of the research questions was around the difficulty of introducing further input to an already bulging scheme of



work which covered a detailed and complex curriculum. Initial response to the research proposal was simply that there wasn't time to introduce this topic and as it had a less solid link to the standards for teacher training then it would not be given priority. Ofsted (2012) in the Schools Inspection Framework refer to behaviour and safety of pupils in the school as one of the key judgement areas for Ofsted inspections. The Children and Young People's coalition for mental health consider that:

Providing support for young people with behavioural and emotional difficulties and supporting their emotional and mental wellbeing will help demonstrate that your school is actively working to improve this element of the Ofsted inspection. (2010, p.11)

This link to the standards will be considered further as part of the findings chapter.

Kretschmann (2000), Hillert and Shmitz (2004) postulated that staff need to learn how to deal with stressful situations both in and out of work and to keep the impact of such situations on students to a minimum. I would suggest that this applies equally to trainee teachers as they are entering a stressful profession whilst balancing the needs of an intense year of study. Thus I agree with their conclusion that:

Empowering teachers becomes an important means for not only promoting students' mental health but also for benefitting staff. (2004, p.67)

This viewpoint needs to be communicated to staff and ITT students to encourage them to consider mental health issues and their effects on teaching and learning as staff may need to see the personal benefit of this consideration before they engage with awareness-raising around their own mental health which will have as a by-product a positive impact on their students and colleagues too.

Garner (2010) considers the issue of burnout for teachers and particularly links this to pre service staff. The link to this thesis and the PGCE students who were participants is therefore pertinent. I concur with Garner's opinion based on the work of Chang (2009), Brophy (1998) and Meyer (2009) that:

Although younger teachers have the greatest propensity for burnout and teachers who understand their students' emotions may experience fewer feelings of burnout, pre-service teachers report that they receive very little training about how to develop social and emotional skills in students or about how to manage their own feelings and external displays of emotion. (20010, p.310)

Managing stress therefore can affect teachers' ability to employ positive strategies in the classroom and it is likely as this thesis postulates that managing their own wellbeing will be an important facet of teacher training for our trainees.

Positive teacher emotions are associated with the use of effective teaching strategies whereas high levels of negative teacher emotion appear to impact teachers' motivation to teach and students' ability to learn.... Competent teachers therefore attend to their own emotions as well as those of their students (Garner 2010 p 310)

In *Mind Matters* (2010) there are clear statements intending to highlight the importance of staff having awareness of mental health issues. In fact the link is made between knowledge and understanding of mental health and the 'efficacy of their work with young people.'(p38) The argument is formulated that the basis of being able to act as 'role models' and to 'operate as confidantes' is inextricably linked to their attitude to mental health.(p38) The link to stress for staff and the stress caused by educational activity is summarised thus:

When school staff begin to understand mental health and wellbeing they begin to understand some of the stressors that are endemic within their profession and roles '... 'Education staff need opportunities to talk about their emotions or anxiety or depression as a prelude to how they operate in the classroom. Time for reflection allows staff to explore their attitudes and any stigma that may be attached to mental health issues for young people, themselves and others. (2010, p.42)

The *Mind Matters* report also includes statistics around teachers leaving the profession due to stress and burnout. They claim that in Australia 24% of the 25,155 new teachers employed in 2006 will have left by 2015. The report suggests that often the most able teachers are likely to leave and that 25-40% burnout in the first 3-5 years of practice. (p43) Although this introduces an international perspective and there may be other variables which are not considered in the report the argument that stress and not dealing with emotional issues leads to teachers leaving the profession is convincing.

A report by the NASUWT into Teachers' Mental Health summarises the extent of the problem of stress for teachers in the UK and confirmed that:

Stress and professional burnout among teachers in the UK has contributed significantly to an unnecessary and wasteful exodus from the profession.... It has been estimated that around one in three UK teachers find their occupation extremely stressful, two out of every three teachers have experienced work related stress and for one third of these teachers the result has been absence from work. (2010, p.2)

The most worrying finding of the above report was around school leaders and their management of employees with stress or mental health issues.

School leaders felt that the financial implications associated with providing additional teacher support were a barrier to providing support for teachers and the stigma associated with stress and mental health problems in schools was also identified as a major obstacle to providing early intervention and appropriate and timely management support. (2010, p.5)

There is an examination of the literature around stigma at the end of this section in 2.4

Rogers and Pilgrim (1997) recorded that lay people believed that social stressors were the cause of mental health issues but they also believed that the solution to an individual's issue lay within that individual and that there was not a wider societal responsibility to reduce stress.

In a study based in France Kovess- Masfety et al. (2007) take a European perspective and claim that:

.studies designed to compare teachers' mental health to that of other educational groups often describe a higher level of mental fatigue among teachers, i.e. psychological distress and burnout. (2007, p.1177)

This section has looked at the high levels of stress and attrition in the teaching profession both in the UK and internationally. The following section on the stigma surrounding mental health issues is an over- arching concern for all three previously discussed topics in this chapter. Stigma is an issue which came to light early on in the research process as I began to discuss with colleagues and academics from other institutions my plan to look at mental health awareness within ITT. At once I was reminded that this was, 'a sensitive issue', and some people made it clear that they would be reluctant to take part. The issue of the stigma attached to mental ill health which is not attached to physical ill health will be investigated here and will be returned to in the analysis of findings in chapter 5.

## **2.4 Stigma and mental health issues**

The particular issue of mental ill health is attached to stigma which is well recognised. Green *et al.* (2005) consider the use of alternative terminology and suggest :

.. adopting social and emotional well-being as an alternative to the term mental health, a term that is often equated with mental illness, (2005, p.31)

Campaigns like 'Time to Change; Time to Talk' maintain the terminology of mental health issues and problems but aim to reduce the stigma through discussion. Many celebrities have made statements/ videos/tweets around the issues they are facing with their own mental health to try to achieve an openness in dealing with the subject matter. Learners who feel isolated and misunderstood may not be able to continue with their studies and to reach their potential. Dearne Valley College and MIND embarked on a creative writing project with adults with mental health issues and they introduced their work with the statement:

We needed to challenge the pattern of disempowerment which is rife amongst people with mental health difficulties as society categorises this group of people and the stigma is often accepted by the sufferers themselves in their relationship to their own conditions.(1997, p.1)

This has important ramifications for those working in the field of education; already there is a power imbalance between teachers and learners but this could be further complicated by power imbalances affecting teachers or learners dealing with negative mental health issues. Stigmatisation can cause bullying and lower self-esteem which will affect teaching and learning.

Rogers and Pilgrim (2005) consider three strands of stigmatisation. People are considered to have a:

..lack of intelligibility, a lack of social competence and the presence of violence. (2005, p.158)

All three factors are linked to teaching and learning and could lead to a lack of communication and a breakdown of personalised learning.

City and Guilds (2010) produced a briefing note about Mental Health, Education and Training and they deal in detail with the issue of stigma to which they apply an international perspective. They claim the problem is 'universal' and that in many countries discrimination comes from within families and communities; in summary:

Stigma in relation to mental illness has a negative impact on equality and social inclusion, and therefore has implications for health protection. There is evidence that stigma has an effect on the course and outcome of mental illness and on the quality of life of the persons affected and their families. (2010, p.3)

The 2010 Prince's Trust Youth Index considers that this is an issue best dealt with in education and as early as possible with young children as they claim that in the early years is when children pick up their attitudes to mental health and therefore that by focusing on early years' intervention it should be possible to reduce stigma. They report that teenagers hold the most stigmatised views around mental health and research has suggested that an experiential approach is the most effective in reducing stigma.

This section has shown links in the literature to all three facets postulated in the thesis around awareness for staff and students needing to encompass; awareness of specific conditions, awareness of the teaching and learning process and awareness of stress and staff wellbeing. ITT students and tutors need awareness of specific conditions; their rates of incidence and the likelihood of stigma being associated with the condition. They also need awareness of how to challenge stigma and stereotypes and to dispel myths and misconceptions around mental health issues. They need an awareness of being part of a whole school policy to support positive mental health and lastly they need awareness of their own prejudices and means of working towards a more inclusive practice and awareness of how to deal with the prejudices and fear of others towards their own mental health issues within a stressful profession.

In the next chapter I will discuss the research design and the particular methodological approach adopted for this study.

## **\_Chapter 3 Methodology**

This chapter will present the methodology underpinning the research for this thesis. The question of whether there was a discernible need for awareness raising around mental health issues for staff and students was presented in Chapter one, under the research question: **What are ITT staff and students' perspectives on mental health as a barrier to teaching and learning?** This chapter outlines the methods chosen to provide answers to the research question and explains the theoretical basis for the decisions made about which methods would be utilised. The chapter provides a philosophical underpinning and allows the reader to share my particular positionality before summarising the ethical concerns which were pertinent to the thesis. The aims of the chapter can be summarised as:

1. To provide a clear theoretical basis for the research
2. To highlight the ethical concerns affecting the study and how these were mitigated as far as possible.
3. To explain the demographics of the research and to look in detail at the individual methods selected and provide justification for the choices made.
4. To outline the data collection process and to clarify how the data was prepared for analysis.

### **Research design.**

The diagram 3.1 shows the progression of data collection throughout the research. The thesis records the data from 3 distinct phases of research which took place over a 3 year period across 3 HEIs.

3:1

Phase 1 Questionnaires. Online to staff and students across 3 HEIs Mixture of Quantitative questions based on statistics around incidence and Qualitative questions asking for evidence of awareness and opinions.



Phase 2 Semi- Structured Interviews

Staff participants only.

Questions around responsibilities, referrals, placements and awareness.

30 minute duration

Phase 3 Model Making Focus Groups

Student participants only

To allow discussion around awareness and experiences

No set questions.

The first section of this chapter 3.1 introduces the ontology and epistemology underpinning the thesis. Section 3.2 offers a summary of the definition and demographics of the particular research. In 3.3 my positionality is summarised. 3.4 outlines methods of data collection and how these were applied during the research. Section 3.5 Considers the preparation and analysis of the data and finally 3.6 offers a summary of the ethical concerns throughout the research process

### **3.1 Philosophical approach underpinning the study.**

Ontologically I am adopting a naturalistic or constructivist position. I intend to look as impartially as possible at the lenses through which individuals see and interpret reality (Rubin and Rubin 2012). The study will try to map the positions and experiences of student teachers and their ITT lecturers, as it is accepted that meanings and understanding are plural and subjective. It could be argued however that there is also an element of pragmatism in my study as I have utilised multiple methods and my choices of method are ultimately focused on creating a study that best answers the question posed which itself has a focus on a practical outcome to the study.

In terms of initial and overarching design the approach that I have adopted in the study is phenomenological .Van Manen (1990) considered that this approach could lead to a description of the 'essence' or ' the very nature' of what was being studied. (p. 177). The study described in the thesis is considering the phenomenon of mental health awareness. Applying this theory to the complex concept of mental health awareness is a challenge because I am not considering the shared experience of ITT students and teachers of mental health issues affecting their own teaching and learning, although some participants made disclosures to me during all three phases of the study. Questions in all three phases were open to allow for the voice of the participant around their shared experience of mental health awareness Creswell suggests that,

to fully describe how participants view the phenomenon, researchers must bracket out, as much as possible, their own experience. (2007, p.61).

The qualitative questions in the questionnaire, the semi structured interview questions and the model- making process all allow participants to share their



experiences and the data produced should lead to opportunities to 'horizontalise' and then to form 'clusters of meaning' (Moustakas 1994).

This chapter will now consider the wider philosophical underpinnings of educational research. I agree with Pring who states that:

Issues which traditionally have concerned philosophers permeate every aspect of educational thinking. (2012, p.12)

and therefore I am applying a philosophical standpoint to the thinking around this study. It is possible to look at the research question from three philosophical standpoints. Broadly philosophical approaches can be considered as: analytical, speculative and prescriptive. **Analytical** philosophy requires consideration of the meaning of the terms being enquired about. In this instance, 'mental health', 'teaching and learning' and 'awareness- raising' could be terms which are liable to be misunderstood or could have a variety of associations which affect their meaning. **Speculative** philosophy would be concerned with the wider overarching questions e.g. what is the purpose of education? What values underpin the system of education and how do these translate into action for learners or teachers with mental health issues? Also, is there a definite causal link between education and mental health issues? A prescriptive philosophical approach would consider how teaching and learning and mental health should be managed to ensure the best outcome for both teachers and learners. **Prescriptive** philosophy should be evident in policy which is drawn up to provide guidance on best practice. Each of these approaches will be applied to the question of whether ITT courses should contain specific targeted mental health awareness raising to give a philosophical underpinning to the methodology applied during the research.

The starting point for this philosophical consideration will be an analytical attempt at finding a working definition of the term 'Mental Health' which will be used throughout to inform the study. The definition will have an impact on the data collection methods chosen and on the presentation of data within the thesis. I propose that in the awareness raising materials, which will be disseminated to participants following completion of the study, to define mental health in positive terms rather than use a definition from a medical model perspective which could reinforce stereotypes and

misconceptions. A possible definition of mental health, is provided by Paulus (2009) who considers that,

It (mental health) is a positive concept, displayed in the ways people meet the challenges of their socio cultural contexts constructively and the way in which they are able to include their own interests and concerns in the life they lead. (2009, p.290)

This is in stark contrast to the stigmatised view of mental health 'disorders' and 'difficulties' which is couched in medical language and is probably what people think of immediately when the topic is raised. Wells *et al.* (2003) adapted the Mental Health Foundation (2001) definition to claim that the definition of positive mental wellbeing involved:

.. self- confidence, assertiveness, empathy, the capacity to develop emotionally, creatively, intellectually and spiritually. The capacity to initiate and sustain mutually satisfying personal relationships and the capacity to face problems, resolve and learn from them. To use and enjoy solitude, to play and have fun, to laugh at oneself and at the world. (2003, 197)

These positive definitions are my preferred starting point for awareness raising and thus they will be shared with participants in the research in the pack of awareness raising materials that will be developed as an outcome of the project. These materials will form the basis of an attempt to dispel myths about mental health and to promote the notion of positive mental wellbeing rather than mental illness. Both definitions above were important in my decisions about appropriate methods for the research because only qualitative methods would allow participants to share their own definitions and opinions. It was vital that negative definitions and associations could be shared and that there was an opportunity, post research, to provide a more positive definition which could be used to move understanding forward.

A speculative approach to the topic of this research demands that I consider the underpinning values of education as a whole. Current school policy has been criticised for having too strong a focus on academic success rather than an holistic aim with regard to pupils' spiritual, moral and physical development as enshrined in the National Curriculum. The *Equality Act 2010* places a legal obligation on citizens to not discriminate against people by virtue of their protected characteristics and this is then written into policies at a school level for equality and diversity, anti- bullying and safeguarding. Values which currently underpin schooling could however be

considered to be based on capitalist ideologies as the market is encouraged into setting up of free schools and academies. School selection criteria and processes for deciding where children are schooled are open to scrutiny and some unfair practices have been uncovered. It could be that pupils who have a mental health issue could be seen as problematic and undesirable by admissions tutors for the school and that pupils who are more vulnerable to developing mental health issues; such as those in the looked after system or from areas of particular deprivation would be less likely to be successful in acquiring a place in the school of their choice. It is possible too that selection criteria and interviews in HEIs for ITT courses could see mental health issues as an issue in terms of fitness to practice. All these issues can only be interrogated using qualitative methods and questions about fitness to practice were included in the Phase 2 interviews to ensure that this topic was considered.

Prescriptively there is a need to suggest how best to manage the topic of mental health awareness for teachers in ITT and trainees themselves. Policies which impact on practice in this regard would be the *Equality Act (2010)*, *The National Framework for Mental Health (2004)*, *ECM (2003)* and *SENDA (2001)*. The current study attempts to measure awareness of pertinent policies and the extent of coverage within the current curriculum of each of these policies. Also it must be considered that policy may not always lead to best practice and ITT trainees and tutors need to critically evaluate policy and seek to influence future policy changes. The element of policy which underpins the thesis is the preparedness of student teachers for their Tier 1 responsibilities. The method chosen to gauge preparedness is the questionnaire which combined quantitative and qualitative types of questions to allow participants to firstly say whether they were aware of the National Framework and then to go on to discuss their preparedness for this issue in longer answers.

This section has summarised the philosophical underpinning to the study reported in the thesis and the chapter will now consider the specific definition of research and the demographics surrounding this particular study.

## 3.2 Research Definition and Demographics

### Definitions of research

This section will consider some definitions of what research might involve before distilling the discussion down into technical areas around specific methods and approaches to this particular project. I align myself with Rubin and Rubin (2012) and plan to be a 'respectful listener or observer of other peoples' worlds who recognises that her own slant affects what is learned, is less authoritative in write up and leaves more room for participants' contending and overlapping views.'(p.23). This quote encapsulates a view of the sort of researcher I want to be. The next consideration is around definitions of the research process itself so it might be beneficial to begin by identifying various definitions of research; Thomas (2009) claims that research is about, 'disciplined, balanced enquiry conducted in a critical spirit'. (p.13) It could be contestable that the planned project is 'balanced' because of the insider nature of the research and the underlying interest in the topic which suggests a definite bias. The 'critical spirit' of the enquiry might overcome this and the commitment to reflective practice and to allowing the results of research to surprise could also suggest a balanced approach. Other definitions might also be applied; In the introduction to Research Methods and Methodologies Coe (2012) suggests six elements which are recognisable characteristics of educational research. That it is: 'Critical, Systematic, Transparent, Evidential, Theoretical and Original.'(p.10-11) Several of these characteristics are controversial and there is a lack of emphasis on ethical concerns which might be considered within transparency but are not clearly specified.

'Systematic implies linear and although the plan, as discussed on page 2 of this chapter, was to conduct three distinct phases of research, in a linear manner, this in reality seldom happened. Instead participants were: not available; were out on placement; wanted to wait until reading week and many other events prevented the systematic application of the plan. Some interviews from phase 2 happened earlier than some responses to the phase 1 questionnaires and so it has to be concluded that the three phases were three approaches to collection of three data sets rather than being always consecutive. The attempt to be transparent is a strong feature but it must be said that the report of positionality in 3.3 is my own social construction and as such is obviously subjective and might not be 'truthful' in all its claims. Evidence has been collected but it is qualitative in the most part and again the reader relies on

the veracity of the recording of data from all phases. Originality is an issue because research with a similar focus was published (before my own study was completed) Bostock, Kitt and Kitt (2010) The originality that can be seen therefore is about asking the question of HEIs not involved in previous research and from asking course tutors and leaders about the curriculum as well as asking students on their programmes. The other original feature is that this piece considers the importance of awareness for PGCE students on Primary and FE programmes whereas the 'Why Wait' (Bostock, Kitt and Kitt 2010) paper considers only secondary teachers as needing to be aware. This study also suggests three distinct arguments for awareness raising.

One of the chosen definitions for this study is taken from Clough and Nutbrown (2012) 'All social research sets out with specific purposes from a particular position and aims to persuade readers of the significance of its claims. These claims are always broadly political.' (p.4) It is clear that the purpose of my study is to discover information about the level of awareness of participants on PGCE courses. My position is clearly stated and the link between health and education is proposed as one that can be accommodated. The detailed account of the research findings and process attempt to persuade the reader that conclusions and recommendations have a sound basis linked to appropriate theory and practice from a range of perspectives. The political element is in proposing changes to practice which always have a cost implication whether in money, time or both and which often need to be driven by a top down initiative. Again the lack of a specific mention of ethical underpinning is missing from this definition although the text exhorts researchers to consider the ethical implications of each section and to 'maintain a careful transparency around their work and diligently report all aspects of their studies, analysing data and reporting findings faithfully.' (2012, p.22) Nixon, Walker and Clough (2003) consider Bourdieu's insistence that 'criticism and watchfulness are required' and they add the proviso that these must both consider the specific research and look at the 'world' of education in which the research will be accepted.

The planned research could be categorised as mixed method research as there is an element of quantitative measurement in Phases 1 and 3. Biesta (2012) considers that the mixing of methods may just be a matter of pragmatism and not a principled decision. When dealing with human participants pragmatism definitely has a place in research because without access and compliance there would be no data. To

suggest a lack of principles however is not acceptable to me, as the author of the study, because that could suggest a lack of ethical and theoretical awareness which is not the case.

Greene *et al.* (1989) suggested 5 purposes for mixed methods: 'Triangulation, complementarity, initiation, development and expansion'. (p. 56 ) There are elements of these purposes in the design as the quantitative sections of the questionnaires are an initial attempt at collecting data which is broadly comparable and can then be complimented by the deeper, richer data from the interviews. The work undertaken for this study meets the definition of Johnson et al (2007, p.12) who summarise mixed methods as:

... the type of research in which a researcher combines elements of qualitative and quantitative research approaches for the broad purpose of breadth and depth of understanding and corroboration.

Foreman-Peck and Winch (2010, p. 103) suggest that quantitative data might be useful in outlining a need or a problem which then could be followed up in a qualitative light through focus groups and questionnaires to present possible explanations and theories . The planned phasing of the project meant that the results of the questionnaires could highlight a perceived lack of awareness and possibly requests for changes in practice which then could be further probed during phases 2 and 3. Although some questionnaire responses were collected later than planned there were enough early responses to move on to phase 2.

The research question looks at awareness in the first instance across a range of participants who are merely asked to select from multiple choice questions around statistics. The follow up interviews and focus groups allow for a deeper and richer data set to be compiled which starts to ask subsidiary questions. Some of these are:

- Do the PGCE (Primary, Secondary and FE) and the BA (Primary and Learning Support) curricula embed mental health issues or teach them explicitly?
- Is mental health awareness and understanding of Tier 1 responsibilities best gained during preparation for placement or through CPD once qualified?
- What are the views of ITT tutors about raising awareness?

- What are the views/ thoughts/ feelings of ITT students around mental health issues and teaching and learning?
- Is there any input from CAMHS into the ITT curriculum?

Having considered and justified the research plan the groups who participated in the research will now be outlined and specific features of the participants will be highlighted.

### **Selection of sites, participants and research demographics**

In order to answer the questions listed 3 HEIs were selected. One is my own institution, one a midlands university college and finally a teacher training based university. Access was managed through known named members of staff in all 3 places. The numbers of participants was difficult to estimate because access was only guaranteed to approach the staff and students and as all participation was through self- selection it could be that the respondents would have been predominantly from one or more institutions and there would not be an equal representation from each place. **In Phase 1; the questionnaires** 189 responses were received to the initial questionnaire which was administered online via the Bristol Surveys online portal. This was considered to be an adequate number to progress with to the following phases. **In Phase 2; interviews** 8 staff interviews were conducted, with at least one participant from each institution. **In Phase 3; model-making focus groups** I conducted three focus groups with approximately 6 students in each, one per institution, resulting in the students making 16 creative representations of their views/feelings about mental health pertaining to teaching and learning. One member of staff disclosed a specific interest in mental health due to managing a diagnosed condition and it could reasonably be inferred that the questionnaire responses and models from students in that tutor's group might have evidenced greater awareness due to a new awareness raising session that had been added to their curriculum. Another staff member who was interviewed focused for her group on the third stated reason for awareness; the wellbeing of teacher in a stressful profession. The curriculum for this group was the same as for all other PGCE groups within her institution but extra material, strategies and coping mechanisms were introduced to students in this particular group throughout the course which again could have affected their results. The anonymity of the

questionnaires and the focus groups however meant that there was no way to match up the responses to the institutions and so the notion of matches can only be inferred. Other demographic issues which could have affected the results were: the lived experiences of staff and students; the incidence of mental ill health in the sample; the incidence of mental health issues affecting the cohorts within the placement schools and the content of the curriculum across the 3 institutions with regard to mental health awareness raising.

Having considered the specific groups of participants the following section attempts to capture my position with regard to the research and the participants.

### **3.3 Positionality: Matching the researcher to the topic.**

Nixon, Walker and Clough (2003, p.13) consider that,

We are ourselves positioned by virtue of our class, gender, race, sexuality and so on. Neither we nor the subjects we seek to understand are blank social slates; we are embedded within particular biographies and the communities from whom we take our identities.

The topic of my research crosses a boundary between health and education which is wholly appropriate to my personal career path. Having worked in Psychiatric medicine as a pharmacy technician my interest and knowledge around mental health grew. I trained new technicians and pre- registration pharmacists and enjoyment of this aspect of my work above others led me to change direction and to pursue a career in teaching. Making sure that people have adequate and specific training to meet their needs and positively impact on service users has been an element of both careers and using continuing professional development to maintain quality and improve standards has been at the forefront of my work and study. The motivation for planning this research is based on my commitment to individualised learning and the belief, based on experience, that

I strongly concur with Prever (2006, p.5) when he surmises that;

..any failure to address mental health issues in school will affect pupils' capacity to learn effectively.

It seems strange that other issues e.g. social deprivation have led to major changes in provision of services. Breakfast clubs, for example, are commonplace as practitioners have understood the impact that deficiencies in nutrition can have on



concentration. Dealing with anxiety or a compulsive disorder would just as obviously have an effect on learning and concentration but provision to deal with this is sparse.

Peter Wilson, Director of Young Minds considers a fundamental issue which needs to be addressed. He says,

Mental health and education these are words and concepts that have over time rarely sat comfortably with each other. (In Atkinson and Hornby 2002 p .6)

I was aware that my own study might uncover reluctance, by ITT students and staff, to take part in specific, targeted, awareness- raising activity over the issue of mental health affecting teaching and learning if student teachers and their tutors did not recognise this as being part of their professional role. It is possible that the notion of one named person in each school as being responsible for all aspects of safeguarding will influence the participants and they will assume that mental health awareness just means being ready to refer learners who display behaviour which is of concern.

Weare (2001) explains why she thinks that professionals from the two areas of health and education view mental health differently;

Mental health professionals are concerned with the individual, troubled, troublesome and SEN whilst teachers are concerned with developing students' intellectual, logical, technical and sometimes creative powers but rarely their emotional. (2001, p.34)

This is an interesting perspective as, if Weare is right then teachers are not going to recognise mental health awareness as being of importance to their practice and indeed may even see the topic as detracting from their already full quota of responsibilities in developing all Weare's listed aspects in their learners.

Rothi *et al.* (2008) found that teaching staff were only able to identify potential problems in pupils by applying a 'deviancy model'. Teachers use their experience of normative behaviour and spot deficiencies in rule following. (p.1225)

This may fit in with the notion of only referring if behaviour is unexpected or if learners can't, or won't conform. These quotes suggest that there will be reluctance to incorporate deeper investigations into mental health awareness as staff are going to consider that their remit doesn't cover this medicalised world and that it will detract

from the important, subject specific pedagogy which needs to take precedence due to the assessment, target driven nature of education.

Prever (2006, p.6) contests that:

Positive terms, such as 'mental health' have not always been employed by school based professionals who traditionally have worked from a different frame of reference using the currency of 'behaviour problems', 'dysfunction' and 'disaffected.'

This semantic dichotomy would suggest that interface between teachers in Tier 1 and mental health professionals in tiers 2-4 might be difficult as educational professionals may not feel equipped with medical terminology and CAMHS staff may feel divorced from school based activity.

This issue of language and attitude is at the heart of my commitment as a practitioner to individualised learning and inclusion. In my practice as a psychiatric health care professional I quickly needed to reframe the concept of 'normality' and 'normal behaviour'. It was apparent that as patients learned to manage their condition/ medication/ treatment, to see their behaviour as abnormal or in any way deviant would not lead to providing them with holistic support.

When inclusive practice was introduced into FE with the policy based on the Special Educational Needs and Disability Act (SENDA 2001). The requirement was for colleges to make any 'reasonable adjustment' to ensure that students with difference were treated equally and fairly. I was involved in writing and delivering staff development sessions to colleagues around college explaining the implications of the new legal requirements. Often people spoke about their 'normal' group for GCSE or A level and I found this an unhelpful concept on which to build an inclusive practice; planning for the 'group' means that staff might not have been able to see the needs of individual learners. This means also that differentiation is more difficult to achieve. The issue of attitude is important as staff may well consider as, 'other' anyone displaying behaviour/ needs which were not usual to the group. The danger is that those perceived as 'other' might easily become isolated and could face rejection.

Rogers and Pilgrim (1997) studied lay views around mental health and found that people could not construct a positive view of mental health and that there was a focus on deranged and dangerous behaviour. They suggest that the term still

provoked visions of madness and psychosis and that the most common element of mental ill health, depression, was not an initial association. This is in stark contrast to the positive definitions of mental health introduced on page 45. It seems to suggest that there is a need to combat the negative associations and focus by offering a more positive emphasis. This is the basis of the plan to provide an awareness raising online pack of materials to all participants following the research.

It is not desirable for teachers to become mental health 'experts' and in no way is this thesis suggesting that as an outcome. The pressure of the curriculum and the testing/inspection regimes in place constrain staff and make time for professional development limited to topics which are essential to the running of any school. It seems possible though, that not providing specific training or opportunities to discuss strategies for breaking down this particular barrier to learning might in practice cause teachers to miss an opportunity to strengthen their skills and that giving teachers confidence in managing behaviour in the classroom and making referrals to other professionals will mean that all parties are suitably supported. It is also necessary to guard against the danger of labelling and referral being the only strategies that teachers have in relation to this issue especially as the reality of multi-agency support may involve a long wait for support and a continuation of classroom behaviours which need to be dealt with immediately.

In staff development sessions that I have run around the topic of inclusion it was common to find colleagues who were keen to support students and who were sympathetic but through lack of awareness and information they felt inadequately prepared to empathise and offer appropriate guidance and support. Anecdotally staff often expressed their fear of 'making things worse' because of a lack of training. Finney (2006) adds to this by claiming that many teachers do care about the emotional wellbeing of their pupils but they also report being under stress themselves and the pressures of assessment deadlines, inspections and league tables take precedence over other concerns.

Due to the health/ education crossover the thesis suggests specific targeted input, relevant particularly to teachers, which is aimed at bridging the gap between teaching and learning and understanding/ awareness of mental health issues

Having decided on the question to be answered specific methods of gathering data were planned. The following section outlines the three phases of data gathering and looks at the strengths and weaknesses of each method chosen.

### **3.4 Data gathering**

The project planned to utilise predominantly qualitative data but there is an element of quantitative analysis of the initial Phase 1 surveys which has a two-fold use. The comparative element of responses provides a rough indication of the 'awareness' that is at the heart of the research question and it is possible to quantify the number of respondents who claim to need more input around the topic. That data set may well be of use to course leaders and senior managers as they review the curriculum and consider the student voice element at their annual evaluations. The basic analysis of that part of the questionnaire also enhanced the progression into Phase 2 of the project. If the analysis had revealed an awareness which had not been predicted or a lack of interest in further participation then the question would have had to be reconsidered and the project changed to allow for the new information. This mixing of methods is considered by Burgess (1989, p.33) to be a positive, 'Some of the most fruitful research includes a combination of methodological approaches.' It should however be reflected on here that the complex topic and the various data collection methods meant that the data set produced was likely to be complicated and not to fit neatly into a structured analysis.

The survey data also has a qualitative element in that it includes text boxes for fuller answers and for opinions to be recorded. The subsequent phases offered fuller and more personalised opportunities to gather thoughts/ feelings and opinions around the issue. It is in these text boxes however that information about feelings might be most explicitly stated by students. In the model-making focus groups students were not given specific questions to answer and they may have modelled the feelings of their learners rather than their own feelings. The last question on the survey asked directly how people felt so I hoped that the findings would include statements, 'I feel.....'

Having identified an area for research an initial question, about whether trainees needed awareness-raising, was created. It was necessary to draft and redraft the question to gradually eradicate words which could suggest my opinion and to

increase opportunities for the participants to answer an open and genuine question. This assertion has to be tempered by the supposition that in asking the question, interest in the topic and an inferred opinion could be discerned by the participants and this might affect the results. I decided not to ask a series of closed question about whether awareness was lacking after a short trial and development of the research question; **What are ITT staff and students' perspectives on mental health as a barrier to teaching and learning?** This calls for a study designed to look at the perceptions of the staff and trainees themselves and, rather than impose my preconceived ideas about their awareness, the three phases record qualitatively the views of two groups of participants from three HEIs. The research question was decided upon in terms of what was researchable, as abstract notions are obviously difficult.

Initial reading and trialling of the questionnaires and semi- structured interviews raised important issues around the language of mental health and the needs of the trainees. The multidisciplinary nature of the topic may be complicated by the fact that there are two very distinct and hitherto, often unconnected discourses, which may be the cause of unease and even fear; health and education. The Me and My School review of TAMHS (Targeted Adolescent Mental Health in Schools) (2009) considered that TAMHS staff highlighted the, 'challenges in finding a common language to use between mental health providers and schools.'(p.12)

Another restricting factor that has to be considered throughout is that there is also clearly a tension between the requirements of the curriculum for ITT, which has to firstly produce teachers who meet the national standards and are focused on attainment and progress but also include curriculum input around issues of wellbeing and barriers to learning which may be considered less measurable and not an area of specific interest for inspection regimes.

### **Phase 1. Questionnaires**

The research question was investigated by firstly using an online quantitative survey; the purpose of which was to provide a rough measure of awareness around the topic of mental health as it impacts on teaching and learning. The awareness testing element of the piece was mainly delivered through the questionnaires in phase 1 which asked questions designed to prompt further enquiry and to lead trainees and

their tutors to want to know more. A sample of the questionnaire can be found in appendix 2.

14 questions were drafted and 5 were based on statistical measures around mental health in the U.K. with a specific focus on young people and children's statistics. Other questions were about the nature of the participants, their awareness of the recent campaign, 'Time to Talk', and whether they had at any point undertaken specific mental health awareness training. There was a direct question about the National Framework for children and young people and teachers' Tier 1 responsibilities as it was felt that this would be a strong indicator of awareness which was again directly linked to the research question. The penultimate question asked participants to gauge the extent to which they had guessed the responses. This was in no way an attempt to quantify the reliability of the data but an opportunity for reflection for the participants who may use the answer to drive forward reading and research into the subject for their own professional development.

The questionnaire allowed for more detailed responses in text boxes and a final text box for general comments was incorporated to maximise the data retrieval from this method. The questionnaire was available online via Bristol Online Surveys (BOS) and the link to the survey was distributed via administrative staff to all students on applicable courses in 3 HEIs<sup>2</sup> in the Northwest and one in the Midlands. Pilot questionnaires were tested on a pilot student group and amended in light of their responses. The completed survey was predicted to take no longer than 10 minutes which was considered an appropriate investment of time for participants. Questions about awareness of an emotive issue have an affective element and my contact details were attached to the survey. Many disclosures were made following and during the three phases of the research and appropriate referrals were advised and links were provided to a range of outside organisations and to the university's wellbeing services. The questionnaire considers specific conditions and their prevalence but it is not my view that teachers need to be aware about treatment options, specialised provision or medical diagnostic procedures

A range of disadvantages of this initial method were noted. Response rates were difficult to predict and the online tool asked for a maximum number of participants. As the questionnaire was made available to students from other HEIs in addition to

my own institution I estimated 400 respondents. In fact there were 128 online responses and 61 paper based questionnaires were also completed by students across a range of class based situations who agreed to participate but where there were no IT facilities available. This data then had to be incorporated into the online results which added a time consideration but I decided that the maximum number of available responses should be used as data from the survey were richer and more detailed in some instances than expected. The relatively low response rate will be reflected on further in the analysis of findings in chapter 4 but I determined that 189 responses from Phase 1 were sufficient to warrant continuing into Phase 2 where there were 8 staff interviews conducted. The lower initial number of ITT Post Graduate responses led to the paper based additional sessions to attempt to achieve a balance. Some participants who had knowledge and experience to share around questions 8 and 9 were not able to complete within 10 minutes and as this had been the contracted , although approximate, time agreed it was possible that this meant less full answers to the last few questions. One participant entered an abusive remark in the very last text box having filled in the rest of the answers. The anonymity of respondents meant that it was not possible to find out whether this was due to frustration with the process or whether the topic had upset this individual.

**Phase 2. Individual, semi- structured interviews** were conducted with staff from three HEIs to allow them to voice their opinions, concerns and reaction to the initial question about whether ITT programmes should contain curriculum input around mental health or some specific awareness training. Staff were asked about their own training and encouraged to consider the three strands of the research in relation to their practice. Staff were interviewed at a mutually convenient time and each interview was 30 minutes in length. I went to the office of the member of staff and checked that they were still willing to participate and comfortable to be recorded. The questions acted as prompts and participants were not asked all questions if in their initial discussion it became clear that other questions were not applicable. The interviews were recorded and transcribed and notes were made during the interview as an aide memoire. Transcriptions were made as soon after the interview as possible to try to capture the data whilst the event was recent. Rubin and Rubin (2012, p.7) point to the importance of the relationship between the two parties in an interview situation. They postulate that in building an open and trusting relationship,

interviewer and interviewee work towards forming, ' a conversational partnership,' and embark on 'a joint process of discovery', by sharing respect, experience and insights. In the interviews some disclosures were made about students on ITT courses and or family members of the participants. Rubin and Rubin also remind the researcher that:

The responsive interviewing approach accepts that both the researcher and those being studied are people with emotions. Ideally the interviewer should be empathetic and sensitive to the emotional content of the interviewee's answers. (2012, p.37)

One of the issues with interviewing as a technique was the possibility of mismatching stylistic questioning devices during the semi structured talk. I was aware of my own propensity to use chat to create a bond with the interviewee and to intersperse questions with conversation to regulate the pace and intensity of the questioning. This could be very irritating and distracting to interviewees who might feel that conversation which takes a wider turn or seems to move away from the focus is wasting their time so a balance has to be struck. On one hand a nervous participant who feels pressurised by the recording process and the formality introduced in this, possibly unfamiliar situation will need to be helped to relax and allowed time to settle into the process. In the interview transcripts it became clear that I was involved in more conversational interludes with participants from other institutions or with participants from the home institution with whom I had not worked before. In a condensed sense the attempt was to forge bonds and create trust through initial and occasionally intermittent sections of conversation about own practice and shared issues. The length of the interview was not exceeded so it might be considered that the data was slightly less rich from these occasions when input from the interviewer was included in the overall running time. This however could be reflected on as a positive as all participants concluded by showing interest in the project and if change in practice is to happen then it might be as a result of these shared conversations.

**Phase 3. Model- Making Focus Groups** were held for students across a range of groups at each HEI. These groups of students usually no more than 6 in each group met and participated in a modelling session where they made a model of their attitude/ feelings/ understanding around mental health and teaching and learning. Model making was chosen to offer participants a sense of safety and to embed the notion of distance between the speaker and the audience which talking about the



model facilitates. It was considered inappropriate and possibly damaging to directly question students about their perceptions as the topic is sensitive and often leads to disclosures. The models were made from a range of available craft materials. Students were given 30 minutes to complete their creations and then they spent just a couple of minutes each describing their creation to the focus group participants and explaining how their views on mental health should be understood.

Pink (2007) considers that the use of the visual in social science research has been controversial and that there are those who wonder if:

visual images could usefully support the observational project of social science. (p.9)

She goes on to report that,

Visual ethnographers were forced to confront the accusation that their visual images lacked objectivity and scientific rigour. (2007, p.9)

The advantages of modelling are that it allows participants to discuss emotive and often personal situations through the medium of the final product. In this instance a further advantage was that the technique could be incorporated into the teaching practice of the participants and this extra relevance was highlighted to ensure that students felt that their time was being used productively. It has to be considered that, 'visual research methods cannot be used independently of other methods', according to Pink (2007, p.21) The model as a form of data is also problematic and the method of analysis applied to such a visual form of information needed careful consideration. Instead of transcribing the words of the presentation from each model I constructed a short narrative which attempted to record the main concepts in the model and reflect on the meaning that had been inferred from the model itself and the words used to describe it by its creator. Thus there was a fusion of meaning; what the model maker meant and what the observer felt was being conveyed. The constructedness of this data has to be acknowledged and the analysis of findings from Phase 3 could be considered as subjective. The reflexive approach to all data might negate some aspects of this subjectivity but overall I agree with Pink (2007) who postulates that we would be wrong to think that, subjectivity could or should be avoided or eradicated. (p.23) Pillow (2003, p.176) suggests that qualitative researchers need to show that they are: 'making visible, through reflexivity how we do the work of representation.'

This is an element of the thesis which is achieved through evaluation of the process, the planning and the results which is recorded in this thesis in chapter 5.

A more practical disadvantage of model making is that it puts pressure on students to create something instantly and it does not suit all learning styles. The timing element was also an issue because in some instances the sharing of the model didn't allow much time per person to discuss their feelings and the underpinning of their creations. A one hour time slot was difficult to negotiate in some very full timetables so trying to fit everyone's contribution into the hour was a compromise to ensure participation. It was considered that longer sessions would have seemed less attractive to students who have full days timetabled at university from 9.15 a.m. to 4.15 p.m.

At the start of each session I set out clearly and firmly the rules of confidentiality and assured students that they did not have to disclose any personal information unless they wanted to. Others in the group were looking at and appreciating the model as the person was speaking. The models were filmed but the person speaking was not photographed so that a form of anonymity was created and the words and model were separated from the speaker. It was very noticeable that students took this opportunity to discuss feelings and beliefs openly and this was also the case with staff in interviews. 2 or 3 disclosures were made in each group even though the students didn't know me and in some instances had only just met each other. I had prepared for the issue of disclosure by having available materials and contact numbers of organisations within and without the HEI to give to students. The emotional impact of disclosure is more difficult to plan for and this is discussed further in the ethics section of this chapter. Although I was confident in dealing with emotional responses and sharing of difficult issues the reaction of the group was more difficult to predict. Some learners had self-selected to be participants in this phase of the project and this could have been because they saw it as an outlet to share their issues and worries with a member of staff and with their peers. Other students may not have considered this possibility when they agreed to take part and might have been upset or concerned by the emotional element to these sessions. Referrals were not only offered to those who had disclosed an issue but follow up individual tutorials were also offered to other participants who might need to discuss in confidence what they had seen/ heard and their reflections after the event.

The preparation, presentation and analysis of the data gathered over the three phases of the research is discussed in chapters; 4 and 5. The following section of this chapter outlines the treatment of the data and offers justification for decisions made.

### **3.5 Data Preparation and Analysis**

#### **Phase 1 Data from the questionnaires**

Data from the questionnaires was captured via the Bristol Online Survey software and was converted, by the programme, into graphical blocks; one per question when appropriate. The data provided by the programme is presented graphically in chapter 4 with a short descriptor indicating the correct answer and offering a statistical indication of how many participants had answered correctly. The incorrect answers were highlighted too and in some instances these revealed attitudes and allowed inferences to be made about myths and misconceptions surrounding the topic.

The answers to the qualitative questions were presented in the form of lists and these were included as appendix 3 to allow the reader to see the full range of responses. A statistical element of analysis was applied to these answers whenever possible and actual quoted statements from each of the questions were included in the presentation of findings. The analysis of the data was manually created and a summary is discussed in chapter 5 which is linked to the research question and aims/objectives and also linked to relevant literature (discussed in Chapter 2) to situate the findings from this study within research in the field. .

#### **Phase 2 Data from the interviews**

Data from the interviews was transcribed and the transcripts were applied to the NVIVO software to help to elucidate common themes and patterns in the responses. The transcriptions are included as appendix 5 and the nodes identified are presented in chapter 4 in a graphical format so that the reader can clearly see the overlap between comments and the connections between data from Phases 2 and 3.

Each of the nodes is listed in chapter 4 and analysed and discussed in chapter 5. Links are made between the initial research question, the aims and objectives of the project and the literature review so that conclusions are drawn based on data from

all 3 Phases. Recommendations and an overall summary of the thesis are provided in chapter 5.

### **Phase 3 Data**

Data from the model-making focus groups was twofold. The models created were the first consideration and the words surrounding these models during the presentations added to the understanding of the visual phenomenon. The presentations were transcribed from the video footage but it was felt that this left out some depth of explanation which had been shared during the model making process and the response to the model which added a richer understanding of the thoughts and feelings of the participants.

To analyse the data from the models a narrative was constructed for each one which allowed for reflection and revisiting of the video footage and the models themselves to be sure that the meaning was captured as accurately as possible. The data produced in the form of these narratives was then fed into NVIVO to allow for a closer analysis of the thematic basis of the models. The nodes produced were also linked to the Phase 2 data so that a cross qualitative thematic review could be presented. This review is linked in Chapter 5 to the Phase 1 data analysis, to the aims and objectives of the study and to the literature review to illustrate the main themes and conclusions which could be drawn from this phase of the research.

The following section of this chapter will consider the ethical implications which were considered from the initial framing of a suitable question and constructing a framework through to the analysis of the findings and the conclusion.

### **3.6 Ethical Issues**

Ethics according to Foreman-Peck and Winch (2010) are:

concerned with morally right ways of acting, with the promotion of benefits and the avoidance of harm to the individuals with whom one has dealings. (p.109)

Nixon, Walker and Clough (2003, p.1) exhort us to ensure that methodology itself is morally grounded. They surmise that:

For us that moral ground requires an approach to educational research that recognises the commonality of thought and that engages the public in thoughtful debate regarding the ends and purposes of education.

All aspects of the planned research, from the framing of the question to the construction of a conclusion based on the findings, have ethical implications attached to them and there is potential for harm as the research subject is sensitive and emotive for many potential participants. Ethical approval was sought and granted from the approval committee at the University of Sheffield and BERA guidelines (2004) were adopted throughout. The referral strategies outlined by CAMHS were utilised to enable participants to follow up on any issues raised about pupils from their practice. It was made clear at the start of every focus group that individual pupils or staff members would not be discussed during the focus groups.

Permission was sought from appropriate gatekeepers in three HEIs to allow me to contact and invite participation from both lecturers and students across a range of ITT programmes. The initial permissions were from Deans of School and in one instance the Principal of the Teacher Training Institution. Individual consents were then sought from lecturers and students who were advised about the purpose of the research and the limitations of the study. Wellington(2000) reminds us that, 'participants in a research study have the right to be informed about the aims, purpose and likely publication of findings involved in the research and of potential consequences for participants, and to give their informed consent before participating in research.'(p.56) The participation information form is in appendix 1.

Participants across all phases were clearly told that this was not an action research project and thus, even if changes to practice could be inferred from the findings there was no obligation on the part of any of the HEIs involved to respond to the findings in that way. At the end of the study a pack of awareness raising materials would be offered to all participating institutions, staff and individuals but this in no way suggests that they will be used in practice. There are several features of the project which are likely to remain (in the short term at least ) and these include: the lead lecture for 1.25 hours for PGCE FE students and taught input into a module on Health and Wellbeing for Early Childhood Studies BA students, many of whom go on to do post graduate teacher training for primary. Following the interviews I was invited to participate in a SEN conference for all PGCE students in the home

institution, the first of which being in January 2014 and the launch of the online pack of materials coincides with this conference when all students will attend a 1 hour workshop. Before findings from the study are disseminated participants will be offered an opportunity to review their contributions and if necessary block the inclusion of certain sections of text. Thus the views of Foreman-Peck and Winch (2010) that participants become, 'active collaborators,' (p.36) will be relevant in this process. Following interviews and analysis of the three phases of data an attempt will be made to contact providers of ITT regionally with a view to setting up a contact group and taking the project further.

### **Phase 1 ethical issues around questionnaires**

Informed consent included statements in the introduction to the questionnaires where participants were made aware of rigorous attempts at confidentiality and anonymity. As there were few identifying characteristics in the design of the questionnaire it would have been impossible to trace comments and answers back to any institution and definitely not to any individual. This level of anonymity was not afforded to participants who completed the questionnaires on paper with a group of their peers as it might have been possible for the researcher to know which batch of paper based responses came from which group. This was avoided by placing all paper based copies into a plastic folder and deliberately shuffling the papers to mix up the groups of participants, however this does not completely equal the anonymity of the online group because the paper based copies were only offered to participants in the home HEI and therefore a measure of identification was possible.

### **Phase 2 ethical issues around interviews**

Burgess, Sieminski and Arthur (2006) suggest that there are specific ethical considerations relevant to the use of interviews. They classify interviews as, 'social dialogue between two people both of whom bring their own social background and personality to the situation.'(p.35)

Participants for interview were invited by email or self- selected as a response to the information sent out with the questionnaire. Thus consent was assumed on the basis of agreeing to be interviewed. At the start of the interview participants were asked whether they were comfortable with the recording of the session and given the

opportunity to go ahead without the recorder if preferred. Nothing on the notes from the semi structured interview sheets or on the tape identified participants to the readers of the research although obviously voice and accent along with content made the material identifiable to me. The recorder and notes were stored in a locked filing cabinet and only accessed for transcription away from the home HEI. During presentation of the findings and the recommendations of the report no mention was made around the practice of any named institution or any individual. The transcripts across the three institutions were intermingled in the findings so that it wasn't possible to make judgements about specific places or people.

### **Phase 3 ethical issues in model-making focus groups**

The focus group participants were invited to attend by email following their self-selection. Some people put themselves forward after completion of the questionnaires and others following attendance at a lead lecture for PGCE students which was added to the diet of lead lectures this year to allow dissemination of the research and initiation of discussion around the topic for pre service teacher trainees.

At the start of each focus group there was a period of setting ground rules before the modelling was introduced. Participants were advised that they could withdraw at any time and given access to promotional materials from the university's wellbeing centre and from outside agencies with a mental health focus. Disclosure was discussed and participants were assured that the modelling process need not be about their own mental health and wellbeing issues but if they felt that to be an appropriate focus then such disclosure would be met with empathy and support in a protected environment. All participants were reminded about the need for confidentiality and that it was not acceptable to discuss actual members of staff or pupils from their experience by name or any other identifying feature.

This chapter has presented the research question and discussed and justified the methodology underpinning the study. My own positionality with regard to the topic and the participants was considered here to offer a rationale for the choices outlined. The methods of data collection and preparation for analysis have been discussed.

## **Chapter 4 Presentation and Analysis of Findings**

The following chapter presents and analyses the findings of the three phases of research and is sensitive to the suggestion of Nixon, Walker and Clough (2003, p.1) that:



Research exists not only to provide policy makers and practitioners with evidence, but to provide as a public resource interpretations of the evidence that speak to the conditions pertaining and precise points and within specific public sectors.

The **aims of the chapter** are to:

1. Present the findings of the three phases of the research in accessible formats.
2. Share the narratives from the model making focus groups and visually represent the models created.
3. Through NVIVO present the key themes and motifs of phases 2 and 3
4. Undertake a detailed analysis of each phase of the research
5. Present the results of the analysis clearly

#### **Chapter 4.1 Questionnaire data.**

The link to the questionnaire was sent via the Bristol Online Survey (BOS) website to 3 HEIs, two in the North West and one in the Midlands. Two of the HEIs had specific teacher training courses offered within the school of education and the third is a teacher training only University College. The questionnaire had been piloted with a group of FdA Learning Support 3<sup>rd</sup> year students and changes made accordingly. The Bristol Online Survey site was utilised to create an online survey but in one HEI groups without internet access completed on paper and these questionnaires were then added in manually with the online entries.

The questionnaire was comprised of fourteen questions, 5 of which were statistically orientated to broadly assess awareness of the scale of the issue of mental health and how children and young people are affected. There were questions which went to the heart of the overall research question and asked academics and student teachers whether they knew that the National Framework for Mental Health existed and which Tier of professionals they fitted into. The final, qualitative question asked people directly to assess their awareness and to make a statement which could sum up their thoughts and feelings. The question about the latest TV campaign could be considered less than directly relevant but it was included both as a measure again of overall awareness, and as a means to link in the third strand of why teacher trainees need to be aware in terms of their own mental health and how work affects wellbeing. The 'time to talk, time to change', campaign is now a lottery and charity funded health awareness initiative (originally funded by Comic Relief and the Department of Health) which attempts to dispel stigma and myth around mental health issues by explaining that talking is a positive strategy and that we should treat

mental ill health in the same way as physical ill health. The advert produced is aimed at young adults in particular as the scenarios show young professionals in the workplace. This therefore has a direct implication for young post graduates entering a stressful occupation.

The analysis will begin with the statistical questions, as, to a certain extent, these data can be more straightforward in terms of analysis and interpretation.

Variables.

It is necessary to consider the effect of the design of the question and the range of available choices in relation to the answers given. Guessing was encouraged as it was thought that responses which said just that the value was unknown would be of *less use in the evaluative process. The measure of awareness then would have* been simply a matter of: I know, I think I know, I don't know. By adding a question about the amount of guesswork involved it was hoped that the respondents would answer honestly and admit to guessing whereas without this option answers might have been recorded which were based on a guess but the reader might have mistakenly considered them to be due to knowledge. This guesswork component however has added an element of uncertainty to the process of analysing the statistical questions because it is possible that respondents could have guessed everything and also possible that even when respondents claimed to have known some answers they might have been mistaken. By looking at the 5 questions against question 12: *In this survey I mostly guessed/ guessed some/knew some/knew all.* It should be possible to estimate the incidence of the latter scenario but not the former. Another element of uncertainty stems from the possibility that respondents were led by the range of possible answers. In each case a range of answers was proffered which contained values above and below the correct statistic. For questions 1; *In any given year what percentage of children have a mental health problem?* and 4; *In the UK how many children are diagnosed with a severe mental health disorder?* the correct answer was in the 3<sup>rd</sup> position and this might have affected the guesses made because respondents could have stuck to a pattern in their guesswork but in fact question 4 had a very low correct response rate compared to 40.2% in question 1. In question 1 there should have been a further option to make it standardised. No one from the pilot group noticed the difference





and I felt it unlikely to significantly shift the answers if a 40% value was added so no change was made

#### 4.1 Findings from the questionnaires\_\*\*= correct answer






1. In any given year in the UK what percentage of children have a mental health problem?			
1%:		7.4%	14
10%:		28.0%	53
**20%:		40.2%	76
30%:		24.3%	46

The initial chapter in the literature review is based on literature around statistical measures of mental health incidence in children and young people. Therefore question 1. asks for a percentage, in any given year in the UK, for any mental health problem. The correct answer was identified by 40.2% of respondents which equates to 76 people. Almost as many respondents, (35.4%) felt that the figure was less than the 20% and a quarter over estimated at 30%. The number grossly underestimating at 1 % was quite low at 7.4%






2. In the average secondary school class how many young people will currently have a mental health problem?			
1:		9.5%	18

**3:		28.6%	54
5:		27.5%	52
7:		23.3%	44
10:		11.1%	21



The second question links to the Young Minds research that conveniently summarises a range of statistics into the concept of an average secondary school class. This also links to question 1 in that in any given year the figure is double that of at any given time. It is clear that averages involve times when the figure is higher than 3 out of the class (the correct response) as well as times when it is less. The questions were planned to be thought provoking and it was hoped that respondents would start to wonder about when the most stressful times of the year would be for pupils and also about which year groups might be most affected. 28.6% of respondents were correct and the majority interestingly over estimated.

3. Approximately how many people in the UK are diagnosed with an eating disorder each year?			
250,000:		21.2%	40
500,000:		31.7%	60
750,000:		25.9%	49
**1 million:		15.3%	29
1,250,000:		5.8%	11

Question 3 had the lowest proportion of correct responses of the first statistical set of questions. 15.3% correctly chose 1 million people. A small number felt it was the highest possible option of 1.25 million but mostly respondents underestimated by at least 250,000. Over half felt that it was 500,000 or less so this is not being recognised as a growing issue. This is despite eating disorders being one of the most talked about issues and one that has been covered in popular culture and highly publicised due to celebrity disclosures. The reason for this under reporting is obviously not possible to ascertain from this rough measure so could be the focus of further research questions.

4. In the UK how many children are diagnosed with SEVERE mental health disorders in any one year?			
25,000:		31.2%	59
35,000:		35.4%	67
**45,000:		15.3%	29
55,000:		12.2%	23
65,000:		5.8%	11

Question 4 attempted to judge awareness of the number of children with disorders categorised as 'severe' to distinguish this from those with a general diagnosis. It is important to reiterate that the diagnosis of mental health conditions in children is not coherent and often a diagnosis can take several years to come to due to the reluctance of medical practitioners to diagnose children with conditions which used to be considered as only affecting adults. Fifteen point three percent of questionnaire responses selected the 45,000 correct figure, 18% overestimated but 66.6% considered the number to be at least 10,000 less. This will be tied to the answers for question 8 to see the range of disorders which were listed and how many of them were severe. To evaluate this link further it would have been better to have asked respondents in question 8 to name as many of the diagnosable conditions from questions 1, 3 and 5 as they could so that a comparison could have been made.






5. Have you undertaken any specific Mental Health Awareness raising training?			
Yes:		11.6%	22
No:		88.4%	167

**5. a.** If yes please indicate when and where you underwent training. (Approximate dates are sufficient) How long did the training last?

Question 5 showed that 88.4% of those completing the questionnaire had no formal or informal training around mental health issues. 22 people identified some training within their careers so far. 6/189 (3%) had done training courses which were directly linked to children and young people's mental health. Of these 2 teacher trainees had received full, CAMHS based training from the local authority over a number of weeks. One of these was in the role of a teaching assistant at the time of the




training. The other 4 had undertaken short courses one of which had a social work focus and one was college based about the mental health issues affecting adolescents.

General mental health training which included a course entitled Mental Health First Aid were attended by 9/189(5%) respondents. Of the 9, one member of staff cited the HEI's PCPD course and another staff respondent claimed awareness from general training over 10 years in post. One person had training around post natal depression from the NHS and another had been on a course which focused on mental health awareness of the issues facing older people. A 1 day course by the careers service about making choices was also listed. 2 responses listed courses for addiction awareness and 5 people had attended sessions on stress in the workplace which ranged in length from 1 hour to half a day.

6. Are you aware of the National Service Framework for Children and Young People? Which Tier will you be/ are you working within in your practice?			
Not Aware:		91.0%	172
**Tier1:		5.8%	11
Tier2:		1.6%	3
Tier3:		0.5%	1
Tier4:		1.1%	2

Question 6 was a pivotally important question for the study as it asked directly about the National Framework for mental health and the tier into which teachers fit. Only 5.8% correctly identified that as tier 1. Most replied that they had no knowledge of the framework and the inference drawn from this is that they would not therefore be aware of their responsibilities under the framework. This is despite Andrew Lansley's (former health secretary) assertion (DoH 2011) that front line staff would be aware and appropriately trained. It is considered unlikely that the people whose answers selected higher tiers were aware of the framework at all.

7. Mental health disorders in adults are as common as asthma.

**True:		62.4%	118
False:		13.2%	25
Don't know:		24.3%	46

Question 7 was the only true/ false question and was added to make people think about the links between adult conditions and children's. The question is about adults and links mental health to asthma which is a common enough condition for people to be aware of. 118 respondents decided that this was true and even allowing for the inevitable guesswork, it seemed reasonable to that number of people that this could be the case. The statistic was meant to provoke a reaction and also to make a link between the two conditions in childhood too. Additionally the point is that many childhood disorders continue on into adulthood and 75% of all mental health issues in adults begin in adolescence so it is important that practitioners consider this. Early identification, referral, diagnosis and treatment of both conditions is vital for successful management of the condition so again this is a link. The link to mortality between the two conditions is not being made here and also asthma can be a lifetime condition which many mental health issues are not. In evaluating the question it could have been made clearer which factors in the comparison could be statistically evidenced in addition to the basic measure of incidence which is all the question deals with. It was interesting that 37.5% considered the answer to be false but it is not possible to know whether they assumed it was lower or higher. Again a more sophisticated question might have been able to draw out this additional information.

Questions 8 and 9 asked for specific conditions and symptoms to be listed. This was not a popular question for some respondents and some generalised that children could have all the mental health conditions that adults could have so there was no need to list them. Some offered no input for question 8 and others claimed not to know any specific conditions. Overall the lists were useful as indicators of awareness of particular conditions and a measure of whether some conditions were being over emphasised. It was interesting to note the differences in terminology between the participants as some were more familiar with the medical terminology and others used more commonplace ways of indicating what they meant.

In question 8 the most recognised and listed condition is depression and 83/189(44%) responses were noted. This is possibly high because of the prevalence of depression in adults and the frequency of diagnosis in adults. Diagnosis in children and young people is increasing but it is certainly not the most common condition for children with an incidence of around 0.9% children in the UK (Young Minds) In addition to the broad category of depression Bipolar was listed by 32/189(17%) respondents and this was the fifth highest figure recorded. It would be interesting to know why so many people specified bipolar when only 3/189(2%) recorded manic depression. Possibly the answer to the high number of respondents links to interview 1 with an academic member of staff who teaches mental health awareness from the position of living with and managing being bipolar themselves. It is likely that the cohort given this awareness training would be very aware of this condition possibly above all others.

Although anxiety is more common in children 3.3% of children in the UK (Young Minds) only 52/189(28%) of responses listed this. Again this may be due to the links to the condition in adulthood rather than just thinking about children. Night terrors, separation anxiety, anxiety associated with transitions all should suggest that children are more prone to the condition than the responses suggest.

Eating disorders were listed at 68/189(36%) and anorexia 28/189(15%) with bulimia 24/189(13%). This figure is not indicative of the prevalence of the condition in adults but could have been affected by the consideration that children are less affected or could have been lower because of the key stage that the teacher trainees were going into. Eating disorders are diagnosed more in adolescence and adulthood so perhaps only secondary/ FE PGCE students were thinking of this as a relevant condition. The broad descriptors used in the questionnaire which just divide staff and students do not allow this to be investigated further.

Stress was reported in 14/189(7%) of responses and this was very low. It may be that the notion of stress in young children is affected by a historical construct around a carefree childhood. Weare (2004) considers that:

The idea of an innocent and untroubled childhood is largely a myth. (p.4)



As all school aged pupils will be academically assessed, both internally and externally, during the school year it might be reasonable to consider that assessments will be linked to stress for some. This resonates directly with the second reason to be aware that this thesis is proposing as I am suggesting that teachers need to be aware of the effects of the teaching and learning process on mental health and it also links with the third reason that teachers need to be aware of the stressful nature of the profession because if teachers are aware of their own mental health needs and can manage wellbeing, it seems more likely that they will be able to positively influence the wellbeing of their pupils and model strategies for coping with stress.

ADHD and ADD are reported as 37/189(20%) and 7/189(4%) respectively. This is higher than the reported incidence of 1.7% (Counselling Directory 2013) and is interesting because this is obviously a condition that teacher trainees have been made aware of. A possible inference could be that this is due to the effects on classroom management of these conditions and that the topic will have been covered in behaviour management and in terms of classroom layout and use of support staff. Children with a diagnosis for ADHD and ADD will have additional support and often the TA and SENCO will have developed strategies and undergone training for dealing with this condition in mainstream.

Self-harm was reported by only 19/189 (10%) and this is grossly under representative of the scale of the issue. It is possible again that a primary/ key stage 1 focus will have led to under-reporting but this is an issue which has been reported on extensively in the press and reports such as Truth Hurts are clear about the scale of the problem for children as young as seven years of age. Possibly because self-harming is a hidden and secretive activity there is less awareness of the condition. This issue has been used as a story line in some television soaps which feature older teenagers e.g. Hollyoaks, Eastenders and Emmerdale.

Interestingly 42/189(22%) of responses listed Schizophrenia as a condition which affects children. In fact schizophrenia only develops in late adolescence and early adulthood and only affects 1.1% of the population over the age of 18. (NIMH) This appears therefore to be an over representation and is interesting due to the possible inference that when we mention mental health the association is with not just mental

ill health but the more extreme cases of mental ill health. The link to danger and madness has been suggested in the literature review (Rogers and Pilgrim 2005) and it may be this that leads to the anomalous recognition of this extreme condition. Another possible explanation is that schizophrenia makes headline news occasionally and is used in fiction (e.g. *Shutter Island* 2010) and documentaries as a dramatic topic. Popular culture makes it possible to think of people hearing voices as a common occurrence; e.g. a recent *Hollyoaks* story dealt with a character called Newt, hearing voices from beyond the grave. A source for further research would be to look at how popular culture represents mental health and whether that has a direct impact on what people consider to be true.

Obsessive Compulsive Disorder OCD was reported at 27/189(14%) which was the sixth highest figure. The actual incidence is 1.2% of the population (OCD-UK) so once again there is a relatively high recognition rate but this may be because there is a higher incidence of severe symptoms within that group than those with mild symptoms only. Again this has been the subject of storylines in *Hollyoaks* and *Home and Away* which might have raised its profile.

There were a range of disorders reported by a small minority which included SAD, PTSD, BDD, sleep disorder and personality disorder. It is possible that these are listed due to experience with individual children or from personal/ family experience. It is very likely that the incidence of sleep disorders in young children is far higher than the 2/189 (1%) would suggest and night terrors and sleep disturbances will obviously have an effect on teaching and learning.

Phobias and school phobia in particular were only listed by 8/189(4%) and 1/189(0.5%) respectively. The incidence of phobias across the general population is 1.9% (ONS) so this is an under representation. Phobias can also lead to compulsive behaviours and it is important to try to find the antecedent to the behaviour rather than just work on ways to make the behaviour conform to policy and practice. Agoraphobia was listed by 2 respondents and this is unlikely to affect children at all so its inclusion is interesting.

Some respondents listed possible causes of mental health issues and symptoms rather than disorders and these included bullying, low self- esteem, obsession with TV., ill health, bereavement, lack of confidence, tics, poverty, Aids and lifestyle

choices /experiences. These were often single figure responses and it is possible that again they were due to an association with a particular individual or critical incident.

More intriguing were the responses about dyslexia, dyspraxia, autism and Asperger's syndrome. Autism reached 21/189 (11%) which is of concern because the issue of neuro- processing is obviously a key component in this list and it is possible that students have included issues of the brain instead of mental health issues around wellbeing. Parkinson's disease was also listed which again suggests a brain function deficit model of understanding the term. The definition of mental health selected in the methodology chapter on page 45 might prove a useful balance to this view and should be included in the information pack so that trainees are clear about the parameters and how to categorise issues around difference. The positive definition suggested that a definition of positive mental wellbeing involved:

...self- confidence, assertiveness, empathy, the capacity to develop emotionally, creatively, intellectually and spiritually. The capacity to initiate and sustain mutually satisfying personal relationships and the capacity to face problems, resolve and learn from them. ...To use and enjoy solitude, to play and have fun, to laugh at oneself and at the world. (MHF 2001, p.197 cited in Wells 2003)

The responses could be considered a positive feature if the conditions are being listed as part of any difference in mental processing and if no stigma is being attached. Obviously if the stigma associated with mental health is a reality and these respondents are attaching it to these conditions too then the positive turns into a negative.

One other single response was, 'mental disabilities' and this old fashioned and value laden comment suggests that it was from someone rooted in the medical model. Memory loss was stated by 1 individual too and this was a strange comment which seemed to be more a question 9 answer.

Several responses mentioned psychosis and some linked this to drug or alcohol abuse.

Q9 asked respondents about visible symptoms and what they would expect to observe in class in correspondence with the conditions they had identified in question 8 which has asked for a list of conditions known to the respondent. The

range of responses was wide but there were few symptoms with a higher incidence of recognition. Some participants felt that the question was not relevant or that the range of symptoms was prohibitively long so they only asserted that they could list symptoms but did not list any. The point of the question was to make participants think about their experiences of practice so far and to consider what was possible to see in class. Some respondents just listed symptoms without any mention of how these could be evident in a classroom situation. Others took the opportunity to give fuller answers which linked the symptoms to the conditions listed in question 8 and to offer examples of school based incidences e.g. getting changed for PE which would be a time to look out for change and note behaviours.

Being withdrawn 40/189 (21%) had the highest incidence. In primary education it would arguably be possible to notice a change in a child's engagement with the curriculum and with other children more readily than in a secondary class. In FE where class sizes may be smaller change should again be noticeable. Disruptive behaviour 32/189 (17%) was the second highest and this is in line with the high incidence of ADHD and other conditions listed in question 8. Behaviour as a focus is wholly appropriate because outward behaviour allows practitioners to notice signs which may make them think about what is happening inwardly. It is however necessary to not just note the behaviour and ensure conformity but to investigate the antecedent of the demonstrated behaviour. 22/189 (12%) of responses listed being quiet as a symptom so it is clear that some respondents thought that disruption was not always an indicator.

37/189 (20%) of respondents noted that they would expect to see concentration affected negatively by a range of mental health issues. 17/189 (9%) noted that there would be a concurrent lack of enthusiasm and enjoyment in tasks and this again may be more noticeable in some environments/ subject areas/ key stages, than others.

Aggression and anger were listed by 15/189 (8%) and 10/189(5%) respectively and it would be interesting to have been able to drill down to their question 8 answers to see what conditions they felt these attributes were attached to. 17/189 (9%) of responses listed mood variations and swings.




Being tired and losing interest in physical appearance were noted by 18/189 (10%) and 15/189 (8%) respectively although some of the comments about physical

appearance could have been aimed at the weight loss and self-harm issues as there were also mentions of changing clothes for games and wearing baggy clothes to disguise thinness. The tiredness is linked to depression and this is a difficult symptom to spot in class because child development is accompanied by periods of intense growth which causes tiredness and at certain stages increased tiredness is a common element rather than a sign that something is amiss. Research on teenagers e.g. (National Sleep Foundation) has found that they are more alert and less tired in the afternoons and that early morning lessons will be affected by a natural tiredness.

The emphasis on schizophrenia in question 8 led to an anomalous 8/189(4%) of responses about students who were responding to internal voices. It is not clear how these symptoms would be visible. Likewise hallucinations and paranoia are not symptoms that are easily recognisable or visible. Two respondents mentioned secret bingeing and eating and again it is not clear how these would be visible. It is also less clear how signs of self-harm, mentioned by 6/189 (3%) of people could be noticed as this is a secret activity which is kept hidden at all costs. It might have been that the answers pertaining to self-harm were linked to covering up and not wanting to change clothes etc. rather than direct evidence of the behaviour itself.

All other answers, listed in appendix 3, were noted by fewer than 5/189 (3%) and these mostly considered the negative emotions of feeling anxious, scared, sad, lonely etc. which are associated with a range of mental health issues. There were some comments about being over confident and loud and shouting out which link to the ADHD from question 8. Most respondents seem confident in pointing out signs of depression and eating disorders but it is less clear how disorders and phobias are symptomized.

**10. Are girls or boys more affected by mental health issues?**

Girls:		23.8%	45
**Boys:		24.3%	46
No difference:		51.9%	98

Question 10 is another statistically based question which considers the role of gender aligned to mental health disorders in children. Just less than a quarter of answers were correct in identifying boys as being most affected. An almost equal number of replies felt that girls would be more affected and interestingly double the number considered it unlikely that there was a gender difference.

Question 11 was linked to a televised promotional campaign about mental health which has been running since 2011 following on from earlier campaigns. The campaign was funded by the Department of Health and Comic Relief although now other organisations have offered funding. It is entitled; It's Time to Talk; Time to Change and its focus is on the need to overcome the fear and stigma around discussing mental health issues. 32/189(17%) people had part of the slogan right or just described the focus around stigma and the need to talk. 4/189 (2%) had recorded the full slogan. 140/189(74%) had no awareness of the campaign and the remaining responses suggested other possible titles some of which were relevant but did not mention the key words.

**12. In this survey I.....**

Mostly guessed the responses:		47.6%	90
Guessed some responses:		30.2%	57
Knew some answers:		20.1%	38
Knew all the answers:		0.0%	0
Other ( <i>please specify</i> ):		2.1%	4

Question 12 was added so that respondents could assess freely the level to which they had guessed the answers. Guessing was by far the way that most people approached the questions although 20% considered that they knew some answers. It seems likely that question 1, which asked about the percentage of children with diagnosable conditions and question 7, which was a true/false question linking mental health issues to asthma, which had the greatest proportion of correct answers would have been identified by the 20% but again this broad brush instrument does not allow the interrogation of the data to that extent.

Question 14, which asked for the views of participants around their awareness and feelings with regard to mental health issues, was added to allow participants to make a qualitative comment. Many followed the pattern of just gauging their awareness and using descriptors such as, 'a little bit/ fairly/have some awareness but...' Others made statements which linked their awareness to experience on a personal level or from involvement with family/ friends. This was a useful addition as it explained previous awareness as being from outside the institution rather than from learning as part of the PGCE course.

Overall the number of respondents who claimed to be unaware of mental health issues was by far the greatest at 89/189 (47%) , 35/189 (19%) recorded that they had some awareness and 8 of these disclosed that they had a diagnosis of a mental health issue themselves whilst 8 others had a family member so had at least awareness of one particular condition. 5/189( 3%) answers said that this was not an

important issue, 1 claiming that the numbers involved were too small to be significant. 42/189 (22%) stated the need for more information. 7/189(4%) described themselves as having an adequate awareness and 2/189(1%) said they were very aware.

The qualitative comments listed in appendix 3 have several common elements. There is an interesting use of terminology which puts this topic firmly in the medical model of disability and many comments use, 'suffer, suffering, struggling' as terms to describe the experiences of people with a whole range of conditions. One person summarises,

'I don't know much about it at all... it is worrying to think how many children may be suffering in silence.'

Some respondents seem confused by the term mental health issues and wonder if it is the same as, 'mental illness' or even, 'mental disability'. No answer suggests a positive treatment of the phrase and words like, 'stigma' are repeated with one respondent claiming that,

'Mental health has a bad stigma. Can't see it being broken down and don't know how to deal with it.'

Another comment was that mental health is, 'a taboo subject and needs to be talked about more.' A lecturer in ITT claims that,

'Mental health is associated with stigma and misconception so is a complex aspect of teaching and learning.'

One answer which links strongly with the argument for awareness raising is the person who is 'concerned.' This person considers that,

'I do not feel particularly aware at all. I try and make no judgements about people with mental health issues; but sometimes I am concerned for their safety and the safety of those around them.'

It is clear that the stigma and misconception mentioned by the previous respondent is influencing this person's view.

Several people describe their own experiences of dealing with mental health issues whilst engaging in learning. One respondent in particular recorded a negative experience within HE. He/ she wrote that:



‘ I suffer from a mental health disability myself and my experiences have been that academics are not only unaware of such issues but are very prejudiced about them and can act in highly discriminatory and oppressive ways towards people with mental health issues.’

This is of concern obviously due to this person’s negative learning experience but also because ITT tutors model good practice and this is one of the strengths of the provision.

Interestingly several responses claimed to have awareness of issues affecting adults; whether through personal experience or that of family and friends but many claimed not to know what mental health issues children were dealing with. This is a key indicator for the need to raise awareness in a targeted specific way which would link to the key stages of each ITT course and be clear about the issues relevant to specific groups and stages of development.

There were several respondents who stated that they didn’t know how unaware they were before completing the survey. One person expressed, ‘surprise’ at how little they knew. This gave the survey a sense of purpose and it was useful to reflect that without a reason for thinking of the topic then maybe the lack of awareness would not have been raised. This is in conflict with one respondent who said that they could find this information easily online and that they didn’t see the reason for listing conditions and completing all the questions. This person concluded that,

‘if I need the mental health statistics I could find the latest data online.’

They do then also state,

‘ at least the questionnaire has made me aware of mental disorders in children’,

Although the questionnaires were designed to gather data around awareness this response highlights a positive side effect of completion and it could be inferred that without the questions being asked this person may not have realised the gap in their knowledge or known what to look up online. The more positive view that the survey had highlighted a lack of awareness and had, ‘ provided the impetus for exploring mental health issues in more depth’ was repeated by several participants some of whom had already started some research and been further surprised by their findings.

Some staff respondents said they had no formal training but had learned by supporting students. The numbers of students involved was reported as quite low. One person said 'several students in recent years,' and another said they have, 'some students each year on the course...' One member of staff said they would 'try to support' students experiencing difficulties and this person also would, 'try to pre-empt where I can.' This respondent mentioned the media as a source of information and also had personal experience of 'contact with young people struggling.' The media was mentioned in another response as *East Enders* was listed as a reason for being aware.

Some answers to question 14 were in the form of a statement about perceptions. One answer states,

'I am personally aware. I believe it can affect anyone and at any time. Many variables can affect individuals and how they cope with the rigours of everyday life.'

A further summary was, 'Paying attention to our mental health is very important.'

Several respondents asked for further training and support as part of their course and one person concluded that,

'I think we need to be far more aware of issues that we have to face in the classroom so that we have the ability to deal with unforeseen situations. This should be a core subject during training.'

A very interesting summary of the complexities was provided by one member of staff who pointed out the very practical difficulties of spotting, diagnosing and referring (our Tier 1 responsibilities) in a busy classroom. This person suggested:

'I can be quite clear about signs and symptoms but in a busy classroom where patterns of behaviour evolve it is hard to step back and realise where you and the child/ young person have got to in your behaviour together-- getting more outcome focused rather than relationship led means it gets harder to pick up the signals- time together is fragmented when teaching children/ young people/ adults so consistency of interaction means that knowledge is even more fragmented.'

In Chapter 5 the findings presented in this chapter will be analysed further in light of the research questions and aims and comparisons will be made to the literature review and the methodology chapters to lead to conclusions which will be discussed in Chapter 6.

The next section of this chapter will outline the findings from Phase 2 of the research which were the semi- structured interviews with staff.

#### **4.2 Phase 2 Presentation and Analysis of Findings from staff interviews**

The transcripts from staff interviews are included in appendix 5 and the content of the transcripts were uploaded into NVIVO for comparative and thematic analysis (see section 4.3b). 4.2 includes some direct quotes from the interviewees which encapsulate the main findings which were then organised utilising the software into nodes for comparison with findings from other phases. All names in this section are pseudonyms.

The interviews were semi structured and the questions are included in appendix 4. The use of the structured questions allowed some comparisons to be made and these are analysed in this section. Further analysis of the results in comparison to the aims and objectives of the thesis and in light of the literature and methodology will be undertaken in Chapter 5. Conclusions drawn from the data in this phase are recorded in chapter 6.

There were 8 staff interviews across the 3 HEIs. From my home HEI there were 5 interviews conducted, two from the second HEI and only 1 in the third institution.

Seven out of the 8 respondents were female and this needs to be reflected on. There are definitely fewer male members of staff on the PGCE primary programmes across the 3 HEI's but the one male interviewee is from this group. This means that no male PGCE staff teaching on the Secondary or FE provision volunteered to be interviewed.

All staff interviewed had a teaching qualification; 5PGCE, 2 BEd and 1 Cert Ed (because of a specialism in SEN which did not have a PGCE group at the time).

Only one interviewee had ever had any training around mental health awareness and that was in a previous career as a guidance counsellor. None of the respondents had received training as part of their PGCE or similar courses and none had undertaken training once qualified as a teacher or since joining the University's teacher training team. All interviewees were personal tutors with class sizes around 20 or smaller.

Each of the interviewees was asked about their own awareness of mental health issues and if they had direct experience of how mental health affected teaching and learning. Participants were comfortable to disclose mental health issues that they had experienced and many drew on the experiences of family members, and / or of colleagues. These open disclosures were very positive ways to open a discussion and the structured questions were often abandoned as the discussion covered their content.

Several participants expressed surprise at themselves or other close family members being diagnosed with depression. The stereotype of 'nervy' stressed people being typical of someone likely to be depressed was considered by respondents who admitted having to reframe their views following a diagnosis of someone who had always been cheerful, positive and organised. The inference of the opposite of each characteristic being more usual was explored and often comments about 'everyone' and 'anyone' being affected were made in conclusion.

Other common issues were around the capacity of the curriculum to include any information or sessions on topics such as this and the standards driven approach to ITT which affected the content and delivery of the course.

The following section will summarise the main considerations of each interview in turn. The node tree diagrams in section 4.3b) will draw linked comments into thematic schema to summarise and consolidate the findings.

### **Summary of interview with Vanessa**

Vanessa is a Senior Lecturer teaching on a PGCE secondary course in a Teacher Training University. She has direct experience of an on-going mental health issue which had been shared with her learners and colleagues in an attempt to begin a discussion around the topic and to challenge stereotypes. The reaction to this disclosure among colleagues was puzzling to this person because the colleagues were considered to be 'intelligent' and 'mature' and yet they were made unsure and uncomfortable by this new knowledge. Vanessa discussed the awareness- raising session that had been introduced at her home institution and the materials that were made available to students after the session for further information. The initial awareness raising session was delivered before students went out on placement and

the respondent stated clearly that, 'they need it as soon as possible' and, 'definitely before they go out on placement'. In the final minutes of this interview Vanessa raised the possibility of creating a regional or even national network to encourage sharing of the good practice which was being developed. She felt that even in her own institution there was an overall lack of awareness and she expressed surprise that many members of staff and students still harboured serious misconceptions about mental health despite having her there championing the cause for awareness.

### **Interview with Sandra**

Sandra is a Lecturer and Course Leader teaching on a PGCE secondary course in a Midlands HEI. Sandra began with positive statements about her own awareness based on family circumstances. She reflected that in her role as personal tutor there had been many students over the years who had not coped well with the rigours of the course and who had needed extra support. The main focus of this interview was that the PGCE itself was an, 'intense', course which piled pressure onto students and every year, 'the tissues come out in February'. Sandra spent time in the interview exploring the notion of vulnerability involved in, 'laying yourself bare' as a pre- service teacher trainee.

Sandra was not personally aware of the National Service Framework for Mental Health (2004) but surmised that it may be mentioned to trainees under the umbrella heading of 'safeguarding.' She could not be sure that this happened as not all staff were present during content under that heading.

Encouragingly Sandra recorded a commitment to look into this topic further herself and to consider when it could be incorporated into the course. There was a statement made that,

'actually we should know about it before we go out. I think perhaps people worry though that a little knowledge is a dangerous thing.'

Sandra at the end of the session returned to her statement at the start about being aware and summarised the position with,

'I think I am aware but I probably don't know as much as I ought to'.

The other interesting facets of this interview were the final two comments that,

'I think it's just so scary; it's much scarier than any physical illness.'

And

‘It’s all above the young teacher, they would never get involved. I’ve never been involved in multi-agency anything except when I was head of year.’

### **Interview with Lynn**

Lynn is a Senior Lecturer teaching on a PGCE Primary Education course at a Northern HEI. In this interview Lynn openly shared a personal experience of pre natal depression which she had been affected by and she explained that there had been an element of surprise here as the, ‘type of person’ likely to be diagnosed was discussed. Lynn was an experienced Primary school teacher and she also had numerous experiences of colleagues dealing with stress and sometimes having to leave the profession early. There was a very interesting discussion about how difficult it was to support colleagues in these circumstances alongside the pressures of being a deputy head and the cover arrangements needed etc. which put pressure on the whole system.

The most noticeable aspect of this interview was the link made between outstanding practitioners and an outstanding OFSTED rating for the course and the pressure that that conferred onto the trainee teachers. The interviewee claimed that,

‘I think our students are taught in detail how to strive for perfection but they aren’t taught explicitly how to protect their own mental health or that of their learners.’

The course team had discussed their delivery of matters around inclusion and a positive development during this interview was that the interviewer was invited to participate in the SEN conference in January 2014 which aimed to cover a wide range of issues affecting teaching and learning via workshops and speakers. Lynn affirmed that,

‘we (the staff team) have identified this as an area to be developed.’

This development is partly related to the initial statement of this interview when the first comment was that,

‘we need to make them aware and equip them with strategies to cope otherwise all our good work in producing outstanding practitioners will be wasted and they won’t stay.’

### **Interview with Justine**

Justine is a Senior Lecturer teaching across a range of ITT programmes in a northern HEI. Justine had a background in advice and guidance and was the only

respondent to have had mental health awareness training in her past career. The content of the course plus many examples from experience were shared and links were made to when this knowledge was inputted into the curriculum for current PGCE students. Even though, 'the curriculum is already bunged' there were opportunities taken to mention trainee's own mental health in preparation for placement and in training for interviews

Many students had been supported by this tutor and she drew well on the wider services of the university to provide additional support. Mention was made particularly about being 'flexible with the timings of the course' as much as possible and advocates from student services had been utilised to help students apply for extensions due to extenuating circumstances to allow them to have extra time to complete the course.

The additional time was not the only consideration and it was in this interview that the first mention was made of, 'Fitness to Practice' and the resilience needed to work in the sector and to have a positive placement experience. Justine considered the difficulties of placing student teachers who might not be able to complete the usual number of placement hours or who might need extra support to do so. 'A disclosure of mental health issues could make finding a placement more difficult and head teachers might worry about taking someone on.' The issue of disclosure came up again when the respondent considered that, due to the stigma attached to mental ill health, 'students could be reluctant to share experiences in class for fear of a lack of confidentiality.' Also this was an issue because students are entering a 'very competitive work market and they don't want to disadvantage themselves.'

An interesting comment was made here about the timing of the planned conference in January in that this respondent felt that having a conference immediately following the placement would lead to students,

'...knowing what they don't know, if you know what I mean?'

This was the first time that anyone had suggested that student teachers shouldn't be given this information before placement but be allowed to go on placement and then return to discuss experiences and questions which had arisen and to then find out about barriers to learning and how to overcome them. This was in direct contrast to

Vanessa's and Lynn's interviews when there was a definite conclusion that students needed this information prior to entering placement. Justine was keen on the notion of a pack of information being made available as a starting point for reading and research around issues affecting practice but again felt that this was likely to be sought out after placement.

Justine added a cautionary note to the interview when she reflected that,

‘in the past we have had some learners with mental health issues who have had attention seeking personalities and a manipulative nature which may put people off getting involved.’

This was tempered by the final comment however that,

‘not all students with mental health issues are the same though and everyone needs to be treated as an individual.’

### **Interview with Janet**

Janet is a Senior Lecturer teaching on a PGCE Lifelong Learning Sector. She was extremely enthusiastic about this topic and was very aware of mental health issues affecting teaching and learning as she prepared the pre service teacher trainees for functional skills and employability and stressed the prevalence of mental health issues which trainees would meet in all their classes.

The notable difference in this interview to the others, apart from Vanessa, was that this person had developed a range of strategies which modelled positive practice around wellbeing and used these in class so that all student teachers were able to take the good practice out into placement with them.

The good practice included using case studies based on actual learners as a basis for discussion around curriculum planning and classroom management. This could be shared across the school but it may be that other group tutors wouldn't have such a wealth of experiences to call upon or that they wouldn't recognise the students in these case studies as being representative of their own groups.

One of the most interesting statements in Janet's interview was,

‘On another note though I also tell my people that it is ok to cry and to feel overwhelmed by the demands of the course and the demands of the learners they meet.’



This links with the supposition that I made in the introduction to the thesis that possibly creating a space where students are told that it is acceptable and where they are even encouraged to discuss their feelings and insecurities allows this to become a feature of the course.

Janet went on to point out the benefits to students of having time dedicated to consideration of their feelings and emotions and is perhaps in a minority among the interviewees recorded here in claiming that,

‘The focus on meeting targets and measuring attainment in classes is obviously a priority but trainees need to consider the positive effects of breaking down barriers to learning.’

An interesting discussion ensued about trainee teachers worrying about soft skills and not being focused on technical accuracy with regard to delivery. Janet does conclude that there are,

‘Some trainees who are so concerned with the mechanics and administrative elements of learning to teach that they just can’t deal with anything more abstract at the start.’

Another interesting section of this interview is involved with placement of students and the role of occupational health in assessing people as, ‘fit to practice’. This echoes Lynn’s interview and similar concerns are expressed here about sending someone out into practice without the resilience to cope and possibly damaging the relationship between the HEI and placement providers.

Janet was keen to share practical tips and strategies and these could be incorporated into an awareness raising pack so that trainees could all have access to a range of activities aimed to improving or sustaining their wellbeing. Vanessa also offered to share the content of her awareness raising power-point as a starting point for the pack.

### **Interview with James**

James is a Senior Lecturer and course leader for a PGCE Primary at a Northern HEI. He was very honest in stating at the start that there was no formal, planned input around mental health awareness on the course at present but that there was a

willingness to discuss it and to consider how and where it could be added. The course leader did state that there was some informal work done around the wellbeing of the trainees but the following statement fits in with other course leaders' conclusions around the full curriculum and what are considered to be the most important elements of the PGCE course. He stated that,

'We do mention those issues (wellbeing) to our trainees but their mental health concerns will always be secondary to be honest as the whole course is aimed at meeting the standards and there isn't anywhere in the standards that links to mental health awareness specifically. I think we only cover it in terms of inclusion and that's a wide umbrella. '

When reflecting on his experiences of practice James introduced an important point which is reiterated in other interviews.

'I think many of the behavioural issues we deal with in schools may have a root cause in mental health issues. It is easier in primary education to notice changes and to work with the children to make differences. I think in secondary classes you have so little contact time and so many classes to get to know that it must be harder.'

The ideas of a full curriculum and of large class sizes are stated by several respondents as a reason for the lack of awareness- raising embedded into the teacher training course and into preparation for placement. James agreed with Sandra when he mentioned that this was not a topic pertinent to young newly qualified teachers who would simply be expected to refer any concerns on and he wondered whether other -members of school staff are in a better position to spot and support issues in class. He says that,

'I think the TAs in classes are often in a position to chat to children more and to notice if they are distressed. TA work is often 1:1 or in small groups and they have opportunities to take children out for quiet time or reflection.'

James also concurs with Lynn and Janet who considered that placing a student teacher with a mental health issue in a school or college placement setting was a concern. James said that:

'It is tricky to place trainee teachers in placements when you have concerns about their resilience because lots of head teachers would be wary about taking on someone who might need lots of support. It is often better to describe the issues facing a student rather than labelling them as being depressed as the stigma is something that I think could go against someone in such a competitive profession.'

These issues of vulnerability and stigma are of great concern and the discussion moved on to the legal and policy framework which meant that there are requirements not to discriminate against anyone in terms of their mental health. The response from James to this was to consider that:

‘Even though prospective employers and placement providers would abide by the law; if I am honest I think they would see the possible problems rather than the positives. ‘

### **Interview with Nuala**

Nuala is a Senior Lecturer teaching on PGCE Secondary at a Northern HEI; she expressed surprise about the people she had seen going off with stress whilst in practice, she stated that,

‘Sometimes it was a real surprise who was struggling, people you had thought of as being strong and organised would suddenly not be there. In terms of here (the university) it is students that I notice most and every year there are at least one or two in the group who will not finish on time or who will leave.’

Nuala added her concerns to Lynn and Janet about placement and about how to judge a person’s suitability and resilience at interview. She claims that, ‘We try at interview to get a measure of resilience but it isn’t an easy thing to spot.’ In the same vein but thinking more about retention than recruitment Nuala stated that,

‘ I think that sometimes students disappear off the radar and suddenly stop attending and I wonder maybe if there were signs and symptoms that we could have spotted that would have meant supporting people better and maybe retaining them too.’

Nuala had been spurred into further research by the awareness raising questionnaire and commented that:

‘...the questionnaire made me realise that I hadn’t thought of this in terms of younger children either; always in terms of staff and older teenagers maybe. I think I could tell when someone was anxious or depressed but that does presume that they will be acting in a certain way and is that a bit simple?’

This statement prompted a discussion about the worth of having input on signs and symptoms. I postulated that it was possible to stress that these were typical symptoms and that not all or even most would be seen at any one time. The input being suggested in the awareness pack is more about classroom strategies and the confidence which comes with awareness. Nuala then considered her own experience and said that,

‘I think I see stress and anxiety quite a lot. It’s hard to tell about depression because I presume the symptoms are the same. I hadn’t thought about eating disorders being so common until I looked up the stats after doing the questionnaire and that was a wake- up call. I have never seen any direct evidence of self- harm but then again I thought about this in terms of cuts and since doing some research I can see that there are lots of ways which I didn’t know about.’

This use of the questionnaire as a springboard for personal research is very encouraging and Nuala admitted that at present students had no input on mental health in any part of the course but that she now considered that

‘We don’t cover it directly definitely although I am thinking now that we should.’

### **Interview with Rosemary**

Rosemary is a Senior Lecturer in a Northern HEI delivering PGCE Secondary. This interview started with a disclosure about a family member who had become stressed in work as a teacher. Rosemary reflected that,

‘ He used to go in very first thing and stay till really late because that’s what everyone did but he was becoming distressed and getting so tired that he took some time off and when he went back it was very different. He leaves now at a reasonable time and makes time in the day to go for a walk and find some relaxation. Teaching is such a stressful occupation so you have to know your limits.’

The difference between secondary and primary schools was emphasised several times during this interview and this links with earlier transcripts which suggest that your key stage has an impact on the way that awareness is considered appropriate and who might be deemed most in need of the information. Rosemary stated that,

‘I think in school teaching in a big secondary there were obviously issues to deal with but we tended to put them under the umbrella title of EBD. That was the jargon of the time and most issues were dealt with in terms of behaviour and making it possible for people to manage the school demands without being excluded.’

It is possible to infer that support for behaviour may have included 1:1 support and out of class provision which would be beneficial for students with mental health issues but the issue of definition and language is pertinent to the study and will be at the heart of any awareness raising sessions and materials produced following the research.

The issue of who needs to know what has been discussed in several interviews and Rosemary agrees with Sandra and James who feel that a newly qualified teacher would only need to refer issues on. Rosemary was confident in stating that:

‘we know that all our trainees have knowledge of who to refer young people to if they think there is a safeguarding issue. As a trainee or even a new teacher all you would be expected to do is to refer.’

Rosemary was not overly concerned about specific input targeted at key stages but did accept that the new conference on SEN planned for all students on PGCE Primary and Secondary for January 2014 would benefit from a session on mental health issues. Interestingly she requested that I deliver any planned sessions because she claimed that,

‘..... I don’t think anyone on the course would be comfortable running a workshop. It is an area( inclusion) that we know we are needing to improve on and some trainees have asked for more input as at the minute we rely on an online pack of materials and one day’s teaching per year about lots of different issues.’

With regard to the specific topic of mental health Rosemary claims that because of a subject specialism there are only ever requests from students about issues affecting teaching and learning for those students with visual or hearing impairments. There was however a consideration that,

‘There is no specific input on mental health as such but we do talk a little bit about work life balance and I think we would say that under this broad brush approach we do mention things which would help.’

The end of the interview covered a topic that had resonance with other interviewees concerns around the time needed to complete elements of study for learners with mental health issues. Rosemary reported some positive outcomes,

‘We have had people suspend and come back and successfully finish but they usually need extra time and to maybe split their placement over more months. With an EC (Extenuating Circumstances) agreed it is possible to finish the teaching practice later which has helped. ‘

#### **4.3a) Phase 3 Presentation of Findings from Focus Groups**

The models made by students in focus group sessions have been analysed in two ways. Initially I have composed a narrative for each model to draw together input from the process of the model making with an explanation of the product. The narratives I have constructed offer a still photograph of the product of the session along with a commentary which describes what the model represents and how it was presented. Highlights from the transcriptions of the session are included to ensure that the voice of the participant is represented and not the opinion of the researcher.

The following pages contain the narratives compiled during the model making sessions and the data from them is analysed in Chapter 5 before conclusions are recorded in Chapter 6. All names are pseudonyms in this section.

**Anna's model figure 4.1**



The pink box represents the classroom and the blue person at the top is teaching their best lesson with the intention that all learners will meet the learning objectives. The teacher is looking towards the whiteboard and is sure that everyone is listening intently. They assume that as there is no noise or disruption from the learner that they must be learning.

The blue learner at the bottom of the picture is seated, slouched backwards and is seeing in front of them a wall covered in wiggly lines which represents the barrier in communication by showing a physical divide and that the sound waves are masked by interference too. This means that despite the teacher's best efforts the learner has no idea what they are talking about and the lesson is not going any way to breaking down barriers for this learner or to encouraging communication between the two sides of the divide. The barrier is made from almost transparent material representing the fact that the barrier is flimsy and not permanent.

The model learner's head can be seen to contain lots of multi coloured, jumbled thoughts and worries and these are visually represented here with the glittery decoration. If the teacher took down the wall and looked intently at the learner they would see the outward signs of the issues inside this person. It might be that if the teacher was aware of the effects of mental health on teaching and learning that they might be looking for signs and ready to break down the barriers. Anna said that: 'the teacher is writing and talking but the student can't understand anything because they are not able to learn'. Breaking down the barrier would depend on the teacher recognising that it exists and they would also have to notice the student's behaviour and confusion recognising that it exists and they would also have to notice the



student's behaviour and confusion.

**Barbara and group. Figure 4.2**

The sad young person at the top of the model is looking down at his/her life and educational experience. The areas represented by the clay islands are linked together as these are all facets of one young person. The separate island has hurdles to represent the barriers to learning which are in a different place to show

that school is in the corner of the adolescent's world and has its own issues to overcome. As all the islands are contained within the box this represents the whole world of this young person and its limits are set.

The model combines words and colours to share the multiple effects of having mental ill health. This group have identified the feelings that can be strongest as: 'sadness, anger and loneliness'. These would all have to be dealt with whilst trying to manoeuvre past the barriers in the school setting.

The right hand island represents the pressures on the young person to conform and fit in. He/ she is looking despondently at all those areas because they all have their own pressures and could increase the stress on the individual.

The yellow of the box is a happy colour but the parts of this person are represented by dark and mono-coloured lumpy clay. The spokesperson concludes by saying that; 'once you have helped students past the barriers you could get them to participate but only when the barriers were removed.'



**Ellie's model. Figure 4.3** The model can be folded back on itself to show only one view at a time and this is how Ellie presented it to the group. The faces in the model represent a particular learner that Ellie has been teaching at her placement. The model is a simplistic portrayal of emotions which are split into happy and sad. Colour and the sunny image represent happy and the face on the right has a smile. The



background paper is yellow which represents happiness. The top has rain and despondent faces. The X and √ are deliberately educational symbols which we use to convey a judgement and these here represent the mood of the teenager.

When the sad picture is presented in class the learner doesn't engage in tasks or in discussion. The red X represents this refusal to take part or to talk about the issues which are making today a sad day. Ellie suggests that there could be lots of reasons behind this, '... he could feel anger; he could be frustrated or just sad. There are lots of reasons and we can't see them all.'

By revealing the happy emotions page Ellie shows that you can move from unhappy through to happy and she thinks this is possible. '.. whatever day it is or who is around you.' She claims that with help and encouragement and when teachers don't judge then everyone can get a tick for managing their emotions.

The model was displayed one side at a time and then opened up to show the movement between the two halves. This opening up represents removing the barriers from the X side and allowing the √ to be seen.

#### Frances' Model figure 4.4



Figure 4.4 represents a learner's journey and the stages and hurdles to be managed within teaching and learning.

The yellow person at the start line is sitting and not ready to begin the race. Words around the body and repeated question marks demonstrate how confusing and distressing it can be to begin a course of study and this model focuses on how hard learning is perceived to be. This may be because the learner lacks self-esteem, ability or confidence and any of these could be because they have additional issues to deal with. The hurdles at the start are tall and the most difficult. With the 'help' and 'support' which underpin the barriers the hurdles become smaller and the journey seems to get easier.

The model also shows the softer skills and other achievements that sit alongside the academic content of the course. The learner is represented seated again at the end of the journey but not alone, friends are present and the sparkly material represents happiness and confidence.

Frances shared the difficulties faced by her learners in terms of: language barriers, coming from areas of deprivation, not used to being in a classroom, stress levels and a range of mental health conditions. The model shows the job of the teacher in reducing the size of the barriers.

### Gina's Model Figure 4.5



This was a complex model which offered many ideas. The shiny materials on the right of the picture represent a shiny, glamorous world and it is to this that people are drawn and want to move but also it is against this that they measure their lives and the people on the left in their own, less glamorous part of the world can see the shiny, perfect parts. In the left hand group there are 'people of different colours, different ages and with different problems.' They are slightly separated from each other because they might think that they are the only ones with this particular issue. For example there is a mother here with a new baby and another mother with a teenage daughter. Each could assume that the other has it easy and that they wouldn't understand the issues that each one faces.

Gina states and repeats that, 'mental health issues transcends all barriers.' She uses the examples of celebrities. 'I was really surprised when I recently read about celebrities who had come out and said that they had mental health issues; you would

never think that these glamorous people would have problems at home but it doesn't matter who you are, anyone can have mental health issues.'

Gina said that, 'as teachers we need to open our minds.'

The group on the left represent people of all ages, abilities, colours and life stages. The message is that teachers can help people move towards the lighter, shinier and happier parts of the world.

#### **Helen's model Figure 4.6**



The outside of the box represents the classroom

m and is shiny because it is seen as desirable by the learners and it is what they are trying to achieve. The model is static but it represents movement by using the sunken areas and being moved physically around as Helen explains the premise. The learner is represented by dull coloured clay and is initially in a sunken position because they are depressed and they feel deflated and less on a par with their peers. The journey to the shiny perimeter for this learner is harder than for those who are already at the surface.

The model is complicated as it reveals the learner's journey through the classroom and how it unfolds. The learning in the first section is all scrambled and this is

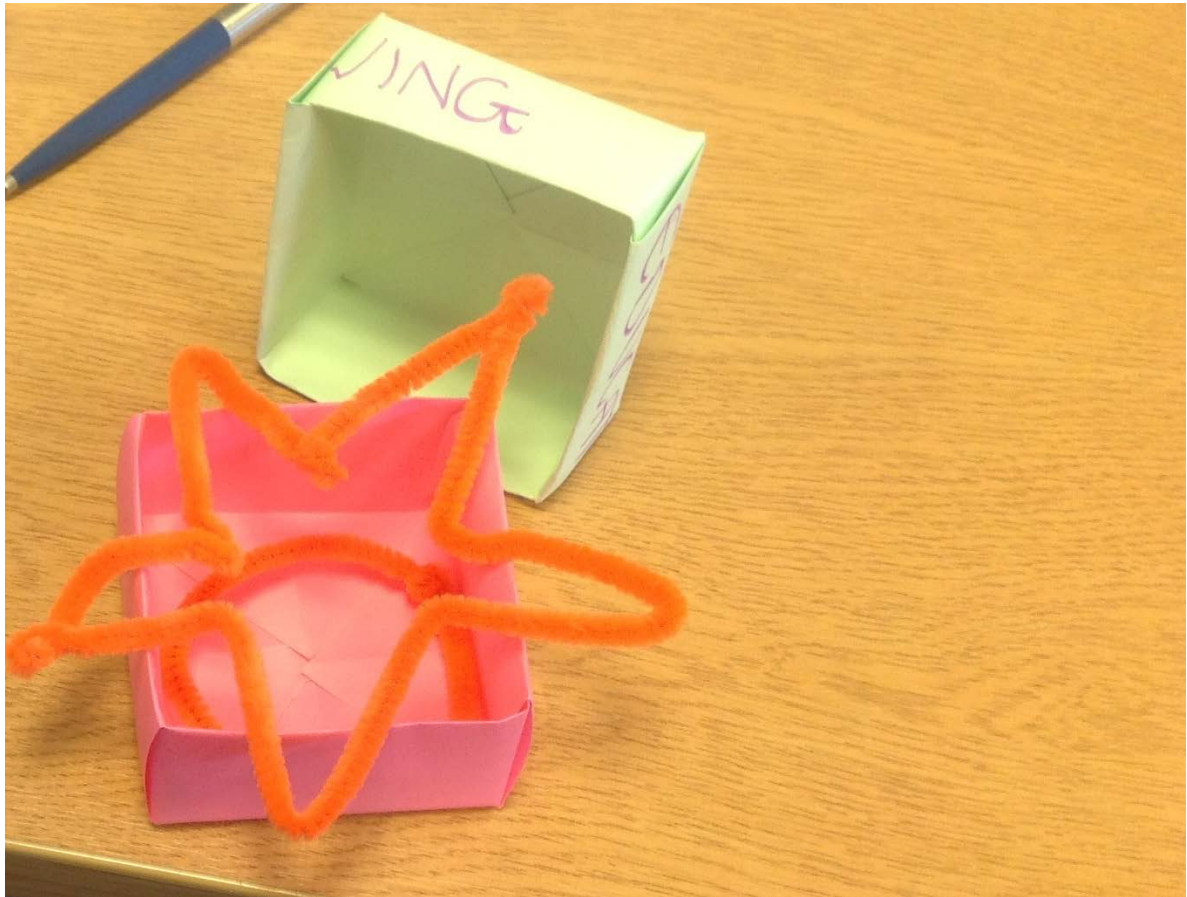
represented by the mono colour elastic bands to show that everything is confusing and bland and that the learner finds it difficult to engage with learning because of their depression.

The next section represents movement and success in small steps as the learner is no longer separate from the learning. There is a connection and this is considered to be the role of the teacher; to break down the barriers and remove the difficulties so that the, 'separate pieces merge with each other and they are in tandem because the learner is learning from their peers'. Thus the importance of relationships in learning is depicted and the fact that in all key stages peer learning and assessment are a positive feature. As the learner is garnering help from her peers they too are enjoying helping her and being part of her learning journey. This acceptance of difference and putting empathy into practice is modelled by the teacher who gently facilitates movement throughout the confusing model to the success at the edge.

The onlooker can see the change in the learner which the teacher has noticed. In each segment, the previously deflated person is starting to change and begins to form bonds and relationships; whereas at the start they were withdrawn and isolated.

The colours begin to merge to represent the oneness of this emerging person. The learner is discovering how to manage her depression and to move forward with her learning. There is open dialogue with the group and talking helps too. The very colourful last stage represents a celebration of learning. The 20 week segment of learning has been successfully completed and she has produced a booklet which is, 'all about herself.' The depression may still be a factor in this person's journey but this small segment of learning, taken at a suitable pace has been a success and she can move on to new segments from a higher base line as shown by her higher status on the model.

### Imogen's Model Figure 4.7



The box is a simple representation of learning. The box represents education and the tangle of pipe cleaners represents a learner with complexities which are not all on the surface.

If you are a learner with no difficulties you can fit perfectly into the box but this learner has mental health issues which are represented by the jumbled nature of the model and the teacher can try to force the learner to fit in but it is clearly impossible. Imogen describes the people who fit perfectly as 'happy' and their learning journey is 'easy' and 'smooth'. The learner depicted here however can only access parts of learning which come into contact with the surface area inside the box. The bits sticking out at the side represent missed opportunities and because of the spiral curriculum once missed some of this information can never be revisited and the gaps are there permanently.

This easy model makes many points simultaneously and visually. The need to make learners conform is the first point being made as we try to make all learners fit one size of box. The teacher is unable to repackage the learning into a container that fits the learner and this is what personalised learning would look like. There is also a time element here as the learner is wedged into the box to make contact with whatever learning is possible but the bits missed are not made available in any other form. The box concept links with theory from Assessment For Learning and the

'black box' of the classroom and it can be seen that this learner is not going to do well in assessments because they haven't had all the input that they need.

The fact that the learner doesn't fit is obvious to everyone and this must increase their feelings of being 'other' and their discomfort. It is also more obvious to their peers that there is something different about this person and this can make forming relationships more difficult. If the box was more accommodating then the learner could fit alongside their peers and learn from them too. The peers might be empathetic as the difference is now amongst them rather than at a distance. This could link to the notion of exclusion and segregation of learners with difference and the box represents, at present, a medical model of disability as it is rigid and the learner doesn't fit. If the box was altered then it could represent the social model where the learning has been adapted to meet the needs of the learner.



The picture uses feathers which are different colours to represent the range of mental health issues present in the classroom. By placing the teacher in the centre and implanting all the coloured feathers at once onto the teacher's representation it can be seen that the teacher is taking note of all these 'colours'/ issues and having to

deal with them. Jane, in this instance, is portraying what it is like to teach learners who have recently moved to the UK and who are seeking asylum. This particular group of learners have a range of issues and problems specific to them which may be the cause of the great number of mental health problems identified in the model.

Jane comments that, 'I have to forget about my own issues and problems and cover them up.' This was an interesting approach and one which surprised the audience. The point of the model was that by spending so much time and effort dealing with the mental health problems in front of her the trainee felt that the teacher's own wellbeing came second and that the learners were not considerate of her as a person but felt that her professional persona meant that she didn't have any issues of her own. She went on to disclose that she did have many issues of her own around confidence and self-esteem especially and also many problems in her personal life which meant that maintaining a professional persona was difficult and put her under great strain.

It was good to note that as this short presentation was made the other trainees present were keen to support and to offer advice to this person. It links well with strand 3 of the current research as teacher's wellbeing is postulated as a reason to be aware of mental health issues. The trainee was advised to ask for help in dealing with the mental health problems of her learners and to look for outside agencies who could provide assistance. Her own mental health was suffering as a result of work and she was also advised to undertake some training or counselling to offload the pressures of work in a timely manner.

This presentation was thought provoking as all the others in the focus group had been looking at mental health issues as they affect learning and are a barrier to learners' success. This model represented the teacher's mental health issues as caused by being part of a stressful profession and by trying to deal with the myriad support needs of a challenging and specific group whilst managing her own personal life and the difficulties inherent in it.



**Karen's model Figure 4.9**



The model is colourful and complex and represents the journey of a trainee teacher into placement.

There are different segments here represented by different colours. There are dark areas and fragmented sections leading to some bright colours and a shiny, happy area.

The dark segment represents the feelings of anxiety and depression which surrounded the trainee as she was in a difficult position because a placement could not be found for her early in the course and when other trainees were being sorted and starting placement this person felt singled out and alarmed by the fact that she would go into placement late.

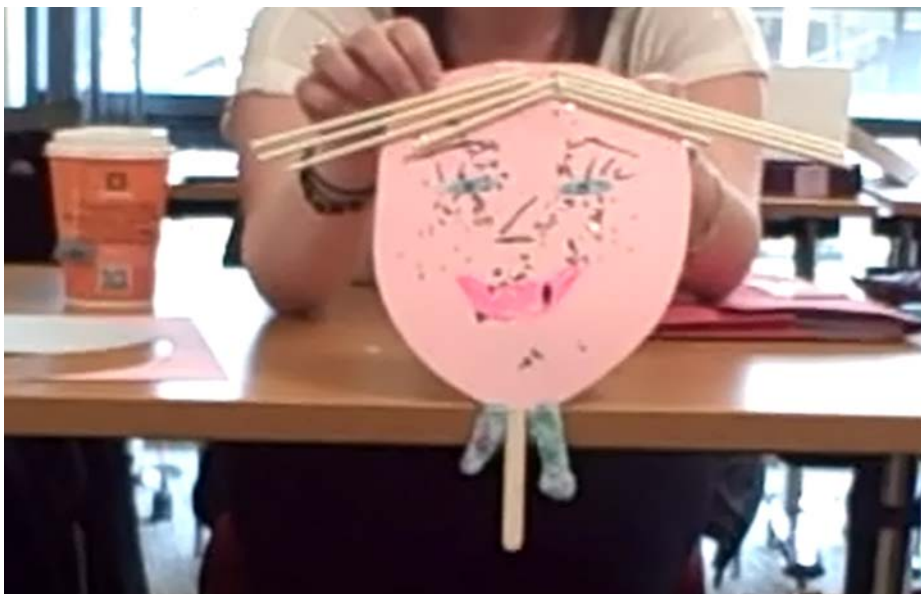
The dark areas also represent the thoughts and worries of the young people who have to attend the PRU where placement was finally found. The trainee readily admits being anxious and concerned about discipline issues and motivation of pupils

within this environment. She had a very negative notion of what would happen and how other staff members would react to her. She was sure that the pupils would be difficult, resistant to learning and impossible to teach.

The spiky areas therefore represent all the problems and negativity that the trainee and her pupils bring with them to the PRU. The trainee reports feeling demotivated and having lost hope as she assumed that the placement would not be a success.

The reality of the placement though was so different and the shiny happy place on the model represents the strongly supportive and individualised nature of the environment within the organisation. The pupils and staff were delightful and supportive of each other and the whole organisation was run in a spirit of cooperation and for getting the best learning experience possible. Karen says that, 'the children just drift into this happy place and their happy faces are a wonderful outcome' 'This model is representative of a journey into teaching and learning both from the pupils' and teacher's perspective and it shows the danger in stereotyping and assuming which is very pertinent to the project as often the stigma attached to mental health issues is based on ignorance and assumptions.

#### **Linda's Model Figure 4.10**



This model was very simple but made a great impact. The mask was made of shiny, beautiful materials and displayed prominently so that all attention was drawn to it. The trainee then made the point that a mask was for hiding behind and the audience had to consider what was behind the mask.

This was an effective way to consider the lengths learners with mental health issues might go to in order to defuse attention away from the condition and the way it makes them feel. The mask makes them appear in control and confident. The mask might draw people to them or just mean that people don't notice them as being 'other'.

Linda said that, the outside world perceives them as being happy and smiling and wonderful.'

The removal of the mask revealed a small, clay person who was made from clay of different colours all moulded together. The statue was small and insignificant and had a bowed head. Linda described them as, 'a tiny, chaotic person who really needs help, but who is hidden behind a beautiful, competent persona.'

This presentation was thought provoking in that it went to the heart of what teachers can notice about their pupils and their colleagues or mentees and whether it is always possible to get to know the person behind the mask. It was considered by the group likely that only when you were trusted and had proved that you were interested in finding out would the real person reveal themselves. If you were thought to be someone who would judge or be concerned with appearances then you would not be deemed as someone who could help.

The discussion also moved on to the masks that teachers have to wear. As with Jane the teacher may also have issues that they are dealing with and mental health concerns that they are trying not to share. The trainee teachers all considered whether they would be open about their concerns with placement tutors or mentors and there was a frank discussion about the vulnerability that could come with disclosure. As teaching is a highly competitive profession to enter and the pressures of work can exacerbate mental health issues or even cause them then it was deemed unwise to disclose early or directly. The group suggested the course tutor/ personal tutor at university to be a safer first person to remove the mask in front of but some even found this idea distressing as this person is involved in writing references for you post- graduation and giving them information which is sensitive and might count against you in competition with other candidates is a risk.

This links with the input from interview as the tutor involved was also worried about disclosure to potential employers and felt that head teachers would be unlikely to discriminate positively for candidates with mental health issues as the negative rhetoric and association would be too powerful to ignore.

## Michael's model Figure 4.11



The model is complex and it appears that a lot of thought went into the design. The trainee is new to teaching and very keen to draw on the experiences of peers in the group who might already have teaching experience.

The complex twisted nature of the emotions involved in dealing with a mental health issues is represented here clearly and the cool clear water at the bottom is inviting but might also be frightening if you feel as if you are drowning.

Michael said that it was difficult for an un-experienced teacher to understand what was going on when they saw the tangled mess in front of them. The group were quick to point out that even teachers with lots of experience could feel just as confused and overwhelmed by this issue.

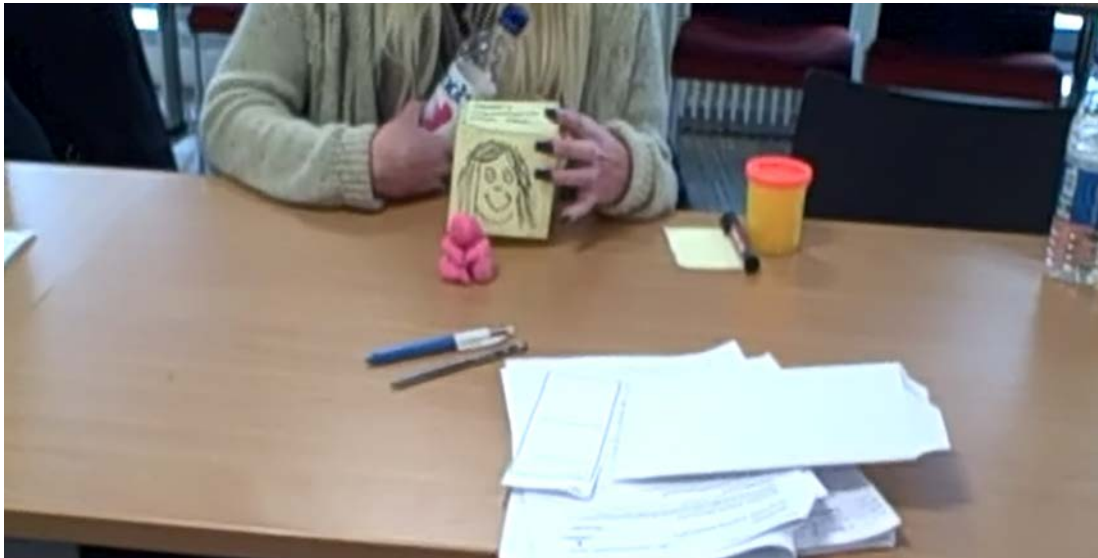
The diving board represents fear and opportunity at the same time. The temptation might be to run away and consider it too scary and this can be applied to the pupils and to the teacher. The other temptation might be to dive in and risk getting tangled up in the web of confusion. For the pupil this might mean that things could feel even worse and when they eventually break through the emotional tangle there is the new danger of drowning in the new environment at the bottom. The safest course of action therefore might be inaction and trainees discussed times when they have felt unable to move through a particular issue or when they felt that no action was possible because the problems seemed insurmountable.

For the teacher the diving in represents the biggest fear around mental health issues which is making the situation far worse. If we dive in without knowledge and strategy this could be a valid issue. Also the teacher might dive in and get stuck themselves and their own mental health could be negatively impacted upon. They need to have planned an exit strategy and know how to turn to outside agencies or other levels of support to help them to break through. The group considered a counselling model where counsellors have supervision to be able to offload cases so that they don't become burdened and overwhelmed. If teachers are to support pupils with mental

health issues then they too will need a mechanism for offloading which needs to be in place and secure before they 'dive' in.

The discussion came to a conclusion with the decision that it was probably quite hard to make things worse by saying something and that not diving in gave the impression that we don't care and would make the person stuck in the mess feel much worse.

#### **Nichola's model Figure 4.12**



This trainee has chosen to use the idea of a box which has been used by other model makers. The box is beautifully decorated and the presentation is very similar to Linda who represented hiding behind a mask.

Here the trainee and her daughter are seen hiding within the box. The box is what the outside world is able to appreciate and consider and they are both therefore deemed to be happy confident and successful.

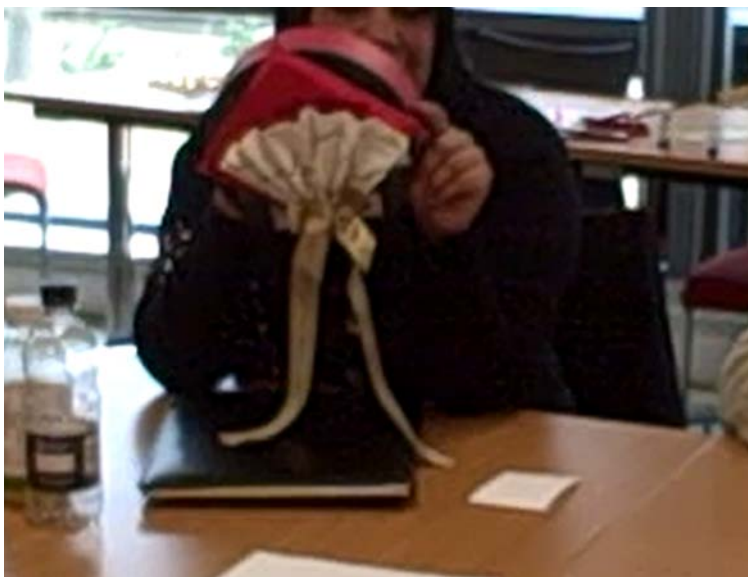
The reality within the box is that both people are damaged by a relationship breakdown and are really sad and hurt. The inside of the box is stark and plain and has no decoration or features which relieve the monotony. The pair are trapped and closed in by the box but cannot open themselves up often as they assume that others will not want to listen or will not understand.

This presentation was necessarily short as the presenter became tearful and admitted to feeling like crying. The disclosure was dealt with well by the group and she was supported and empathised with. The group dynamic was interesting here because some people rushed forward and others just sat quietly and waited until she felt composed again. Although the group had not met before it was interesting to note the degree of compassion and support afforded to this individual and other group members shared their strategies for coping based on similar experiences. The reaction to the opening of the box and the sharing was therefore a positive and it is hoped that the trainee will attempt this in other relationships as the obvious

empathy and interest might have dispelled her fear that no one would want to know. The presenter also shared that she felt vulnerable in her disclosure and as soon as she had said it she wished that it could be retracted. The group made her feel that she had done the right thing and the next presenter also shared a disclosure so the group had obviously created a safe and supportive environment

It could be considered that having volunteered for a focus group the members were disposed positively to supporting others with mental health issues. It was interesting that within the group more than half of participants disclosed mental health issues that they, or a family member, were currently dealing with. The number of disclosure in this group and following the lead lecture mentioned on page 144 were in excess of the expected number of disclosures when considered against the average. It might have been that people who were dealing with these issues themselves were more likely to choose to join the focus group or that the pressures of undergoing teacher training have caused or exacerbated issues. This is an area for further research.

#### **Olivia's model Figure 4.13**

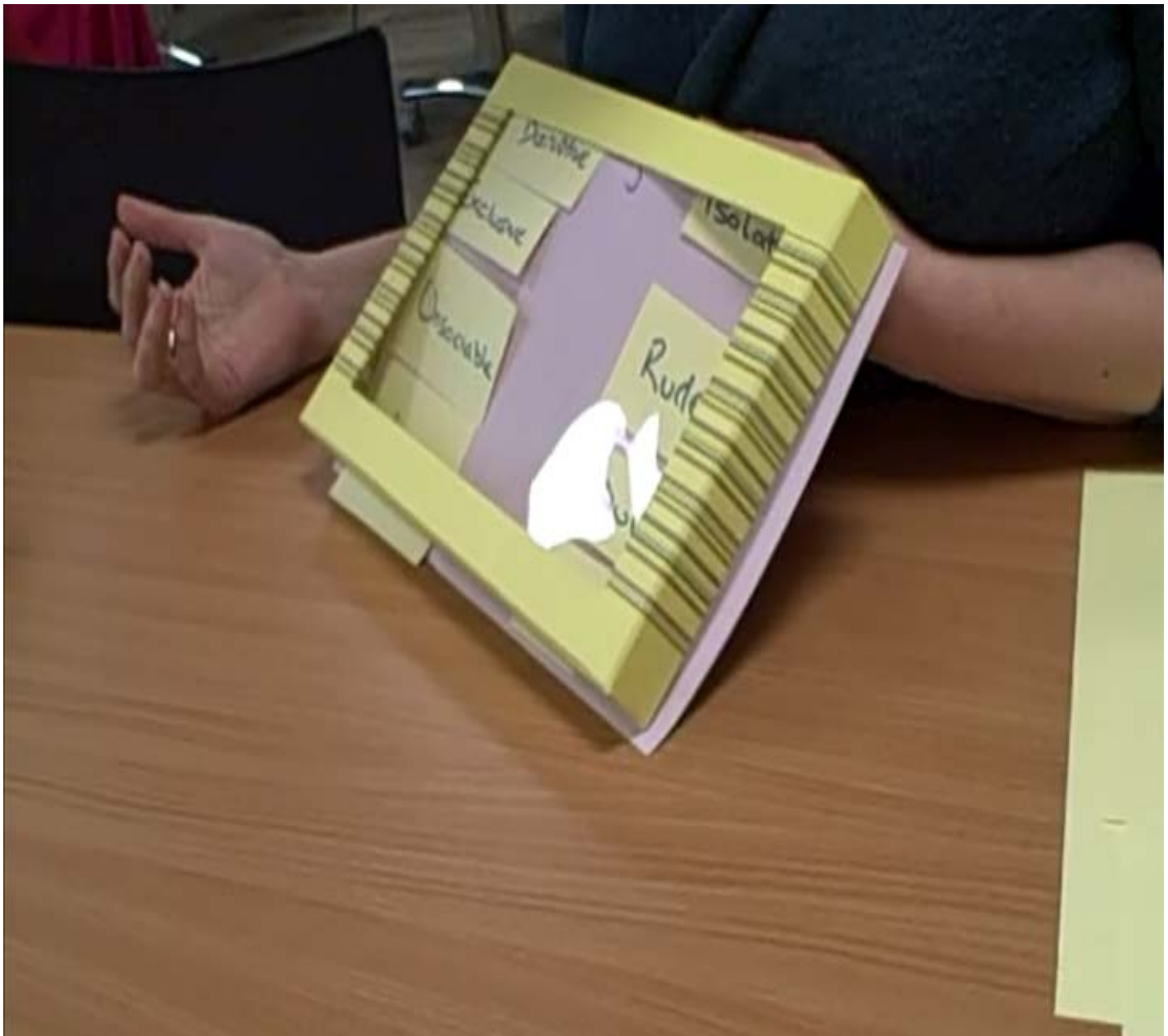


This model took the longest to make and was the most elaborate of the session. The trainee moved away from the main table and utilised a wide range of materials from the craft items on offer. The box was chosen first and then layer upon layer of complexity was added. The rest of the group were waiting for some time for this person to re-join them.

The trainee commented that she had made the box out of nothing at all and that she considered life to be like that. 'You can create beautiful things from nothing'. The trainee disclosed feelings of panic and distress brought on by the stress of the activity and of being in the group. This was due to the fact that her husband had been ill and that she was very frightened by his illness. She described feelings of anxiety which had led to inertia and meant that she was behind with all her

assignments for the course. Although she was saying that she was a confident and unemotional person she was crying freely at the same time and again the recording was stopped so that others in the group could move in to offer support and encouragement.

The underpinning message coming out of this presentation was that passion is important in teaching and feelings cannot and should not be shut out of practice. This trainee felt that her hurt and worry allowed her to connect with her students in placement and be seen as approachable and warm. She realised that crying in front of the group was acceptable but crying in her class wouldn't be but she expressed relief at having found a safe and caring environment in which to talk about her worries and the group members again stepped in and offered strategies and ideas about ways to deal with the backlog of work. (Refer to page 70 for the ethical considerations and plans for dealing with this type of disclosure.)

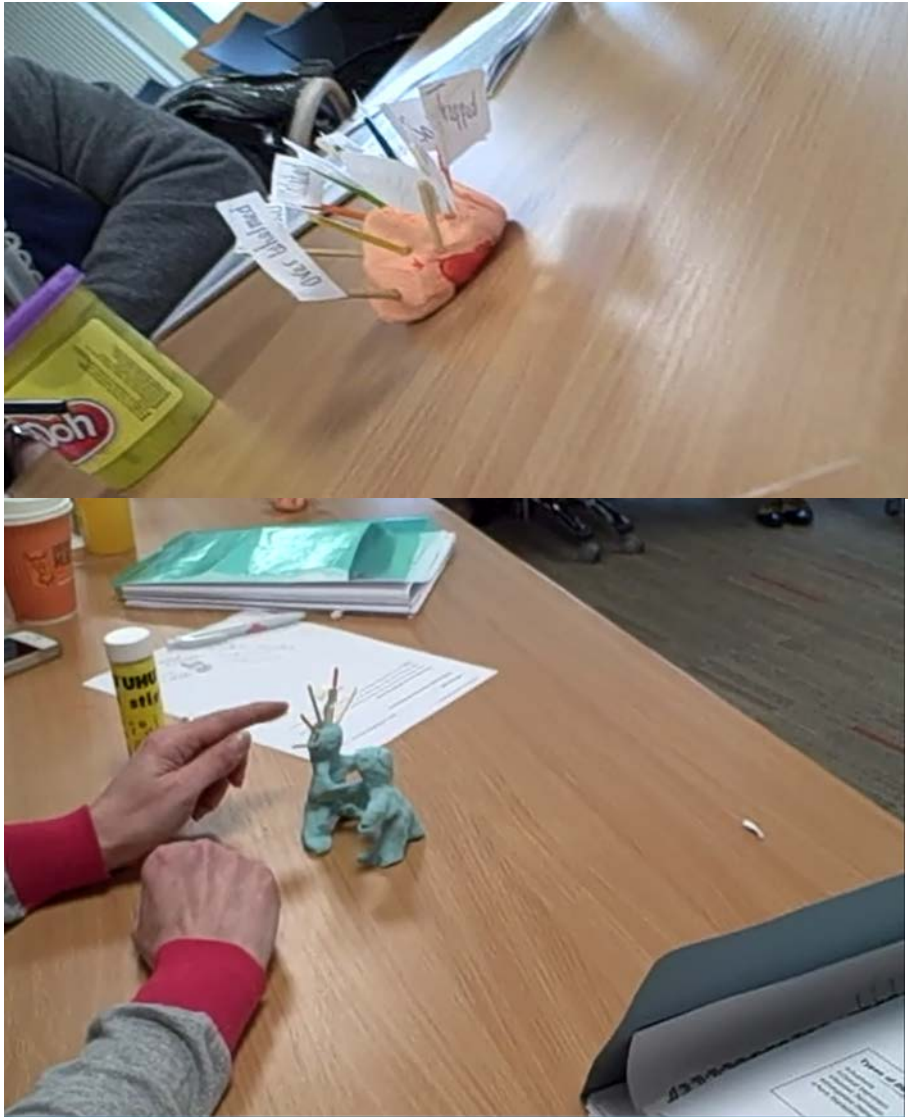


The box represents the classroom and the transparent layer represents the teacher's view. The words underneath are all negative elements of behaviour which the teacher sees first and the see through barrier means that it might be that those words are the only impression the teacher takes away from the encounter with her students.

During the presentation the box was opened and the teacher showed that when she removed the cover it was possible to peel back the post-its and reveal the reason for the outward behaviour. Thus, 'isolated' for example, reveals 'alone' which is the explanation for the child's outward behaviour. The model therefore exhorts teachers to not accept the first impression made by behaviour in the classroom but to be aware of the barriers which are constructed unconsciously by students for protection. Vulnerable students with mental health issues could therefore appear as disengaged, isolated and awkward at first and to remove the barriers and unpeel the layers of complexity would only be possible if a positive working relationship, based on trust has been established.

### **Final Group Presentations Figures 4.15 and 4.16**





Both these presentations were short but they went together well as they represented the two models of inclusion and polar opposite ways to approach the topic.

Two participants worked together on figure 4.15 and they came up with a list of how they felt about mental health and their learners on placement. The list was creatively displayed but obviously these were linguistically intelligent learners who felt quite uncomfortable working in this largely visual medium. This was interesting to reflect on because the method had been chosen for the freedom it would confer upon participants and yet these trainees were limited and uncomfortable because of their perceived difficulty with creative ideas which might explain the negative terminology that they recorded. They used words such as, 'sad, frightened, alone, suicidal and isolated.' These were then added to by even more intense 'angry, overwhelmed, anxious and trapped.' The trainees were not negative in their approach to pupils who felt these emotions and were keen to help but they felt that their lack of knowledge meant that they didn't have the skills or confidence to tackle these emotions in a positive way. They both considered that referral was their only method of choice.

Figure 4.16 depicts a model that was opposite in that it was created to show the supportive relationship between teacher and pupil. In this simple model the teacher is reaching out and holding up the pupil and the student teacher reported that she felt that it was an integral part of her job to make this connection. The sticks represent the knowledge that the teacher has to impart but no knowledge has been transferred because the learner isn't able to receive the information in their distressed state. This trainee also professed a lack of experience in dealing with difficulties but felt that an empathetic approach based on the awareness that a mutually respectful relationship was needed would be the best start to helping the learner.

This section has met the 2<sup>nd</sup> aim of this chapter sharing the narratives from the focus group sessions. The following section identifies the key themes through NVIVO analysis which is the third stated aim of chapter 4.

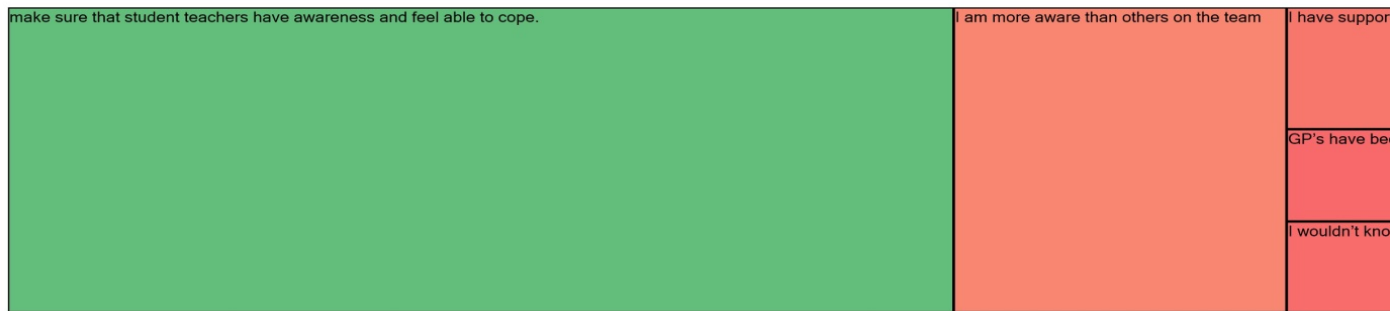
#### **4.3b) Thematic review of data from phases 2 and 3**

Data from Phases 2 and 3 of the project were analysed via NVIVO. This allowed for coding into nodes and connecting nodes into tree maps so that the reader can see in a tabular form the most frequently mentioned phrases and connected issues which came out of both the interviews and the model making sessions. The node trees compiled are listed in Appendix 6. The use of a computerised system was an attempt to enhance the depth of understanding of the data and not in any way to minimise the effort needed to visit and revisit the interview transcripts and the model narratives. 'Tools extend and qualitatively change human capacities,' according to Gilbert (2002, p, 222). Texts were imported into the programme from interview transcripts and the model narratives and the use of NVIVO allowed for searches of individual words and of phrases to note levels of incidence and these are included in Appendix 7. From these initial searches themes were highlighted and the phrases which included the key word were made into nodes. Interconnecting nodes were highlighted and these were then mapped together into tree maps which could be analysed one by one.

The node tree map below shows comments around the awareness of both staff and students. These comments were the most recurrent and the diagram shows the range and incidence of each statement.

Figure 4.3.1

Nodes compared by number of items coded



In figure 4.3. 1 the incidence of references to awareness was 43 which made it the most reported type of comment which was not surprising as questions in the interviews asked specifically about awareness and asked people to assess their current status. As can be seen in the depiction the majority of statements were around making student teachers aware and this was linked to them feeling able to cope better with the needs of their own pupils but also with their own wellbeing needs. In the interviews staff mostly expressed some awareness with 5 sources claiming to be more aware than others on their team for various reasons. One source and reference was made to the fact that only a quarter of GPs have participated in specific training around mental health and this interviewee reported an incident when her GP had to Google a clash of medication which she had pointed out to him as he was unaware and preparing to prescribe a contra-indicated combination of medication. She asked the interviewer to consider the appropriateness of the GP using a search engine to seek information during a consultation due to a lack of subject knowledge. This was a relevant link as the patient made the comparison between the professional contexts of the GP surgery and the classroom and wondered about the likely outcomes of an observed lesson where the practitioner had to Google information during the session.

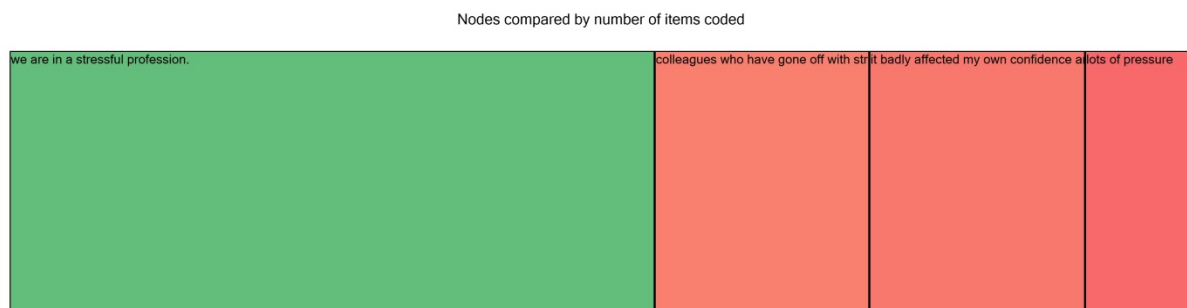
One source specifically mentioned supporting students with eating disorders but didn't give details of what type of support they had offered and how successful their support strategies had been.

In one interview the interviewee claimed a lack of awareness around specific conditions and explained that the questionnaire and the interview questions had led to a reflection on whether she had been aware that younger children could be

diagnosed with any mental health condition. This person taught on a secondary PGCE course and was comfortable with the idea that adolescents and adults could experience less than positive mental health. Also in this interview the person claimed awareness to start due to having a family member with depression but summarised her position at the end by saying that she thought she was aware but probably wasn't as aware as she needed to be.

The second node tree map shows comments around the issue of stress in the teaching profession and this linked to the initial notion that teacher trainees need to be aware of the stress associated with their chosen career path and that they need specific input to raise this awareness. The wellbeing of teachers and a work life balance are considered in the literature review in Chapter 2 Garner (2010 p310) stated that 'competent teachers therefore attend to their own emotions as well as those of their students.' In figure 4.3.2 the number of references to the stress involved in teaching and learning was 32 which made it the second most reported comment.

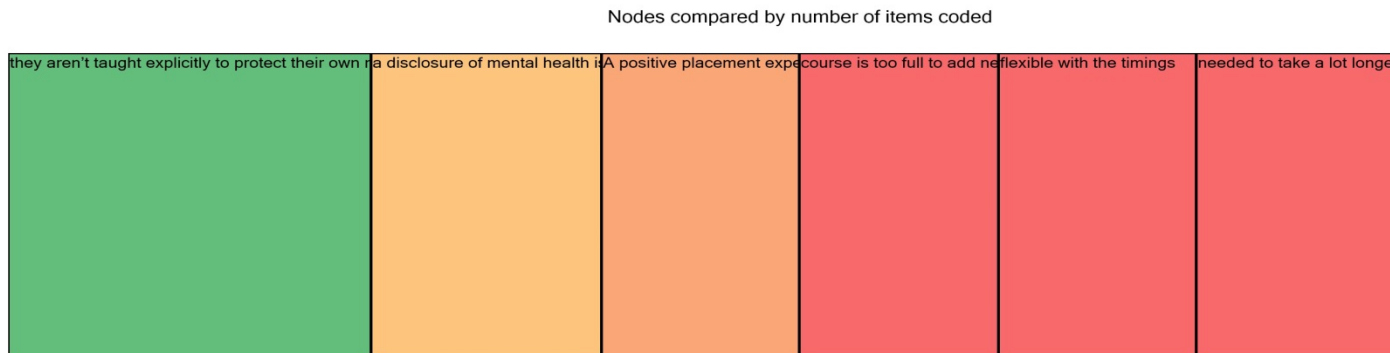
Figure 4.3.2.



A comment about stress was made in 12 out of 22 sources thus 55% of respondents in interviews and/ or focus groups mentioned stress as being of concern. Some of the associated comments shown above in figure 4.3.2 are that many serving teachers knew colleagues who had been away from work due to stress related illnesses. Some talked about burn out and colleagues who had left the profession early. One respondent recorded the negative effects on her wellbeing of trying to support a student with mental health needs who subsequently left the course after making official complaints. The confidence and stress link was made by 4 people in

4 different instances. The issue of being under lots of pressure was applied to the teacher trainees, ITT staff and school teaching staff.

Figure 4.3.3



This third tree map shows nodes reflecting how often course content and specific curriculum input was mentioned. The highest incidence of comment was around not having any specific input in the course currently which was raised in 3 sources via 4 references. The additional linked comment that trainees aren't explicitly taught to protect the mental health of their learners of themselves takes that incidence to 8 sources and 18 references. This is a very significant outcome for the research as in Chapter 1 page 17 there is a query about how much the topic of mental health may be embedded into programmes as there are no specific modules which list it in the module specification. This map appears to show that the embedding is not part of the course structure for a range of courses across the three HEIs.

Figure 4.3.4

Nodes compared by number of items coded



The fourth and final node tree diagram figure 4.3.4 deals with statements around the experiences of students with mental health issues. In this diagram it is clear that there is an overwhelmingly negative view of people 'struggling' with mental health issues and needing support and specialist interventions. This use of language suggests that people's ideas and concepts might still be rooted in a medical model of disability and the notion of struggling with an illness has passive connotations making the person seem less in control. The statements around stigma appear in 4 sources via 6 references and this is an issue which also was commented on in Q14 of the questionnaires which asked ITT staff and students to comment on their feelings towards and awareness of mental health issues.

There are statements in figure 4.3.4 around the 'types' of learners with mental health issues and one respondent recorded that learners with 'attention seeking' behaviour and with a tendency to be 'manipulative' might put staff off becoming involved in supporting learners in future cohorts. This is balanced by the statement by the same participant that of course this should not be so and that all learners should be treated as individuals and given equality of opportunity. This notion of not seeing people as individuals and possibly problematising the issue of mental health has appeared in several interview transcripts. Course leaders who have to place students in placement organisations surmise that they may be less accepted by the managers of host organisations as they expect them to not perform as well as their counterparts.

The issue of empathy is touched upon here with the conclusion that, 'you can't see what is going on in other people's heads.' This comment was from Vanessa's

interview. She had been dismayed by the reaction of her colleagues when she made a disclosure about her own mental health condition. The idea of being able to see inside the 'thought bubbles' was a useful tool to consider how little we know about the thoughts and feelings of those around us. The comment in Nuala's interview about outward behaviour being a simplistic measure of how people were really feeling is thought provoking because as we can't see inside the thought bubbles then we can only use outward signs as cues to when something less than positive is happening internally.

### **Chapter summary**

This chapter has met its aims by presenting the findings in accessible formats. A clear attempt has been made to represent the complex, multi-faceted data without losing the essence of the lived experiences of the participants. The narratives from the model making sessions have been included as part of my analysis of the meaning of both the process and the final created product. Through the use of the node tree diagrams the NVIVO results have been explored. The following chapter examines the results from the findings in relation to the overall aims of the thesis, the extent to which they answer the research questions and the links to the chapters on Literature and Methodology.

## **Chapter 5 Discussion and evaluation**

### **Aims of the chapter**

The aims of this chapter are to:

- Make links between the analysis of findings from chapter 4 to the aim and the objectives of the thesis.
- Examine the connections between the literature review and the findings.
- Evaluate the process of the research.

Firstly the overall aim of the research will be reasserted and the findings will be mapped against the specific objectives to assess the extent to which the objectives have been reached.

To begin his chapter the aim will be linked with data from the three phases of the research. Next the chapter will consider each specific outcome in turn. The objectives set for the thesis are numbered 1-3 and this nomenclature will be retained to make clear the links between the outcome and the data which is most pertinent to it. Thus O1 will categorise data being highlighted to; **'Critically evaluate participants' views around their current awareness of mental health.**

O2 will link to data to, **' Explore the tensions within the ITT curriculum between trainees' need for awareness of mental health issues and the input needed to produce competent practitioners'.**

Lastly O3 will define data, **'Analyse the feelings and opinions of participants towards mental health issues.'**

The overall aim of this thesis is; **To discover whether teacher trainees and their tutors are aware of their responsibilities towards their pupils in terms of promoting positive mental health, negating the damaging effects of the teaching and learning process and providing support and referrals for pupils, colleagues and themselves to maintain wellbeing.**

### **5.1 Questionnaire data linked to the overall aim**

Question 6(**Are you aware of the national service framework for children and young people?**) links to the aim stated above. 91% of respondents were unaware or incorrect about the tier of the national framework which applied to them as teachers and this is a statistically significant measure from which an inference could be drawn that without some input into the curriculum for the particular groups involved in the



research their awareness will not be improved. Tier 1 responsibilities are to promote positive mental health and to spot and refer mental health issues to other professionals. Thus the responses to this question link directly to the first aspect of the aim as stated on the previous page.

Obviously responses to question 14, which invited participants to comment on their awareness and feelings around mental health issues has direct applicability to the aim. Some participants stated that they needed more information and/ or training and other qualitative comments can be seen to clearly link to all 3 outcomes and to the aim and overarching question. Interestingly one of the strongest messages from this data is that some participants, both staff and students, were not aware of their lack of awareness until prompted to answer the survey questions. This has a direct impact on evaluation of all findings and is related to the overall question because measuring the extent to which staff and students perceive a need has possibly been altered by their involvement with the questions. This issue of not knowing what it is you don't know will be reflected on in chapter 6 as it possible that without some initial question based input trainees and their tutors may consider their awareness adequate.

### **Interview data linked to the overall aim**

Interview data related to the aim was around awareness of support for pupils and support for staff regarding wellbeing. The issue of negating the harmful effects of the teaching and learning process is only tangentially referred to in terms of breaking down barriers to learning and creating a positive learning environment. Some staff, however, did mention the stressful nature of the PGCE course which is intensive and causes distress for trainees every year which is another reference for the central aspect of the aim.

Vanessa's interview directly provided data for the aim. Vanessa has created an awareness-raising session for her trainees and conducted CPD sessions for her colleagues because of her belief that awareness-raising is key to breaking down barriers to learning and to reducing stigma.

In Lynn's interview she repeatedly referred to the pressures of becoming a teacher and the inspection and grading regime which affects trainees and NQTs in addition to more senior staff. Lynn reflected on the number of colleagues who had left the

profession through not having strategies to cope with stress. As Lynn disclosed a mental health issue from her past she commented that this had increased her understanding of the indiscriminate nature of mental ill health and had heightened her empathy for her trainees and her colleagues

One of the strengths of Justine's practice links to the aim of the thesis in that she was very aware of how and when to refer students to appropriate services.

Janet's description of her practice mapped to the aim above as she had introduced awareness raising sessions and lead lectures on mental health. In her interview she also discussed the wellbeing of her trainees and how she built in time to allow for discussion of feelings and discussed openly how to deal with negative emotions whilst on the course and when qualified.

In terms of the aim of the thesis Rosemary showed awareness of the need to support her trainees through various mechanisms and there was an element of teaching in the course which dealt with wellbeing

### **Model making data linked to the overall aim**

Anna's model is making the point that teachers are unaware of barriers to learning such as mental health issues but they shouldn't be. The portrayal of teaching as a one way process links to the overall aim

Ellie is able to draw on strategies which she has developed to negate the negative effects of teaching and learning which links with part of the overall aim of the thesis.

Frances' specific mention of support is associated with the overall aim.

Jane's model offered a really different perspective because the teacher's own mental health was under pressure and she was being damaged by the process of caring for her learners' issues; the overall aim is evidenced through this model.

Michael's model is predominantly about feelings; he discusses the, 'complex, twisted emotions' of new teachers. Rosemary and Sandra raised the notion of mental health issues being outside the scope of newly qualified staff but Michael wants to dive in. Michael's model linked to the overall aim as the discussion moved into suitable methods of support and referral for both staff and students.

Patricia reiterated points from previous input and focused on the overall aim of the thesis in her discussion around needing to break down barriers to learning especially for vulnerable learners.

In the first of the final two models the creators felt that referral was the only method they could employ which again aligned to interview data around NQTs and what they could be expected to know and cope with. The second and final model, which was a contrast, focused on the integral part of a teacher's job which was to make a connection between pupil and teacher based on empathy and mutual respect.

Having considered data linked to the aim of the thesis this chapter will now look in turn at the objectives set at the start of the research and identify data which meets the outcomes.

**5.2 01** Critically evaluate participants' views around their current awareness of mental health. **Questionnaire data linked to O1**

In the questionnaire data the first four questions were definitely linked to O1 as they asked directly about current awareness. A reasonable inference from the responses to these questions is that as 40% was the highest recorded score (which included a percentage of those guessing the answer) then awareness seemed to be an issue for at least between 60 to 84.7% of respondents. Taking into account that a proportion of respondents have guessed both correctly and incorrectly the data can only suggest as a starting point that there is a lack of awareness in this particular cohort around the specific measures of awareness questioned in this opening section of the survey.

Question 5 changes focus and provides a stand- alone measure of training around mental health awareness. This links to O1 and O2 and begins to draw in data which will be evaluated against the overall aim and the overarching research question. A lack of training for 88.4% of respondents is one measure of their awareness and could suggest a gap in the curriculum for ITT. This statistic alone however, does not evidence a need for training but merely records a lack of training for the majority of students and staff in the participant groups questioned. It is possible that training is not necessary to achieve awareness and also it may be that those without training do not consider it necessary or desirable.

Question 6 is about awareness of the National Framework for Mental Health and is at the heart of the overarching question and links to the aim stated above and O1. 91% of respondents were unaware or incorrect about the tier of the national framework which applied to them as teachers and this is a statistically significant measure from which an inference could be drawn that without some input into the curriculum for the particular groups involved in the research their awareness will not be enhanced.

Questions 8 to 11 are about specific conditions and the latest health campaign and data is linked to O1. In general, recording of specific conditions applicable to children and young people was inaccurate either through over or under estimating the scale of the various issues highlighted. This is problematic data as the complexity of the reporting does not directly impact on the learning outcomes or the title question. This data can be linked to some comments in question 14 when some participants recorded that it was only through completing the survey that they were spurred on to research around relevant conditions.

Question 12 showed that there were a high proportion of responses which had been guessed in the survey and this links directly with O1 and indirectly with O2 as 77.8% of respondents either guessed all or some answers. This again suggests that for these cohorts, in the 3 HEIs involved, input into the curriculum could be justified as a lack of awareness is being demonstrated.

### **Interview data linked to O1**

Sandra's comment, 'I think I am aware but I probably don't know as much as I should do.' links to O1. The input from this research then could merely act as a stimulus for further personal research or for seeking out further training.

Justine was aware of mental health issues due to a past career and specific training for her previous role; Janet, like Justine and Vanessa was very aware of mental health issues affecting both students and trainees in the lifelong learning sector. Interestingly these three staff interviewees claimed to have more awareness than their colleagues but only Vanessa had attempted to create any CPD to share her expertise. Nuala also expressed being more aware than her colleagues in the

Secondary PGCE team; however the questionnaire had provided an impetus for personal research as it made her realise that perhaps she was in need of further input.

One of James' unique contributions, which is linked to O1, was to mention that the most appropriate staff to be aware of mental health might not be teachers but rather teaching assistants who often worked 1:1 or in small groups, O1. This is in contrast to the work of Sweeney (2003) and Weare (2005 and 2011) who suggest that it is the role of every member of staff, within a whole school approach, rather than something which can be delegated to named individuals or specific job descriptions.

### **Model making data linked to O1**

Anna's model is making the point that teachers are unaware of barriers to learning such as mental health issues but they shouldn't be. The portrayal of teaching as a one way process links to O1.

Ellie is very aware of mental health issues and shows her understanding and empathy towards learners who exhibit the negative behaviours pictured in her model.

Barbara and her team made a model about barriers too and again O1 was directly tackled.

Frances' model links with O1 as she is definitely aware of barriers and aims to reduce them for her students whenever possible. Her specific mention of support is associated with the overall aim and her focus on soft skills and the social side of education refers the reader back to the literature on whole school approaches and the importance of pastoral support.

Gina has been made aware of mental health issues through the media. This link to O1 is interesting because it is possible that this unspecific and untargeted information may have an impact on her practice. The inference may be here that awareness raising which is not sensationalised or based on the experience of celebrities or fictional characters might better prepare teachers for the classroom.

Helen shows awareness and understands the affective nature of her role as a teacher and the need for her to manage relationships within the learning environment.

### **5.3 O2, ' Explore the tensions within the ITT curriculum between trainees' need for awareness of mental health issues and the input needed to produce competent practitioners.**

#### **Questionnaire data linked to O2**

Question 5, which asks about specific training, links to O1 and O2. A lack of training for 88.4% of respondents is one measure of their awareness and could suggest a gap in the curriculum for ITT

Question 6 about the National Framework links to O2 and again an inference could be drawn that without some input into the curriculum for the particular groups involved in the research their awareness will not be enhanced.

Question 12 asked about whether answers were known or guessed and this showed that there were a high proportion of responses which had been guessed in the survey and this links indirectly with O2 as 77.8% of respondents either guessed all or some answers. This again suggests that for these cohorts, in the 3 HEIs involved, input into the curriculum could be justified as a lack of awareness is being demonstrated.

In answer to question 14 which asked for general comments some participants stated that they needed more information and/ or training, which is directly associated with O2

#### **Interview Data linked to O2**

It is clear from Vanessa's responses that she advocated a targeted, specific approach and that she felt that trainees needed this input to prepare them for placement rather than once they were in service. . Vanessa holds a position which has allowed her to introduce this topic as a CPD element for colleagues which she felt was an important step to increase awareness for this and future cohorts. Although she agreed that the curriculum for ITT is crowded she disagreed with several other respondents that there was no room for this input. The students at her institution had been present for one awareness raising session and this links to the Bostock , Klitt and Kitt (2010) research as the team there had introduced an awareness session and tested confidence around the topic before and afterwards. The results in both institutions suggested that students had benefitted from this individual session and Vanessa reported that her students were engaged and interested in the topic and keen to further their research following the awareness raising input. This links with several respondents from the questionnaire and two

other interviewees; Sandra and Rosemary who reported that until they had seen the questionnaire their lack of awareness had never been highlighted.

All other interviewees except for Justine recorded that there should be input into the curriculum as soon as possible; O2, but Justine postulated that following the first placement would be the ideal time

Lynn was keen to share awareness with her students particularly around their own mental health

Janet, like Justine and Vanessa was very aware of mental health issues affecting both students and trainees in the lifelong learning sector. O1, O2 and O3. Janet had addressed O2 by introducing strategies for coping with mental health into her teaching and by modelling coping mechanisms. Due to Janet's interest in this thesis she also requested a workshop to be offered to trainees on the topic and a lead lecture to the entire PGCE FE cohort to raise awareness. The workshop and the lead lecture are discussed in the outcomes section of this chapter

James also concurred with previous interviewees regarding curriculum overload and the focus on standards and inspection but he hadn't considered the conclusion of Paulus 2009 that, 'mental health and achievement affect each other positively' p 292.

Nuala too was concerned about the fullness of the curriculum but her overall conclusion was that this topic should be added.

Rosemary and James agree that there is a difference between the way this topic affects work in primary and secondary settings. Rosemary also concurs with Sandra when she claims that this is not an issue which a NQT or young teacher would be directly concerned with; this is in contrast to the findings from the literature e.g. Weare 2005. The emphasis for the curriculum input according to Rosemary therefore should be around referral; this is in conflict with the notion of the whole school approach and the findings of Morgan (2007).

### **Model Making data linked to O2**

Anna's model is making the point that teachers are unaware of barriers to learning such as mental health issues but they shouldn't be. The portrayal of teaching as a one way process links to O2

Barbara and her team made a model about barriers too and O2 is linked to the model because there is nothing in the current curriculum about how to break down the barriers and reduce the negatives

### **5.4 O3 'Analyse the feelings and opinions of participants towards mental health issues'.**

### **Questionnaire data for O3**

Questions 8 to 11 are applicable via inference to O3. In general, recording of specific conditions applicable to children and young people was inaccurate either through over or under estimating the scale of the various issues highlighted. This is problematic data as the complexity of the reporting does not directly impact on the learning outcomes

Obviously question 14 is linked directly to O3 and records more about feelings and opinions

### **Interview data linked to O3**

Vanessa's interview also links with the literature around stigma and misconceptions (Rogers and Pilgrim 2005) as she reports that her colleagues were disturbed by her disclosure of bipolar and that their reaction was unexpectedly discriminative. Her frank and direct discussion about her feelings is the strongest data for O3.

Lynn's interview linked most strongly to the literature around stress and teacher wellbeing (Holmes, 2005). She repeatedly referred to the pressures of becoming a teacher and the inspection and grading regime which affects trainees and NQTs in addition to more senior staff. Lynn reflected on the number of colleagues who had left the profession through not having strategies to cope with stress. As Lynn disclosed a mental health issue from her past she commented that this had increased her understanding of the indiscriminate nature of mental ill health and had heightened her empathy for her trainees and her colleagues

Justine introduced an emotive component with her comments about manipulative students in the past making staff reluctant to work with new students with mental health issues and this links to the literature around misconceptions and stigma (Rogers and Pilgrim 2005). One of the strengths of Justine's practice links to the aim of the thesis in that she was very aware of how and when to refer students to appropriate services.

Janet, like Justine and Vanessa was very aware of mental health issues affecting both students and trainees in the lifelong learning sector.

James echoes Janet and Justine's concerns over placing a trainee for placement if there has been a disclosure of mental health issues. His comments about head teachers' concerns linked to the literature on stigma and comments on resilience link



to the literature around stress and the demands on staff (Garner 2010; Mind Matters 2010).

The affective nature of teaching and learning was discussed by Nuala in terms of resilience and stress and this maps to the literature around stress for teachers and maintaining wellbeing to retain teachers in the profession (Holmes 2006).

Rosemary considered it unlikely that any team member would feel comfortable delivering a suitable session of CPD which is a clear indication of how uncomfortable this topic makes people feel.

### **Model Making data linked to O3**

O3 is met through the discussion around the negative feelings around mental health and the problematizing of the issue by Barbara and her group. This can be directly associated with the literature around stigma in 2.4.

Ellie is very aware of mental health issues and shows her understanding and empathy towards learners who exhibit the negative behaviours pictured in her model.

Frances' model links with O1 and O3. She is definitely aware of the barriers and aims to reduce them for her students whenever possible. Her specific mention of support is associated with the overall aim and her focus on soft skills and the social side of education refers the reader back to the literature on whole school approaches and the importance of pastoral support.

Helen's model has a strong emphasis on feelings and empathy

Imogen shows an awareness of 'otherness' through her model and this links to the literature around stigma. O3 is attempted through an investigation around the possible feelings of the learner who doesn't fit in with their peers. A possible inference from this is that teachers have to make the learning environment, 'more accommodating' which links to the literature around the whole school approach.

Karen's model can be aligned with the literature around stigma and stereotypes as she had preconceived ideas about the learners that she was going to meet in the PRU. The O3 statements about her feelings of anxiety and depression are a strong feature of this piece.

Linda too discusses feelings openly, O3 and there is an open discussion around disclosure here which can be aligned with the interview data from James, Justine and Janet who all express concern about the way such a disclosure will be received in the workplace.

Michael's model is predominantly about feelings, O3; he discusses the, 'complex, twisted emotions' of new teachers. Rosemary and Sandra raised the notion of mental health issues being outside the scope of newly qualified staff but Michael wants to dive in. His reason for hesitating is fear and this is fear of making things worse which links to Finney (2006) who also found that practising teachers were concerned but were fearful. Michael's model also linked to the overall aim as the discussion moved into suitable methods of support and referral for both staff and students.

Nichola's model was also all about feelings and linked most directly to the literature around stress for staff and the demands of a role which meant setting aside her own feelings. There were associations here with James and Justine who were concerned about vulnerability following disclosure especially whilst looking for a placement or employment.

Olivia was visibly distressed in her presentation and O3 was evidenced as she discussed her own mental health issues whilst dealing with the rigours of the PGCE course. Although she saw her distress as a negative she was able to conclude that it was a sign of her passion for teaching and getting it right and also she understood that her own depression would increase her empathy for her learners. This model links to the literature on teacher stress and the idea that unless a teacher manages their own wellbeing then they can't really help their learners to do so.

The final two models linked to O3 most strongly because of their focus on feelings and emotions. They felt that referral was the only method they could employ which again lined to interview data around NQTs and what they could be expected to know and cope with. The other model which was a contrast focused on the integral part of a teacher's job which is to make a connection between pupil and teacher based on empathy and mutual respect. This links well to Anna's model at the start which looked at what happened when the barrier was in place.

## **Links to the literature review**

### **Questionnaire data linking to the literature review**

There are strong associations in the data from question 14 which link back to the literature 2.4 around stigma and fear

### **Interview data linking to the literature review.**

Frances' focus on soft skills and the social side of education refers the reader back to the literature on whole school approaches and the importance of pastoral support.

Vanessa links to the Bostock, Kitts and Kitts (2010) research as the team there had also introduced an awareness session and tested confidence around the topic before and afterwards. The results in both institutions suggested that students had benefitted from this individual session and Vanessa reported that her students were engaged and interested in the topic and keen to further their research following the awareness raising input. Vanessa's interview also links with the literature around stigma and misconceptions (Rogers and Pilgrim 2005) as she reports that her colleagues were dismayed by her disclosure of bipolar and that their reaction was unexpectedly discriminative

Lynn's interview linked most strongly to the literature around stress and teacher wellbeing (Holmes 2006).

Rosemary and Sandra are concerned that newly qualified and trainee teachers shouldn't be overwhelmed by responsibilities and they claim that in secondary education staff just have an obligation to refer any concerns to a named person. This is not the findings of the research from Weare (2005) who claims that a whole school approach in which all staff are involved is the most successful. Also this is in conflict with the findings of Morgan (2007).

### **Model making data linked to the Literature review.**

Jane's model linked clearly to the literature around teacher stress and burnout;

Michael's model showed the diving platform and he explained that his reason for hesitating before diving in is fear and this is fear of making things worse which links

to Finney (2006) who also found that practising teachers were concerned but were fearful.

Gina has been made aware of mental health issues through the media. She demonstrates surprise about the indiscriminate nature of who is affected, which links to the literature around misconceptions and stigma

Imogen shows an awareness of, 'otherness' through her model and this links to the literature around stigma

Jane's model offered a really different perspective because the teacher's own mental health was under pressure and she was being damaged by the process of caring for her learners' issues. This model linked clearly to the literature around teacher stress and burnout.

Karen's model can be aligned with the literature around stigma and stereotypes as she had preconceived ideas about the learners that she was going to meet in the PRU.

Olivia's model links to the literature on teacher stress and the idea that unless a teacher manages their own wellbeing then they can't really help their learners to do so.

The chapter thus far has considered the application of data gathered during the research to the overall aim, individual objectives and literature review of the thesis.

The next section provides an evaluation of the process of research and an acknowledgement of the limitations of the study before chapter 6 which offers a conclusion and recommendations based on the data.

## **Evaluation**

Prior to concluding the thesis this section is concerned with recognising openly some of the limitations of the study. Silverman (2000, p. 35) stated that, 'in qualitative research what happens in the field in your attempt to gather your data is itself a source of data rather than just a technical problem in need of a solution.' This section does not adopt a self-deprecating approach but rather an acknowledgement

of reflective and reflexive events. Reflection underpins my practice generally but has been particularly utilised in my research. Burgess, Sieminski and Arthur (2006) suggest that reflection has to be at the centre of the whole research process. Researchers are reminded to, '...consider the implications of your methods, values, biases and decisions for the knowledge about the social world that is generated.' (p.39).

A reflective overview of the findings reveals that the data collected does not fit neatly into a structured analysis. Although there are clear links between the data and the set aims and objectives there are also extraneous conclusions which need to be acknowledged. The most striking conclusion which was not predicted is that data from the groups who had done a session of awareness training was markedly different to the results from the groups who had not been trained. . Another challenging aspect of conducting this research study has been the swift changes to ITT provision engineered and introduced by the current coalition government. The current emphasis on Teach First, Teach Direct and Troops into Teachers will have an impact on the number of teacher trainees who will complete a PGCE qualification based at a university centre. For the short term, the author is convinced that the project is worthwhile and it has already made an impact on staff , students and practice which it is hoped will continue for as long as possible. In my review of the work I do however have to consider the longer term implications of the policy change. It is possible that the pack of materials which are being created to support awareness- raising in the host institution could be made available to schools, who are offering the set of new teacher training programmes, as part of the training course that partner institutions provide. If this is a shorter course and not a full PGCE as is being suggested then an online pack might be more practical as time for direct delivery will be even more restricted than it is currently. The danger of purely online materials is that they would not challenge misconceptions and correct misapprehensions. The need for awareness is not just in terms of providing information it is also about changing attitudes and ensuring that equality of opportunity is possible.

The more mundane issues that have been recorded in my research diary will be summarised in this section of the chapter as they have had as great an impact as the policy change and have affected my view about, and response to, research

opportunities in future. This research was initially put forward through an email to all academic staff involved in ITT at the three HEIs and invitations were given to visit course teams and talk about the planned research before permission was requested from course leaders to approach students. Interestingly some course teams were more than a little reluctant to have input into the project from the beginning and it was put to me bluntly that this was a very sensitive issue which didn't seem an appropriate topic for research. Some staff shared concerns about giving students, 'something else to worry about not knowing', as they were newly in place on the PGCE programmes and often overwhelmed by the demands of the course. Others stated that there just wasn't time within the current curriculum to add any more content as already sessions were fully planned for. The issue of sensitivity was a source of further reflection as it seemed that the inference was that it was best not to discuss contentious or difficult issues with students on these programmes. When I eventually approached individual members of the teams involved and course leaders individually the response I had was positive. I think there are pressure points in the academic year and it was possible that the initial email arrived when colleagues were already stressed and concerned about fitting in all the components of a very full curriculum. It is also possible that staff who felt they were less aware about this issue than others may have felt under pressure and I am an unknown to many of the people contacted so perhaps they were reluctant to let someone into their classes without knowing more about the person and their study. Certainly access was not a problem when I had had 1:1 conversations with staff or when one of the team had allowed me to interview them. The response after phase 2 was much more positive and I have been invited to participate in all the courses that I sought access to at my home institution and have already begun to deliver awareness- raising across the school of education.

I also have to consider that, on an inter- personal level, my passion for this subject may be off putting to others. It came to my attention that some people felt that I was offering these sessions as a means of sharing personal experiences of mental ill health and that colleagues were worried about this possibility. When I shared with them the rationale based on my previous work and a life- long interest they immediately warmed to the idea. This was interesting to reflect on because it meant that there might be prejudice and a promotion of stereotyping within our practice. In

another HEI where the course leader was managing bipolar depression the reaction of staff was similarly anxious and slightly negative even though before disclosure they had been perfectly happy with the person's work. Some colleagues even asked how they were to deal with this person now that the disclosure was public and the level of discomfort was only worn away gradually as colleagues realised that nothing had changed.

The starting point of the planning of this research was in acknowledging that the enquiry is seeking to answer qualitative questions and to probe into the opinions and feelings around the topic of mental health and its impact on teaching and learning, which is highly subjective work. Objective analysis and recording seems to be impossible to achieve in the realm of social science research if indeed in any field. Research involving people is open to criticism as subjective but this research seeks to uncover thoughts and perceptions which are inherently subjective concepts and thus the approach taken has attempted to share with the reader the positionality of the writer and to present findings transparently so that the reader will be in a position to accept or reject the conclusions drawn. The insider position of the researcher and the possibility that participants would self-select on the basis of an interest or experience of the topic and thus not be representative has also been reflected upon. The composition of the groups in the model making sessions was definitely affected by prior input around mental health both by the tutors of two PGCE groups and by awareness raising sessions having been delivered to them at various points before their participation. The models produced in the first two groups demonstrated an enhanced awareness and some elements of how to deal with mental health as a practitioner which other groups did not match.

### **Chapter summary:**

This short chapter has improved the, 'radical questioning', of the data recorded following the, 'radical looking and listening' processes of the 3 data collection phases. (Clough and Nutbrown 2012, p.243). Links between the data and the overall question have been postulated and an attempt has been made to match the findings to the aim of the thesis and the specific learning outcomes outlined in chapter one. Connections between the literature in chapter two and the findings

have been made and these will form the basis of the conclusions drawn in chapter six. The evaluation of the process of research demonstrates the reflective practice involved and the following chapter will evidence reflexivity and feeding forward into suggestions for further research and possible implications of this piece of research for the individual participant organisations and the wider field of teacher education wherever possible.



## Chapter 6

### Conclusion and Recommendations

Aims of the chapter:

- To summarise the relationship between the completed work and the original research question.
- To state clearly what the thesis has demonstrated and headline specific findings.
- To consider suggested implications from the data and how these could feed forward into further research.
- To make specific recommendations for practice.

To begin this final chapter there is a statement to summarise the originality and impact of the thesis. This work set out to record the perceptions of staff and students in ITT around mental health. No other work in the literature had approached the question of awareness- raising for trainees from primary, secondary and FE phases or across several institutions. This piece also puts forward the holistic notion that there are three distinct reasons to be aware of mental health issues and that each reason is pertinent to teachers across all key stages. Thus the literature and methodology have allowed for an investigation into how aware teachers and teacher trainees are about mental health issues which present in classrooms and which could have an impact on their practice; whilst also considering awareness around the effects of the teaching and learning process on mental health; both for teachers and pupils and finally investigating awareness around the particular mental health issue of teacher stress and burnout. It is hoped that the account of the research has recorded transparently the voices of the participants and provided a sense of the essence of the phenomenon of mental health awareness to fit with the title: **Staff and Students' perspectives on mental health awareness.**

The chapter will continue with a break-down of the conclusions from each section of the thesis.

**6.1 What are ITT staff and students' perspectives on mental health as a barrier to teaching and learning?** Firstly going back to this overall question it can be seen from the questionnaire, interview and model making data that ITT trainees and staff, in the three institutions involved, have demonstrated a need for input to raise mental health awareness to meet their Tier 1 responsibilities as set out in the National Framework. The majority of respondents; both staff and students, were not aware of the framework at all and certainly felt that their only responsibility to their learners would be in a referral capacity to one other named member of school staff.

The questionnaires were the strongest indicators of a lack of awareness and respondents clearly stated that they wished / needed to know more. In the interview data the staff mostly claimed to be aware themselves and indeed to be more aware than their colleagues on the course teams. During some interviews however some participants amended these statements to allow for the possibility that they actually knew less than they thought or needed to know. An interesting point was that for many respondents the questionnaire or the interview questions were the stimulus to think about the topic for the first time and to research further. Justine sums this up as '**not knowing what it is you don't know**'. This is an important finding of the thesis and is vital in planning input into IT curricula because it could be that if an optional session was offered to raise awareness many trainees and staff might consider their current level of awareness as satisfactory and not attend. If they were firstly offered some means to measure their awareness however they might change their perception and seek the opportunity to extend their awareness. In both the Bostock, Kitt and Kitt (2010) research and in Vanessa's practice compulsory awareness raising sessions had been introduced across the whole cohort which meant that students and staff didn't have to decide whether to attend.

Having considered the initial question it is now essential to return to some of the statements and questions outlined in chapter one and to attempt to evaluate the extent to which they have been answered, explained or refuted by the research. The initial statement to consider is my view that mental health awareness would break down barriers to learning and make learners more confident. Kate Fallon, general secretary of the Association of Educational Psychologists claims that,

It is important for teachers to realise that they don't have to call in experts all the time.....day to day these caring adults have got the resources to help. They just need guidance and the confidence to do it. (Cited in Maddern 2010, p.19)

This links to the findings from the model making phase of the research and to some questionnaire responses. The model makers from groups which had been involved in awareness raising sessions offered strategies to break down barriers to communication and learning and this was in noticeable contrast to groups who had no awareness raising training, whose participants highlighted that barriers existed but were more negative in their description of mental health issues in teaching and learning. Anna's comment that 'Breaking down the barrier would depend on the teacher recognising that it exists' is key data which links with the findings of Bostock, Kitt and Kitt (2010) who measured confidence before and after an awareness raising session and also agrees with Vanessa's analysis of her group of trainees who showed increased confidence in breaking down barriers to learning following one session of awareness raising which she had delivered.

Linked to the notion of confidence in chapter one the statement was made that awareness-raising was necessary to challenge the stereotypes, myths and misconceptions around mental ill health and to ensure that staff are confident and aware rather than concerned or even frightened. Gina stated that , 'Mental health issues transcend all barriers and affect anyone and everyone' to raise awareness within her model making group that there were no 'types' of staff or student who would be affected. Evidence throughout the three phases of research suggested that trainees and tutors were expressing negative thoughts and feelings about mental health issues and even participants who stated how important it was to be aware often included syntax which suggested that their thinking was rooted in a medical model e.g. 'suffering', 'struggling'. This links with the findings from the literature around stigma and fear. The experience of Vanessa when she disclosed her own condition to colleagues and a qualitative statement from one response to question 14 which recorded a similar negative experience in an HE setting on disclosure from a student to an academic member of staff are evidence that there is work to be done to challenge misconceptions and to promote a positive view of mental health which could be then transferred into practice. This would need to facilitate a change of perspective from the stigmatised view which is held by many people with regard to mental health issues which is recorded by Rogers and Pilgrim who claim that stigma

involves thinking that there is, ' a lack of intelligibility, a lack of social competence and the presence of violence.'(2005, p. 158) Paulus 2009 claims that the means to make this change involves, 'empowering teachers', which he claims, 'becomes an important means for not only promoting students' mental health but also for the benefit of staff.' (p.294) Gina says that 'as teachers we need to open our minds' and this is a powerful message from the data.

The outcomes of the research were a means to draw together questions and approaches that developed as the research methodology was planned. This chapter now considers the 'clusters of meaning' (Moustakas 1994) which can be constructed from findings for each outcome.

**The first outcome; To attempt to measure current awareness of mental health issues and their effect on teaching and learning** was met through all three phases of the research. The questionnaires were the most direct method of attempting to measure awareness of mental health issues which would have an impact on learning. Respondents commented on the levels of incidence of specific conditions and on their own awareness level through the mixture of quantitative and qualitative questions. It must be noted that rephrasing of the questions or choosing other question design may have led to a change in the response and the word 'measure' is problematic because none of the phases offered a precise quantitative 'measure'.

Most respondents linked their awareness to teaching and learning situations but some were only aware through contact with family members or friends and they had not considered the implications of this awareness for their work with children, young people and adults.

Imogen's summary that ' The learner with mental health issues can only access parts of learning and misses opportunities' is an important point linked to attainment which can be built into awareness raising for future groups.

Some of the model makers were part of groups led by tutors with strong awareness and who had delivered specific sessions to their trainees on the topic of mental health. This awareness was evident in the models produced. This leads to reflection on a particular feature of this research which is hard to eliminate but which will affect

the overall conclusion and that is the possibility that participation was only from people who already had an interest from the start. Thus, although the invitation to complete the survey and to attend the focus groups or be interviewed was open to all members of staff and students it may be that only individuals positively predisposed to the topic actually came forward. The measure of awareness therefore might more suitably be ascribed to a sub group of the overall cohorts invited. .

**Outcome 2 was, To consider the curriculum for ITT and whether mental health awareness should be added to current and future programmes.** Most of the evidence pertinent to this outcome was from staff interviews although there were comments from students in the questionnaires and during model making that said they needed more input that was specific to their needs. All interviewees across the 3 HEIs called for input. Some courses had already incorporated the topic whilst others were planning to do so in the new academic year. These statements from staff had to be balanced with the view also expressed that the curriculum for ITT was already too full and that there was a danger of overloading students with information and worrying them about another issue to cope with. Michael's complicated model showed graphically the feelings of inexperienced teachers without awareness raising. The description of the complex, twisted emotions involved in dealing with mental health issues was data which has influenced the production of materials to raise awareness so that teachers can see the 'diving board' Michael was balanced on as an opportunity rather than something to be feared.

Vanessa and Janet had already incorporated content and the model makers from those groups demonstrated that they had enhanced awareness. The Bostock , Kitt and Kitt(2010) paper entitled, 'Why Wait?' has been drawn upon during this thesis and the findings from their research showed that there was an increase in confidence amongst trainees after just one awareness raising session. The element of planning for future programmes built into this objective was based on the development of PGCE curricula but the questions were not formulated to receive responses about how to manage this in light of the major changes to ITT which focus on school based training rather than university based learning with school based placements.

**The third outcome; To assess the feelings and opinions of students and staff engaged in ITT towards mental health** is discussed through all the phases. It may be considered that the statements made in the questionnaires in response to question 14 are the most reliable as they are less susceptible to elements of value judgement which might be a factor during the face to face phases. Thus, without knowledge of the researcher and without the feeling that they might need to respond in a particular manner to maintain a professional stance, the anonymous responses might be a reflection of respondents' actual feelings and thoughts. To counter this assertion it must be noted that several respondents in the face to face phases did record fearful /worried/ concerned reactions to the topic which suggests a willingness to be open and transparent.

The issues around fear and stigma were frequent and occurred in all phases. Many responses problematised the issue of mental health and in this way reinforced the findings of Rogers and Pilgrim (1997) from the literature review page 42. The notion of learning through experience and by dealing with mental health concerns in practice was not a strong feature of the data. Staff at interview were asked directly to talk about experiences from practice which made them aware of mental health issues and how to strategise around them but many of these answers dealt solely with the mental health issues of family members or affecting the respondent personally and examples from practice were talked about in terms of students who had withdrawn or had to be referred to student services.

**6.2** Having considered the individual objectives of the research this section looks at possible conclusions from the overall aim of the research. It could be deemed reasonable to conclude that a majority of respondents across 3 HEIs; both staff and student participants, were unaware of Tier 1 responsibilities to promote positive mental health and in most cases were unaware of the national framework altogether. Feelings expressed across all phases were often negative and fearful so a positive view of mental health was unlikely to be promoted within the practice of the respondents. Other views were that staff should only be involved in the referral of pupils exhibiting behaviour which could be caused by underlying mental health issues which falls far short of the full requirement to: provide support and referrals for pupils, colleagues and themselves to maintain wellbeing. Most staff and trainees were aware of referral procedures and some felt very strongly that this was the only

achievable or appropriate role for newly qualified staff. The notion of one named person dealing with the needs of learners with extra and additional requirements was reiterated by both staff and trainees although again that is not indicative of current policy and the view of the previous government that , ' Mental health is everyone's business.' and the current government's statement that there is , 'no health without mental health'. This ethos is in direct opposition to the view of Hornby and Atkinson (2003, p.8) who conclude that,

Schools have a vital role to play in the promotion of children's mental wellbeing and the prevention of mental health problems. Teachers need to be aware of the importance of fulfilling their roles in providing a whole school approach to mental health.

This thesis has postulated that there are three strands of awareness-raising needed for trainee teachers and ITT tutors. Each strand has been embedded into the three phases of the research and it is necessary to conclude whether this initial notion has provided a useful categorisation and whether there is evidence that all three stands were deemed important to the participants.

The first element of awareness was around the rates of prevalence of conditions which affect children, young people and adults and which could be presented with in class. This has been discussed in an evaluation of objective one. It is possible to infer from the findings that this thesis concurs with the conclusion of Graham et al. (2011) who summarise that,

The place to begin such conversations ( around mental health) is in the early period of initial teacher training so that those choosing teaching as a career are firmly grounded in the diverse challenges, possibilities and realities of contemporary childhood. p. 494

The idea of awareness around the damaging effects of the teaching and learning process proved more problematic to discern within the findings. Very few respondents in the questionnaires mentioned the negative effects of the teaching and learning process unless it was around the delivery of the PGCE itself. This element was tackled best in the model making sessions as practitioners considered the barriers that students faced and how they could be broken down to allow learning to progress. It is also possible to infer understanding of this strand of awareness however from the interview data around the curriculum and the stresses and strains of undertaking an ITT programme. Sandra and Janet both highlighted times in the

year when trainees would be upset and emotional and Janet went as far as to advise her trainees that to feel overwhelmed by the demands of the course was usual. There was no input into any of the ITT programmes studied which encouraged trainees to be aware of the negative impact of their practice on the mental health of their learners. In awareness-raising sessions and in lead lectures there is a strong element of surprise when trainees are asked to consider the damaging effects of the teaching and learning process on their own pupils.

The third strand of awareness suggested was around teacher wellbeing. Not surprisingly all staff interviews involved discussion about the wellbeing of teachers and how trainees need to be aware of the stressful profession that they were entering and the impact on their own wellbeing. Although most programmes represented did not have specific mental health awareness sessions or content; all discussed with trainees going out into placement the importance of maintaining a work life balance but this was often the only perspective covered.

### **Anticipated Outcomes**

Some anticipated outcomes were put forward in chapter one and these will be looked at in turn to compare with the actual outcomes recorded. The first of these is that it was considered likely when planning the research that I might meet reluctance from participants; both staff and students. Reluctance was encountered from staff and students but the reasons for this cannot be inferred from the data gathered as the most pertinent questions are about the lack of participation, that is, the number of staff and students who chose not to participate rather than the odd negative comments within the data.

Another element of my initial discussion around the topic suggested that I expected to encounter a deviancy/disaffected view of mental health issues from teachers. It was also possible that staff and trainees would have views of mental ill health linked to danger and madness as found by Rogers and Pilgrim (1997) There were certainly elements of this in all phases of the research and the over estimation of the prevalence of severe mental health issues for children and young people might also be an example of how this attitude affects practice. Use of language from a medical model of disability is also evidence of a negative approach as no participant put forward a positive definition of mental health.



One question which was not answered by the current research but which will have an impact on future research into this topic is when it is optimum to input the awareness- raising material into the curriculum. The initial chapter considered that it might be found that participants felt that only qualified, experienced teachers could or should be aware of the topic. During the data analysis it was discovered that most staff participants and trainee respondents to the questionnaire felt that during training was the best time to give trainees this specific training. One staff participant felt that until trainees had done a placement block they wouldn't be able to make the necessary links between theory and practice which would help them to make sense of the information in the awareness- raising session. There was no evidence that staff or trainees in this study felt that after graduating was a more appropriate time but there were voices which considered whether the input was really necessary even post qualification as they felt that the role of newly qualified or standard grade teachers was only to know who to refer pupils/ information to within the school setting.

### **Practical Outcomes.**

My intention is to close this body of work with the production of a pack of information available online and in hard copy for all students and staff. Already I have delivered a lead lecture to the PGCE FE student body which prompted many positive responses and fuelled interest in follow- up activities. This lecture will be a yearly event. It is interesting to note that from the 120 students present there were 18, immediate, follow- up disclosures. These were made by students who felt able to talk to me (a relative stranger) about their difficulties and struggles with their own mental health issues and the study that they were undergoing. It was noted that none of the disclosures had been made to the subject specialist staff and no one had accessed the wellbeing service at the university. Following the lecture referrals were made to the appropriate student support services and information was shared about relevant agencies. Students commented that it was good to be able to talk to someone with an obvious interest in the topic. Next year when this lecture is scheduled I plan to book rooms adjoining the lecture theatre and to offer individual appointments as the demand was intense and keeping people waiting to speak about such sensitive issues was unacceptable.

Another change to the curriculum is the input around mental health into a conference on inclusion for all PGCE school trainees at my home institution. These workshops will offer an introduction to the pack of materials and a rationale for why trainee teachers need to access the materials. Workshops are also being offered in the autumn term to the PGCE FE trainees and these will be based on the model making methodology to introduce this as a means of tackling abstract and emotive issues within practice. The workshops for both events are offered on the basis of choice so it is possible again that only those with an initial interest will select the option. The lead lecture for PGCE FE is open to all students so there is an opportunity to input for 45 minutes to the entire cohort and then offer follow up sessions if requested. A session on mental health has been added to the Health and Wellbeing module offered to undergraduates within the school of education and individual tutorials have been offered to any student writing about mental health for this module or for their major study.

In the other institutions involved in the research there are already planned sessions around awareness raising being delivered by individual tutors to their own groups of trainees but there are no plans as yet to widen this opportunity out to the entire group of PGCE students. The possibility of developing a network of tutors interested and involved with this branch of inclusion has been put forward and it is hoped that through dissemination of this paper a regional network could be established which would enable practitioners to share good practice.

This summary of practical outcomes leads to a section on the overall conclusions being claimed by the current research and the plans for further research which could be deemed reasonable from the findings of this piece.

### **Overall conclusions**

This research has been phenomenological in approach in trying to describe the essence of awareness around mental health issues in teaching and learning.

Creswell suggests that to:

Fully describe how participants view the phenomenon researchers need to bracket out, as much as possible, their own experience. (2007, p.61)

It could be considered that as this research was constructed in direct response to a set of personal experiences then it has not been possible to, 'bracket' myself out if that is indeed ever possible or even desirable. The findings of the research however did record as openly and transparently as possible the voices of staff and trainees and offered multiple qualitative opportunities for them to give a detailed account of their lived experiences of the issue. It can therefore be concluded that the research has offered a response to the questions, aim and objectives based on the views, opinions and feelings of the participants.

It is an interesting conclusion that the government's view about what their policy is, in terms of mental health and the role of teachers, and the understanding of staff and students on ITT programmes does not match. The DoH (2011) report claims that: 'Front line staff will be knowledgeable, motivated and supported'. (p.36) but in this research there was no evidence of current awareness of the existence of the National Framework or of the Tier 1 responsibilities of teachers as 'front line staff'. So the conclusion can be drawn that awareness- raising around the framework is needed to ensure that the policy is implemented. The research can suggest that as trainees and their tutors stated that they needed input into wider issues around mental health and its effects on teaching and learning that it is reasonable for these and future cohorts to be offered awareness raising sessions. The timing and content of this input can only be inferred from this research as it is possible that the initial postulation of the three reasons to be aware could have omitted other, equally valid aspects of awareness raising or could have gone beyond the needs of the trainees for awareness raising which has a direct link to their practice on placement and when qualified.

Although the changes to ITT may mean that alternative methods of raising awareness will need to be researched into; it is possible to conclude that the demands for this awareness to equip teachers and teaching assistants to meet the need of an ever diversifying cohort of children, young people and adults, are proven. Rothi *et al.* (2008) consider that:

as a consequence of the changing school pupil population there is a need for innovation in ITT that encompasses the spectrum of abilities and needs among pupils. (p.128)

The data definitely allows us to conclude that teachers and trainees express clearly their need for awareness to deal with the mental health needs of the class, their colleagues and themselves. This concurs with Holmes (2005, p.11) who concludes that:

Those who are not on top of who they are emotionally, what affects their emotional wellbeing and how to move themselves towards rebalancing their individual life are clearly not equipped to help others to do the same.

The predictions by the WHO and Mindfull about the growing incidence of mental health issues across the population, along with the statistical evidence provided in 2.1 could lead to the conclusion that this issue will become more important if we are to ensure that children and young people will have access to support and referrals to specialist professionals from the other tiers within CAMHS. This thesis concurs with Nind and Weare's conclusion to their study which suggested that:

The characteristics of more effective interventions included focusing on positive mental health, balancing universal and targeted approaches, starting early with the youngest child and continuing with the older ones... a whole school approach combining social skills development, curriculum and teacher training. (2011, p.4)

The particular features of this statement that apply to the current research are its focus on the full age range rather than just on secondary education and above, and the need for teacher training changes to ensure that staff can, from their time on placement, through to QTS and beyond into their career, be part of a whole school approach to recognising, supporting and referring children and young people with mental health issues.

Another conclusion which was borne out by the data is that there are misconceptions about mental health and an element of fear and discomfort in dealing with the topic. Common mistakes were around: gender imbalance, prevalence and severity of conditions and whose role it is to recognise the issue and offer support. Empathy was seen as a tool for teachers and this was a skill which was demonstrated through disclosures made in the model making sessions. Over half of the respondents felt that stress for teachers was of concern but practical measures to deal with stress were only included in the sessions of two staff respondents and others relied on referring trainees to reading around work life balance.

A final overarching conclusion is that the complex and rather 'messy' nature of the data produced has made it possible to really delve into the feelings and perceptions of the participants and to record their lived experiences of mental health issues affecting teaching and learning.

This section of chapter 6 has summarised the conclusions that can reasonably be drawn from the findings analysed in chapter 4 and discussed in chapter 5. The following section will consider the implications of the findings for possible further research and any implications for practice which can be disseminated.

### **6.3 Further Possible Research**

Having described the new approach to ITT introduced by the current coalition government an obvious initial consideration is whether this research could be extended to input around mental health awareness raising in the new ITT, school based, models of delivery. A starting point for this deliberation will be the findings pertaining to the sample of current staff teaching across a range of HEIs and a range of programmes who took part in this research. It is not clear from the work that this group are representative of all staff delivering ITT programmes in university settings in the north of England and it certainly would be without the scope of the study to suggest that the staff data is indicative of a national or UK picture. It is realistic however to conclude that the lack of awareness training, across their whole career, for these members of course teams across three HEIs will have had an impact on the curriculum for their trainees over a period of years. As all the staff participants were highly experienced ex practitioners from primary, secondary and FE backgrounds and only one respondent had received training from CAMHS( in a previous TA role), it could be inferred that other practitioners currently employed in SCITTS and Teach Direct schools might have had a similar lack of training. Future research may therefore consider the development of a school based input around mental health awareness which could be delivered by an external agency or through an awareness- raising online pack of materials to ensure that pre- qualified teachers from partner schools attached to the institutions involved in this research would be made aware.

A second strand of new research would be around the efficacy of the approach being piloted following this research which involves direct delivery of an awareness- raising session for some trainees through a lead lecture and the offer of workshops as an option for others. The online pack of materials is to be attached to the dummy module in Unilearn for students and staff to access and I have made an offer of follow up sessions for individuals or groups interested in further research. Further research could be structured to compare and contrast the efficacy of the approaches on offer to enable planning which ensures equality of opportunity to all trainees. Alternative strategies to raise awareness must also be acknowledged and built into further research proposals. Throughout this thesis I have drawn on my own cross curricular understanding and experience and postulated that awareness raising which is targeted and specific for ITT trainees and staff would be best delivered by a colleague from the school of education such as myself. Other studies have postulated that the best method to train teachers is by using CAMHS staff in schools and training situations to work alongside teachers and to increase their awareness of and confidence in dealing with mental health issues. Atkins et al. (2010) conclude that:

using mental health staff as 'educational enhancers' ... may be wise and is a different paradigm for traditional mental health practices in schools. P .42

The NFER report into the role of Primary mental health workers in education also concludes that:

An early report suggested that primary mental health workers from CAMHS would be employed to help Tier 1 workers such as teachers to support the mental health of children, develop relationships within local areas and be the link between schools and CAMHS. (Atkinson, Lamont and Wright 2010, p.5)

A third possible avenue of further research would be to investigate the possibility of setting up a network of teachers across various sectors to enable the sharing of good practice. Using social networking it would be possible to create a network which is regional rather than local. A national network seems a daunting prospect but would definitely mean that good practice could be disseminated across the ITT field and it may be that if this network was instigated, set up and moderated by teachers, teacher trainers and trainees rather than colleagues from other CAMHS services then it might be that the reluctance to embrace issues which can be seen as

medical and lacking in relevance to practitioners as expressed in the findings of this piece is diminished.

The questionnaire data provided several avenues for further research. It would be interesting to research into why some mental health conditions e.g. schizophrenia are over estimated in terms of prevalence whilst others, e.g. eating disorders were under estimated.

Another strand of further research could well be around the lack of recognition of the No Health without Mental Health paper and the National Framework for Mental Health which staff and trainees in ITT were mostly unaware about despite being named as an important group of Tier 1 professionals. The literature around school as an obvious place for young people's mental health issues to be noticed, supported and referred assumes that teachers will be aware and willing to take on this role. The current coalition state that 'Front line staff will be knowledgeable, motivated and supported' (DoH 2011, p.36) yet few staff or trainees in the current study had heard about the policy. This could lead to further research about the links between health initiatives and education as it may be that the lack of a common language and common understanding discussed in chapter one is one of the reasons that teachers are unaware. A research study that looked into syntax which meets the needs of teachers and trainees around the topic of mental health might introduce terms which challenge misconceptions and reduce stigma. This is linked to a conclusion drawn from the interview data that staff were comfortable introducing the notion of staff wellbeing and work life balance but asked for someone outside the team to deliver awareness raising about mental health issues. This was so even when the same staff deliver sessions on inclusion and are comfortable discussing physical issues which affect inclusion.

Another aspect of the research which would be worthy of more study would be around the success in terms of recognition of the current TV campaign whose slogan has been incorporated into the research question. The website for Time to Talk ; Time to Change boasts a recognition rate of 84 % however in this study recognition of even part of the slogan was far less at only 17%. More work is needed to consider whether again this is seen as a health campaign and nothing to do with education. The use of various media outlets to enhance awareness needs to be

investigated for this particular group so that the most effective methods of conveying messages about mental health can be built into awareness raising sessions and into the online pack.

Gender was another factor which was under researched in the current study and research into; how boys and girls manage mental health issues in schools and what differences there are in their support needs, would be a useful study. The data around gender in this work was limited to a lack of awareness that boys are overall more affected than girls by mental health issues. As in adults the percentages change it is possible that respondents were assuming that the gender difference is the same in children and young people.

#### **6.4 Recommendations**

I wish to begin this section with a statement of overarching conclusion. The overarching conclusion that I am proposing for this thesis is that awareness raising will lead to an increase in confidence in staff to recognise, support, develop classroom strategies and refer pupils on to appropriate CAMHS colleagues; this is directly linked to their role as Tier 1 staff within the National Framework for Mental Health. The recommendations that follow therefore are built on this premise and discuss how awareness raising can be incorporated and introduced into the consciousness of teacher trainers and trainees rather than whether awareness raising is worthwhile.

From the data gathered over three phases, without straying from the findings and generalising, is it possible to make some recommendations for practice for at least the institutions involved in the research and especially with regard to their current programme offer of university taught PGCE courses for primary, secondary and FE sectors. I clearly recognise here that to widen the recommendations to other programmes within schools of education and to include plans for the new suite of ITT qualifications and delivery methods is not possible from this study.

If I were to repeat the study then the change to school based delivery would mean researching into school based practice around awareness- raising and including school based trainers and mentors in the data. Other changes would include revising some of the questionnaire questions to make it possible for the links between



questions to be made rather than for each question to stand alone. The curriculum and whether there is time for any input in this area could be considered in more detail and sharing good practice from other institutions might offer practitioners ideas about how to incorporate awareness of mental health and other issues of inclusion into the studies of the trainees. A very important aspect of the study which would need to change would be around the issue of sampling and participants who have self-selected themselves to be included in the study. This has introduced an element of caution when dealing with the results of all three phases of data because it is possible that a prior interest is the reason for participation and that the views recorded are not indicative of the wider populations of staff or trainees.

From the findings of the current research firstly it is recommended that staff teams build into the academic year allocated time to allow themselves and their trainees to have an open discussion around the topic of how mental health issues can affect teaching and learning. Mind Matters (2010, p. 42) states that;

Education staff need opportunities to talk about their emotions or anxiety and depression as a prelude to how they operate in the classroom. Time for reflection allows staff to explore their attitudes and any stigma that may be attached to mental health issues for young people, themselves and others.

In chapter one I reflect that allowing learners to explore these issues openly and recognising the affective domain in teaching and learning has led to open disclosures and the development of positive and respectful working relationships. Paulus (2009) makes clear links between mental health awareness and achievement and this is a powerful selling point for the issue to be included in the curriculum as he concludes that:

.. it is therefore worthwhile investing in monitoring and promoting positive mental health. (p.292)

Secondly, therefore, to ensure that teacher trainees and their tutors start their examination of the issue with a positive definition, I am proposing that the Mental Health Foundation's (2001) definition of mental health be used as an introduction to awareness raising sessions to help staff and trainees to challenge the myths and misconceptions around the topic and to reframe the issue in a positive light. The definition records that mental health is about:

Self- confidence, assertiveness, empathy, the capacity to develop emotionally, creatively, intellectually and spiritually. The capacity to initiate and sustain mutually satisfying personal relationships and the capacity to face problems, resolve and learn from them. To use and enjoy solitude, to play and have fun, to laugh at oneself and at the world. (2001, p.197 cited in Wells 2003)

This definition links with the National Curriculum statements of intent and is equally applicable to the various sectors within ITT and to staff, trainees and learners alike.

A third recommendation is for staff teams to decide how and when they wish input into the curriculum around this issues so that the 'targeted' and 'specific' nature of the awareness raising can be achieved. The findings recorded differences between the key stages in terms of what was deemed appropriate and when trainees might best take on board new information without causing stress and overload. If the online pack is to be used it can be stored on Unilearn and date release can be employed so that access is not allowed until an appropriate juncture in each programme.

A final recommendation would be that mechanisms need to be introduced to ensure that good practice is disseminated across each institution and that all members of course teams are included and involved in raising awareness. At present the data suggests pockets of good practice within each institution and within some course teams. Parity of experience is an important aspect of all teacher training programmes and it is essential therefore that **all trainees** receive information and opportunities to discuss and research around this issue so that the practitioners are not just outstanding in terms of their creativity and delivery but also outstanding members of Tier 1 of the National Framework for Mental Health who are able to recognise, support and refer and to work with CAMHS colleagues from other tiers to be part of best practice for all learners in their classes. It is possible that a social networking approach to this topic across and even between the institutions taking part in the research would provide a platform to encourage discussion and to facilitate the sharing of good practice. In addition making online resources available to staff and students would build on the practice in my home institution of supporting subject specialist teacher trainees through an online platform with set tasks and deadlines for completion. This online work culminates in a conference for subject specialists and as a conference for inclusion for primary and secondary trainees on inclusion is already planned it would be possible to adopt a similar strategy for this purpose.

This chapter has summarised the conclusions which can be drawn from the data recorded in chapter 4 and discussed and evaluated in chapter 5. Recommendations have been suggested for further research and to improve current practice.

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## Appendix 1

**Title of Project: Would targeted input to raise awareness of mental health issues better equip newly qualified primary and secondary school teachers to manage their responsibilities as front line tier 1 staff?**

**Name of Researcher: Julie Dalton**

**Participant Identification Number for this proje**  
**Please initial box**

1. I confirm that I have read and understand the information sheet for the above project and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. (Contact researcher [j.dalton@hud.ac.uk](mailto:j.dalton@hud.ac.uk))

Direct line: 01484 478119)

3. I understand that my responses will be anonymised before analysis.

4. I agree to take part in the above research project.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Lead Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*To be signed and dated in presence of the participant*

Copies:

The participant will receive a copy of the signed and dated participant consent form and the information sheet. A copy of the signed and dated consent form will be placed in the project's main record in room CEG/10, (Queensgate campus, University of Huddersfield) within the researcher's private, locked filing cabinet.

## Appendix 2

# Mental Health Awareness Questionnaire

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## Mental Health Awareness Questionnaire

Please attempt to answer all questions; guessing is acceptable. Feel free in the final question to record any comments including a general statement about how aware of mental health issues you consider yourself to be and whether you feel that mental health awareness training would be of benefit to you in your career.

Note that once you have clicked on the CONTINUE button your answers are submitted and you can not return to review or amend that page.

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### Statistics around mental health issues in the UK

These questions all relate to the most recently published data for the UK

1. In any given year in the UK what percentage of children have a mental health problem ?

1%  10%  20%  30%

2. In the average secondary school class how many young people will currently have a mental health problem?

1  3  5  7  10

3. Approximately how many people in the UK are diagnosed with an eating disorder each year?

250,000  500,000  750,000  1 million  1,250,000

4. In the UK how many children are diagnosed with SEVERE mental health disorders in any

one year?

- 25,000  35,000  45,000  55,000  65,000

## Your personal awareness

These questions consider your knowledge and understanding of mental health issues as they pertain to educational practitioners

5. Have you undertaken any specific Mental Health Awareness raising training?

- Yes  No

If yes please indicate when and where you underwent training. (Approximate dates are sufficient) How long did the training last?

6. Are you aware of the National Service Framework for Children and Young People? Which Tier will you be/ are you working within in your practice?

- Not Aware  Tier1  Tier2  Tier3  Tier4

7. Mental health disorders in adults are as common as asthma.

- True  False  Don't know

8. Make a list of any mental health disorders which you know can affect children and young people.

9. From your list for Q8 could you describe symptoms of each disorder which may present in class ?

10. Are girls or boys more affected by mental health issues?

- Girls  Boys  No difference

11. What is the slogan for the latest televised campaign to challenge the stigma around mental health?

12. In this survey I....

- Mostly guessed the responses  Guessed some responses  Knew some answers  
 Knew all the answers  
 Other (*please specify*):

13. I am a/ an.....

Academic in SEPD  Undergraduate student in SEPD  Professional/ Post Graduate ITT in SEPD

14. Please use this final box to make comments about how aware you feel. If you would like further information about mental health issues email [j.dalton@hud.ac.uk](mailto:j.dalton@hud.ac.uk) There will also be an opportunity to join a student focus group which will look in more depth at how mental health impacts on teaching and learning. A separate email will follow.

Continue >

Survey testing only

Check Answers & Continue >

107536654;:::1..

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## Appendix 3 Questionnaire Results to Qualitative Questions

### Results For Question 8.

8. Make a list of any mental health disorders which you know can affect children and young people.

1 Eating disorders 2 ADHD

1. personality disorder 2. eating disorder 3. anxiety 4. sleeping disorder

ADD ADHD Anxiety Depression

addiction psychosis depression bipolar disorder personality disorder ADHD

ADHD

Adhd Aspergus Eating disorders

adhd dyslexia aspergers

ADHD Stress Depression Anxiety Lack of confidence

ADHD TORRETTE

ADHD Autism Asperges syndrome Schizophrenia Depression

ADHD Depression Anorexia Anxiety

ADHD, ADD, BDD, PTSD, eating disorders, Aspergers (however it could be argued hat it is not a disorder) etc....there's lots of mental heath issues that can effect children and there's different criteria, e.g. for a child's diagnosis there is strict critria etc.

ADHD, depression, anorexia, obsessive compulsive disorder, trichotillimania, panic attacks, schizophrenia, tourettes,

ADHT Bulima

ADHT Self harm

aids

all - children are people

All that can affect adults?

anorexia, suicide,depression, anxiety, bullying, low self esteem,

Anorexia Anxiety Depression ADHD Schizophrenia Bulimia Elective mutism

anorexia bulimia self-harm anxiety ADD

anorexia depression obesity

anorexia bullemia depression and anxiety

Anorexia / Bulemia ADD / ADHD Aspergus / Autism Dyslexia / Dyspraxia

anorexia bulimia OCD depression ADHD



## Anorexia Nervosa & Bulimia Nervosa

Anorexia, bulimia, depression, anxiety disorder, school phobia, drug induced psychosis, drug abuse, substance misuse, self harm, ADHD, autism, and asperger

Anorexia, bulimia, depression,

anorexia/bulimia depression/ anxiety schizophrenia self-harm

Anxiety

anxiety depression eating disorders body dysmorphia agoraphobia schizophrenia psychosis personality disorders paranoia

anxiety ADHD

anxiety autism

anxiety OCD Eating disorders depression

Anxiety, schizophrenia, eating disorders, depression

Aspergers Emotional issues

Asperges, autism,

Autism

autism

autism

autism bipolar

Autism OCD SAD Anorexia, Bulimia, depression

Autism Schizophrenia ADHD

Autism, ADHD,

Behaviour problems, eating problems, drugs, schizophrenic , bullying, poverty and I'll health

Bi Polar Depression Anxiety self harm eating disorders

Bi-polar Depression Anxiety Eating disorders

Bi-polar disorder ADHD depression anxiety schizophrenia anorexia bulimia autism

bi-polar disorder; depression; eating disorders; paranoid schizophrenia; phobias

bipola

Bipolar Depression (Clinical and non clinical) Schizophrenia Aspergers (is this classed as a mental health issue?) Autism

Bipolar Self Harm

Bulimia Anorexia Depression

Depression, anxiety, eating disorders, schizophrenia

Depression Eating

depression

depression

depression

Depression

Depression

depression anorexia ADHD schizophrenia

depression anorexia body dysmorphia bulimia schizophrenia

Depression Anorexia Bulimia Anxiety

depression anxiety

Depression Anxiety Bipolar Schizophrenia OCD

depression anxiety eating disorders mood disorders schizophrenia bipolar phobias

depression anxiety paranoia psychosis anorexia-nervosa bulimia SAD bipolar schizophrenia

depression anxiety stress bereavement Range of eating disorders bipolar disorder

Depression anxiety anorexia bulimia

Depression Anxiety disorders ADHD Stress

Depression Bi Polar Eating disorders Self harming

Depression Bipolar Eating disorders

depression bullying emotional abuse bi polar disorder self harming emotional stress e.g. death  
 in family self worthlessness  
 Depression Eating disorders ADHD  
 depression eating disorders anxiety phobias  
 depression eating disorders compulsive disorders  
 depression eating disorders OCD  
 Depression Eating Disorders Schizophrenia  
 Depression Eating Disorders Schizophrenia Self Harm  
 Depression eating disorders self harming  
 depression eating disorders stress OCD  
 depression multiple personality disorder bipolar  
 depression OCD eating disorders  
 depression OCD schizophrenia  
 depression psychosis post traumatic stress disorder autism  
 depression schizophrenia obsessive compulsive disorder addiction eating disorders  
 depression eating disorder adhd  
 depression anorexia/ eating disorders OCD  
 depression anxiety  
 depression anxiety Asperger's  
 depression eating disorder bipolar schizophrenia  
 depression eating disorders  
 depression eating disorders  
 Depression Eating disorders  
 depression eating disorders anxiety schizophrenia ADHD Autism  
 depression stress  
 depression anxiety low self esteem self harm ADHD eating disorders  
 Depression Autism? stress eating disorders  
 Depression Eating disorders ADHD  
 depression eating disorders bipolar  
 depression eating disorders OCD  
 depression eating disorders self-harm  
 depression OCD ADHD  
 Depression Schizophrenia Anxiety OCD  
 Depression Stress Anorexia ADHD  
 depression alcohol and drug dependency psychosis ADHD  
 depression bipolar anorexia bulimia SAD OCD  
 Depression, eating disorders  
 depression, anxieties, all types of phobia, hypersensitivity, dysmorphias, insomnia, etc...  
 Depression, anxiety, eating disorders, severe mental health problems e.g. schizophrenia, bi  
 polar disorder  
 depression, anxiety, eating disorders, schizophrenia, bipolar disorders, self harm, OCD  
 Depression, Anxiety, personality disorders, dementia (secondary effects), OCD, Food/eating  
 disorders, ADHD, ADD, Phobias, Stress, Attachment disorder, Bipolar, Schizophrenia, Body  
 image/sexuality disorders,  
 Depression, bipolar,  
 Depression, schizophrenia,  
 Depression, schizophrenia, Anorexia, bipolar, Bulimia  
 depression, substance abuse, phobias, psychotherapy, mental disabilities, lifestyle choices or  
 experiences,  
 depression anorexia body image disformia

Depression in children Psychotic illness  
 don't know  
 Don't know  
 don't know  
 Dyslexia  
 dyslexia anxiety depression  
 Dyslexia Asperges ADHD Autism  
 dyslexia bipolar ADD Phobias Paranoia  
 Eating disorder Depression Anxiety  
 eating disorders  
 eating disorders  
 eating disorders anxiety stress depression  
 eating disorders behaviour problems tic disorders  
 Eating disorders Depression Anxiety  
 eating disorders depression anxiety schizophrenia  
 eating disorders drugs ADHD  
 eating disorders emotional abuse  
 eating disorders schizophrenia depression self harming  
 Eating disorders Schizophrenia  
 eating disorders schizophrenia depression  
 Eating disorders Self-harm  
 eating disorders self harm  
 eating disorders (anorexia, bulimia)  
 eating disorders are mental health disorders, depression  
 Eating disorders depression psychosis schizophrenia post traumatic stress disorder  
 acrophobia manic depression postnatal depression adhd  
 eating disorders OCD depression/ anxiety schizophrenia  
 eating, phobias, depression, bipolar,  
 eating e.g. bulimia, anorexia split personality  
 grey,pale skin hair loss mood swings unusual food rituals headache wearing baggy clothes  
 dramatic weight loss especially in a short time obsession with weight, calories dizziness,  
 feeling cold insomnia  
 I am unaware of mental health disorders  
 I don't know any  
 Mental health problems will affect all those around the sufferer, however if the question  
 means which mental disorders do children get then I'm not confident in giving you them all.  
 Depression OCD Memory loss ADHD  
 Most if not all mental health disorders that are found in adults can be seen in children.  
 n/a  
 n/a  
 n/a  
 n/a  
 N/A  
 n/a  
 n/a  
 N/A  
 N/A  
 none  
 Not aware  
 not sure

Obsessed with TV and games  
 OCD Schizophrenia Depression psychotic disorder anxiety disorder eating disorder  
 OCD ADHD BULIMIA  
 OCD Autism  
 OCD Depression Bipolar  
 OCD Dyslexia  
 OCD Phobias  
 panic attacks depression eating disorders bereavement autism spectrum disorders  
 Parkinson's disease  
 Post natal depression Anxiety / depression Panic attacks Eating disorders schizophrenia  
 manic depression conduct disorder personality disorder obsessive compulsive disorders  
 psychosis  
 psychosis bi polar adhd Tourette's multiple personality disorder depression bulimia anorexia  
 same as adults!!! Bulimia, anorexia, depression, anxiety, bereavement...  
 schizophrenia Bipolar ADHD ADD Autism  
 Schizophrenia Depression Manic episodes Anxiety disorder  
 Schizophrenia Obsessive-Compulsive Disorder (OCD) Post-Traumatic Stress Disorder  
 (PTSD) Bipolar Disorder Mood Disorders  
 Schizophrenia Depression Stress Anxiety  
 Schizophrenia, depression  
 Schizophrenia, Depression  
 SELF HARM EATING DISORDERS Depression and low mood problems with sleep, not  
 being able to sleep or not being able to get up in the morning  
 self harm eating disorders depression  
 self harm depression stress  
 Schizophrenia bipolar Mentally ill Behaviourism  
 stress depression anxiety anorexia bulimia  
 STRESS OCD BIPOLAR DEPRESSION  
 unsure  
 While, I am not aware of specific disorders I am more comfortable observing and listing  
 symptoms

## Results For Question 9.

9. From your list for Q8 could you describe symptoms of each disorder which may present in class ?

■Being moody and irritable - easily upset, 'ratty' or tearful ■Feeling unhappy, miserable and lonely a lot of the time. ■Feeling hopeless

1. A child may refuse to eat during lunch breaks or go to the toilet shortly after eating. The child may become shy and un-attached to other people within the classroom/adults. 2. A child will behave very hyperactive

1. Hallucinations, delusions, paranoia, confusion, Vacant expression. 2. Lack of concentration, lack of enthusiasm, withdrawn, 3. Mood swings, OCD tendencies, blank expression. 4. Panic attacks, worrying.

1. might get a bit dramatic and over confident in the class. 2. might faint in class because does not eat. 3. might have a phobia of something or might even have a panic attack whilst in class. 4. may feel tired and always sleep in class.

?

Abnormal behaviour Lack of concentration Withdrawn

ADD - Concentration issues ADHD - Social interaction with peers and teachers Anxiety - Stress, coping with school life

adhd - behavioural difficulty dyslexia - issues with writing and reading

affect on attendance and attainment

Aggression and unreasonable or angry outbursts, being withdrawn, lethargic, apathy, poor attendance tearful and anxious, low mood

Agoraphobics won't be in lessons. Schizophrenics hear voices so may look paranoid and be talking to themselves. Eating disorder succeeded will look really thin and there are no physical tell tale signs Of depression unless self harming is occurring possible withdrawn anger frustration

Anorexia - low body weight, but see themselves as overweight. Fear of weight gain. Limit or restrictions in relationships, social activities and enjoyment. Bulimia - being excused for a toilet break, binge eating during school. Obsed with body weight. Feeling guilty and ashamed of eating habits.

Anxiety inability to concentrate disruption withdrawn not maintaining friendships

Anxiety agitation, poor concentration, hyperventilation

anxiety- anxious in class

Anxious Nervous Does not like eye contact Does not like personal space invaded Poor coping strategies

anxious panicking

anxious quiet behaviour issues

asperges-part of the autism spectrum Limited empathy, obsessiveness, behavioural difficulty behaviour emotional problems physical appearance

Behaviour issues Been tired/not paying attention/feeling poorly/distracting

Behaviour issues Support in learning Emotional support

behaviour related, self harm, anxiety, loneliness

Behavioural Issues

Being quiet, avoiding people, crying, playing truant (not going into school), drawing attention to themselves by misbehaving and kicking off, aggressiveness, violence, bullying others, physical symptoms e.g. scars/marks on skin from self harming, severe weight loss for an eating disorder

Being sick not concentrating

being sick, not eating, binge eating hearing voices mood swings, unhappy, dont want to do anything anything to hurt themselves purposely

being withdrawn quiet not communicating being lethargic tiredness

bi-polar - considerable variations in mood depression - lack of concentration, poor self - esteem, possible poor attendance Eating disorders - low self esteem P Schizo - mood swings,

personality issues, possible aggression phobias - don't know

cannot spell or read normally, need coloured paper self harm

cant concentrate

cant concentrate

child not contributing in class, child is quiet.

children getting aggressive and if they are not given what they want there behaviour could effect the people that are in the class.

Concentration

concentration

concentration issues, distraction, behavioural issues

crying or laughing excessively displaying dual personality wanting to wash hands or clean

things obsessively cravings or secret binge eating  
 death  
 defiant behaviour abusive behaviour withdrawal inappropriate language or gestures  
 disruptive behaviour inability to concentrate afraid to fail  
 Depressed quiet isolated throwing away lunch  
 Depression - Tiredness Lack of concentration Failure to meet deadlines Absence from classes  
 Bi-polar - Attendance issues Mood swings Drowsiness - linked to medication Eating  
 disorders- Reluctance to participate in certain activities ( physical ones that involve changing)  
 Tiredness Frequent visits to the toilet heightened interest in food/ health issues Self harming -  
 Visible signs of injury Covering up injuries - not wanting to change clothes Being very quite  
 in class or abnormal aggression  
 depression - feeling down, upset, vague anxiety - scared, worried, anorexia - nervous,  
 unwell, down bulimia- tired, sick, down, hungry  
 Depression - withdrawal, lack of self reliance, motivation, apathy, change in behaviour  
 patterns,  
 depression - withdrawn, changing behaviour, quiet  
 depression - withdrawn, lack of motivation, lack of appetite OCD - obsessive behaviours,  
 strange compulsions schizophrenia - hallucinations, confusion, paranoia  
 Depression: feeling low, getting upset and down about little things in life, feeling of  
 unimportance, suicidal. Schizophrenia: Paranoia, may speak to people who aren't there,  
 delusions. Anorexia: unhappy with weight, not eating, having thoughts of being bigger than  
 they actually are. Bipolar: Feeling high/hyper then changing moods to sad and depressed  
 moods, Constantly buying things. Bulimia: feeling horrible or unwanted about self, eating  
 loads of food then making yourself sick.  
 Depression: quiet, withdrawn, lack of secure friendship groups, unacceptable behaviour  
 displayed, frequent absences. Eating Disorder: Physical appearance, not reluctant to take part  
 in activity where they may need to get changed, frequent absences. Compulsive Disorders:  
 Uncertain.  
 difficulty concentrating disruptive behaviour  
 difficulty reading  
 Dis like of food Listening to things that aren't heard  
 disruptive behaviour lack of concentration  
 distracted wane hyper or low activity disorganised poor short term memory vague irritable  
 closed late arrivals/homework  
 disruptive behaviour, attention seeking, mood swings, sometimes opposite way might be  
 quiet, dirty, smelly, torn clothes. unwashed  
 do not know  
 Don't know  
 don't know  
 eating too much eating too little being withdrawn being overly aggressive acting out  
 facial/bodily ticks shouting out  
 eating=lethargy, poor concentration phobias= strange perhaps irrational behaviour  
 depression= withdrawn, quiet bipolar=mood swings  
 feeling sad stressed one minute high then low  
 hiding quiet  
 I am unaware of mental health disorders  
 I could identify some symptoms but not all  
 i don't know  
 inability to concentrate difficulties working with others impaired memory  
 Inability to concentrate Poor attendance

inappropriate use of language Illogical behaviour  
 inattention disruptive behaviour  
 Irritability, distracted, unable to engage, sweating, relationship issues, difficulties in groups,  
 low confidence, low self esteem, self conscious, breathing difficulties, not eating : fainting,  
 mood changes, overactive/underactive,  
 irritability, tiredness, lack of concentration, obsessiveness  
 isolating themselves Good and bad days feeling emotional not eating feeling unpretty look  
 down all the time giddy angry frustrated split personalities violence  
 Lack of attention Lack of social awareness  
 Lack of concentration Tearfulness becomes withdrawn Daydreaming Lack of appetite  
 Weightloss  
 Lack of concentration Uncharacteristic behaviours Loss of temper Apathy School/lesson  
 phobias Attention seeking Agressive behaviours Sulliness Lack of engagement...  
 lack of concentration, disruption, aggression,  
 lack of confidence hyperactivity lack of concentration quiet reserved  
 less concentration behaviour problems  
 looking thin  
 loss weight, hiding food, going to toilet after eating, moodiness  
 loud, unpredictable outbursts Behavioural issues issues in groups over sensitive  
 low mood loss of confidence lack of enjoyment feeling hopeless poor concentration negative  
 thinking tiredness, less of energy  
 low mood quiet withdrawn hiding body hyper being sick  
 may be  
 mood disorders and schizophrenia are more common in class.  
 Mood swings disaffected in the lesson un-cooperation withdrawn  
 Mood swings Wrist marks  
 mood swings, emotional, fatigue, anger  
 mood swings, no interest, negative language. strange attitude to food and how they look/  
 weight change. Obvious marks, secretive, depressed.  
 n/a  
 n/a  
 n/a  
 n/a  
 N/A  
 n/a  
 n/a  
 n/a  
 N/A  
 n/a  
 N/A  
 N/A  
 need to leave class, swetty and unable to breath. Quiet, lonley and not ocmunicating with  
 others,distant and not listening. distracted and not listening, aggressive and disruptive. Quiet  
 not communicationg with friends and being issolated.not joining in activities. distruption,  
 loud , aggressive,  
 no  
 no  
 no  
 NO  
 no

no

no

no

NO

NO

no

no

NO

no

no

no

no

No

no

no

no

NO

no

No concentration shouting out

no eye contact skinny head down just panicking not feeling good

Not all of the symptoms can be present in class and there is a whole depth as to why etc.

however, sometimes the symptoms can be prominent for example in extreme cases of ADHD or ADD....but it's not basic so one cannot just 'describe' them

Not Aware

Not being able to write or read properly. Behaviour problems, hyperactivity. Lack of attention.

not coping not concentrating

Not eating

not eating, binge eating feeling of being alone and stressed

not eating, vomiting, bingeing and purging, lack of confidence, crying, being quiet, anger, negative behaviour

not focused easily distracted

Not in detail

Not listening, fidgeting, interrupting

Not sure

not to make a clinical diagnosis, but I may notice non-characteristic or abnormal behaviours

not wanting to eat. eating and then going to the toilet soon after.

paranoia

paranoid behaviour poor performance behavioural issues

Poor motivation, anger, frustrations etc in class Weight loss Long periods away from school quiet

quiet withdrawn

quiet thin hiding arms- long sleeves

Quiet withdrawn weight loss tiredness

quiet, withdrawn or needy, behaviour issues

restlessness lack of concentration

Schizophrenia: Talking to people who aren't there, displaying frequent changes in behaviour, i.e. aggression. Depression: reserved, quiet, aggressive, reluctant to work in groups.

schizophrenic, symptoms could be hearing noises and voices being scared. The rest could have symptoms, such as depression, anxiety, nervous, hyperactive and suicidal.



self harming eating too much being underweight  
 Severe mood swings Listlessness, non-responsive, Strange ideas and stories, people telling them what they should do Wanting things done in a set way, not wanting to be with some people, strange or inappropriate responses Non participation  
 Short attention span Physical injuries  
 sickness, thin , hiding food hearing voices, suicidal, not wanting to do anything.  
 Some symptoms  
 Sometimes no symptoms Physical appearance Hyperactive Lacks concentration  
 Sorry i don't have the time to do this.  
**TENSE DEPRESSED DOWN**  
 this is extremely varied and will depend on the stable or baseline of behaviour for the child concerned. the renage could include appearing withdrawn, physical appearance (changes to complexion, whites of eyes, perspiration, posture and mobility) frieddnsnip patterns, appearing over confident, and more  
 throwing away lunch tiredness  
 timidness withdrawal nervousness shaking tiredness underweight vomiting overweight  
 tired miserable  
 Tired,restless,unable to concentrate Covering up  
 Too quiet or hyper-active and attention seeking; bullying or aggressive; giving away lunch or throwing it away.  
 torrette- tics of movement or sound, this can lead to behavioural issues. ADHD-Inattention, hyperactivity, and impulsivity are the key behaviors of ADHD.  
 unhappy withdrawn picky eater agressive quite  
 unsure  
 withdrawal lack of motivation exclusion violence  
 withdrawal, agression, mood changes, tiredness...  
 Withdrawl, lethargy, disruption, lack of concentration  
 Withdrawn  
 Withdrawn  
 Withdrawn Excessive tiredness Day dreaming Inappropriate outbursts Constant snacking  
 Refusal to take part in PE  
 withdrawn low energy distracted listless tired disruptive conflict-seeking attention-seeking secretive furtive poorly presented/personal hygiene issues unauthorised absence  
 Withdrawn Weight Swings  
 Withdrawn aggressive  
 withdrawn losing weight  
 withdrawn quiet panic attacks low self-esteem tiredness  
 withdrawn behaviour, glassy eyes, tiredness, lashing out, disruptive behaviour, not eating, food storing, induced vomiting  
 withdrawn symptoms slow learning not getting invlolved in class discussion, self harmimng, loss of weight, extreme sudden mood swings, hatred/fear of certain things, cutting themselves off from other class members, having few friends, poor hygiene  
 Withrdrawn behaviour, paranoia, over exuberance  
 Would be able, hopefully, to pick up that something was wrong  
 x  
 yes  
 Yes  
 Yes maany  
 yes on the whole  
 yes.

## Results For Question 14.

14. Please use this final box to make comments about how aware you feel. If you would like further information about mental health issues email [j.dalton@hud.ac.uk](mailto:j.dalton@hud.ac.uk) There will also be an opportunity to join a student focus group which will look in more depth at how mental health impacts on teaching and learning. A separate email will follow.

-

a little bit aware

as a sufferer of depression I feel that I am fairly aware of issues that affect adults but may be not so clued up as to how they affect young people

aware

Aware of child mental health, but more information during courses would be helpful.

aware of some disorders but not numbers

Aware of some issues.

could brush up on knowledge

don't feel aware

don't know much about it

don't feel that this is really important

don't know much about them

Don't see the need for this

fairly aware

fairly aware

from this survey I can see I have very little awareness of mental health issues.

have some awareness

have some awareness

I am aware but most are really hard to spot and many emotions can look like a mental illness but is not actually one

I am aware of certain areas and feel I do need to be more informed of Child Mental Health issues and would like further training to raise my awareness

I am aware of certain issues, having worked with adult learners with mental health problems but have always asked to receive training.

I am aware that a lot of my students have a lot of other issues going on at home that affects their mood and concentration in class.

I am aware that mental illness is a problem with children as my sister suffered but I would like more information regarding mental health in the early years as I am not very aware.

I am eager to know more about mental health

I am fully aware of mental health disorders and help that is available as I have suffered with several of the ones I mentioned in a previous question

I am no longer as aware of figures and data relating to this topic.

I AM NOT AWARE

I am not aware

I am not aware about any of the following questions I just answered

I am not very aware and have never had any training

I am not very aware of mental health issues in school

I am personally aware of mental illness. I believe it can affect anyone at anytime. Many variables can affect individuals and how they cope with the rigors of everyday life.

I am reasonably aware of mental health issues in adults, but not in children.

I am very aware that students with mental health problems are increasing in HE and think all staff need to be made more aware of best ways of working with these students, but the problem is the diversity within the group

i am aware of certain disorders but i'm not aware of the symptoms properly

I do feel very aware about mental health issues, but would be interested in further information.

I do not feel that aware of mental health issues, the recent television and radio advert has stuck in my head and i have seen / heard it several times but unsure of the slogan

I do not feel particularly aware at all. I try and make no judgements about people with mental health issues; but sometimes I am concerned for their safety and the safety of those around them.

I do not know much about mental illness, however I am a little aware about this mental health issue. Have read about it in the papers and heard things about it on the news .

I don't feel aware at all... it is worrying to think about how many children may be suffering in silence.

I don't feel very aware about mental health issues in young people at all. I was never given any real education on these matters other than children that were in my class and suffered from some form of mental health issue.

I don't have much awareness of mental health illnesses

I don't know a lot about mental health issues, even though some people in my family and friends have mental health issues.

i don't really know much about mental health problems, however i tried my best in answering the questions.

i don't know much about mental illnesses

I feel a little aware but that I could learn more.

I feel as though I know a bit about mental health after to caring for a family member who has suffered from mental health issues. However, I do feel like if I had, had a better understanding of mental health issues it would have been easier to understand my family member whom I cared for issues.

I feel equipped to notice some signs and would know where to seek further advice

I feel I am aware of some mental health issues but would like to know more.

I feel I am aware to some degree but mainly through contact with young people struggling with mental health issues and media programmes that I am interested in rather than specific training through work. I have students each year on my course who experience mental health issues each year which I try and support (and pre-empt) where I can.

I feel I have a certain level of awareness due to the fact that several students in recent years have suffered with mental health issues.

I feel I have a low to medium awareness of these issues

I feel I have little awareness of the scope of mental health problems in the classroom

I feel I need to increase my knowledge around the prevalence of mental health disorders in post 16 education in particular within the boundaries of my role and within the college environment.

I feel I would benefit from more input on mental awareness

i feel moderately aware but not very informed about the impact of mental health issues within younger people

i feel quite aware but not as much

i feel quite aware but would like to learn more and will be using mental health as an assignment topic

I feel quite aware having worked directly with children and young people for a number of

years and from being involved in education provision for those already in the children and young people's workforce or planning to join it. I also try to keep on top of current affairs and general developments.

I feel that I do not feel aware of mental health problems at all. I am even confused about if mental health problems are classed as SEN in school.

I feel that I do not know anything on the effects on mental health on children. I feel it would be beneficial to know this as I may have these children in my classroom.

i feel that i do not know much at all about mental health and the only condition i knew was because it was on eastenders

I feel that I have some awareness of mental health issues.

I feel that my awareness on this subject was poor.

I feel very uninformed regarding mental health issues.

I felt I am not aware of mental health issues which are present among school children and young people. It was an eye opener when I had a look at a few national statistics after completing the survey.

I find that the information can easily be found online, if i need the mental health statistics i could find the latest data online. It has at least made me aware of mental disorders in children. Also question nine was in all honesty a waste of time it would have taken more than the 10 minutes specified when i started this questionnaire.

I guessed all of the questions. I am not studying SEPD, and I have very little awareness of mental health or any signs/symptoms.

I have answered Q13 but I am not in SEPD. I am currently on the Ba early primary course and I have applied for an extended placement at an SEN setting this year. I feel any input regarding special needs will help my development in all settings.

I have bipolar, so I would be very happy to talk with you about having a mental health condition and teaching. Sarah Trussler Head of Primary Leeds Trinity University College  
s.trussler@leedstrinity.ac.uk

I have family with personality disorder and skitsofernia (can't spell)

I have personal awareness and experience and exp as a teacher of young children..

I have some awareness of mental health issues concerning children but would require further training to be comfortable in this area.

I have some knowledge of mental illness through helping someone who was going through a mental disorder at the time.

I have some understanding but not enough.

I have very limited knowledge of mental health problems in children and young adults.

I I feel reasonable aware but there is much more to know

I know depression is a problem with children and have a niece who suffers with anorexia but know little else and do not know how I would support children in my class.

I know I am not aware enough about mental health problems in children. I am aware how common they are but I do not know enough about symptoms or strategies to support children with mental health problems.

I know nothing about mental health

I only feel aware of mental health disorders due to the fact I currently suffer from Depression. If I didn't then I'm not entirely sure I would know where to go for support.

I realise I feel unaware of the extent these issues impact on teaching and learning and how prevalent they are in society today.

I suffer from a mental health disability myself, and my experiences have been that academics are not only unaware of such issues, but are very prejudiced about them and can act in highly discriminatory and oppressive ways towards people with mental health issues. I feel my own experience has given me some awareness, but I need to learn much more about other

conditions than my own and about their impact on students and colleagues in teaching and learning.

I suffer from poor mental health as an adult but am not aware of the issues which children face

I think Mental Health Issues are an area that many people shy away from due to the severity of them. I think awareness could be raised much more as currently some young people may label themselves to avoid being in trouble.

I think we need to be far more aware of issues that we have to face in the classroom so that we have the ability to deal with unforeseen situations. This should be a core subject during training.

I used to work in the child and adolescent mental health team several years ago, so feel that I have some knowledge.

I will be interested please in finding out more on how mental health impacts on teaching and learning.

I wish more people were aware of mental illness and I wish I would know the answers to all these questions since it is an issue close to my heart so I will now make sure I know all the answers to better my knowledge for the future.

I would be grateful for further information on mental health as i would like to develop my knowledge in this area.

I would be interested in finding out more.

I'm not sure it's helpful to generalise from 5 - 18 years old. I'm not well informed but would anticipate some variation between pre- and post- adolescence.

I'm surprised by my lack of awareness at the number of children with mental health issues.

It has made me realise how little I know and that I need to read up and keep up to date.

know a little bit

know very little

know very little

Lacking in experience in supporting / identifying children with mental health issues

less aware at this stage

Limited knowledge Would be interested in MH issues with EFL learners Are there differences between UK and Asian learners?

mental health has had a bad stigma Cant see it being broken down and don't know how to deal with it.

mental health is still a taboo subject and needs to be talked about more.

more formal input required

Mostly aware but sometimes struggle to know where and who to refer to

My brother, who is deaf, has recently been diagnosed as having Schizophrenia so I am slowly learning more about this illness.

n/a

n/a

n/a

n/a

N/A

n/a

N/a

N/A

N/C

Na

NA

need more information

Need to be more aware  
need to know more  
need to know more  
No comment  
no comments. as an ITT there is a training session planned at the placement school  
No further comment  
none  
not as aware as I thought  
not at all aware  
not aware  
not aware  
not aware  
not aware  
NOT AWARE  
not aware  
Not aware Could research it further if necessary  
not aware at all  
not aware at all  
not aware enough  
not aware very much  
not interested very small number affected  
not particularly  
Not sure  
not too aware  
not very  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
not very aware  
Not very aware  
not very aware  
Not very aware  
not very aware  
not very aware of mental health issues at all - have a friend that have been diagnosed with depression but otherwise that is about it.  
not very sure  
Not very!  
nothing to add  
Obviously not aware enough.  
paying attention to our mental health is very important.

People in my family have mental health

Poorly equipped

Pretty unaware of mental health in children but I am on a childhood studies course so will cover this topic

Should know more

some awareness

Some practical help would be a good idea

Survey useful as it made me think

Thanks

This exercise has highlighted my lack of awareness. It has certainly provided the impetus for exploring mental health issues in more depth.

This questionnaire has raised my awareness and would be interested to know of any training available that would support the work I do as a teacher and ITT lecturer.

this survey has made me want to be more aware and I would definitely be interested in a focus groups and extra information.

totally unable to answer questions- my knowledge is very limited  
very aware.

Very little awareness

Very little awareness - all the questions were guessed

Very low level of awareness

very unaware

Very unaware definitely need more training on this subject and how to meet student's needs  
very unaware.

when i am thinking about this i can be quite clear about signs and symptoms in the busy classroom where patterns of behaviour evolve its hard to step back and realise where you and the child and young person have got to in your behaviour together. getting more outcome focused rather than relationship led means it gets harder to pick up on the signals - time together is fragmented teaching children young people and adults so consistency of interaction means knowledge is even more fragmented - MH is associated with stigma and misconception so is a complex aspect of teaching and learning

would like to find out more

would like to know more

you dick

## Appendix 4

Semi Structured Interview

Gender:

Teaching Experience:

Teaching Qualification:

Mental Health Training course:

Personal Tutor:

Avge number of students per class

How would you assess your awareness of mental health.

Is your awareness related to experiences you have had with students/ staff/ self

Have you had any specific training around mental health issues a) in house b)self taught c)bought in

You volunteered to take part in the interview was this based on interest. Is this interest based on experience/ cpd/ reflective practice?

What type of experiences have you to draw on about how mental health affects teaching and learning?

Is there a named person on your course who deals with referrals to other services for students.

Is there a placement element on your course? How are students prepared for placement? Is there any specific input on mental health in the body of the course?



Who would you refer students to if you were concerned about their mental health?

What local agencies/ bodies are you aware of who work in Huddersfield

## Appendix 5

### Interview transcript 1 Vanessa

Teaching experience 20 years      Teaching qual. PGCE

Mental Health training no

Personal tutor Yes

Number per class 20 plus

I: Thanks for agreeing to the interview. You offered to input into the research based on your experiences and interest. Could you outline these?

I1: Yes, I am a PGCE course leader and Head of Department and I am bi-polar so have direct experience of how mental health issues affect teaching and learning. I am therefore really keen to make sure that student teachers have awareness and feel able to cope.

I: I have found that colleagues think the curriculum is too full to fit in a session on mental health. I can't help thinking that there must be a gap or there must be somebody who'd like to finish early one afternoon and let me have them for a little bit. My plan however is to produce a resource which people can have so they're not going away from the institution and nobody ever mentioned it to them.

**Interviewee:** Yep they must have something. We do a session and then follow it up with an information pack so that students can refer to it later.

I: Do they get that before they go out on placement?

I1: Yes, they need it as soon as possible. I signed up to that website I don't know if you have, time to change website so I get their blogs and stuff and it is fairly easy to make it in your face but sensitive. That is a good place to start with an awareness raising session.

I: Could you draw on some experiences from practice which shows how mental health affects teaching? I had a PGCE student e.g. who refused to teach a particular

class because there was a guy in it that she considered dangerous , without any reason other than he had a mental health issue.

**I1:** That's just born of fear isn't it, fear and ignorance. But you don't know what's going on in people's heads. I really wish you could see the thought bubbles sometimes because when I did the training with my staff to most of them it was they didn't know that I had bi-polar before the training and a couple of them said so how do we deal with you now and it's like but I've been here five years and actually tomorrow it's going to be no different to the five years you've known me up till now and I find it really fascinating these very very intelligent experienced people and even at their ages I mean they're most of them at least ten years older than me saying what do I do now. You think if they're doing it, what are 20 year olds thinking?

Children will ask questions as well I mean I find my younger one, they've only known I'm bipolar for about a year, and he'll say something totally out of the blue we will be driving somewhere having a laugh about something he'll turn to me and say, 'can you die from bipolar?' 'Well I'm not planning on it! Then a month or two months will go past and it'll be , ' you know the medication you take is it horrible?' And it's that sort of thing that you need isn't it, how does it feel to be deaf? You know it needs to be normal conversation so that it's not hidden I mean obviously you don't want somebody constantly saying you feeling alright today or are you depressed? but not asking and not mentioning it doesn't help either. I was surprised when I started the sessions here that there was such a lack of awareness about mental health and that lots of people had serious misconceptions.

I: I've been really interested in what I've found out from phase 1 which were questionnaires because as I said I sort of thought there wasn't an awful lot of awareness but it was really really shocking to see it in black and white

**I1:** There's a statistic in the presentation that I have printed off for you that tells you how many GP's have been trained on mental health and it's something like a quarter and you're thinking they're the ones providing the diagnosis but the diagnosis for depression is a sheet of paper anyway with your hospital and anxiety depression score.

I go in and they'll suggest some sort of medicine and I'll go isn't that counter-indicative to what I'm taking now because like you're not supposed to take Ibuprofen for example but I can't have that because it's got Ibuprofen in it, oh has it and then they start googling and you're thinking hang on a minute I'm sat in the doctors and you're googling it's not on. I mean teachers are supposed to know things teachers can't sit there googling in class do you? Oh hang on a minute can't remember that bit.

I observed some poor student this week I'm an external examiner for Birmingham so I went down and the poor girl she was teaching in the staff room for a start because they use the staff room as a classroom and I was thinking you don't put a student in there so she did have teachers come in and get coffee while she was in the middle of a lesson it was just awful. Then she had this group and she said come on there's one more type of connective I've got on this list and the kids are sitting there

thinking, I'm sure there isn't and she's saying, ' what about then?' and the kids go but that's a time connective miss and you've asked us not to do those and she said, ' ha, I was just checking!' and you're thinking, oh you poor thing as I'm sat there writing notes. First of all it was guess what's inside my head and then it was wrong.

I: Is there anything else you would like to add?

I1: It's just so important and I was hoping that out of your research there might be an opportunity to work together and to start a network perhaps across the region to share good practice and to make sure that trainees get information before they set off into work.

I; That would be a great outcome. I think I have been focusing on the local implications but this has made me think about what needs to be done to disseminate this further and to get the message out that this is worth talking about.

## **Interview number 2      **Sandra****

Teaching experience 22 years

Mental health training no

Personal tutor yes

Avg number fallen to 14

i: if you're thinking about your own awareness then, around mental health, because you've not had any training how aware do you think you feel?

Interviewee: To be honest with you I feel like I know quite a bit about it, my Mum had a nervous breakdown and had dementia and alzheimer's so I feel like I've gone through it. So my Mum had a nervous breakdown when I got married so that was quite a long time ago and she recovered and got back to full capacity but I wouldn't have said I knew anything about it up until that point. I thought she was having epileptic fits and that's what we rang the doctor with and when I found out it was a nervous breakdown it was unbelievable.

i: It is a very thin line and when you cross it it's something that's really noticeable

I2: and it really challenges perceptions I think because you know I think everybody most people think of things like that happening to people who are perhaps you know sort of nervy people and my Mum was never like that she had a strong career it was completely out of the blue but that obviously changed the awareness that it can happen to anybody and everybody

i: So do you think you supported students with mental health issues?

I2: Yes I do both in school and here.

i: So what sort of things do you think you notice?

I2: In terms of here, I think issues well different things. I've supported one of my students has an eating disorder, she wasn't eating at all. I've had another student who just, just was stressed and not coping with lots of things I think the course is really stressful. So you know quite a few students over the years where everthing's just got on top of them. In school I had one pupil that I got quite close to just with family issues basically but you know not coping, one of them was stemmed from a bereavement with her Dad and then she just lost the plot really, just not coping with the demands made of her so that sort of thing. I suppose over the years I've dealt with it

I: I'm thinking if people were aware of mental health it would be for themselves, for the learners they were working with and for the overall impact on the organisation.

I2: and I think you know learning how to teach is so intense isn't it. It's because you're laying yourself bare really aren't you. Both in terms of kids having a go at you but also in terms of what other teachers say in terms of observations. We say, right we will teach you a little bit about it then you're going to do it then we are going to say you could have done this better. We would never do that consciously when we're teaching but we do that every time and I just think it's a really emotional rollercoaster that students go on and you know the tissues always come out in February and you can almost time it. When the pressure just gets too much. When they start that certain placement and think I've got to do all this again build relationships both with staff and just like walking into a staffroom I just think it's incredible pressure we put on people.

J.D: So if on your course if there were people who you had concerns about or placements had concerns about is there a named person on your course that would sort of look at that or is it all

I2: It would always go through the personal tutor for example I'm personal tutor for usually half of the music students and I go and see them on placements so the personal tutor sees them right from the word go so does all the academic tutorials with them and any personal tutorials that they want to do so I would be the first port of call and then I would direct them perhaps to student services

i: and do you have any input from student services because we have a mental health officer and I just wondered if they had any input in your induction?

I2: I think yes the student services do come down and talk and explain all the range of services they do but they do that as a whole PGCE course at the beginning.

i: So if they were going out into placement again you've got that personal tutor link and have they got a mentor?

I2: They have a subject mentor and they have a professional mentor so the professional mentor; their role is to oversee all the students that are in the schools so sometimes they say in their induction say if you've got any problems don't hesitate to come to me and often they can be a source of sometimes they don't want to talk to their subject mentor because it's too close and they know they're being assessed in a sense by that person so often they will go and talk to their professional mentor but

probably 9 times out of 10 they would come to us still even on placement because during the first placement we will see them every week anyway and then in the second placement they have my mobile and email they can just contact me if they've got an issue and that tends to be how it works.

i: When we're sending them into teaching, there's a national framework for mental health for youngsters and adolescents and teachers fall into tier one of that framework. So we're meant to identify and refer, that's all, you're not meant to be an expert. I am very keen not to be saying that any input on mental health that I am trying to think about in terms of the future isn't going to be a huge part of anything at all. It's just going to be a sort of how to get people into placements able to do that tier one and meet that tier one responsibility. I just wondered if that was mentioned anywhere?

I2: I don't think it is. It might come under the safeguarding discussion but I'm not in there for that. It might come under that, Lesley-Ann might be able to tell you whether that happens. That's where it'll be if it's anywhere. We do a session on safeguarding and working with outside agencies and they get that in school as well so they have a IPD programme, initial professional development programme which happens in school in both placements and schools organise that across the placements and because they get students from different places at slightly different times they'll drop into that. So at least once during the year they'll get a contextual base; training on how it works in that particular environment so it will probably be mentioned at that point as well. They'll get a session on working with form groups, it might come into there and certainly they get that in school as well.

i: So equality and diversity is that embedded into the different things?

I2: No we do specific sessions on inclusion and things like aspergers and that sort of thing. They do specifically talk about that but I'm not sure if that's classed as that.

i: I'm wondering whether we are assuming that implicit knowledge because of a 189 responses to the questionnaire that I sent out and the awareness was incredibly low. And lots of people said it was low, and said 'I don't know anything' and that's fine or said 'I don't know anything but I'm sure I'll find out because I'm going out' but other people said that they were aware and yet they still they didn't show awareness in their responses.

I2: That's a little like me, I think I'm aware but actually I probably don't know as much as I ought to.

i: I think maybe because the age thing is becoming more of an issue in terms of how young people are getting eating disorders and how young people are starting to get anxiety and depression that's now diagnosable, maybe that's something that we need to think about in terms of keeping up to date.

I2: Yeah, it's the pressure again that they're put under. My daughter gets totally

screwed up about homework, it's almost like OCD, she has to do her homework as soon as she gets in through the door and if anything deviates from that it's like a disaster. And it's just like, where does that come from? We've never put that pressure on her.

i: No, but inside pressure is interesting. As I said, when I was doing PGC mentoring I had people who came and said 'there's something really strange about this person' or 'there's something about this person I don't know what it is, I think I'm going to make it worse or might upset that person' and those sort of things made me think, is it something you could only learn when you go out and do it and as you say, as you're supporting something you'll think 'actually this is probably more a mental health issue than a physical issue but it's an issue we've got to deal with' or is it something you think you might have benefited from knowing before you went into practice?

I2: I think actually we ought to do something about it before you go out. Certainly, it's difficult because my mum's issue happened in '89 and that's when I started teaching but I can't remember doing anything about it at all. I mean we did basic medical stuff, I remember doing all about epileptic fits, we did do basic medical stuff but nothing on that. The thing is, it's all, I mean we all have mental health issues, but you know you're on a spectrum. I think that people might be worried that a little knowledge is a dangerous thing because in a sense you're told to always refer; so as a young teacher you would always be told there's a named person in school and that's who you go and tell.

i: I think before you can assess and work out who it is they should be referred to and what's happening sometimes, someone has told you something and there is that need then to respond and to empathise and understanding perhaps helps to do that.

I2: I agree, I mean in a sense, I've never sort of spotted anything, you know, in terms of the things that I've dealt with and referred have always been sort of people who've come to me and cried on my shoulder. I can't remember a time when I've looked at somebody and thought 'mm..perhaps I need to...' and that's probably because I don't know enough about it to spot those signs. The trouble is, it's hard isn't it when you're seeing 400 kids a week as a music teacher, it's not that same environment as perhaps primary.

JD: So differences are harder to spot definitely with your age group. And also with the normal teenage patterns of behaviour which a lot of things get put down to. I mean weepiness and struggling with stress, are part of that condition and constantly battling with yourself until you're a person. Of course there is also a stigma attached to mental health issues.

I2: My experience with my mum is that it's just an issue that's not dealt with very well. The nurses don't seem to be able to deal with it, my mum had cancer in the end, in the hospitals they couldn't deal with the dementia and she ended up being wheeled in her bed and just being put in the corridor with the nurses because they couldn't

leave her. It was done for the best intentions but it was horrendous. They couldn't deal with it. I think it's just so scary, it's much scarier than any physical illness.

i: But I suppose the recovery is the thing though, because so many people recover fully and even if people have things like bipolar that they have to live with and manage, the treatments are so much better that people are living with and managing and you'd be amazed at how many people are living and managing and working full time and so on. We need to talk about the positives.

Interviewee: Yeah, it's been in the news, the politicians were talking about the tv campaign, weren't they, last week?

i: Yes, the policy changes that brought national framework in and said people had to work together is interesting because authorities deal with that in different ways.

I2: Again it's always above the young teacher, they would never get involved. I've never been involved with multi agency anything except when I was head of year for a short time.

i: I think that's right, we need to know that what we're suggesting is going to be applicable, it isn't that awareness needs to be taken to that level otherwise we'd be giving people information that might just worry them, which wouldn't be any use at all.

I2: Thankyou, that was really interesting. It's just something I haven't thought about from a work point of view.

i: Thank you very much for your time and responses.

### **Interview Transcript Interview 3 Lynn**

Teaching Experience 15 years

Teaching qualification BEd

Mental health training no

Personal tutor Yes

Avg number of students per class 20

I: How would you assess your awareness of mental health?

I3 : I feel quite aware of how mental health impacts on teachers and the fact that we are in a stressful profession. I think we need to make trainee teachers aware of this and equip them with strategies to cope otherwise all our good work in producing outstanding practitioners will be wasted and they won't stay. I think the course being recognised as outstanding means that we put lots of pressure on our students to be the best. I suppose that for some who struggle with their mental health that pressure

might prove to be too much but we do also provide lots of support and are approachable so that people can come and say I need more help.

I also have an awareness based on my own pre natal depression and friends and colleagues' experiences from the teaching profession. It was interesting that when I was pregnant I felt awful and was unable to cope and it really surprised me to discover that I had depression. I had always thought that, busy, positive people like me couldn't be depressed and yet here I was feeling tired and unable to do my normal daily jobs. I had been made a deputy head too and the stress of that new position, along with the demands of the staff, was heavy at the time. I had CBT and would recommend it to anyone. I realised that lots of the not coping thoughts and the negative, worrying internal talk was under my control and could be changed into something more positive. The counselling/ talking therapy was definitely the answer for me. I have known other colleagues who have gone off with stress and some of those have not been able to return. The management of this as a deputy was one of the hardest parts of the job

I: thanks for volunteering to take part in the interview did you do this because you had an interest in the topic already?

I3: We have, as a team, been discussing lots of inclusion issues and how best to deal with them as we have identified this area as one that could be developed. The plan is in the new academic year to run an inclusion conference joint with the secondary ITT students so that all teacher trainees have access to lectures and workshops over 2 days. Would you be able to provide some input at the conference?

I Of course, I would be happy to discuss this with the team and have already been approached by the course leader to have some involvement. I can produce a pack of information online to back up the workshop/ seminar and will tailor the content to meet the needs of your groups.

I3: That will be really useful. We are aware of a need to cover SEN in a more systematic way as at the moment the issue of safeguarding is the over-riding focus and the course is too full to add new modules.

I; what type of experiences have you to draw on from practice about how MH affects teaching and learning?

I3: I have direct experience from a primary setting with children who have been dealing with bereavement. This affects different ages differently. Younger children just let it all out and are not aware that they should try to limit or hide emotional responses. This can be disruptive and it is hard to apply the behaviour policy to this set of circumstances. Older children can hide things and the response is sometimes displaced and not at all what you would expect. They know it is not acceptable to



talk openly about feelings and missing their loved one in front of their peers but this repression can make them angry and withdrawn.

I also often had to deal with girls who were going through puberty before leaving primary school and this is happening earlier and earlier so is an issue for new primary teachers who may assume everything will happen later.

Other MH issues arose from children in the looked after sector whether they were being fostered or adopted. There were also children whose behaviour spiralled into violence and those who sought attention for all the wrong reasons.

I: Who is the person on your course to deal with referrals for students to other services?

I3: we all deal with our own personal tutees and the course leader takes overall responsibility for student wellbeing.

I; How are students prepared for placements on the course?

I3; There is a detailed placement induction and we visit placements at the start to make sure that there are no issues. I would say though that we are reactive in our approach to MH awareness at the moment because no one gets specific input on the topic before they go out and it would only come up in the debrief in response to what students have reported as their experiences.

I think our students are taught in detail how to be reflective practitioners and how to strive for perfection but they aren't taught explicitly to protect their own mental health or the mental health of their learners.

Newly qualified and experienced staff who don't have partners/ friends/ parents who are aware of the stresses of the job can burn out very easily. They need someone to say , 'stop now' and to ensure that there are checks and balances in place to maintain a work- life balance.

I always use the 'raisin' analogy for teachers as the profession can easily reduce the bright, fresh grapes that we put into practice to dried out, wrinkly raisins without protection and the rate of burn out is too high. We all know people who have had to go off on the sick with stress from the profession. This of course in turn is difficult to manage as it means that staff who remain are under additional stress to cope with the shortfall of their absent colleague.

I: Many thanks for your time and for sharing your ideas. I look forward to working with the team at the conference.

#### **Interview Transcript 4 Justine**

Teaching experience 20 years

Teaching qualification PGCE

Mental health training course; Yes some years ago when working in guidance and support role; stress management

Personal tutor yes

Average number in class 11

I; How would you assess your awareness of MH?

I4; I have some awareness through dealing with students over the years. I have a particular student on the course at present who made a disclosure in December and was planning to leave. It was up to me to talk to her and to refer her to counselling at the university. Unfortunately they didn't respond as quickly as she needed them to and the situation deteriorated. The team gave her lots of time and support and she suspended her studies and got ECs for her assignments so that she can come back when she is ready. This is very important as we have had other people who have needed to take a lot longer to complete. We have had students in the past who have had advocates from student services help them to apply for ECs and the students have been grateful for the support. I think the university has things in place to support students and staff but people need to know how to access them and need to know who to go to. The mental health guy David is really helpful and we have encouraged students to go to the mental health awareness days when there are cake stalls etc over in the central services building. This is good as it gets people talking.

I; Is there a placement element on the course? How does mental health impact?

It is difficult to find placements for students generally but a disclosure of mental health issues could make it even more difficult as there will be head teachers who would not feel sure about taking on a student for placement who was less than fully fit for work. Occupational health should be able to assess fitness to practice so that we are sure that we are sending out people with the resilience to cope on placement but if I had any doubt I would be cautious and maybe look for a less intense placement experience or lessen the hours to make it manageable. This would be in the interest of all parties and goes back to the point about being flexible with the timings of the course for students who may need to take time away from their studies. A positive placement experience can boost confidence and morale and I can think of particular students who have really benefitted from the new set of relationships from placement and have been treated really well.

I: Do you prepare ITTs for placement by making them aware of the mental health issues they could come across in practice?

I4; I think we do mention it but we mention lots of possible issues and we don't cover any in detail. It comes under the umbrella of equal opportunities and not

stereotyping. There is a definite stigma attached still to mental health issues and students could be reluctant to share their own experiences in class for fear of a lack of confidentiality. They are also entering a work market which is very competitive and wouldn't want to disadvantage themselves. There is no forum at the moment for people to discuss issues that they have noticed in practice although obviously students are reflecting and evaluating their placements and there could be instances in the reflections about what has happened and what they have seen. The conference planned for next year in January will hopefully be at a time when people are returning from placement and will give them an opportunity to find out more about lots of SEN issues including this one. Perhaps students need to have been on placement before they come to conference so that they are aware of what they don't know; if you know what I mean.

I; Are there any other opportunities to teach about MH ?

I4; We do cover mental health when we teach interviewing skills and it is touched upon in the professional practice module . Because of my background in advice and guidance I think I am more aware than others on the team as I have had the counselling training which gives me confidence to deal with whatever students present with. Also I use my background to draw on for examples of what student can expect to find in different placements and I mention depression and stress in this session .

I; Anything else you would like to add?

I4; We have had instances where students have appeared to have an attention seeking personality and have been quite manipulative in their dealings with the system and this maybe puts people off getting involved. Not all students with mental health issues are the same though and everyone should be treated as an individual.

This has made me think about the issue and how I might incorporate it more into the course. Of course we haven't any spare time and the curriculum is bugged already. We rely on students doing lots of reading around and this may be another issue that they need to research. If you produce some online materials that may be a starting point at least for where to go next with their reading. I think unless they come across something specific they are more likely to be worried about their own subject knowledge and curriculum area to be honest at the start and it may only be later on in their careers when they have settled down into teaching when they look at wider issues. Of course that could mean that they miss signs and don't support their learners fully but the reality is we are trying to prepare them for everything in a year and the danger is that we get driven by the standards and by what we need to teach to meet them rather than by what trainees may need to know.

i.Many thanks for your time and your contribution. It has been very interesting.

## **Interview Transcript 5. Janet**

Gender F

Teaching experience 22years

Teaching qual. Cert Ed (post graduate but no PGCE for SEN at the time)

Mental health training Not in current position

Personal tutor Yes

Number in class 20 avge

I How would you assess your awareness of mental health?

I5; I am very aware because I cover the Skills for Life groups for PGCE and I have taught in FE in SEN departments across basic skills and special needs. I am disability needs coordinator for the school of Education and am involved in the assessment of needs of students who are coming onto the courses across our ITT provision. In my specific curriculum area which is now called Functional skills and employability the students will meet many learners with a range of mental health issues in all their classes. Mental health issues affect the prison population statistically more often and some of my group do their placements in prisons. Also there is a link between higher levels of mental health issues and poverty and low literacy is also a factor so that means that all of my group needs to be aware.

I: could you give me some examples from practice about how mental health affects teaching and learning?

I5: There are so many. When I start the planning and assessment module I use case studies called

‘Who are the learners?’ and these are all real learners taken from my practice. Some of them have depression ; due to poverty, unemployment, bereavement and divorce. Others have stress related conditions and phobias, including school phobia, and this is useful in looking at how adult education and post 16 work is different to compulsory teaching.

There are some negative examples from my practice too as I have sometimes tried to support students who have not been in a place to accept support and i have had to remove some people from placement which is never easy. One person in particular made a formal complaint about our handling of her particular issue and it badly affected my own confidence and made me really stressed. Luckily this is unusual and the strategies I have been building up for years make me strong enough to deal with the demands of my groups.

There are often reflections from past students about critical incidents dealing with the mental health issues of their own learners and I use these to illustrate the variety in what practice may include. Some trainees have had to deal with learners who self-harm and have reflected that they didn't know what to do or say beyond what was written in the safeguarding policy of their placement institution.

I: That exact scenario was the basis for the decision to pursue this line of enquiry in the 1<sup>st</sup> instance. One of my teaching assistants on the FdA Learning Support was working for looked after children's services and took a young person to a GCSE exam. She noticed in the car evidence of recent self-harm and said in class that although she knew the person at work to report it to she didn't know what to say or not to say to the young person sitting next to her. That sparked my interest into how aware people are of different mental health issues. How ready do you think your learners are to deal with this type of concern?

I5; at the start it really depends on their own experiences and life so far. Some people are really aware due to having conditions themselves or dealing with a family member who has had issues. Others are very surprised that this is a topic which we deal with so often, and there are some trainees who are so concerned with the mechanics and administrative elements of learning to teach that they just can't deal with anything more abstract at the start. I have had trainees who claim that these issues are private to the learner and are nothing to do with the teaching and learning but they usually accept quite quickly that they need to adjust their thinking in light of the case studies or from sharing the experiences of their peers.

I: Is there a named person on the PGCE who deals with referrals to student services for trainees who might need extra support?

I5: In the first instance group tutors deal with referrals but the course leader has to be kept in the loop as it is his job to know the status of all students and to check their fitness to practice etc. This has become a big issue for us in recent years as many more people are applying for the course and disclosing mental health issues. If they disclose on application then it is helpful as we can set up necessary support and apply for extra time for assessments etc. in advance. The most difficult area for us is the placement issue as we have delicate relationships with placement providers and we need to maintain these for future cohorts. It should be possible for occupational health to assess fitness to practice from their dealing with the applicant but often we find their reports conflict with how the trainee presents in class and how their issue affects their practice. I think that despite our best efforts occupational health still don't understand the complexities of the course and the stresses and strains of the placement on trainees. It would be good to think that someone in occupational health would be looking at this specific issue but of course we don't want to preclude people from the course or discriminate against them because they are dealing with particular issues. It is on the other hand not fair or kind to put people into practice knowing that their resilience is low or that they are likely to struggle with the

demands of the placement. In these instances it might be possible for trainees to postpone the placement modules until they are feeling stronger and this type of condition usually involves them applying for ECs and taking a lot longer to complete.

I: How do you prepare your trainees for placement with regard to their own wellbeing and that of their learners?

I5: We do lots of exercises and discuss lots of case studies. I introduce my group to several techniques to manage stress and I engage them with ideas and strategies that will hopefully help them to cope. We do relaxation and positive assertions. We fill our 'happy bottles' with precious, happy memories and 'drink from them' when things are getting tough.

I: That's a technique called 'anchoring' which is very positive if people can learn and practice it. I also used assertion cards with groups of adult literacy learners which were home-made and very simple but which made an enormous difference in class.

I5: Indeed. Having a card in your pencil case or your purse to take out and read over when you feel stress levels rising is a good strategy. I also share my own routines such as starting in the morning in front of the mirror asserting the positive attributes that I bring to the job.

On another note though I also tell my people that it is ok to cry and to feel overwhelmed by the demands of the course and the demands of the learners they meet. Telling them that it is ok to cry and that this is almost to be expected it could have a negative effect of making them feel odd if they feel in control the whole time but this is compensated by the fact that trainees can turn up for tutorial saying 'I can't cope' and after a cry and a chat we discuss that this is common and a temporary feature and they go away feeling stronger. I think space to discuss how you are feeling and to remind people that teaching and learning is a stressful enterprise sometimes is useful and I try to fit this in whenever possible. I hope that trainees will take all the strategies introduced to help them and use them with their learners in classes but sometimes they feel unsure about how to incorporate these soft skills into sessions especially if they are delivering a set scheme of work within a tight deadline. The focus on meeting targets and measuring attainment in classes is obviously a priority but trainees need to consider the positive effects of breaking down barriers to learning.

I: It was interesting that at specialist conference several trainees raised the issue of getting to know their students and wondered whether time spent doing this was well spent. It was almost as if people needed permission from their peers to get involved with students and find out about them.

I5: This is a common concern. The technical, delivery model of teaching is quite persuasive. There has to be a personal connection and teaching is affective and

impacts on emotions. The example I gave earlier of the student who complained had a very negative effect on my self-esteem and could have changed my approach to getting to know the next cohort. Thankfully my experience told me that I was usually successful in supporting trainees into practice and that this one person's behaviour and anger was not a reason to change.

I: Is there anything else you haven't had a chance to say?

I5: No I think we have covered most of our good practice. I think we have to model how to support mental wellbeing with our trainees so that they then will support their own students.

### **Gender M James**

Teaching Experience Primary and HE

Teaching qual BEd

Mental health training; none

Personal tutor Yes and course leader

Avg number of students 20 plus

I: How would you assess your awareness of mental health issues?

I6: I would say I am quite aware of issues which can affect teachers and I know how many people suffer with stress in the profession. I have supported students on the PGCE and BA who have had eating disorders and we have one student in the current cohort who is sometimes unable to attend and is intermittently ill through not eating. I am aware of self-harm as a phenomenon which seems to be growing and this is a concern for us all. I have read the recent articles in the press and the TES about very young children and depression which is also obviously a concern for primary school teachers. I know that on the course at the minute we don't have any input about mental health issues and I am glad to be talking to you about it as it means that we can now think of what we need to add and how to do it.

I: have you had any specific training around the issue yourself either here or when you worked in school?

I6: No, I think we did some inset about work life balance and stress management but that was a long time ago. We do mention those issues to our trainees but their mental health concerns will always be secondary to be honest as the whole course is aimed at meeting the standards and there isn't anywhere in the standards that links to mental health awareness specifically. I think we only cover it in terms of inclusion and that's a wide umbrella.

I: What type of experiences have you to draw on from practice?

I6: I think many of the behavioural issues we deal with in schools may have a root cause in mental health issues. It is easier in primary education to notice changes and to work with the children to make differences. I think in secondary classes you have so little contact time and so many classes to get to know that it must be harder. Of course in primary even though you have the same class all year there are 30 children or more in some cases and a very packed curriculum to deliver so it would have to be in SEAL or PSE type lessons that some topics could be explored. I think the TAs in classes are often in a position to chat to children more and to notice if they are distressed. TA work is often 1:1 or in small groups and they have opportunities to take children out for quiet time or reflection.

I have dealt here in the university with students who have been depressed and sometimes they have had to suspend or even withdraw. It is tricky to place trainee teachers in placements when you have concerns about their resilience because lots of head teachers would be wary about taking on someone who might need lots of support. It is often better to describe the issues facing a student rather than labelling them as being depressed as the stigma is something that I think could go against someone in such a competitive profession. Even though prospective employers and placement providers would abide by the law if I am honest I think they would see the possible problems rather than the positives.

I: Is there a named person on your course to make referrals?

I am a personal tutor and the course tutor so it would be me unless a student teacher chose to disclose or ask for support from a female member of the team which has happened sometimes. We do have an induction from student services at the start of the course when students get chance to meet the wellbeing team and find out how to access the counselling services etc.

How do you prepare students for placement? Is there any input about mental health in the preparation?

No, we may discuss issues in response to individual questions but these are usually about more practical concerns like what to wear and how to fit in in the staff room. We are planning a joint conference with the secondary PGCE students for the new academic year on all aspects of SEN as we feel that this is something that we cover using a broad brush approach rather than specific topics in any detail. If you are available there would be an opportunity to include some input on mental health awareness raising at that event and then everyone going out into placement would have some information.

I: I would be happy to meet them at conference and before then we could look at targeted information which would be specific and most relevant for your trainees.



I6: That's good, so although we haven't anything in place at the minute we have as a team identified it as an area for development and the conference is a first step to tackle this and other issues around difference .

I: are you aware of the university's services for supporting positive mental health and what is available in Huddersfield?

I6: We have all student service teams represented at induction and we are happy to refer students and if required to accompany them to appointments. The wider agencies are not as familiar to us but we always would suggest the GP as a first contact if a student is unhappy or unwell. The university has a health centre on site so it is easy to get appointments. In schools trainee teachers may be working with other agencies such as the CAHMS team but I have no direct experience of the work they do as they didn't exist as an organisation when I was in primary practice.

I: is there anything else that you feel you want to add?

I6: Not really, just to say that we are aware of the importance of the issue and are happy to build on our current practice to improve awareness across the course. It is bound to make a positive difference along with better understanding of other SEN issues which we hope the conference will address.

I: Many thanks for your time. Your input was really useful.

### **Interview 7 Nuala**

Gender F

Teaching experience 17yrs

PGCE

Mental health training no

Personal tutor Y

Avge number 22

I: How would you assess your awareness of Mental Health issues?

I7:I would say I know quite a lot from dealing with students and the stresses of teaching and seeing colleagues going off with various conditions over the years. I think teaching can be quite an intense occupation and it was usual when I worked in schools to be covering for absent staff most of the year but especially around inspection time and when there were assessments due. I think the PGCE course is quite intense too and some students every year find it too much and can't cope. We try at interview to get a measure of resilience but it isn't an easy thing to spot. I wouldn't know about specific conditions though and the questionnaire made me realise that I hadn't thought of this in terms of younger children either; always in

terms of staff and older teenagers maybe. I think I could tell when someone was anxious or depressed but that does presume that they will be acting in a certain way and is that a bit simple?

I: Have you had any specific training about mental health issues either here in the HEI or when you were teaching in school?

I7: Not here and I think the only courses in school were around behaviour so we mentioned ADHD and other issues which could affect behaviour. Also we did have an inset about work life balance so in terms of our own wellbeing and there was a guest speaker talking about strategies for managing stress and using time efficiently etc.

I: You kindly volunteered to take part in the interview; have you an interest in the topic?

I7: I am interested yes. I think that sometimes students disappear off the radar and suddenly stop attending and I wonder maybe if there were signs and symptoms that we could have spotted that would have meant supporting people better and maybe retaining them too. Obviously if a student comes and wants to chat about anything I am ready and happy to listen but that's probably a hard thing to do if you are feeling poorly or having a wobble and it might be easier to just hide it and not say anything.

I: what experiences can you draw on from work or life to illustrate the effects of mental health issues?

I7: As I said I have worked with people who have gone off with nervous breakdowns and stress. Unfortunately when you teach in a busy department in a big secondary school you don't sometimes notice what's going on until it's too late. I had close friends who I spent time with in breaks and out of school but other members of staff I would only have time to say a quick hello too. Sometimes it was a real surprise who was struggling, people you had thought of as being strong and organised would suddenly not be there. In terms of here is it students that I notice most and every year there are at least one or two in the group who will not finish on time or who will leave. We try our best to support everyone but there are times when they are all under pressure to submit assignments and teaching files and then it is hard to know who can cope and who can't. The university has student services and we have them in at the start so everyone knows what is available. If someone came with a specific need for support I would be the person who refers them and I have done this in the past. I think it feels safer than trying to support someone myself because I have no special training. Some students do take up counselling or support from the wellbeing team and then come back and finish and others just have to stop because they are not well enough to continue.

I: What type of conditions do you think present in your classes?

I7: I think I see stress and anxiety quite a lot. It's hard to tell about depression because I presume the symptoms are the same. I hadn't thought about eating disorders being so common until I looked up the stats after doing the questionnaire and that was a wake- up call. I have never seen any direct evidence of self- harm but then again I thought about this in terms of cuts and since doing some research see that there are lots of ways which I didn't know about.

I: In your preparation of students for placement what do you tell them about mental health?

I7; To be blunt probably nothing. We don't cover it directly definitely although I am thinking now that we should . We do talk to students a lot about safe guarding and equal opportunities so I suppose it's touched upon in that way. Also when they study behaviour it may be suggested as a reason for unusual behaviour so there's a link there. We have had students come back from placement and talk about this in the de briefing session. This might be because they have been teaching in a class where a child has had a bereavement or been upset by divorcing parents etc. This gives the group an opportunity to think about it.

I; Are you aware of local agencies to support you in this work?

I7: Not really. I would rely on the university's services and expect them to refer students on. I did see on the t.v. the mindfull campaign to get mental health taught in all schools very recently so that was timely and I think it's a good idea.

I; Many thanks for your time and interest. It is good to have perspectives from other HEIs to work with.

### **Interview Transcript 8 Rosemary**

Gender F

Teaching Experience 28 years

Teaching Qualification PGCE

Mental health training course No

Personal tutor Yes

Avge number of students 18

I: Thank you for taking part in the interview. I know how busy you are and really appreciate the time. Could I ask you how you would assess your own awareness of mental health issues?

I8: That's fine. I feel quite aware. I definitely have empathy for people and am approachable and as a personal tutor I would be the first port of call. I also know about it because my husband had a bit of a breakdown and nearly burned out

completely as a teacher. He used to go in very first thing and stay till really late because that's what everyone does but he was becoming distressed and getting so tired that he took some time off and when he went back it was very different. He leaves now at a reasonable time and makes time in the day to go for a walk and find some relaxation. Teaching is such a stressful occupation so you have to know your limits.

I: What kinds of experiences can you draw on from your own teaching; here or in schools?

I8: I think in school teaching in a big secondary there were obviously issues to deal with but we tended to put them under the umbrella title of EBD. That was the jargon of the time and most issues were dealt with in terms of behaviour and making it possible for people to manage the school demands without being excluded. Here in HE the issue that we tackle most is safeguarding now so this would all come under that title and we know that all our trainees have knowledge of who to refer young people to if they think there is a safeguarding issue. As a trainee or even a new teacher all you would be expected to do is to refer. I remember one major issue when one of our trainees became quite unwell as the year went on and her behaviour was cause for concern. She suspended her studies and had treatment but she didn't return and I think that was because she found teaching too intense and stressful.

I: Thanks for that, how do you prepare students to go out on placement? Is there any specific mention of mental health issues?

I8: We do have placement induction and we talk through lots of things. There is no specific input on mental health as such but we do talk a little bit about work life balance and I think we would say that under this broad brush approach we do mention things which would help. In the course induction at the start of the year we do have a student services input and David the mental health coordinator is there. The counsellors come too and have a brief chat. The trouble is that when people are out on placement they would find it hard to make an appointment with student services but we would remind them about the available services if they came forward with an issue. They have lots of support on placement from a subject mentor and professional mentor so there are always people to ask.

I: My next question was about who you would refer people to if they needed help. Do you have contact with local agencies?

I8: I think that at the university we would depend on the services in house and they might refer someone on. We do suggest the GP as the first appointment and counselling etc to supplement that. We have had people suspend and come back and successfully finish but they usually need extra time and to maybe split their placement over more months. With and EC agreed it is possible to finish the teaching practice later which has helped.

I: Have you any modules which could be adapted to include input on mental health as there isn't any at the minute?

I8: Not really but we have plans to join with the primary BA and Primary PGCE students for a conference about all sorts of difficulties and disabilities so it would definitely fit into that. I think it will be called a SEN conference next January and if you want to do some input it would be welcomed as I don't think anyone on the course would be comfortable running a workshop. It is an area that we know we are needing to improve on and some trainees have asked for more input as at the minute we rely on an online pack of materials and one day's teaching per year about lots of different issues. We tend to find that trainees want to know about pupils with visual and hearing impairment most but that might be because we are in the music department and that is what they wonder how to deal with. We have specialist input from Music for the Deaf which they always enjoy. The conference should allow input from more specialist areas so that people have somewhere to start from.

I: Many thanks for your time. That was a very interesting interview and I am looking forward to writing materials for the conference and to add to your online pack so that we can increase awareness.

## Appendix 6

Nodes compared by number of items coded

struggle with their mental health	you don't know what's going on in peoples head	definite stigma	Not all students with men	it's not that same environment as pe
				it needs to be normal conversation

Nodes compared by number of items coded

<p>make sure that student teachers have awareness and feel able to cope.</p>	<p>I am more aware than others on the team</p>	<p>I have supported students on the PG</p>	<p>GP's have been trained (mental health)</p>	<p>I wouldn't know about sp</p>
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Nodes compared by number of items coded

<p>they aren't taught explicitly to protect their own</p>	<p>a disclosure of mental health</p>	<p>A positive placement experience</p>	<p>course is too full to add new</p>	<p>flexible with the timings</p>	<p>needed to take a lot longer</p>	<p>no one gets specific input</p>
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Nodes compared by number of items coded

we are in a stressful profession.	colleagues who have gone off with strit	badly affected my own confidence a	lots of pressure
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18/07/2013 16:30

Appendix 7  
Node Summary  
Mental Health in Teaching and Learning  
18/07/2013 16:30

Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded	Duration Coded
<b>Node</b>					
Nickname:	Nodes\\a disclosure of mental health issues could make it even more difficult				
Classification:					
Aggregated:	No				
Document	3	5	61	5	



**Nickname:** Nodes\\A positive placement experience can boost confidence and morale

**Classification:**

**Aggregated:** No

Document	3	3	45	3
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**Nickname:** Nodes\\attention seeking

**Classification:**

**Aggregated:** No

Document	1	2	5	2
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**Nickname:** Nodes\\colleagues who have gone off with stress

**Classification:**

**Aggregated:** No

Document	2	2	17	2
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Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded	Duration Coded
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**Nickname:** Nodes\\course is too full to add new modules.

**Classification:**

**Aggregated:** No

Document	4	6	60	6
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**Nickname:** Nodes\\definite stigma

**Classification:**

**Aggregated:** No

Document	4	6	76	6
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**Nickname:** Nodes\\fitness to practice

**Classification:**

**Aggregated:** No

Document	2	3	25	3
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**Nickname:** Nodes\\flexible with the timings

**Classification:**

**Aggregated:** No

Document	3	4	46	4
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**Nickname:** Nodes\\GP's have been trained on mental health and it's something like a quarter

**Classification:**

**Aggregated:** No

Document	1	1	13	1
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Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded	Duration Coded
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**Nickname:** Nodes\\I am more aware than others on the team

**Classification:**

**Aggregated:** No

Document	5	6	83	6
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**Nickname:** Nodes\\I have supported students on the PGCE and BA who have had eating disorders

**Classification:**

**Aggregated:** No

Document	1	3	54	3
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**Nickname:** Nodes\\I wouldn't know about specific conditions though and the questionnaire made me realise that I hadn't thought of this in terms of younger children either; always in terms of staff and older teenagers

**Classification:**

**Aggregated:** No

Document	1	2	97	2
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**Nickname:** Nodes\\it badly affected my own confidence and made me really stressed

**Classification:**

**Aggregated:** No

Document	1	1	11	1
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**Nickname:** Nodes\\it needs to be normal conversation so that it's not hidden

**Classification:**

**Aggregated:** No

Document	1	2	20	2
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Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded	Duration Coded
-------------	-------------------	-----------------------------	-----------------------	----------------------------	----------------

**Nickname:** Nodes\\it's not that same environment as perhaps primary.

**Classification:**

**Aggregated:** No

Document	2	3	43	3
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**Nickname:** Nodes\\lots of pressure

**Classification:**

**Aggregated:** No

Document	2	2	11	2
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**Nickname:** Nodes\\make sure that student teachers have awareness and feel able to cope.

**Classification:**

**Aggregated:** No

Document	5	27	453	27
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**Nickname:** Nodes\\mental health awareness days

**Classification:**

**Aggregated:** No

Document	1	1	4	1
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**Nickname:** Nodes\\needed to take a lot longer to complete.

**Classification:**

**Aggregated:** No

Document	1	1	8	1
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Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded	Duration Coded
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**Nickname:** Nodes\\no one gets specific input on the topic

**Classification:**

**Aggregated:** No

Document	3	4	45	4	
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**Nickname:** Nodes\\Not all students with mental health issues are the same

**Classification:**

**Aggregated:** No

Document	3	3	32	3	
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**Nickname:** Nodes\\start a network perhaps across the region to share good practice

**Classification:**

**Aggregated:** No

Document	2	2	42	2	
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**Nickname:** Nodes\\struggle with their mental health

**Classification:**

**Aggregated:** No

Document	1	1	5	1	
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Nodes\\TAs in classes are often in a position to chat to children more and to notice if they are distressed. Their work is often 1~1 or in small groups and they have opportunities to take children out for quiet time or reflection.

**Nickname:**

**Classification:**

**Aggregated:** No

Document	1	1	43	1	
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Source Type	Number of Sources	Number of Coding References	Number of Words Coded	Number of Paragraphs Coded	Duration Coded
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**Nickname:** Nodes\\they aren't taught explicitly to protect their own mental health or the mental health of their learners.

**Classification:**

**Aggregated:** No

Document	5	14	250	14	
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**Nickname:** Nodes\\we are in a stressful profession.

**Classification:**

**Aggregated:** No

Document	5	21	253	21	
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**Nickname:** Nodes\\you don't know what's going on in people's heads.

**Classification:**

**Aggregated:** No

Document	2	3	41	3	
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## Appendix 8

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### Four Level approach to Whole School Change

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