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Educational community stakeholders' perspectives about teachers' responsibilities for mental health promotion in Maltese schools

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Abstract

The role of school teachers in promoting students' mental health is receiving increasing international attention. However, before venturing into schools with new initiatives such as mental health promotion, it is essential to take into account local contextual affordances and constraints. One issue is whether teachers and other school community stakeholders believe that activities related to mental health promotion are within teachers' realms of responsibility and capabilities. This paper reports findings from two questionnaire-based studies in Malta. The first questionnaire, about teachers' responsibilities in areas related to developing students' positive mental health, was delivered to community stakeholders attending three public lectures. The second questionnaire asked teaching staff in seven schools about their knowledge and capabilities for teaching to promote positive mental health. Results from the two studies indicate a foundation of support for whole school approaches to mental health promotion. Teachers' responses from the second study indicate that many teachers do not feel strongly efficacious and knowledgeable about their roles in mental health promotion. Implications for teacher professional learning are discussed.

Introduction: the Maltese context

The school education system in Malta is undergoing a number of changes. These include the recent launch of a new national curriculum (MEEF, 2013), a national policy on core competencies in primary education (MECYS, 2009), and a focus on inclusive education that includes the recruitment of learning support assistants in regular schools (MEYE, 2002). In addition, a major structural change in the Maltese Secondary School system includes the adoption of a comprehensive system of secondary schooling, which involves the phasing out of the Junior Lyceum examinations and Church entrance examinations, introduction of assessment benchmarks and removal of streaming, and establishment of ten regional colleges for the whole country (MEYE 2005). These changes have been taking place in the light of an inclusive, humanistic, democratic and holistic vision of education enshrined in the Maltese National Curriculum (MEYE, 1999; MEEF, 2011), and the gradual dismantling of a system based on segregation and examinations.

A parallel development in Malta has been more awareness on the need to broaden the educational agenda, focusing on both the cognitive and affective dimensions of education, as underlined in the recently published National Curriculum Framework (MEEF, 2013). This shift in the goals of education has been brought about by various factors, including the casualties of the examination- and performance-oriented system, the move towards inclusive education, insights provided by the international literature on emotional intelligence, emotional literacy and social and emotional learning, and rising social, emotional and behaviour problems for Maltese children and youth (Cefai, Cooper and Camilleri, 2008).

For instance, a national study carried out in Maltese schools found that about 10 per cent of the student population experienced social, emotional and/or behaviour problems, with clear implications for both their academic achievement and mental health (Cefai, Cooper, & Camilleri, 2008). In a study carried out by the World Health Organisation (WHO, 2008), Maltese students rated their health and wellbeing quite poorly. They reported that they felt amongst the most pressured students in the study, with the pressure increasing across the secondary school years (43% of 11 year old females and 30% of 11 year old males, and 69% of 15 year old females and 60% of 15 year old males, reported feeling stressed by school work). Also in the WHO report, although school-based bullying in

Malta was reported to be lower than the European Union (EU) average, violence was reported to be well above the EU average, particularly amongst 13-15 year old students. Another study amongst OECD countries, based upon reports from school staff, suggested that almost half of lower secondary students in Malta intimidated or verbally abused other students, which was significantly higher than the study average (OECD, 2009). Furthermore, according to the *European Perinatal Health Report* (EURO-PERISTAT, 2008) Malta has a relatively high rate of teenage pregnancies compared to other European Union countries. Whereas births to teenage mothers generally account for less than 3 per cent of all deliveries in the EU, Malta has a teenage delivery rate of 5.8 per cent (based on 2004 figures). The EURO-PERISTAT report underlined the increased risks for younger mothers associated with social and healthcare factors, including lower social status, mothers dropping out of school, and poverty (half of single parents in Malta live on or below the poverty line; EUROSTAT, 2010). Research by Slee and Murray-Harvey (2007) has identified the significant role that social factors such as poverty play in mediating mental health outcomes. More than one five children in Malta are at the risk of poverty (EUROSTAT, 2010). Furthermore, the National Statistics Office (NSO, 2007) has reported that the rate of family breakdown in Malta has increased significantly in the last decades, with about 10 per cent of marriages breaking down, leading to consequences for family income, housing and child care. The *Families at Risk* report by Slee (2006) made connections between poorer mental health and families experiencing social disadvantage due to gender, low educational levels, and poorer employment/income.

The above portrait on the health and wellbeing of Maltese children and youth underlines the social and emotional challenges faced by young people, and the consequent potential risks for their psychological wellbeing. The World Health Organisation definition of mental health highlights that mental health is not just the absence of dysfunction, but also the positive expression of each person's full potential:

Mental health is "a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2011 p.1).

Protective factors for developing positive mental health, and avoiding mental health difficulties, are conceived as residing in the family context (e.g., effective parenting), the child (e.g., social, emotional and behavioural competencies), and the environment (e.g., schools) (Graetz et al., 2008). Wilkinson and Marmot's (2003) advice was, inter alia, that governments should promote coping skills through education, and that the health impact of early education lasts a lifetime. Mental health promotional activities in schools are specifically recommended by the World Health Organisation (WHO, 2011), and this is reflected in government policy statements. For example, the United Kingdom Department for Education National Strategies document advises that, "Social, emotional and behavioural skills underlie almost every aspect of school, home and community life, including effective learning and getting on with other people (DCSF, 2009). In Australia, the Federal Government has committed AU$18.4 million to enable the KidsMatter Primary School Mental Health Promotion Initiative to be expanded to 2100 primary schools by June 2014 (KidsMatter, 2010). A parallel initiative is being trialled in Australian early childhood centres (KMEC, 2011). From the United States, the Academic, Social, and Emotional Learning Act of 2009 embeds social and emotional education in schools (CASEL, 2011a). The Maltese National Minimum Curriculum (MEYE, 1999) highlights the need for an holistic education, emphasising that emotional development is inextricably linked to academic learning and the quality of life provided by the school. This is also reflected in the recently published Maltese National Curriculum Framework (MEEF, 2011), which emphasises the crucial importance of developing children's well being and self esteem as part of the mainstream educational process. Personal and Social Education (PSD) focusing on the development of intrapersonal and interpersonal skills was introduced as a regular subject in Maltese secondary schools in the early 1990s and more recently on a part-time basis delivered by visiting PSD teachers in primary schools. More recently Nurture Groups, Circle Time and Learning Support Zones have been introduced in various primary and secondary schools to promote mental health and emotional literacy amongst children and young people. Concurrently, programs such as the European Union FP7 Marie Curie International Research Staff Exchange Scheme, which supports a 2011-2013 collaborative project between universities in Malta, England and Australia to investigate international

similarities and differences in the promotion of positive mental health in schools (EC, 2011), show that mental health promotion in schools is an issue of international priority.

Schools as settings for mental health promotion

Schools are logical settings for universal, targeted and indicated mental health promotion initiatives. Identifying schools as settings for mental health promotion activities can capitalise upon the availability of children and youth, and can enable the design and delivery of long-term interventions that can respond to the systemic and developmental nature of students' social and emotional capabilities (Greenberg, Domitrovich, & Bumbarger, 2001; Greenberg, Domitrovich, Graczyk, & Zins, 2005; Peth-Pierce, 2000; Weare & Gray, 2003). Furthermore, strong evidence now exists that supports the positive outcomes of locating mental health promotion initiatives in school settings. For example, a recent meta-analysis of 213 universal social and emotional learning programs in schools by Durlak, Weissberg, Dymnicki, Taylor, & Schellinger (2011) showed that, compared to controls, participants demonstrated significantly improved social and emotional skills, attitudes, behaviour, and academic performance. Similarly, Slee et al. (2009) reported a reduction in students' mental health difficulties following the KidsMatter Primary Mental Health Intervention in 100 Australian schools.

A range of activities to support the development of students' social and emotional capabilities have been introduced in recent years in Maltese schools. These include the use of Circle Time for emotional literacy in primary schools (on a voluntary basis), the introduction of nurture groups in primary schools to provide social and emotional support for young children experiencing social, emotional and behaviour difficulties (SEBD), the introduction of Learning Support Zones in secondary schools to provide behaviour support and emotional literacy for students in difficulty, and peripatetic SEBD teachers to provide behaviour support and emotional literacy in schools (see Cefai, Cooper and Camilleri, 2008; Cefai and Cooper, 2011). The new National Curriculum Framework (MEEF, 2011) proposes a stronger accent on developing students' social and emotional literacy in schools, seeking to provide a more balanced education. The Education Directorate in Malta has also commissioned the preparation of a report investigating the feasibility of introducing social and emotional education as part of the core curriculum in

Maltese primary schools (Cefai et al, in press). However, explicit reference to social and emotional education as belonging to a broader suite of mental health promotional activities, for delivery to all students, is still at an initial stage in Maltese schools.

Askell-Williams, Lawson, and Slee (2009) have argued that venturing into schools with new initiatives, such as mental health promotion, without taking into account the constraints and affordances of local contexts, is likely to under-utilize schools' strengths. Furthermore, potential difficulties might be encountered if areas that need extra support or alternative methods of intervention are not recognised. For example, one potential difficulty noted by Rowling (2007) was the tension that teachers and other practitioners in schools may experience as they come to terms with new and changing professional roles associated with school-based mental health promotion. Rowling noted that teachers, internal support staff, and staff from external agencies working in schools, might feel threatened, might lack confidence and knowledge to work in different ways, may see what they value being challenged and their work undervalued, and may lobby to maintain their positions of influence and expertise. Some stakeholders may react negatively, for, "while an expanded approach is not a replacement for current practice but an enhancement, conceptually it is different practice from what they have been trained in" (Rowling, 2007 p. 26). For example, in a study by Reinke, Stormont, Herman, Puri, and Goel (2011), 89 per cent of teachers agreed that schools should be involved in addressing children's mental health needs. However, only 34 per cent of teachers reported that they felt they had the skills necessary to support these needs in children. Similarly, from an evaluation of the MindMatters secondary school mental health promotion initiative in Australia, Askell-Williams, Lawson and Murray-Harvey (2005, p. 103) reported the following lament from a secondary school teacher: "This is not our area of teaching: how can you expect us to deal with any of this?" Furthermore, there is a lack of well-founded community knowledge and continuing stigma associated with the field of mental health, captured in the following comment from a school counsellor in an Australian study "...because I think people still think mental health means you are mentally ill" (Slee et al., 2009 p. 65). Similarly, in a recent study with Maltese primary school teachers and heads of schools, most of the participants did not know the meaning of the term 'emotional intelligence' (Pace, 2011). The participants in Pace's study agreed, however,

on the importance of social and emotional education in schools, but argued that they did not have adequate knowledge and skills to practise social and emotional education in their schools and classrooms.

To achieve success with the introduction of reforms, such as the inclusion of curricula for mental health promotion in school systems, designers and implementers *must* address the perceptions, attitudes and concerns of teachers and other school community stakeholders (Fullan, 2007). This imperative, combined with changing international perspectives about locating mental health promotion activities in schools, and further, combined with the climate of change in Maltese schools outlined above, led to the research questions addressed in this paper, as follows:

1. What are educational community stakeholders' perspectives about teachers' roles in mental health promotion in Maltese schools?
2. What are the perspectives of teaching staff about their knowledge and confidence for mental health promotion in Maltese schools?

Method

Ethics
The research reported in this paper was undertaken by researchers from two universities. Ethics approvals were obtained from the ethics committees of both universities, and also from the Education Directorate of Malta. Participation was informed, voluntary and anonymous.

Study 1: Community stakeholders' perspectives
This section describes the method and results of Study 1, where questionnaires were delivered to interested community stakeholders attending three public lectures about mental health promotion.

Questionnaire Items
Based upon reviews of literature and previous questionnaires, 14 questionnaire items were developed to assess educational community stakeholders' perspectives of teachers' roles in various aspects of school-based mental health promotion. Attention was paid to

the wording of the items to ensure that they were suitable for completion by respondents from a broad range of backgrounds. Nine items were sourced from the skill-sets recommended by the Collaborative for Academic, Social and Emotional Learning (CASEL, 2011b), namely, self management, self awareness, responsible decision making, social awareness and relationship skills. Two items inquired about optimism and coping (Slee et al., 2009) and three items were purposefully designed to refer more generally to teachers' roles. Participants were asked to respond on a 7-point Likert scale, with scale anchors of Very Strongly Disagree (1) to Very Strongly Agree (7).

Context for questionnaire delivery

Three public lectures about mental health promotion in schools were advertised broadly and delivered in Malta. Attendees were invited to complete questionnaires prior to the commencement of the lectures. It was anticipated that attendees would have a pre-existing interest in mental health. However, no prediction was made about whether participants would, or would not, support teachers' involvement in school-based mental health promotion initiatives. Participants placed their questionnaires in a sealed collection box before the public lecture commenced in order to ensure that the lecture contents did not influence their responses.

Results

One hundred and five questionnaires were returned from a total attendance at the lectures of 156 people. It was observed that some people attended more than one of the public lectures, and so attendees were requested to complete the questionnaire only once. Therefore it is not possible to calculate the exact response rate; however it is estimated at 90 per cent. Missing values were less than one per cent.

Seventeen respondents were males, 83 were female and five did not record their gender. Participants' ages ranged from 21 to 67 years. For nationality, 103 indicated Maltese, one Maltese/Australian and one Finnish. Participants' occupational status is recorded in Table 1, showing that the majority of attendees were school teachers, followed by school management and education support positions. Twenty one respondents indicated that they were undertaking Masters degrees, generally in the field of education.

Table 1: Occupations of respondents

Occupations	Frequency
Specialist school teacher (social & emotional & behavioural support)	22
School teacher (general)	28
Learning support assistant	7
Trainee psychologist	5
School counsellor/guidance teacher	12
School management/education officer	10
Social/youth worker	9
Inclusion coordinator	3
University academics/students	3
Other	6

Table 2 shows the median response scores for each questionnaire item, indicating that the data were highly skewed towards score 6 or 7 on the 7-point scales. This indicates that most respondents highly favoured teachers' roles in activities related to mental health promotion.

Table 2: Median responses to each questionnaire item

Questionnaire item	Median Response on the 7-point scale
1. Teachers should teach students how to make responsible decisions.	6
2. Teachers should teach students how to recognise their strong points.	7
3. Teachers should only concentrate on academic subjects, not on social and emotional skills (reversed).	7
4. Teachers should teach students how to form good relationships within the family.	6
5. Teachers should make sure they know how to promote students' positive mental health.	6
6. Teachers should teach students how to be optimistic.	6
7. Teachers should teach students how to cope with life overall.	6
8. Teachers should teach students how to manage their feelings.	6
9. Teachers should teach students how to feel good about themselves.	6
10. Teachers should teach students how to form good relationships with their peers.	6
11. Teachers should teach students how to apply social and emotional skills outside the classroom.	6
12. Teachers should teach students how to solve personal and social problems.	6
13. Teachers should teach students how to take account of the feelings of other people.	6
14. Teachers should not bother teaching social and emotional skills at school when it will be all undone at home (reversed).	7

Further development of the questionnaire

Study 1 had a limited number of respondents. There is potential to repeat this study with a broader spectrum of community stakeholders in Malta, and possibly in other communities that are at early stages of introducing school-based mental health promotion initiatives. To facilitate further research about investigating community perspectives, we undertook analysis of the psychometric properties of the questionnaire. An exploratory factor analysis (Promax with Oblique Rotation was used with the MLR Estimator) of the 14 items in the questionnaire indicated that a four factor solution fit the data best. Following the exploratory factor analysis (EFA), a Confirmatory Factor Analysis (CFA) of the questionnaire items was undertaken. The CFA model was found to be a good fit after one poorly fitting item (item 14) was dropped from the analysis. All of the factors

were reliable with Coefficient H values greater than 0.90. Based on the groupings of items we identified each of the factors as follows:

- Factor 1 - promoting responsibility - teaching students responsibility and highlighting their strengths
- Factor 2 – academic only - supported only the teaching of academic subjects
- Factor 3 – teaching problem solving
- Factor 4 – teaching SEL

These factors show consistency with the original conceptual design of the questionnaire, confirming the validity of the scale items, and the viability of administering the questionnaire to a broader range of respondents.

Study 2: Perspectives of teaching staff

This section describes the method and results of Study 2, where questionnaires about teachers' roles in mental health promotion were delivered to teaching staff in seven schools.

Questionnaire items

We reviewed a questionnaire originally delivered as part of the KidsMatter Primary Schools mental health initiative in Australia (Slee et al., 2001) and selected contextually appropriate questions to create a Maltese version of the questionnaire. Three questions asked teaching staff about their attitudes towards social and emotional education for students, three questions were about staff self-efficacy for school-based mental health promotion, and five questions asked staff about their knowledge for teaching students to develop social and emotional capabilities. The latter five questions were drawn from the same CASEL model used to design the community stakeholder questionnaire described in Study 1 above. Participants were asked to respond on a 7-point Likert scale, with scale anchors of Very Strongly Disagree (1) to Very Strongly Agree (7), and to return their questionnaire in an anonymous, sealed envelope via a drop box at their school.

Context for questionnaire delivery

All 321 teaching staff (teachers and kindergarten assistants) in three secondary schools and four primary schools, in one College, were invited to complete the questionnaire.

Results

Of the 321 questionnaires delivered, 217 were returned, giving a response rate of 68 per cent. Missing data in the returned questionnaires was less than 1 per cent.

Respondents ranged in age from 20 to 60 years, with, on average, 14.2 years of teaching experience (with a range of 1 to 40 years experience). Females comprised 77 per cent of the sample.

Confirmatory factor analysis of the questions in the original Australian questionnaire had identified three factors; namely, teacher attitudes, teacher self-efficacy, and teacher knowledge, for mental health promotion (see Slee et al., 2009). To investigate the factor structure of the Malta version of the questionnaire, we undertook CFA using asymptotically distribution-free (CFA-ADF) methods available in AMOS (due to the skewed nature of the responses; Tabachnick & Fidell, 2011; Garson, 2009). The factor structure of the Malta data replicated the factor structure of the original Australian questionnaire, providing us with confidence to proceed to interpret the results.

In order to maintain the interpretability of responses on the 7-point Likert scale used in the questionnaire, we calculated average scores for each respondent for each factor. Figure 1 displays the percentage distribution of responses to the factor named Teachers' Attitudes Towards Social and Emotional Education. It can be seen that most participants responded positively, above the mid-point score of 4.
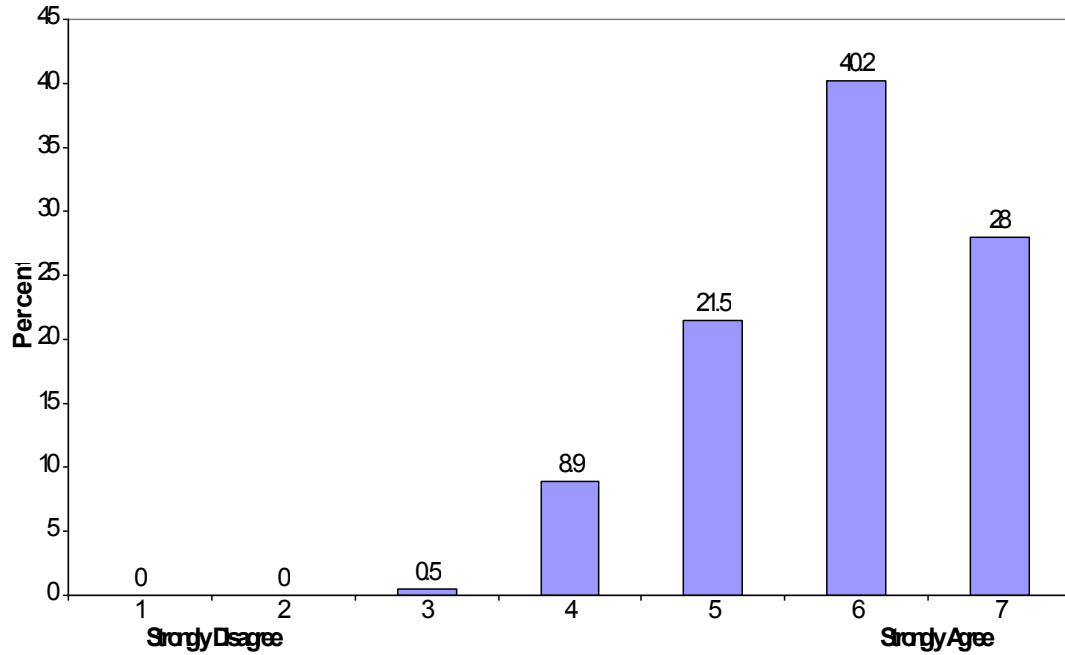
Figure 1: Teachers' Attitudes Towards Social and Emotional Education

Figure 2, of the distribution of Teachers' Self-efficacy for Mental Health Promotion, shows a greater spread of scores, ranging mostly from feeling neutral (score 4) to strongly agree (score 6).
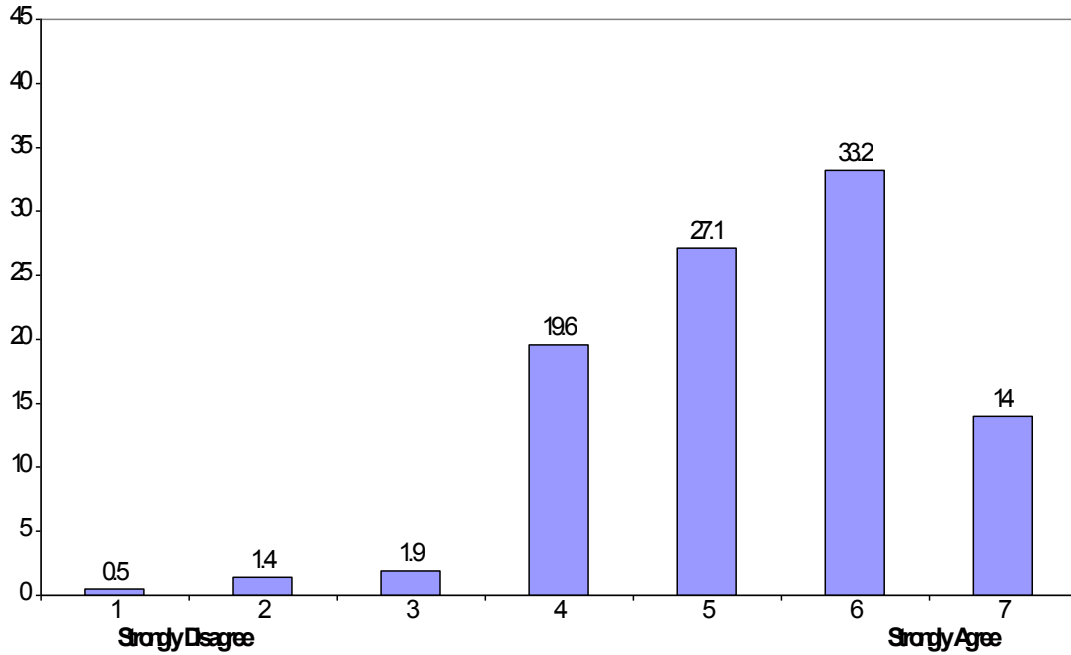
Figure 2: Teachers' Self-Efficacy for Mental Health Promotion

Figure 3 displays respondents' scores on the third factor, Knowledge for Mental Health Promotion, and shows the majority of scores falling around neutral to agree (scores 4 to 5), followed by strongly agree, (score 6).
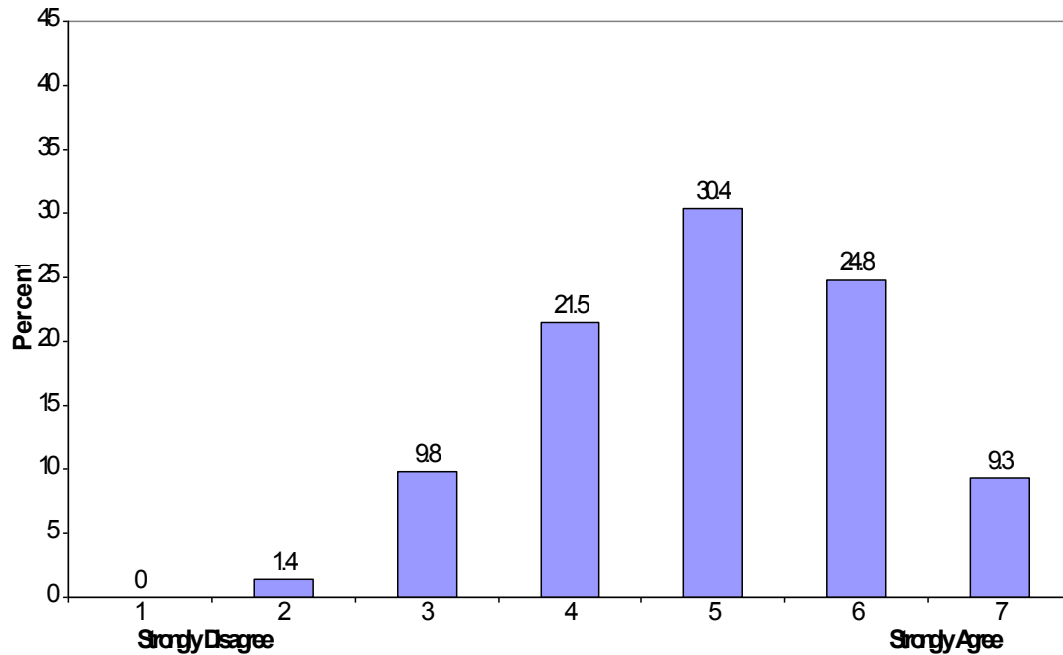
Figure 3: Teachers' Knowledge for Mental Health Promotion

Another way of considering the responses to the questionnaire items is to tally how many staff selected scores 6 or 7, as an indicator of strong agreement, to each questionnaire item. From Table 3 it can be seen that an average of 68 per cent of respondents strongly agreed to the attitudinal items about teaching students social and emotional skills, however less than 50 per cent of respondents strongly agreed to items about self-efficacy and knowledge (averages of 46% and 38% respectively).

Table 3: Percentages of staff responding "Strongly Agree"

Factor and items	% scores 6 or 7 (Strongly Agree)*
Staff attitudes towards SEL	
Staff believe it is important to teach social and emotional skills to students	71
Students can be taught social and emotional skills	67
Students who are socially and emotionally competent learn more at school	66
Average	***68***
Teacher self-efficacy for teaching SEL	
I can help people to develop a sense of belonging within the school community	55
I can provide effective support for parents/caregivers about students' emotional or social or behaviour difficulties	34
I can identify early signs of emotional or social or behaviour difficulties in students	48
Average	***46***
Teacher Knowledge about SEL	
I know how to help students to:	
Develop an awareness of their own feelings	37
Develop an awareness of the thoughts and feelings of other people	35
Develop skills to manage their own emotional or social or behaviour difficulties	33
Develop skills to make responsible decisions	43
Develop skills to establish healthy relationships with other children	45
Average	***38***
*Note: Slight discrepancies between Table 3 and Figures 1,2, and 3 are due to rounding differences.	

Discussion and Conclusions

The first study reported in this paper used a purpose-designed questionnaire to investigate the perspectives of community stakeholders in Malta about school teachers' responsibilities for school-based mental health promotion. Overall, respondents, mostly from psychology and education-related backgrounds, indicated that they believed that teachers should be involved in developing students' capabilities that are considered to be mediators to positive mental health, such as developing social and emotional skills, responsible decision making, and problem solving. These results provide a useful indicator to policy makers and school personnel that the community stakeholders in this

Maltese sample support initiatives that recognise schools as suitable settings for mental health promotion.

The relatively small sample used in Study 1 indicates that the study should be repeated with a broader and larger sample. To facilitate this, factor analysis of the questionnaire showed that it would be a useful tool to be used in further studies. Communities are encouraged to use the questionnaire to investigate, and provoke discussions about, school-based mental health promotion, in their own contexts.

Our second study reported the perspectives of Maltese teaching staff about their attitudes, knowledge and confidence (self-efficacy) for activities related to promoting students' mental health. Results from the second study illustrate that staff have positive attitudes towards mental health promotion activities, such as teaching social and emotional capabilities to students. At this attitudinal level, it seems reasonable to suggest that respondents from both studies, namely the general public and staff in the sample of seven schools, are positive about locating mental health promotion in schools.

However, the responses from teaching staff about their self-efficacy and knowledge for engaging in mental health promotion illustrate some potential difficulties when translating positive attitudes into actual practice. Our results bear similarity to those reported by Reinke et al. (2011), Askell-Williams et al. (2005), and Pace (2011), reviewed earlier in this paper, and indicate that teachers perceive that their efficacy and knowledge are at less than optimal levels for supporting their roles in mental health promotion.

One way of considering this issue is to ask whether communities would be satisfied if only 33 to 55 per cent of teachers strongly agreed that they felt self-efficacious and knowledgeable about teaching, say, literacy or numeracy? Would communities accept that the quality of teacher knowledge and efficacy could be lower when teaching for mental health? If topics such as developing students' social and emotional capabilities are sufficiently valued to warrant inclusion in the formal curriculum, it seems reasonable to argue that teachers' knowledge and efficacy in these domains needs to be of equally high quality as for other subject matter areas. Thus, one clear next step is to turn attention

towards the professional learning needs of teachers, which will require the design and delivery of professional learning programs for a diverse range of teachers' prior conceptions, knowledge, frameworks of practice, beliefs, and situations (Borko, 2004; Little, 1993).

The issue of teacher self efficacy is best captured by the sentiment "I can" (Bandura, 1997), with these words used in the self-efficacy questions in our Study 2. Underlying this sentiment of "I can" are the sources of self-efficacy judgements proposed by Bandura (1997; 2001), such as engaging in successful mastery experiences, observation of valued role models, and verbal persuasion about one's own capabilities. It can be predicted that Bandura's proposed sources of self-efficacy might be limited in the relatively new field of mental health promotion in schools. Accordingly, enabling such experiences for teachers could be usefully included in designs for teacher professional learning.

With respect to teachers' knowledge, as suggested by Askell-Williams, Lawson, and Dix, (2011), the introduction of mental health promotion means that it is not likely that many teachers will have addressed, in their pre-service or in-service teacher education, the different types of knowledge for teaching suggested by Shulman (1986a; 1986b) and others (e.g., Borko, 2004; Borko & Putnam, 1996; Darling-Hammond, 2006; Grossman, 1995), such as subject-matter knowledge and pedagogical content knowledge, in the domain of mental health promotion. For example, for mental health promotion, teachers may need to develop knowledge and capabilities in areas such as:

- increasing adolescents' knowledge about mental health difficulties, such as depression and anxiety disorders (MindMatters, 2010),
- developing students' social and emotional capabilities (CASEL, 2011b; DCSF, 2009; Cefai et al., in print),
- recognising and responding to students demonstrating early signs of mental health difficulties and providing parenting information and support (KidsMatter, 2010; KMEC, 2011; Cefai et al., in print),
- working collaboratively in multi-disciplinary case management teams (Borg, 2009), and

- promoting student-teacher relationships to foster students' psychological health and wellbeing (Murray-Harvey, 2010).

School staff are also likely to need professional learning opportunities to develop their understandings about settings-based models of health promotion in general, and mental health promotion in particular, as framed by the World Health Organisation (WHO, 2011). For example, mental health promotion is often framed in language derived from medical contexts, and thus seems unfamiliar to school-based personnel. Askell-Williams and Lawson (2011) highlighted the need to work from what teachers already know, and especially, to translate the medical-based language of health promotion into language understood by teachers and other school personnel. One example of such knowledge translation is to develop teachers' understandings about the different levels of intervention, namely, universal, targeted and indicated, in programs for mental health promotion and prevention of difficulties. In particular, Askell-Williams and Lawson indicated that school staff exposed to mental health promotion for the first time may respond with the perception that they are required to have knowledge and expertise for indicated interventions for students identified as experiencing mental health difficulties. This level of intervention may cause teachers to react with concern about their own appropriate expertise. However, although not discounting the need for targeted and indicated intervention, a large part of school-based mental health promotion is at the universal level, using expertise that teachers and schools already have. An overview of such strengths includes that:

- Schools are dynamic, making them receptive to change.
- Teachers and support staff have pedagogical knowledge about good teaching and learning.
- Teachers and support staff have the ability to connect with young people: to be role models and significant adults.
- Teachers and support staff can create environments where young people are respected and can achieve success.
- Schools connect with nearly all children/youths.

- Long-term interventions can be planned and implemented.
- School staff have authority and thus can advocate for change at local and political levels

(Collated from Askell-Williams & Lawson, 2009; CASEL, 2011; Cefai, et al, in press; DCSF, 2009; WHO, 2011)

Building from such areas of strength is a positive way forward to equip schools to be viable settings for mental health promotion.

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