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Work done in the margins: A comparative study of mental health literacy in pre-service teacher education in Australia and in Scotland

Ensuring pre-service teachers have strong mental health literacy is vital for progress toward an inclusive, effective education system; yet little is known about how pre-service teachers are prepared for practice with school students who present with poor mental health. The original, internationally comparative small-scale (N=24) qualitative study reported here compared current mental health literacy provision to pre-service teacher education students in Scotland and Australia. Semi-structured telephone interviews with teacher educators who delivered mental health content divulged highly variable, often ad-hoc mental health literacy provision; a concern, given the prevalence of poor mental health affecting children and young people in schools. Thematic data analysis revealed striking commonalities among issues raised by participants from both countries, highlighting the need for urgent improvement in the provision of mental health literacy to pre-service teachers. Results suggest the possibility of strategically developing a joint Australian-Scottish mental health component suitable for delivery in both countries.

Keywords: mental health, teacher education, Australia, Scotland

Introduction

Effective professional practice with students experiencing poor mental health (MH) in school is a challenge for teachers worldwide (Humphrey, Hanley, & Lennie, 2012; Perry et al., 2014). Widely-accepted statistics indicate that 20% of children and young people experience prolonged episodes of poor mental health which are severe enough to negatively affect their daily life in school (WHO 2013). This data underlines the scale of MH as an issue for schools in effort to deliver an inclusive education.

Timely referral to specialist services, child protection issues, responding to psychologically distressed children or young people, and working efficiently with MH

professionals have been highlighted as common problematic areas for educators (Rouf, 2014). Bostock, Kitt, and Kitt (2011) suggest that improvement in how pre-service teachers are prepared to meet the needs of this population holds the promise of developing more educationally inclusive classroom practice. However, research has barely begun to investigate this proposal (Armstrong, Price, & Crowley 2015).

School-based MH initiatives in Australia and Scotland vary in focus but include an emphasis upon educational inclusion. Educational settings are identified as key for enabling greater social justice (J. Atkinson, Nelson, Brooks, C. Atkinson, & Ryan, 2014; Dowdy et al., 2015) within an ethos of mutual respect and trust (Scottish Government, 2013); increasing social awareness of poor MH for children and young people as a general phenomenon, prompted by prominent public campaigns tackling specific issues such as youth suicide or self-harm (Bayer et al., 2009); and pragmatic challenges educational settings face due to their legal obligation to provide inclusive education for students with poor MH in an increasingly competitive, attainment-driven environment that potentially disfavours this vulnerable population (Armstrong & Hallett, 2012; Bonell et al., 2014).

International research has identified challenging or disturbing behaviour by students who experience poor MH as a significant global factor in teacher dissatisfaction and a cascade of negative outcomes for affected professionals (Aloe, Shisler, Norris, Nickerson, & Rinker, 2014; Armstrong et al., 2016). Studies have connected teacher attrition to ‘the psychological assaults’ (Veldman, Tartwijk, Brekelmans, & Wubbels, 2013, p. 63) professionals face in classrooms during highly demanding interactions with psychologically distressed students (Spilt, Koomen, & Thijs, 2011; Westling, 2010). Efforts to improve teachers’ psychological welfare have been described as the ‘other side of the coin’, linked inextricably to the success of

initiatives aimed at improving outcomes for students facing social, emotional or behavioural difficulties (SEBD) in class (Roffey, 2012). In many schools in Australia, Scotland and elsewhere, the widely-used but imprecise labels SEBD or EBD (emotional and behavioural difficulties) appear to be euphemisms for students whose needs would meet clinical MH thresholds (Humphrey & Wigelsworth, 2016).

Research into better equipping educators to respond to students with poor MH also connects with practical-focused efforts to enhance educational inclusion for a wider vulnerable population (Nye et al., 2016). Students with developmental disabilities, for example, appear to have an increased risk of developing clinically significant co-occurring MH difficulties compared to their typically-developing peers (Cicchetti & Cohen, 2016; Einfeld, Ellis, & Emerson, 2011; Simonoff et al., 2008). Many such students in Australia and across the developed world present with challenging behaviour that adversely affects their welfare, and in many cases prompts withdrawal or outright exclusion from mainstream education (Jarvis & McMillan, 2016; Pirrie, Macleod, Cullen, & McCluskey, 2011).

Preparing teachers pre-service or in-service to be more effective in their future professional response when students present with poor MH is a relatively novel concept that has gained impetus through policy initiatives which frame education as a key route to achieving broad-ranging educational and health outcomes for affected children or young people (Bostock et al., 2011; DOH, 2011; Mace, Mulheron, Jones, & Cherian, 2014; Scottish Government & COSLA, 2008; WHO, 2013). The few studies undertaken in teacher education about how child and adolescent MH is addressed have disclosed significant potential benefits for pre-service educators who receive explicit guidance on it as part of teacher preparation (Armstrong et al., 2015; Bostock et al., 2011).

Armstrong et al.'s (2015) study with 100 undergraduate pre-service teachers in South Australia examined 'whether and to what extent there might be a need for greater curriculum content about child and adolescent mental health within teacher education provision' (p. 383). It noted that 'it is currently unclear what, if any, discrete role child and adolescent mental health has in existing pre-service teacher programmes operating in Australia and the wider English-speaking world' (p. 393), and recommended that 'surveying provision within the pre-service educator curriculum might be a key goal for further research' (p. 393).

The qualitative, small-scale (N=11 in Australia; N=13 in Scotland), comparative international pilot study reported here took up this recommendation by investigating what is currently offered to teacher education students in Australia and Scotland in terms of curriculum content devoted explicitly to child and adolescent MH. While both countries are English-speaking, culturally similar, and share similarities in school education and parallel concerns with young people's MH (Education Scotland, 2014; KidsMatter, 2010), they are geographically distant and have historically different approaches to teacher education (White, Bloomfield, & Le Cornu, 2010). This original comparison aimed to identify significant commonalities and differences in pre-service teacher education related to MH to provide useful insights for policy and practice in Australia and Scotland, and contribute to the examination of what skills, knowledge and dispositions may benefit teachers' professional practice with students affected by poor MH (Armstrong et al., 2016; Askell-Williams & Murray-Harvey, 2016). It also aimed to discuss implications for pre-service teacher preparation and mechanisms to support teachers once they begin practising their profession (Askell-Williams & Lawson, 2013).

Methods

Methodology

A pragmatist philosophical perspective (Creswell, 2013), which has an intellectually rich history of scholarship within the education and psychology disciplines (Hall, 2013) and does not adhere to a single epistemological or ontological notion of what constitutes reality (Pring, 2014), was adopted because it allowed choice of the most appropriate research design to address the research aims outlined above (Creswell, 2013; Punch & Oancea, 2014). This purposeful research sought to neither refute nor validate a pre-existing hypothesis, nor develop specific hypotheses for evaluation given the emerging nature of research in this field and shortage of published studies. The approach gives unique options to examine of the skills, knowledge and dispositions that may benefit teachers' professional practice with students affected by poor MH

Participant recruitment

The research involved participation of key staff responsible for teaching and learning in teacher education provision at higher education institutions (HEI) in Australia and Scotland. The Australian Institute for Teaching and School Leadership (AITSL) is the key national professional body whose members 'define and maintain the national professional standards for teachers and the national accreditation standards and procedures for teacher preparation' in Australia (Treagust, Won, Petersen, & Wynne, 2015, p. 81). The AITSL (2016) accredited teacher education programme list (publicly available on the AITSL website) was used to identify Australian universities offering undergraduate teacher education programmes. The public websites of the 47 providers identified were scrutinized manually for mention of the keywords 'mental health', 'disability' and/or 'inclusion', and searched for staff associated with initial teacher

education (ITE). Consequently, 56 individuals from 28 universities across Australia were invited by email to participate in the study. Eleven consented, with two each from Western Australia (WA), South Australia (SA) and Queensland (QLD), three from Victoria (Vic), and one each from Tasmania (Tas) and New South Wales (NSW). Fifty percent of participants also provided postgraduate provision (typically masters-level specialist units or topics). Interestingly, NSW was under-represented given the number of universities contacted. No participants came from universities in the Northern Territory (NT). A larger number of participants would have been ideal to provide a more robust sample size (see Limitations).

A similar process was followed in Scotland. A preliminary trawl through all Scottish university websites was undertaken to identify programmes and associated staff. The General Teaching Council for Scotland, which approves and accredits all Scottish ITE programmes (Smith, 2010), was asked to provide a list of programmes to ensure none were missed. This list identified a further three more specialized programmes (e.g., BMusic Education), resulting in a total of 28 identified programmes leading to provisional teacher registration status. Further investigation (by telephone, email and internet) resulted in a final list of 23 programme directors from eight universities (some individuals had responsibility for more than one programme). All 23 were contacted by email and invited to participate. Unsurprisingly, it was easier to recruit participants where there was a pre-existing professional relationship.

Ethics

Prior to the study commencing, ethical approval was gained separately from Edinburgh University in Scotland and Flinders University in South Australia. Participants were informed of their right to withdraw consent at any time without consequence, and that all data were confidential, and would be anonymized immediately after collection and

stored securely. However, they were also informed that it may be possible to identify responses in published literature arising from the research because of the small population pool from which participants were drawn. Assurance was given that every effort would be made to minimize this possibility.

Data collection

Information was sought from participants via a semi-structured telephone interview about the extent and content of curriculum that explicitly referenced child and adolescent MH in teacher education programmes or courses they taught and/or led. Questions sought to determine further information about the MH literacy provision that participants described, including whether MH was considered in terms of influential concepts such as wellbeing and/or inclusion, and whether specific categories of poor MH (e.g., anxiety, depression or self-harm) were discussed with students. Interviews were digitally recorded and transcribed.

Toward the end of the data-collection period, three universities in Scotland remained unrepresented. Colleagues with personal contacts in those institutions helped identify alternative participants. A total of 24 participants (N=11 in Australia; N=13 in Scotland) provided information. In Australia, seven of the 11 participants responded at the programme level, with 10 referencing a course or sub-part of the programme (unit or topic) for which they were responsible. In Scotland, 13 staff from seven of the eight ITE providers participated. Nine responded from the three universities providing multiple routes to professional accreditation, while one responded from each of the remaining four universities. Nine of the 13 Scottish participants responded in relation to a whole programme or programmes, with four talking specifically about a course for which they had responsibility.

Data analysis

A thematic analysis (TA) method (Clarke & Braun, 2013) was used ‘for systematically identifying, organizing, and offering insight into patterns of meaning (themes) across a data set’ (Braun, Clarke, & Terry, 2015, p. 60). This enabled the researchers ‘to see and make sense of collective or shared meanings and experiences’ (Braun et al., 2015, p. 60). The researchers ensured rigor by following Braun et al.’s (2015) six-phase procedure, undertaking an extended written discussion about themes identified in the data before refining them for this text.

Vaismoradi, Turunen, and Bondas (2013), in their critical comparison of content analysis, a methodology often compared with TA, note that TA has been subjected to criticism due to suggested weaknesses around intercoder reliability (the extent to which those coding data will independently identify the same codes in data analysis using the TA method). Vaismoradi et al. (2013) add: ‘It has been discussed that one researcher merely trains another to think as she or he does when looking at a fragment of text’ (p. 403). They suggest that content analysis seeks to aid intercoder reliability by having more than one coder independently code data.

In this study, separate data coding was undertaken for the Australian and Scottish data sets. After generating an initial coding (phase 2 in Braun et al., 2015), the researchers critically compared and contrasted themes that had been independently identified as arising from each data set (phase 3 in Clarke & Braun, 2013). This process of critical comparison resulted in a lengthy critical dialogue between researchers (in written and oral discussions) as they identified themes that emerged consistently across both cohorts, and a focus on their findings’ possible implications for policy. The researchers found this comparative critical interrogation beneficial and suggest it enhanced the rigor of the TA process at the data analysis stage.

One complexity with interpreting the data was that some participants from both cohorts often referred to an entire programme in their comments and observations whereas others exclusively referenced a specific component (variously described as ‘unit’, ‘course’ or ‘topic’) within a larger programme (see Limitations). This lack of clarity in the scope of responses suggests caution when considering findings that relate to the organizational structure of provision.

Results

The six major themes reported here contain participants’ direct quotes (in italics), with designation of the cohort in parentheses; for example, [AUS 5] refers to data provided by participant 5 from the Australian cohort and [SCOT 7] refers to data provided by participant 7 from the Scottish cohort.

Overall, data from both cohorts disclosed participants’ extensive consideration of how child and adolescent MH should be approached in teacher education provision. One participant pondered:

It’s always a bit of a quandary: how much do we/can we prepare the students? We assume that they know nothing [AUS 5].

Interview data containing these reflections in both cohorts were often accompanied by comments suggesting the speaker’s uncomfortable awareness of the imperfection of the provision they described. For example, in relation to knowledge about child and adolescent MH, one participant glumly observed:

I think if you asked our graduate teachers what they know, they would say, ‘not much...not anywhere near enough’ [AUS 1].

Participants gave a resounding ‘no’ to the proposition that efforts to develop MH literacy should only be started once teachers are in-service (Humphrey & Wigelsworth,

2016). In many cases, participants described how they championed MH provision for pre-service teachers, and detailed the barriers and uncertainties they faced in doing so.

Addressing child and adolescent MH

In their evaluation of provision, three participants from each cohort emphasized a focus on promoting positive emotional health in general. One typically described input on MH for teacher education students as being framed by academic staff as *an integral part of children's social and emotional wellbeing* [AUS 11]. A common approach in Scotland, described by nine participants, was to give student teachers tasks relating to pupils with additional support needs (ASN) to work on whilst on placement in schools. The particular ASN selected depended on the pupils in the class and student teacher interest. Responses suggested that MH was an often investigated issue. Student teachers were encouraged to seek information from practitioners whilst on placement, then research the additional need on return to university, often leading to a presentation to fellow students about what they had learned.

Context and approach used to address child and adolescent MH

Three Australian participants and one Scottish participant referenced developmental psychology as the disciplinary context for curriculum delivered in relation to child and adolescent MH. Even those coming from a clear disciplinary perspective saw the merit of multi-disciplinary approaches. A developmental psychologist, who is a course organizer, commented:

I think the issue of discipline ... is an important one. I have always thought it would be nice to take topics like bullying, or mental health, and have a course or a series of lectures even where you say, 'Here is a topic. What is the take on that from someone coming from a psychological perspective or sociological perspective...'
[SCOT 6].

The notion of different disciplinary perspectives or models was a common theme:

We ask them to look at the learners and whatever ASN needs they have through two models; the deficit model and the social model... Then we ask them to evaluate which one they think is more effective... Most of them will say that obviously the deficit perspective on any learner is not appropriate but the diagnosis part of the deficit model is actually advantageous given that sometimes it triggers resources, for example, actual financial resources for the child [SCOT 13].

Six Scottish participants and one Australian participant briefly referenced attachment theory. Three Australian and five Scottish participants referenced Special Educational Needs/Special Needs and inclusion (often interchangeably), with two of the Australian participants exclusively mentioning inclusion as the guiding framework for delivery.

Health and Wellbeing was by far the most frequently mentioned context, identified by nine Scottish respondents. This is unsurprising given the prominence of Health and Wellbeing in 'Curriculum for Excellence' (Education Scotland, 2014). In terms of the approach used to address MH, nine Scottish participants described MH issues as embedded within the teacher education curriculum they delivered, although three of them also listed specific option courses. Adopting this embedded approach was closely linked to recent changes in the school curriculum that prioritised Health and Wellbeing, and made it the responsibility of all teachers. Some respondents in both cohorts indicated that MH had been carefully embedded as a considered part of the programme they described, but for others MH appeared to be an afterthought. For example, one participant commented:

It is something that is probably covered, perhaps not directly but indirectly through a lot of areas in the programme [SCOT 3].

Several participants commented on the disadvantages inherent in an ‘embedded’ approach to MH. One Australian participant remarked:

It’s not explicit enough if it is embedded into the programme, i.e. unless we can point to specific modules that are addressing mental health [AUS 1].

Details about pre-service teacher education curriculum content (MH) and coverage

When asked whether they were aware of any specific MH conditions referenced by provision, two Australian participants said ‘yes’, highlighting depression and anxiety as being discussed with teacher education students. In the Scottish cohort, four participants reported that this was the case, with all four referencing anxiety and depression, and ADHD, which is technically classified as a MH condition (American Psychiatric Association [APA], 2013).

A majority (n=8) of the Scottish cohort but a smaller number (n=3) of Australian participants highlighted advice on help-seeking strategies as part of the content delivered; specifically, who to go to for further support as a teacher if concerned about a student’s MH. Four of those in Scotland and three in Australia highlighted possible symptoms of poor MH (*what to look out for*) in their description of what was delivered to *undergraduate* teacher education students. Two participants from each cohort noted that challenging behaviour and its connection to MH was covered. This small representation is noteworthy given the significant overlap between students with challenging behaviour and those experiencing acute episodes of poor MH (see Discussion). Only one member of the Australian cohort mentioned child protection in their outline of delivered content in contrast to eight members of the Scottish cohort.

Reasons for addressing MH in the curriculum

Responses to this question disclose potentially significant implications for policy and practice pertinent to teacher education. For example, four members of each cohort indicated that MH figured in the programme within which they taught (or led) purely because it was a personal-professional field of interest, implying that if they were not personally interested it would not have featured in the programme. Some modest differences between the Australian cohort and Scottish cohort also emerged in the data, which may be attributed to larger differences in the respective policy climates and cultural factors. While two Australian participants explicitly referenced risk of suicide as a major reason for curriculum provision, no Scottish participant did so. This is not to say that it was not an implicit consideration. A significant number (n=6) of the Scottish cohort highlighted the need to prepare students practically for the reality of the classroom, the nature of which varied. Common themes referenced included bullying, domestic violence, sectarianism, parental addiction, social media pressures, body image, drug use, sexuality, abuse and bereavement. A worrying number of participants (two in each cohort) disclosed that there was no specific, planned input for MH in the curriculum delivered; that child and adolescent MH was only addressed if it arose by chance in discussion with teacher education students.

Developing the MH curriculum

Participants suggested ways in which they thought MH provision for pre-service teachers may be improved, however, beyond calls for more time from nearly half of the Australians, there was little consensus on what form that improvement should take. One Scottish respondent, echoing many others, described the challenges of deciding what should go in the curriculum:

If you look at teaching in general, it is a kind of ... reflex that any social problem has to be tackled. One of the automatic policy responses is 'get education to do something about it', so whether it is health and wellbeing ... obesity ... drug and alcohol, sexual health, domestic violence ... there is somebody who will come up with what schools should be doing. Then it has a knock-on effect. Never mind literacy and numeracy, there is a whole string of things... So it has always been a struggle to decide what is in and what is out [SCOT 2].

Barriers to provision of MH in the curriculum

Participants were not asked directly what they thought created barriers to the provision of education about MH, but this issue arose in many of the interviews. Three Scottish and two Australian participants identified a fickle policy agenda as unhelpful to their efforts to better equip teacher education students. They reported having to constantly respond to new priorities, for example, *outdoor learning*, *working with parents*, *global citizenship* [SCOT 10]. Recent changes to ITE in Scotland following the 'Donaldson Report: Teaching Scotland's Future' (Scottish Government, 2010) were also mentioned as imposing constraints on what could be provided because further demands were made on the curriculum.

Participants in both Australia and Scotland highlighted the psychological effect of rapid social, economic and technological change as a particular factor affecting student MH, and how this, in turn, posed challenges for teacher education. One Australian participant emphasized how *self-harming is a real issue in schools – you might call it an epidemic* [AUS 4]. This participant went on to comment about how schools and teacher educators both struggled to equip teachers (pre-service or in-service/qualified) with the necessary skills and knowledge to respond to affected students, adding:

Nobody knows what to do about it in schools; there is no guidance. So, it's really difficult to talk about it to students, other than raise awareness [AUS 4].

Other challenges reported included the wide variation in practice across different local authorities in Scotland and at state or territory level in Australia. While each provider (university) is at least notionally preparing students to teach across the whole country, such is the diversity of practice in relation to MH that all initiatives encountered cannot be covered. As one participant commented:

There is lots of policy out there but there is very, very little that says, 'This is a standard programme that primary teachers should be encouraged to learn, understand and put into place'. I couldn't find anything ... So there is absolutely no way we can say to students, 'Here is what you will be doing when it comes to supporting emotional and mental wellbeing' [SCOT 8].

Both cohorts highlighted the limitations of specialist MH provision for in-service teachers. The main agency offering assessment and specialist referral for children or young people experiencing poor MH in both Scotland and Australia is Child and Adolescent Mental Health Services (CAMHS) (KidsMatter, 2010; Scottish Government & COSLA, 2008). Participants expressed the view that CAMHS had severely limited financial resources and was unable to respond to anything other than the most seriously ill students in school. Only one respondent from each cohort described CAMHS as a partner in programme content delivery.

Overall, the data suggest that while providers hold a strong belief that preparation for working with pupils with MH challenges is important, MH education fights for curriculum time alongside competing agendas.

Discussion

Equipping pre-service teachers with consistent, coherent, high-quality knowledge about child MH (and the confidence to use this knowledge) is vital for a number of reasons.

Developing professionals' 'mental health literacy' (Jorm, 2012) has been identified as a

priority for school-based efforts to meet clinical need and for inclusive school-based delivery of MH services (Humphrey & Wigelsworth, 2016). Other literature has stressed how providing teachers with effective professional tools to deal with psychologically distressed students is important for their own welfare and professional self-efficacy (Aloe et al., 2014; Armstrong & Hallett, 2012). In contrast, the limited number of studies suggesting the relevance and utility of high-quality MH provision for pre-service educators (Armstrong et al., 2015; Bostock et al., 2011) reflects participants' impression of its marginalized and insecure status despite their emphasis on its importance.

The data illustrate a wide variation in current practice, with no shared view of what, exactly, should be provided; a situation in line with what happens in schools. Graetz (2016), for example, notes that the 'common picture observed over the years is one of student mental health programs being delivered in the 'margins' of school life, sustained by a few dedicated staff members with minimal – and often precarious – short-term funding' (p. 4).

Understanding participants' identification of a lack of partnership between CAMHS and pre-service teacher MH education providers highlights the stresses on CAMHS' operational situation in Scotland and Australia identified in other research. In Australia, for example, state CAMHS face significant resourcing challenges as they seek to meet demand (Hazel, Sprague, & Sharpe, 2016; SA CAMHS Review, 2014). In Scotland, the 'Mental Health Strategy for Scotland 2012–2015' (Scottish Government, 2012) prioritised access to CAMHS (along with early intervention and parent support). It reported a 34% increase in the CAMHS workforce between 2008 and 2012, and set a target of no more than 18 weeks wait time from December 2014. Despite the latest figures showing an increase in the workforce and progress toward targets, with 84.2%

of young people referred to CAMHS in the first quarter of 2016 being seen within the target time (ISD, 2016), the Scottish Children's Services Coalition believes that children with MH problems continue to wait too long to be seen (Cardwell, 2015). Adding the months taken to get the referral to the 18-week wait, it is easy to see why ITE providers view CAMHS' services as stretched and therefore do not engage with them.

Nevertheless, given that CAMHS are the service charged with meeting the needs of young people with MH challenges, their omission from teacher education delivery, as partners, is concerning.

Wider literature concerned with teacher education policy in Australia has registered concern about how teacher education can develop the capacity to respond effectively to the 'demands of children in crisis' (Aspland, 2006, p. 3) at a time when competency-based standards and over-regulation reduce the capacity for flexibility in teacher education and teacher practice in schools. A significant dilemma participants' identified was whether to adopt a primarily social model of MH for theoretically framing delivery or to rely on a psychological model. While respondents talked of trying to balance a range of approaches, the specific mention of 'attachment' in many Scottish responses reflects the pervasiveness of this theory that now underpins much current social policy in the UK (Kanieski, 2010). Critics of this view's neuroscience variants argue that it may have the potential to lead back to regressive, within-child, deficit approaches in which problems are located within the child (Macleod, 2010).

A concerning trend in the data was framing MH in terms of the larger term 'wellbeing', either in the generic sense that participants rationalized MH delivery in terms of equipping pre-service teachers to help enable children's overall wellbeing or because MH delivery was within courses, units or topics under the explicit banner of wellbeing. There was a tension between universal approaches to promoting positive MH

and specific input focused on identification of, and responses to, young people experiencing particular difficulties. Some respondents identified that the different approaches to supporting young people in practice constrained what they felt able to deliver in teacher education. For example, variation was reported at the basic level of protocols on information-sharing, resulting in university staff reluctance to tell student teachers ‘this is what you should do’.

Policy incentivizes the association between wellbeing and MH in Australia (KidsMatter, 2016) and Scotland (Scottish Government, 2012), with the terms used interchangeably. This conflation has its critics. For example, Humphrey and Wigelsworth’s (2016) account of the need for universal MH screening in schools draws attention to the dangers of subsuming MH within a more generic catch-all promotion of wellbeing in schools: ‘One might also argue that an approach to understanding mental health that purposively ignores or underplays notions of distress risks drawing much-needed support away from those who need it most’ (p. 28).

The data indicated that pre-service teacher education providers are well aware of the wide range of complex issues underpinning poor MH experienced by children or young people, thus disclosing the importance of helping student teachers to develop a nuanced approach to practice in the field and avoid seeking comfort in simplistic, partial explanations of a student’s need; a perspective advocated by recent literature in this field (Armstrong et al., 2016).

Limitations

The relatively small sample size (n=24) necessitates caution in extrapolating wider conclusions. However, consideration of the relatively limited number of teacher education providers in Scotland and Australia, and the typical institutional framing of MH as a specialist area within teacher education programmes suggest that this

population is likely to be small. Hence, our study reflects a factual feature of the population of teacher educators whose influence on what pre-service teacher education programmes deliver in terms of child and adolescent MH is most likely greater than absolute numbers suggest.

Conclusion

This study shows that institution-by-institution variance in the theoretical framing, content and practical delivery of MH was often greater than the variance between the Australian and Scottish cohorts, which shared striking similarities in the issues raised. The particular interest of one university lecturer seemed to determine what was provided in terms of MH, which was delivered in the margins of the main programme of study and varied widely in its form (what and how much specific education about child and adolescent MH pre-service teachers received). Variations in the theoretical framing, content and practical delivery of MH were often due to the charismatic idiosyncrasies of lecturers rather than any underlying principles.

The identified lack of resourcing and institutional status given to MH provision in both countries implies an urgent need for change. Given the increasing policy emphasis on school-based identification and support of children and young people with MH issues, it is essential that teachers entering the profession have the skills, knowledge and confidence for effective practice with all students.

The marginalization of MH provision in ITE programmes underscored by this study discloses some positive opportunities for progress, specifically the benefits of a bold, collaborative, strategic venture involving those delivering teacher education in Australia and in Scotland. Developing a common, theoretically-rich, research-informed programme (and associated learning resources) to enable robust MH literacy for pre-

service teachers would be the venture's major positive outcome. Providing pre-service educators with a flexible set of mental tools suitable for problem-solving and multidisciplinary practice would be a key part of this initiative, with the opportunity for pre-service teachers to explore what makes for strong professional reasoning in the context of practice with students affected by poor MH. The involvement of CAMHS and other key stakeholders in the conceptualization and delivery of any resulting common MH programme would strengthen it by offering students an intellectually compelling multidisciplinary view of child and adolescent MH, and assisting in the development of a common professional language for use in registering MH need (Graham, Phelps, Maddison, & Fitzgerald, 2014). Recent moves toward universal MH screening (Humphrey & Wiglesworth, 2016; Williams, 2013) could be integrated into the programme's conceptualization and delivery. Good-quality, research-informed learning resources already exist to support the development of MH literacy as a key goal of this joint initiative. For instance in Australia, *Response Ability Guide* (Response Ability Guide, 2018) is an accessible learning resource supporting timely identification and effective referral of students with possible MH difficulties. *Kids Matter* (Kids Matter 2018) also provide high-quality, research-based, no-cost resources designed for use in schools.

Finally, nation-specific policy goals pertinent to Australia and Scotland could be referenced into two national versions of the programme, although the study shows more policy commonalities than differences. The fact that both countries are signatories to important international legislation (UN, 2008; WHO, 2009) that is committed to an inclusive and socially just education system for students affected by poor MH demands that teachers come prepared with strong MH literacy as key enablers of this policy

aspiration. Thus, a resulting common MH programme would be a highly-attractive, cogent option for universities, teacher educators and policymakers.

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