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South African Primary School Teachers' Perceptions of their Role in Identification, Referral and Intervention Relating to Mental Health Care for Learners

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Submitted to the University of the Witwatersrand in partial fulfilment of the requirements for the degree of Master of Arts in Clinical Psychology

Declaration

This research report is submitted in partial fulfilment of the requirements of the degree of Master of Arts (Clinical Psychology). I declare that unless specifically indicated otherwise the following is the result of my own work.

Caylen Abrahams

2023

Abstract

Untreated mental health conditions can negatively impact a child's development and future. Early identification, and management of mental health problems (MHPs) is therefore important for children. This research study aimed to understand and explore teachers' experiences and perceptions in relation to the identification and provision of mental health aid for primary school learners. The study entailed interviewing 23 primary school teachers from a school in the Western Cape, South Africa located in a low-income community. Semi-structured individual interviews were designed to explore teachers' experiences and views was recorded and transcribed. The data generated from the interviews was analysed by means of thematic analysis using the computer aided programme, ATLAS.ti v 8. The findings indicated that although teachers struggled to make use of diagnostic terms to describe mental health conditions in their learners, they were able to identify symptoms and behaviours that they associated with poor mental health and to consider possible contributing factors. Acting out and aggressive type behaviours were more easily identified as problematic than behaviours that were less overt. Teachers described frequent experiences of compromised learner mental health, even in the young population with whom they interacted. Teachers saw their role as circumscribed in intervening in relation to MHPs, describing multiple barriers in this regard, including a lack of mental health training, time constraints, large classroom sizes, and academic and pedagogical demands. For this reason, although many teachers were willing to receive additional training and play a more prominent role in mental health aid, their preference was to refer learners and to make use of their school-based mental health services (SBMHS). Teachers noted the efficacy of the SBMHS in aiding their learners but also offered some critical observations about the scale of delivery of services and optimal interfacing between teachers and mental health aid providers.

Keywords: *child mental health; school-based mental health; teacher attitudes; behavioural problems*

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Chapter One

Introduction

Globally, according to the World Health Organisation (2021), 1 in 7 children aged 10-19 years old experience a mental health condition. In South Africa, the influence of certain risk factors such as exposure to gang violence, HIV infection, poverty, teenage pregnancy, and substance abuse, creates a context in which clear social determinants contribute to increased risk of poor mental health outcomes among children (Flisher et al., 2012; Mfidi, 2018). Mental health problems that remain untreated negatively impact the child's life in their development and hinder the ability to live a fulfilling life (World Health Organisation, 2008). Children living with mental health disorders face negative consequences such as engaging in risky behaviour, suicidal thoughts, physical health issues, poor academic performance, and vulnerability to substance abuse (Barry et al., 2013; Loades & Mastroyannopoulou, 2010; Werner-Seidler et al., 2017).

Anxiety and depression are the most prevalent mental health issues among children aged 6-18 years, which if left untreated, can develop into adult psychopathology (Barrett & Turner, 2001; Kieling et al., 2011; Larun et al., 2006). Prevention and intervention in relation to children's mental health disorders (MHD) are crucial at an early age as mental health issues and related behaviours can be modified more easily rather than in later stages of development (Werner-Seidler et al., 2017). However, the provision of mental health services (MHS) for children, specifically in low- and middle-income countries (LMIC), is limited (Barry et al., 2013; Murphy et al., 2017).

Reports in international and South African literature suggest that schools, including preschool and primary schools, are a promising location for the identification of possible mental health disorders in children, allowing for children with difficulties to potentially receive early intervention (Habeger et al., 2018; Headley & Campbell, 2013; Mfidi, 2018; Werner-Seidler et al., 2017). However, the success of mental health services in schools is greatly dependent on the capabilities of school staff, such as teachers. Teachers' perceptions of whether mental health services (MHS) are needed may assist in the approval of

interventions and determine whether MHS are effectively implemented (Frauenholtz et al., 2015; Han & Weiss, 2005; Werner-Seidler et al., 2017). Multiple factors, such as teachers' self-efficacy and their sense of how appropriate MHS are for learners, may determine whether teachers advocate for the delivery of a mental health service in their schools (Han & Weiss, 2005). However, there is minimal research on the perceptions of teachers regarding school-based mental health problems and services, especially in the South African context.

The proposed research, therefore, explored the perceptions primary school teachers have of their role in identifying and assisting with their learners' mental health difficulties, including how they regard existing mental health services and the nature of the interventions that are available to assist their learners. The experiences teachers have regarding their learners' mental health and their possible roles in identifying, intervening, and referring for treatment in dealing with potential mental health problems, was also explored.

Research Aims

The study reported upon here aimed to explore the understandings, experiences, and perceptions of primary school teachers regarding learners' mental health challenges. The study first aimed to explore teachers' perceptions regarding their role in the *identification of potential mental health problems* among their learners. Secondly, the study aimed to explore teachers' perceptions of their role in the *delivery of mental health care* in schools. The third aim was to understand the teachers' *perceptions regarding existing mental health intervention services* for learners with mental health problems.

Rationale

Previous literature has demonstrated that teachers are important role players in the implementation and provision of school-based mental health services (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). Schools are increasingly deemed as the ideal setting for the delivery of mental health services for children (Barry et al., 2013; Mfidi, 2018; Werner-Seidler et al., 2017), as teachers are found to spend a considerable amount of time with children and therefore provide an ideal resource to identify, refer and provide mental health services (Skinner et al., 2019). However, to date, existing research does not appear

to have focused on whether teachers feel willing to take on that role and their ability to do so. The success of a mental health intervention greatly depends on the providers and their ability to execute the role, which could potentially facilitate or hinder the provision and implementation of school-based mental health services (Keiling et al., 2011).

This study provides important information on primary school teachers' perceptions of learners' mental health challenges and of existing school-based mental health services. In addition, the research aimed to fill the gap in the existing research regarding how primary school teachers perceive their own capabilities and roles in their learners' mental health care. It aimed to contribute to the limited existing body of literature in South Africa on teachers' awareness of mental health problems among primary school learners and to explore the lived experiences of a group of teachers working in an LMIC environment in which mental health issues are possibly influenced by social determinants are elevated and intervention resources are limited.

The research is based on a study initially undertaken to complete a Masters Dissertation at Stellenbosch University in 2019. The study was undertaken under the supervision of Dr Bronwynè Coetzee, Senior Lecturer in the Psychology Department at Stellenbosch University, but was not completed beyond the proposal approval and data collection stages. Having cancelled registration for the Masters by Dissertation the research project was subsequently undertaken as a component of the M.A. in Clinical Psychology degree at Wits University, with the agreement of both institutions.

This research report follows the following structure: Chapter two consists of a literature review of relevant literature and findings on the research topic; Chapter three provides the methodology, including the research design; Chapter four outlines the findings of the research study; and Chapter five interprets the findings in regard to the relevant past research. Chapter six includes the conclusion, limitations to the research and recommendations.

Chapter Two

Literature Review

The following literature review will provide an account and understanding of previous research regarding primary school teachers' perceptions of their role in relation to learners' mental health difficulties as well as their perceptions of existing mental health services in schools. Firstly, the seminal study by Loades and Mastroyannopoulou (2006) will be discussed regarding teachers' ability to identify potential mental health difficulties among their learners. The difficulties teachers face when engaging with their learners' mental health challenges will then be explored. An exploration of studies regarding the value of teacher based mental health services will then be discussed, followed by consideration of the efficacy of school based mental health services. Among other references, the systematic review by Hans and Weiss (2005), and the study by Mfidi (2018) conducted in the Eastern Cape, South Africa, will be discussed to provide an understanding regarding teachers' perceptions of school-based mental health problem presentations and related services. Lastly, the teachers' perceptions of their role in the mental health services will be explored.

Teachers' Ability to Identify Mental Health Problems

As indicated in the introduction, there is a rather limited body of literature on teachers' engagement with the mental health of pupils, especially in relation to younger age children. It is therefore useful to present the findings of available research studies in some depth. A study conducted by Loades and Mastroyannopoulou (2010) in Cambridgeshire, England, focused on private and public primary school teachers' ability to recognise common mental health problems in their pupils. The authors used a quantitative, cross-sectional research design with the use of paper-and-pencil case vignettes and follow-up questions (Loades & Mastroyannopoulou, 2010). The case vignettes depicted children with or without mental health disorders and the follow-up questions focused on the teacher's ability to identify, intervene, and rate the severity of the mental health disorders. Loades and Mastroyannopoulou (2010) had three aims, firstly, they aimed to explore the teachers' ability to identify the severity of mental health symptoms, and secondly, whether teachers were

more concerned with emotional or behavioural disorders. Thirdly, they aimed to identify the potential factors that appeared to influence the teacher's accurate identification of a mental health disorder. With a sample of 113 participants, Loades and Mastroyannopoulou (2010) found teachers were able to identify and accurately rate the severity of symptoms. Further most teachers considered a behavioural mental disorder more of a concern than an emotional mental disorder. Lastly, the only significant factor found to influence the accurate identification of mental health disorders was the child's gender (Loades & Mastroyannopoulou, 2010). Teachers were more likely to identify boys with Oppositional Defiant Disorder, than girls, and more likely to identify girls with Separation Anxiety Disorder, than boys (Loades & Mastroyannopoulou, 2010).

A study conducted by Tuffin et. al. (2001) made use of discourse analysis to explore teachers' understanding and general awareness of MHPs among their learners. The study group consisted of eight secondary school teachers in New Zealand. The discourse analysis provided the following findings. Firstly, it was found that teachers' response to describing the term mental health would often involve the description of mental 'illness' (Graham et al., 2011; Tuffin et al., 2001), with mental illness understood as 'bad mental health'. Secondly, when teachers spoke to their understanding of mental health, they described the necessity of mental 'well-being'. Teachers described how mental health involved the need for a 'positive outlook', this included their learners having the ability to have a positive outlook on the future and having self-confidence. The teachers explained that they were assisting learners to find all opportunities to aid in bettering their 'positive outlook' for their futures and in turn their mental health. Additionally, Tuffin et al. (2001) noted that when speaking about mental health the teachers would speak from experiences primarily of others, however, would limit the information they shared about themselves, perhaps indicating some distancing between themselves and mental health difficulties, further speaking to potential feelings of vulnerability or fears of stigmatisation. Overall, the authors found the teachers to have reasonable general knowledge of a range of mental health disorders. The teachers would further attempt to portray this knowledge and align themselves with mental health

professionals by acknowledging the use of a labelling resource. The teachers' use of empathic and normalising language about MHPs was understood to promote the well-being and empowerment of learners with mental health difficulties. Hopes of destigmatisation by teachers were also described, as they noted the hidden nature and suppression around disclosure of MHPs.

A study conducted by Danby and Hamilton (2016) in the United Kingdom focused on gaining insight into teachers' understanding and experiences of the mental health of their learners. Additionally, they aimed to understand the teachers' perceived role in mental health aid for their learners. Danby and Hamilton's (2016) study had a participant group of eighteen, which included nine teachers, seven teaching assistants, and two additional learning needs assistants. The participants highlighted the emotional aspects of mental health difficulties (Danby & Hamilton, 2016). There was an expectation for learners to speak about their emotions and/or mental health difficulties and, similar to findings by Tuffin et al. (2001), that good mental health involved a positive future outlook for learners.

Reinke et al. (2011) completed a study with 292 early childhood and primary school grade teachers in Missouri, USA. The authors found that 75% of their teachers had helped with and/or referred their learners for help with MHPs (Reinke et al., 2011). Many teachers noted behavioural problems such as Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder, and other externalizing behaviours (Reinke et al., 2011).

In the Danby and Hamilton (2016) study the participants noted potential causes for MHPs among their learners as psychosocial, interpersonal, and economic influences. For example, they explained that family environment difficulties were potential causes for learners possible MHPs. Similarly, in the Tuffin et al., (2001) study the teachers in the study expressed concerns for their learner's mental health as they noted the impact of substance abuse on mental health, noting this to be a potential cause for MHPs. Overall, the research into teachers' perceptions and awareness of mental health problems and issues highlighted the following findings. Firstly, it appeared that teachers within the school and classroom environment were better able to identify potential MHPs among their learners compared to

children's caregivers, in many instances. Of note, was teachers' tendency to identify behavioural disorders more than the emotional disorders, with gender being a significant contributing factor in accurate identification of different types of problems. Mental well-being was understood to entail having a positive mindset or positive outlook as an indication of good mental health. Teachers in the above-mentioned studies indicated awareness of stigmatisation of mental health difficulties and hoped to reduce the stigmatisation through more empathetic and normalising language.

Based on the findings one can perhaps sense a rather polarised view between mental health as all good and mental illness as all bad, rather than working along a continuum or even possible co-existing in aspects of a person's life. In addition, when discussing mental health in these studies teachers would tend to not speak from personal experience, instead choosing to speak of experiences that have been reported or witnessed, suggesting some need to distancing themselves from the experience of having potential mental health or of having dealt directly with such difficulties in their classrooms. However, teachers were found to be effective in the referral of learners with potential MHPs. Due to prolonged time spent with their learners' teachers were able to identify changes in their behaviours and to make peer group comparisons in such a way as to assist in identifying potential MHPs. In Preschools in the USA, teachers were found to be better at screening children for potential mental health disorders in terms of conduct, learning, academic and mood functioning, as compared to parents (Greer et al., 2015). The authors concluded that this was in part because the school setting allowed teachers to access a peer group of children within which to compare maladaptive and problematic behaviour, aiding in more accurate identification of mental health issues (Greer et al., 2015). Teachers were noted to be able to identify the severity of the symptoms and recognise the necessity of a SBMHS referral. With teachers having daily interaction with learners, they also appeared to be in the best position to help minimise the congestion of excessive referrals to already strained mental health services by assessing which difficulties required higher level interventions

(Loades & Mastroyannopoulou, 2010). Teachers noted the need, however, for learners to voice their own struggles to aid in faster access to mental health intervention.

In addition to discussing mental health and mental ill health and its identification more broadly, in some of the studies teachers further provided their understanding of the causes of mental health problems, namely psychosocial, interpersonal relationships and economic factors. It is interesting that teachers appeared to place more weight on environmental than genetic factors in the main.

From limited existing literature it is evident that teachers have a valuable understanding of mental health and are able to identify potential mental health problems among their learners. However, there are potential barriers found to engaging with learners' mental health difficulties.

Barriers to Engaging with Mental Health Difficulties

Despite indications of some awareness of mental health issues, studies found teacher's perception of mental health disorders was that they had difficulty identifying the mental health disorders due to a lack of formal training, personal experiences and media influence (Ekornes,2017; Kratt, 2018; Loades & Mastroyannopoulou, 2010). A study conducted by Ekornes (2017) in Norway, employed focus group interviews with 15 lower and upper secondary school teachers. The study aimed to evaluate teachers' stress levels in accordance with their perceived ability and responsibility when aiding learners with MHPs. Ekornes (2017) found that teachers felt significant responsibility for learners' MH, causing an increased workload, feelings of guilt and fears of shortcomings. In a related study, a group of Australian teachers expressed similar concerns that the lack of available referral sources, lack of training, and feelings of isolation acted as barriers to the efficacy of aid for their learners (Graham et al., 2011). In research from Kratt (2018) conducted with 11 primary school teachers in the USA, they aimed to understand teachers' requirements regarding MH aid. Firstly, teachers explained the need for MH knowledge provided through professional training, in the form of compulsory MH modules during their qualification studies. Despite teachers having some general training in psychology, teachers were generally unable to

identify potential mental health issues with confidence and to provide the necessary prevention and intervention measures (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). They noted the need for substantial and effective support systems, describing a multidisciplinary approach to MH aid, including themselves, parents, and other MH professionals. Teachers noted the importance of parent involvement to provide a greater understanding of learners' MH difficulties and to continue the MH aid at home (Kratt, 2018). Teachers felt that a support system in the form of a community resource database, that teachers can access to provide the required MH aid for their learners, would also be helpful.

Additionally, teachers stressed the importance of their own MH, explaining that learners would notice if the teachers themselves were struggling, which could negatively influence their behaviour and well-being. Teachers therefore expressed the need for the presence of a MH professional for themselves as well as pupils (Kratt, 2018).

Research into teachers' engagement with mental health challenges in primary school classrooms suggested that specific training in mental health disorders was needed and the perceptions of mental health difficulties needed to be changed (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). The perception that disorders are only linked to serious illness and diagnosis means that many teachers may not only overlook potential mental health disorders of a less severe nature but that these perceptions regarding severity may perpetuate the stigmatisation of children with such disorders (Mfidi, 2018). Reinke et al. (2011) spoke to the concern that many teachers had felt ill-equipped to manage MHPs, therefore encouraging the need for support and training for teachers. Teachers recognised that it was the responsibility of the school to aid learners with MHPs however, only around 100 of the 292 early childhood and primary school grade teachers in Missouri, USA felt they had the required skills to aid the learners (Reinke et al., 2011). Teachers were found to have the perception that mental disorders tend to fall within the domain of the medical and pathological and are therefore beyond their capabilities and expertise to deal with as educators (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). In addition, with the high prevalence of mental health problems in some contexts, teachers experienced trouble in

balancing attention to academic functioning with responding to mental health needs (Mfidi, 2018). Graham et al. (2011) conducted a study in Australia with 508 primary- and high school teachers to explore their understanding, experiences, beliefs, and sense of self-efficacy in relation to learners' mental health. The findings indicated that although teachers may feel moderately confident to manage learners potential MHPs, they were having difficulty in balancing their role multipolarity (Graham et al., 2011). Ekornes (2017) mirrored these findings noting teachers feel constraints in balancing academic requirements and MH aid. Teachers noted the importance and necessity for individualised time to provide MH aid for learners.

Importance of Teachers in the Delivery of School-based MHS

According to a systematic review conducted by Barry et al. (2013) and a study conducted in Private and Public schools in Southwest Ethiopia by Kerebih et al., (2018) findings showing the integration of mental health services into schools suggest that teachers play an important role in the promotion of mental health. Teachers interact daily in children's lives for a prolonged period, and this provides teachers with a productive opportunity to identify any possible mental health issues (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). According to Ekornes (2017) teachers perceived a significant amount of responsibility, noting a "mother-like role" felt towards their learners, noting at times even losing sleep due to concerns about their learners' MH struggles. Ekornes (2017) found female teachers expressed prominent levels of stress, concern, and feelings of helplessness in relation to their learners who were struggling with more than academic problems. The teachers acknowledged that they noticed changes in a learner's behaviour, speaking to a change in the usual pattern of a child's behaviour as indicating a potential MHP (Tuffin et al., 2001). When children have working parents or caretakers who are burdened by other responsibilities, it may well be that teachers have an advantage in noticing changes and distress in their pupils relative to caretakers. In the Graham et al. (2011) study teachers also drew attention to the parental role they were playing for their learners. With the teacher's ability to identify mental health difficulties, teachers are uniquely positioned to advocate for

and potentially provide some aspects of mental health support in schools (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). In the Reinke et al. (2011) study, teachers reported the importance of continued mental health aid implementation in the classroom.

Efficacy of school-based intervention

Barrett and Turner (2001) conducted a study in Brisbane, Australia with Grade 6 learners in coeducational schools, examining the efficacy of a universal school-based prevention programme for childhood anxiety. Their aim was to test the effectiveness of a Cognitive-Behavioural therapy (CBT) intervention with three intervention conditions, standard curriculum with monitoring conditions (SC), teacher-led intervention (TI), and psychologist-led intervention (PI) (Barrett & Turner, 2001). The PI and TI were equally successful, in terms of a pre- and post-test self-report anxiety measure, with the TI and PI having a greater number of 'at risk' learners moving into the 'healthy' category (Barrett & Turner, 2001). The study provided promising evidence for the implementation of a universal school-based mental health-oriented intervention delivered by teachers, for primary school children with anxiety. Due to the Cognitive-Behavioural Therapy intervention taking place in schools, the intervention was greatly accessible for the children, and the integration into school activity aided the intervention success and met the developmental needs of children at that age (Barrett & Turner, 2001). The possible generalisability of the prevention programme as well as the sustainability was suggested by the findings of the Barret and Turner (2001) study. Other studies supported these findings of efficacy of school based mental health intervention programmes, also finding school-based intervention to be cost-effective (Kerebih et al., 2018; Werner-Seidler et al., 2017).

A meta-analysis conducted by Werner-Seidler et al. (2017) found that school-based prevention programmes are necessary due to the need for increased prevention of anxiety and depression at a young age (5-19 years old). Further, Werner-Seidler et al. (2017) concluded that although a small effect size for both anxiety and depression was found in assessing the efficacy of school-based interventions for these two conditions across a range of studies, school-based prevention programmes should continue to be delivered to children

as even modest improvements could prove significant in terms of prevention of later serious pathology. The school-based intervention showed success particularly for children at risk of developing anxiety (Werner-Seidler et al., 2017). Systematic reviews regarding the efficacy of school-based mental health programmes conducted by Murphy et al. (2017) and the efficacy of school-based mental health interventions in low- and middle-income countries conducted by Barry et al. (2013) supported the finding that school based mental health intervention programmes were worthwhile, concluding that school-based interventions were successful in reaching large populations of children when providing mental health services. Murphy et al. (2017) stated that the eight studies reviewed provided evidence for success in the implementation of programmes across fairly diverse settings and cultural groups and that interventions were significantly effective in improving the children's emotional, academic, and behavioural wellbeing. The Barry et al. (2013) review previously found similar findings – thus two systematic reviews, one conducted in 2013 and the other in 2017, both found similar substantive evidence of the success of classroom-based interventions.

Teachers' perceptions of school-based mental health services

In their systematic review, Han and Weiss (2005) focused on the factors that play a role in the teachers' influence on the successful and sustainable delivery of mental health services in schools. The factors included: the teachers self-efficacy beliefs; the teachers' professional burnout vulnerability, the teachers' beliefs regarding their learner's mental health needs and whether the mental health services would be compatible with their students' mental health needs; and the teachers' beliefs regarding the likely success of the mental health services (Han & Weiss, 2005). As described in the Kratt (2018) study, although teachers appreciate and recognise the effectiveness of a SBMHS, teachers expressed concerns regarding the implementation of and involvement in SBMHS. Notably, frustrations were expressed regarding the sustainability of the programmes that are often introduced to them, noting insufficient programme training (time, amount, and quality). It was thus evident that predictions of likely efficacy were rather complex and involved both factors personal to teachers and factors related to what sort of services were available to pupils and

how teachers perceived these. To advocate for the increased provision of mental health services in schools, the researchers concluded that more research needs to be conducted to explore the perceptions teachers have regarding mental health and their role in providing or facilitating access to mental health aid.

A key issue teachers face is their lack of training and knowledge in mental health disorders and prevention mechanisms (Han & Weiss, 2005). A study conducted by Mfidi (2018) in rural and urban high schools in the Eastern Cape, South Africa, aimed to gain insight into the experiences of the schoolteachers and school health nurses regarding the mental health of South African high school students. Semi-structured interviews were held with seven teachers and focus group discussions were held with eight school health nurses (Mfidi, 2018). School teachers and school health nurses were found to have a lack of appropriate strategies when dealing with learners with mental health issues (Mfidi, 2018). Teachers and nurses struggled to interact with and engage learners as learners did not open up to the teachers or nurses on mental health related issues (Mfidi, 2018). Further, for most of the responses, teachers and nurses were found to refer the learner with a mental health issue to either a parent or the police, rather than providing aid themselves or referring to more appropriate professional services (Mfidi, 2018). One response from a teacher was that although they had received psychological training, they still felt they were not skilful enough to deal with the mental health issues they might encounter (Mfidi, 2018). Teachers mentioned feeling that although learners MHPs may be prominent within the classroom, they still preferred for a mental health professional to aid in learners' MHPs (Graham et al., 2011). As found by Kratt (2018) teachers noted the need for MH professionals' presence in schools. Teachers explained the MH professional should then aid in the understanding, training, creation of resources and assistance for them. However, some teachers in this study despite having the MH professional present, had not known of their presence, or had minimal interaction with them (Kratt, 2018). According to the The White Paper for the Transformation of the Health System in South Africa (Department of Health, 1997), in South Africa the competencies of teachers should be evaluated and developed to promote the successful

implementation of inclusive education and awareness of differing learning needs. While this recommendation does not directly speak to engaging with mental health issues it does suggest that teachers need to expand their awareness and responsiveness to pupil difficulties that might not be purely academic related.

Teachers reporting a lack of psychological training and lack of confidence to intervene and deal with mental health difficulties was also a problem identified in studies done by Frauenholtz et al. (2015) and Frauenholtz et al. (2017). Further, learners with a mental health disorder were constantly being referred to other parties as a strategy for intervention and treatment. Although referral might be appropriate, depending on the severity of the problems pupils might present with, referral to external sources meant that teachers were not able to follow-up with the learner due to their lack of involvement. Referral also tended to mean that teachers gave up any responsibility they might feel to intervene in complementary or parallel ways alongside intervention from mental health professionals. In the Mfidi (2018) study the constant referral of students was found to hinder the success of school based mental health services as this precluded the use of interdisciplinary teams consisting of teachers and counsellors who could work cohesively in aiding the student (Mfidi, 2018). The studies conducted by Frauenholtz et al. (2015) and Frauenholtz et al (2017) focused on the importance of interdisciplinary working and collaboration of school staff to ensure the accurate and successful delivery of school based MHS. Teachers explained that if provided with an increase in time and resources they are able to participate and commit to the mental health of their learners (Graham et al., 2011). Graham et al. (2011) noted teachers to acknowledge the significance of working in collaboration with the leaners' family and additional support. However, the teachers additionally expressed frustrations regarding the amount of support received from these other parties.

A study conducted by Askell-Williams and Lawson (2013) consisted of focused interviews with 37 Australian primary school teachers from 10 schools. The study aimed to understand teachers' knowledge and confidence level to promote mental health in their school and its community. Around 19 of the teachers indicated that they did not feel their

mental health promotion knowledge was of high quality (Askell-Williams & Lawson, 2013). However, with the presence and assistance of their SBMHS, Kids Matter initiative, the teachers indicated positive attitude changes towards mental health and the appreciation for them to have improved knowledge about mental health and awareness of changes in their learners' behaviour. Further, teachers noted the improvement of their mental health promotion knowledge due to the presence of their SBMHS. Askell-Williams and Lawson (2013) from their findings encouraged the presence of mental health promotion initiatives as these provide opportunities for teachers to have improved knowledge, attitudes, and professional development regarding mental health for their learners. Reinke et al. (2011) described the importance of the SBMHS to provide an opportunity for teachers to learn, adapt, and improve their self-efficacy when aiding learners with MHPs. However, they have noted the importance of mental health knowledge to be present in teachers' prior training (Askell-Williams & Lawson, 2013).

The Mfidi (2018) research sheds some light on the likely state of mental health services in schools in a LMIC, such as South Africa. According to the Education white paper 6 (Department of Education, 2006) there is an expected provision of District-based support teams that teachers can rely on. The support provided by District-based support team would include instructional, curriculum and assessment aid in the form of learner support materials, assessment instruments and professional support for teachers themselves (Department of Education, 2001). It is evident that even in the White Paper there is little explicit attention to the mental health needs of learners and to what kinds of roles teachers might play in this regard, nor to what kinds of support teachers themselves may require to deal with such issues when they inevitably present in the classroom on occasion. The Mfidi (2018) study was one of the only studies specific to this topic conducted in South Africa. Of note, was the importance of aiding teachers in integrating mental health aid and promotion within their daily routines and teachings (Graham et al., 2011; Reinke et al., 2011).

Considering the review of research concerning the sustainability of school-based prevention-programmes (Han & Weiss, 2005), one can note the important role teachers play

in the approval and successful delivery of a school-based prevention programme. A determining factor for the teachers' referrals to and their belief of the efficacy of a school-based prevention programme were the severity of the possible mental health difficulty their learners may have (Han & Weiss, 2005). Teachers were found to be more open to the mental health services, if they believed it would help their learners (Han & Weiss, 2005). Factors such as thorough administration, training, self-efficacy in administering the programme and their own beliefs about MH were seen to influence teachers' support for a SBMHS or programme (Han & Weiss, 2005). An additional valuable aspect was the continued support provided to teachers by the MH professional, by learning the skills, and how to adapt the programme to their already established routine and listening to teachers' input regarding the programme. Following the training and implementation of the MH programme, sustainability is further impacted by the teachers' purely intrinsic motivation, independence, and commitment to any programme (Han & Weiss, 2005).

Teachers' perceptions of their role in MHS

As noted by Ekornes (2017), teachers interacted with and provided MH aid differently based on their personal views, experiences, and competence. A series of studies conducted by Frauenholtz et al. (2015) and Frauenholtz et al. (2017) in the United States of America, focused on school employee's knowledge of children's mental health issues and their ability to identify, support, and collaborate among themselves to provide appropriate mental health care. The larger of the studies they conducted consisted of 251 participants who responded to an anonymous online survey focusing on the self-efficacy beliefs and ability of certified and classified school employees to recognise and intervene with children's mental health (Frauenholtz et al., 2015). A second study consisting of 52 participants taking part in focus group discussions focused on the mental health literacy of all school employees (teachers, teacher's aides, and custodial staff) and whether this literacy aided in the provision of mental health aid or not (Frauenholtz et al., 2017). In both studies it was found that many of the school employees experienced challenges in helping children with mental health issues (Frauenholtz et al., 2015; Frauenholtz et al., 2017). School employees were found to have a

lack of knowledge in terms of identifying mental health symptoms, in appreciating the role of psychiatric and other medications, and in defining their role in providing mental health aid (Frauenholtz et al., 2017). In the larger study 64% of the certified staff members were confident in their ability to recognise children with mental health symptoms (Frauenholtz et al., 2015). However, only 50.9% believed they had the skills to intervene and provide mental health aid (Frauenholtz et al., 2015). There was thus a fairly large discrepancy in awareness of mental health problems and in the felt capacity to intervene to address such problems when they were identified. Teachers acknowledged their fears regarding the management of MH difficulties such as Depression and Suicidality. The teachers explained their fears due to their lack of mental health training and professional development, however despite the described fears, the teachers described needing to remain composed and professional for the learners. The need to remain composed for their learners perhaps speaks to their acknowledgement of the importance of containment for learners with potential MHPs (Tuffin et al., 2001). Lack of mental health related psychological training was the key factor in the lack of knowledge or confidence school employees reported with regard to how to engage with children's mental health difficulties (Frauenholtz et al., 2015; Frauenholtz et al., 2017). As found by Ekornes (2017), teachers' perceived MH knowledge and competence was increased following MH training. A study conducted by von der Embse et al., (2018) in the USA, involved MHP screening intervention training for teachers. The study had 91 participants, 57 receiving the training and 34 being the control population. As noted by von der Embse et al., (2018) ,teachers that had been trained in the screening process were more confident in their MH screening knowledge, ability, and effectivity.

Conclusion

In summary, the Loades and Mastroyannopoulou (2010) study found teachers in the UK to have the ability to accurately identify certain mental health disorders and to rate the severity of conditions. However, as found by Mfidi (2018) in South Africa and Frauenholtz et al. (2015) and Frauenholtz et al. (2017) in the United States of America, not all teachers feel competent either to identify or to assist children with mental health problems. Teachers'

wariness in engaging with mental health difficulties appears to stem from the fact that they have a lack of confidence in their skills to intervene and provide mental health services for the learners. Several studies (Frauenholtz et al., 2015; Frauenholtz et al., 2017; Han & Weiss, 2005) seem to suggest that teachers require specific psychological training to accurately identify and deliver school-based interventions for mental health difficulties and disorders. While Loades and Mastroyannopoulou (2010) found some teachers to be capable of identifying mental health disorders in learners, other researchers such as Mfidi (2018), Frauenholtz et al. (2015) and Frauenholtz et al. (2017), found that teachers believed they needed more training in identifying potential mental health disorders and in what role they could play in terms of intervention or care. As found by Han and Weiss (2005) and Werner-Seidler et al. (2017) more research is needed in determining the role teachers may feel comfortable to play in school-based interventions for children with mental health difficulties.

Chapter Three

Methodology

Research Design

This research study utilised an exploratory, qualitative research design, to provide insight into primary school teachers' lived experiences, to understand their perceptions regarding their role in the care of mental health difficulties in pupils. The exploratory research design was used as it allowed for the understanding of the primary school teachers' perceptions of these concepts and experiences (Maxwell, 2013). The exploratory research design allows for identification of future research topics based on the current research findings. Although many of the existing studies in the area had made use of a quantitative approach to this topic, the qualitative research design was anticipated to provide rich findings in allowing for the understanding of the social and cultural aspects that might influence an individual's perspective and further, aspects that might uphold or change their perspectives (Maxwell, 2013). As will be further elaborated below, semi-structured interviews with teachers were conducted at a primary school in the Western Cape province in South Africa, as this allowed for the documentation of narratives from the teachers themselves that generated detail about their experiences and perceptions.

Research Questions

1. What are primary school teachers' perceptions regarding the presence and significance of mental health difficulties among their learners?
2. What experiences do primary school teachers have in identifying and engaging with symptoms of a potential mental health disorder in their learners?
3. What are primary school teachers' perceptions of existing school-based mental health services?
4. What are primary school teachers' perceptions of their role in the referral and intervention process in relation to mental health difficulties among their learners?

Theoretical Approach

The research is situated broadly in a Realist (Maxwell, 2013) perspective with the understanding that some Interpretive (Goldkuhl, 2012) aspects are apparent in the data analysis. The Realist approach combines a Realist Ontology, which follows the understanding that outside of our own beliefs and constructions of the world, a real world is also present and a Constructivist Epistemology, which holds that what we know of this world is based on an individualistic perspective formed from a particular point of view (Maxwell, 2013). The interpretivist paradigm aims to understand the individual's subjective meaning of a phenomena or experience (Goldkuhl, 2012). The individual's experiences, beliefs and understandings of a phenomenon are core to understanding the area of interest to the researcher and are used as building blocks for theorising phenomena. The understanding of a phenomenon is possible during the process of interpretation of the individual's subjective meanings of the phenomenon, retaining the appreciation that the individual operates in a material world.

In this instance I was interested in teachers' experiential accounts of dealing with mental health difficulties among children in their care and in their subjective perceptions of their roles and capabilities in responding to such cases. I was also interested in their perceptions of existing services available and what function they might play in enabling children to receive optimal interventions. To this extent it is noted that the data generated was treated as an accurate account of teachers' experiences and perceptions during the analysis, while remaining aware of the fact that the material that emerged was filtered via the lenses of the teachers that participated in the study.

I also appreciate that as a researcher, I played an important role in the development and understanding of the participants' experiences (Gale, 2006) and as far as possible I aimed to be aware of my biases and assumptions as I conducted the research and made interpretations regarding the data (Eatough & Smith, 2008). Thus, it is recognised that the interpretation of the data was dependent both on how the participants understood and

conveyed their experiences and my understanding of how the participants created meaning from their experiences (Gale, 2006).

Participants

Data was collected from a group of primary school teachers from a South African government funded Primary School in the Western Cape. Purposive sampling (Palinkas et al., 2015) was used as the school and teachers were chosen as it is a public primary school in South Africa, allowing for exploration of teachers' experiences and perceptions in a school situated in a LMIC context and based on the fact that the staff were willing to participate to better their learners' lives. Purposive sampling makes use of strategic selection of the research population to provide most effective, suitable, meaningful, and rich data to answer the research questions (Palinkas et al., 2015). The school employed 25 teachers, along with additional school staff (i.e., School Nurse, Caretaker, Teaching Assistants) and catered for 748 learners in 2020 when the data were collected, with a teacher-learner average ratio of 1:30. The school is situated in close proximity to Stellenbosch, in a predominantly Coloured community, with teachers reporting high rates of violence, and poverty in the area. The school served their primary community with grades ranging from Pre-Grade R to Grade 7. With the school being situated in a relatively poor area, with most learners coming from low economic status families, resources such as school lunches and transport were described to be a difficulty for a number of the learners. The school was therefore supported by multiple non-governmental organisations (NGO), including the South Africa's National School Nutrition Programme (Devereux et al., 2018) and an NGO providing free school-based therapeutic counselling and psycho-social support to educators, caregivers, and learners. Permission to conduct the research at the primary school was received from the school principal (Appendix 1).

The research aimed to include as many participants as possible from the primary school total of 25 teachers, who were engaged in teaching pupils in grades Pre-R to Grade 7. The participants were recruited via an Invitational Flyer (Appendix 2). The invitational flyer provided information regarding the study and was handed out to some teachers and the

principal of the school. Additionally, the teachers were briefed regarding the research project in an information session during a staff meeting, held at their convenience. There were no exclusion criteria based on sample population. The participant inclusion criteria were the following:

- Teacher at the primary school
- Teaching a primary school grade
- Comfortable to be interviewed in English or Afrikaans

Socio-demographic information for the 23 participants can be found in the tables below, providing a general description of the composition of the participant group.

Table 1

Age, Gender, and Language of Participants

Age		Gender		Language	
20-29	5	Female	21	Afrikaans	21
30-39	4	Male	2	English	2
40-49	3				
50-59	8				
60-69	3				

Table 2

Education Training, Teaching Experience and Psychology Training of Participants

Education Training		Experience		Psychology Training	
Certificate	2	01-09 years	7	Counselling Course	1
Diploma	12	10-19 years	5	Psychology Course	2
Degree and Higher	9	20-29 years	3	Bachelors in Psychology	3
		30-39 years	6	None	17
		40+ years	2		

Data Collection

Instrument

A socio-demographic questionnaire (Appendix 3) and semi-structured interview schedule (Given, 2008) was used to collect data for the study. The socio-demographic questionnaire was used to provide a profile of the research participants. The semi-structured interview schedule aimed to allow for questions to be addressed in a way that elicited an understanding of the proposed research aims and objectives while still allowing a rich narrative to be explored (Given, 2008), which is ideal in understanding participants' lived experiences and the way this has influenced their perceptions. The semi-structured interview consisted of twelve questions developed by the researcher and supervisor, Dr Bronwynè Coetzee, based on the research aims of the research topic. The interview questions were aimed at understanding the teachers' perception of learners' mental health as well as the teachers' understanding of their role in mental health aid for their learners and their perceptions of existing and optimal interventions (Appendix 4). The interviews took place at the convenience of each participant, arranged during February and March of 2020. Due to the busy schedule teachers have, the interview was created to be short and took about 30-40 minutes to complete.

The interviews took place in a private and secure room within the Primary School premises. The venue was located on the school premises to maximise ease of access for the teacher. The teachers who had agreed to participate in the study completed the socio-demographic questionnaire themselves and subsequently the semi-structured interview was conducted by me with each participant.

The socio-demographic questionnaire and semi-structured interview were self-generated in conjunction with input from a research supervisor, in 2019. The semi-structured interview is attached as an appendix (Appendix 4) and is relatively straightforward in that it was designed to elicit answers related to the research questions. The semi-structured interview schedule was inspired by the semi-structured focus group interview employed by Frauenholtz et al. (2017) who focused on four questions namely: participants previous

experience with mental health issues amongst their students; secondly, teachers' mental health training, thirdly, their view of their current mental health knowledge, and lastly how their knowledge has aided them in identifying potential mental health issues among their learners and their collaboration with mental health professionals. The semi-structured interview posed both closed and open-ended questions that were elaborated on in such a way that patterns of response could be identified, but also that participants had room to elaborate on answers and to introduce unexpected information (Given, 2008).

The semi-structured interview was audio-recorded with the verbal permission of the participant. I transcribed the interviews verbatim. Anonymity was ensured by using pseudonyms and eliminating any personally identifying information from transcriptions during the data collection and data analysis processes and the research findings were only shared with research supervisors, initially with Dr Bronwynè Coetzee from Stellenbosch University (SU) (initial supervisor of the project), and secondarily, Prof Gillian Eagle, who supervised the data analysis and interpretation and write up of this Research Report based on a Transfer of Data Agreement between Wits and SU (Appendix 8). The data collected were stored on a password protected laptop and shared with supervisors via a password protected One Drive File.

Data Analysis

Thematic Analysis was used in analysing the data collected (Braun & Clarke, 2013). Recurring and significant themes were identified across the interview transcripts to create a holistic understanding of the material generated and how it articulated with the research questions. The transcribed interviews were coded and analysed using the computer aided programme ATLAS.ti v 8.

I followed the thematic analysis steps set out by Braun and Clarke (2013) in executing the analysis and interpretation. The first phase as developed by Braun and Clarke (2013) is to familiarise oneself with the data – this included reading the transcripts multiple times. The second step entailed generating initial codes based on my reading of the data and I then began to group these initial codes into themes (Braun & Clarke, 2013). The next

phases entailed reviewing the themes and defining and naming them to allow for a clear description of those codes and the data set (Braun & Clarke, 2013). Throughout this process my supervisor, Prof Eagle, played a co-researcher role in reading the interview material and assisting in the identification and refinement of themes. The themes that were generated in this co-analysis process were then also discussed in a joint meeting with Dr Coetzee in which consensus was achieved in terms of the final theme structure. The final step entailed writing the report with the use of the themes to answer the research questions.

The thematic analysis aimed to provide a clear understanding of the teachers' lived experiences with regard to the research focus and the collective and dominant perceptions they expressed in the interviews.

Considerations in Ensuring Research Rigour

Trustworthiness

The trustworthiness of qualitative research lies in the evaluation of its reliability, validity, generalisability, and objectivity, which can be achieved using Guba's model (Krefting, 1991). Guba's model consists of four constructs to ensure the trustworthiness of a qualitative study, namely: credibility, transferability, dependability, and confirmability (Guba, 1981).

Credibility refers to the internal validity of the qualitative research (Guba, 1981). The understanding participants have regarding their subjective meanings of an experience was respected during the research process to attempt to ensure the 'truth' value of the research findings (Guba, 1981). As I trust will be evident in the description and discussion of the data, I aimed to represent teachers' own opinions and experiences as accurately as possible, using substantiating quotations from interviews to convey this.

Transferability relates to the external validity and generalisability of the study (Guba, 1981). Krefting (1991) explains transferability to be the ability for the findings of the research to be generalised to other populations or settings. Due to this research focusing on individuals' unique perceptions and experiences of children's mental health, the research cannot be easily generalisable to other contexts, but careful description of the population

studied, and the method employed (as outlined in this chapter) should allow anyone reading the findings to consider applicability to other related contexts.

Dependability refers to the reliability of the research and is related to the possibility of the accurate and successful replication of the study (Krefting, 1991). The study method has been presented with clarity and includes the nature of the participants, data collection tools and data analysis methods, to allow for potential replication of the study.

Confirmability refers to the study being free from the researcher's bias, motivation and perceptions while conducting the interviews and analysing the data (Krefting, 1991). As the researcher, I aimed attempt to remain aware of my own positioning and interpretations throughout the research process. In addition, the data generated from the interviews was co-analysed by two different supervisor/s to varying degrees and efforts were made to achieve consensus on the final themes generated.

Reflexivity

As with the credibility (Guba, 1981) of the research, reflexivity plays a significant role in the research process. Reflexivity relates to the researcher reflecting on their possible contribution to the development of the meanings during the research process (Willig, 2013), both in terms of influencing data collection and data analysis. In this instance there were certain considerations I entertained while conducting the research such as my degree of identification with the teachers as regards aspects of their life experiences and the possibility that teachers may have felt somewhat inhibited in expressing their opinions regarding mental health difficulties and treatment to someone who they knew was training to become a psychologist. A brief section on reflexive considerations is included in the Conclusion chapter of the report addressing these kinds of observations.

Ethical Considerations

Ethical Clearance

The study made use of an existing set of data, collected by the researcher in 2020. As the data was initially collected with the aim of completing a Master of Arts (Psychology) at Stellenbosch University, ethical clearance to conduct the research was obtained from the

Research Ethics Committee: Social, Behavioural and Education Research (SBER) at Stellenbosch University (SU) on the 8th of August 2019 [Ethical Clearance Number: REC-2019-10375] (Appendix 6). Given these circumstances and following a formal data transfer agreement between SU and the University of the Witwatersrand (Wits), at which the research report is currently being submitted for degree award purposes, a waiver for further ethical clearance was granted at Wits on the 21st of June 2021 [Protocol Number: Mclin/21/01W] (Appendix 9).

Informed Consent Process

Before conducting the interviews, I obtained written informed consent from participants (See Appendix 5). At the outset of each meeting, I provided the teachers with the informed consent information to read through and sign and requested separate permission to make an audio recording of the interview. The research project did not involve any deception as participants were made aware of the research aims and objectives.

Participants were made aware that they could choose to withdraw from the research project at any point of time and could refuse to answer any of the questions asked. While it was not expected that participants would experience distress or discomfort because of taking part in the study, if needed, I offered to refer participants to Marie-Louise van Heerden, school office manager at the Community Keepers branch on the school grounds, for a free counselling session. If this had been needed participants were also made aware that they could be referred for further help from appropriate organisations/support groups/ counsellors, etc. In conducting the interviews, it did not prove necessary for any participant to seek counselling support due to taking part in the research.

Audio recordings of the interviews will be permanently deleted once the examination process of the research report has been completed and any written responses to the demographic questionnaire and the interview notes will be securely disposed of after five years as indicated below. The participant has a copy of the informed consent that they have signed to keep. The participants were provided with my contact details if they had any queries and concerns regarding the research project.

In order to extend permission to access the anonymised transcripts and data to Prof Eagle the participants were contacted to request their endorsement of this process. All participants indicated their consent to have the data accessed by the second supervisor on the project.

Anonymity and Confidentiality

The participants were made aware that any data collected would be confidential and their names would not be used, instead Pseudonyms such as “Participant 1” have been assigned to them. The demographic data collected, such as age and years of teaching experience, cannot be linked to a participant as no names were attached to the data. The school’s name and address will not be used in any publications to maintain anonymity and confidentiality for all learners, participants, and other school staff. In the write-up of the Research Report the name of the Primary School does not appear in any instance, including in the Principal’s Permission Letter (Appendix 1) and the Invitational Flyer (Appendix 2).

The only potential risk of this research project could have been some inconvenience for teachers in terms of time to take part in the research interview. However, this was minimised by ensuring the data collection time was most convenient for the participant, preferably before or after classes and during an open period.

Protection of Data

The data is saved as an encrypted folder which is password-protected and all hardcopy data such as the informed consent, socio-demographic questionnaires and interview notes are stored in Dr. Bronwynè Coetzee’s locked office in a locked cabinet. All data collected will be destroyed after five years in keeping with the directive of the Research Ethics Committee of Stellenbosch University, that approved the proposed research study. All information regarding the data security and storage, data sharing, and confidentiality was provided to the participants in the informed consent (See Appendix 5).

Chapter Four

Findings

This chapter explores the data collected from 23 participants at a Western Cape Primary School. The data is presented according to emergent themes and sub-themes from the data analysis. These themes include participants' experience and understanding of concepts of mental health and their reported capacity to identify types and the causes of mental health difficulties from their experiences. Additionally, factors that influence the extent to which participants felt able to provide mental health services to their learners are discussed, including their perceptions of barriers, and facilitating features in providing learners with mental health support. The presentation of results also focuses on the participants' feelings and experiences regarding having school-based mental health services present at their school, both positive and negative, and their recommendations for any changes that might improve the delivery of such. The table below gives a clear picture of the core themes identified in the thematic analysis and the layout of the chapter in terms of discussion of themes.

Table 3

Findings: Themes and Sub-themes

Theme	Sub-Theme
General awareness of mental health difficulties among learners	Understanding of what Mental Health entails Frequent experiences of learner mental health problems
Identification of Mental Health Problems (MHPs) in learners	Identification of 'externalizing' problem behaviours Recognition of compromised functioning in cognitive and emotional domains Teachers' capacity to identify MHPS in learners.
Appreciation of contributing factors of mental health difficulties among learners	Home context Community and social environment related difficulties

Role of teachers in the provision of or referral to mental health services	Parental/caretaker role Approaching and addressing possible mental health problems with learners Barriers to providing mental health aid as teachers. Facilitators to providing mental health aid as teachers. Additional resources utilised to manage Mental Health Problems in learners.
Interface and involvement with school based mental health services (SBHMS)	Productive two-way communication between personnel Incorporation of input from teachers for referral and psychoeducation Minimal help for high volume in need Insufficient communication between stakeholders Location of services non-optimal in terms of proximity Pressure related to liaising with MHSP's.
Overarching Evaluations of SBMHS	Recognise improvement in learners. Relieving teachers of double burden Extension of teacher knowledge about mental health Recognition of expertise of SBMHS to deal with MHPs

General Awareness of Mental Health Difficulties Among Learners

Understanding of What Mental Health Entails

Overall, participants understood the term 'mental health' as encompassing the learners' 'health of mind and soul' and as related to the learners' overall well-being, with some noting the value of learners having a positive mindset. A few provided an understanding of mental health that included the idea that mental health influenced the learners' behaviours and problem-solving ability. However, most participants did not make

use of a diagnostic vocabulary regarding mental health difficulties, with only a few making mention of terms such as Depression, Attention Deficit Hyperactivity Disorder and Fetal Alcohol Syndrome.

> I think mental health, uhm, means your ability to cope with things that are happening around you, with your feelings and what you are experiencing. Uhm, so if your mental health is not, if you are not well adjusted, then you not, you going to struggle coping with the things that are happening around you and if you are well adjusted and your mental health is in a good state, then you will be able to deal well with things that happen or changes that happen around you. (Participant 13)

and

> My understanding is that when you are at the mental level that you should be, then it will help you with your decisions, visions for your life and long-term goals which you have set for yourself. Therefore, I believe if someone is mentally healthy then they have the ability to make good decisions (Participant 19)

and

> I understand that if a person is positive or sees the good in life and learn from it, then it becomes an easier life for you, as your mentality and health actually becomes friendlier and better. However, a more morbid person, becomes more morbid when they focus on others' faults… So, I will say positive thoughts will help a person to lead a more positive and better life (Participant 2)

It was evident that in some respects appreciation of what constituted problematic mental health was based on how this contrasted with good mental health. From the above quotations it is apparent that the teachers understood sound mental health to help with decision making, good physical health, ability to manage affect, and a positive future outlook, among other aspects. Participants seemed to have clear ideas about mental health and to feel comfortable in expressing these ideas. Participants recognized the importance of good mental health amongst their learners, noting from personal experiences how this benefitted pupils and influenced other aspects of their well-being. They explained that similarly, mental

health difficulties, whether taking the form of Behavioral, Emotional, or Cognitive difficulties (as will be discussed further), negatively influenced learners' well-being and performance in other aspects of their lives.

> I always see how poor mental health negatively impacts their daily progress, behaviours and how they are as a person. Overall, it negatively influences a person if they are unable to make the correct decisions… All these years I have noticed that if there is hurt, pain and heartbreak, if we do not help the learners to process, or if we do not portray the necessary empathy and walk that journey with the child, then they remain behind. This disadvantage causes a barrier, hinders being able to live a meaningful life and to be able to socialize, which all has a bad effect on your life and lessens the impact on everything that he or she approaches. (Participant 19)

Frequent Experiences of Learner Mental Health Problems

The majority of participants (20) stated that they have had experiences of learners having mental health difficulties. Most participants noted having regular experiences, with some participants noting daily encounters with mental health difficulties, while others mentioned experiences throughout their years of teaching. Participant 23 explained, *"We are exposed to it very often because a child's socioeconomic circumstances can lead to a child having poor mental health"* and Participant 10 noted, *"Yes, daily, you know, when they just don't worry (referring to the fact that the learners portray an attitude of not caring if they face teacher censure discipline). I just refer them".*

Three out of the 23 participants stated not having any experiences regarding mental health difficulties among their learners, however, two of these participants later noted that they had observed either emotional or behavioral difficulties in learners. As seen with Participant 8, *"Uhm, no not yet… Look emotional problem do present themselves in many incidents"* and Participant 9 agreed by saying*, "In the classroom... no, not so many"*.

Overall, it was apparent that teachers felt that concern over mental health problems in the children they dealt with was legitimate and that they frequently observed behaviors that signaled to them that these young pupils were psychologically distressed.

Identification Of Mental Health Problems (MHPs) In Learners

When asked to elaborate on how they noticed that children might be struggling with mental health difficulties, interviewees referred to a range of signs and behaviors, most of which did not involve direct communication of problems by pupils themselves.

Identification of 'Externalizing' Problem Behaviours

There appeared to be a better ability to identify overt behaviors that might be indicative of potential mental health difficulties as compared to being aware of more 'internalizing behaviors', such as withdrawal. It is likely that teachers noted such behaviors as these were often disruptive in the school space. Most participants associated and identified behavioral difficulties as indicative of potential or present MHPs among their learners. In addition to focusing on overt behavioral problems, most participants understood MHPs as evident in behaviour that was out of the norm, either in terms of their own experience as teachers or according to society. MHPs were thus associated with extremes of some kind or with divergence from common repertoires of childhood behavioural expression.

> Behavioural problems are when the child, in our classes, or in school, their behaviour is of a disruptive nature, it is not normal behaviour, and the behaviour that continues to become worse, which becomes a problem at the end of the day (Participant 22)

And Participant 13 stated, *"Behavioural, children with behavioural problems, behave, uhm, in an unacceptable manner. Like so they will… act out in a way that or respond to situations in a way that is not socially acceptable."*

The participants were able to identify common behavioural problems such as abnormal aggressiveness, fighting, swearing, absenteeism, stealing, being disrespectful, teasing other learners; with bullying of other children being a major concern. As noted by

Participant 13, *"They are very aggressive… fights and verbal abuse and things like that… fighting or screaming or throwing a tantrum"* and Participant 4 explained:

> Bully behaviour is very bad, hey. I don't think our children can differentiate between what bullying behaviour is and what isn't. They are so used to speaking bad about the other, or poke, or hurt them, they think they are just playing but they don't actually realise that they are hurting the other.

and Participant 3:

> In most cases is it the children that actually have deeper underlying problems also that at the end of the day portray it through their behaviour, for example, bullying behaviour, fighting, speaking out of turn, swear and those types of things, and for most of the incidents… who completely lose themselves, speak loudly. I mean it is good but there is a time when a person can speak like that… and many times it borders bullying behaviour.

Participant 4 added *"Bully, they become extremely angry, beside themselves with anger, they cannot even think because they become so angry for small things. It occurs on a daily basis, but the bullying behavior occurs the most."*

Participant 3 indicates that s/he becomes concerned about children when s/he notices harsh or fierce behaviour being demonstrated and is sensitive to the fact that such behaviour may be indicative of deeper underlying problems. Like Participant 4, Participant 3 suggests that aggressive behaviour that may be indicative of MHPs may overlap with bullying behaviour. What was rather striking in many of the interviewee's accounts was how aggressive many of the pupils were, how unconscious they were of the impact of such behaviour, and how often MHPs seemed to manifest in forms of interpersonal violence or abuse of others, even in these very young children.

Behavioural problems further consisted of exaggerated sensitivity, defensiveness, and discrimination towards peers, all of which also suggested to teachers that children were poorly adjusted. Although these kinds of problems were difficult to handle, as will be further elaborated later, several teachers seemed to appreciate that these kinds of interpersonally

aggressive behaviours of various kinds represented a form of acting out or displacement of discomfort, although they did not explicitly use these kinds of terms. The fact that they linked these externalising signs to MHPs suggested that they viewed not only the behaviours as problematic, but also perhaps understood the impetus for such behaviours to be some form of psychological distress.

> Another child would take something from them, and they would hurt the person, or uhm, somebody would, uhm, say something to them and their first reaction would be to hurt the person back, and not just like a hurt like a hit or something like a smack or something, like a hurt them with something you can use like a weapon (Participant 15)

And Participant 17 also noted, *"many of them tell you lies, now they will tell you "no I didn't do anything teacher, it was another child".*

It is interesting to note that the kinds of behavioural problems that might conventionally be associated with older, adolescent phase child development, seemed to be present in this younger population of scholars.

Recognition of Compromised Functioning in Cognitive And Emotional Domains

In addition to referring to behavioural problems as indicative of MHPs, several interviewees selected out problems in the domain of cognitive and emotional functioning as observable signs of MHPs in children at their school. These kinds of signs were spontaneously mentioned by fewer of the participants than the behavioural indicators, however, and tended to be described in relation to specific interview prompts.

Cognitive problems were conceptualised as involving problems in thinking and logic, and as evident in learners not understanding academic work or displaying learning problems. As described by Participant 16 *"Cognitive, is with your thoughts, argument formation I will say, how can you think logically, logically order something… think and problem-solving issues"* and Participant 12 explained:

> Cognitive I will understand it is how he develops, does he understand what we are doing, especially mathematics, the concepts, the values, in the counting and what else, all that forms, it starts here (pointing to the head), does he understand?

Participant 17 further stated, *"Cognitive problems is the thoughts of the child, hey, how he thinks, our children cannot actually think and reason".*

Common cognitive problems identified by the participants entailed difficulties in concentration and in problem solving as well as struggles with reading, writing, spelling, and counting. As Participant 20 said, *"Like with the minimising, our children don't want take part, our children do not want to listen… Word sums they do not want to understand it, dividing, everyone must get an equal amount".*

In addition, Participant 2 noted problems in comprehension and observed that this negatively affected a child's capacity to engage with academic work.

> But in general, they also do not have understanding, they also don't read with understanding, that he can understand what is expected from him. If it is not a straightforward question, then he will struggle with it, sometimes they don't even answer the question. (Participant 2)

In the main participants seemed to perceive cognitive or learning difficulties as a sub-category of MHPs. They were less clear as to whether these problems were due to underlying psychological distress as opposed to cognitive deficits than they were in relation to 'acting out' type behaviours.

Several interviewees elaborated on emotional indicators that might be illustrative of MHPS. Emotional problems were described as manifesting in response to stress and pressure.

> Emotional problems are, for instance, when they have to do something that is a little bit challenging. Uhm, they either would give up or they would start to cry, or they would start to disturb another child, that, that's they emotionally not there, or they not developed yet that they can handle situation they in. Also, emotionally, when

there is a new situation or when they maybe in a new class, they don't know how to adapt, uhm, with their new peers. (Participant 15)

And Participant 18 noted similarly, *"I think many of our children because they are so emotionally illiterate…They do not understand why they are the way they are, and then they act out on that"*. Both participants 15 and 18 (in keeping with other interviewees) suggested that children with MHPs were less resilient and displayed a weakened capacity to deal with change or with tasks that required perseverance. In addition, both participants suggest that the children they observe lack insight into their own psychological states (*they emotionally not there, or they not developed yet*; *they are emotionally illiterate*), and therefore display feeling states behaviourally. As is evident in the just cited quotation, Participant 18 explicitly makes a connection between 'acting out' and lack of emotional self-awareness. The teachers suggested these children were less emotionally mature than their peers in managing their feeling states.

Some of the types of emotional problem displays identified by the participants included crying, the portraying of contradictory or opposing emotions (such as joking about something sad or difficult), being excessively quiet or withdrawn, excessive stoicism, and changes in usual temperament (such as a usually cheerful child becoming sulky).

> And then you get that child that is totally emotional, come to school crying, don't want to be at school, want to go home and then you get the child that cries for seconds and then quiet and then suddenly cry again and then you think, 'oh my word what's wrong now?' So, then you have to…You do get a lot of different emotions people, children that don't cry, they will look you straight in the face and be like I want to be brave because at home 'you must not cry, if you cry you will get a hiding' so we tend not to cry, they very brave. (Participant 6)

and

> Something that I pick up quickly is that many children are withdrawn in the classroom, withdrawn, and that you can easily… They do not easily express the emotions that they really want, it is as if they express it in the opposite manner,

when he must be sad then they do the opposite than showing sadness. (Participant 2)

What is evident in these two quotations and was also evident in other participant interviews, was that teachers were observant of emotional displays by learners and were concerned about both openly distressed children and those who attempted to cover up or hide their emotional states from others. They were also aware of both family and peer group pressure for even these young children not to appear too vulnerable within the public space of the classroom or school.

Teachers' Capacity to Identify MHPs In Learners

Although teachers' broad sense of their role in dealing with MHPs will be elaborated in sub-section 4, it was evident that participants felt that they could play a role in identifying MHPs by virtue of their familiarity and contact with pupils over time. Participants placed importance on knowing their learners well. This included knowing their personalities, living circumstances, and possible life traumas. In this way the participants explained they could easily identify possible MHPs as they are able to distinguish abnormalities or changes in a learner's mood and behaviour, while additionally, very often being able to understand the causes of such a change in mental well-being.

When you know a child and he act differently than what he usually does, he begins crying over things that he does not usually cry over. Or he gets angry at things that he does not usually get angry about, then you know that there is like emotional, uhm, problems, but then you must also know your learner. (Participant 18)

And Participant 12 explained *"I can see it immediately, actually with the child's schoolwork, 'you did your work so nicely yesterday, what is then happening with you now?'… For example, this one boy… he was very quiet, now he is quarrelsome."*

and

No, the majority of the incidents they do not come, it is rather something a person must have, a sixth sense that you must have to identify and then you refer them maybe if you see the signs and symptoms of it. (Participant 22)

While there was a belief that they were well placed to identify MHPs, there was an observed tendency that some participants seemed to hope that given the right opportunity learners would approach and communicate potential mental health difficulties themselves to teachers. This expectation or hope was held despite many participants noting that their young learners were often unable to articulate, identify and understand their own emotions. In other cases, teachers were able to appreciate that they might need to invite disclosure or to create a context in which this was possible.

> I think maybe they are just a little young to understand what is happening, they don't understand what they are feeling yet. So, they don't, they are not at a point in their own lives where they can, can verbalise what they are feeling necessarily, to them are only two emotions, they are either happy or they are sad, or they are angry. So, they don't know how to verbalise any other emotions, they don't understand what they are feeling so I think it is difficult for them to come and speak to you and say, 'I'm feeling sad' or 'I'm feeling angry'. There are some instances where, where I've approached a child when I can see something is not quite right and then they can tell me, uhm, yes, I'm not feeling right or yes so. (Participant 13)

And Participant 17 agreed by stating "*Not actually no, or they do not show it, they do not come and speak to you about it… they would not actually come to you and share their emotions, not at all, no.*"

In summary it appeared that all of the teachers interviewed felt they had some understanding of what constituted mental health difficulties in their learners. At a general level their identification of problems was often to do with observing children's behavior as departing from their peer group norm or as departing from what the teacher had come to know as the usual 'style' of the individual child. Given their daily and ongoing contact with children in their care, teachers felt they were well placed to observe children closely and to identify when problems appeared to have arisen, and in many instances, they saw it as their responsibility to invite sharing of worries or distress or to monitor what appeared to be maladaptive. It was evident that for most participants identification of MHPs was associated

with observations of overt, ‘acting out’ type behaviors that drew attention because they were disruptive in the classroom and tended to involve interpersonal conflicts. Several teachers seemed to appreciate that such behaviors might be evidence of underlying distress that found expression in this form. When probed, some teachers also identified cognitive or learning difficulties as associated with MHPs, although they seemed to perceive such problems as to do with cognitive deficits as opposed to being by-products of other mental health difficulties, such as loss of concentration to do with traumatization or anxiety. In discussing emotional indications of possible MHPs there was evidence that some interviewees were aware that increased withdrawal or quietness might also be a sign that a child was in trouble, and this was important to note. Several participants referred to the emotional or psychological immaturity of their pupils as compounding their difficulties, as these young children could not easily comprehend, translate, and regulate their emotional states, and in this respect, teachers seemed sensitive to the role they might need to play in facilitating communication of problems.

Having discussed the central findings as regards the identification of mental health difficulties in learners, the second broad theme presents the main observations concerning teachers’ understandings of the causes of such difficulties in their pupils.

Contributing Factors Of Mental Health Difficulties Among Learners

Perceptions regarding the contributing factors of why pupils might develop MHPS were not initially foregrounded in the interview schedule, however it was evident that most of the teachers included some discussion of this aspect in their interview responses and that this material should consequently constitute a core theme. The participants’ explanations and descriptions of the term ‘mental health’ tended to expand to include their attributions concerning the significant contributions for the presence of mental health difficulties among learners in their school community. In the main difficulties were perceived to stem from environmental influences rather than innate or genetic vulnerabilities. For most participants in considering what might produce MHPS in pupils focus was placed on negative influences,

such as learners' living circumstances, lack of parental guidance, and socio-economic factors.

Home Context

A prominent contributing factor of learner difficulties identified by interviewees was parents' inability to fulfil expected parental duties for their children. Participants believed that in many instances the parents of their learners were not providing emotional education or cognitive stimulation, and nor were they setting heathy relationship examples for the learners while at home. Participants believed these parental failures in guidance and involvement negatively impacted the learners' well-being and mental health, in turn influencing their behavioral, cognitive, and emotional functioning while at school.

> The majority of the children play the role of the parents; I don't think children know what the behaviour of children should be and what the behaviour of an adult should be. They are raised in this way, as little adults… they are old and they portray themselves in class this way as well, and the respect emerges, and the depression becomes worse… because they have that pressure of 'where do we get food?', 'how do we manage at home?' and this is very worrying, but it is actually that they do not receive the love and attention at home. (Participant 4)

and

> But I think even, even like the little things, even like the parents yelling at each other and, and that does impact the children. So, they, they like in a house, maybe in the house where there is tension, or like, it's an unhappy household and obviously that impacts how the child then comes to school on a Monday morning. (Participant 13)

Additionally, Participant 14 noted *"Emotional problems… many children did not receive the stimulation needed before preschool and now they do not know how to manage their emotions."*

Participants explained that due to socio-economic and parental difficulties the learners' basic needs, such as secure shelter, provision of food and overall physical care,

were not being met in some instances. The incapacity to fulfill learners' basic needs was believed to significantly influence their mental health.

> Every child comes from a different background and household. For one, when they arrive at home sandwiches are made and Mom is at home, food is provided tonight, the child is washed. Then there is another child from a different household, that arrives home this afternoon with no Mom or anybody else to receive him after school, 'I must manage my own food until Mom arrives home tonight', 'I have to take off my own school clothes and I have to search for something to eat at home'. This all has a big contribution to the child's mental health because of the child's household circumstances… and actually also just to say, 'I am also here, also giving me attention'. (Participant 5)

In this instance Participant 5 suggests that while poverty and deprivation in and of themselves put children at risk in terms of physical and mental health, the shame associated with impoverished living circumstances is also difficult for children to bear. Like Participant 4, quoted above, Participant 5 also suggests that many children have to be precociously self-sufficient and to fend for themselves at a young age (*they are raised as little adults*; *I must manage my own food until Mom arrives home tonight)*. These family-life related stressors were seen to contribute to mental health difficulties in learners, via feelings of frustration, shame, and heaviness.

Many teachers made mention of home being a dysregulating environment for their learners, as they noted that behavioral difficulties often increased directly before and after the weekend or holidays.

> Especially on Mondays… our children have increased behavioural problems… and funny enough it improves by Wednesday… and then it seems to me things have settled at home… and then Fridays, Thursdays, I don't know, then they are again beside themselves… I do not know now if it is because they think it is the weekend. (Participant 3)

And Participant 2 explained “I realized if children go home over the weekend and even vacation times then the child is not the same child that you left. Sometimes maybe better, others a little worse off.”

Although home and environmental difficulties were inter-related, parents of children often known to be struggling with issues of poverty, unemployment and lack of resources, several teachers made mention of problematic community and environmental circumstances as contributing to the development of MHPs, in addition to parental and familial stressors.

Community And Social Environment Related Difficulties

In speaking about the broader community from which their pupils came, participants explained the negative influence of neighbors and peers who tended to act as problematic role models for learners, in turn influencing the potential for mental health difficulties.

> Our children’s role models from who they learn… is my biggest concern, because our children do not learn from people that influence them positively, but rather negatively. I am laying specific emphasis on the criminals that are released from jail and are amongst our children, then the children will learn that slang and to speak to each other about it. (Participant 2)

More specifically several interviewees referred to exposure to people with criminal records and to violent interactions and displays, such that their pupils’ own means of attempting to resolve conflicts became excessively aggressive.

In addition to mentioning deprivation and exposure to negative role models, participants further acknowledged the possible traumas and abuse the learners had experienced, also contributing to potential mental health difficulties. Trauma exposure might be direct and indirect (such as witnessing violent assaults) and could occur both inside and outside the home. Teachers were aware that many of the children they taught lived in dangerous environments with high risk of exposure to traumatic incidents.

> I think a lot of the learners that we work with have a lot of things impacting them in their lives, they experience a lot of traumas constantly, so I don’t think, I think maybe not all of them, but to a degree maybe all of them have experienced some

> trauma, and obviously that effects the way that they uhm cope with other things in their life. Yes, so I think, yes, a lot of children in my class have, well their mental health might not be as well, as good as you'd would want them to be at an age of seven or eight years' old. (Participant 13)

and

> Children are sad, they are angry, uhm, they are maybe frustrated a lot, …because they know that something is wrong, but they can't work through that necessarily if they don't have that emotional intelligence for that yet. Uhm, I think stuff happens in the community and then they don't realise, they don't know how to feel about it. So, there will be like over the weekend might have been a knife fight or something like that, and then they see it happening, they experience it, but they don't know how to, you know, work through it, or talk about it. (Participant 13)

Although the teachers did not explicitly refer to traumatic stress symptoms or posttraumatic stress disorder (PTSD), they were aware that exposure to traumatic events could make children anxious and dysfunctional in a range of ways.

In thinking about probable contributing factors that might influence the development of MHPs it was evident that teachers were acutely aware of the social and environmental contexts within which the children they taught were growing up and that in many instances these were non-optimal for psychological health. They appreciated that it might be difficult for children to thrive in such environments and that whatever support the school could provide this was very often against a backdrop of a living environment characterised by deprivation, parental absences, and high trauma exposure. The interviewees seemed very clear in their minds that environmental rather than innate factors were at the root of MHPs and in the main seemed to have considerable compassion for the fact that many children faced hardships and difficulties in their everyday lives. It was again evident that several teachers noted that the developmental capacities of their young learners were insufficient to help them to comprehend, manage and engage with the life pressures and demands they faced, often coupled with inadequate caretaker support at home.

Having discussed teachers' perceptions of causal factors in relation to MHPs the fourth theme addresses teachers' ideas as to what their role might be in dealing with and responding to the presence of MHPs in pupils in their classrooms.

Role of Teachers in the Provision of, or Referral to Mental Health Services

Parental/Caretaker Role

As previously discussed, participants believed a potential cause for poor mental health difficulties among learners was the non-optimal social context that learners were raised in. Immense value was placed on guidance and support regarding emotional maturity and knowledge, cognitive stimulation, and behavioral discipline being provided within their home contexts. Participants explained that they need to additionally provide this guidance in the class in order to aid their learners and their academic progress. Participants therefore mentioned playing the parent/caretaker role in the learners' lives, with many calling the learners 'their children'. The parental role included providing the attention, containment, financial and emotional education that they perceived had not been offered by the learners' parents. The following quotes from Participant 4 and Participant 8 place specific concern on the lack of attention or positive influence provided by parents and the need to compensate for this in the classroom.

> I have this whole thing that I want my class to understand that this is our house, and you are my children for a year… So, I try to make them understand that here we have our rules, and it is my rules in the class and this is our rules… that you (learners) belong to something, and hopefully what they see… teacher can also be sad in front of you (learners)… I share a lot of my life with them so that they can see what a family should look like, my family is not perfect, but this is how a mother should behave… and a child's correct routine and life. (Participant 4)

and

> If you provide that child with that physical attention and care just at school where they can feel this is a place that I can feel safe… because they know that there are people that care about them and that want to help them. (Participant 8)

The participants emphasized the importance of containment and a sense of belonging for their learners, and by doing so hoped that the learners would feel an increased sense of self-worth and importance. This included the establishment of rules that participants wanted the learners to obey and creating an atmosphere of ease with regards to general communication and interaction.

Many participants believed the learners were their responsibility at school, therefore participants would refer to the learners as their 'children', explaining that they feel that they act as the parent in school. Related to taking on this kind of parental responsibility, several participants explained that they believed that they should be the first source of help for the learner before referring them for other professional services. Participant 17 noted *"Look it is obviously first the teacher, it is the teachers' duty to firstly work with the learner before you would give them to someone else."*; and *"But I think the teacher is the first person that must try and handle it."* (Participant 23) and

> Yes, and we have learnt over the years to tell them to tell us, and it is a secret, but I cannot promise that I won't share it with someone else because if it is serious, then I have to share it with someone else… but the little ones do not know so nicely yet, so they will just come. (Participant 20)

It was apparent that teachers were mindful of being available to children in a caretaking kind of role, but also that there might be occasions on which their input as teachers would be insufficient in terms of handling a problem and when they would need to draw on the skills of other personnel, as will be elaborated further in subsequent discussion.

Approaching and Addressing Possible Mental Health Problems with Learners

Since participants generally felt they were to identify potential MHPs they additionally felt the first step to providing aid was to speak to the learner. By speaking to the pupils, the participants hoped to contain them, understand the reason for difficulties, and determine the level of aid to be offered. By addressing the learner teachers aimed to ease some possible anxiety or heightened reactions to an incident. In initiating contact with a learner, they seemed to want to convey that they viewed children's responses as important and to

acknowledge that they were aware of changes in behavior and the possible impact of incidents on the children in their care. In some instances, teachers would approach learners and share their observations about a change of mood or demeanor as an encouragement to talk further.

> Yes, when they see that a child is like, quiet, and I will call the child and say 'what's wrong? Why you quiet? You not so quiet, this is not a normal situation'. So then 'what happened? Why, why are you sad? Why don't you want to talk to me?' … but you have to say, 'it's our secret, you tell me, and I can see if I can help you'. So yes, and some of them say nothing is wrong and then they will just look at you with his face, you will see the tears and then you can see, ok, something is wrong, 'do you want someone else to talk to you? Must I ask someone to come and talk to you'. (Participant 6)

Participant 6 indicates that she takes an invitational approach in engaging with her pupils and is also willing to refer elsewhere if the child perhaps finds it difficult to talk to her. Again, she references the fact that children may attempt to hide their distress in the school setting and that teachers need to be sensitive in their style of approach. Participants aimed to introduce opportunities for learners to feel comfortable to express their difficulties. For example, they spoke of inviting learners to tell 'the news' about their weekend or to write a letter to them.

> Not actually no, or they do not show it, they do not come and speak to you about it… I have a little jar in the class, and I tell them that if they have a problem, place your letter inside. Just write me a letter, put in there and then this afternoon I will read it, but they would not actually come to you and share their emotions, not at all, no. (Participant 17)

and *"Or sometimes they speak about it during the weekend news, then all the incidents are revealed, and now you must try and take the positive out of it and say what was right and what was wrong."* (Participant 14).

Participants also considered the timing of providing aid or making the referral to mental health services to be significant for the learners. They mentioned being aware of the impact of having a learner receive mental health aid in front of other learners. The stigma of being identified as having a mental health problem appeared to be present amongst learners and their peers, as participants mentioned pupils' fear of teasing or bullying, and fear and embarrassment in discussing mental health difficulties or seeking aid. Participant 19 explained *"Other children that belittle their friends and that also has an emotional impact on them, because they do not have the courage to speak."*

In being sensitive to potential stigmatisation and embarrassment, participants also discussed waiting to interact with the learner, speaking during the interval or outside of the classroom, as well as sometimes writing letters or notes to a pupil. Additionally, they discussed wanting to assist the learner to contain themselves so that they were calmer before talking to a teacher, creating more ease for the learner to discuss their mental health difficulties. Overall, it seemed that several of the participants perceived it as important to create a context in which learners might feel safe to share difficulties with them and in which they might be a first port of call in actively engaging with possible distress and attempting to intervene at the level of initial containment. Teachers' concern and empathy for their pupils was very evident in this area of discussion in the interviews, many of them displaying considerable insight into the need to approach children with possible MHPs in a very sensitive manner.

Barriers to Providing Mental Health Aid as Teachers

Although, the majority of participants were willing to engage to some extent with children's mental health difficulties, as a group the participants also noted multiple barriers to the provision of mental health services. One central concern that emerged was the pressure to meet the demands of the curriculum as a priority in their work. Many participants stated that academic tuition and input is of major importance within the school environment and high-performance results are expected time constraints were therefore a concern for many participants as they felt there was simply not sufficient time to both maintain academic

standards and to devote time and attention on the mental health of the learners. In addition, many participants explained that the class size was of concern if the participants were to attempt to act as mental health care facilitators more formally. The participants explained that there are simply too many learners in one class and to focus on each learner and their individual needs would be impossible in terms of the demands placed on them to instruct learners well. Frustrations regarding these barriers were expressed spontaneously by many of the participants, as they provided explanations as to why they were perhaps not in the optimal position to provide more mental health aid to children in general. Participant 18 noted *"So much pressure from the curriculum that the curriculum actually overrules all the help and mental… services at the school"*, and *"We do have such instances in our classes that we do not always address because we focus on academics, even though we know we need to develop the child holistically"* (Participant 20) and

> I have 48 children in my class, I cannot monitor 48 children the whole time regarding what makes them tick and what irritates the one child, or especially if he has low cognitive functioning, there will be things that will trigger him, compared to a child that does not have it. (Participant 18)

As previously mentioned, participants explained that they already play multifaceted roles while being a teacher, pointing to the fact that the workload can be daunting even without the burden of providing MHS for their learners. Participants expressed frustration and concern about the burden of the workload placed on them and emphasised their sense of being potentially overstretched. There was an expression of exhaustion and accounts of feeling overworked already. Therefore, the expectation of being a mental health aid provider did not seem viable for them, as seen by Participant 13 *"Yes, you the nurse, you the lawyer, you are the policeman"* and

> So, I think the task of a teacher is a big task, you are a welfare worker, you are a psychologist, you are a pastor, you are, you are a policeman, you are a security officer, you are all of that and at the end of the day you are still a teacher as well. (Participant 23)

And *"Yes, you are a Mother, you are a social worker, you are a teacher, you are a doctor and everything in the class. We actually have a big role that we play."* (Participant 11)

Further, the lack of knowledge and training in mental health service provision emerged as a common concern as participants felt they simply did not have sufficient experience in or knowledge about handling learners' MHPs. Some participants expressed concerns about not providing the correct aid or causing further harm to the learner. There appeared to be a fear of possibly making the mental health difficulty or incident worse due to lack of training in dealing with mental health difficulties. Some participants explained that it is not their job and believed that the SBMHS should intervene since they were specifically trained to assist learners with MHPs. Participant 2 explained *"You cannot burden the teacher with psychological problems, even social work problems that they are not trained for"* and *"And that is what they want, you psychologists want us to address the psychological problems more while it is not our role"* (Participant 20) and

> See I can also sometimes think as a teacher I am doing the right thing, but actually maybe I'm not helping the child. I think I'm helping the child but may, maybe I'm making… an issue worse. So, so uhm I will definitely want to help as a teacher and equip myself to help that child because I think as a, because I'm responsible for the child and I must be in a space where I trust, the child trusts me and as a teacher I must be equipped to help the child. (Participant 15)

And *"That is what I can do, further I do not have the knowledge on how to work with the child so, outside is obviously people that are qualified that can work with children like this."* (Participant 5)

Despite being fearful of being inept or causing more harm, many participants explained that they are willing to be trained in mental health related intervention skills in order to help pupils in the classes and to support interventions for a learner who is currently undergoing treatment at the SBMHS.

> I think it would be a good thing for teachers. It's just like teachers get first aid training, you need, if, if a child breaks his arm you need to know what to do and,

> uhm, emotional problems is, can be, just as, have a great as, even more, greater effect as broken arm, but you can't see it necessarily. So having that skills as a teacher to be able to identify, when a child is, we can see when a child is acting differently but understanding maybe why or how to pick up on more subtle signs, uhm, that you might not be aware of at the moment. (Participant 13)

And Participant 15 explained *"I would say if they gave, like, you are coming in to give regular guidance or something, if it is on black on white. Uhm, just trainings, just give trainings or documentation just to know how to handle these children."*

When participants felt they would not be helpful or the MHP was beyond their scope, they felt it best to refer to their partner SBMHS. This appeared to lessen the fear of being out of their depth in handling situations and also reassured them about not being over-stretched in terms of work-related demands. Some participants explained that their primary role involved referring to SBMHS or any other relevant committee or organisation that would help the learners with the possible MHP, this being dependent on the extent of the problem. As Participant 23 stated *"And if he cannot see, if he or she sees they cannot, uhm the problem is getting bigger then call in help. Either refer the child to someone, but we cannot just leave it there"*, And *"And if I see I can now not do anything then I will refer to CK"* (Participant 17).

And Participant 19 noted *"The teachers are the first people that must identify it, and if we identify it, we must immediately make use of the provided referral framework and support framework from the school."*

The barriers to providing mental health aid came up spontaneously within the interviews and spoke to the concerns and fears the participants have as regards pupil mental health difficulties and their role, if any, in intervening in response to these kinds of difficulties. Worries about the impact of providing mental health aid included that their already heavy workload would be increased and fears of not meeting academic work demands. Additionally, there was concern about not providing the correct mental health aid and fear that they might cause more harm to the learner not having the requisite skills to engage with confidence. To ease this concern many were willing to receive mental health

training, speaking to their wish to help learners to the best of their capabilities, and acknowledging the importance of the mental health awareness in their personal lives as well. Having discussed the main barriers participants spoke of in respect of offering mental health interventions, the following sub-theme focuses on the facilitators teachers spoke of regarding their role in mental health aid provision for their learners.

Facilitators to Providing Mental Health Aid as Teachers

Firstly, participants recognised the need for MHS, as they expressed the importance of early recognition and treatment of MHPs to attempt to ensure improvement in the learners' potential mental health difficulties. Participants explained that they believe any possible MHP should be addressed immediately, and that generally they are able to intervene reasonably promptly within the classroom or teaching context. This aids in timely help for the learner compared to the reality of the long waiting lists learners are placed on to be helped by third parties, such as the SBMHS. Participant 4 explained *"It is a very good thing if you can see the children are having a problem with bullying behaviour or they have a problem with respect, address it immediately, do not still say we have to place this on our planning and, then it has passed, address it immediately."*

The participants' relationships with the learners were also of importance and in general the ongoing contact that teachers had with learners provided them with a platform from which to intervene as someone known and familiar. Many participants felt that the learners were their responsibility at school, including in terms of their emotional wellbeing (as illustrated previously), and explained that they should first attempt to support and assist the learner before referring the learner for formal external help.

The classroom dynamic was also seen as possibly facilitative in providing MHS as there is easy accessibility to learners as teachers work with learners throughout the school day and can pick up and act on issues over the course of a day or over a few days. Further, the participants are able to help many learners with possible MHPs at once within a bigger group by, for example, providing containment in enforcing rules and discipline, as well as by creating a sense of camaraderie when dealing with traumas that may then be processed

together as a class. As Participant 10 said, *"I address it and then… I like to involve my children also, because then it is not just the one-on-one lesson, then everyone is able to learn from it in the class"*, And Participant 4, *"So, I try to let them understand that here we have rules, and this is my rules in the class, and this is our rules, our class, that they belong to something"* and

> Maybe weekly sessions in a class, maybe 20 minutes, maybe come in and address maybe something that's a problem or play a game or do something that will, that will reinforce positive behaviour. Uhm, so like, uhm, a behaviour class almost… and also if, if, if in those classes, I want to say if they can teach skills, then, then we might not even get to a point where a child needs to go to a, cause they might, might have then learnt some skills that they can use to deal with whatever they are feeling or what's happening around them. (Participant 13)

Participants further focused on the referral process and explained that it is important to inform the parents of the learner's possible MHPs. This was done in order to explain and possibly guide parents on how to help their children. By speaking to the parents, the teacher can then also fulfil the further role of drawing the MHP to the parent's attention and providing some psychoeducation.

> First address the parent, like we cannot just send the child away but then the parent does not know what is going on. So, you must first inform the parent, the parent must then, I will say fill in a form to say that he or she understands, and that the child may go. So, you must always first involve the parent otherwise there will be big trouble. (Participant 8)

and

> And with the parents and so on and then I will ask the parents, look we see no, this is a bit deeper. I always say I cannot always and do not have to know everything, but the learner's actions portray that there is a problem. (Participant 19)

As mentioned previously, participants were able to recognise the importance of prompt identification of potential MHPs and their opportunities to facilitate such identification.

Participants also indicated appreciation of inputs already received and willingness to receive training to aid in the prompt identification of potential MHPs and the capacity to provide containment and basic aid before referring to the SBMHS.

Additional Resources Teachers Utilised to Manage Mental Health Problems in Learners

Additional resources were found to be essential for participants. Although some mentioned the use of discipline as important in dealing with behavioural problems, equally, several participants indicated constraints on being able to discipline learners as they previously had in the past, due to new legislation prohibiting manners of engaging with and discipling learners. However, there were alternative mechanisms to manage behavioural difficulties, such as verbal interventions, or writing issues up in the '*little black book*' where the learner's name is written, and continued difficulties are noted until they subside, or further aid is required.

> I would say it is difficult as a teacher and the children's rights and so many rights that children have makes it difficult to manage the child… things you could do in the past is now against the law… So, I try to manage them on a verbal level… which is not always helpful because they always want to do the opposite. (Participant 2)

and

> They must be punished but you do not have to punish them by hitting them, I punish them by keeping them in the class and then we discuss what they had done, so that they know what they have done is wrong but that won't be allowed. (Participant 8)

Interestingly in these sections of the interviews, participants appeared to be talking mainly about 'acting out' kinds of mental health related difficulties and it was apparent that they almost felt that containment and discipline were one and the same when it came to assisting with behavioural problems. There did not appear to be much reflection about how this intervention might or might not be helpful to children, but rather some sense that teachers needed to find ways of limit setting or exercising control.

A few participants focused on using their spiritual beliefs as means to provide aid for mental health difficulties.

> I sing choruses… usually choruses about the love for Jesus is the first thing I sing always, and one time I was singing and singing, and I did not even know the impact it has on the children… and while I was singing, a child was crying and I was wondering what is wrong with the child, but he was just crying, it was his manner of expressing (Participant 21)

While a minority of interviewees mentioned drawing upon religious or spiritual forms of guidance or intervention, these seemed designed to assist them in their roles as much as to have a direct impact on learners. One can see that Participant 21 felt moved to see the child cry but was not quite sure how to intervene although they had a sense that their choral singing was soothing to the boy in some way.

Some participants explained that their role involved referring not only to SBMHS, but also to other relevant organisations beyond the school that would hopefully help the learners, depending on the severity and nature of the difficulties.

> Normally you first contact the parents or the people that look after the learner, but sometimes they don't have parents, sometimes it's the older sister that has to look after them or grandmother or an aunt, or a foster, that's a foster child maybe. So, you contact those persons and then you have a form that you can fill in, like we have Khula and CK, and then you discussed that with Khula. Khula does house, uhm, they go to the house and see and talk to the people and see the situation that child is staying in and what is going on and from there it develops. So, the one guy, the one boy who sleeps in the (car), I got a hold of Khula, and Khula said but this child is like, must go to someone else because his mum can't look after him. So, then it's, they are, it's in their court now, I can't do anything because I'm not registered. I'm not registered to do anything, so the people, I just do referrals. So, our referrals are Khula and Community, Khula and then refer ACVV, ACFF. And all that Goede Hoop people. (Participant 6)

And Participant 13 explained "*So, I think that it shouldn't be one person, there should be, there should be multiple people that the child can, wherever he feels most comfortable to go to, then he can approach that person.*"

In summary, participants brought up the above-mentioned barriers and facilitators spontaneously within the interviews, with the majority focusing on the best method and process to aid their learners when they portray potential MHPs. The main concern for participants was the lack of training regarding mental health aid and the lack of capacity to take on the role of mental health aid provider in addition to the many other roles they currently played in learners' lives. Nevertheless, the well-being of their learners still appeared to be of considerable importance for the participants. The majority of the participants were eager or willing to receive mental health training as they recognized the significance of prompt identification and basic aid regarding mental health issues. Further, it appeared that the participants recognized the role they could play in the identification and prevention of potential MHPs, while acknowledging that both time constraints on their part, and the severity of the problems with which children presented would determine whether to refer to more specialised available resources. There was a fair amount of variation in interviewee's levels of comfort with attempting to engage with MHPS themselves prior to referral, with some teachers seeming fairly confident to initially try to help on their own and others indicating that they would very quickly refer to professionals as they were not comfortable to engage children on these kinds of issues. Overall, the participants focused on the well-being of their learners and how to aid them in the best way possible with regards to their own role and the use of additional resources.

Interface and Involvement with School Based Mental Health Services (SBHMS)

Teachers reported both positive and negative views and experiences in relation to their engagement with SBHMs.

Productive two-way communication between personnel

Most participants seemed to be involved in the SBMHS in some manner. Several interviewees explained that they were involved by regularly speaking to the counsellors

based within the school and with those who visit the school. Discussions would be based on concerns regarding an individual learner, a classroom problem, or the progress of a learner who had already been referred to and was attending some sort of SBMHS intervention.

> But besides that, hey, I must actually say we have a very good relationship with each other, she knows exactly when she comes to me, it is that one, and I do not want to know what happens inside there, they are… it is confidential, but I want to at least know, she will tell me, he is progressing at least, ask how is his emotional behaviour in the class? Just those types of things, I do not want to know the circumstances or what happens inside there. (Participant 4)

and

> So, on a monthly basis we come together when it suits, like when (SBMHS provider) is here today then she already knows that when she is finished, she comes and speaks to me. She speaks to me regarding the child. I ask how far she has gotten with the child, is there any progress, even though she does not, they are not allowed to discuss what they experienced with the child, but I want to, I query about the child and how he is progressing (Participant 23)

From the tone of the conversation, it seemed that there were cooperative relationships between SBMHS providers and teachers – with recognition on both sides of the value of regular consultation and feedback in the interests of the learner. As is evident in the two illustrative quotations, teachers were also aware of the importance of boundaries and confidentiality. Although they did not raise this as a problem it is worth noting that this may be a complex area to negotiate for both teachers and mental health counsellors in terms of quite how much feedback is necessary and useful to advance pupil care.

Good Incorporation of Input from Teachers for Referral and Psychoeducation

Some participants are part of the SBMHS Committee at the school where they work, which is a committee consisting of a number of the teachers in the school along with the counsellors from the SBMHS organisation. Discussions in the meetings consist of participants providing feedback on existing school conditions broadly and providing input into

what mental health topics should be covered for the upcoming terms. Further, discussion regarding possible learner referrals to external MHS, if needed, also takes place within this committee.

> I am on the CK Committee. So, we decide with the counsellor, we decide what we will be doing with the children this term, which theme we will be discussing with them, and when we will be taking the smaller groups and then there is the big groups. So I am on that committee, and we achieve a lot of good from it (Participant 11)

Minimal Help for High Volume in Need

While participants recognised the need for MHS for their learners, a common concern was that while there were simply not enough employees at the SBMHS to assist all of those in trouble. This led to long waiting lists which is a concern in that it meant that learners could be getting worse during waiting times or not obtain any help at all.

> And it is a good thing, but it is not always a practical, helpful solution for our children because the SBMHS work one-on-one with children, and we have too many problems or behaviour problems with the children. Therefore, if you work one-on-one with children then you are only able to see one child once a year which isn't enough. So, the SBMHS probably reach a tenth of the hundreds of those problems, which isn't actually helpful for us (Participant 2)

and

> If you have 30 children in your class, and there are 15 classes, they can't help those children all the time, and you only have so many days in a year and then there's holidays in between. So, so if you miss the opportunity to help that child and a week goes by and a month goes by, the year goes by, the problem gets bigger. So, the need is actually to help that child now, to be able to help that child now. I think most of the children, most of the children goes on in the system and then they never get helped, because there was just so much help to be offered to the children (Participant 15)

As is evident, participants pointed to limitations both in terms of the mode of service delivery (individual intervention) and in terms of the ratio of children with MHPs to specialised staff available to treat them. In these comments there is a level of despondency about capacity to treat, and concerns about some children being denied optimal care. Frustration seems to be expressed towards circumstances rather than towards the deliverers of mental health care, although Participant 2 does seem to suggest that modes of care delivery other than one-to-one counselling might need to be considered.

Insufficient Communication Between Stakeholders

In contrast to the earlier discussion in which it was noted that several participants reported a good flow of information exchange between teachers and MH service providers, a concern raised by some participants was the lack of communication between teachers and the SBMHS staff. As noted previously, the participants explained that they were aware of the confidentiality that needs to be maintained between the SBMHS staff and the learner. However, the participants explained that somewhat more extended communication would be appreciated, reinforcing the observation that this is perhaps a difficult area to negotiate. Communication regarding progress and what the participants could do with the learner in the class, both in terms of pupil management and in terms of enhancing treatment, were common requests from the participants.

> There is no feedback. The communication is a problem, we must take each other by the hand. The teacher feels that they are left in the dark as to how to handle the learner when the learner comes back to the class. There is not clarity given in terms of what the problem is and what the plan is to help the learner (Participant 10)

Location of Services Non-Optimal in Terms of Proximity

The school where the participants teach is situated on two campuses with the SBMHS offices situated in only one setting. This raised a concern for participants regarding the logistics of the office being and feeling distant for some learners. The participants explained that the learners from the non-proximal campus might not feel comfortable going to the SBMHS staff as they are too far away and not familiar with the second campus, nor

are they well known to staff and students there. This might make pupils feel added anxiety in an already difficult context.

> I think it's also difficult, because the CK office is at the other campus, so they not uhm, I think if they, if they had an office here and maybe were here two days a week. That the children can see they are here and feel, okay I can approach them because they are available to me, then that might also help (Participant 13)

And Participant 14 agreed, *"The school psychologist I know, we are in the foundation phase… but our other grades don't see them at all, not at all and they are not really involved with our section".*

In more general terms it seems that easy geographical access to services and familiarity with the service provider setting is optimal for good MHSP.

Pressure Related to Liaising with MHPs

Participants expressed the difficulties they experienced due to the process of having a child attend the SBMHS as adding to their workload. Firstly, the administration involved in referring the learner to the SBMHS was a concern.

> But it places a lot of work on the teacher. The teacher already has a lot of work that needs to be done, the books and all the other papers is on the table and then the SBMHS form, that you must still fill in, gets lost under all those other things (Participant 10)

and

> And the form gets filled in. So, there is a whole protocol that must be followed, to get to them… you report it, you speak to the psychologist, with the SBMHS, she brings a form, then we must fill it in, she then looks if there is a place for them, then they are put on the waiting list… and then as soon as there is an opening then they will be seen. If it is an urgent matter… then it gets discussed immediately. Then there is… then the form can be filled out afterward and the conversation but there is a protocol that needs to be followed so that they can be seen (Participant 9)

and

> The teacher rather does not want to do the referral, then the learner floats along and that is one thing about my work that frustrates me a lot, because I feel they just can't, then they don't want to refer the child, because they don't feel like doing the work, it is just too much work for them because they already have so much admin (Participant 18)

Participants further explain that to attend counselling the learners are absent from classes for their sessions. The participants brought a concern surrounding learners then losing valuable contact time with teachers and falling behind in schoolwork. This in turn increased the pressure and demands placed on the participants, and for some interviewees brought into question which was more important, academics or mental health? Participant 10 explained *"What about the academic work? Yes, they get helped, but what is more important their academic work or something else?"*

and

> So much pressure from the curriculum, that the curriculum actually overrules all the help and the mental health… because even if the child goes to the SBMHS then it's the case of I'm going to… the child misses contact time. (Participant 18)

And Participant 20 further noted, *"At the end of the term, they don't look for psychological reports, they look for academic reports."*

Overarching Evaluations of SBMHS

Recognise Improvement in Learners

As previously discussed, participants recognised the need for MHS for their learners, and most participants discussed improvements in the mental health of learners who attended the SBMHS. They further recognised having SBMHS as a priority for all schools, especially low-income schools.

> Every school must have it, because every school has their problems that they deal with, especially in, come, I say, non-government schools, ag I mean no-fee schools… So, we work with farm children in the sense of, where they get exposed to more things at the end of the day and they come to school with those socio-

> economic challenges… but I feel that it would have to be at schools, and that there must be someone like that at the school (Participant 1)

Participants noted the positive impact the SBMHS has had on learners, many noting that due to the challenges the learners face, to have the SBMHS present has contributed to learner improvement and has helped to fulfil an important need that cannot routinely be delivered in the classroom. Participant 9 stated *"It must, because there is an improvement that I can see in the children's behaviour when they attended a good number of those sessions."* and

> So, if they begin feeling, but this is how a person does things, if they go regularly, then I think they will also improve, because they know that, that there are people that actually care about them and that want to help them (Participant 8)

Relieving Teachers of Double Burden

As outlined previously, several participants explained that they do not feel it is their job to handle MHPs as they do not feel well enough trained to do this, and there is not enough time to both intervene in this area and deliver on academic responsibilities. Some participants recognised that the SBMHS are there to help the learners as well as to support the teachers.

> Yes, I will tell you it does help, not just the SBMHS, but if all schools had help for the teachers… because you cannot burden teachers with psychological problems, even social work problems that he is not trained for. Even with counselling, but counselling goes along with psychology as well and the department or from external people, and they can do it, where a child gets hurt and then you can send them to a specific person, because we must send the child to the janitor that trained in first aid now, but she also has her own work to do, now she must take away time from her work to see to the child, which is problematic for her now again. I must sacrifice time to listen to that child's social problems and problems aren't simple problems, and how many… And I don't have time, because I need to work, for the whole week I just have one free half hour… So, help from outside will be good but then it must

be help that allows teachers to be free so that teachers can educate, which he is trained for (Participant 2)

Extension of Teacher Knowledge about Mental Health

Although many participants stated they do not feel they are trained to deal with learners' MHPs themselves, a few participants mentioned that the SBMHS provides useful training for teachers in the form of workshops, such as Participant 9 *"I am on their committee, we have meetings, we speak about the problems that are present and the teachers receive training… So, we get that (training) yes, we get that."*

Recognition of Expertise of SBMHS to Deal with MHPs

Overall, participants felt that the presence of the SBMHS is important as it frees up time for teachers to focus on academic issues and provides support for them. However, the main positive aspect recognised was the fact that, unlike teachers, SBMHS personnel had the specific training and insight to deal with MHPs. Teachers therefor expressed a certain trust in and eagerness to refer children to the SBMHS rather than dealing with MHPs in their pupils themselves.

> Like I say many of children don't open up easily towards us and we do not have the experience to support and help children with mental health problems. So, and the counsellors and those people know exactly what to do. And they know, for example, what is the next step, and the teachers don't always have the time to do the next step and the next step. So, it is a very good thing that, if you, for example, can identify the problem and then refer to the SBMHS and they have the knowledge to take it further (Participant 3)

and

> Look here, we have the SBMHS organisation, so I will say they are my best bet because they are trained, they know. We are not trained to do the treatment, we can give hugs, we can support. Offer help, but must you not have the specific training to know how to deal with the situations or what? (Participant 12)

It is evident that, in the main, within the primary school within which the research took place, participants had positive experiences of the mental health services and service providers who were there to respond to the needs of their pupils. While there were logistical and resource problems, such as the geographical location of the service and the ratio of counsellors to pupils with difficulties, teachers appeared to generally work well with mental health service providers and to value their role. Although this varied across participants, teachers appeared to link with counsellors at both individual and organizational levels, such as via a committee. Some issues in relation to the formal referral process and the boundaries around confidentiality were viewed as taxing for teachers. Overall, however, teachers appeared to feel that the presence of in-house, school based mental health service provision benefitted both them and their pupils, freeing teachers up to concentrate on academic work demands as best fitted their expertise, and in some instances, producing observable beneficial changes in learners. For those teachers who were interested there also appeared to be opportunities for learning more about mental health problems in children and how to identify and manage them, via workshops and discussions with counsellors. Most participants endorsed the idea that SBMHS would be useful to schools such as theirs, and especially useful in impoverished communities where children are exposed to neglect, deprivation and high rates of violence and trauma, and in which families do not have resources to provide optimal care and cannot afford private counselling or psychiatric services.

Having presented the core findings of the research the following chapter goes on to present a discussion of the findings, including a comparison of how these findings articulate with previous research findings.

Chapter 5

Discussion

The Discussion chapter will focus on the interpretation of the research findings in relation to previously published research. Previous literature has demonstrated that teachers are important role players in the implementation and provision of school based mental health services (Loades & Mastroyannopoulou, 2010; Mfidi, 2018). Schools are increasingly deemed as the ideal setting for the delivery of mental health services for children (Barry et al., 2013; Mfidi, 2018; Werner-Seidler et al., 2017), as teachers spend a considerable amount of time with the children and therefore provide an ideal resource to identify, refer and provide mental health services (Skinner et al., 2019).

The purpose of this study was to gain a greater understanding of Primary School Teacher' perceptions of the Mental Health of their learners. The study centred around four research questions:

1. What are primary school teachers' perceptions regarding the presence and significance of mental health difficulties among their learners?
2. What experiences do primary school teachers have in identifying and engaging with symptoms of a potential mental health disorder in their learners?
3. What are primary school teachers' perceptions of existing school based mental health services?
4. What are primary school teachers' perceptions of their role in the referral and intervention process in relation to mental health difficulties among their learners?

The aim of this chapter is to address these questions based on the themes that emerged, while noting the differences, similarities, and articulations with regards to the research studies reviewed in Chapter One.

Interpretation of Research Findings

Awareness and Identification of Mental Health Difficulties

The first theme focused on the general awareness teachers reported with regards to potential or existing MHPs amongst their primary school learners. This theme provided an understanding of the teachers' understanding of what mental health entails as well as their experiences of MHPs amongst their learners. The teachers expressed legitimate concern for the learners' mental health. They explained that sound mental health directly influences how a learner is able manage their emotional, behavioural, and cognitive capacity. As found by Tuffin et al., (2001) and Danby and Hamilton (2016) when describing their understanding of MH, teachers explained MH to consist of a state of 'well-being'. This understanding of 'well-being' involved the need for a positive outlook for the future and having self-confidence. The teachers in the current research held similar views about optimal mental health to those found in the literature and this appreciation of what mental health entails also seemed to extend to an understanding that non-optimal mental health compromised academic and social adjustment. They noted how important mental health is amongst their learners, as they report significant changes in the learner's behaviour, ability to problem-solve and perform academically, as well as being able to regulate their emotions when their mental health is disturbed. Teachers observed that they have frequent experiences of noting aspects of their learners' mental health due to the amount of time they spend with them during the school day. In keeping with the research findings of Barry et al. (2013), and Kerebih et al. (2018), teachers were able to recognise the important role they play in the recognition of potential MHPs in learners due to their daily interaction and proximity to the learners. As an example, teachers in the study argued that they could observe both when a child's behaviour departed from the norm of peer related development (as identified in Greer et al.'s study, 2015) and when it might be uncharacteristic for that particular learner (in keeping with Tuffin et al., 2001). Similar to other research findings, the teachers in the study also believed that they may sometimes be better attuned to learners' difficulties than already over-burdened caregivers.

Most teachers in the study did not make use of a diagnostic vocabulary regarding mental health difficulties, with only a few uses of terms such as Depression, Attention Deficit Hyperactivity Disorder and Fetal Alcohol Syndrome. As found by Loades and Mastroyannopoulou (2010), it seems that while teachers were able to identify symptoms, they did not necessarily have the technical kind of vocabulary to describe 'conditions'. As will be evident from the discussion of findings, teachers made reference to children's behaviors and mood states as indicative of mental health problems, highlighting their observational capacities in this regard, but displayed a lack of professional knowledge base to make diagnostic judgements. These results regarding the lack of mental health knowledge and diagnosis are understandable when taking into consideration that 17 participants had no prior mental health training or knowledge. This is one of the areas in which teachers felt a need to rely on trained mental health professionals, i.e., to make more in-depth assessments of problems they picked up and on the basis of this to determine necessary interventions.

The findings of the study were that generally teachers have a reasonably astute awareness of their learners' mental health and can play a significant role in the identification of learners' mental health difficulties.

As reported by Loades and Mastroyannopoulou (2010), in the current study teachers also tended to identify externalizing behavioural symptoms of MHPs more evidently than internalising symptoms. Behavioural changes such as aggressiveness, use of foul language, absenteeism, and bullying, were all recognised by teachers as indicators of potential MHPs amongst their learners. Unlike the findings by Loades and Mastroyannopoulou (2010), teachers did not report identifying certain symptoms or MHPs based on gender patterns. However, teachers did note that behavioural problems that might conventionally be associated with adolescent phase child development seemed to be present in this younger population of scholars. It is likely that teachers noted such behaviors as these were often disruptive at school, however, a sub-group of the participants appeared to appreciate that these behavioural symptoms might represent displacement of internal emotional struggles, and/or stem from difficulties in articulation or symbolisation of distress. In this respect they

displayed a fairly sophisticated understanding of possible psychic processes at work. This perspective also meant they were less judgemental and punitive towards children displaying these kinds of behaviours in some instances.

Additionally, teachers recognised that poor mental health may be evident through a decreased ability in the learner's cognitive functioning and/or emotion regulation. Cognitive difficulties were described as affecting comprehension and capacity to reason both in arithmetic and language related subjects. Teachers were less sure as to the likely causes of cognitive deficits, although a few did link deterioration in academic performance to underlying psychological distress.

Emotional difficulties were described as manifesting in response to external pressures or stressors felt by the learners. The learners that appeared to have difficulty regulating their emotions were described as perhaps being less resilient, with a weakened capacity for distress tolerance. Lack of emotional self-confidence and other awareness was reported by teachers, and some of the more emotionally laden symptomatic presentations were recognised as crying, withdrawal, or stoicism. Teachers additionally appreciated that learners were subjected to societal pressures not to show emotional vulnerability. In general, there seemed to be a tendency for those learners that show potential MHPs through behavioural difficulties to be identified more rapidly compared to those with less overt emotional distress symptoms.

Teachers acknowledged a preference for learners to be able to voice their own potential difficulties to them, perhaps with the hope of aiding in the quicker identification of difficulties. This hope seemed somewhat unrealistic given that most of those interviewed understood that it might be difficult for children to comprehend their own problems and to be proactive in help-seeking in a context where vulnerability was often ridiculed or risky. Danby and Hamilton (2016) reported similar findings, noting that teachers had an expectation or would prefer for learners to initiate and voice their difficulties themselves. Teachers also seem to prefer not having to make the decision to depart from an academic role and to take on responsibilities by inviting disclosure from children, although this varied across the

participant group, with some teachers more relaxed about taking the initiative to approach learners who might be in trouble.

Causes of Mental Health Difficulties Among Learners

Teachers spontaneously provided their understanding and reasoning regarding the causes of mental health difficulties amongst their learners. Teachers perceived MHPs to originate from environmental influences rather than innate or genetic vulnerabilities. A study conducted by Danby and Hamilton (2016) noted teachers to recognize interpersonal, psychosocial, and economic factors to have influenced the presence of potential MHPs and the findings of the current study tend to reflect similar perspectives. Teachers in this study, noted knowing their learners well as they often reside in the same community and in some instances have taught the learners' older family members - thus being in a position to know information about home and environmental circumstances. Teachers noted home contexts as possible causes for MHPs, including children having to become self-sufficient and over parentified, parents not providing expected emotional and cognitive stimulation for their children and the perceived inability for parents to set boundaries and appropriate examples for their children. Danby and Hamilton (2016) had reported teachers to express concern for the family environment difficulties as a potential contributing factor to potential MHPs amongst learners and the findings of this study resonate with these observations.

The community and social environment causal factors included poverty and deprivation. Due to socio-economic and parental difficulties, the learners' basic needs, such as secure shelter, provision of food and overall physical care, were not being met in some instances. These circumstances placed learners at risk in terms of physical and mental health, and the shame associated with impoverished living circumstances was also appreciated to be difficult for the learners to endure. Moreover, teachers noted risks of trauma exposure for learners in their community contexts that may cause or increase MHPs. The trauma exposure may be direct or indirect for the learners, with examples of sexual assault, proximity to criminals, witnessing traumatic events and display of inappropriate coping mechanisms. Teachers were found to sympathize with their learners who may

experience these kinds of events. Kratt (2018) noted teachers hope for extended support in the form of community awareness and involvement. In the case of the current research teachers appeared to view environmental problems as pervasive and endemic and to see their role as aiding children to manage in such circumstances, rather than to seek to actively change them.

Role of Teachers in the Provision of, or Referral to Mental Health Services

Teachers in this study recognised the role they play in the provision of timely help for the learner compared to the reality of the long waiting lists learners are placed on to be helped by third parties such as the SBMHS. Teachers noted that their positionality in the classrooms allowed for prompt identification of problem, and delivery of appropriate aid in some instances, before referring to mental health services. In keeping with the findings of Loades and Mastroyannopoulou (2010), teachers were able to minimise the congestion of referrals to mental health services.

Teachers reported taking on the parent/caretaker role in learners' lives, which included providing the attention, containment, financial and emotional education that may have been lacking for some learners. Ekornes (2017) reported teachers to feel responsible for their learners while at school, describing themselves as playing a 'mother-like role' for their learners. The concern for their learners appears to be significant as teachers in the Ekornes (2017) study described the loss of sleep related to concerns for their pupils and feelings of helplessness. In the current study, although teachers did not describe quite the same levels of impact upon them, it was evident that most participants felt empathy for their learners who were struggling. Three or four of the teachers (all women) made explicit reference to feeling themselves to be in mothering or parental roles in relation to the young children they were educating and to this role encompassing nurturing interactions beyond those related to academic activities.

Teachers in this study described their role as often involving containment for a learner who might portray mental health difficulties. Containment would include speaking to the learner in a sensitive manner to ease some possible anxiety, acknowledging changes in

behavior and talking through the possible impact of incidents on them. As found by Tuffin et al. (2001) teachers recognized the importance of remaining composed and professional for their learners in moments of distress. In addition to being nurturing, teachers also attempted to assist in boundary setting and the creation of safety through routine and predictability. Teachers appreciated the opportunity to help many learners with possible MHPs at once within a bigger group by, for example, providing containment in enforcing rules and discipline, or by creating a feeling of amity when dealing with traumas, that might then be processed together.

Teachers would provide containment and aid in a sensitive manner as they are aware of the stigma of mental health present amongst learners and in this instance spoke about their learners being embarrassed to display emotion or open distress in public and about needing to appear stoic or indifferent to hurts. The stigma associated with psychological struggles may contribute to a lack of comfort in learners to discuss mental health difficulties or to seek aid. In this respect the study finding regarding shame around revealing or disclosure MHPs and associated help-seeking dovetailed with those of Tuffin et al. (2001) and others. It was striking that even among the young learners spoken about in the study there was already a culture of secrecy and aversion related to exposure of MHPs.

Teachers noted multiple barriers to providing mental health aid. Barriers included time constraints and curriculum delivery expectations, which weighed heavily on them. Teachers reported insufficient time to both maintain academic standards and provide attention to the mental health of the learners. Mfidi (2018) has similarly noted the time management difficulties that are present when having to balance academics and mental health provision for learners. Concerns and difficulties in balancing the academic expectations with providing for MH aid seemed to be a pervasive issue across related research studies (Graham et al., 2011; Greer et al.,2017; Mfidi, 2018) and is clearly an area of concern that needs to be addressed if teachers are to be drawn in any further to formally taking on pupil mental health related responsibilities.

Teachers in the current research reported their lack of knowledge, training, and experience to be of significant concern and were cautious about their capability to provide mental health aid for their learners. As past researchers have found, despite receiving some general training in mental health, teachers have significant concerns regarding their lack of professional training, personal experience, and knowledge to provide mental health services (Frauenholtz et al., 2015; Frauenholtz et al., 2017; Hand & Weiss, 2005; Loades & Mastroyannopoulou, 2010; Mfidi, 2018). A sense that mental health provision was out of their scope of competence was reported by the participants. They noted the required training and experience mental health professionals had in the school based mental health services and felt they were better equipped to intervene, especially for more serious problems. The teachers reported their primary role as referring to SBMHS or any other relevant committees or organisations that would help the learners with the possible MHP. Teachers explained their willingness to aid learners as much they could in accordance with their training and experience in mental health. Despite being fearful of being inept or causing more harm, many participants explained that they are willing to be trained in MHS in order to help pupils in the classroom and to support interventions for a learner who is currently undergoing treatment at the SBMHS. Kratt (2018) noted that teachers wanted more professional MH training, suggesting it to be integrated into their qualification studies. Although participants in the current study did not mention this, a sub-group expressed their motivation to be upskilled in knowledge about child mental health issues and interventions and some found the engagement with mental health professionals stimulating in terms of learning.

Interface and Involvement with School Based Mental Health Services

Several teachers across different grade levels mentioned being a part of the SBMHS Committee at the school where they work. In the meetings participants provided feedback on existing school conditions broadly and input into what mental health topics should be covered for the upcoming terms. Further, discussion regarding possible learner referrals to external MHS also takes place within this committee. As discussed by Han and Weiss (2005), the success and sustainability of the SBMHS was dependent on the continued

support provided to and by teachers in interaction with mental health professionals. In the case of the school in point this relationship appeared to be working generally well.

Teachers raised concerns with regards to the limitations both in terms of the mode of service delivery (individual intervention) and in terms of the ratio of children with MHPs to specialised staff available to treat them at their present SBMHS. Mfidi (2018) also reported on concern about limited resources for high referrals, a problem that may be particularly significant in an under resourced context such as South Africa Once learners were being provided aid by the SBMHS, some teachers reported feeling somewhat 'in the dark' regarding learner's progress and what support they should provide in the classroom to aid treatment Frauenholtz et al. (2015) and Frauenholtz et al. (2017) reported on the importance of working as a multidisciplinary team when providing MH aid to learners. they reported teachers felt that due to a lack of involvement with SBMHS, they were not able to follow-up even though referral was appropriate based on the severity of their learners' MH difficulty. Teachers in this study were aware of the importance of boundaries and confidentiality, however, they expressed the need for increased involvement with the SBMHS treatment plan for a learner and it is possible that feedback to teachers could be amplified without compromising confidentiality.

Additionally, the geographical layout of the school meant that the SBMHS were situated on only one of the two school campuses. The teachers explained that the learners from the non-proximal campus might not feel comfortable going to the SBMHS staff as they are too far away and not familiar with the second campus, nor are they well known to staff and students there. This might make pupils feel added anxiety in an already difficult context. Proximity and familiarity thus seem important in locating supplementary services.

Lastly, teachers noted the impact of learners attending the SBMHS during class periods. The absenteeism due to the attendance at the SBMHS caused the teacher to feel increased stress for the learner to still meet their academic requirements. Again, these reports indicate the difficulty for teachers in balancing the relative importance of academic performance and attention to mental health of learners.

Overarching Evaluations of School Based Mental Health Services

Despite the above concerns and frustration noted by teachers with regards to the SBMHS, teachers recognised the positive impact the SBMHS has had, especially in their deprived and high violence community setting. Systematic reviews conducted by Barry et al. (2013) and Murphy et al. (2017) noted the implementation of SBMHS in LMIC to be effective as they were found to significantly improve learners' academic, emotional, and behavioural wellbeing among diverse cultural groups. Teachers in the study reported the SBMHS to ease their burden by aiding learners with mental health care.

Teachers in the study expressed that the SBMHS personnel had the specific training and insight to deal with MHPs, therefor they described trust in and eagerness to refer children to the SBMHS rather than dealing with MHPs in their pupils themselves. Most participants endorsed the idea that SBMHS would be useful to schools such as theirs, and especially useful in impoverished communities where children are exposed to neglect, deprivation and high rates of violence and trauma, and in which families do not have resources to provide optimal care or to afford private counselling or psychiatric services.

Overall, the teachers in the current study appeared to take learners' mental health seriously and many of them were comfortable to intervene in less formal ways to help children to recognize and manage difficult mental states and behaviors. Almost all of the participants were concerned that time constraints and lack of formal training in mental health interventions limited their capacity to address difficulties, even when they were ideally placed to observe signs of distress and struggle. The participants therefore appreciated the availability of specialized school based mental health services, retaining concerns about logistical issues such as economies of scale for professional treatment administration. The findings of this research are largely in keeping with those of previous researchers. However, it is noteworthy that similar issues and concerns presented among a group of teachers engaged in educating a younger group of children than the cohorts that have previously been studied.

Chapter 6

Conclusion, Limitations, Reflexive Considerations, and Recommendations

Conclusion

This research study aimed to explore and understand primary school teachers' understanding of MH for their learners as well as their perception of the role they play in the provision of MH aid for their learners. Throughout the research multiple themes spontaneously emerged with regards to the MH of primary school learners. The participating teachers were found to elaborate on their understandings by offering their perceptions of the causes of MHPs amongst their learners. They further offered valued observations regarding their perceptions of the SBMHS present at their school.

Teachers in this study demonstrated significant appreciation for the MH of their learners, the majority recognising the importance of their learners' mental well-being and how it had impacted their academic performance. Although teachers had difficulties providing a diagnostic definition for MH or MH disorders, they had extensive exposure to their learners which allowed them to be in a prime position to identify potential MHPs in everyday observational terms. The externalising behaviours or symptoms of potential MHPs were more easily recognised than the internalising behaviours of the learners. The portrayal of various emotional, and behavioural indicators or 'symptoms' was understood to be the expression of potential MHPs for learners in many instances.

The learners' living conditions were considered of concern and as primarily causal of potential MHPs. Teachers expressed concern regarding the role of unfulfilled parental duties (e.g., emotional education and cognitive stimulation) in contributing to learner stress and incapacity to cope with stress. Additionally, basic needs not being met was also considered a contributing factor for learners' potential MHPs. Teachers felt responsible for their learners during school attendance, several reporting feeling the need to play a 'mother-like' role for their learners. Teachers explained playing multifaceted roles such as being the learner's parent, doctor, social worker, and MH aid provider. Teachers often felt overwhelmed by the responsibility and noted significant difficulties in balancing their roles with needing to meet

pedological task demands. Additionally, teachers felt they did not possess the required MH training and knowledge to assist learners with the potential MHPs. Fears regarding their role in providing MH aid included possibly providing incorrect aid and causing increased distress for the learner. Teachers spoke openly regarding their lack of confidence and self-efficacy beliefs regarding their lack of MH knowledge and skill. Additionally, teachers spoke to a range of factors that were non-optimal to them providing MH aid, which included a lack of time and resources, and large classroom sizes.

The presence of SBMHS was appreciated by teachers. Teachers reported SBMHS members are professionally trained and have the required knowledge to effectively aid learners. The majority recognised their role as teachers to be the early identification of potential MHPS and to then refer to the SBMHS for professional aid. Teachers spoke to the improvement they had witnessed in their learners following their SBMHS attendance. Teachers felt their presence to be of significance in a LMIC school and community context. The SBMHS were reported to have lessened the responsibility and concerns of the teachers by managing their learners' potential MHPs. The SBMHS were reported to also have provided MH knowledge and training, doing so in response to some input from teachers. The sustainability of the SBMHS programme was also appreciated due to the services being found to be generalisable and cost-effective. Teachers had however expressed some concerns regarding the SBMHS, mainly regarding their capacity, as many learners appeared to require their services with too few staff. Teachers further urged an increase in communication, hoping for an interdisciplinary approach to the MH aid for their learners. Additionally, teachers were appreciative for the provision of support, training, and promotion of MH for their learners and themselves.

Overall, teachers appeared to agree to playing a role in the identification and management of potential MH aid for their learners. However, to do so they mentioned requiring professional MH training, additional time, and resources, as well as the support of a multidisciplinary team (e.g., inclusion of parents, SBMHS, and any other required professional support).

Reflexive Considerations

The positioning of myself, a young Coloured female, studying Psychology as the researcher, should also be taken into consideration for this research study. The majority of the participants were 'Coloured' women, ranging in age. The possible familiarity and relatedness experienced between the researcher and the participants should be taken into consideration. This familiarity seemed to contribute to good rapport between me and the participants. However, due to the awareness that I was engaged in Psychology studies the participants may have been somewhat less critical of mental health professionals than they might otherwise have been, although they did volunteer some useful critical observations about the SBMHS.

Limitations

Firstly, the sample size for this research study was somewhat small, consisting of 23 participants. The teachers were all drawn from one primary school in the Western Cape of South Africa. The participants were also predominantly female (21). The study was only representative of one school in one community, and therefor generalisability was not intended. Rather, the results represent one community that may face unique challenges the may contribute to the presence of MHPs. However, it is important to note that of those who could have taken part in the study, only two teachers from the school declined. The sample was thus well representative of opinions and experiences across teachers and grades within the school. The data collection site was also selected because it was located in a low income, high-violence exposed community and it is argued that the findings may have particular relevance for similar kinds of contexts.

An additional consideration for this research study was the timing of the study. The data collection had taken place before the COVID-19 pandemic and nationwide lockdown. The COVID-19 pandemic has had a significant impact on the mental and physical well-being of many, and in turn the experiences and perceptions of learners' MH and MH aid may have changed following the COVID-19 pandemic. The study was not able to assess this dimension that may well have exacerbated existing stressors for both learners and teachers.

Lastly, although efforts were made to ensure accurate representation of interview content, it is possible that some nuances of communication and expression were lost in the translation of material from Afrikaans to English.

Taking into consideration the aforementioned limitations the research study was able to provide insight of the experiences and perceptions of a set of primary school teachers, that has previously had limited research.

Recommendations

1. Teachers in this research study expressed interest and appreciation for additional mental health awareness training. Additional training in the identification and management of mental health would be helpful for teachers to aid their learners in the classrooms. Based on the findings, teachers had difficulty identifying more internalised behaviours which may be as significant as externalising behaviours in early detection of problems.
2. Teachers spoke to the support and guidance they receive from each other. A recommendation would be to create an opportunity for teachers to share their experiences, suggestions, and possible referral options. The additional support may relieve the serious responsibility felt by teachers.
3. Teachers had expressed the concern regarding the multiple roles they play for their learners and in the school. Teachers had additionally expressed frustrations regarding the expectations regarding academic demands and aiding learners' mental health. A helpful consideration is for schools to provide teachers with clarity on the expectations for teachers' role in the provision of learners' mental health aid.
4. Teachers had expressed a barrier regarding the interdisciplinary approach to learner mental health aid. The lack of communication or more so feedback, was a concern for teachers. Ongoing liaison and feedback should be present between the SBMHS and teachers to ensure the continued and effective MH aid for their learners.

5. A recommendation based on the previous point, is for the SBMHS to arrange a routine meeting or visit with teachers. This meeting could therefore be used to provide the respective teacher with the appropriate feedback and suggestions for the learner's mental health aid. As mentioned, teachers had formed a committee with the present SBMHS. However, additional individualised cooperation may be helpful.
6. As previously mentioned, this research study was only representative of one school in one community. A research recommendation is for future research to include a bigger research population, more representative of different communities and settings.

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Appendices

Appendix 1: Principal Permission Letter

100

3 APRIL 2018

Dear Principal _____,

Re: 'Perception and conceptualization of mental health and stigma amongst learners and teacher's study' to take place at your school during the third term of 2019 and first and second term 2020.

Thank you for taking the time to meet with Dr Coetzee and Caylen, regarding the Primary school learners' and Teachers' perception and conceptualization of mental health and stigma study we would like to undertake at your school, _____ Primary School during 2019-2020.

Here is a summary of the problem we aim to address:

In this study we aim to explore and understand how primary school teachers and learners understand and think about mental health and mental health issues. To unpack this a bit more, we aim to

1. Explore teachers understanding and experiences of mental health (including mental health services)
2. Explore the role teachers believe they play in children's mental health.
3. Explore teachers' beliefs regarding the need for mental health services in schools.
4. Explore teachers' ability to recognize mental health issues or symptoms thereof.

We are also interested in understanding how grade 5 to 7 learners perceive mental health and stigma. Here we aim to:

1. Explore learners' understanding of mental health, mental disorders, and stigma and to

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2. Explore learners' attitudes and beliefs towards these concepts.
3. Explore learners' of stigma and how this influences their perception of mental health

The work for this study will be broken down as follows:

1. Interview with teachers and grade 5 to 7 learners' (aged 11-14 years) during the third term of 2019 and, if not complete, during the first and second term of 2020.
2. Once-off interviews with all the teachers at the school regarding their perception of children 's mental health.
3. Once-off interviews with grade 5 to 7 learners at the school regarding their conceptualization and perception of mental healthcare

Following on from this meeting today, we will apply to Stellenbosch University Ethics Committee for ethical approval and will seek approval to conduct the study from the Western Cape Department of Education.

Please could I ask that you sign below (on this day 03/04/2019) — acknowledging this meeting took place and that you agree to this study taking place provided all the necessary approvals are granted to us.

Signature Principal _____ (school principal):

Signature Dr. Bronwyne Coetzee (supervisor): _____

Signature Caylen Abrahams (student): _____

With best wishes,

Dr Bronwyne Coetzee

Lektor I Lecturer: Sielkundel Psychology

Dept. Sielkunde/Fakulteit Lettere en Sosiale Wetenskappe I Dept. Psychology Faculty of Arts & Social Sciences I Isebe LeSayikholoji e: bronwyne@sun.ac.za I t: +27 21 808 3979 | a: RW Wilcocks gebou, Ryneveld Straat I RW

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http://www.sun.ac.za/psychology 00000

Appendix 2: Invitational Flyer

The research study aims to understand the perceptions primary school teachers have regarding their learner's mental health.

The study will focus on the perceptions you, as a teacher, have regarding your learner's mental health. This includes:

- your experiences with learner's mental health
- your ability to recognize potential mental health disorders.
- the role you believe you play in the delivery of mental health services provided in schools.

Data will be collected in the form of face-to-face interviews with the researcher. All interviews will be scheduled as per your convenience, on the [redacted] School Premise.

Your participation is your choice. You can decide to stop participating at any stage.

You will remain anonymous and confidential throughout the research process.

Researcher: Caylen Abrahams (19447698@sun.ac.za)
Supervisor: Dr Bronwyné Coetzee

Appendix 3: Socio-demographic Questionnaire

Socio-demographic Questionnaire **Participant: __**

1) Age

_____

2) Gender

- Male
- Female

3) Education Training
   - Certificate
   - Diploma
   - Degree and above
   - Specify _____

4) Years of study for abovementioned education:

_____

5) Current Employment Status?

   - Employed full time
   - Employed part time

6. Grade Teaching:

_____

7. Number of students per class:

_____

8. Teaching Experience?

   - Less than 1 year
   - 1-9 years
   - 10-19 years
   - 20-29 years
   - 30-39 years
   - 40+ years

9. Any Formal Psychology or Mental Health Training?
   - Psychology Course

- Counselling Course
- B(Psych) / Ba (Psych) degree
- Ba (Psych)Hons
- Ma (Thesis) Psychology
- Registered Psychologist
- Registered Counsellor
- None of the above
- Other_____

10. Mental Health Services available in your school?

Yes ☐

No ☐

If yes, who administers the services for the learners? _____

_____

Appendix 4: Semi-structured Interview

Research Topic: Teachers' perceptions of primary school learners' mental health
Research Question: What are teachers' perceptions of primary school children's mental health?
Interview Schedule
Opening:
Hello, I am Caylen Abrahams from Stellenbosch University. How are you doing today?
Today I would like to ask you some questions regarding your perceptions of mental health. This will include your understanding of mental health, any possible experiences regarding the mental health of your learners. As well as your stance on the provision of mental health services in schools.
This will be used in my research regarding the perceptions' teachers have of their primary school learners' mental health.
The interview will take about 30-40 minutes, are you comfortable and available to answer some questions today?
Body:

1. What does the term mental health or mental health problems mean to you?
    a) Tell me about your experiences regarding the mental health* (or term used by participant) of your learners?
    b) How often have you been exposed to children with mental health* issues?
    c) Do your learners speak to you about possible mental health* issues?
2. What do you understand by emotional problems?
    a) What emotional problems are common in your classroom?
    b) How do you typically deal with these issues?
3. What do you understand by behavioural problems?
    a) What behavioural problems are common in your classroom?
    b) How do you typically deal with these issues?
4. What do you understand by cognitive problems?
    a) What cognitive problems are common in your classroom?
    b) How do you typically deal with these issues?
5. Do you think having mental health* services (i.e., counselling services/psychological services/psychoeducational services) available in schools should be a priority? Why/why not?
6. If one of your learners portrayed possible mental health* issues, what do you believe your role is in helping that learner?
7. If not involved, what do you think will make you feel more comfortable/motivated to become more involved in learners' mental health* services?
8. How have you been involved in the mental health* services at school?
9. Whom do you believe should be dealing with learners' mental health* issues?
    a) Why do you believe that person should be in this role?
10. Do you believe having psychology or mental health training will aid you in helping a learner with a possible mental health issue?
11. Are you open to receiving such training and playing a more significant role (if not already) in the mental health* services for children?
12. What do you think could help promote mental health* in schools?

Conclusion:
1. I truly appreciate you taking this time to do this interview and answering all the questions. Is there anything else you would like to add or questions you have for me?
2. That concludes the interview; thank you again for taking part in this research.
[*In relation to the term Mental Health throughout the interview, the term the participant has identified and uses to recognise as mental health will be used throughout, to maintain understanding.]

Appendix 5: Participant Informed Consent Form

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

You are invited to take part in a study conducted by Caylen Abrahams, from the Psychology Department at Stellenbosch University. You were approached as a possible participant because you are a Primary School teacher at _____ Primary School.

1. PURPOSE OF THE STUDY

The research study aims to understand the perceptions primary school teachers have regarding their learner's mental health. This includes your experiences with your learner's mental health and your ability to recognize possible mental health disorders. We will also be focusing on what you believe your role should be in the mental health services at school.

2. WHAT WILL BE ASKED OF ME?

If you agree to take part in this study, you will be asked to participate in one, 30-40minute, face-to-face interview with the researcher. This will include a socio-demographic questionnaire, interview, and case vignettes. The socio-demographic questions pertain to the amount of years teaching and any psychological training. Secondly, an interview will take place with questions focusing on understanding your perception of learner's mental health and the role you play in the mental health services at school. Lastly, a series of case vignettes will be presented, this includes scenarios of a learner depicting a mental health disorder or not. The case vignettes are followed with follow-up questions based on each scenario.

3. POSSIBLE RISKS AND DISCOMFORTS

There are no foreseeable risks with the proposed research. The interviews will be scheduled to take place at your convenience on the _____ Primary School premises. The research study does not involve any deception. Your name and participation in this research study will always remain anonymous and confidential. You can choose to not answer any question/s from the interview and withdraw from the research study at any stage. The research study poses no health risk to you, however if you feel triggered by any of the questions, you may leave the interview immediately and speak to the counselling services at the school.

4. POSSIBLE BENEFITS TO PARTICIPANTS AND/OR TO THE SOCIETY

There are no direct benefits for your participation. However, the research topic allows for better understanding of the factors that ensure the provision of mental health services in primary schools.

5. PAYMENT FOR PARTICIPATION

You will not receive any payment for your participation in this research study.

6. PROTECTION OF YOUR INFORMATION, CONFIDENTIALITY, AND IDENTITY

Any information you share with me during this study and that could possibly identify you as a participant will be protected. This will be done with the use of an assigned Pseudonym for example "Participant 1", which will be used throughout the research process. You will not be identified throughout the research process.

The data collected from the interviews will be stored on a personal laptop that is password protected, that only I and my supervisor, Dr. Bronwynè Coetzee, have access to. If you choose to withdraw from the research study at any stage, it will entail all data collected from you to not be used in the research project and the data collected will be deleted by myself.

The data collected to complete a Masters (Thesis) in Psychology as well as an article based on the research findings. The interview will be audio-recorded, if you allow, and notes will be made during the interview process. Only myself and my supervisor will have access to the audio recordings and will not be edited by anyone. When the article regarding the research findings will be published as a M(thesis) Psychology and article, your anonymity will remain with the assigned pseudonym.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you agree to take part in this study, you may withdraw at any time without any consequence. You may also refuse to answer any questions you don't want to answer and still remain in the study.

8. RESEARCHERS' CONTACT INFORMATION

If you have any questions or concerns about this study, please feel free to contact Caylen Abrahams at 0612550199 or 19447698@sun.ac.za and/or the supervisor Dr. Bronwynè Coetzee at bronwyne@sun.ac.za.

9. RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study.

If you have questions regarding your rights as a research participant, contact Ms Maléne Fouché [mfouche@sun.ac.za; 021 808 4622] at the Division for Research Development.

DECLARATION OF CONSENT BY THE PARTICIPANT

As the participant I confirm that:

- I have read the above information and it is written in a language that I am comfortable with.
- I have had a chance to ask questions and all my questions have been answered.
- All issues related to privacy, and the confidentiality and use of the information I provide, have been explained.

By signing below, I _____ (name of participant) agree to take part in this research study, as conducted by Caylen Abrahams (name of principal investigator).

_____ _____
Signature of Participant Date

DECLARATION BY THE PRINCIPAL INVESTIGATOR

As the **principal investigator,** I hereby declare that the information contained in this document has been thoroughly explained to the participant. I also declare that the participant has been encouraged (and has been given ample time) to ask any questions. In addition, I would like to select the following option:

	The conversation with the participant was conducted in a language in which the participant is fluent.
	The conversation with the participant was conducted with the assistance of a translator (who has signed a non-disclosure agreement), and this "Consent Form" is available to the participant in a language in which the participant is fluent.

_____ _____

Signature of Principal Investigator **Date**

Appendix 6: Ethics Approval-Stellenbosch University

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

NOTICE OF APPROVAL

REC: Social, Behavioural and Education Research (SBER) - Initial Application Form

9 September 2019

Project number: 10375

Project Title: Primary School Teachers' Perceptions of Learners' Mental Health

Dear Ms Caylen Abrahams

Your response to stipulations submitted on 8 August 2019 was reviewed and approved by the REC: Humanities.

Please note the following for your approved submission:

Ethics approval period:

Protocol approval date (Humanities)	Protocol expiration date (Humanities)
5 August 2019	4 August 2020

GENERAL COMMENTS:

Please take note of the General Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

If the researcher deviates in any way from the proposal approved by the REC: Humanities, the researcher must notify the REC of these changes.

Please use your SU project number (10375) on any documents or correspondence with the REC concerning your project.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

FOR CONTINUATION OF PROJECTS AFTER REC APPROVAL PERIOD

Please note that a progress report should be submitted to the Research Ethics Committee: Humanities before the approval period has expired if a continuation of ethics approval is required. The Committee will then consider the continuation of the project for a further year (if necessary)

Included Documents:

Document Type	File Name	Date	Version
Recruitment material	Masters Invitational Flyer	01/07/2019	1

Data collection tool	Socio-Demographic Questionnaire	01/07/2019	1
Data collection tool	28.06.19-Interview Questionnaire	01/07/2019	1
Default	Reviewer Comments and Changes Table	01/07/2019	1
Default	Preliminary Principal Permission	01/07/2019	1
Default	WCED letter_supervisor	01/07/2019	1
Budget	Research Budget	01/07/2019	1
Letter of support_counselling	Risk Mitigation Letter - Caylen Abrahams	01/07/2019	1
Default	Caylen Abrahams-WCED application form	01/07/2019	1
Research Protocol/Proposal	19447698 Caylen Abrahams M(Thesis) Proposal	03/07/2019	2
Informed Consent Form	SU HUMANITIES Consent form template_Written 1 (1)	03/07/2019	2
Default	Research approval letter	08/08/2019	1
Default	Caylen_Risk Mitigation Doc	08/08/2019	1
Default	Response to REC-10375	08/08/2019	1

If you have any questions or need further help, please contact the REC office at cgraham@sun.ac.za.

Sincerely,

Clarissa Graham

REC Coordinator: Research Ethics Committee: Human Research (Humanities)

National Health Research Ethics Committee (NHREC) registration number: REC-050411-032.
The Research Ethics Committee: Humanities complies with the SA National Health Act No.61 2003 as it pertains to health research. In addition, this committee abides by the ethical norms and principles for research established by the Declaration of Helsinki (2013) and the Department of Health Guidelines for Ethical Research:
Principles Structures and Processes (2nd Ed.) 2015. Annually a number of projects may be selected randomly for an external audit.

Investigator Responsibilities

Protection of Human Research Participants

Some of the general responsibilities investigators have when conducting research involving human participants are listed below:

1.Conducting the Research. You are responsible for making sure that the research is conducted according to the REC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research. You must also ensure that the research is conducted within the standards of your field of research.

2.Participant Enrollment. You may not recruit or enroll participants prior to the REC approval date or after the expiration date of REC approval. All recruitment materials for any form of media must be approved by the REC prior to their use.

3.Informed Consent. You are responsible for obtaining and documenting effective informed consent using **only** the REC-approved consent documents/process, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least five (5) years.

4.Continuing Review. The REC must review and approve all REC-approved research proposals at intervals appropriate to the degree of risk but not less than once per year. There is **no grace period.** Prior to the date on which the REC approval of the research expires, **it is your responsibility to submit the progress report in a timely fashion to ensure a lapse in REC approval does not occur.** If REC approval of your research lapses, you must stop new participant enrollment, and contact the REC office immediately.

5.Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the REC for review using the current
Amendment Form. You **may not initiate** any amendments or changes to your research without first obtaining written REC review and approval. The **only exception** is when it is necessary to eliminate apparent immediate hazards to participants and the REC should be immediately informed of this necessity.

6.Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research related injuries, occurring at this institution or at other performance sites must be reported to Malene Fouche within **five (5) days** of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the RECs requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Research Ethics Committee Standard Operating Procedures. All reportable events should be submitted to the REC using the Serious Adverse Event Report Form.

7.Research Record Keeping. You must keep the following research related records, at a minimum, in a secure location for a minimum of five years: the REC approved research proposal and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the REC

8.Provision of Counselling or emergency support. When a dedicated counsellor or psychologist provides support to a participant without prior REC review and approval, to the extent permitted by law, such activities will not be recognised as research nor the data used in support of research. Such cases should be indicated in the progress report or final report.

9.Final reports. When you have completed (no further participant enrollment, interactions, or interventions) or stopped work on your research, you must submit a Final Report to the REC.

10.On-Site Evaluations, Inspections, or Audits. If you are notified that your research will be reviewed or audited by the sponsor or any other external agency or any internal group, you must inform the REC immediately of the impending audit/evaluation.

Appendix 7: Ethical Waiver Application

University of the Witwatersrand, Johannesburg

***Ethics WAIVER Application Form* for *Human Research Ethics Committee (HREC Non-Medical)* (SCHOOL ETHICS COMMITTEES: Revised January 2021)**

Instructions

1. This form must be completed by Honours (4th year) and Masters by Coursework and Research Report students who are applying for a WAIVERED ethics clearance. Note that waivers for staff non-degree applications, PhD and research Masters students must complete the online ethics application form.
2. Completed waiver applications must be submitted to the relevant School Ethics Committee.
3. Applications may be submitted as hard or soft (electronic) copies, but the first page of the application must contain the signatures of the student and supervisor. Final revised versions must be in soft (electronic) copy as all documentation will be archived.
4. Incomplete or handwritten applications will **NOT** be considered, including where signatures are missing.

Complete this checklist to show that you have the correct documents:

x	Completed ***Ethics Application Form***.
x	Copy of the ***Research proposal***

SIGNATURES (REQUIRED)

Declaration: We, the signatories, declare that all information on this form is correct and that we will strive to maintain the highest ethical standards in this research at all times, according to disciplinary and university expectations, recognising that ethical practice in research is always a continuing process.

I recognise that it is my responsibility to conduct my research in an ethical manner according to Guidelines of the University of the Witwatersrand, according to any laws and/or legal frameworks that may apply, and according to the norms and expectations of my discipline. In preparing this Application for Ethics Clearance form, I have consulted the ***Guidelines for Human Research Ethics Clearance Application / Non-Medical*** (available on this website https://www.wits.ac.za/research/researcher-support/research-ethics/ethics-committees/). In receiving ethics clearance, I agree to abide by the conditions of data collection as outlined in the *Guidelines* document.	es	o

By signing this form, the researcher and supervisor of this project undertake to ensure that any amendments to this project that are required by the Human Research Ethics Committee (Non-Medical) and School Ethics Committees are made before the project commences.

	Date	Name	Signature*
Student	29.04.2021	Caylen Abrahams	
Supervisor	04/05/2021	Dr Bronwyne Coetzee at US for data collection Prof Gillian Eagle at Wits for analysis and write-up (Transfer of data agreement in place)	G.Eagle

*electronic signatures are permitted

1. Summary of risk categories of this research project

1.1 Does this project involve human participants? *If YES, you need to apply for full ethics clearance through the relevant committee*

x Yes ☐ No

1.2 I have read and understood the risk categories table *Applicants must have read the table of risk level category definitions on the final page of this document. This table is also available on the University Ethics Committee webpage.*

x Yes ☐ No

1.3 The applicant must tick the box for the risk category that best applies to this project:

Risk category	Tick the appropriate box
No risk	X (analysis of previously-collected data)
Minimal risk	
Low risk	
Medium risk	
High risk	

Only No Risk studies can be considered for a wa

Studies falling in all other risk categories must c

full

ethics form and be referred to the School comm

1.4 I confirm that I understand that if my research changes to include human participants, or secondary analysis of data collected from human participants, or a different risk category other than 'no risk', it is my responsibility to immediately apply for full ethics clearance from the relevant committee

x Yes ☐ No

2. Researcher's personal data

Your family name: Abrahams	Your first name: Caylen
Title: ☐ r ☐ s ☐ Other : _____	
School:	University of the Witwatersrand
Your student number:	2259960
Your email:	2259960@students.wits.ac.za
Your tel number:	0609895584
Name of supervisor(s):	Prof Gillian Eagle
Your supervisor's Wits email:	Gillian.Eagle@wits.ac.za
Your supervisor's Wits tel number:	0117174528

3. Research project

3.1 Title of research project: South African Primary School Teachers' Perceptions of their Role in Identification, Referral and Intervention Relating to Mental Health Care for Learners

3.2 Is this research for degree purposes?

x Yes ☐ No

3.3 If YES, for what degree?

	Honours	x	Masters (research report)		Other (specify) _____

3.4 Has the proposal been **approved** by the relevant School or Faculty higher degrees committee or other unit?

	Yes		No	x	Submitted and pending

3.5 What are the **aims and objectives** of the research? (Please be specific)

1. Explore teachers' perceptions regarding their role in the identification of potential mental health problems amongst their learners.
2. Explore teachers' perceptions of their role in the delivery of mental health care in schools. Their perception of their role would include potential difficulties, opinions and beliefs regarding their capabilities, the prioritisation of time and the possible expectation they feel is placed on them when managing mental health difficulties amongst their learners.
3. Understand the teachers' perceptions of existing mental health intervention services for learners with mental health problems.

3.6 Summary or abstract of the research (100 words maximum)

Give a brief outline of the research plan such that reviewers can understand what the study is about, what data you will use, how you will collect or get access to the data, and what analyses will be used

The proposed study will conduct an exploratory qualitative approach, grounded in the Realist Perspective, exploring Primary School Teachers' perceptions regarding their role in the mental health care of their learners. The data was previously-collected by the student (principal investigator) in 2019, via individual semi-structured interviews, at one public Primary School situated in the Western Cape, with the aim to complete a Masters Dissertation at Stellenbosch University. However, the student has terminated her previous dissertation registration and is currently enrolled in an MAClinical Psychology degree. The research project is now being completed in accordance with requirements for the Main clinical Psychology degree.A data transfer agreement has been entered into Stellenbosch University and the University of the Witwatersrand to use the data for this proposed research. Thematic Analysis will be used for the data analysis.

3.7 Will this study reuse data that have been previously collected by other researchers?

	Yes		x	Not by other researchers but has been previously been collected.

If **YES**, do you have written permission to reuse the data?
If you don't, you must obtain this permission from the principal investigator

	X	Yes		No

3.8 Is this application for a multi-student project (i.e. several students working on exactly the same topic under the same supervisor)?

	Yes		x	No

If **YES**, list the names and student numbers of additional students working on this project: N/A

Appendix 8: Data Transfer Agreement

DATA TRANSFER AGREEMENT

("Agreement")

Bet

STELLENBOSCH ("Pr")

Physical	R.W. Wilcocks Building 2037, Victoria Street, Stellenbosch, South
Postal	Private Bag X1, Matieland, Stellenbosch, 7602, South Afric
Telefax	+27 (0)21 808
Telephone	+27 (0)21 808
Contact Co r m	Legal Advisor: Mrs Shehaam shehaam@sun.
Contact Project and related Email	Dr B bronwyne@sun.
Sig who warrants that s/he is duly authorised to sign	Anthony Leysens (Apr 26, 2021 12:08 GMT+2
	Prof A
P	Dean-Faculty of
	Apr 26,

and

THE UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG,
acting through its Faculty of Humanities, School of Human Community Development
("Recipient")

Physical Address	1 Jan Smuts Avenue, Braamfontein, Johannesburg, Research Development Office, 10th Floor, Solomon Mahlangu House, Republic of South Africa
Postal Address	10th Floor, Solomon Mahlangu House, Private Bag 3, Wits 2050 Republic of South Africa
Telefax Number	N/A
Telephone Number	+27 (0)11 717 1152
Contact Person	General Correspondence: Prof. Gillian Eagle
Email Address	General Correspondence: Gillian.Eagle@wits.ac.za
Legal Notices	Office of the Director: Legal Services 5th Floor, Senate House 1 Jan Smuts Avenue Braamfontein Johannesburg
Signature who warrants that s/he is duly authorised to sign	Lynn Morris Lynn Morris (Apr 22, 2021 08:17 GMT+2)

Name	Prof. Lynn Morris	
Position	Deputy Vice-Chancellor: Research and Innovation	
Date	Apr 22, 2021	
Research Project title: **Primary school teachers perceptions of learners' mental health**		Contract number: S007149
Research Period: 4th February 2019 - 31st March 2022		SU Ethical Clearance number: Project: 10375

Data type:
Human tissue or blood samples [ ]; Cell components [ ]; Plants or organisms [ ]; Animals [ ];
Genetically Modified Organisms [ ] Transcriptions of interview data (elaborated further below)

Preamble

Whereas the RECIPIENT and the PROVIDER are working in collaboration on the project known as "Primary School Teachers Perceptions of L***earners'*** Mental Health" ("the Research Project");

Whereas, this Agreement will govern the transfer of the Data from the PROVIDER to the RECIPIENT in furtherance of the Research Project.

Now therefore, upon execution of this Agreement, the PROVIDER and the RECIPIENT agree to the following:

1. The Agreement applies to the transfer of the Data or portions thereof (collectively, the "DATA", clause 20) for purposes of the Research Project (clause 21). The DATA is being made available by Dr Bronwyne Coetzee ("Investigator") and resulted from research conducted by Investigator as an employee of the PROVIDER. the Data will be made available to the RECIPIENT.

2. The DATA provided by the PROVIDER will be de-identified. The RECIPIENT will not be provided with any information that could be used to identify the participants from whom the DATA was collected,
although the PROVIDER may retain a confidential link to the participant's identity. Neither the RECIPIENT, nor the RECIPENTS other employees or scientists shall make any attempts to determine the identity of those participants, or to contact the participants.

3. The RECIPIENT agrees that the DATA is to be used solely for teaching and academic research purposes as outlined herein; will not be used in human subjects, in clinical trials, or for diagnostic purposes involving human subjects or for any profit-making or commercial purposes without the explicit written consent of the PROVIDER which consent will not be unreasonably be withheld. and is to be used only at the RECIPIENT facility/laboratory and for the furtherance of the Research Project.

4. Neither the RECIPIENT nor any other person authorized to use the DATA under the Agreement shall make available the DATA or any portion of the DATA to any person or entity other than research
personnel under the Recipients Scientist's immediate and direct control. No person authorized to use

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the DATA shall be allowed to take or send the DATA to any location other than the facility or laboratory address without the PROVIDERS's prior written consent which consent will not be unreasonable be withheld.

5. The RECIPIENT agrees to use the DATA in an appropriate manner and in compliance with all applicable laws and regulations and internationally accepted scientific best practice not necessarily embedded in legislation.

6. The PROVIDER warrants that it has obtained Institutional Review Board / Research Ethics Committee approval required for the transfer and use of this DATA in the Research Project.

7. Legal title to the DATA shall remain with the PROVIDER and nothing in the Agreement grants the RECIPIENT any rights under any patents nor any rights to use the DATA or any product(s) or process(es) derived from or with the DATA for profit-making or commercial purposes. Except as otherwise provided in paragraph 9 of this Agreement, the RECIPIENT shall maintain the confidentiality of the PROVIDERS's proprietary information relating to the DATA. The RECIPIENT will hold the DATA in custody solely for the purposes of the Research Project as set forth in this Agreement.

8. The RECIPIENT acknowledges that the DATA is or may be the subject of a patent application. Except as provided in this Agreement, no express or implied licenses or other rights are provided to the RECIPIENT under any patents, patent applications, trade secrets or other proprietary rights of PROVIDER, including any altered forms of the DATA made by the RECIPIENT.

9. The transfer of the DATA constitutes a non-exclusive license to use the DATA solely for teaching and academic research purposes. As required in terms of clause 3 above, the RECIPIENT agrees to negotiate in good faith a license with the PROVIDER prior to making any profit-making or commercial use of the DATA or any product(s) or process(es) derived from or incorporating the DATA. The PROVIDER shall have no obligation to grant such a license to the RECIPIENT and may grant exclusive or non-exclusive licenses to others who may be investigating uses of the DATA.

10. If the RECIPIENT wishes to publish results of the Research Project. The RECIPIENT will furnish the PROVIDER with a copy of any such manuscript or abstract at least thirty (30) calendar days prior to submitting such publication to the scientific journal or to examiners, to give the PROVIDER the opportunity to contribute to the manuscript as co-author and to give the PROVIDER the opportunity of requesting the removal of any proprietary confidential information pertaining to the DATA . The RECIPIENT must comply with the PROVIDERS removal requirement to the reasonable satisfaction of the PROVIDER prior to submitting such publication.

11. The RECIPIENT shall acknowledge the PROVIDER as the source of the DATA, and co-author in any publication of the Research Project results.

12. Except as explicitly elsewhere stated in this Agreement, the DATA is provided without warranty of merchantability or fitness for a particular purpose or any other warranty, express or implied. The PROVIDER makes no representation or warranty that the use of the DATA will not infringe any patent or other proprietary right.

13. In no event shall the PROVIDER be liable for any use by the RECIPIENT of the DATA or for any loss, claim, damage, or liability, of any kind or nature that may arise from or in connection with this Agreement or the use of the DATA. The RECIPIENT hereby agrees to defend, indemnify, and hold harmless the

PROVIDER and the PROVIDER's officers, agents, and employees from any liability, claim, loss or damage, costs, or judgments of whatsoever kind or nature arising out of the use or disposition of the DATA by the RECIPIENT.

14. The RECIPIENT will use the DATA in compliance with all applicable laws, governmental regulations, and guidelines, including without limitation any regulations or guidelines pertaining to research that may be applicable to the DATA.

15. The DATA is provided without a fee to cover the preparation and distribution of the DATA requested by the RECIPIENT and the transfer of the DATA shall not be considered a sale of the DATA to the RECIPIENT.

16. Confidentiality Obligations: Unless the PROVIDER specifically authorizes in writing, the RECIPEINT must:

(a) not use the PROVIDER's Information and the DATA, except for the Research Project;

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(b) not analyze the PROVIDER 's DATA to determine the composition of DATA other than for the Purpose;

(c) not measure the properties of 's DATA, except as reasonably necessary to the PROVIDER accomplish the Research Project;

(d) not make PROVIDER 's Information or the DATA in independent form available to others (including patent offices);

(e) limit access to the PROVIDER 's Information and the DATA to persons requiring that access to achieve the Research Project, provided those persons are subject to obligations no less restrictive than this Agreement;

(f) deliver to the PROVIDER or destroy any unused PROVIDER 's DATA and all of the 's copies of the PROVIDER 's Information, when requested by the PROVIDER; and

(g) not file any patent, utility model or design application disclosing any of the 's Confidential PROVIDER Information.

(h) The RECIPIENT will report to the PROVIDER any loss or unauthorized release of the DATA in breach of this Agreement within twenty four (24) hours of becoming aware of the loss or unauthorized release.

(i) Any loss or unauthorized release of the DATA will be investigated by all Parties to this Agreement.

(j) Commercial use of the DATA or the generated array is strictly prohibited.

16.1. Confidentiality Period: The obligations of clause 16 are binding for a period of 10 (ten) years.

16.2. Exclusions: The obligations of Paragraph 2 do not apply to any portion of the PROVIDER's Information that the Recipient can prove:

(a) was available to the public through no fault of the Recipient,

(b) the Recipient already possessed prior to receipt from the PROVIDER, (c) the Recipient acquired from a third party without obligation of confidence, or (d) was independently developed by or for the Recipient.

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17. Moreover, the Recipient may comply with a court order compelling production of the PROVIDER 's Information, but the Recipient must give the PROVIDER reasonable prior notice and use reasonable efforts to obtain confidential protection for that Information. Detailed information is not excluded from the obligations of Paragraph 2 merely because that detailed information is embraced by more general information excluded under (a), (b), (c) or (d). Information concerning combinations of items is not excluded unless the combination itself and its principles of operation fall within (a), and (b).

18. This Agreement will terminate on completion of the Research Period or as long as the RECIPIENT has possession of the DATA if longer. Upon the effective date of termination, the RECIPIENT will discontinue their use of the DATA and will, upon direction of the PROVIDER, return or destroy the DATA; except the RECIPIENT shall not be required to destroy any DATA which has been created pursuant to automatic archiving and back-up procedures and cannot be reasonably deleted.

General

19.1 This Agreement shall come into full force and effect on the date on which it is signed by both Parties and shall remain in full force and effect for the duration of the Research Period, or as long as the Recipient has possession of the DATA if longer.

19.2 Either Party may terminate this Agreement forthwith by thirty (30) calendar days prior notice of termination in writing:

19.2.1 upon termination of this Agreement, the RECIPIENT'S rights to use the DATA will cease and the RECIPIENT will discontinue all use of the DATA; and

19.2.2 all other terms and conditions hereunder will continue unaffected. For the avoidance of doubt, surviving any termination or expiration of this Agreement (unless provided otherwise by the PROVIDER), is the agreement by the RECIPIENT that the RECIPIENT shall not use the DATA for profit-making or commercial purposes.

19.3 Neither Party shall assign or transfer any interest in this Agreement without prior written approval of the other Party, which approval will not be unreasonably be withheld.

19.4 No amendment, consent or waiver of terms and conditions of this Agreement shall bind either Party unless in writing and signed by both Parties. Any such amendment, consent, or waiver shall be effective only in the specific instance and for the specific purpose given.

19.5 This Agreement embodies the entire agreement between the Parties hereto and no provision of this Agreement may be changed except by the written and signed consent of the Parties hereto.

19.6 This Agreement shall be governed by South African Law and the South African Courts shall have exclusive jurisdiction to deal with any dispute which may arise out of or in connection with this Agreement.

The DATA

This Agreement concerns the following DATA to be provided to the Recipient:

Description of Data

The data in question are two fold: namely, (1) the audio recordings (.mp3/mp4 files) of the interviews conducted between the student Caylen Abrahams and twenty three (23) primary school teachers (i.e. 23 x .mp3/.mp4 audio recordings); and the twenty three (23) word documents/transcripts (.doc/ .docx) of the transcription of these audio data collected as part of her MA thesis in Psychology at Stellenbosch University under the supervision of Dr Coetzee. The data also include twenty three (23) documents of completed demographic data collected from the teachers – variables collected were age, gender, teaching educational status, year of study, number of years teaching experience, formal training in mental health, current grade teaching, number of students in class, whether mental heath services are available at the school. The data also include twenty three (23) consent forms of participants.

The Research Project

The manner in which and the extent to which the DATA may be used by the Recipient are as follows:

The Recipient can use the demographic data and transcriptions of the twenty three (23) interviews to analyse and write up as part of the research report (RR) that needs to be completed by Ms Caylen Abrahams in order to obtain her Masters of Arts in Clinical Psychology Degree from the University of the Witwatersrand, Johannesburg. These data, once analysed, may also be included in a research paper submitted for journal publication in a peer reviewed and accredited journal.

~ END ~

LM
LM

26042021 Partially Executed Agreement Wits &
SU Gillian Eagle S007149

Final Audit Report 2021-04-26

Created:	2021-04-26
By:	Aslam Arnolds (aslam@sun.ac.za)
Status:	Signed
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Appendix 9: Ethics Approval- The University of the Witwatersrand

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE: **PROTOCOL NUMBER: MCLIN/21/01W**

PROJECT TITLE:	Primary School Teachers' Perceptions of their Role in Identification, Referral and Intervention Relating to Mental Health Care for Learners
INVESTIGATOR	Abrahams Caylen (2259960)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	11 June 2021
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	No Risk
EXPIRY DATE	31 December 2023

ISSUE DATE OF CERTIFICATE 21 June 2021 CHAIRPERSON ____ G.Eagle

_____

(Prof. Gillian Eagle)

Cc: Prof. Gillian Eagle (Supervisor)

_____

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

_____ _____/_____/_____01 07 2021

Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES