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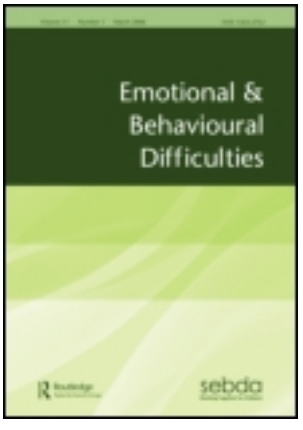

Emotional and Behavioural Difficulties
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rebd20

Teacher training intervention for early identification of common child mental health problems in Pakistan

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Published online: 25 Aug 2013.

To cite this article: S. A. Hussein & P. Vostanis (2013) Teacher training intervention for early identification of common child mental health problems in Pakistan, Emotional and Behavioural Difficulties, 18:3, 284-296, DOI: 10.1080/13632752.2013.819254

To link to this article: http://dx.doi.org/10.1080/13632752.2013.819254

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Emotional and Behavioural Difficulties, 2013
Vol. 18, No. 3, 284–296, http://dx.doi.org/10.1080/13632752.2013.819254

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Teacher training intervention for early identification of common child mental health problems in Pakistan

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School-based interventions involving teacher training programmes have been shown to benefit teachers' ability to identify and manage child mental health problems in developed countries. However, very few studies have been conducted in low-income countries with limited specialist services. The aim of the study was to evaluate the impact of the training programme on teachers' knowledge and awareness. A total of 114 primary school teachers from five schools in Karachi participated in a two-day (10–12 hours) workshop to provide them with an understanding of common child mental health problems and train them in basic skills. Their pre- and post-training knowledge was evaluated through a rating scale and open-ended questions. Single tailed *t*-test, involving paired differences, was applied for participants' scores. Pre-/post-training differences were statistically significant. The training sessions were associated with an improvement in teachers' knowledge and awareness of various signs and symptoms of common child mental health problems. The greatest improvement was noted in response to strategies of managing difficult behaviours, as 61% of respondents were able to formulate appropriate behavioural management techniques after the training. In low-income developing countries like Pakistan, teachers should be trained in early-intervention programmes for the identification and school-based management of less complex emotional and behavioural problems. Such interventions can maximise the use of sparse mental health resources.

Keywords: child mental health; school; teachers; training; Pakistan

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Introduction

While schools are primarily concerned with education, mental health is essential to learning as well as to social and emotional development. Schools are, therefore, well placed to identify mental health problems, manage those of lesser severity early and liaise with appropriate services. School teachers have extended contact with children on a daily basis and are often in a position to recognize early signs that pose a risk for a child's academic, social, emotional or behavioural functioning (Feeney-Kettler et al. 2010; Loades and Mastroyannopoulou 2010). This has important implications for teacher training, particularly as previous studies have demonstrated that educational interventions can improve the accuracy of both teacher and GP identification of children with mental health problems (Dwyer, Nicholson, and Battistutta 2006). Similar findings have been established for teacher recognition of attention deficit hyperactivity disorder and classroom-based management techniques (Moldavsky et al. 2013; Sayal 2006). These findings are particularly

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relevant to low-income countries with limited mental health resources, and where schools and teachers can adopt a more prominent preventive role (Atkinson and Hornby 2002; Mubbashar and Saeed 2001). In a study in Pakistan, qualified teachers who attended a brief course on child mental health were more able to identify children with behavioural difficulties, and to manage such difficulties in the classroom environment (Syed and Hussein 2009). Other studies have reported that, with adequate knowledge and support, teachers are able to provide 'front-line' detection and referral to mental health services (Gott 2003). The effectiveness of such training programmes indicates that it is possible to conduct school-based interventions by using available resources.

Epidemiological research in Pakistan has established a high prevalence of child mental health problems. Approximately 17% of mainstream primary school children aged 5–11 in Karachi, were found to have a diagnosable psychiatric disorder, while additional youngsters experienced social and emotional difficulties that did not meet symptom criteria but that caused considerable distress and impairment in their daily functioning (Hussein, Bankart, and Vostanis 2013). Unfortunately, there is a significant gap between children in need of treatment and those who actually receive mental health input. Failures in early identification and appropriate treatment for children remains a major public health concern (Syed, Hussein, and Yousafzai 2007). No school-based training programmes for child mental health issues have been previously reported for this country. Thus, the aims of this study were to develop and evaluate a school-based teacher training programme on the early identification of common child mental health problems and to evaluate whether teachers' knowledge and awareness improved.

Methods

A mixed-methods design was used that combined pre- and post-training rating scales, as well as qualitative analysis of open-ended questions.

Setting and sample

This study was carried out at five schools in various areas of Karachi. The Educational Authority was informed about the study and written consent was obtained from the school principals and participants. The schools were further asked to identify 30 teachers (preferably class teacher) from Grades 1 to 5. This range was selected as it represents the age for compulsory schooling in Pakistan according to the 'Compulsory Primary Education Ordinance (Government of Pakistan 2002), therefore it ensured a representative and homogenous sample of school children.

A 12-hour training programme on child mental health problems was developed for primary school teachers (Grade 1–5, pupils aged 5–11 years). This consisted of six sessions of about two hours each. The sessions were delivered by a Child and Adolescent Psychologist, who also had research and educational experience. She used an interactive approach and a combination of video clips, handouts and supporting materials. The intervention was tailored for the Pakistani school context based on similar school-based training and included the following components (Henningham et al. 2012; Webster-Stratton, Gaspar, and Seabra-Santos 2012):

(1) an understanding of child development and learning age-appropriate behaviours, including a description of common child mental health problems, how these present at school and the risk and protective factors for their onset and maintenance,

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(2) emphasis being placed on building positive relationships with children and parents, which was the foundation of the training programme, and being proactive in managing children's behaviours,
(3) additional roleplay, practical activities and small-group exercises designed based on the experiences and concerns of Pakistani teachers,
(4) supplementary case vignettes showing Pakistani classrooms,
(5) handouts being revised to include examples relevant to the Pakistani context.

Measures

A questionnaire was designed to assess teachers' knowledge of various aspects of mental health. Teachers' knowledge and recognition of child mental health problems was measured by rating scales. The questionnaire consisted of two sections. The first section covered demographic details (age, gender, teaching experience, qualifications and previous training). The second section consisted of items related to presentation and symptoms of child mental health problems. The questionnaires were administered before and after the workshop. The pre- and the post-training questionnaires comprised of the same questions to evaluate the knowledge imparted by the intervention. Both had 20 questions in total, with three possible responses, 'Yes', 'No' and 'Do not know'. Questions 1–13 consisted of various case situations requesting participants to identify the most appropriate ways of managing difficult behaviours in different settings. Questions 14 to 20 related to the presentation, causes and prevalence of child mental health problems. Each question was scored as 1 for one correct answer and 0 for a wrong answer or 'Do not know', with a highest possible attainable score of 20.

An open-ended question asked participants to provide further information on their experience of the training.

The questionnaire was developed in English and back-translated into Urdu. A total of 140 teachers completed the questionnaire pre-training and 114 completed it post-training. Both pre- and post-training data were available for those 114 teachers (see Appendix for sample questionnaire).

Analysis

Quantitative data

Data were entered in the SPSS version 14. Descriptive statistics were applied for background variables and means were calculated along with frequencies of correct and incorrect responses before and after the training. *t*-test on paired differences was applied between pre- and post-training scores.

Qualitative data

Qualitative data were analysed using thematic methods (Joffe and Yardley 2004). Thematic analysis is a flexible, descriptive method that allows the emergence of a narrative to formulate the important features relevant to the research question (Braun and Clarke 2006). The analysis as such forms a framework for recommendations and suggestions and provides a platform for building future research.

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Results

Demographic profile

Complete pre and post analysis data were available for $n = 114$ teachers. All participants were female. Of those, one third were aged 21–25 years (35%) and only 5% were above the age of 40 years. One third (36.1%) of the participants had a Bachelor's degree and only 6.7% had a higher professional degree. Among the sample, 38.5% had an average of 5–10 years teaching experience, 23.1% had 1–2 years of experience and 21.5% had less than one year of teaching experience. The majority of the participants (53.6%) had previous training experience mainly related to teaching and subject-based learning, but none had previously attended any training related to child psychology or behaviour management.

Pre-/post-training comparison

The total mean scores for pre-training was 12.00 (SD + 2.54) and for post-training 13.00 (SD + 2.56), respectively. Changes of specific responses were determined by calculating percentages. A total of 27.1% of participants with correct responses in the pre-training forms also answered correctly post-training; 25% of the participants' responses that were incorrect in the pre-training evaluation remained incorrect in the post-test evaluation. However, 8.33% of the participants who had answered correctly pre-training gave incorrect responses post-training.

The greatest improvement was noted in response to different strategies of managing difficult behaviours, as 61% of respondents were able to recognize appropriate behavioural management techniques in post- compared to pre-training. The least improvement was reported in relation to causes of mental health problems, as only 2.7% of respondents answered correctly post-test, compared to pre-test. In all, 4.16% of respondents were able to give correct responses on the identification of mental health problems and 8.3% on their presentation.

When single tailed *t*-test involving paired differences was applied the differences in the pre- and post-training scores were statistically significant ($t = 8.02$, $p = 0.001$). The effect size for this analysis was ($d = 0.43$) (Table 1).

Qualitative analysis

Open-ended feedback forms revealed several key features regarding the perceived usefulness of the training intervention. Four themes emerged: (1) positive features and shortcomings, (2) appraisal of the handbook, (3) perceived impact of training and (4) suggested improvements.

Table 1. *T*-test on differences between pre- and post-training scores.

Intervention		Mean	SD	SE
Pre-training		12.00	2.54	0.22
Post-training		13.00	2.56	0.24
t	Df	SE	95% CI	*P* value
8.02	113	0.0095	0.95–0.57	0.0001

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Table 2. Outline for training intervention with teachers.

Session 1 Introduction	Session 2 Child growth and development	Session 3 Factors effecting child mental health
• Discussion on mental health and social taboos • Group discussions on common childhood problems	• Stages of healthy child development ➢ Physical ➢ Social ➢ Emotional ➢ Intellectual ➢ Moral	• Risk and resilience factors for common mental health problems • Cause of mental health difficulties in children ➢ Role of school, family, media an society
Session 4 **Rates and types of child mental health disorders**	**Session 5** **Behaviour management I**	**Session 6** **Managing inappropriate behaviour**
• When does a problem become a disorders • Child mental health disorders in Pakistan ➢ Anxiety (emotional disorders) ➢ Mood disorders ➢ Behaviour contracts	• Classroom management of behavioural problems ➢ Setting rules and consequences ➢ Praise and rewards ➢ Handling inappropriate behaviour	• Specific behaviour management strategies for disruptive child ➢ Catch me being good ➢ Star charts ➢ Behaviour disorders ➢ Token economy ➢ Time-out

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Theme 1: positive comments and proposed shortcomings

While respondents found the training '*very interesting*' and '*useful*', the most prominent positive feature was increase in knowledge about the presentation of different behavioural and emotional problems. On the whole, professionals were highly appreciative and receptive to being trained in child mental health issues:

I am a trained teacher, but even during our training we have never previously discussed about Child Psychology, and in particular about the common problems children face. As a teacher I have come across several pupils with behavioural and emotional difficulties and have tried my best to help them, but this training has taught me some very useful skills and techniques on how best to identify and manage children with difficulties. (Teacher, Grade 3)

Theme 2: appraisal of the handbook and training resources

Analysis revealed predominantly positive perceptions of the Child's Emotional Well-being Handbook, with some respondents describing it as being '*brilliant*', '*excellent*' and '*really good*'. Participants reported that they found its content informative and a useful reference, particularly for less experienced staff:

> I really like the handbook; I mean, it adds to what we learnt during the training. It is clearly laid out, with a lot of classroom-based examples, as well management strategies. The self-evaluation tools and quizzes at the end are also useful to help us keep check on our learning and performance. (Montessori Teacher)

Theme 3: perceived impact of training

Participants reported that the training had an impact on their knowledge, their teaching practice and on the need to work jointly with parents and other mental health professionals in order to work collectively to meet children's needs. All participants reported that they would recommend the programme to others:

> The best part of the training was the focus on the need for collaborative practice, working jointly with parents, school and other professionals, with the aim of helping the child. This is the best example of a holistic approach towards child development. I would definitely recommend this training to all teachers. (Class Teacher, Grade 5)

Theme 4: suggested improvements

An important theme that emerged from this evaluation was on ways of improving the training programme through the inclusion of school heads and policy makers:

> The training touched upon some of the most useful aspects of dealing with children. The strategies and techniques shared during the training will help to deal effectively with children, however, many of the recommended management strategies can only work with the consent of school Heads. Future training should emphasise the attendance of school management authorities and decision makers to ensure definite and consistent change within the school system. (Primary Class Co-ordinator)

A commonly expressed view was that the training could be adapted to suit the needs of different professionals, that is, pitching it to their experience, grade level of the pupils, as well as the school location. Although the training programme should ultimately apply to all children, the materials focused specifically on children aged $2\frac{1}{2}$–8 years. Participants suggested that these should be widened to secondary school pupils and even younger children attending nursery or play-school. The need for parental training sessions was also emphasized:

> The training focused on very essential aspects of understanding and managing children with difficulties. It is essential that future training focuses on the needs of adolescents and younger children. Training can be designed separately for teachers, depending on their own professional background and experience. Schools in under-privileged areas have greater needs and challenges, which can be addressed through a separate programme. The need to involve parents is also essential. (Class Teacher, Grade 5)

Discussion

The training sessions were associated with an improvement in teachers' knowledge and awareness of various signs and symptoms of common child mental health problems. The findings of the study have particular relevance to developing countries like Pakistan. The most recent estimate of the Pakistani population is nearly 160 million, with half below the age of 18 years. The total number of psychiatrists in the country is about 300, out of whom only 2–4 have training in child and adolescent psychiatry, almost always obtained in a developed nation (Mian 2013).

At present in Pakistan there are very few services to meet the needs of the vast majority of these children. Previous studies have highlighted the urgent requirement for research

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evidence that will help to identify priority areas for child mental health policy and services. One of these priorities is clearly to enhance the skills of primary health care workers and other front line professionals, including teachers (Rahman et al. 2000). Studies from developed countries have shown that school teachers can be successfully trained for mental health service promotion (Perfect and Morris 2011; Webster-Stratton, Gaspar, and Seabra-Santos 2012). This is the first study of its kind in Pakistan where school teachers attended a brief training programme on awareness and management of children with mental health difficulties.

The majority of primary school teachers reported overall improvement in general mental health awareness after the training workshop. However, some concepts suggested less change, as knowledge alone could not alter their practical perceptions. Many participants held the belief that people with mental illness are morally weak and a curse for the family, or that they can never fulfil their responsibilities. Although at post-workshop there was some change in these perceptions, anti-stigma campaigns are crucial for teachers as well as for the general public.

The majority of teachers had an understanding of the various aetiological factors of child mental health problems, with improvement in their knowledge after the workshop. However, a substantial proportion continued to answer incorrectly. This also has important implications, as within the community, children or adults suffering from mental health problems are often advised to 'be strong' or use their willpower to contain their mental ill health. Understanding the biological basis of severe mental illness remains limited, as a substantial number of teachers stated that not being close to religious practices can predispose to developing a mental illness.

Overall, teachers provided positive feedback on the training, and requested that future sessions incorporate more time and practice activities related to classroom strategies and behavioural management techniques. They reported that the implementation of behavioural plans and management strategies were the most important topics. Future interventions could also include approaches to help manage teachers' stress and frustration resulting from children with behavioural difficulties in the classroom (Gale and Vostanis 2003). Potential benefits would be that referrals are appropriate and timely, the potential for misdiagnosis is reduced and the quality of care for diagnosed children is improved (Perfect and Morris 2011).

This study also had a number of limitations. The methodological components such as the baseline recognition exercise, the educational sessions and the post-training measure constituted a complex project. As there was no control group, changes in knowledge could not be attributed to the intervention or might differentially reflect each of these components. In terms of measures, the study used questionnaires rather than interviews. The questionnaire was based on a rating scale. Additional use of interview data can provide more in-depth understanding of teachers' knowledge and attitudes in the future. The questionnaire was designed specifically for this study and was not standardized. Questions remain about whether improvement in knowledge can be maintained over time and whether such endeavours improve long-term outcomes. Future studies should include a follow-up stage to monitor and evaluate the impact of the training through the school academic year.

Recommendations and implications

Despite these limitations, this study concludes that training teachers can increase their knowledge of common child mental health problems. Further follow-up studies are needed to determine teachers' ability to recognize or manage children with difficulties in classroom settings. Future evaluation should preferably adopt a randomized controlled trial design.

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With a longer period of follow-up and anticipated referral to specialist services, children's symptomatic improvement and the cost-effectiveness of such an intervention can also be investigated (Sayal 2006). As each teacher will get to know several hundred pupils over the years, educational approaches may be more cost-effective than those targeting health care professionals such as GPs (Ford, Goodman, and Meltzer 2004; Sayal, Taylor, and Beecham 2003).

A sound research methodology would produce outcomes that are of international relevance and in keeping with recommendations that school-based mental health promotion and training programmes could facilitate the early and accurate identification and school-based management of children with mental health problems (Committee on School Health 2004; Walter, Gouze, and Lim 2006). Previous studies suggested that school-based mental health interventions are particularly recommended in low-income, developing countries like Pakistan, where mental health problems are highly stigmatized. Positive mental health training interventions focusing on early identification can thus reduce social and service barriers (Dogra et al. 2005; Rahman et al. 2000).

Earlier studies evaluating the effect of a school mental health programme in Pakistan, reported that knowledge, attitudes and superstitions significantly improved in a group of school children, their friends and neighbours after the implementation of the programme (Rahman, Mubbashar, and Gater 1998; Tareen et al. 2009). The effectiveness of this intervention indicates that it is possible to conduct school-based interventions using available limited resources. Since the extent of child mental health problems in Pakistan far exceeds the available resources, it is essential that teachers receive ongoing support to ensure that schools and educational authorities meet children's mental health needs. Replication of the current study (with an improved methodology), and extending it to include questions concerning the process by which teachers make decisions about whether or not a child has a problem, would provide further insight into this under-researched area.

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Acknowledgements

The study was conducted by the Child Development Programme team under the Hussaini Foundation Pakistan. We graciously render our deepest gratitude to the schools and teachers that were part of study, for their extreme co-operation. Our special thanks to Ms Aliya Sibtain, Ms Baneen Ali Raza, Ms Fatima Hassan and Ms Sukaina Raza, who facilitated with training workshops.

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Appendix
Child Management Questionnaire- Teacher Version (CMQ-T)

Section A- Demographics

(1) Name. . .. .
(2) Gender: male ☐ female ☐
(3) Professional background. . .. .
(4) Length of time since qualification. . .. .
(5) Length of time working at the current school. . .. .
(6) Have you ever undertaken any training in relation to children's educational needs? yes ☐ no ☐

Read each of classroom situations below and highlight the answer you feel is most appropriate. (Only one response per item is correct).

(1) ***When a child's behavior threatens to disrupt a class discussion, what is the first action for the teacher to take?***
   (a) deal promptly with the student on a one-to-one basis after having the rest of the class proceed to another task.
   (b) remind the classroom rules and issue a verbal warning
   (c) send the student to the principal's office
   (d) stop the discussion, verbally reprimand the student, then continue the discussion.

(2) ***A child in your class is extremely over-active, unfocused and impulsive. This student's behavior is causing a significant distraction in your class. Which of these actions is inappropriate?***
   (a) after class, quietly notify the school principal that you suspect the child has behaviour problem.
   (b) isolate the student from the rest of the group by sending them out of the class so that s/he will not interfere with the rest of the classes learning.
   (c) phone the student's parents the following day to discuss the problems you are experiencing and ask them for help or suggestions.
   (d) Make the child wear the black punishment cap and stand outside the classroom.

(3) ***A pupil in your class seems to goes through each day feeling uneasy and tense. She constantly worries about her work, her friends and family. Her behaviour fits the category of:***
   (a) a child with learning problems
   (b) an anxious child
   (c) a depressed child
   (d) an autistic child

(4) ***A bright girl in your class suddenly shows change in her behaviour, she is not completing her work and shows no interest in activities she previously enjoyed. When you talk to her she tells you that she is worried because her mum and dad are always fighting. What should be your response?***
   (a) it is a family problem so teachers should not interfere.
   (b) you discuss the issue with the school principal without letting her parents know.
   (c) you call her parents to discuss the impact of their behaviour on her.
   (d) it is a normal response to the situation and will get better itself.

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(5) ***A 10 year old girl in your class has lost her mother six months back after a painful battle with Cancer. The girl is now back at school but seems to be withdrawn and quite all of the time. She is doing her class work but does not wish to interact with others. What should be your response?***
- (a) try and explain to her that her mother's death was the will of Allah and that she should accept and move on.
- (b) it is a family problem so teachers should not interfere.
- (c) you call her father/guardian to discuss how to help the girl & family cope.
- (d) it is a normal response to the situation, so it will get better itself.

(6) ***A teacher observes two children arguing in the school playground, one of them hits the other and uses swear words and abusive language. What should be the appropriate response?***
- (a) Ignore the behaviour, they are just kids.
- (b) Take no action as they are not students of her class.
- (c) Inform the parents in the half-term meeting.
- (d) Remind the students of the rules and provide immediate punishment.

(7) ***A 9 year old girl is very bright and intelligent, but you notice that she has difficulty concentrating on the task, and despite all your efforts she can't has difficulty waiting for her turn and always blurts out the answers, she also can't sit still she moves around in the class disturbing others. What should be the appropriate response?***
- (a) after class, quietly notify the school authorities that you suspect the child has behaviour problem.
- (b) call her to explain that she is a bright child but does not put in the effort needed to achieve.
- (c) phone the student's parents the following day to discuss the problems you are experiencing and ask them for help or suggestions.
- (d) send the child to the principal's office for constantly disturbing the teacher and other students.

(8) ***In the classroom when setting up rules which of the following is not appropriate?***
- (a) if rules are broken students should be punished
- (b) students should not be involved in setting rules
- (c) rules should be simple and short
- (d) parents should be informed about the rules and actions taken when rules are broken.

(9) ***Which of the following fulfils the definition of "consistently" enforcing rules?***
- (a) the consequence can only be enforced by the school principal.
- (b) everyone receives the same consequence for breaking a rule.
- (c) substitutes teacher are not expected to enforce the rules.
- (d) the same consequence occurs for all inappropriate behaviour

(10) ***When should parents be made aware of the classroom rules?***
- (a) at the beginning of the school year
- (b) at the end of the first term
- (c) when their child first breaks a rule
- (d) when their child has broken rules multiple times

(11) ***What do children learn from punishment?***
- (a) that you have their best interests in mind.
- (b) that they have paid for their misdeed and are free do it again.

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(c) that they should not misbehave.
(d) that they are naught.

(12) ***What is the secret to effective discipline?***
(a) having clearly defined rules and consequences.
(b) using punishment effectively
(c) working out how to make children follow the rules
(d) realizing that you cannot make children do anything.

(13) ***Which one of these statement is incorrect for a well managed classroom?***
(a) less distractions
(b) strict student teachers relationship
(c) more time for learning and activities
(d) less need for punishment

(14) ***Mental health is defined as:***
(a) a constant feeling of contentment
(b) Having mental health problems
(c) striking a balance in all aspects of your life - social, physical, spiritual, economic, mental
(d) achieving a period of 12–18 months without a psychiatric episode

(15) ***Mental illness is:***
(a) An untreatable health condition.
(b) A health condition that makes the person violent and crazy.
(c) A health condition that changes a person's thinking, feelings, or behaviour (or all three)
(d) A health condition which is the result of black magic and evil eye.

(16) ***Who is most likely to get a mental illness?***
(a) people from poorer backgrounds
(b) adults
(c) people with stressful jobs
(d) mental illness can affect anyone, regardless of intelligence, social class or income level.

(17) ***What percentage of Pakistani children have mental health disorders during childhood?***
(a) 3 to 5%
(b) 6 to 10%
(c) 11 to 20%
(d) 21 to 30%

(18) ***Which of the following factors is considered as the major cause of mental health problems in children?***
(a) combination of genes and environmental factors
(b) poor parenting
(c) a personal weakness of character
(d) black magic and evil eye.

(19) ***Anxiety disorders can affect children as well as adults. What are the most common signs and symptoms?***
(a) worries, irritability and physical symptoms such as aches and pains
(b) aggression and violence to self or others
(c) negative feelings of hopelessness and sleep problems
(d) poor appetite and physical symptoms such as aches and pains

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(20) ***Depression is common. When is depression most likely to occur?***

(a) in childhood
(b) in adolescence
(c) in older adulthood
(d) depression can occur at any age.

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