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Attitudes of teachers in Austria toward the implementation of a
mental health curriculum in schools

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1. Introduction

1.1. Relevance

1.1.1. *Prevalence of mental health problems among youth and their consequences*

Many mental health problems have their onset early in life, which results in a significant prevalence of mental disorders among youth, posing a serious challenge to society. When considering the total of all adult mental disorders, research has shown that around 50% of them start before adolescents turn 15; this figure increases to 75% by 18 years of age (Wykes et al., 2015). A meta-analysis that used data from 41 studies conducted in 27 countries between 1985 and 2012 found a global pooled prevalence of mental disorders in children and adolescents of 13.4% (Polanczyk et al., 2015). Other studies point out that one in five school-age children will suffer from social, emotional, and behavioral difficulties (Loades & Mastroyannopoulou, 2010). The Covid-19 pandemic—and the social isolation that resulted from it—might have worsened the situation and increased these numbers further (Ma et al., 2023).

A similar picture emerges when looking at children in Austria. In a study with 3446 Austrian adolescents (Philipp et al., 2018), 16.5% received a score that was clinically relevant (internalizing disorders—17.8%—were more than twice as frequent as externalizing disorders—7.4%). What is more, pupils with subthreshold disorders amounted to 12.7%, of whom a large proportion (92.5%) has not been given any support in dealing with their mental problems. The authors conclude that a significant percentage of adolescents in Austria are at risk for mental disorders. Another study's findings support this idea, reporting a point prevalence of 21.89% in 10-18-year-old pupils, which even rises to 23.93% when the estimate is corrected for a sample of children whom school-based surveys do not reach (Wagner et al., 2017). On top of this, when using a multi-wave design, the number of children with at least one mental disorder triples and reaches 35.8% (Wagner et al., 2017). Hence, it seems that the number of children and adolescents struggling with their mental health at any given time is significant. When looking at longitudinal data as analyzed by the German BELLA study, it can be concluded that a high percentage of these mental health problems also seems to persist for a long time (Ravens-Sieberer et al., 2015). A follow-up was conducted after six years, which showed that more than 30% of disorders were still in existence.

Mental disorders can have adverse short- and long-term effects on many areas of children's lives, such as relationships, education, achievement, and life expectancy. They can take the shape of dysfunctional social behavior, reduced educational performance, and—in the long

term—result in impaired physical as well as mental health during their adult life (Bhatia & Bhatia, 2007; Kessler et al., 1995; Patel et al., 2007).

1.1.2. The youth's access to support

The significant incidence of mental illness among youth is accompanied by a large treatment gap, as the majority of disorders remain unrecognized and untreated (World Health Organization, 2014). A study that examined mental-health service use found that only 45.3% of children experiencing a clinical disorder had received treatment in the past year (Green et al., 2013). Checking in with 1255 children in the 7-17-year range over a period of six years, the BELLA study discovered that 33% of the participants who acutely or recurrently suffered from a mental health problem received professional help, while 63.9% of those with persistent mental health problems did (Ravens-Sieberer et al., 2015). One explanation for the low numbers is that young people are 80% less likely to reach out for support when they need it (Hall et al., 2019). Help-seeking can be described as "an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern" (Rickwood & Thomas, 2012, p. 180), while said assistance can be delivered formally by mental health professionals or informally by family and friends (Jorm, 2012). There are several barriers that might prevent help-seeking. The first theme stems from limited knowledge about mental health. If children cannot recognize symptoms of mental disorders, the probability that they will take measures to receive help, such as talking to an adult, decreases (Olsson & Kennedy, 2010). Secondly, social factors play a significant role. Especially among youth, stigmatization by the peer group may be a culprit when children avoid reaching out for support (Chandra & Minkovitz, 2006; Radez et al., 2020). A possible reason might be the stigmatizing influence of media, where people who are mentally ill are often portrayed very negatively (Riebschleger et al., 2014). Stigma can be described as "a mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against, and excluded from participating in a number of different areas of society" (World Health Organization, 2001b, p. 16). Children and adolescents suffering from mental illness may feel shame, embarrassment, and guilt, be afraid of being stigmatized, and hesitate to reach out for help (Radez et al., 2020; Seven et al., 2021). Stigma is influenced by knowledge about mental health, as prejudice and discrimination toward the mentally ill are fueled by a lack thereof (Spiker & Hammer, 2019). A third main barrier is doubts about the relationship with a mental health professional and the hesitancy to trust a stranger (Radez et al., 2020). Lastly, systemic factors such as the cost and availability of treatment as well as logistical matters pose a barrier to young

people (Radez et al., 2020). Many children and adolescents are also unaware of where they can receive help (Radez et al., 2020).

1.1.3. Recognition of the need for early intervention and prevention

Until recently, the focus of mental health research on youth was mainly on how to address existing disorders. Recently, however, awareness has grown regarding the importance of prevention and the necessity to foster positive mental health (Mansfield et al., 2020). It has been shown that interventions that are conducted early, before symptoms become deeply ingrained, can be more effective than treating disorders that have already manifested (Cefai & Camilleri, 2015). The years in primary school appear to be a particularly crucial period for such interventions, as protective and risk factors that children experience at that age can have a profound impact on their outcomes in school and their future mental health (Cefai & Camilleri, 2015). It has been suggested that this can be tackled by teaching children about mental health and illness, so that problems are recognized early and help-seeking becomes more likely (Marinucci et al., 2022). An early intervention policy like this would play an important role in attempting to decrease the burden that disorders pose on health systems, society, and the economy (Ma et al., 2023). That is why global organizations like the World Health Organization (WHO) and the European Union (EU) are implementing strategies that follow a preventive approach, such as the WHO's Mental Health Action Plan 2013–2020 and its update extending to 2030, which has the goal that 80% of countries install at least three mental health intervention programs on a national scale that include multiple sectors (World Health Organization, 2013a, 2021)

1.2. The project "COMET4Kids"

"COMET4Kids: A COmprehensive MEntal health literacy Training for primary school children" is a collaborative, interdisciplinary project of the University of Vienna and the Pädagogische Hochschule Niederösterreich (teacher training college in Lower Austria) at the intersection of the fields of clinical psychology, educational psychology, and teacher education. Its main goal is the development and evaluation of a preventive mental health literacy program in primary schools. This study, with its focus on teacher attitudes toward such programs, helps inform the development phase of the project and will thus hopefully enable the researchers to optimize feasibility and teacher acceptance toward the program.

1.3. Significance of the study and the project

Around half of all mental health problems begin before individuals reach 15 years of age (Wykes et al., 2015). With a global pooled prevalence of mental disorders in children and adolescents of 13.4%—which may be an underestimate according to the cited study’s authors—the total number is significant (Polanczyk et al., 2015). Mental health problems also seem to persist at a high rate (Ravens-Sieberer et al., 2015). Considering these numbers, it is concerning that *mental health literacy (MHL)*, which describes “the knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 182), is low among youth (Olsson & Kennedy, 2010). Part of this is the fact that it may be difficult for children to become aware of their own mental health problems (Jorm, 2012). If they do recognize a mental health problem in themselves, they may often hesitate to talk to mental health professionals (Radez et al., 2020). Children and adolescents spend a large part of their time in school, which puts teachers in a good position to support them by recognizing potential disorders and providing help (O’Farrell et al., 2023). However, teachers lack education, confidence, and resources—such as time—when it comes to mental-health support (Reinke et al., 2011). Thus, on the one hand, the right training should be implemented to tackle the lack of education (Marinucci et al., 2022). On the other hand, McDaid et al. (2017) recommends including mental health in the curriculum and school culture. This would add further resources by providing time and a theoretical framework for teachers to rely on. In the development and implementation of interventions like this, it is recommended to collaborate with key stakeholders such as teachers and mental health professionals for the following reasons. Feasibility of interventions can be increased by drawing on stakeholder’s experience with real-world conditions (Marinucci et al., 2023). Furthermore, by taking into account the needs of the target population as well as its perspective on new programs, this increases the likelihood of acceptance and willingness to put them into practice (Grové et al., 2023). While there are many studies internationally that examine teacher perspectives on this matter (e.g., Marinucci et al., 2023; O’Farrell et al., 2023), there is still a need to conduct such research in Austria. This study therefore aims to obtain insight on how teachers in Austria perceive the introduction and implementation of a mental health curriculum. Using this information will enable the COMET4Kids project to develop a more effective curriculum for implementation in schools.

2. Theoretical background

2.1. Definitions

2.1.1. *Definition of the term "mental health"*

Over time, different definitions of mental health have been proposed. Stepping away from the concept of mental health as the mere absence of mental illness, the WHO defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." (World Health Organization, 2002a). According to Keyes (2014; as cited in Galderisi et al., 2015), mental health encompasses emotional wellbeing (happiness, interest in life, satisfaction), psychological wellbeing (self-acceptance, coping with daily responsibilities, good relationships, life satisfaction), and social wellbeing (contribution, social integration, social actualization, social coherence). Arguing for a more holistic view regarding the emotional experience, Galderisi et al. (2015) points out that people can find themselves in difficult situations in which it would be considered mentally healthy to experience negative emotions, and in which it would be maladaptive and unhealthy to experience wellbeing. Jahoda's division of mental health into the three aspects of self-realization, sense of mastery over the environment, and sense of autonomy (1958; as cited in Galderisi et al., 2015) was criticized for representing the values of the Western world and therefore claimed to not provide a universal definition.

Considering the criticism of previous concepts, Galderisi et al. (2015, p. 231) proposed a new definition of mental health:

Mental health is a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of internal equilibrium.

2.1.2. Definition of the term "wellbeing"

In the Oxford English Dictionary (n.d.), *wellbeing* is defined as "the state of being healthy, happy, or prosperous; physical, psychological, or moral welfare." According to the World Health Organization (2001a), *wellbeing* is "a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions. Well-being encompasses quality of life and the ability of people and societies to contribute to the world with a sense of meaning and purpose."

In research, there are two traditions that look at different aspects of *wellbeing*: *hedonic wellbeing*—also called *emotional wellbeing*—pertains to experiencing happiness and satisfaction as well as an interest in life (Keyes, 2007), while *eudaimonic wellbeing* focuses more on optimal individual functioning—also called *psychological wellbeing*—and on social functioning. *Psychological wellbeing* includes the elements self-acceptance, purpose in life, positive relations to others, autonomy, environmental mastery, and personal growth (Ryff & Keyes, 1995). *Social wellbeing* is characterized by elements such as social integration and social contribution (Keyes, 1998).

Over time, the concept of *wellbeing* has seen increased use in academic literature and education, frequently as a synonym for *mental health* (Hughes & Spanner, 2019). However, a more precise definition of the term has not been agreed upon. Criticism of the term labels it "intangible, difficult to define and even harder to measure" (Thomas, 2009, p. 11).

The Oxford English Dictionary (n.d.) and the WHO spell the word with a hyphen: "*well-being*". However, most other authors cited in this thesis spell it without a hyphen: "*wellbeing*". For the sake of maximizing consistency, *wellbeing* was spelled without a hyphen in this thesis.

2.2. Mental health literacy (MHL): history, definition, and relevance

2.2.1. Historical context

The concept of *mental health literacy (MHL)* has emerged as a subdomain of the larger field of *health literacy (HL)* (Kutcher et al., 2016). In the early stage of its development, *health literacy* was mainly situated in the healthcare environment and originated from the observation that low functional literacy results in poor health (Dewalt et al., 2005). *HL* was defined as "the ability to gain access to, understand, and use information in ways which promote and maintain good health" (Nutbeam et al., 1993; as cited in Jorm, 2000). Later on, additions were made to this definition by the World Health Organization (WHO), which also included in it "the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand, and

use information in ways which promote and maintain good health” (World Health Organization, 2009). Emphasizing the importance of possessing good *HL*, the WHO called it ”a stronger predictor of an individual’s health status than income, employment status, education and racial or ethnic group” (World Health Organization, 2013b, p. 7). The concept of *HL* has gained wide acceptance among the public and the advantage of knowing what to do regarding the prevention, intervention, and treatment for major physical diseases can be considered common knowledge (Jorm, 2012). Examples are the awareness of the importance of safe sex regarding the prevention of HIV, of consuming a healthy diet, of being able to recognize early signs of cancer, and of knowing where to seek professional help as well as the likely benefits of treatments (Jorm, 2012). Considering mental health, however, the situation differs greatly from that of physical *health literacy*. Many people have only limited knowledge about what to do to prevent mental disorders or how to help others experiencing them (Jorm, 2012). They avoid treatments or postpone them and are unconvinced of their benefits (Jorm, 2012). Jorm and colleagues were the first to become aware of this situation and emphasized the importance of conducting more research into public knowledge about mental disorders as a way to enable the implementation of measures that aim toward improving it. Up to that point, public knowledge had not been considered an important factor—the focus was instead on the ability of general practitioners and other healthcare workers to recognize and act on mental disorders (Jorm, 2012). To change the status quo and increase public awareness, Jorm and colleagues coined the term *mental health literacy*.

2.2.2. Definition

They defined *MHL* as ”knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, p. 182). It comprised six components:

- (a) the ability to recognize specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. (Jorm, 2000, p. 396)

Following this first definition, interest in the concept of *MHL* has grown among researchers, and as a result, the definition has evolved (Nobre et al., 2021). One criticism that arose was the

lack of focus on positive mental health and wellbeing. It was claimed by some researchers that describing mental health solely as the absence of mental disorders would be incomplete—such a definition would not be helpful for the promotion of good mental health (de Carvalho et al., 2022). Suggestions were made to move away from a purely medical model and include abilities that help maintain and promote good mental health. As a way to integrate them, some researchers proposed considering *MHL* as a multi-construct that integrates yet distinguishes mental disorder knowledge and positive mental health, thereby allowing each part to be measured separately (Spiker & Hammer, 2019). Positive mental health is defined by the WHO as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2013a, p. 6). Research seems to support the idea that the two constructs mental health/wellbeing and mental illness do not overlap (de Carvalho et al., 2022). Following these developments, the definition of *MHL* has been refined. It is now considered to include:

- (1) Understanding how to obtain and maintain good mental health, (2) understanding mental disorders and their treatments, (3) decreasing stigma related to mental disorders, and (4) enhancing help-seeking efficacy (knowing when, where, and how to obtain good mental health care and developing competencies needed for self-care).

(Kutcher et al., 2016b, p. 567)

2.2.3. Effects of low/high levels of *MHL*

Research highlights the effects of low *MHL* on help-seeking. If there is a lack of knowledge about symptoms of mental disorders, the likelihood that a person will recognize the development of a disorder diminishes, which, as a consequence, lowers the chance that they will seek treatment (Gulliver et al., 2010; Olsson & Kennedy, 2010). An additional barrier can be the knowledge about professional help available and beliefs about the effectiveness of treatments. Recognizing a mental disorder is only the first step; people must also know where and how to obtain professional help (Jorm, 2012). Furthermore, if people do not believe that professional treatments will help them, they will not turn to professionals for help—or if they do so, there is a high probability that they will not be very committed to following the treatment advice (Jorm, 2012). On the other hand, a person benefits from increased *MHL* in a variety of ways. There is a number of

studies that demonstrates the positive effects of increased mental health knowledge. People are more likely to disclose their mental illness to friends and family and show a greater intention to use mental health services (Rüsch et al., 2011). Along with increased help-seeking, there is a negative relationship between mental health knowledge and stigma (Griffiths et al., 2008). Already in early childhood, stigmatizing attitudes can arise (Kaushik et al., 2016). which in turn may cause an avoidance to seek help (Chandra & Minkovitz, 2006). When parents hold stigmatizing beliefs toward mental health difficulties, they can become an additional barrier for their children to receiving support (Ekornes, 2015).

2.2.4. Sub-concepts

Over time, the concept of *MHL* has evolved and several sub-concepts have been developed that focus on different populations. This enables a more precise discussion about the relevance of *MHL* for these groups and in different contexts. The following section provides an overview of two sub-concepts that are relevant to this study: *youth MHL* and *educator MHL*.

Youth MHL. Ten-year-old children have the capability and are willing to have conversations about mental health (Roose et al., 2003). However, research indicates that *MHL* information cannot be delivered in a one-size-fits-all manner but instead has to be tailored to the specific recipients' developmental stage (Kutcher, Wei, & Coniglio, 2016). Consequently, providing health information that fits their specific needs would be more applicable to children and thus be more effective than using the standard framework (Bale et al., 2020). In order to address this challenge, Bale et al. (2020) proposed the *MHL* Child Focused Model, which applies the concept of *MHL* to the domain of children and adolescents. Its six components include: 1) recognizing changes in mental health, 2) knowledge of help-seeking actions, 3) knowledge of available support, 4) knowledge about the influences on mental health, 5) coping and resilience, and 6) attitudes toward mental health. Although this model was developed for children who are at least ten years old, the researchers argue that it can be adjusted for application to children of a younger age. When it comes to the actual *MHL* needs of children and adolescents, there is a lack of knowledge. It is unclear how knowledgeable they actually are about what to do if adverse mental health symptoms arise, when they are stressed, and how to deal with stigma (Radez et al., 2020). However, it appears that *youth MHL* is rather low (Olsson & Kennedy, 2010). Increasing the *MHL* of children and adolescents could provide many benefits. As described above, the knowledge gap when it comes to mental health provides a significant barrier to youths' access to support. Instead of only tackling mental illnesses once they are already present, children would

learn how to recognize deteriorations in their mental health early on and how to deal with them by self-management and help-seeking, thereby acquiring skills that prevent disorders (Bale et al., 2020). Following the definition of positive mental health by the World Health Organization (2005), resilience would improve and facilitate dealing with everyday stressors, while children's ability to perform at school would also increase. Looking ahead, improving *MHL* in children may therefore be an important factor in reducing the prevalence of mental disorders in society.

Educator MHL/MHL for supporting children (MHLSC). The role of teachers has changed, as it has moved away from only teaching academics to also teaching social-emotional skills and addressing their pupils' mental health (Graham et al., 2011). Spending so much time with their students, they are in a unique position to recognize changes in their behavior and developing mental health problems. The concept of *educator MHL*—also called *MHL for supporting children (MHLSC)*—describes adults' knowledge about the mental health of children (Johnson et al., 2023). It is important to differentiate it from adult *MHL*, as not only do mental health difficulties present very differently across different periods of the lifespan, but the ways in which they can be managed and prevented also differ widely (Johnson et al., 2023). Children experiencing mental health problems are rather unlikely to seek help independently, and hence, a gatekeeper adult needs to have the ability to recognize the problem and the knowledge regarding what to do about it (Ní Chorcora & Swords, 2022; Stiffman et al., 2004). Since research about *MHLSC* is still in its infancy, there is a lack of investigation of adults' knowledge and recognition of disorders that occur in childhood—with the only exception of ADHD, which has been studied extensively in this regard (Johnson et al., 2023). On top of that, the existing studies have used a variety of methods to measure knowledge and recognition, which complicates comparison (Johnson et al., 2023). A common method is the use of vignettes, which can be considered less than perfect, since there are significant differences in results when comparing studies using vignettes with studies using real-life cases. While vignette studies show that adults can recognize mental disorders in children fairly well, studies that examine teachers' recognition of disorders in children they know observe a much lower ability to successfully do so (Johnson et al., 2023). The same picture emerges when parents' ability to recognize disorders is tested with vignettes versus with their own children (Villatoro et al., 2018). One reason for this difference seems to be that symptoms in vignettes are presented in a checklist-like manner, while real life is more complex and subtle (Headley & Campbell, 2013). In a study that compared teachers' sympathy and help-seeking intentions toward a real child with intellectual disabilities and a vignette, ratings

were higher for the vignette (Lucas et al., 2008). Johnson et al. (2023) conclude that the ecological validity of vignettes may be unfavourable in the context of adults' evaluation of children. In order to solve the problem of heterogeneity in the field of *MHLSC*, they suggest that research should agree on a definition and a framework, so it can be clearly differentiated from other concepts of *MHL*.

2.2.5. Measurement issues of MHL

A number of measures to examine people's *MHL* have been developed; however, they exhibit several weaknesses. These pertain to their inconsistent methodology as well as their theoretical underpinnings (Mansfield et al., 2020; Spiker & Hammer, 2019). Due to the construct confusion that *MHL* has been subject to, there is no solid basis for the development of measures (Mansfield et al., 2020; Spiker & Hammer, 2019). This led to a strong heterogeneity of measures and thus results, a situation which makes accurate comparison, for example in the shape of quantitative meta-analyses, very difficult or impossible (Johnson et al., 2023).

What is more, there is also a lack of measures that are psychometrically tested, which means that most are insufficiently validated (Kutcher et al., 2016a; Mansfield et al., 2020). When looking at the tools evaluating *MHL*, it becomes clear that a drawback common to most of them is that they do not measure all components of the construct simultaneously – especially the vignette studies fall short in this regard (Kutcher et al., 2016a). Besides their incompleteness, most scales that are used to evaluate *MHL* are not psychometrically robust (Bale et al., 2018; Wei et al., 2016). Consequently, few validated scales for measuring *MHL* exist, in particular when it comes to assessing children's *MHL* (Bale et al., 2018; Mansfield et al., 2020). All these problems apply to general *MHL* as well as to *youth MHL*, which is why there are calls for improving the understanding of the meaning of *MHL* for youth (Mansfield et al., 2020).

2.2.6. MHL in schools

In the 1990s, the WHO began to raise awareness of the idea that schools are an excellent place for the implementation of mental health interventions for youth (Graham et al., 2011). They are an especially useful setting because the majority of disorders have started to develop by the age of 18 (Wykes et al., 2015). Furthermore, schools already are a supportive environment for learning and a large percentage of children spend a big part of their time there (McDaid et al., 2017), especially children from underrepresented groups who are more prone to experiencing mental health problems (Green et al., 2005). Children seem to have very little knowledge about mental health (Olsson & Kennedy, 2010), hence, as mentioned above, they would benefit greatly

from education in this regard. In the past decade, the teaching of *social-emotional learning (SEL)* has risen in popularity, which demonstrates the increased importance schools place on mental health (Marinucci et al., 2022). *SEL* is a term that describes “competencies in understanding and managing one’s emotions, positive relationship skills, and responsible decision-making for personal, social, and collective wellbeing” (Marinucci et al., 2022, p. 3). While overlapping in parts, there are also many differences between *SEL* and *MHL*, the teaching of which is making its way into schools more recently. Standalone features of *MHL* are the emphasis on acquiring knowledge about mental health and the associated vocabulary, as well as becoming aware of how and where one can seek help when experiencing mental health problems (Marinucci et al., 2022). As a way of effectively teaching *MHL*, it is suggested to integrate it into existing structures such as schools and, for example, deliver it as part of the curriculum (McDaid et al., 2017; McLuckie et al., 2013).

2.3. Teacher attitudes toward mental health and wellbeing promotion

The research to date seems to show that most teachers are positively inclined toward mental health promotion. In one often-cited study, the majority of participants indicated that they personally viewed mental health education as very important (45%) or extremely important (44%), with less than 2% indicating that it was of little or no importance (Graham et al., 2011). Teachers also seem to believe that teaching *MHL* can strengthen student skills such as resilience and help-seeking (Marinucci et al., 2023). However, they were found to be a little less confident in its ability to improve academic performance than health professionals (Marinucci et al., 2023).

While apparently viewed positively by most teachers, the increasing focus on dealing with the mental health of students and the resulting changes in their role also poses a challenge to them. In the following, previous findings about their perception of these changes and their attitudes toward them will be discussed.

2.3.1. Self-efficacy, perception of training, and fears

Teacher self-efficacy in promoting student mental health can be defined as “a teacher’s belief in their capacity to successfully support students’ mental health needs” (Brann et al., 2020, p. 200). When it comes to the implementation of mental health promotion in schools, this seems to be an important aspect to consider. As has been shown, the perceived efficacy of dealing with mental health issues can influence the confidence in doing so (Williams et al., 2007). Confidence in helping, in turn, can not only significantly predict helping behaviors, but also increase the effectiveness and appropriateness of this help (Rossetto et al., 2016). More knowledge about

mental illness, on the other hand, increases the tendency to help people struggling with mental health difficulties (Rossetto et al., 2016). Considering these findings, it comes as no surprise that teachers' knowledge and professional training greatly affect their ability to support student mental health (Phillippo & Kelly, 2013).

Perception of knowledge, skills, and training. A common theme in the research is the perceived lack of training (O'Farrell et al., 2023). Teachers feel that they neither have adequate knowledge (Graham et al., 2011) nor the necessary skills (Rothì et al., 2008). In one study, 85% of teachers stated they need additional mental health training (Moon et al., 2017). In another, they were asked to consider the statement "I feel I have the knowledge to meet mental health needs", with which 4 % strongly agreed, 24% agreed, 31% were neutral, 34% disagreed, and 5% strongly disagreed (Reinke et al., 2011, p. 7). The statement "I feel I have the skills to meet mental health needs" was met with 4% strong agreement, 30% agreement, 29% neutral responses, 32% disagreement, and 5% strong disagreement (Reinke et al., 2011, p. 7). With 39% and 37% disagreement respectively, large percentages of teachers do not consider themselves knowledgeable and skillful in this area. In a Norwegian study, only small percentages of teachers claimed to possess sufficient knowledge and know-how about mental health: 42.6% disagreed or strongly disagreed with the statement that they have knowledge regarding mental health that they can use to support students experiencing difficulties, 18.3% agreed or strongly agreed that they know how to help students developing difficulties, and only 12.5% agreed or strongly agreed that they know what to do in order to prevent mental health problems (Ekornes, 2017).

Teachers' perceived challenges and fears regarding their self-efficacy. When reviewing studies that investigated how confident teachers feel, an ambivalent picture emerges. The majority of teachers seem to be at least quite confident about carrying out mental health programs (71%); however, it cannot be neglected that 19% feel only a little confident and 6% do not feel confident at all (Graham et al., 2011). Confidence in fostering mental health seems to be higher in personal contexts than in the professional context (Graham et al., 2011). Other studies have also found that a number of teachers seem to possess low confidence in dealing with mental health issues in their pupils (Giles-Kaye et al., 2022) and consistently mention feeling incompetent, frustrated, and helpless (Rothì et al., 2008).

When combining the low confidence many teachers possess in this context with the feeling of not being adequately prepared for supporting the mental health of their students, it becomes clear that the increasing focus on mental health in schools makes teachers subject to increased stress

and risk of burnout (Reinke et al., 2011). Some teachers feel overwhelmed by the expectations they feel resting on them, one being that "we should have all the answers" (Williams et al., 2007, p. 100). For example, it is difficult for many to differentiate normal mood fluctuations from mental health problems that are more serious (Ekornes, 2015). The recognition of internalizing disorders also poses a particular challenge to teachers, as students suffering from these are more often neglected than the more disruptive students with externalizing difficulties (Papandrea & Winefield, 2011).

Suggestions for improvements. In the vast majority of studies, teachers were willing to take part in further training in mental health support (O'Farrell et al., 2023). Reinke et al. (2011) asked teachers to name the three areas in which they felt the greatest need for this additional training—this could include the provision of knowledge as well as skills training. The top three were: "(1) Strategies for working with children with externalizing behavior problems, (2) recognizing and understanding mental health issues in children, and (3) training in classroom management and behavioral interventions." (Reinke et al., 2011, p. 7). Regarding their own mental health, teachers require support in order to be able to cope with dangers such as burnout, "low morale, lack of respect, little acknowledgement, limited support and increasing demands from students, schools and community" (Graham et al., 2011, p. 491).

2.3.2. The teacher role

The role of school teachers has undergone a significant transformation in recent years, as it is no longer limited to the instruction of core academic subjects such as Maths, English, and Science (Graham et al., 2011). Initially focusing mostly on academic performance, the purpose of education has expanded to also addressing social, emotional, and mental health needs of young people (Marinucci et al., 2023). This is also reflected in the statement of the World Health Organization that it is the duty of school staff to foster student learning—which includes promoting mental health literacy (World Health Organization, 2002b). Spending such a large amount of time in close contact with their pupils places them in a unique position to support children's mental health, as it facilitates detecting changes and arising difficulties (Venkataraman et al., 2019). Besides this possibility to monitor the mental health of children and intervene when deemed necessary, it is suggested by researchers that teaching mental health literacy should become a part of the school curriculum in order to increase mental health knowledge, help-seeking and coping (Jorm, 2012).

Considering these additions to the traditional teacher role, it is clear that the work of a

teacher is becoming increasingly complex and challenging. As stated before, it is important to have teachers on board with this transformation in order to ensure maximum effectiveness of new initiatives. In the following, an overview is given of previous research findings regarding the attitudes of teachers toward their role in the context of a growing focus on mental health support in schools.

Role perception. A teacher's role is highly subjective, meaning their perception of it will shape how they approach and perform their duties (McAllister et al., 2007). A great number of studies support the idea that teachers believe schools should address mental health needs and consider dealing with mental health promotion to be part of their role (Ekornes, 2017; Graham et al., 2011; Reinke et al., 2011). In order to foster the learning abilities of students, teachers find themselves having to attend to mental health issues every day (Rothì et al., 2008). They consider wellbeing and learning not as separate, but as interwoven (Samnøy et al., 2022). Most teachers seem not only to view it as their professional duty but also feel personally responsible for helping their students (Ekornes, 2017). In a UK study, teachers saw their role as a holistic one that incorporates health support and interventions; they indicated feeling an obligation to take care of their pupils (Harvest, 2018; as cited in O'Farrell et al., 2023). An explanation delivered by teachers is that students with mental health problems often have few people whom they can trust and talk to openly, even more so if they do not have a good relationship with their parents (Ekornes, 2017).

On the other hand, there are also voices expressing doubt. In one study, 89% of teachers agreed that mental health needs should be addressed in schools; however, teachers only considered behavioral interventions their job, while social-emotional lessons were perceived as being more suitable for school psychologists (Reinke et al., 2011). In accordance with that, some teachers still view mental health interventions as peripheral, with their focus remaining on academic teaching (Corcoran & Finney, 2014). A minority of teachers seem to strongly believe that attending to the social and emotional wellbeing of pupils is not part of their role (Graham et al., 2011; Marinucci et al., 2023).

O'Farrell et al. (2023) suggest that there might be cultural differences, since in the studies they reviewed, US teachers appeared to be more willing to attend to the mental health of students than teachers in the UK.

Regarding the gender of the teacher, it was found that female teachers seem to be more likely to consider taking care of the emotional wellbeing of their pupils as their responsibility

(Ekornes, 2017). Some even speak of adopting a "mother-like" role (Ekornes, 2017, p. 348).

Role perception also appears to differ at different levels of the school system. Teachers at upper secondary schools seem to feel less responsible for supporting students with mental health difficulties than lower secondary school teachers and teachers at primary schools (Ekornes, 2017). An explanation for this shift might be the increasing academic pressure and the resulting time scarcity, which possibly lead to the perception of mental health support as a burden and distraction from the actual task (Ekornes, 2017).

Teachers' perceived challenges and fears regarding their role. In light of increasing demands and training that is perceived as inadequate, teachers feel concerned about the rising complexity of their role (Giles-Kaye et al., 2022). They fear that their increasing mental health responsibilities are overshadowing their primary role as educators (O'Farrell et al., 2023), as they struggle to strike a balance between appropriately caring for students' mental health and also fulfilling their academic responsibilities (Ekornes, 2017). Some also mention being overwhelmed by the immense expectations they feel subjected to, as they feel they have to "'cure, solve and mediate' in all areas of children's social, emotional health and behavior" (Graham et al., 2011, p. 492). This is reflected in the following statement by a teacher: "'I'm expected to teach, I'm expected to deliver really good lessons, I'm expected to, you know, look after the educational needs of my children. And as much as I'd love to support them pastorally, I physically don't have the capacity'" (Harvest, 2018; as cited in O'Farrell et al., 2023, p. 273). While teachers have to deal with such excessive demands, the lack of clarity they perceive in their role (Mansfield et al., 2021) only adds to their confusion about just how much responsibility they should bear in addressing mental health in their students.

2.3.3. The relevance of teachers' own mental health in providing mental health support

The expansion of their role brings with it mental health challenges for teachers. Specifically, the lack of training regarding the support of mental health in students results in a lot of stress for teachers and thus increases the risk of burnout (Reinke et al., 2011). On top of that, as has just been described, the increasing expectations toward their role feel overwhelming to many. An impairment of teachers' own mental health can influence their ability to help students, although it is not entirely clear in which way. On the one hand, teachers with a history of mental health problems might be better at recognizing telltale signs in pupils (Harvest, 2018; as cited in O'Farrell, 2023). On the other hand, some degree of wellbeing is considered necessary by

teachers in order to be able to help their students. As one teacher states, "stressed adults can't help stressed kids" (Graham et al., 2011, p. 491). Struggling with mental health difficulties themselves might impair teachers' willingness and ability to notice and then support students with problems (Kidger et al., 2010). Therefore, teachers might benefit not only from more extensive training in supporting children, but also from receiving education in improving their own resilience (Cefai et al., 2021).

2.3.4. Summary

According to teachers, there is a substantial lack of training regarding the support of students with mental health difficulties. They state not having sufficient knowledge about all aspects of the process, namely preventing, recognizing, and supporting such students, which produces a feeling of not being competent and confident. This results, on the one hand, in a decreased ability to adequately help, and, on the other hand, in increased teacher stress in the face of high demands and low abilities. Teachers who do not feel a sense of wellbeing themselves seem to be much less able and willing to support students who would need their help. Hence, the provision of adequate teacher training in mental health seems to be of vital importance for the project of mental health support in schools.

When it comes to the perception of their role, it appears that most teachers are very motivated to support children's mental health, consider it part of their role—even a personal responsibility—and see learning and wellbeing as interwoven. However, some teachers strongly object to this expansion of their role, they still see teaching academics as their primary focus and view mental health support as peripheral. This might be associated with the overtaxation many teachers feel in the face of increasing demands and inadequate training. Clarifying responsibilities of teachers and expectations toward them will help ensure that they know their professional boundaries, so they can act in alignment with the scope of mental health support in schools and avoid making diagnoses or giving other support that belongs to the domain of mental health professionals (Fortier et al., 2016).

2.4. Research questions and hypotheses

The aim of this thesis is to inform the development of a mental health curriculum by examining Austrian teacher attitudes toward the implementation of a mental health curriculum in schools. Based on this, the following research questions emerged.

- Research question 1: What is the attitude of teachers in Austria toward the implementation

of a mental health curriculum in schools?

- Research question 2: Does labeling interventions *mental health promotion* or *wellbeing promotion* make a difference in teachers' perception?

2.4.1. Research question 1

Regarding research question 1, "What is the attitude of teachers in Austria toward the implementation of a mental health curriculum in schools?", several exploratory questions were posed to the data:

- To what degree do teachers in Austria believe that mental health promotion in schools can improve student performance and mental health outcomes?
- To what degree do teachers in Austria consider it a necessity to implement mental health promotion in schools?
- What is the level of teachers' self-efficacy in responding to mental health problems among their students?
- To what degree do teachers in Austria support the idea of promoting student wellbeing in their classrooms?
- What kind of resources are available to teachers in Austrian schools when it comes to the promotion of students' social-emotional wellbeing?
- Which elements of *MHL* do teachers in Austria currently teach in their classrooms?

Furthermore, several confirmatory hypotheses were formulated based on the existing literature. Older teachers were found to be less inclined to possess positive views on children with mental health problems (Anderson et al., 2012). When it comes to the gender of teachers, findings are ambivalent. Mansfield et al. (2021) found no connection between a teacher's gender and the capacity to support the mental health of their students. Other findings endorse a small effect of gender, with female teachers more strongly endorsing that students' social-emotional skills can be improved through training (Askell-Williams & Cefai, 2014). The years a teacher has been in practice were not found to predict the capacity for promoting student wellbeing (Askell-Williams & Cefai, 2014; Mansfield et al., 2021). Teachers' self-efficacy in mental health promotion was found to be significantly positively correlated with their attitudes toward it (Huang et al., 2021).

The school level teachers were teaching in was found to significantly predict their capacity; it was higher for teachers working in secondary schools as compared to teachers in primary schools (Mansfield et al., 2021).

The specific hypotheses are:

H1: A teacher's age negatively predicts their anticipation that mental health promotion will be effective.

H2: A teacher's age negatively predicts their perceived necessity to implement mental health promotion in schools.

H3: A teacher's gender does not predict their self-efficacy in responding to mental health problems among their students.

H4: A teacher's years in profession do not predict their self-efficacy in responding to mental health problems among their students.

H5: Teachers with higher levels of self-efficacy in responding to mental health problems among their students tend to anticipate that mental health promotion will be more effective.

H6: Teachers with higher levels of self-efficacy in responding to mental health problems among their students tend to perceive a greater necessity to implement mental health promotion in schools.

H7: Teachers in secondary schools have higher levels of self-efficacy in responding to mental health problems among their students than teachers in primary schools.

2.4.2. Research question 2

Related to research question 2, "Does the distinction between labeling interventions *mental health promotion* and *wellbeing promotion* make a difference in teachers' perception?", previous research has found that teachers perceive *mental health* and *wellbeing* as interconnected concepts (Gatt et al., 2024). Some teachers seemed to prefer the term *wellbeing*, as they feared the stigma they associated with the term *mental health* and wanted to protect children from discussions

about it (Danby & Hamilton, 2016).

Therefore, the following hypotheses were formulated:

H8: Teachers in Austria have similar conceptions of the terms *Psychische Gesundheit* (*mental health*) and *Wohlbefinden* (*wellbeing*), with a greater tendency of the term *mental health* to be associated with stigma and mental disorders.

H9: The self-efficacy of teachers in responding to mental health problems among their students significantly positively correlates with their attitude toward wellbeing promotion.

3. Method

3.1. Research design

This is a mixed-methods study, as it collected qualitative and quantitative data in order to learn about Austrian teacher attitudes toward the implementation of a mental health curriculum in schools. Quantitative data were used to statistically analyze the findings, while qualitative data were queried in order to obtain insight into teachers' conceptions of certain mental health terms. The quantitative data was analyzed using descriptive statistics, frequency analysis, correlation, and linear regression; the qualitative data was analyzed using deductive thematic analysis. The creation and implementation of the survey were carried out with Sosci Survey, a website offering tools for conducting online surveys in the social sciences. Emails were then sent out with links to the survey. When starting to complete it, participants were first instructed on the purpose of the study and had to agree to the data-protection terms before continuing.

3.2. Participants

Participants were recruited in two ways. First, emails were sent out to students of the Pädagogische Hochschule Niederösterreich (teacher training college in Lower Austria). Second, emails were sent to a number of schools in Vienna, Austria, with the polite request to pass on the survey to their teachers. The survey was conducted from May 2024 to January 2025. Inclusion criteria were teaching at a primary school, a secondary school, or a vocational school as a student of the teaching profession or as a regular teacher. In total, 118 responses were recorded, of which 56 responses had to be excluded because of missing entries. Data cleaning left the sample with 62 participants; an overview of their characteristics is shown in Table 1. Twenty-seven teachers stated that they had completed additional training; a list of the titles of these trainings can be found in the appendix (Table 8).

3.3. Development and design of the survey

The survey was based on a review of the literature and consists of several parts from different pre-existing surveys. This was done with the aim of covering all aspects of teacher attitudes and *MHL* that were of particular interest.

In the following, the different surveys—which were used in whole or in part in the present study—are described, then information is given about what parts were used and how they were put together. Afterwards, additional items that were added are outlined, and lastly, an overview of the translation process is given.

Table 1.
Participant characteristics (N = 62)

Category	Sub-category	<i>n</i> (proportion %) ¹
Gender (<i>n</i> = 53)	Male	9 (17.0%)
	Female	44 (83.0%)
Age (<i>n</i> = 55)	18-24	8 (14.5%)
	25-34	21 (38.2%)
	35-44	9 (16.4%)
	45-54	9 (16.4%)
	55-64	8 (14.5%)
Educational background (<i>n</i> = 56)	Studying for Bachelor's degree	19 (30.6%)
	Bachelor's degree	4 (6.5%)
	Studying for Master's degree	6 (9.7%)
	Master's degree	8 (12.9%)
	Diplom ²	15 (24.2%)
	Lateral entry	4 (6.5%)
Type of school (<i>n</i> = 62)	Primary school	18 (29.0%)
	Lower secondary school	7 (11.3%)
	Upper secondary school	23 (37.1%)
	Special needs school	9 (14.5%)
	Vocational school	5 (8.1%)
School environment (<i>n</i> = 57)	Urban	45 (78.9%)
	Suburban	7 (12.3%)
	Rural	5 (8.8%)
Years in practice (<i>n</i> = 56)	0-5	31 (55.4%)
	6-10	5 (8.9%)
	11-15	5 (8.9%)
	16-20	5 (8.9%)
	21-25	3 (5.4%)
	26+	7 (12.5%)

Notes.

¹ Percentages are relative to the *n* of the respective variables.

² A "Diplom" is equivalent to a Master's degree.

3.4. Materials

3.4.1. *Survey about general perspectives on mental health education*

Drawing on previous literature, Marinucci et al. (2023) created a 51-item mixed-method survey in order to collect exploratory data about Australian school staff's perspectives on mental health education. The purpose of the individual items was to deliver descriptive data; they were not originally combined into a scale. The first part of the study consisted of 30 quantitative items which intended to obtain general perspectives on mental health education and *MHL* in schools. Ratings had to be made using a 5-point Likert scale that took three different shapes, depending on the item (the number ratings are the scores that were assigned by the authors and were not shown in the survey): 1=strongly disagree, 2=somewhat disagree, 3=neither agree nor disagree, 4=somewhat agree, 5=strongly agree; 1=extremely useful, 2=very useful, 3=moderately useful, 4=slightly useful, 5=not at all useful; 1=extremely important, 2=very important, 3=moderately important, 4=slightly important, 5=not at all important. In the second part, 15 qualitative items aimed at obtaining more detailed information about the participants' views. The response format was text entry and there was no limit to its length.

A factor analysis showed the possibility of separating the items into four different factors: "Attitudes towards how mental health affects student ability", "Attitudes towards school role in mental health education", "Attitudes towards delivery of mental health education", and "Attitudes towards confidence of delivering mental health education in schools" (A. Marinucci, personal communication, November 27, 2023). Some items loaded negatively, which means that, for these, a high score indicates a negative attitude toward mental health promotion.

Adaptations in this study. There were some adaptations made for the purpose of this study. For easier referencing, the factors were labeled factor A ("Attitudes towards how mental health affects student ability"), factor B ("Attitudes towards delivery of mental health education"), and factor C ("Attitudes towards confidence of delivering mental health education in schools"). The items of the factor "Attitudes towards delivery of mental health education" were not used, since they deal with ways to present mental health information, which was not a focus of this study.

Factor C was slightly adapted by changing the formulations of the items from asking about the general situation in schools to asking about the specific school of the respective participant. As a result, we expected to obtain more meaningful information, as teachers may be better and more precisely able to judge the situation in their own schools than in the whole school system.

Furthermore, we added two items that did not come from the original survey. These asked about the perceived importance of talking about mental health (C1: "At our school, we believe it's important to talk about mental health.") and the promotion of additional training in mental health promotion (C5: "Our school promotes further training for staff in the area of mental health education for students.").

Ratings were made on a 5-point Likert scale that showed the number ratings from 1 to 5 with the extrema labeled "strongly disagree" (1) and "strongly agree" (5). In order for high scores to represent results positively connected with mental health promotion, the scores of the items with negative loadings in the factor analysis were inverted in our analysis. The respective items are marked.

The 15 qualitative items were not used in this study.

The complete list of items and the German translations that were used can be found in the appendix (see Table 9).

3.4.2. School Mental Health Self-efficacy Teacher Survey (SMH-SETS)

The *School Mental Health Self-efficacy Teacher Survey (SMH-SETS)*; Brann et al., 2020) is a scale that measures teachers' self-efficacy in responding to mental health problems in their students. It was developed by consulting literature on self-efficacy, teacher self-efficacy scales, mental health literacy, and going through a systematic feedback process with experts in school mental health, scale development, and teacher training. As a result, teacher mental health self-efficacy was defined as "a teacher's belief in their capacity to successfully support students' mental health needs" (Brann et al., 2020, p. 200) and operationalized into four categories: teaching students who have mental health needs, responding to mental health concerns, recognizing mental health concerns, and promoting mental health.

The final scale consists of 15 items that cover all four activities. Each item has the stem "I feel confident in my ability to..." and ratings are made on a 6-point Likert scale with the answer options "Strongly disagree", "Disagree", "Somewhat disagree", "Somewhat agree", "Agree", and "Strongly agree". The 6-point Likert scale was chosen after consideration of a self-efficacy instrument that already existed (Boone et al., 2014, as cited in Brann et al., 2020; Enochs & Riggs, 1990, as cited in Brann et al., 2020) and the psychometric properties of its scores.

A Rasch analysis was conducted in order to test the scale's psychometric functioning. It supported the unidimensionality of the scale, showing that all items reflect a single trait. This means that all individual item scores can be added and thus result in one score that can then be

interpreted. To increase interpretability of this raw score, the authors created a score conversion table that enables the assignment of a Rasch person measure score to each raw score. Internal consistency was high (Cronbach's $\alpha = 0.91$) and the results suggested construct validity. However, the authors also mention the need to evaluate criterion validity, test the psychometric properties with larger and more diverse samples, as well as to assess the appropriateness of the items across different teaching settings (e.g. primary school, high school, etc.).

Adaptations in this study. For the purpose of this study, it was decided to change the response format from a 6-point Likert scale to a 5-point Likert scale. This enabled participants to choose a neutral stance rather than forcing them to select a tendency. Ratings were made on a scale from one to five, with one being labeled "Strongly disagree" and five being labeled "Strongly agree". The scores in between the extrema were simply labeled with the respective number in order to signal an increasing score.

The complete list of items and the German translations that were used can be found in the appendix (see Table 10).

3.4.3. Attitudes Toward Wellbeing Promotion scale (ATWP)

The *Attitudes Toward Wellbeing Promotion* scale (ATWP; Byrne et al., 2021) is a 10-item scale that measures two factors: teachers' attitudes toward promoting student wellbeing as well as toward the wellbeing policies and curricula that are currently in use. Ratings are made on a five-point Likert scale with the following options: "Strongly disagree", "Disagree", "Neither agree nor disagree", "Agree", and "Strongly agree", which was done in line with Vagias (2006).

The development of the ATWP scale went through three stages: first, experts and educators assessed the content validity. Second, an exploratory factor analysis was conducted, followed by a confirmatory factor analysis as a third step. During this process, the initially proposed four sub-scales were reduced to two. All 10 items loaded in these two factors, and the factors themselves are uncorrelated, with their discriminant validity established. Goodness-of-fit indices showed acceptable fit values (Root Mean Square Error of Approximation = 0.03, 90% CI = 0.00 - 0.80; Standardized Root Mean Square Residual = 0.07; Close Fit Index = 0.98; Tucker-Lewis Index = 0.98). Reliability analysis using McDonald's Omega yielded good values for the full ATWP scale ($\omega_t = 0.81$) and the wellbeing promotion sub-scale ($\omega_t = 0.82$) as well as an acceptable value for the policies and curriculum sub-scale ($\omega_t = 0.75$). These results led the authors to the conclusion that the ATWP scale can be considered a psychometrically sound instrument.

Adaptations in this study. For this study, only the "attitudes toward wellbeing promotion" subscale was used; we did not ask about policies and curricula. Ratings were made on a scale from one to five, with 1 being labeled "Strongly disagree" and 5 being labeled "Strongly agree". The scores in between the extrema were simply labeled with the respective number.

The complete list of items and the German translations that were used can be found in the appendix (see Table 11).

3.4.4. Teachers' conception of mental health terms

This part consisted of two open questions that asked participants what they understand by the following two terms: *Psychische Gesundheit* (English: *psychological health*) and *Wohlbefinden* (English: *wellbeing*).

3.4.5. Mental health resources available to teachers

This part of the survey consisted of seven questions regarding the resources available to teachers in their respective schools that are relevant for the area of mental health, e.g., whether there are school-wide measures for the support of social-emotional wellbeing, whether resources are provided that enable the preparation of teaching classes about social-emotional wellbeing, and whether there are school psychologists who can be consulted and who work with children in the school.

Ratings were made on a 5-point Likert scale with the extrema being labeled "none" and "a lot". Response options in between were not labeled. For the analysis, responses were given the values of 1 ("none") to 5 ("a lot").

The results of this part of the survey can be found in the appendix (see Table 7).

3.4.6. Teaching MHL in class

This part of the survey was intended to provide an overview of topics and activities regarding mental health promotion that are talked about or conducted in class. Questions were created so that several components of the *MHL* model are covered: recognition of mental disorders, knowledge and beliefs about risk factors and causes, knowledge and beliefs about self-help (resilience), knowledge of how to seek mental health information, as well as attitudes that facilitate help-seeking (stigma).

The results of this part of the survey can be found in the appendix (see Figure 1, Figure 2, Figure 3, Figure 4, Figure 5).

3.4.7. Sociodemographic questions

The sociodemographic part included questions about their age and gender, years of experience, education status, the country they teach in, the environment of the school, and additional training regarding psychosocial competencies they have completed.

3.4.8. Translation process

In order for the questionnaire to be easily comprehensible for Austrian teachers, it was translated from the source language English to German. The translation process was based on the parallel-blind technique as mentioned in Behling and Law (2000, p.23ff). After the author and a supervisor translated the items individually, another supervisor joined for a discussion, which resulted in a new translation that merged the best features of the original two translations. One advantage of this technique is its practicality. It is one of the fastest methods and more time-efficient than, for example, translation/back-translation. Furthermore, it exhibits good source language transparency, which relates to the researchers having control over the translation as well as the security that checking two translations against each other provides. A disadvantage mentioned in the literature is the limited role the researcher can play in the translation process unless he or she is fluent in both languages. This did not apply to the present study since everybody was fluent in German as well as in English.

After following the protocol of the parallel-blind technique, we extended the process by asking for additional feedback from one of the project managers, which was then incorporated.

As a last step, a pre-study was conducted in which participants completed the study questionnaire. Besides the contents previously discussed, it included some additional questions about their conception of what certain terms mean, and also gave them the opportunity to make comments about items if they did not understand fully what these were supposed to mean. The findings from this step were again incorporated and led to the final version of the questionnaire.

3.5. Procedure

The survey was conducted on SoSci Survey and took around 10-15 minutes to complete. The layout of the questionnaire was optimized for smartphones, which were expected to be the most used medium for completion. Prior to the start of the actual survey, participants were briefly introduced to the Comet4Kids-project, which was followed by the information that this survey would be about their experiences concerning and attitudes toward the topic of mental health in schools. The second page gave information on data protection, emphasizing the anonymous

nature of the data and its exclusive use for scientific purposes within the project. A box had to be checked to indicate consent to the processing of their data as described.

Before the main part of the survey, participants were asked to give information about their teaching activities, which meant answering questions about the type of school they were currently teaching in and their education.

Then the main part of the study ensued, consisting of the three scales *survey about general perspectives on mental health education*, *SMH-SETS*, and *ATWP*.

Following that, the surveys about resources and *MHL* components had to be completed.

After enquiring about sociodemographic data, the survey finished with two open questions concerning the comprehension of terms used in this study.

3.6. Data analysis

Analysis was carried out using IBM SPSS Statistics (Version 29.0.1.0; IBM Corp., 2023). The survey data were of quantitative and qualitative nature.

The quantitative data were analyzed using descriptive statistics and frequency analysis, correlation, and linear regression.

The qualitative data were analyzed using deductive thematic analysis, following Naeem et al.'s (2023) six-step process. First, to get familiar with the data, the responses were read several times. Quotes that exemplified different viewpoints were selected. Second, recurring ideas and terms were identified and chosen as keywords. In the third step, termed coding, segments of the data were assigned codes, which are short phrases or words that encapsulate the segment's respective meaning. Fourth, codes were grouped into themes that describe the data in a more abstract way by revealing overarching patterns. Fifth, concepts were defined that emerged from reviewing the keywords, codes, and themes. And sixth, in the last step, a conceptual model was developed integrating findings with the existing theory.

3.7. Missing data

There were some missing values in the variables *gender* (15%), *age* (11%), *years in practice* (10%), as well as in the purely descriptive statistics about available mental health resources and teaching *MHL* in class. This is likely primarily due to survey attrition, as this information was collected in the later parts of the survey. Little's MCAR test was not significant for all models that included these variables, thus the hypothesis that missing values were MCAR (Missing Completely at Random) was not rejected. Consequently, a pairwise-deletion approach could be applied, which describes the use of all data that is available for any given statistic (Schafer &

Graham, 2002). As a result, some parameters were based on different subsets of the sample. The corresponding sample sizes are reported with each result. A sensitivity analysis was conducted using multiple imputation ($m = 5$; predictive mean matching for *age* and *years in practice*, logistic regression for *gender*). Results were robust: multiple imputation led to nearly identical outcomes for the statistical tests with *age* and *years in practice* with no change in statistical significance. In the test that used *gender*, the difference between the groups somewhat decreased, but this also did not affect significance. Hence, the outcomes based on pairwise deletion are reported in the results section.

4. Results

4.1. Research question 1

4.1.1. Exploratory statistics

Survey about general perspectives on mental health education. In the following, descriptive statistics will be given for the three factors of the *survey about general perspectives on mental health education* (Marinucci et al., 2023).

Factor A: Attitudes towards how mental health affects student ability. This factor measured the attitude of participants regarding the ability of mental health promotion to improve students' ability to cope with mental health problems. Results can be found in Table 2.

Results show a similar pattern across the items, with between 74.2% and 90.3% of participants giving a rating of 4 or higher on the 5-point Likert scale. Means range from 4.18 to 4.45, with high values indicating an approving attitude. Item A1 ("Mental health initiatives can strengthen academic performance.") exhibits the lowest mean and the highest percentage of participants who are undecided or disagree, (25.8%), which is at least twice as large as in the other items. Item A2 ("Mental health initiatives can strengthen mental health.") exhibits the highest mean and the largest percentage of participants who strongly agree (59.7%).

A sum score of all items in factor A was created for each participant. Possible scores ranged from 6 to 30; the observed scores range from 15 to 30 ($M = 26.18$, $SD = 3.71$). The distribution was moderately negatively skewed ($g_1 = -0.77$, $SE = 0.30$, $z = -2.54$) and showed a kurtosis that was only minimally flatter than the normal distribution ($g_2 = -0.09$, $SE = 0.60$, $z = -0.15$). Because the skewness z -value exceeds ± 1.96 , the data deviate from normality with respect to skewness, whereas the kurtosis z -value indicates no significant departure from normality.

Table 2.

Results of factor A: "Attitudes towards how mental health affects student ability" (n = 62)

Item	Description						M	SD
		strongly disagree (1)	2	3	4	strongly agree (5)		
A1	Mental health initiatives can strengthen academic performance.	0%	1.6%	24.2%	29.0%	45.2%	4.18	.86
A2	Mental health initiatives can strengthen mental health.	0%	1.6%	11.3%	27.4%	59.7%	4.45	.76
A3	Mental health initiatives can strengthen resilience.	0%	3.2%	8.1%	38.7%	50.0%	4.35	.77
A4	Mental health initiatives can strengthen help-seeking.	0%	4.8%	8.1%	33.9%	53.2%	4.35	.83
A5	Mental health initiatives can strengthen adaptive coping.	0%	1.6%	8.1%	37.1%	53.2%	4.42	.71
A6	Mental health initiatives can strengthen responding to others.	0%	1.6%	8.1%	37.1%	53.2%	4.42	.71

Notes.

Factor and items stem from the *survey about general perspectives on mental health education* (Marinucci et al., 2023; A. Marinucci, personal communication, November 27, 2023).

Factor B: Attitudes towards school role in mental health education. This factor measured participants' perceived necessity to implement mental health promotion in schools. Results can be found in Table 3.

Results show a similar pattern as in factor A, with between 77.4% and 98.4% of participants giving a rating of 4 or higher on the 5-point Likert scale. Means range from 4.21 to 4.94, with

high values indicating an approving attitude. Items B3 ("Mental health education should be part of the curriculum.") and B4 ("Teachers need adequate training.") exhibit the lowest means and the highest percentages of participants who are undecided or disagree ($\approx 21\%$), which are at least four times as large as in the other items.

A sum score of all items in factor B was created for each participant. Possible scores ranged from 5 to 25; the observed scores range from 15 to 25 ($M = 22.55$, $SD = 2.79$). The distribution was moderately negatively skewed ($g_1 = -0.96$, $SE = 0.30$, $z = -3.15$) and exhibited a kurtosis that was only minimally flatter than the normal distribution ($g_2 = -0.07$, $SE = 0.60$, $z = -0.12$). Because the skewness z -value exceeds ± 1.96 , the data deviate from normality with respect to skewness, whereas the kurtosis z -value indicates no significant departure from normality.

Table 3.

Results of factor B: "Attitudes towards school role in mental health education" ($n = 62$)

Item	Description	strongly disagree (1)					strongly agree (5)	
		0%	2	3	4		M	SD
B1	Schools need to take a preventive approach.	0%	1.6%	6.5%	29.0%	62.9%	4.53	.70
B2	Students need to know where to seek help.	0%	0%	1.6%	3.2%	95.2%	4.94	.31
B3	Mental health education should be part of the curriculum.	1.6%	4.8%	14.5%	21.0%	58.1%	4.29	1.00
B4	Teachers need adequate training.	0%	8.1%	14.5%	25.8%	51.6%	4.21	.98
B5	Teachers need to understand mental health problems.	0%	1.6%	4.8%	27.4%	66.1%	4.58	.67

Notes.

Factor and items stem from the *survey about general perspectives on mental health education* (Marinucci et al., 2023; A. Marinucci, personal communication, November 27, 2023).

Factor C: Attitudes towards delivery of mental health education. This factor measured teachers' assessment of the delivery of mental health education in schools. In our questionnaire, items were slightly adapted in order to ask participants about the specific schools they were currently teaching in. The adapted items in German can be found in the appendix (Table 9).

A high mean value represents a favourable attitude toward mental health promotion. Mean scores of items C1-C3 were inverted in order to be in alignment with this interpretation, since disagreement signaled a positive attitude toward mental health promotion. Results can be found in Table 4.

Means range from 1.93 to 3.36. Items C5 ("Our school promotes further training for staff in the area of mental health education for students.") and C7 ("My school has a clear policy on mental health education.") exhibit the lowest means and also met with the most disagreement (58% and 72.5% respectively). Item C3 ("There are barriers to implementing mental health promotion.") exhibits the greatest variation.

Table 4.

Results of factor C: "Attitudes towards delivery of mental health education" (n = 62)

Item	Description	strongly disagree (1) 2 3 4					strongly agree (5) M SD	
C1	It is difficult to talk about mental health with students.	11.3%	30.6%	35.5%	14.5%	8.1%	3.23 ²	1.09
C2	Parents are reluctant to mental health education with students. (n = 59)	18.6%	16.9%	52.5%	5.1%	6.8%	3.36 ²	1.06
C3	There are barriers to implementing mental health promotion. (n = 61)	24.6%	18.0%	26.2%	16.4%	14.8%	3.21 ²	1.38
C4	At our school, we believe it's important to talk about mental health. ¹	6.5%	21.0%	27.4%	38.7%	6.5%	3.18	1.05

Item	Description	1	2	3	4	5	M	SD
C5	Our school promotes further training for staff in the area of mental health education for students. ¹	40.3%	17.7%	32.3%	8.1%	1.6%	2.13	1.09
C6	Schools place high importance on mental health.	6.5%	19.4%	35.5%	27.4%	11.3%	3.18	1.08
C7	My school has a clear policy on mental health education. (<i>n</i> = 61)	44.3%	29.5%	18.0%	4.9%	3.3%	1.93	1.06

Notes.

Factor and items stem from the *survey about general perspectives on mental health education* (Marinucci et al., 2023; A. Marinucci, personal communication, November 27, 2023).

¹ This item does not come from the original scale. It is the English translation of the item that was created for the German questionnaire.

² This item's scores were inverted in the analysis, so a high score represents a positive attitude toward mental health promotion and vice versa.

School Mental Health Self-efficacy Teacher Survey (SMH-SETS). The *SMH-SETS* measures participants' self-efficacy in responding to students' mental health problems. On a 5-point Likert scale, they responded to different statements covering several aspects of self-efficacy, each with the stem "I feel competent to...". Results can be found in Table 5.

Means range from 2.81 to 4.13, with high values indicating a greater level of self-efficacy. Items S2 ("recognize when there is a student with an externalizing concern."—85.0% state feeling competent), S14 ("promote the social skills of students in my classroom."—77.4% state feeling competent), and S15 ("promote the emotional skills of students in my classroom."—71.0% state feeling competent) exhibit the largest mean scores with values of 4.0 or higher. Items with the lowest levels of self-efficacy as indicated by mean scores below 3 are S3 ("recognize when a student is displaying indicators of exposure to trauma."—40.3% reported not feeling competent), S5 ("provide academic instruction to students with an externalizing concern."—37.1% reported

Table 5.*Results of the School Mental Health Self-efficacy Teacher Survey (SMH-SETS) (n = 62)*

Item	I feel competent to...	strongly disagree (1)	2	3	4	strongly agree (5)	M	SD
S1	recognize when there is a student with an internalizing concern.	6.5%	9.7%	24.2%	46.8%	12.9%	3.50	1.05
S2	recognize when there is a student with an externalizing concern.	1.6%	4.8%	8.1%	50.0%	35.5%	4.13	.88
S3	recognize when a student is displaying indicators of exposure to trauma.	9.7%	30.6%	25.8%	24.2%	9.7%	2.94	1.16
S4	provide academic instruction to students with an internalizing concern.	9.7%	21.0%	30.6%	33.9%	4.8%	3.03	1.07
S5	provide academic instruction to students with an externalizing concern.	12.9%	24.2%	29.0%	27.4%	6.5%	2.90	1.14
S6	provide academic instruction to students from diverse backgrounds who have mental health concerns.	8.1%	21.0%	21.0%	37.1%	12.9%	3.26	1.17
S7	consider cultural needs in promoting students' mental health.	14.5%	27.4%	22.6%	21.0%	14.5%	2.94	1.29
S8	respond when a student is in crisis.	8.1%	21.0%	24.2%	30.6%	16.1%	3.26	1.20

Item	I feel competent to...	strongly disagree (1)	2	3	4	strongly agree (5)	M	SD
S9	respond when a student is displaying aggressive behavior.	6.5%	21.0%	25.8%	30.6%	16.1%	3.29	1.17
S10	respond to a student who is expressing suicidal thoughts.	21.0%	29.0%	14.5%	19.4%	16.1%	2.81	1.40
S11	refer a student to mental health providers.	1.6%	14.5%	16.1%	38.7%	29.0%	3.79	1.07
S12	offer assistance in the classroom to student with mental health concerns.	1.6%	19.4%	19.4%	38.7%	21.0%	3.58	1.08
S13	discuss student mental health concerns with parents.	9.7%	17.7%	32.3%	22.6%	17.7%	3.21	1.22
S14	promote the social skills of students in my classroom.	0%	1.6%	21.0%	41.9%	35.5%	4.11	.79
S15	promote the emotional skills of students in my classroom.	0%	3.2%	25.8%	38.7%	32.3%	4.00	.85

Notes.

The *SMH-SETS* stems from Brann et al. (2020).

Items are shortened for better readability. Full items and the German translations that were used can be found in the appendix (see Table 10).

not feeling competent), S7 ("consider cultural needs in promoting students' mental health."—41.9% reported not feeling competent), and S10 ("respond to a student who is expressing suicidal thoughts."—50% reported not feeling competent). The items with the greatest variation are S7 ("consider cultural needs in promoting students' mental health.") and S10 ("respond to a student who is expressing suicidal thoughts."). Teachers feel more competent to recognize a student with an externalizing concern (S2) than one with an internalizing concern (S1), however, they feel slightly more competent in providing academic instruction to students with an internalizing concern (S3 vs. S4).

A sum score of all items in the *SMH-SETS* was created for each participant. Possible scores ranged from 15 to 75; the observed scores range from 26 to 73 ($M = 50.74$, $SD = 11.47$). The distribution was slightly negatively skewed ($g_1 = -0.21$, $SE = 0.30$, $z = -0.70$) and showed a marginally flatter kurtosis than the normal distribution ($g_2 = -0.77$, $SE = 0.60$, $z = -1.28$). As both z -values lie within ± 1.96 , no significant deviation from normality is present.

Attitudes Toward Wellbeing Promotion scale (ATWP). The *ATWP* scale measures teachers' attitudes toward wellbeing promotion in the classroom. Five statements have to be rated on a 5-point Likert scale. A high mean value represents a favourable attitude toward wellbeing promotion. Mean scores of Items W1, W2, and W3 were inverted in order to be in alignment with this interpretation, since disagreement signaled a positive attitude. Results can be found in Table 6.

Means range from 3.87 to 4.56. Item W5 ("Teachers should not be tasked with the promotion of student wellbeing.") exhibits the greatest variation. While 64.5% of teachers disagree (i.e., think that teachers should promote wellbeing), 35.5% are neutral or at least somewhat agree with the statement (i.e., think that teachers should not be tasked with wellbeing promotion). 80.7% of participants at least somewhat agree that promoting student wellbeing is fulfilling (W3), 93.5% at least somewhat agree that it makes them happy (W4). On the other hand, 9.7% of participants at least somewhat agree that attending to student wellbeing can make them uncomfortable (W2).

Table 6.*Results of the Attitudes Toward Wellbeing Promotion scale (ATWP) (n = 62)*

Item	Description	strongly disagree (1)					strongly agree (5)	
			2	3	4		M	SD
W1	I tend to avoid dealing with students' social or emotional issues.	56.5%	30.6%	8.1%	4.8%	0%	4.39 ¹	.84
W2	Attending to student wellbeing can make me feel uncomfortable.	33.9%	32.3%	24.2%	3.2%	6.5%	3.84 ¹	1.13
W3	Promoting student wellbeing is a fulfilling experience for me.	1.6%	3.2%	14.5%	22.6%	58.1%	4.32	.95
W4	Promoting student wellbeing makes me feel happy.	1.6%	1.6%	3.2%	25.8%	67.7%	4.56	.78
W5	Teachers should not be tasked with the promotion of student wellbeing.	43.5%	21.0%	19.4%	11.3%	4.8%	3.87 ¹	1.24

*Notes.*The *ATWP* stems from Byrne et al. (2021).

¹ These items' scores were inverted in the analysis, so a high score represents a positive attitude toward wellbeing promotion and vice versa.

4.1.2. Hypothesis testing

H1: A teacher's age predicts their anticipation that mental health promotion will be effective.

In order to test the hypothesis that age predicts teachers' anticipated effectiveness of mental health promotion, a linear regression was performed with age as independent variable and the sum score on factor A ("Attitudes towards how mental health affects student ability") of the *survey about general perspectives on mental health education* as dependent variable ($n = 55$).

Preliminary analyses were conducted to test the assumptions of linear regression. Visual inspection of the residual plots suggested linearity, homoskedasticity, and normality of residuals. The assumption of independence of residuals was evaluated using the Durbin-Watson statistic. The analysis yielded a value of $DW = 1.96$, which suggests that there was no significant autocorrelation among the residuals (the null hypothesis can be assumed for values between 1.53 and 2.40 in a model with $n = 55$ and one predictor). Evaluating Cook's distances, no observation surpassed the commonly used threshold of 1, which would be a sign of a highly influential outlier. Two observations ($D = 0.17$; $D = 0.12$) surpassed the more conservative $4/n$ cut-off criterion ($4/55 \approx 0.07$), indicating at least some influence. Inspection of the data did not suggest any measurement errors, so they were kept in the final model.

The overall regression model was not significant, with $F_{1, 53} = 2.53$, $p = .118$. Age explained 5% of the variance in the anticipation that mental health promotion will be effective ($R^2 = .05$, adjusted $R^2 = .03$).

A teacher's age did not significantly predict their anticipation that mental health promotion will be effective ($B = -0.06$, $SE = 0.04$, $\beta = -.21$, $t_{53} = -1.59$, $p = .118$, 95% $CI = -0.13; 0.02$).

H2: A teacher's age predicts their perceived necessity to implement mental health promotion in schools.

In order to test the hypothesis that age predicts the perceived necessity to implement mental health promotion in schools, a linear regression was performed with age as independent variable and the sum score on factor B ("Attitudes towards school role in mental health education") of the *survey about general perspectives on mental health education* as dependent variable ($n = 55$).

Preliminary analyses were conducted to test the assumptions of linear regression. Visual inspection of the residual plots suggested linearity, homoskedasticity, and normality of residuals.

The assumption of independence of residuals was evaluated using the Durbin-Watson statistic. The analysis yielded a value of $DW = 2.36$, which suggests that there was no significant autocorrelation among the residuals (the null hypothesis can be assumed for values between 1.53 and 2.40 in a model with $n = 55$ and one predictor). Evaluating Cook's distances, no observation surpassed the commonly used threshold of 1. Three observations ($D = 0.16$; $D = 0.11$; $D = 0.09$) surpassed the $4/n$ cut-off criterion ($4/55 \approx 0.07$). Inspection of the data did not suggest any measurement errors, so they were kept in the final model.

The overall regression model was significant, with $F(1, 53) = 17.49, p < .001$. Age explained 25% of the variance in the perceived necessity to implement mental health promotion in schools ($R^2 = .25$, adjusted $R^2 = .23$), indicating a large effect size according to Cohen (1988).

Age significantly negatively predicted the degree to which implementing mental health promotion in schools was perceived as a necessity ($B = -0.11, SE = 0.03, \beta = -.50, t_{53} = -4.18, p < .001, 95\% CI = -0.16; -0.06$). The standardized regression coefficient β further suggests a large effect size according to Cohen (1988).

H3: A teacher's gender does not predict their self-efficacy in responding to mental health problems among their students.

In order to test the hypothesis that gender does not predict the level of self-efficacy a teacher possesses in responding to mental health problems among their students, an independent samples t -test was performed with the score on the *SMH-SETS* as dependent variable and *gender* as grouping variable ($n = 53$).

Preliminary analyses were conducted to test the assumptions of an independent samples t -test. Since group membership was determined by gender, independence of the groups was established. The dependent variable *self-efficacy* had a possible range of values from 15 to 75 and could therefore be considered metric. The Shapiro-Wilk test (recommended for small sample sizes $n < 50$) was not significant, showing that normality of each of the two groups could not be rejected. The Levene test was significant, however, indicating a violation of the homogeneity-of-variance assumption ($p = .022$). Therefore, the results of Welch's corrected t -test, which does not assume equal variances, are reported.

Female participants ($n = 44$) reported an average self-efficacy score of $M = 50.98 (SD = 12.22)$, while male participants ($n = 9$) reported a mean score of $M = 48.33 (SD = 6.60)$.

The results of Welch's corrected t -test showed that the difference between female and

male participants' self-efficacy scores was not statistically significant ($t(21.24) = 0.92, p = .367$ (two-tailed), 95% CI [-3.32, 8.61]).

H4: A teacher's years in practice do not predict their self-efficacy in responding to mental health problems among their students.

In order to test the hypothesis that a teacher's years in practice do not predict their self-efficacy in responding to mental health problems among their students, a linear regression was performed with years in practice as independent variable and the score on the *SMH-SETS* as dependent variable ($n = 56$).

Preliminary analyses were conducted to test the assumptions of linear regression. Visual inspection of the residual plots suggested linearity, homoskedasticity, and normality of residuals. The assumption of independence of residuals was evaluated using the Durbin-Watson statistic. The analysis yielded a value of $DW = 2.13$, which suggests that there was no significant autocorrelation among the residuals (the null hypothesis can be assumed for values between 1.53 and 2.40 in a model with $n = 56$ and one predictor). Evaluating Cook's distances, no observation surpassed the commonly used threshold of 1. One observation ($D = 0.073$) slightly surpassed the $4/n$ cut-off criterion ($4/56 \approx 0.07$); inspection of the data did not suggest any measurement errors, so they were kept in the final model.

The overall regression model was not significant, with $F(1, 54) = 0.05, p = 0.831$. Years in practice explained 0.1% of the variance in the self-efficacy in responding to mental health problems among their students ($R^2 = .00$, adjusted $R^2 = -.02$).

A teachers' years in practice did not significantly predict their self-efficacy in responding to mental health problems among their students ($B = 0.03, SE = 0.14, \beta = .03, t_{54} = 0.21, p = 0.831, 95\% CI = -0.24; 0.30$).

H5: Teachers with higher levels of self-efficacy in responding to mental health problems among their students tend to anticipate that mental health promotion will be more effective.

In order to test the hypothesis that teachers with higher levels of self-efficacy in responding to mental health problems among their students tend to anticipate that mental health promotion will be more effective, a linear regression was performed with the score on the *SMH-SETS* as independent variable and the score on factor A ("Attitudes towards how mental health affects student ability") of the *survey about general perspectives on mental health education* as dependent

variable ($n = 62$).

Preliminary analyses were conducted to test the assumptions of linear regression. Visual inspection of the residual plots suggested linearity, homoskedasticity, and normality of residuals. The assumption of independence of residuals was evaluated using the Durbin-Watson statistic. The analysis yielded a value of $DW = 1.82$, which suggests that there was no significant autocorrelation among the residuals (the null hypothesis can be assumed for values between 1.55 and 2.38 in a model with $n = 60$ and one predictor). Evaluating Cook's distances, no observation surpassed the commonly used threshold of 1. One observation ($D = 0.07$) slightly surpassed the $4/n$ cut-off criterion ($4/62 \approx 0.06$); Inspection of the data did not suggest any measurement errors, so it was kept in the final model.

The overall regression model was significant, with $F(1, 60) = 4.55, p = .037$. Self-efficacy explained 7% of the variance in teachers' anticipation that mental health promotion will be effective ($R^2 = .07$, adjusted $R^2 = .06$), indicating a small to medium effect size according to Cohen (1988).

Higher levels of self-efficacy in responding to mental health problems in their students significantly predicted a greater tendency to anticipate that mental health promotion will be effective ($B = .09, SE = 0.04, \beta = .27, t_{60} = 2.13, p = .037, 95\% CI = 0.01; 0.17$). The standardized regression coefficient β suggests a medium effect size according to Cohen (1988).

H6: Teachers with higher levels of self-efficacy in responding to mental health problems among their students tend to perceive a greater necessity to implement mental health promotion in schools.

In order to test the hypothesis that teachers with higher levels of self-efficacy in responding to mental health problems among their students tend to perceive a greater necessity to implement mental health promotion in schools, a linear regression was performed with the score on the *SMH-SETS* as independent variable and the sum score on factor B ("Attitudes towards school role in mental health education") of the *survey about general perspectives on mental health education* as dependent variable ($n = 62$).

Preliminary analyses were conducted to test the assumptions of linear regression. Visual inspection of the residual plots suggested linearity and homoskedasticity of residuals. The normality assumption of residuals was not met. However, for $n > 30$, normality can be assumed according to the Central Limit Theorem. The assumption of independence of residuals was evaluated using the Durbin-Watson statistic. The analysis yielded a value of $DW = 1.74$, which

suggests that there was no significant autocorrelation among the residuals (the null hypothesis can be assumed for values between 1.55 and 2.38 in a model with $n \approx 60$ and one predictor). Evaluating Cook's distances, no observation surpassed the commonly used threshold of 1. Two observations ($D = 0.14$; $D = 0.09$) surpassed the $4/n$ cut-off criterion ($4/60 \approx 0.06$); inspection of the data did not suggest any measurement errors, so they were kept in the final model.

The overall regression model was not significant, with $F(1, 60) = 0.02$, $p = .89$. Self-efficacy explained 0% of the variance in teachers' perceived necessity to implement mental health promotion ($R^2 = .00$, adjusted $R^2 = -.02$).

Self-efficacy in responding to mental health problems among their students did not significantly predict a tendency to perceive a greater necessity to implement mental health promotion in schools ($B = .004$, $SE = 0.03$, $\beta = .02$, $t(60) = 0.14$, $p = .89$, 95% $CI = -0.06; 0.07$).

H7: Teachers in secondary schools have higher levels of self-efficacy in responding to mental health problems among their students than teachers in primary schools.

In order to test the hypothesis that teachers in secondary schools have higher levels of self-efficacy in responding to mental health problems among their students than teachers in primary schools, an independent samples t -test was performed with scores on the *SMH-SETS* as dependent variable and school level as grouping variable ($n = 48$).

Preliminary analyses were conducted to test the assumptions of an independent samples t -test. Since group membership was determined by teaching in one type of school, independence of the groups was established. The dependent variable "Self-efficacy" had a possible range of values from 15 to 75 and could therefore be considered metric. The Shapiro-Wilk test (recommended for small sample sizes $n < 50$) was not significant, showing that normality of each of the two groups could not be rejected. The Levene test was also not significant, indicating homogeneity of variances ($p = .478$). Therefore, the assumptions of an independent samples t -test were met.

The average self-efficacy score of primary school teachers ($M = 51.67$, $SD = 12.31$) was larger than the average score of secondary school teachers ($M = 48.90$, $SD = 11.37$). This was contrary to the direction that was assumed in the hypothesis. Therefore, the hypothesis can be rejected.

The results of the independent samples t -test showed that the difference between primary and secondary school teachers' self-efficacy scores was also not statistically significant ($t(46) = 0.79$, $p = .433$ (two-tailed), 95% $CI = -4.27, 9.81$).

4.2. Research question 2

H8: Teachers in Austria have similar conceptions of the terms *Psychische Gesundheit* (mental health) and *Wohlbefinden* (wellbeing), with a greater tendency of the term *mental health* to be associated with stigma and mental disorders.

The test of this hypothesis was tackled through a deductive thematic analysis of teachers' responses to two open questions that requested them to explain the two terms respectively. The results are presented in the following.

Teachers' conception of the term "Psychische Gesundheit" ("Mental health"). Three main themes were identified: psychological and emotional wellbeing, functioning, and social participation.

Psychological and emotional wellbeing. This theme can be defined by the absence of mental disorders and as a state of wellbeing, contentment, and physical health. The state is characterized by possessing a healthy level of self-confidence, self-awareness, and the ability to regulate emotions. Codes/keywords for this theme were: emotional/psychological wellbeing, contentment, self-awareness, emotional balance, emotion regulation, self-confidence, absence of illness. Psychological health was described as "geistiges und emotionales Wohlbefinden" ("mental and emotional wellbeing") and as "Abwesenheit von Diagnosen und Leidensdruck, altersentsprechende Kompetenz zur Emotionsregulation" ("Absence of diagnoses and subjective distress, age-appropriate competence in emotion regulation"). One participant emphasized the threat that a lack of attention to one's own mental health while trying to help others can pose: "Man vergisst auf seine eige [sic] psychische Gesundheit zu achten und als Lehrperson versuche ich den Kindern eine gute Zukunft zu hinterlassen bzw ihnen eine Möglichkeit für bessere Lebenschancen anzubieten. Dabei vergisst man seine eigene psychische Gesundheit und so macht man sich selbst fertig." ("One forgets to pay attention to one's own psychological health and as a teacher I try to provide children with a good future and give them opportunities for a better life. In doing so, one forgets one's own psychological health and ends up wearing oneself out.")

Functioning. This theme can be characterized by resilience and the ability to cope with daily life, having a sense of meaning and being able to take responsibility. Codes/keywords for this theme were: resilience, coping, meaning, responsibility, learning motivation, contribution. One participant described it like this: "Psychische Gesundheit bedeutet für mich, dass man mental "fit" genug ist, um sich als Teil der Gesellschaft zu sehen, die täglichen Herausforderungen zu meistern und auch dazu fähig ist Verantwortung für diese Gesellschaft zu übernehmen, was

immer wieder auch bedeutet, Belastungen auszuhalten.” (“To me, mental health means being mentally “fit” enough to consider oneself a part of society, to cope with the daily challenges, and also to be able to take responsibility for society, which often means having to endure burdens.”)

Social participation. This theme emphasizes the ability to form healthy relationships and participate socially, to communicate openly, and to set boundaries. Codes/keywords for this theme were: social participation, ability to form healthy relationships, open communication of emotions and needs, prevention of negative experiences such as bullying and loneliness. Participants mentioned “soziale Kompetenzen” (“social competence”), and “Dass die Kinder ihre eigenen Gefühle und Bedürfnisse, aber auch die der anderen erkennen und respektieren können. Dass sie sich nicht verstellen müssen. Dass offene Gespräche möglich sind.” (“That the children are able to recognize and respect their own feelings and needs, as well as those of others. That they do not have to pretend to be someone they are not. That open conversations are possible.”).

Conceptual framework. Participants described *mental health* by referring to psychological and emotional wellbeing, functioning, and social participation. This is congruent with the definition of Keyes (2014; as cited in Galderisi et al., 2015), according to whom *mental health* encompasses emotional, psychological, and social wellbeing. Functioning, which was an important aspect to participants in this study, corresponds to the concept of coping with daily responsibilities, which, according to Keyes (2014; as cited in Galderisi et al., 2015), can be considered a part of psychological wellbeing.

Teachers’ conception of the term “Wohlbefinden” (“Wellbeing”) Four main themes were identified: contentment and inner stability, social integration, safety, and functioning.

Contentment and inner stability. This theme describes the state of feeling well and at ease. The person is in harmony with oneself, which entails accepting oneself and being able to authentically be oneself. On the other hand, there is also the feeling of being at peace with how things are. Example keywords/codes were: feeling well, at ease/inner harmony, authenticity. One participant described it like this: “Wohlbefinden ist also ein subjektives Erleben von Gesundheit, Zufriedenheit und einem allgemeinen Gleichgewicht in allen Lebensbereichen.” (“Wellbeing is a subjective experience of health, contentment, and a general balance in all areas of life.”).

Social integration. This theme describes the state of being socially integrated and having a sense of belonging. Example keywords/codes were: social environment, sense of belonging, community. One participant said it like this: “Das Wohlbefinden ist ein Zustand der auch stark von der Gruppe abhängt, in der man sich befindet. Ein gutes Wohlbefinden weist darauf hin,

dass man sich im sozialen Kontext wohlfühlen [sic] und auch für andere einen Wohlfühlfaktor darstellt.” (“Wellbeing is a state that strongly depends on the group you are part of. A good sense of wellbeing indicates that you feel comfortable in a social context and that you also contribute to a sense of wellbeing for others.”).

Safety. This theme describes the feeling of being safe in one’s environment. Example keywords/codes were: feeling safe in one’s environment, no fear of doing/saying things, no bullying. Participants described wellbeing as a “Gefühl von Sicherheit [...] im eigenen Körper oder an Orten.” (“Feeling safe in one’s own body or in certain places.”). For another, it was “Sich an einem Ort oder unter bestimmten Menschen sicher und gut aufgehoben zu fühlen.” (“Feeling safe and comfortable in a certain place or with certain people.”).

Functioning. This theme describes the ability to cope with the challenges of daily life without being overwhelmed by stress and pressure. Example keywords/codes were: positive thinking, free from stress, not feeling overwhelmed by expectations, ability to make decisions, being motivated. A participant mentioned “die Hürden des Alltags gut meistern, nach einem Tief im Leben nach vorne schauen können, allgemein positiv in den Tag gehen können” (“To be able to cope well with the challenges of everyday life, to look ahead after setbacks, and to generally approach each day with a positive attitude.”). The impact of teacher stress on children was also emphasized: “Wenn es LehrerInnen und Eltern gutgeht [sic], dann geht es auch den SchülerInnen gut. Wenn LehrerInnen und Eltern immer mehr Stress erfahren, dann haben auch die Kinder psychische Probleme. Und wir haben VIEL mehr Stress als früher!!” (“When teachers and parents are doing well, the students are also doing well. When teachers and parents experience increasing stress, children also develop mental problems. And we are experiencing MUCH more stress than we used to!!”).

Conceptual framework. Participants in this study described *wellbeing* by referring to a sense of contentment and being at peace with how things are. These coincide with the concept of *emotional wellbeing* that is mentioned in the literature (e.g., Keyes, 2007). Participants also characterized *wellbeing* by a sense of self-acceptance, by the ability to cope with daily challenges, by being socially integrated and by having a feeling of being safe in one’s environment. Self-acceptance and the ability to cope with daily challenges are part of the concept of *psychological wellbeing*, as termed by the literature (e.g., Ryff & Keyes, 1995). Social integration corresponds with *social wellbeing* (e.g., Keyes, 1998). The feeling of safety in one’s environment is not mentioned explicitly in the reviewed literature, however, it is mentioned by many participants

and therefore seems to be an important aspect of *wellbeing* to teachers in this survey.

H9: The self-efficacy of teachers in responding to mental health problems among their students significantly positively correlates with their attitude toward wellbeing promotion.

In order to test this hypothesis, a correlation was conducted using the scores on the *School Mental Health Self-efficacy Teacher Survey (SMH-SETS)* and the *Attitudes Toward Wellbeing Promotion scale (ATWP)* ($n = 62$).

Preliminary analyses were conducted to test the assumptions of a correlation. Both variables are metric and visual inspection suggests a linear relationship and homoskedasticity. Scores on the *SMH-SETS* fulfill the assumption of normality, for scores on the *ATWP* this assumption is rejected. However, for $n > 30$, normality can be assumed according to the Central Limit Theorem. Evaluating Cook's distances, no observation surpassed the commonly used threshold of 1. Two observations ($D = 0.08$; $D = 0.07$) slightly surpassed the $4/n$ cut-off criterion ($4/62 \approx 0.06$); inspection of the data did not suggest any measurement errors, so they were kept in the final model.

The analysis revealed a statistically significant positive correlation between scores on the *ATWP* scale and the *SMH-SETS* ($r_{60} = .36$, $p = .004$, 95% CI [.12, .56]), indicating a medium effect size according to Cohen (1988). Higher levels of self-efficacy in mental health promotion are associated with more positive attitudes toward wellbeing promotion.

5. Discussion

5.1. Research question 1

The first research question asked:

- What is the attitude of teachers in Austria toward the implementation of a mental health curriculum in schools?

Mental health promotion and student abilities. Most teachers in the sample endorsed the idea that mental health promotion initiatives can improve student abilities such as academic performance, mental health, resilience, help-seeking, coping with difficulties, and responding to others. This is in line with previous research (e.g., Marinucci et al., 2023). The ability to improve academic performance was at least partially supported by 74.2%, while the other abilities received around 90% agreement. This means that 25.8% of participants were neutral or disagreed with the statement that mental health initiatives can strengthen academic performance, which is at least twice as many as for all the other abilities. This scepticism is reflected in previous findings, in which teachers were a little less confident in the ability of teaching *MHL* to improve academic performance than health professionals were (Marinucci et al., 2023). A significant percentage of teachers therefore seems to believe that other skills and characteristics of children outweigh the influence of their mental health when it comes to academic performance.

Mental health promotion and the school/teacher role. Participants also on average held slightly to strongly positive attitudes toward the school and teacher role in mental health promotion. Most endorsed the idea that schools should take a preventative approach (91.9%), that mental health education should be part of the curriculum (79.1%), and that students need to know where to seek help (98.4%). Regarding the role of teachers, the large majority of participants indicated that teachers need adequate knowledge — i.e., to understand mental health problems (93.5%) — and adequate training (77.4%). This is in line with previous findings that teachers regard mental health education as very important (Graham et al., 2011) and that they see it not only as their obligation, but also as their responsibility to support students with mental health problems (Ekornes, 2017). Still, it cannot be neglected that a considerable 20.9% of participants disagree that mental health education should be part of the curriculum. In favor of a more effective implementation of a mental health curriculum, efforts should be made to address doubts and insecurities of teachers in order to lower this number.

Mental health promotion and its delivery at schools. When it came to attitudes toward the delivery of mental health education at the respective schools of the participants, the

range of participants' scores corresponded to neutral to somewhat negative ratings. Participants on average scored neutral regarding whether it is difficult to talk about mental health with students, whether parents are reluctant about mental health education for students, whether there are barriers to implementing mental health promotion, whether it is believed to be important to talk about mental health at the respective participant's school, and whether the respective participant's school places high importance on mental health. Participants on average somewhat disagreed with the statements that their school promotes further training in the area of mental health education and that their school has a clear policy on mental health education. The fact that so seemingly few schools promote further training seems to be an important aspect to focus on, considering that both the literature and participants in this study highlight that teachers need adequate training. Furthermore, the low prevalence of a clear school policy is alarming, since it has been found that the implementation of school interventions without sufficient clarity and meticulousness can prove to be ineffective (Weare & Nind, 2011).

Teachers' self-efficacy in responding to mental health problems in their students.

In the *School Mental Health Self-efficacy Teacher Survey (SMH-SETS)*, participants on average somewhat agreed that they feel competent in recognizing students with externalizing concerns, which comes as no surprise considering the striking nature of these disorders. To a similar degree, they feel competent in promoting social and emotional skills in their students. Since social-emotional learning interventions have been subject to increased popularity in the last decade and belong to the most common interventions (Patalay et al., 2017), teachers may have become accustomed to promoting these skills in class and thus feel comfortable with it. The other items achieved mean scores that were close to a neutral rating of 3. Items with particularly high rates of disagreement (i.e., a feeling of incompetence) were "provide academic instruction to students with an externalizing concern" (37.1% slight or strong disagreement), "recognize when a student is displaying indicators of exposure to trauma" (40.3%), "consider cultural needs in promoting students' mental health" (41.9%), and "respond to a student who is expressing suicidal thoughts" (50.0%). Students who have experienced trauma and who express suicidal thoughts arguably represent more severe cases that are out of the ordinary and require more specific knowledge and skills in dealing with them. With such large percentages of teachers not feeling competent in handling these issues, it appears that the appropriate abilities are not or at least not sufficiently taught in teacher education. A need for better training can also be observed when it comes to handling students with externalizing concerns, as many participants

state that they struggle with providing academic instruction to them. This might be problematic, considering that these students make up around 7.4% of the adolescent population in Austria (Philipp et al., 2018) and that they tend to disturb classes with their behavior.

Effect of teacher age on attitudes toward mental health promotion. Contrary to the formulated hypothesis, a teacher's age did not negatively predict the degree to which they expected that mental health promotion will be effective. However, a teacher's age did negatively predict their perceived necessity to implement mental health promotion in schools. This is an interesting finding, as it suggests that older teachers have similar expectations toward the effectiveness of mental health promotion, but they are much less likely to think that it needs to be implemented in schools. There might be two possible explanations for this result. Older teachers might not perceive a sufficient presence of mental health problems in school children in order to justify the implementation of such a program. Due to society's increasing awareness of mental health issues in recent times, younger teachers may be more sensitive regarding the recognition of these issues in students. On the other hand, older teachers may have a lower tendency than young teachers to believe that mental health problems should receive special attention in schools. They may be more likely to see responsibility for treatment lie outside of school, with parents or psychologists. By indicating that they perceive less of a need for a mental health program, older teachers may have expressed their opposition to its implementation. One possible reason could be that they may be more resistant to a change in school culture than younger teachers. There is a need for further research in order to test these hypotheses.

Effect of gender on self-efficacy. Following Mansfield et al. (2021), it was hypothesized that gender would not predict the self-efficacy in responding to mental health problems in their students. The data supported this initial finding; a difference in the self-efficacy of male and female teachers was not present. There is research that has found a difference between genders, with female teachers more strongly believing in the effectiveness of social-emotional skills-training (Askill-Williams & Cefai, 2014); however, this difference does not seem to transfer to the perceived capacity to deal with mental health problems in their students.

Effect of years in practice on self-efficacy. In line with previous research (Askill-Williams & Cefai, 2014; Mansfield et al., 2021), years in practice were hypothesized to have no impact on the self-efficacy in responding to mental health problems in their students. The data supported this hypothesis; no influence of the years in practice on self-efficacy was found. This suggests that teachers' capacity to support students with mental health problems does not

significantly improve with work experience; on the contrary, it may be independent of it.

Self-efficacy and attitudes toward mental health promotion. Following previous research, two hypotheses were formulated regarding the influence of self-efficacy in responding to mental health problems in their students on teachers' attitudes toward mental health promotion. Greater self-efficacy was expected to correspond with an increased anticipation that mental health initiatives would be effective, i.e., improve student skills. The data supported this hypothesis. Furthermore, greater self-efficacy was expected to predict a higher tendency to perceive a necessity to implement mental health promotion in schools. This hypothesis was not supported by the data. Based on these findings, the following conclusions can be drawn. In order to increase teachers' anticipated effectiveness of mental health initiatives, it seems to be a valid approach to target teachers' self-efficacy in responding to mental health problems. By believing they have the skills to support children with mental health issues, they are also more likely to expect mental health initiatives to be more effective. This further underlines the need for adequate teacher training. On the other hand, improving teachers' self-efficacy might not be the key in convincing teachers of the need for mental health promotion in schools. There may be other factors that more strongly influence this attitude. This corresponds with other findings in this study, which showed that older teachers equally strongly believed in mental health initiatives to be effective, but but were significantly less likely to see a need for them to be implemented in schools.

Comparison of self-efficacy in primary vs. secondary school teachers. The hypothesis that secondary school teachers have greater self-efficacy in responding to mental health problems in their students than primary school teachers was not supported by the data. Previous research had found higher levels of self-efficacy in secondary teachers (Mansfield et al., 2021) as well as greater support for school staff in secondary schools (Patalay et al., 2017). The lack of a difference may be due to several reasons. One might be that there are differences across countries regarding school culture and systems. Furthermore, secondary school teachers might not possess greater self-efficacy despite being more competent. This could be caused by a more frequent exposure to more complex disorders that increasingly appear in the teenage years. Another possibility is that primary school teachers may have a more holistic understanding of teaching children, with a greater focus on the wellbeing of their pupils and being under less pressure regarding academic instruction.

5.2. Research question 2

The second research question asked:

- Does labeling interventions "mental health promotion" or "wellbeing promotion" make a difference in teachers' perception?

Wellbeing promotion. In order to compare possible differences in attitudes toward mental health promotion and wellbeing promotion, participants were asked about their attitude toward wellbeing promotion. On average, they reacted slightly to strongly positively, with only 4.8% of participants stating that they tend to avoid dealing with students' social and emotional issues, and 9.7% stating that attending to student wellbeing can make them feel uncomfortable. In contrast, 80.7% agreed that attending to student wellbeing is fulfilling, and 93.5% agreed that it makes them feel happy. When confronted with the statement "Teachers should not be tasked with the promotion of student wellbeing", 16.1% agreed and 19.4% were neutral, which still is around a third of participants being uncertain about or opposed to wellbeing promotion. It seems interesting that around 80-90% find wellbeing promotion fulfilling and state that it elicits happiness in them, but only 64.5% think that teachers should be tasked with it. One possible reason for this discrepancy might be—besides experiencing fears and insecurities—that at least some teachers want to feel autonomy in promoting wellbeing and do not like the idea of being told to do it. Another reason might be that socially desirable response patterns to some extent distorted the numbers. It might have felt cold-hearted to participants to indicate that promoting student wellbeing is not fulfilling or does not make them feel happy, so some might have reacted more positively than their actual tendency might suggest.

Mental health promotion vs. wellbeing promotion. Teachers' conceptions of the two terms were analyzed using deductive thematic analysis. The perceived core aspect of both terms can be summarized as psychological and emotional wellbeing, although slight differences emerged. Regarding *mental health*, participants mentioned an absence of disorders and a state of wellbeing and contentment, accompanied by the ability to regulate emotions as well as exhibiting healthy levels of self-confidence and self-awareness. When it came to *wellbeing*, the theme was similar, but the wordings indicated more focus on inner harmony. Participants highlighted feeling well, at ease, and at peace with oneself and with external circumstances. This was also reflected in the frequent occurrence of the aspect of safety (in the sense of feeling safe in one's environment) in participants' descriptions of wellbeing, while it did not seem to come to their minds when thinking about mental health. As Galderisi et al. (2015) pointed out, possessing a good level of *mental health* can also be demonstrated in difficult situations—which might sometimes also be characterized by a lack of safety—, while it could be considered unhealthy to

experience *wellbeing* in some of these same situations. Both *mental health* and *wellbeing* equally included descriptions of healthy functioning—i.e., the ability to cope with daily life—and social integration, which includes the skill to form healthy relationships and experiencing a sense of belonging. As initially expected, teachers' conceptions of *mental health* and *wellbeing* appear to mostly overlap. Further supporting the hypothesis, *mental health* was associated with the theme of mental disorders, while participants did not explicitly mention it when describing *wellbeing*. However, participants did not refer to stigma in their definitions of *mental health*.

When testing the association between participants' scores in a self-efficacy regarding mental health promotion scale (*SMH-SETS*) and their scores on the *Attitudes Toward Wellbeing Promotion scale (ATWP)*, a significant correlation of a moderate size was found.

To conclude, teachers may be similarly inclined toward and comfortable with mental health promotion and wellbeing promotion. However, there might be some difference in their perception of initiatives bearing either of these labels. When teachers are confronted with an initiative whose label includes *mental health*, they may be more likely to associate it with mental disorders and emotion regulation, while they may tend to associate an initiative using the term *wellbeing* with learning how to achieve a state of feeling well and safe.

5.3. Limitations and further implications

Several limitations of this study should be acknowledged. First, the small sample size potentially reduces the reliability of the findings. Second, participants in this study were aware of the focus on mental health education when deciding whether to take part. This could have resulted in teachers who were more positively inclined toward mental health education to be more motivated to do so. On the other hand, it could also be argued that teachers who were strongly opposed to mental health education saw this as an opportunity to voice their doubts. This means that the undecided and neutral teachers, in comparison, might have been less motivated to complete the survey and were therefore possibly underrepresented. Third, the survey inquired about subjective evaluations, which might have distorted some scores due to biases such as socially desirable response patterns. The *SMH-SETS* only assessed participants' felt competence and did not assess their actual level. Some teachers might have been more competent than they believed themselves to be and vice versa. Finally, as this study was conducted with teachers in Austria with the goal of examining local attitudes, the findings cannot be generalized to a larger, international population.

Given these limitations, there is a need for studies in Austria with larger and more represen-

tative samples which assure that teachers with attitudes along the whole spectrum are adequately represented in the sample. This study provided insight into the level of self-efficacy teachers report with respect to different aspects of promoting mental health in their students. Teachers also indicated that adequate training is necessary. Further research should investigate the specific areas in which teachers perceive a need for additional training. However, since self-efficacy did not predict the perceived necessity of implementing mental health promotion, other potential determinants should be explored. Future studies should also investigate why older teachers—despite believing just as strongly in the effectiveness of such programs—seem to be much less likely to perceive a need for them.

6. Conclusion

The current study was conducted with teachers who were teaching or studying for the teaching profession in Austria and aimed at examining their attitudes toward the implementation of a mental health curriculum in schools. The majority of participants expressed positive attitudes toward mental health and wellbeing promotion, as they believed that mental health promotion would be effective in improving student skills. They also supported the idea of schools and also themselves assuming a more active role in promoting the mental health of their students. In contrast, they saw the current delivery of mental health promotion in their respective schools more critically. While most items in this scale received a neutral rating, the majority of participants disagreed with the statement that there is designated staff training and a clear policy regarding mental health education in their schools. In order to provide a solid ground for mental health initiatives, it will be important to improve these aspects in the future. On average, participants somewhat agreed that they feel competent in promoting student wellbeing, although there are some aspects that only received a neutral rating, such as recognizing trauma, considering cultural needs, and responding to suicidal thoughts. Higher levels of self-efficacy predicted an increased anticipation that mental health promotion will be effective, but did not have an impact on the perceived necessity of such initiatives. This indicates that more efforts than just improving teachers' self-efficacy may be needed in order to convince teachers of their usefulness. Gender and years in practice did not have an effect on self-efficacy in responding to mental health problems. Comparing primary and secondary school teachers, no difference was found in self-efficacy in responding to students' mental health problems. Older teachers expected that mental health promotion will be effective to the same degree that younger teachers did, but they were less likely to indicate a necessity to implement it in schools. In order to get teachers of all ages on board with this transformation, further research is needed that takes a closer look at why this might be the case. In light of the often synonymous use of the terms *mental health* and *wellbeing* when labeling interventions, possible differences in teachers' conceptions of the terms were examined. In this study, teachers' inclination toward mental health promotion and wellbeing promotion was moderately correlated. While their conceptions of the terms mostly overlapped, they may be more likely to associate initiatives with a *mental health* label with the topics of mental disorders and emotion regulation, and initiatives with a *wellbeing* label with how to achieve a state of feeling well and safe.

More research is needed that examines the attitude of teachers in Austria toward mental

health promotion in schools, as these attitudes are a key factor for implementing such initiatives effectively within the curriculum.

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Acronyms

ATWP Attitudes Toward Wellbeing Promotion scale. 4, 31, 34, 43, 44, 53, 59, 75, 97

HL health literacy. 12, 13

MHL mental health literacy. 3, 4, 10, 12–18, 24, 27, 29, 32, 34, 54, 82

MHLSC MHL for supporting children. 3, 16, 17

SEL social-emotional learning. 18, 55

SMH-SETS School Mental Health Self-efficacy Teacher Survey. 4, 30, 34, 40–43, 46–49, 53, 55, 59, 75, 96

WHO World Health Organization. 12–14

Appendix

A. Abstract (EN)

Internationally, awareness is growing that it may be useful to teach children and adolescents about mental health as a preventative strategy. One way to improve their mental health literacy—i.e., the knowledge and skills that help prevent mental disorders and maintain mental health—is to introduce designated classes into the school curriculum. Considering teacher attitudes toward mental health promotion in schools is an important aspect of ensuring the feasibility and effectiveness of such initiatives. To address the lack of such research in Austria, a quantitative and qualitative survey was completed by 62 teachers and students of the teaching profession. Results showed that, overall, teachers in this study tend to believe that mental health promotion will be effective in improving student skills and that schools should take on an active role. Teacher age negatively predicted the perceived necessity to implement mental health initiatives in schools, but not the anticipation of their effectiveness. Self-efficacy in responding to mental health problems in students predicted the anticipated effectiveness of mental health initiatives, but not the perceived necessity of their implementation. Gender did not predict the level of self-efficacy. No difference between self-efficacy levels of primary and secondary school teachers was found. A deductive thematic analysis indicated that, while teachers' conceptions of *mental health* and *wellbeing* largely overlap, they also associate each term with distinct elements. Further research is needed to build on these findings and thereby enable an effective implementation of mental health promotion in Austrian schools.

B. Abstract (GER)

International wächst das Bewusstsein dafür, dass es als Präventionsstrategie sinnvoll sein kann, Kindern und Jugendlichen Wissen über psychische Gesundheit zu vermitteln. Eine Möglichkeit, ihre psychische Gesundheitskompetenz—also jene Kenntnisse und Fähigkeiten, die psychischen Störungen vorbeugen und psychische Gesundheit erhalten—zu verbessern, besteht darin, entsprechenden Unterricht im Schulcurriculum zu verankern. Die Einstellungen von Lehrkräften zur Förderung psychischer Gesundheit in Schulen sind dabei ein wichtiger Faktor, um die Umsetzbarkeit und Wirksamkeit solcher Initiativen sicherzustellen. Um die in Österreich bestehende Forschungslücke zu schließen, wurde eine quantitative und qualitative Befragung durchgeführt, an der 62 Lehrkräfte sowie Lehramtsstudierende teilnahmen. Die Mehrheit der befragten Lehrpersonen ist der Ansicht, dass Maßnahmen zur Förderung psychischer Gesundheit die Kompetenzen der Schüler*innen wirksam verbessern können und unterstützt den Ansatz, dass Schulen eine aktive Rolle hierbei übernehmen sollten. Das Alter der Lehrkräfte sagte die wahrgenommene Notwendigkeit, Programme zur psychischen Gesundheit in Schulen einzuführen, negativ voraus, nicht jedoch deren erwartete Wirksamkeit. Die Selbstwirksamkeit im Umgang mit psychischen Problemen von Schüler*innen sagte die erwartete Wirksamkeit entsprechender Initiativen voraus, nicht aber die wahrgenommene Notwendigkeit ihrer Implementierung. Das Geschlecht hatte keinen Einfluss auf die Ausprägung der Selbstwirksamkeit. Zwischen den Selbstwirksamkeitswerten von Lehrkräften der Primar- und Sekundarstufe zeigte sich kein Unterschied. Eine deduktive thematische Analyse ergab, dass sich die Vorstellungen der Lehrkräfte von den Begriffen *psychische Gesundheit* und *Wohlbefinden* weitgehend überschneiden, sie jedoch auch voneinander abweichende Assoziationen hervorrufen. Weitere Forschung ist notwendig, um diese Ergebnisse zu ergänzen und eine effektive Umsetzung der psychischen Gesundheitsförderung an österreichischen Schulen zu ermöglichen.

C. Mental health resources available to teachers

In this part of the questionnaire, participants were asked about the mental health resources that are available to them in their schools. They could respond on a 5-point Likert scale with the extrema labeled "none" and "a lot". Results can be found in Table 7.

Means range between 2.22 and 2.75. Items R1 ("Are there school-wide initiatives for students' social-emotional well-being that are implemented by you or your colleagues within the classroom setting?") and R7 ("At your school, are there school psychologists or social workers you can consult if you have questions or concerns regarding the psychosocial well-being of individual children?") received at least a medium score of 3 or higher from around 60% of participants. Approximately one half of the participants gave such a score to Items R2 ("Does your school offer social-emotional well-being programs for students that are led by external personnel within the classroom setting (e.g., workshops)?"), R4 ("Does your school provide resources that you can use to prepare lessons on social-emotional well-being?"), and R6 ("Does your school have school psychologists and/or social workers, or other personnel, who address the psychosocial well-being of individual children?"). The lowest percentage of scores of 3 or higher—around 35 to 40%—received Items R3 ("Does your school offer social-emotional well-being programs for students that are led by school psychologists and/or social workers within the classroom setting?") and R5 ("Are there resources (e.g., learning programs, workbooks, etc.) on social-emotional well-being that you use in your classroom instruction?").

Table 7.*Mental health resources available to teachers (n=61)*

Item	Description	none (1)	2	3	4	a lot (5)	M	SD
R1	Are there school-wide initiatives for students' social-emotional wellbeing that are implemented by you or your colleagues within the classroom setting?	16.4%	23.0%	47.5%	11.5%	1.6%	2.59	.96
R2	Does your school offer social-emotional wellbeing programs for students that are led by external personnel within the classroom setting (e.g., workshops)?	21.3%	27.9%	23.0%	23.0%	4.9%	2.62	1.20
R3	Does your school offer social-emotional wellbeing programs for students that are led by school psychologists and/or social workers within the classroom setting?	29.5%	29.5%	19.7%	21.3%	0%	2.33	1.12
R4	Does your school provide resources that you can use to prepare lessons on social-emotional wellbeing?	21.3%	26.2%	32.8%	16.4%	3.3%	2.54	1.10
R5	Are there resources (e.g., learning programs, workbooks, etc.) on social-emotional wellbeing that you use in your classroom instruction?	31.7%	33.3%	18.3%	15.0%	1.7%	2.22	1.11
R6	Does your school have school psychologists and/or social workers, or other personnel, who address the psychosocial wellbeing of individual children?	18.0%	27.9%	27.9%	21.3%	4.9%	2.67	1.15

Item	Description	none (1)	2	3	4	a lot (5)	M	SD
R7	At your school, are there school psychologists or social workers you can consult if you have questions or concerns regarding the psychosocial well-being of individual children?	21.3%	23.0%	23.0%	24.6%	8.2%	2.75	1.27

Note. Participants replied on a 5-point Likert scale with the extrema "none" and "a lot", they did not see any numbers. In the analysis, values were assigned from 1 (none) to 5 (a lot).

D. Teaching MHL in class

This part of the questionnaire inquired participants about their teaching of MHL in the classroom. Several aspects of MHL were covered, namely: recognizing mental health (Figure 1), resources for mental health support (Figure 2), mental health influences (Figure 3), resilience (Figure 4), and stigma (Figure 5). All items began with "In my classes, I teach...", participants could then reply affirmatively by ticking a box next to the different statements.

D.1. Recognizing mental health

When it comes to recognizing mental health (Figure 1), the majority of participants teaches recognizing one's emotions, motivation and goal setting, and a healthy lifestyle—around 56 to 69%. Recognizing and labeling changes in one's behavior is taught significantly less, by around a third of participants.

In my classes, I teach...

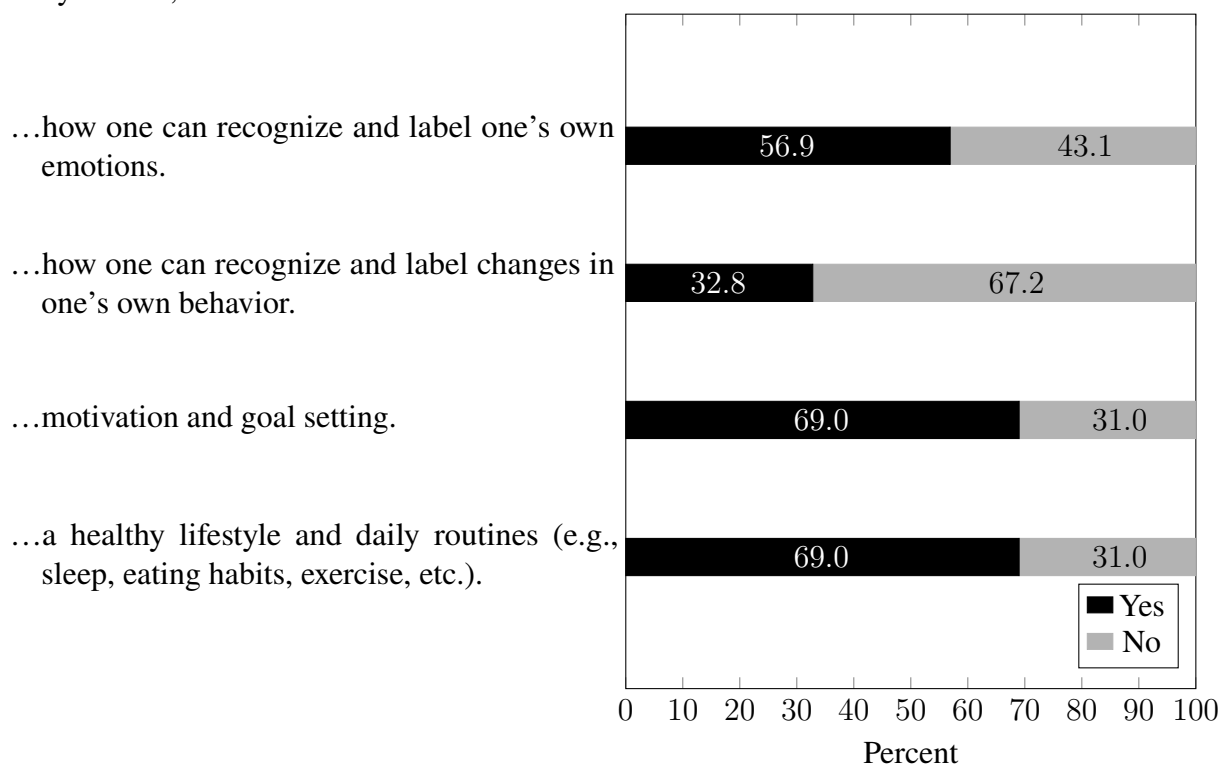


Figure 1. Teaching MHL in class: recognizing mental health (n=58)

D.2. Resources for mental health support

Regarding resources for mental health support (Figure 2), two thirds of participants teach students which adults they can turn to for support and around one half talk to them about available school resources. Books and online resources about mental health as well as telephone support lines are significantly less often subject in class, as they are mentioned by around one fifth to one third of participants.

In my classes, I teach...

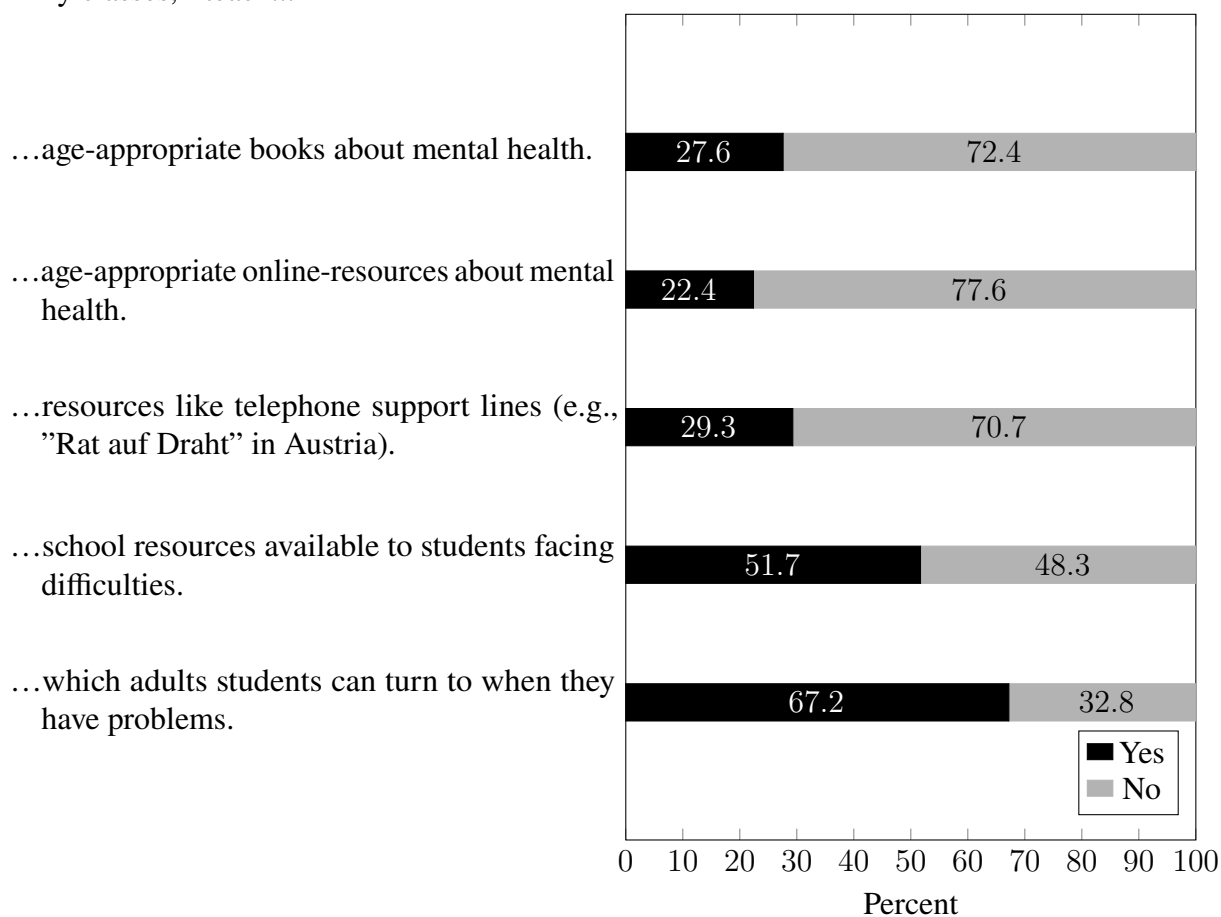


Figure 2. Teaching MHL in class: resources for mental health support (n=58)

D.3. Mental health influences

The different influences on mental health (Figure 3) vary a lot in how much they are subject in class. Social factors that affect mental health are taught by a large majority of participants, environmental factors by around half of them, and for biological factors around a third replied "Yes".

In my classes, I teach ...

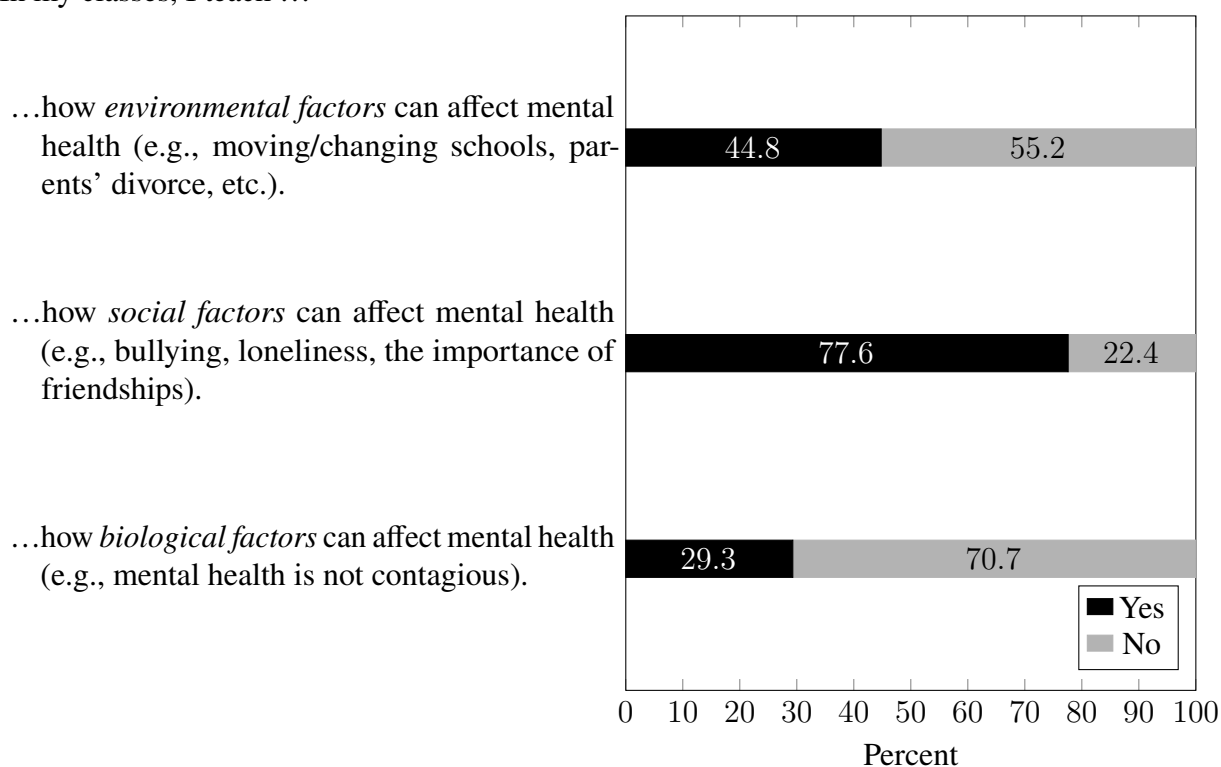


Figure 3. Teaching MHL in class: mental health influences (n=58)

D.4. Resilience

Most aspects of resilience (Figure 4), namely activities that support wellbeing, open communication, healthy lifestyle, and how to cope with difficulties, are already taught by the large majority of participants. Being subject less often, around half indicate teaching relaxation exercises and mindfulness.

In my classes, I teach...

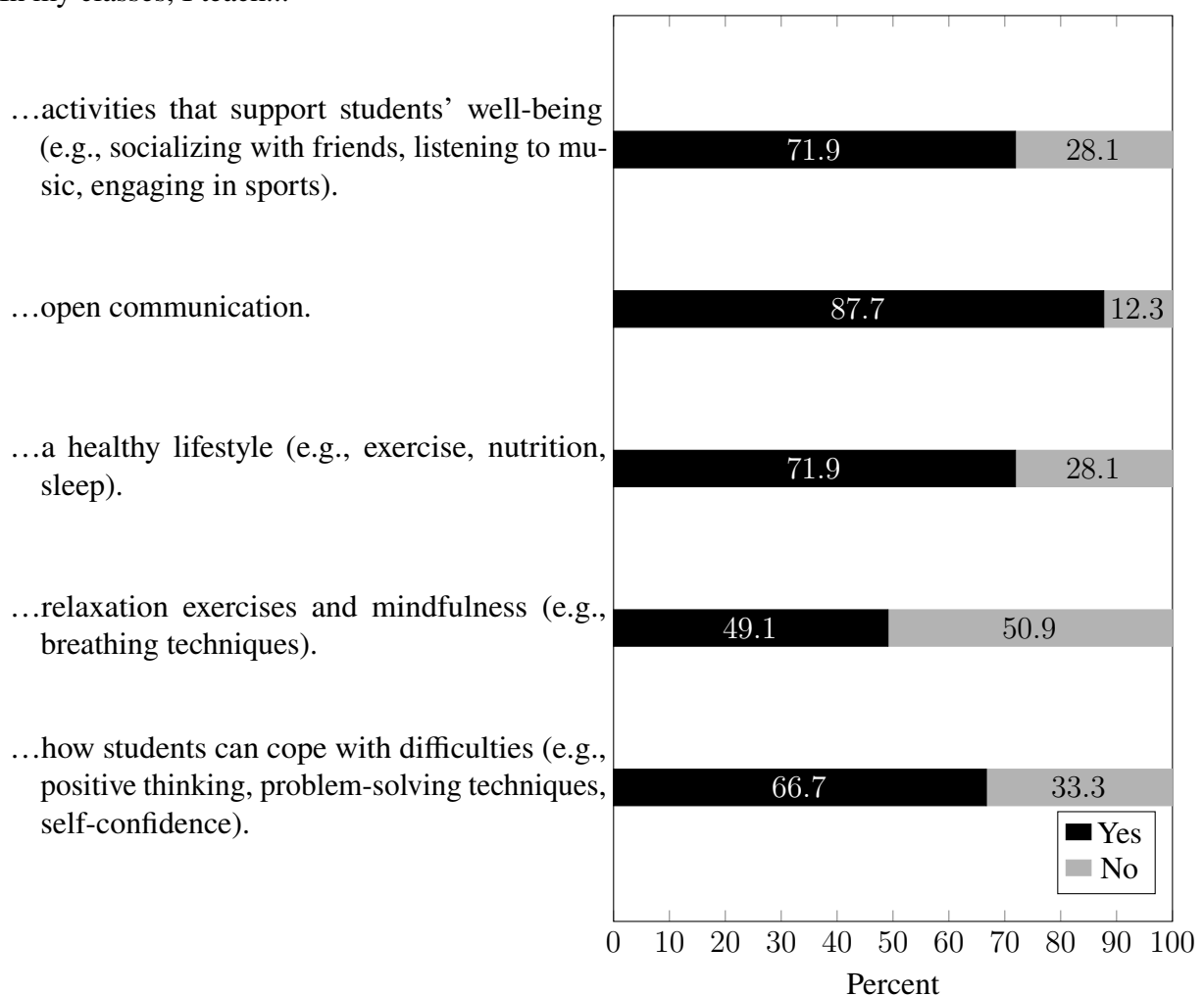


Figure 4. Teaching MHL in class: resilience (n=57)

D.5. Stigma

Regarding stigma (Figure 5), a vast majority of participants teach their students how they can help and support each other. A bit less present in class are the topics help-seeking behavior and how to reduce stigma, these are taught by around half of participants.

In my classes, I teach...

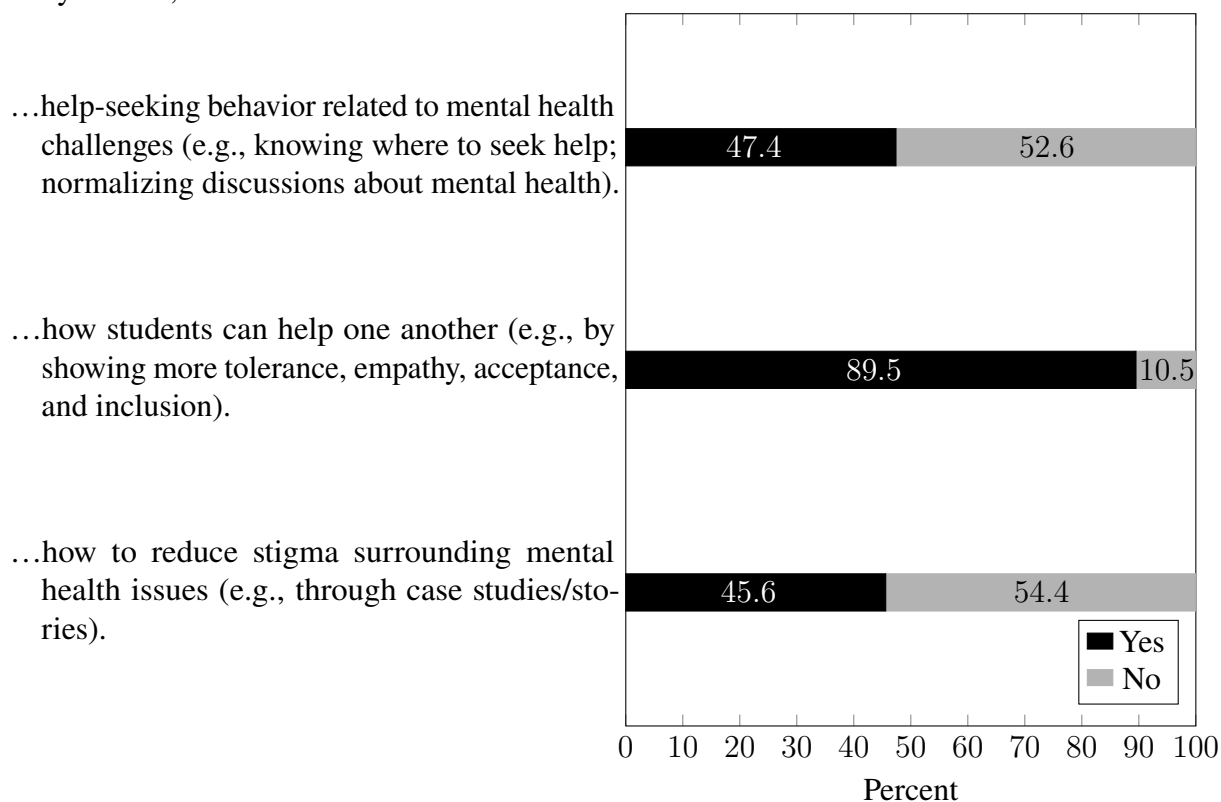


Figure 5. Teaching MHL in class: stigma (n=57)

E. Titles of additional training

Table 8.

Additional trainings mentioned by participants

Kinder und Jugendliche stärken
psychosoziale Inhalte (Mobbing, Panikattacken erkennen, ...)
Wer stört wen? Zur Diversität des kindlichen Verhaltens.
No-Blame-Approach
Peer-Mediation
Gewaltprävention
Mobbing
psychische Gesundheit
Resilienz bei Schülerinnen
Brauchen alle auffälligen Schüler eine Diagnose?
Psychohygiene und Achtsamkeitsübungen im Unterricht wirksam einsetzen
Gewaltfreie Kommunikation
Thomas-Gordon-Methode
Suizidprävention
Selbstverletzung
Im Portfolio des: Schulleitung und Schulorganisation der PH Wien
Ausbildung Lebens- und Sozialberaterin (entwicklungsfördernde Methode "Arbeit am Tonfeld")
div. Weiterbildungen für Psychologie (zuletzt Angst und Angststörungen)
Soziales Lernen
Konfliktmanagement
z.B. Umgang mit verhaltensauffälligen Schüler*innen
ADHS und die Folgen im Unterricht
Fluchterfahrungen und Trauma
Hypersensibilität
Resilienz
Atem, Stimme, Stimmung
Besser Streiten

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Psychologie/Philosophie auf Lehramt studiert + Ethik-Lehrgang

Psycho-soziale Gesundheit

Konfliktbewältigung in der Klasse und im Lehrkörper

Schulmeditation

berufsbegleitende Ausbildung Kunsttherapie

SCHILF

Mental Health Days

Entspannungsmethoden für Lehrer

Naturwahrnehmung

Konfliktlösung

F. Questionnaires

Table 9.

Full items of the "survey about general perspectives on mental health education" and their German translations/adaptations as used for this study

Factor	Item	Original	German translation/adaptation
Factor A	A1	School-based mental health initiatives strengthen student's academic performance.	Schulbasierte Maßnahmen zum Thema psychische Gesundheit können dazu beitragen, die schulischen Leistungen der Schüler*innen zu stärken.
	A2	School-based mental health initiatives strengthen student's mental health and wellbeing.	Schulbasierte Maßnahmen zum Thema psychische Gesundheit können dazu beitragen, die psychische Gesundheit und das Wohlbefinden der Schüler*innen zu stärken.
	A3	School-based mental health initiatives strengthen student's resilience.	Schulbasierte Maßnahmen zum Thema psychische Gesundheit können dazu beitragen, die Resilienz (Belastbarkeit und Widerstandsfähigkeit) der Schüler*innen zu stärken.
	A4	School-based mental health initiatives strengthen student's help-seeking behaviour.	Schulbasierte Maßnahmen zum Thema psychische Gesundheit können Schüler*innen dazu befähigen, sich Hilfe zu holen, wenn nötig.
	A5	School-based mental health initiatives strengthen student's adaptive coping behaviours.	Schulbasierte Maßnahmen zum Thema psychische Gesundheit können Schüler*innen helfen, mit Schwierigkeiten konstruktiv umzugehen.

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Factor	Item	Original	German translation/adaptation
	A6	School-based mental health initiatives strengthen student's responding to others.	Schulbasierte Maßnahmen zum Thema psychische Gesundheit können verbessern, wie Schüler*innen miteinander umgehen und aufeinander reagieren.
Factor B	B1	Schools need to take a preventative approach to mental health.	Schulen sollten einen präventiven / vorsorglichen Ansatz zur Förderung von psychischer Gesundheit verfolgen.
	B2	Students need to be aware of where to seek help for mental health problems.	Schüler*innen sollten wissen, wohin sie sich wenden können, wenn sie Probleme mit ihrer psychischen Gesundheit haben.
	B3	Mental health education should be a part of the curriculum.	Es sollte Teil des Lehrplans sein, Wissen und Strategien zum Erhalt von psychischer Gesundheit zu vermitteln.
	B4	Teachers need adequate training to manage child and adolescent mental health.	Lehrkräfte sollten adäquat aus- und fortgebildet werden, um sich um die psychische Gesundheit und das Wohlbefinden von Kindern und Jugendlichen kümmern zu können.
	B5	Teachers need to understand mental health problems.	Es ist notwendig, dass Lehrkräfte psychische Gesundheitsprobleme verstehen, die Schüler*innen betreffen könnten.

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Factor	Item	Original	German translation/adaptation
Factor C	C1	At our school, we believe it's important to talk about mental health. ¹	An meiner Schule legen wir Wert darauf, über psychische Gesundheit zu sprechen.
	C2	It is difficult to talk about mental health at school with students. ²	An meiner Schule ist es schwierig, mit Schüler*innen über psychische Gesundheit zu sprechen. ²
	C3	Parents do not want school staff to discuss mental health at school. ²	An meiner Schule wollen Eltern nicht, dass Schulpersonal die psychische Gesundheit in der Schule thematisiert. ²
	C4	There are barriers to teachers implementing mental health promotion in schools. ²	An meiner Schule stoße ich auf Hindernisse bei der Durchführung von Fördermaßnahmen für die psychische Gesundheit. ²
	C5	Our school promotes further training for staff in the area of mental health education for students. ¹	An meiner Schule werden Weiterbildungen bezüglich der Wissensvermittlung zu psychischer Gesundheit für Schüler*innen angeregt.
	C6	Schools place high importance on the mental health of students.	Meine Schule legt großen Wert auf die psychische Gesundheit der Schüler*innen.
	C7	My school has a clear policy on the type of information we teach about mental health.	An meiner Schule gibt es eine klare Richtlinie, welche Informationen und Inhalte wir zum Thema psychische Gesundheit unterrichten.

Notes.

The *survey about general perspectives on mental health education* stems from Marinucci et al. (2023) and A. Marinucci (personal communication, November 27, 2023).

¹ This item does not come from the original scale. It is the English translation of the item that was created for the German questionnaire.

² This item loaded negatively in a factor analysis. Hence, it was inverted in order for high scores to represent a positive attitude toward mental health promotion.

Table 10.*Full items of the SMH-SETS and their German translations*

Item	Original ("I feel competent to...")	German translation ("Ich fühle mich kompetent,...")
S1	recognize when there is a student with an internalizing concern (e.g., depression and/or anxiety symptoms).	Rückzugsverhalten mit negativem Selbstwert bei einem/r Schüler*in zu erkennen (z.B. Symptome einer Depression und/oder Angststörung).
S2	recognize when there is a student with an externalizing concern (e.g., defiant, hyperactive and/or aggressive behavior).	aggressives und anti-soziales Verhalten bei einem/r Schüler*in zu erkennen (z.B. aufsässiges, hyperaktives, und/oder aggressives Verhalten).
S3	recognize when a student is displaying indicators of exposure to trauma (e.g., intense event that threatens harm to emotional and/or physical well-being such as natural disaster, violence, serious injury, or sexual abuse).	Anzeichen für erlebtes Trauma bei einem/r Schüler*in zu erkennen (z.B. Extremsituationen - wie Naturkatastrophen, Gewalt, schwerwiegende Verletzungen oder sexuelle Übergriffe -, die das emotionale und/oder körperliche Wohlbefinden bedrohen).

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Item	Original ("I feel competent to...")	German translation ("Ich fühle mich kompetent,...")
S4	provide academic instruction to students with an internalizing concern (e.g., depression and/or anxiety symptoms).	eine/n Schüler*in, der/die Rückzugsverhalten mit negativem Selbstwert zeigt (z.B. Symptome einer Depression und/oder Angststörung), in den Unterricht zu integrieren.
S5	provide academic instruction to students with an externalizing concern (e.g., defiant, hyperactive and/or aggressive behavior).	eine*n Schüler*in, der/die aggressives und anti-soziales Verhalten zeigt (z.B. aufsässiges, hyperaktives und/oder aggressives Verhalten), in den Unterricht zu integrieren.
S6	provide academic instruction to students from diverse backgrounds who have mental health concerns.	Schüler*innen in den Unterricht zu integrieren, die in unterschiedlichen Lebenssituationen Probleme mit ihrer psychischen Gesundheit haben (z.B. Scheidung der Eltern, Eltern mit psychischer Erkrankung, Fluchthintergrund).
S7	consider cultural needs in promoting students' mental health.	kulturelle Bedürfnisse bei der Förderung von psychischer Gesundheit zu beachten.
S8	respond when a student is in crisis (e.g., pose a potential threat of harm to themselves or others).	zu reagieren, wenn ein*e Schüler*in in einer akuten Krise ist (z.B. mit dem Risiko, sich selbst oder andere zu gefährden).

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Item	Original ("I feel competent to...")	German translation ("Ich fühle mich kompetent,...")
S9	respond when a student is displaying aggressive behavior.	zu reagieren, wenn ein*e Schüler*in aggressives Verhalten zeigt.
S10	respond to a student who is expressing suicidal thoughts.	auf eine*n Schüler*in einzugehen, der/die Suizidgedanken äußert.
S11	refer a student to the appropriate mental health providers.	eine*n Schüler*in an die passenden Stellen, die für psychische Gesundheit zuständig sind, zu verweisen.
S12	offer assistance in the classroom when a student is struggling with a mental health concern.	eine*n Schüler*in in der Klasse zu unterstützen, wenn es Anzeichen gibt, dass er/sie Probleme mit der psychischen Gesundheit hat.
S13	discuss student mental health concerns with parents.	mit Eltern von Schüler*innen über Bedenken hinsichtlich der psychischen Gesundheit ihrer Kinder zu sprechen.
S14	promote the social skills of students in my classroom.	soziale Kompetenzen der Schüler*innen in meiner Klasse zu fördern.
S15	promote the emotional skills of students in my classroom.	emotionale Kompetenzen der Schüler*innen in meiner Klasse zu fördern.

Note. The *SMH-SETS* stems from Brann et al. (2020).

Table 11.*Full items of the ATWP and their German translations/adaptations*

Item	Original	German translation
W1	I tend to avoid dealing with students' social or emotional issues. ¹	Ich vermeide es eher, mich mit sozialen oder emotionalen Problemen von Schüler*innen auseinanderzusetzen. ¹
W2	Attending to student wellbeing can make me feel uncomfortable. ¹	Es fällt mir schwer, mich um das Wohlbefinden von Schüler*innen zu kümmern. ¹
W3	Promoting student wellbeing is a fulfilling experience for me.	Für mich ist es erfüllend, das Wohlbefinden der Schüler*innen zu stärken.
W4	Promoting student wellbeing makes me feel happy.	Ich freue mich, wenn ich das Wohlbefinden der Schüler*innen stärken kann.
W5	Teachers should not be tasked with the promotion of student wellbeing. ¹	Ich als Lehrkraft sollte NICHT mit der Förderung des Wohlbefindens der Schüler*innen beauftragt werden. ¹

Notes.

The ATWP stems from Byrne et al. (2021).

¹ This item loaded negatively in a factor analysis. Hence, it was inverted in order for high scores to represent a positive attitude toward mental health promotion.

Table 12.*Items of "Mental health resources available to teachers" and the original German version*

Item	English translation	German
R1	Are there school-wide initiatives for students' social-emotional wellbeing that are implemented by you or your colleagues within the classroom setting?	Gibt es an Ihrer Schule übergreifende Maßnahmen für Schüler*innen zu sozial-emotionalem Wohlbefinden, die von Ihnen selbst oder Kolleg*innen im Rahmen des Unterrichts durchgeführt werden?
R2	Does your school offer social-emotional wellbeing programs for students that are led by external personnel within the classroom setting (e.g., workshops)?	Gibt es an Ihrer Schule Maßnahmen für Schüler*innen zu sozial-emotionalem Wohlbefinden, die von externem Personal im Rahmen des Unterrichts durchgeführt werden (z.B. Workshops)?
R3	Does your school offer social-emotional wellbeing programs for students that are led by school psychologists and/or social workers within the classroom setting?	Gibt es an Ihrer Schule Maßnahmen zu sozial-emotionalem Wohlbefinden der Schüler*innen, das von Schulpsycholog*innen und / oder Schulsozialarbeiter*innen im Rahmen des Unterrichts durchgeführt werden?

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Item	English translation	German
R4	Does your school provide resources that you can use to prepare lessons on social-emotional wellbeing?	Gibt es an Ihrer Schule Ressourcen, die Sie nutzen können, um Unterrichtseinheiten zu sozial-emotionalem Wohlbefinden vorzubereiten (z.B. Manuale, Unterrichtsmaterialien, Kinderbücher, Budget für externe Workshops/Ausflüge)?
R5	Are there resources (e.g., learning programs, workbooks, etc.) on social-emotional wellbeing that you use in your classroom instruction?	Gibt es in Ihrer Klasse Maßnahmen (z.B. Lernprogramme, Arbeitsmappen, etc.) zum sozial-emotionalen Wohlbefinden, die Sie selbst im Rahmen des Unterrichts durchführen?
R6	Does your school have school psychologists and/or social workers, or other personnel, who address the psychosocial wellbeing of individual children?	Gibt es an Ihrer Schule Schulpsycholog*innen und / oder Schulsozialarbeiter*innen oder anderes Personal, das sich mit dem psychosozialen Wohlbefinden einzelner Kinder beschäftigt?
R7	At your school, are there school psychologists or social workers you can consult if you have questions or concerns regarding the psychosocial wellbeing of individual children?	Gibt es an Ihrer Schule Schulpsycholog*innen oder Sozialarbeiter*innen, an die Sie sich wenden können, wenn Sie Fragen oder Anliegen bezüglich des psychosozialen Wohlbefindens einzelner Kinder haben?

Table 13.*Items of "Teaching MHL in class" and their original German versions*

Component	Item (English translation)	Item (German)
Recognizing mental health	<i>In my class I teach...</i>	<i>In meinem Unterricht behandle ich...</i>
	how one can recognize and label one's own emotions.	, wie man die eigenen Gefühle erkennt und benennt.
	how one can recognize and label changes in one's own behavior.	, wie man Veränderungen im eigenen Verhalten erkennt und benennt.
	motivation and goal setting.	Motivation und Zielsetzungen.
	a healthy lifestyle and daily routines (e.g., sleep, eating habits, exercise, etc.).	einen gesunden Lebensstil und tägliche Routinen (z.B. Schlaf, Essen, Bewegung, etc.).

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Component	Item (English translation)	Item (German)
Resources for mental health support	<i>In my class I teach...</i>	<i>In meinem Unterricht behandle ich...</i>
	age-appropriate books about mental health.	altersgerechte Bücher zum Thema psychische Gesundheit.
	age-appropriate online-resources about mental health.	altersgerechte Online-Ressourcen zum Thema psychische Gesundheit.
	resources like telephone support lines (e.g., “Rat auf Draht” in Austria).	Ressourcen wie Telefonberatungen (z.B. Rat auf Draht).
	school resources available to students facing difficulties.	Schulressourcen, auf die Schülerinnen bei Problemen zurückgreifen können.
	which adults students can turn to when they have problems.	, an welche Erwachsenen Schülerinnen sich bei Problemen wenden können.
<i>continued on the next page</i>		

Component	Item (English translation)	Item (German)
Mental health influences	<i>In my class I teach...</i>	<i>In meinem Unterricht behandle ich...</i>
	how environmental factors can affect mental health (e.g., moving/changing schools, parents' divorce, etc.).	wie Umweltfaktoren die psychische Gesundheit beeinflussen können (z.B. Umzug/Schulwechsel, Scheidung der Eltern usw.).
	how social factors can affect mental health (e.g., bullying, loneliness, the importance of friendships).	wie soziale Faktoren die psychische Gesundheit beeinflussen können (z.B. Mobbing, Einsamkeit, Bedeutung von Freundschaften).
	how biological factors can affect mental health (e.g., mental health is not contagious).	wie biologische Faktoren die psychische Gesundheit beeinflussen können (z.B. dass psychische Gesundheit nicht ansteckend ist).
Resilience	<i>In my class I teach...</i>	<i>In meinem Unterricht behandle ich...</i>

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Component	Item (English translation)	Item (German)
	activities that support students' well-being (e.g., socializing with friends, listening to music, engaging in sports).	Aktivitäten, die Schüler*innen guttun (z.B. Zeit mit Freund*innen, Musik, Sport).
	open communication.	offene Kommunikation.
	a healthy lifestyle (e.g., exercise, nutrition, sleep).	einen gesunden Lebensstil (z.B. Sport, Ernährung, Schlaf).
	relaxation exercises and mindfulness (e.g., breathing techniques).	Entspannungsübungen und Mindfulness (z.B. Atemtechniken).
	how students can cope with difficulties (e.g., positive thinking, problem-solving techniques, self-confidence).	, wie Schüler*innen mit Schwierigkeiten umgehen können (z.B. positive Gedanken, Problemlösungstechniken, Selbstvertrauen).
Stigma	<i>In my class I teach...</i>	<i>In meinem Unterricht behandle ich...</i>

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Component	Item (English translation)	Item (German)
	help-seeking behavior related to mental health challenges (e.g., knowing where to seek help; normalizing discussions about mental health).	Hilfesuchverhalten bei psychischen Problemen (z.B.: Wo kann ich mir Hilfe suchen?; Normalisierung des Sprechens über psychische Probleme).
	how students can help one another (e.g., by showing more tolerance, empathy, acceptance, and inclusion).	, wie Schüler*innen einander helfen können (z.B. mehr Toleranz, Empathie, Akzeptanz und Inklusion).
	how to reduce stigma surrounding mental health issues (e.g., through case studies/stories).	, wie Vorurteile bezüglich psychischer Probleme reduziert werden können (z.B. Fallbeispiele / Geschichten).