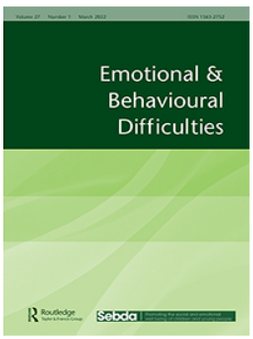

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Primary school based mental health practitioners' perspectives of school-based screening for childhood mental disorders and intervention delivery: A qualitative study

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ABSTRACT

Schools may be well-placed to identify signs of mental health (MH) problems in children; however, there has been little research into how school-based screening and intervention initiatives should be delivered. One-to-one in-depth interviews were carried out with 15 practitioners that support children's MH within primary school settings. Data were analysed with template analysis. We explored practitioners' perceptions of a school-based screening/intervention programme for childhood MH problems and views about potential barriers to uptake. Three themes were identified. First, practitioners described feeling overwhelmed by the volume of children requiring support and the limited capacity of their service. Second, practitioners identified potential barriers to engagement in a school screening/intervention programme, including familial concerns about stigma. Finally, practitioners were optimistic that a screening/intervention programme could have positive effects for children who might otherwise not be identified as potentially benefitting from support. This study highlights that a primary school-based screening/intervention programme designed in partnership with stakeholders would be well received by practitioners supporting MH within school settings.

KEYWORDS

Primary school; screening; intervention; child; mental health; education

Introduction

Many mental health problems first occur in childhood or adolescence (Kessler et al. 2007) and recent evidence suggests their prevalence among children is increasing (NHS Digital 2020a). Without appropriate identification and treatment, mental health problems in childhood can bring persistent negative impacts on daily functioning and quality of life, relationships with others, educational attainment, and sleep patterns (Kessler et al. 2007, 2012; McCrone et al. 2008).

Effective and cost-effective treatments for childhood mental health problems do exist, yet very few children successfully access them (Reardon, Harvey, and Creswell 2019) Families report experiencing a number of barriers to seeking and accessing help, including parental concerns about seeking formal help due to potential stigma or fears of being blamed for their child's difficulties; uncertainty whether

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their child's psychological problems are developmentally 'normal' or indicate a clinically significant problem; uncertainty about where and how to seek formal help for their child, and are deterred by the perception that mental health services are oversubscribed and help cannot be easily accessed (Reardon et al. 2017). Childhood mental health problems may also go unidentified and unsupported due to poor recognition of common mental disorders by other adults responsible for their care (Levitt et al. 2007). For example, recent research has shown that teachers often feel poorly equipped to identify children with mental health problems (Newlove-Delgado et al. 2021) and there is limited consideration of mental health in the initial training most teachers receive (Soneson et al. 2018).

As most children attend and spend the majority of their time at school, schools may be a promising setting to overcome barriers to identification and early intervention for child mental health problems. In recent years, schools have placed increasing importance on fostering child psychological wellbeing, with many schools expanding their mental health programmes or services, delivering additional staff training (e.g. mental health first aid training), and trialling clinical treatments adapted for classroom settings (McLoone, Hudson, and Rapee 2006; Weist et al. 2007).

In light of this shift towards addressing child mental health problems within schools, one route for overcoming common barriers associated accessing support is school-based screening with early intervention for those that 'screen positive' for common mental health problems (Anderson et al. 2019). Previous research studies have found that school screening/intervention initiatives can be effective in supporting child mental health problems (e.g. Hoare, Bott, and Robinson 2017)), as well as leading to improvements in children's daily functioning and educational attainment (Burns and Rapee 2021). However, school-based screening/intervention programmes have not always been well received. Studies have found that families and schools can hold concerns about school-based screening programmes include risks of potentially harmful outcomes, such as misidentification, stigmatisation, or a lack of available follow-up care (Burns and Rapee 2021; Childs-Fegredo et al. 2021; Soneson et al. 2018).

A recent nationally representative survey found that six in ten UK children (aged 5 to 16) with a probable mental disorder were receiving regular support through their school (NHS Digital 2020b), in primary schools this is predominantly for behavioural and emotional disorders (Finning et al., 2020; Ogundele, 2018).(Finning et al., 2020; Ogundele, 2018) However, the nature and type of mental health support that is available varies markedly between schools (Department of Health & Department for Education 2017). For example, some UK schools employ an Emotional Literacy Support Assistant (ELSA) who receive six days of training about child mental health (Burton 2021), others may have school counsellors, and other schools may have access to an (often part-time) educational psychologist who will have received more extensive training (Lyonette et al. 2019). A recent development in England is the new Mental Health Support Teams initiative which is embedding Education Mental Health Practitioners in schools to provide low intensity interventions and to support schools in developing prevention focused initiatives (NHS 2020). These various school-based mental health practitioners could be the ideal workforce to implement systematic and integrated approaches to screening and intervention provision, however this rarely occurs within UK schools (Department for Education 2017). An understanding of the perceptions of and concerns of mental health practitioners in UK primary schools about the use of school screening/intervention programmes would help to inform future programme implementation.

The aim of this study was to qualitatively examine the perceptions of practitioners (from a range of professional backgrounds) that support children's mental health in primary school settings about a) the design and delivery of using school-based screening to identify and offer support to children with likely mental health problems, b) practitioners beliefs about the possible implications such procedures may have, and c) practitioners views about potential barriers to engagement in order to ensure that school-based procedures are designed in ways that are acceptable to school staff, fit well with existing school support and practices, and overcome barriers to accessing care. We took a qualitative approach in order to gain an in-depth understanding of practitioner's views and to allow participants to describe in their own words their perceptions of the potential value of and issues relating to procedures for delivering a school-based screening and intervention programme.

Methods

This study received ethical approval from the Central University Research Ethics Committee at the University of Oxford (REF R64620/RE001). All participants provided written informed consent prior to participation.

The present study is nested within a larger programme of research which aims to develop a series of procedures for screening and intervention for childhood anxiety problems in primary schools (Williamson et al. 2021a). While the wider research focus is on childhood anxiety problems, the current study considers common mental disorders more broadly.

Participants

We sought to recruit participants who provide mental health support in primary school settings as the views of these practitioners have been under-represented in research about school-based screening and intervention. Given this study's experiential focus, and the limited research that has been carried out with educational mental health practitioners to date, we prioritised sample specificity when considering the 'informational power' of our sampling strategy (Malterud, Siersma, and Guassora 2016). Namely, we sought in-depth insights from a specific sample of practitioners who had experience in their role of supporting children's mental health in school settings to address our research aim (Malterud, Siersma, and Guassora 2016). Inclusion criteria were currently providing mental health services to children and young people in an educational setting, being aged 18 years or more, English speaking, and willingness to provide informed consent. We use the term 'Practitioners' throughout to describe the group of participants that included educational psychologists, Child Wellbeing Practitioners (CWP), Special Educational Needs Coordinator (SENCOs), and Emotional Literacy Support Assistants (ELSAs).

To recruit participants, convenience sampling was used, and study advertisements were sent to two organisations responsible for providing training to practitioners that deliver mental health support within schools as well as circulating study advertisements via mailing lists and social media. Potential participants who contacted the research team were provided with an electronic copy of the information sheet. Consent forms were sent to participants via email, with signed copies returned prior to participation.

Of the 63 practitioners who contacted the research team to participate, 15 were recruited and interviewed (23.8%) between June – August 2020. This sample was selected to support cross-case analysis of a range of practitioner backgrounds and experiences of providing mental health support in primary school settings. Participants were selected as they contacted the research team and once 15 participants had been recruited, this was considered to be a good range of practitioner views and an acceptable sample size given the research team resources and analytic approach. Six practitioners worked as ELSAs, three as Educational Psychologists (EP), two as SENCOs, two as Children's Wellbeing Practitioners (CWPs), and two as Educational Mental Health Professionals (EMHP). The present sample consisted of 14 (93.3%) females with an average age of 38 years (10.5 SD), and 13 (86.6%) participants were White British. One participant was British Indian, while another was Middle Eastern. Practitioners worked in a range of primary schools from across England -including in London, Telford, and Oxfordshire – which are diverse regions with varying rates of social deprivation (Office of National Statistics 2021). Practitioners worked for primary schools which in England typically include children aged 5–11 years.

Procedure

In-depth, one-to-one interviews were carried out with school-based mental health practitioners by telephone or video call using Microsoft Teams (MS Teams) as per participant preference.

Participants were asked for their views on the different stages of using screening as a route to identify psychological problems – with a particular focus on anxiety problems as these are particularly common mental health problems in primary school aged children (Polanczyk et al. 2015) – and to offer interventions within primary schools, including: (i) dissemination: how screening should be introduced to a year-group of participants; (ii) identification: how child difficulties should be identified; (iii) feedback: how families should be informed of the outcomes of screening and offered support; and (iv) secondary outcomes: the potential impact that using screening to identify children suitable for school-based intervention may have on a family and school community. Interview questions drew on questioning techniques informed by the Critical Incident Approach (Butterfield et al. 2005) to explore participants' views about aspects of the procedures which might help or hinder a positive experience. The interview schedule can be found in Supplementary Material.

If the interview was carried out by video call, participants were shown visual representations of the different steps involved (i.e. a generic image of a school surrounded by families was shown during questions about the potential impact screening may have on a school community). The images were shown to represent the different stages of using screening to identify and support child anxiety difficulties. If the interview was conducted by telephone, participants were asked the same interview questions but not shown the images. All participants were asked to discuss their thoughts, feelings and concerns about each stage, with questions including: 'What would be the best way to do this?', 'Who do you think would be best placed to do this?', 'What might need to be done to help this part happen?', 'Where would be the best place for this to happen?', 'When is the best time to do this?', 'Do you have any concerns about this stage?'. Interviews lasted on average 50 minutes (range = 27–70 minutes) and were audio-recorded with an audio-recorder and transcribed verbatim.

Data analysis

Nvivo 12 software was used to support data analysis and organisation. Data were analysed using Template Analysis (King 1998), an approach that allows for the organisation of data sets with a focus on the research questions while allowing the voices of participants to be heard (Brooks et al. 2015) In template analysis, a template is a set of coding categories. An initial 'a priori' template is developed following familiarisation with the dataset, and is then revised iteratively through coding of data, until it can account for all data relevant to the research questions. This initial or *a priori* template (set of coding categories) can be developed from inductive analysis of the first transcripts, or from externally-generated categories based on theory or existing evidence, or from a combined approach (Brooks et al. 2015). This study used the combined approach. The primary author (VW) created an initial template of *a priori* codes which were informed by several sources, including: the study's research aims, interview schedule questions and the data collected, as well as the empirical literature on child mental health and school-based interventions (e.g. (Childs-Fegredo et al. 2021; Newlove-Delgado et al. 2021; Reardon, Harvey, and Creswell 2019; Soneson et al. 2018)). Once this initial template was developed, authors (VW & ML) analysed transcripts in a more 'top down' manner, following the provisional structure of the template, and modifying the template where necessary. Data collection and analysis took place simultaneously to allow emerging topics of interest to be investigated further in subsequent interviews. For example, researchers were able to explore topics that were salient to participants, including the impact of the COVID-19 pandemic on their caseload. Members of the research team (VW, CC, ML) held a progress review midway through data collection and analysis and revised the template to include aspects of the dataset that were not covered by the initial template. Authors (VW, TF, CC, ML) have experience with qualitative methods and child mental health.

Once all of the data had been coded, the populated template was then circulated, discussed and refined with the full authorship team who have expertise in qualitative methods and/or child mental health, including school-based mental health programmes. This was done in 'real time,' via a shared online document, so that co-analysts (SS, FM, IM, TF) could respond to suggestions and comments of

Table 1. Coding template of included themes.

Template Category 1 – The vicarious impact of providing care on practitioners themselves
• Practitioners feel overwhelmed by the volume of children needing their mental health services.
• Practitioners are not able to help all children in need of psychological support.
• Being unable to help children can be distressing for practitioners themselves.
• The approaches used by practitioners to cope with their own distress.
Template Category 2 – Potential secondary beneficial effects of introducing a primary school-based screening and intervention programme
• Informing parents, children and teachers about mental health problems can be a way to reduce mental health stigma.
• Programme psychoeducation may improve discussion of mental health in schools.
• Families may become more comfortable seeking mental health treatment at school (or other providers)
Template Category 3 – A school-based screening and intervention programme may have adverse effects which should be considered
• More children may be identified as needing psychological support.
• Universal screening ('opt out') may overcome stigma-related barriers to participation for children/parents.
• The screening questionnaire may be distressing and could be seen as a test by children/parents.
• Feedback needs to be delivered sensitively and positively framed to families.
• There is a pressing need for accessible follow on help and referrals after the intervention if required.

others. Themes relating to the research aims were developed and each theme was identified, refined, and verified through team consensus. The finalised template (Table 1) was then organised for reporting here, based around three cross-cutting themes.

Results

Three overarching themes and several sub-themes were developed. These themes reflect how practitioners: (i) feel overwhelmed by the demand for mental health support; (ii) feel hopeful and optimistic that integrated school screening/intervention would be a beneficial addition to current services; (iii) and school-based integrated screening/intervention must be tailored to both the school context and families' concerns.

Practitioners feel overwhelmed by the demand for mental health support

Practitioners described circumstances where they encountered large numbers of children who were experiencing distress due to mental health problems and who they felt would benefit greatly from appropriate formal support. Yet many practitioners reported that they were often unable to provide support to a large proportion of these children due to insufficient resources and/or expertise to meet the current demand. Practitioners reported that this exposure to large numbers of both very distressed children and their parents/carers during the course of their career could be very upsetting and frustrating for them personally. Some practitioners also described encountering school-level barriers to providing mental health care to children, with some schools and school contexts described as being unsupportive or insensitive to child mental health problems often due to school staff being overwhelmed with other responsibilities or due to mental health related stigma.

To manage their own distress at being unable to help all children and their families, several practitioners described focusing on the positive aspects of their role (e.g. focusing on the progress children they are able treat have made), with some practitioners reporting going to great lengths to offer families at least some support. As seen in the quotes below, two practitioners described the impact of providing mental health in schools to a large number of children had on their own wellbeing and the efforts made to cope with their own distress:

> *Practitioner (ID 05): I had such bad anxiety and depression because it felt hopeless but now I think it's OK because the shift that I've seen in people when I have helped them to recognise that they're pretty awesome and they have got the capacity to keep going is enough to help me keep going . . . I think you can either just throw the towel in at this point and go 'well there's not enough money so why bother?' or we can say 'well we've got this bit of money let's do the best we can with it.'*

Practitioner (ID 09): I've got to be honest this is again [this is] why I retrained, some of it out there is just unbelievable. Some of the SENCO provision and . . . the prejudice, the language used in schools it's really, really shocking. I think sometimes we can work from a point of enlightenment and we know that we would never view things like that, but I think on the ground it can be pretty shocking

These two quotes illustrate how distressing, and indeed shocking, some practitioners found the current lack of provision of mental health care for children in schools. As practitioners described their excessively oversubscribed services, some discussed how initiating a school-wide screening programme may highlight a number of additional children who were previously not identified as struggling with mental health problems. Nonetheless many practitioners were positive about screening, but critically, they also noted the importance of screening being followed with an offer of evidence-based intervention for those who did have likely mental health problems given the numerous barriers to existing services.

Practitioner (ID 014) Parents might just think this [programme] is something that's going on at school, they may have no concern about their child's anxiety and then all of a sudden they get a letter saying your child is probably anxious and it might be a real shock to them . . . [parents should be told] there are good evidence-based treatments for children and young people and they can get help so they don't suddenly feel like 'oh no' . . . otherwise they might just get this letter and just feel really 'where do I go with it now?'.

Practitioner (ID 03): It's not like you are leaving them with nothing is it, that would feel very uncomfortable . . . I think it's quite a nice way of helping with that actually and that they have got something they can try so they don't feel completely abandoned . . . it's not as if you are just saying 'well that's all we can do'. I think that feels OK to me.

This latter account illustrates some practitioners' feelings of concern about the lack of available psychological care for families, with the language used (i.e. *'leaving them with nothing,' 'feel completely abandoned'*) underscoring the importance of follow on support being readily accessible post-screening.

Practitioners feel hopeful and optimistic that an in-school screening/intervention would be a beneficial addition to current services

Practitioners described with optimism how delivering a screening and parent-led intervention programme in a school setting could have a number of beneficial effects in supplementing current and overstretched mental health services. For example, most practitioners considered that introducing a screening and parent-led intervention programme could have several positive implications for a school community, including normalising discussions of mental health in schools and increasing emotional literacy amongst staff, parents and students. One practitioner described:

Practitioner (ID 14): Well, I think one of the things is . . . the school starting to be a place where these conversations about mental health and wellbeing are the norm and not something which is whispered about in secret because of stigma and that person is 'mental' and 'crazy' and that kind of, you know, the language that you see being bantered about. So, I definitely think one of the potential benefits could just be yes just kind of affecting the ethos of the school and the way in which it is comfortable with talking about something like anxiety. Yes, and children starting to talk to each other a bit more and we talked about emotional literacy and just using that language a bit more with each other in a more positive peer to peer support.

As seen in this extract, this practitioner was optimistic that an integrated screening and intervention programme had the potential to improve the language used in discussions of mental health in school communities potentially fostering a more supportive environment where mental health was openly discussed. Practitioners also reported that a school-based screening/intervention programme could potentially lower the incidence of long-term child mental health problems by reducing stigma and encouraging early help-seeking amongst families. Moreover, it was considered that this may positively influence families' perceptions of and relationship with their child's school. By schools being involved in the screening/intervention process (e.g. by the school disseminating information about the programme), families may come to see their child's school as a more supportive place to

access help for child mental health problems. For instance, two practitioners describe here the broader secondary impacts offering a school-based screening and intervention programme may have on the relationship between schools and families:

> *Practitioner (ID 04): I would hope that it would reduce the stigma around it and I would hope that it would be something that other parents would be interested in . . . and that as those children progress through school they can take what they've learnt with their parents and use it so that when they get to secondary school, or even when they get to SATS in year 6 and things like that they can use what they've learnt to prevent it from being such an issue then.*

> *Practitioner (ID 14): One of the things that this has the potential to do is increase communication between the parent and the school so . . . the parent may be more likely to approach the school if they want to seek extra support and be signposted or they can share [their progress] with the school so that actually the school can be a bit more involved in, well I guess the school can be more aware actually of what work has been done.*

In these extracts there was generally a sense that carrying out integrated screening and intervention in primary schools could go some way towards not only reducing mental health related stigma and improving help-seeking, but also that the process may enhance the quality of communication between parents and school.

School-based screening/intervention must be tailored to the school curriculum and families concerns

For such benefits to be actualised, however, a number of practitioners described that a school-based screening and intervention programme would need to carefully consider both the school context in which it was embedded as well as the needs of participating families. Practitioners considered that it would be beneficial to include age-appropriate psycho-education as a component of the screening process. Given the limited amount of school resources and staff time available, several practitioners considered that delivering the screening and psycho-education procedures would be most likely to succeed longer term if they could be incorporated into a schools' existing mental health education curriculum. For example, participants considered that, as part of the screening process, delivering an in-school assembly, parents evening or workshop to provide information about the process, psycho-education, and help-seeking information could be beneficial. In addition, two practitioners described below their thoughts on how to maximise this integration in to the primary school setting:

> *Practitioner (ID 05): It will get forgotten straight away unless it's embedded in the PSHE curriculum. So, you kind of need to speak to [school] again about how does this fit into your curriculum and your wider learning? . . . I think there has to be some way otherwise it's a token thing, people tick a box and say 'oh we did that marvellous thing' and it's not followed up . . . So, we have to shift the whole culture.*

> *Practitioner (ID 04): Yes. I'd probably do it [psychoeducation] as in a class discussion which they're probably used to doing and ask for examples for things . . . And then I would probably doing it quite interactive and open it up and see what they know and what they think [anxiety] is because I work with young people where they'll say that they're worried or they're anxious and they're not really because they don't really understand what it is or what it feels like it's just because someone has told them that's what it is or that's what they're feeling. So I'd probably start with just seeing what they thought it was and maybe give some examples of when they've experienced it . . . And then see from there and maybe look at how to make yourself feel better and see what they do and see which things they can do on their own*

Practitioners reported that some parents may feel concerned about an integrated school-based screening and intervention programme and could come to see screening measures as a 'test' or feel that they had failed as parents if their child screened positive for a likely mental health problem. Practitioners described how accessible psychoeducation about child mental health and transparent, sensitive information about the purpose and potential benefits of the screening and intervention pathway would be needed to allay family's participation concerns. One practitioner stated:

> *Practitioner (ID 17): It's very positive but it's also very, 'oh my child is coming up to Year 4 they're going to have to do the questionnaire!' . . . I think [there would be] anxiety in the parents about the topic of anxiety, so yes. It can be very*

sensitive, it's a very sensitive area to some people . . . It's like anything isn't it whether it's like in Year 6 when they have their sex education lesson . . . it's the big thing of Year 6 and then if you've got Year 4 label of 'oh that's when they do the anxiety tests' . . . It's convincing every parent that this is good because some parents don't want a label or don't want to admit things.

Here this practitioner describes how some families could find taking part in screening for a mental health difficulty to be a worrying experience and illustrates the potential impact that labelling the process as 'testing' could have on acceptability. It was also thought that mental health related stigma beliefs could prevent families from engaging with the screening, and practitioners considered that an 'opt out' (rather than 'opt in') approach may result in screening feeling more inclusive across the year group and improve the chances of struggling children being identified. Nonetheless, many practitioners reported concerns that a proportion of children who received the intervention may need additional formal help and they felt it was important for any screening and intervention programme to have carefully considered the longer term arrangements to support families in accessing such care. Practitioners also felt it was important that the programme was not a 'one off', rather the screening/intervention programme should run annually. The comments from the two practitioners below illustrate the potential challenges that may arise following the programme process:

Practitioner (ID 17): From my point of view, I would say an opt-out thing. I think it's very easy for, well it's like anything the amount of mailings and information that sometimes goes home from school at any one time parents do tend to ignore a lot of emails, forms and just 'oh that'll go away or put it on the backburner'. I think it would be much more beneficial to opt-out . . . From my point of view . . . it's kind of recognised between the school and the parents that we have a concern here, but you are aiming to reach out to parents that have never given a thought maybe that there maybe anxiety issues in children to target everybody.

Practitioner (ID 05): It's not enough just to tick a box and say we've had this lovely [school pathway] thing in Year 4 once tick a box, those kids will be fine, because that's just naive. If we want to keep people out of prison and out of adult mental health systems then we've got to have hope that these things can have an impact but you have to be so realistic about the follow up and the feedback and keep it embedded . . . Otherwise, it's tokenistic.

As seen in these extracts, many practitioners reflected on the specific barriers families may encounter to participating in the screening/intervention programme. The key to long term success of the programme was proposed to be accessible, longer-term support. Some of these barriers (e.g. 'opting out') may be more easily addressed than others (e.g. improving access to ongoing care).

Discussion

This study examined the perceptions of practitioners that offer support for mental health problems in primary school-settings about the design and delivery of an integrated school-based screening/intervention programme. Three key findings were observed. First, we found that primary school-based practitioners feel overwhelmed by the current demand for mental health support. Second, despite these concerns, practitioners were hopeful and optimistic that an in-school screening programme if coupled with intervention would be a beneficial addition to existing services offered in schools. Finally, practitioners emphasised that a school-based screening/intervention must be tailored to fit in the school context and to address families' concerns to be successfully implemented.

Practitioners' reports of feeling overwhelmed by the current demand for their psychological services in primary schools are consistent with the existing literature that suggests that rates of childhood mental health disorders are rising (NHS Digital 2020a) and that children and young people often face long waits for support for mental health problems (Schraeder and Reid 2015; Smith et al. 2018). That practitioners feel overwhelmed, and in some cases distressed themselves, by the sheer volume of children requiring their support and not always being able to deliver care could suggest this population may be at risk of burnout, moral injury, or other forms of vicarious distress (Williamson et al. 2021b). Burnout is not uncommon in individuals working with vulnerable children

and this syndrome of emotional exhaustion can lead to a deterioration in the quality of care provided (Mcfadden 2016) with high rates of burnout found in school counsellors (King, Subotic-Kerry, and O'Dea 2018), and teachers (Talmor, R, and Feigin 2007). That said, practitioners described drawing on a range of coping strategies – such as focusing on positives – in an effort to manage adaptively in their role. Nonetheless, currently there is little provision for the clinical support and supervision of practitioners working in mental health roles in schools in the UK (Carroll et al. 2020; Department for Education 2021b). As initiatives to expand the delivery of mental health programmes in schools continue to grow, additional research is needed to better understand the support needs of practitioners working in educational mental health settings to ensure that can deliver high quality support for children and safeguard their own wellbeing.

It seems inevitable that introducing universal screening for mental disorders in primary schools could have the potential to highlight additional children requiring support from already busy practitioners. However, a recent study shows that a school counselling service did not in fact increase referrals to CAMHS and indicated that appropriate intervention may in fact contain certain youth mental health problems (Grant et al. 2021). In order for it to be successful, practitioners described a need for the programme to incorporate follow up care and support for children who did not respond to initial intervention. Moreover, consistent with a previous study which examined the views of both parents and school staff (Childs-Fegredo et al. 2021), for an integrated screening/intervention programme to be successfully embedded in a school, practitioners felt that several steps would need to be taken to allay possible concerns held by school staff and families. For example, the programme's procedures and study information would need to be appropriate for and logistically fit with a school's existing mental health education curriculum and be sensitively communicated to avoid families feeling blamed or stigmatised. Previous research has found that parents who have struggled to access mental health treatment for their child through schools can describe feeling blamed by school staff for their child's difficulties (Baker, Arnold, and Meagher 2011) and concerns about mental health-related stigma are a key barrier to seeking help for child mental health problems (Reardon et al. 2017; Reardon, Harvey, and Creswell 2019). This underscores the importance of incorporating the views of stakeholders and families in school-based screening/intervention programme design as well as carefully piloting study materials prior to administration to ensure the information communicated is accessible, understandable and appropriate.

In addition to meeting the primary aims of increasing access to early intervention for children with likely mental health problems, practitioners were generally optimistic that the inclusion of an integrated screening/intervention programme in primary schools could have positive secondary effects for a school, including normalising discussions of mental health, reducing stigma, encouraging early help-seeking, and encouraging a sense of schools as a supportive place to access care for child mental health problems. Indeed, reduction in stigma and improved future help-seeking is a commonly cited potential secondary benefit or 'side effect' of school screening/interventions (Humphrey and Wigelsworth 2016) and positive results have been observed in terms of reduced mental health stigma following school-based screening/intervention programmes for older children and young people (Eisenberg, Downs, and Golberstein 2012; Lindow et al. 2020). Yet it currently is unclear whether such benefits are equally achievable for younger children and their families. This reflects an important consideration for future studies when evaluating the effectiveness or success of their school-based screening/intervention programmes.

This study has several strengths and weaknesses. Among the strengths is the inclusion of practitioners with a range of expertise and involvement in providing mental health care to primary school children. (e.g. ELSAs, SENCOs, CWPs). Participation in the study was also confidential and carried out remotely, which may have facilitated disclosure of practitioners lived experiences (Greenfield, Midanik, and Rogers 2000). Among the weaknesses is the convenience sampling strategy and the limited demographic diversity of the sample in terms of gender and ethnic background. While this demographic profile is similar to the UK teaching population (Department for Education 2021a), it is not clear to what extent the findings will translate to

other contexts, include those outside the UK. Finally, we did not collect demographic information relating to practitioners specific training or years of experience or details about the level of support available to address mental health needs within the school. It is possible that more years of experience, or working in a school with more funds available for psychological support may influence perceptions of school screening/intervention programmes which should be considered in future studies.

In summary, the findings of this study, first, underscore the difficulties faced by practitioners in providing psychological support to children in primary schools due to the high demand for support for child mental health problems. Second, to successfully implement a school-based screening/intervention programme steps need to be taken to overcome possible concerns of both school staff and families, including the need to address stigma and ensure that follow-on care will be accessible (Soneson et al. 2018). As such, the development and delivery of screening and intervention programmes for mental health problems should be carried out in partnership with parents, school staff, and key stakeholders to ensure the programme is acceptable and can be effectively incorporated into the school context. Finally, despite implementation concerns, this study indicates that a sufficiently resourced school-based screening and the delivery of an evidence-based intervention could be well received and welcomed by practitioners delivering mental health support in school settings.

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