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Primary school-based screening for childhood mental health problems and intervention delivery: a qualitative study of parents in challenging circumstances

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ABSTRACT

Few children with mental health problems access evidence-based interventions. Primary schools may be an ideal setting to improve access to treatment through screening and intervention programmes, but some families' circumstances and experiences may increase barriers to benefiting from this approach. Interviews were carried out with parents of children living in potentially challenging circumstances, including foster and military-connected families. We aimed to explore parent perceptions of a school-based screening/intervention programme and potential barriers to uptake. Parents described that due to their past experiences, that they might not trust or engage with a school-based screening/intervention. Nonetheless, parents considered that the delivery of a sensitive school screening/intervention programme might provide an opportunity for schools to strengthen their relationship with families. These findings highlight the need for future school-based screening/intervention programmes for child mental health to consider the needs of families of children from varied circumstances, and ensure steps are taken to promote trust.

KEYWORDS
Mental health; intervention; school; screening; parent; child

Mental health problems are a leading cause of ill-health and disability (NHS Digital 2016). The first onset of many mental health problems occurs in childhood (Kessler et al. 2007, 2012); with the median age of some common mental health problems (such as anxiety) being around the time that children finish primary school (Kessler et al. 2007; Vasileva et al. 2021). Moreover, recent research has suggested that the extent of mental health problems in children is on the rise, with a recent study in England finding that one in six children and young people meet likely case criteria for a common mental health problem (Deighton et al. 2019). Without appropriate identification and treatment, a significant proportion of children with mental health problems are likely to continue to experience symptoms into adulthood, causing chronic difficulties in social, educational, and family functioning (Kessler et al. 2007, 2012; McCrone, Dhanasiri, and Patel et al. 2008).

Despite the pervasive and chronic nature of many mental health problems, treatment and support is often challenging for families to access for their children. Barriers to treatment can include

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problems with disorder identification, parental concerns about their child's difficulties being minimised or dismissed by professionals or the child and/or family being labelled in ways that might be unhelpful for them now and/or in the future, a lack of clarity about how to access formal help, and long waiting lists for child and adolescent mental health services (CAMHS) (Reardon, Harvey, and Creswell 2020,8; Reardon et al. 2017). Whilst this is by no means an exhaustive list of potential barriers to care, it highlights the range of individual, organisational and systems-level hurdles families must overcome to access support.

As most children attend school, and spend a significant amount of their time there, primary school settings may be particularly well placed to overcome barriers to early identification and intervention. Universal screening initiatives, where validated measures are administered across the school population, could help identify children who could benefit from support and help families to access support early in order to 'nip' child mental health problems 'in the bud' (Herzig-Anderson et al. 2012; Anderson et al. 2019). Previous studies have found promising evidence for the effectiveness of school-wide screening and interventions for child mental health problems (e.g (Hoare, Bott, and Robinson 2017)). School wide early screening/intervention initiatives may be more cost effective than later professional intervention and lead to improvements in child educational attainment and daily functioning long term (Burns and Rapee 2021). However, school-based screening and interventions are not always well received or seen as acceptable by all families. In fact, a number of recent studies have found low familial engagement with school-based universal screening and intervention programmes (Morgan et al. 2017), with some families expressing concerns that screening initiatives may increase stigmatisation (Soneson et al. 2018). This highlights the need for any school-based screening programme to ensure that the methods of delivery are acceptable and engaging for all families.

Particular child or family characteristics are likely to have an impact on the perceived acceptability of and successful engagement with a school-based screening and intervention programme. Children exposed to chronic stressors, such as serious physical illness, frequent relocations, parental mental illness, or a history of abuse/neglect may be at greater risk of mental health difficulties and could be most likely to benefit from an intervention (Mok et al. 2016, 17; Hysing et al. 2007). However, the challenging circumstances they face may reduce their family's willingness or ability to engage with a school-based programme. In some cases, this may be for practical reasons, for example, where children have frequent relocations or time out of mainstream schooling, such as children of military parents or children with serious physical illnesses (e.g (Perreault, Mcduff, and Dion 2020; Williamson et al. 2018)). For other families, reluctance to participate may be due to personal choice, particularly if there are concerns that their child's needs will not be adequately considered or met by a school-based intervention (York and Jones 2017). Previous studies have also highlighted the importance of good family-school partnerships in contributing towards positive child outcomes (Smith et al., 2020; Sheridan et al., 2017). It is possible that the pre-existing relationship between the family and school may also be a key factor in shaping whether a school-based screening-intervention programme will be perceived as acceptable to families (Smith et al, 2020). For example, the quality of parent-school interactions, including the degree of collaboration between parents and teachers, and home-school information sharing, may influence a family's willingness to engage in a school-based mental health programme. As such, inclusive school-based screening-intervention programmes need to be carefully planned with families varied needs and experiences in mind.

An in-depth understanding of the views of families living in challenging or complex circumstances that may influence the acceptability of and ability to engage with a school-based screening and intervention programme could help ensure such school-based programmes are not only more inclusive but more effectively and appropriately meet the needs of a greater number of families. Therefore, the aim of this study was to explore the perceptions of parents in challenging circumstances, regarding the development of primary school-based screening and intervention programmes for child mental health problems given their previous experiences of interacting with schools.

Method

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 for their participation prior to participation.

The present study is nested within a larger programme of research which is developing and evaluating a series of procedures for screening for childhood anxiety problems in schools and delivering an early parent-led intervention. The protocol for the wider codesign part of the screening – intervention programme is described in detail in Williamson et al. (Williamson et al. 2021) Examining the perspectives of parents who may face particular challenges in engaging with school-based screening/intervention was considered to be an important adjunct to ensure that the school-based procedures being developed would be acceptable, inclusive, and appropriately meet the needs of families. Parents participating in the present study focused on informing the school-based procedures and parents were not offered the screening-intervention programme that was developed.

Sampling and recruitment

The study is experiential in focus, and because this population are under-researched, we prioritised sample specificity when considering the 'informational power' (Malterud, Siersma, and Guassora 2016) of our sampling strategy. That is, we sought in-depth insights, rather than a broader range of perspectives. We use the term 'parent' throughout to refer to both biological parents and primary foster or adoptive caregivers. We aimed to specifically include the views of parents of foster or adoptive children, parents of children with chronic physical illnesses, parents of children with learning difficulties, parents with personal experience of mental health problems themselves, and military-connected parents. We use the term 'parents in challenging circumstances' to describe these parents as no alternative, sensitive term that was inclusive could be found in previous policy documents that adequately reflected the perspective on parenting shared by this group. Participants had to be aged 18 years or more, based in the UK, English speaking, and willing to provide informed consent to be included in the study. We recruited parent participants between March – December 2020. Study advertisements, including study rationale and what taking part would entail, were sent to organisations responsible for providing support to parents within the identified groups (e.g. the Fostering Network, Army Families Federation) as well as circulated via organisation and research institution mailing lists and social media. Parents who expressed interest in taking part were screened for eligibility. We also took a snowball sampling approach, asking participants to share information about the study with other parents that they knew. If eligible, parents were invited to provide informed consent for their participation prior to the study interview.

Participants

We recruited ten parents to the study. The ten participating parents were from different families. Seven participants were female, with an average age of 47.1 years (7.6 SD). Nine participants identified as White British and one as Latin American. Two parents were foster parents, two parents were military-connected parents, one parent had a child with a chronic physical illness, one parent had a child with a learning difficulty, and four parents reported personal experience of mental health problems. The average age of children was 9.2 (SD 3.1, range = 6–16 years) and six children were female. The researchers carrying out data collection did not have pre-existing relationships with the participants.

Procedure

The first author conducted in-depth one-to-one interviews with parents by telephone or remote call on using an online platform (e.g. MS Teams) as per participant preference. Participants were told about the purpose of the study and asked for their views on the several possible stages of school-wide screening to identify common child mental health problems and offer psychological interventions, including: how screening should be introduced to school staff, children and parents; how likely child mental health problems should be screened for or identified; whether any challenges could arise during the screening process; how families should be informed of the outcomes of screening and offered support; and the potential impact that school-based screening and intervention may have on a family as well as the 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.

Where possible if the interview was carried out by MS Teams, participants were shown visual representations of the different steps involved (e.g. an image of a school with families around it was shown during questions about the possible secondary effects of screening and intervention delivery on a school community). 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 person 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 part?', 'How might this step be adapted to fit your family's needs?' Interviews were audio-recorded and transcribed verbatim.

Data analysis

We used Nvivo 12 software to facilitate initial data analysis. Data were analysed using Template Analysis (TA; King 1998, 2012), a commonly used approach that allows for the organisation of data sets with a focus on the research questions while equally honouring the voices of participants (King, 1998, 2012). In TA, a template is a set of coding categories. An initial '*a priori*' template is developed, 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 drawn from theory or existing evidence, or from a combined approach (Brooks et al. 2015). Our study took the hybrid approach. The primary author (VW) created a template of *a priori* codes which were drawn from the data, but scaffolded by the open-ended interview schedule questions, the empirical literature on child mental health and school-based interventions (e.g. including but not limited to (Reardon et al. 2017; Morgan et al. 2017; Soneson et al. 2018), and the study's research questions. Once this first template was developed, we analysed transcripts in a more 'top down' manner, following the provisional structure of the template, and revising the template where necessary. Data collection and analysis took place simultaneously to allow emerging topics of interest to be investigated further in later interviews. We (VW, CC, ML) held a progress review midway through data collection and analysis and modified the template to capture aspects of the dataset that were not covered by the initial template.

Once all the data had been coded and incorporated, the populated template was then shared, discussed and refined with the full authorship team who have expertise in qualitative methods and/or child mental health, including school-based programmes and from an expert by experience perspective. This was done in 'real time,' via a shared online document, so that co-analysts could respond to each other's suggestions and comments. Themes relating to the research aims were developed from the template (see Table 1). Each theme was identified, refined and verified through team consensus. The finalised template was then organised for reporting here, based around three cross-cutting themes.

Table 1. Coding template.

Initial template structure
Template Category 1 – Screening and testing children must be planned, introduced and conducted sensitively
1.A. Screening children: anticipating parents' concerns
• Some parents have had a hard time getting the right help in the past
• Some parents worry about stigma and blame
• Some parents may feel they have enough expertise to manage child mental health difficulties themselves
• Schools may see child mental health difficulties that parents do not
• Some children's fears and worries may be legitimate and not pathological given their circumstances
• Teachers working with the parent and child can come to a shared understanding
Template Category 2 – Providing information about the project is informative and normalises engagement with the project
2. A. Informing parents, children and teachers about mental health problems can be a way to build understanding of mental health and relationships with the intervention.
• Informing school communities about the problem can pave the way for the screening and intervention
2. B Informing parents, children and teachers about mental health problems can be a way to develop peer support structures and a 'whole school' culture.
• Children could be mobilised to educate and support each other
• Parents could educate and support each other
• Families may become more comfortable discussing these things with and at school (or other providers)
Template Category 3 – Facilitating participation for parents is important if a project is to succeed
3. A Schools and researchers need a multi-channel approach to communications
• Parents will respond best if communication comes from trusted people
Final template structure
Template Category 1 – Parents will do whatever they can to support their child's wellbeing
1.A. Fostering their child's wellbeing is a key priority
• Witnessing child mental health problems can be distressing for parents
• Some parents have had a hard time getting the right help in the past
• Being unable to access the right help can be very frustrating for parents
• In the face of barriers to care, parents develop their own expertise to support their child
Template Category 2 – Parents may have concerns about who they can trust when engaging with a school-based screening & intervention
2. A. Parents can lose trust in schools & formal services due to previous experiences of help-seeking difficulties & barriers to care
• Parents would generally welcome a school-based screening/intervention programme
• Previous experiences of accessing care can impact whether parents see the school/ formal services as helpful or not
2. B Informing parents, children and teachers about the screening/intervention programme requires careful consideration & a multi-channel approach to communications
• Parents could have concerns about the reliability & trustworthiness of a screening/intervention programme
• Parents want agency in deciding to participate in the programme & if their data is shared with the school
• Parents may trust communication about the programme from some stakeholders but not others
• Communication from school staff about the programme may enhance credibility
Template Category 3 – School-based screening and intervention may be an opportunity to (re)build or strengthen relationships with and through school
3. A School based screening/intervention may lead to positive changes in the school community's attitude towards mental health
• A collaborative approach to screening may improve the school staff's understanding & future response to child mental health difficulties
• Schools may see child mental health difficulties that parents do not
• Families may come to see the school as a place to seek support for children
• Programme may lead to more open discussions of mental health & a reduction in stigma

Results

Key findings

We identified three overarching themes, reflecting that: a) parents will do whatever they can to support their child's wellbeing; b) parents may have concerns about who they can trust when engaging with a school-based screening and intervention; and c) school-based screening and intervention may be an opportunity to (re)build or strengthen relationships with and through school. Anonymised excerpts have been provided to illustrate the findings.

Parents will do whatever they can to support their child's wellbeing

Many participating parents described how fostering their child's wellbeing was a key priority. In the following extract, the parent's exclusive framing of this priority ('*that's all you care about*') highlights the centrality of children's wellbeing for many parents:

> Parent (child with chronic physical illness): *As a parent the only thing you want for your child is that they are happy, and they like themselves. That's all you care about . . .the minute they are born that's what you want to give them is a safe, secure, happy life, and [you] are really pulled to protect [your] children from adversity or social, emotional mental health difficulties.*

Undoubtedly, this was felt to be a significant motivating factor that should be taken into account when planning school-based screening and interventions. Some parents also described their own distress when seeing their children experiencing mental health problems. In these circumstances, parents reported that getting support for their child's mental health needs could be challenging. Parents had encountered long waiting lists for formal services, felt that school staff that they spoke to about their child's difficulties had been unsupportive or unsympathetic, or were offered support that was inadequate for the complexity of their child's mental health problems. For example, one parent described their difficulties in accessing suitable support from their child's school:

> Parent (foster parent): *It was one of the most violent episodes . . . So I'd gone to school, and I had to show [the school] videos in the end because they didn't believe me and didn't want to believe me.*

This account illustrates some parents' feelings of frustration and the language used ('*they didn't believe me and didn't want to believe me*') underscores how the difficulties faced when attempting to access support for their child could produce an '*us [parent] versus them [school]*' experience.

Despite these barriers to accessing external help, parents described persisting to ensure their child's needs could be met. For example, carrying out their own research to develop the skills and knowledge needed to support their child's difficulties themselves. A number of parents also described seeking out online support groups for parents of children with similar, complex difficulties which were described as a helpful platform to share concerns with other parents and receive advice and reassurance. As a result of their efforts, these parents described how they had become very knowledgeable about their child's difficulties and had developed ways to 'bridge the gap' – such as learning and attempting various therapeutic parenting techniques – until appropriate help could be accessed. For example, here two parents describe the additional planning, reading, and research that they do in order to support their children:

> Parent (foster parent): *When I wasn't able to get to the meetings and support groups . . . I used to watch little YouTubes on therapeutic parenting, with them doing role plays . . . The parents, believe you me, they are going to be worn out. So, if they crash into bed and they can look at something then, which is what a lot of us foster carers do, one or two in the morning we're still trying to think 'Oh my gosh I don't want a day like tomorrow, right what can I do to plan that day to make it different?'*

> Parent (child with learning difficulties): *We've got Facebook . . . this one is for children's disabilities and learning difficulties so we are talking about . . . kids with anxiety and everything . . . and I do research . . . So for me it's easy to go and do research and find the help, a lot of people don't find it.*

As seen in these extracts, there was a sense that parents frequently felt they were left to find their own resources to try and support their children themselves and would often go to great lengths to do so.

Parents may have concerns about who they can trust when engaging with school-based screening and intervention

When asked about their views of a school-based screening and intervention for child mental health difficulties being made available, all parents reported that they would generally consider this

a valuable, helpful opportunity. Nonetheless, given their previous difficulties in accessing support, some parents described having a number of concerns about how the screening/intervention would be executed.

As a result of their struggle to access psychological help for their children, a number of parents described a loss of trust in formal services and/or their child's school. For many, these settings were not seen as a place where their concerns would be listened to, or where appropriate help could be easily accessed. Conversely, the few parents who had not needed to seek formal support for their children from their school (e.g. their child did not have a psychological difficulty) described having trust and confidence in their child's school and school staff. One parent who struggled to receive care for their child described how this arose as a result of being treated as a risk, rather than a resource:

> Parent (child with chronic physical illness): *I think schools can ultimately see parents [as] a safeguarding risk . . . [the] starting point is to presume the worst behaviour in parents . . . Bearing in mind that increasing numbers - who struggle to attend school - of children are being diagnosed with an anxiety related problem, those families are desperate for help, but they are being placed through safeguarding risk procedures . . . [Those parents are] not a child protection risk, they're families who are really struggling to access support . . . Parent blame it's a massive, massive, massive problem . . . that blame/shame cycle is huge within families, within schools, within services . . . So, if you've got a very highly anxious child . . . and if outcomes aren't being met and solutions can't be delivered or found, it's quite easy for it to come back to blame someone and usually it falls on the families' shoulders.*

Parents also highlighted issues relating to trust in the procedures that would be implemented to screen for and provide support for child mental health problems. For example, they raised concerns about whether the screening process would be reliable and accurate, whether the intervention would be delivered by a well-trained clinician who listened and responded to their needs, and whether further support would be accessible if they were to need more help after the intervention ended. One parent stated:

> Parent (military connected): *Parents come in all shapes and sizes . . . I definitely think [a clinician's involvement in screening is] much better because they can explain it and my experience is that parents are also going to be really worried. "What, are you saying my kid is going to be ill?" So, I think having someone who can - a clinician or someone with a clinical understanding - is probably more important.*

Here, this parent describes how it could be worrying to receive feedback that their child had screened positive for a mental health problem. In this context, they felt that they would appreciate an opportunity to discuss their child with someone who brings clinical expertise. Parents also felt that they were experts with regards to their children and wanted their own agency and knowledge to be acknowledged in the screening/intervention process, highlighting the importance of not excluding parents from school-based mental health procedures. For example, parents reported that they would want some control over whether their child took part in the school-based screening process, whether they took up the intervention, and whether any data about their participation in the screening/intervention process was shared with their child's school or other third parties. The comments from two participants below are typical of the concerns that were raised by participating parents:

> Parent (foster parent): *Yes. I wouldn't like you to just go ahead and share [my data with the school], I'd feel that was actually pretty unthoughtful . . . I think because if you don't have a good relationship with the teacher and the child doesn't have a good relationship it just takes them a while to come on board and you don't want to give [the school] any more ammunition to be unkind to the child really.*

> Parent (history of mental health difficulties): *It can come down to what wording you use to start the relationship off, right from the beginning - that it might seem like you as the researchers and then also them as the school those two parties are in a power position potentially over the parent. So, language is really important . . . if the power relationship doesn't feel right or the parent has been let down or judged in the past, they won't go for it next time.*

These worries about data-sharing, relationships, language, and level of involvement indicate how the perceived trustworthiness of a school-based screening and intervention could potentially be either an obstacle or vehicle for parental engagement. Parents described that they would trust and value

communication about the screening/intervention from some stakeholders – but not others. Understanding 'who trusts whom,' is likely to be an important part of implementation planning for schools-based work. For example, parents who had struggled to access support from their child's school reported that they would trust communication from an external clinician or researcher who was felt to be impartial, independent of the school, and knowledgeable about child mental health difficulties. Conversely, other parents described how they would like the class teacher or head-teacher to introduce the screening/intervention, as this would lend credibility, and demonstrate the school's support of the endeavour. For example:

> Parent (military connected): *It's all about buy in isn't it? Buy in. You need the experts, and you need the chain of command, so this big buy in, because we trust that our teachers . . . they know what's right for our kiddies. But the buy in from the headmistress to explain what this is all about so that there's no unknowns . . . if all of a sudden, I was called in to be told 'Your daughter is really anxious,' I'm going to be a little bit upset maybe even a bit 'Oh, what do you mean?' - even if I kind of knew it myself . . . So maybe . . . [it's for] the teacher to say because you know them and obviously you've already met, and 'I'll leave you [and the clinician] together to talk about what's going to happen next,' so you ease them in - because I would find it quite tough.*

This extract illustrates how the context of delivery may determine whether the screening/intervention programme appears trustworthy and underscores how some parents did feel that school staff could be trusted to endorse a programme that could be beneficial to families (*'they know what's right for our kiddies'*). Successful implementation may depend on identifying a range of stakeholders or organisations that can be trusted by the parents and families who are the target of the intervention to disseminate programme information.

A school-based screening and intervention may be an opportunity to (re)build relationships with and through school

Despite the concerns expressed about trustworthiness and acceptability, some parents explained that school-based screening and intervention for child mental health difficulties also presented a promising opportunity to rebuild or strengthen relationships with their child's school. Parents thought the screening process being based in their child's school could improve the school staff's future understanding and response to their child's difficulties. This was particularly so if the screening process was a collaborative effort, including parents, children, and teacher's views. Parents considered that including class teachers' reports in the screening process could be a valuable addition and ensure that their child's difficulties, that may not always be apparent at home, would not go uncaptured. This was especially salient for parents of children who were considered to have significant mental health difficulties. Here, a participant described how the inclusion of teacher report may ensure a more comprehensive assessment of their foster child's difficulties:

> Parent (foster): *I think teachers have a window into how our kids are really doing and quite often they are the ones are the frontline and are seeing it as much as they are at home or sometimes more . . . I think being able to work with the schools is really useful . . . I think it's vital, that home-school bond, because quite often with our children for many, many different reasons -including anxiety - you can have one particular behaviour at school but not at home or vice versa. They can be incredible at school and really tricky at home or the other way around, so actually if you then are opening that dialogue, I think it's vital.*

All parents also considered that a school-based screening and intervention programme had the potential to bring broader benefits and may lead to secondary positive outcomes like improvements in a school community's culture and general perceptions of mental health. Some parents suggested that, as a result of the screening/intervention, families might see the school as a place to seek support for their children. Parents also described that circulating information about the screening/intervention pathway at a school may lead to more open conversations about mental ill health within schools and potentially reduce mental health related stigma within the school. This parent's account illustrates this:

> Parent (history of mental health problems): *I think in terms of the overall effect it would be great because . . . the school will become more supportive of people who are not having a good time. I think the parents will feel closer to the school and trust it more and . . . there will be more of a sense of . . . 'You don't have to suffer in silence' . . . [School is] much closer to home, it's much more familiar and therefore it's much more accessible . . . If people start to feel more supported by the institutions that they rely on in the community . . . it would help destigmatise mental health . . . it would perhaps create slightly more of a community spirit in that everybody has done this questionnaire and there's been a lot of discussion about it.*

This extract illustrates how such a programme, if delivered well, may have the potential to not only offer families more accessible care, but also to nourish a more trusting relationship with staff within their child's school and reduce mental health stigma.

Discussion

The aim of this study was to explore the perceptions of parents of children in particularly challenging circumstances regarding the feasibility of a primary school-based screening and intervention programme for childhood mental health problems given their prior experiences of interacting with schools; their beliefs about the possible implications of such a programme; and views about potential barriers to uptake. Our findings illustrate that parents have a strong desire to support their children's wellbeing yet for some, due to their past experiences or current circumstances, they might not trust and or engage with school-based screening/intervention. However, the findings also suggest that the delivery of a screening/intervention programme may present an opportunity to strengthen or rebuild relationships between school staff and families and pave the way for a more supportive school community and greater partnership between parents and school staff.

Our finding that parents feel strongly about the need to foster their child's wellbeing as a key priority is not unusual and the vicarious distress reported by parents when watching their child struggle with mental health difficulties is also consistent with the broader literature on the negative impact having a child with mental health problems can have on caregiver's own wellbeing (Keenan et al. 2016; Kerns et al. 2017). As has been previously widely reported, parents faced a number of difficulties in accessing formal support for child mental health problems (Reardon, Harvey, and Creswell 2020; York and Jones 2017) with parents often left with no choice but to carry out their own research to learn strategies to support their child until formal help could be accessed. This study illustrates the challenges that parents face as well as the clear demand for mental health support for children. As rates of youth mental health disorders continue to rise (Twenge et al. 2019), it is possible that the challenges faced by parents participating in the present study may be applicable to an increasing number of families in future. As youth mental health services continue to be oversubscribed with long waiting times for care, the interest in and appetite for early school-based screening/intervention programmes is likely to grow – but their success is contingent on understanding and considering barriers to uptake. This study underscores how a well-designed, supportive, and trusted school-based screening and intervention could be especially beneficial to and welcomed by families in a variety of challenging circumstances.

Although families described a clear desire for support, we also found that there may be a number of reasons why families may distrust or not engage with a school-based screening/intervention programme. Our findings highlight that parents may lose trust or confidence in formal services and/or their child's school due to difficulties they have faced in trying to access care in the past. This is consistent with previous research which found that having confidence or trust in service providers is an important part of help-seeking (Boyer, Boyer, and Lutfey 2010), and that families may be concerned about engaging with school screening due to concerns about stigma or further, appropriate help not being accessible (Soneson et al. 2018). The design of accessible and acceptable school-based screening/intervention programmes needs to include careful consideration of how information about such an initiative is shared and by whom, as well as the language that is used to ensure a balance of power between all users and stakeholders. Parents in challenging circumstances,

and their children, will need to ask questions about the screening/intervention programme and be given satisfactory, honest and empathetic answers from the school 'team' and other involved stakeholders (Burns and Rapee 2021). Our findings indicate that due to their lived experiences, families in the types of challenging circumstances that we explored here may trust some stakeholders, but not others, and school-based programmes should communicate information via multiple channels (e.g. directly from school staff, from healthcare teams, from parents to parents) to ensure as many families are able to participate as possible.

Increasingly in healthcare, shared decision making and partnerships are advocated as best practice, with the patient perspective integral to the planning and implementation of treatment, as this approach can improve patient's trust in healthcare services, increase patient satisfaction with treatment, and reduce perceived symptom burden (Adams and Drake 2006). A similar approach, where the concerns of families are sought out and solutions are co-created, is essential when designing and implementing school-based screening/intervention programmes in the future. What is key is that families who may have faced or are currently facing a range of difficulties that may make taking part in a school-based screening/intervention programme more difficult (e.g. parental deployment, child's chronic physical illness, etc.) are not excluded from taking part and deriving benefit from a programme, nor should they be blamed for choosing not to be involved or for being considered 'hard to reach' (Bonevski et al. 2014; Crozier and Davies 2007). Instead, there is a need to actively reach out, include and work in partnership with a diverse range of families and consider what needs or concerns are not currently being met.

Finally, the findings of this study highlight that delivering a well-designed school-based screening/intervention programme may have the potential to build – or rebuild – some families relationships with the school. We found families generally would welcome such a programme and felt that the school staff could gain a better understanding of and response to their child's difficulties through comprehensive screening. Secondary benefits – such as a reduction in mental health related stigma and improved future help seeking across the school community – may also be experienced. To date, secondary school and university based mental health screening/intervention programmes have been successful in reducing stigma and improving help seeking (Eisenberg, Downs, and Golberstein 2012; Wei et al. 2015) – however, whether such benefits can also be achieved in primary schools has received limited research attention to date, but these are important long-term outcomes to evaluate in future studies going forwards. To maximise knock-on benefits for help-seeking and reducing stigma, initiatives need to build in plans for longevity and legacy by ensuring systems are set in place, monitored and maintained over time.

This study has several strengths and weaknesses. Among the strengths is the collection of data from parents with a range of difficult circumstances that may influence their ability or willingness to engage in school-based screening/intervention programmes for childhood mental health problems, including military connected families, parents of children with serious medical conditions, parents with their own mental health problems, and foster parents. Nonetheless, the findings are qualitative and not intended to be generalisable to all families facing similar or different challenging circumstances. Future studies should also consider the needs of other vulnerable groups who may also be offered school screening/interventions, such as refugee families, families who experience domestic violence, families with language barriers, families living in poverty, and families where children struggle to attend school due to mental health problems (Fazel 2018; da Paz and Wallander 2017). Second, although all participants appeared to speak candidly about their experiences during the interviews, it is important to reflect on the potential influence of researcher and participant characteristics (e.g., social desirability) on the data collected. In an attempt to counter this, all participants were informed that participation was anonymous, confidential, and that they could withdraw from the study at any time. A final issue is that our opportunity approach to sampling was limited by opportunity, because the study was largely carried out during the COVID-19 restrictions in the UK (and, as such, interviews needed to be conducted remotely), this may have influenced recruitment

and participation. Nonetheless, the relatively small number of participants also allowed for in-depth data analysis (Crouch and McKenzie 2006; Marshall 1996)

Despite these limitations, the present study provides evidence of the views of families in a range of challenging circumstances on the acceptability of primary school-based screening and intervention programme for child mental health problems. These findings expand on previous studies and provide insight into the pressing concerns and expectations some families in challenging circumstances may have about such programmes, including the struggle between the desire to alleviate their child's psychological difficulties yet feeling distrustful of schools or formal services because of past negative experiences. Future research should consider whether the needs of families can be adequately met by primary school-based screening/intervention programmes and whether building in flexibility to programme procedures may be worthwhile in order to be inclusive and supportive families of children with more complex needs. Our findings illustrate that parents have positive views about primary school-based screening/intervention programmes to identify and provide early support for child mental health problems, including the potential to improve not only child symptoms but also reduce community mental health stigma and improve school responses to familial help-seeking. Nonetheless, for such benefits to be actualised, effective communication with all parents to ensure trust and confidence in the process is key.

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