Journal Article

Addressing the 'elephant in the room'. The role of the primary school practitioner in supporting children's mental well-being

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Abstract

The enthusiasm regarding the school as a place for mental health promotion is powered by a large body of research demonstrating the links between mental health and well-being, academic success and future life opportunities. Despite on-going commitment to mental well-being in the UK, statistics suggest mental health issues are increasing among children and young people. This small-scale qualitative-exploratory study, undertaken in two primary schools in North Wales, reports on how school practitioners perceive, promote and support the mental health and well-being of pupils. The paper highlights a reluctance by practitioners to address mental health topics due to fear of stigma and a desire to protect children. Issues linked to funding, skills and training, together with over-stretched specialist agencies, are making it difficult for school practitioners to support pupils. There is a pressing need for appropriate training opportunities in order for practitioners to be knowledgeable and to feel confident to discuss mental health with children and young people. Schools have a significant role in supporting children's mental well-being and reducing the stigma attached to mental illness but only if this important topic is not regarded as an 'elephant in the room.'

Key words: healthy schools; mental health; mental health stigma; pupil well-being

Introduction

The focus of the mental health of school aged children in the United Kingdom [UK] is gaining momentum. Following the World Health Organization's declaration, in 2005, that mental ill-health is Europe's biggest epidemic, there has been increased intervention in supporting this aspect of health (World Health Organization [WHO], 2005; Ecclestone, 2014). Tabloid headlines such as 'Worrying rise in number of children with depression' (Daily Mail, 2013) and 'Heads calling 999 over mental health' (BBC News, 2015a), have put the mental well-being of children and young people firmly on the political and social agenda. Recently, there has been an increased pledge by both the Westminster Government and the Welsh Government to invest in child and adolescent mental health services. Thus, the focus of this paper is timely as it provides insight into primary school practitioners' experiences of addressing mental health, with the intent to promote more effective work by schools to support pupil well-being. Objectives of the study include i) to explore perceptions school practitioners have of mental health and raising awareness of issues among children ii) to identify some of the mental health issues experienced by pupils iii) to examine the role school practitioners believe they should play in addressing the mental health needs of children.

A great deal of work has been done in recent years to maintain the focus on improving children's and young people's mental health outcomes. However, despite there being a wealth good practice to build on, mental health issues among young people appear to be on the increase and prevalent at an increasingly young age (Young Minds, 2011; National Society for the Prevention of Cruelty to Children [NSPCC], 2014; Burton, 2014; NSPCC, 2015). In a recent survey, involving 15 countries, England is ranked 14th for life satisfaction of its young people, aged between 8 and 12 (The Children's Society, 2015). 1 in 10 children in Wales and England require support or treatment for mental health problems (Welsh Assembly Government [WAG], 2012; Department of Health [DoH], 2014); the majority of whom will experience

stigma and discrimination as a result (Time to Change, 2015a). Girls and young women are particularly at risk of low well-being; with 83% of girls, aged 7 to 11, reported as feeling sad (Girl Guiding Organisation [GGO], 2015). However, claims that mental health issues among young people are rising is rarely challenged. Critics argue that the increase may be explained by increased public awareness of mental health, which has led to better recognition of symptoms and diagnosis (Burton, 2014) and initiatives that have encouraged people to 'come out' with their problems (Ecclestone, 2014). Furthermore, Ecclestone (2014) refers to the five-year review of the *Diagnostic Statistical Manual* for clinical psychologists which results in increasing rates of new behaviours, disorders and syndromes. It is possible that risk-taking behaviours and mood changes, traditionally considered to be normal adolescent development (Burton, 2014), may be labelled as new disorders in the quest to understand and support young people.

Risk factors in the development of poor mental health are wide ranging. Social changes within the 21st century, such as: income inequality, parental conflict and relationship breakdown, parental health, school expectations, cyber-bullying, pressures to have the latest fashion, the perfect body and own the latest technology, can all have a negative impact on young people's mental well-being (Bor et al., 2014; The Children's Society, 2014; Young Minds, 2014a). Studies report the rising numbers of need in relation to self-harm, anxiety, phobias, depression, substance misuse, post-traumatic stress syndrome and attachment, hyperkinetic, conduct, developmental and eating disorders (Wolke et al., 2013; Department for Education [DfE], 2014; Dickins, 2014; Sisak et al., 2014). Within the school environment, the increased testing of pupils is said to contribute to poor behaviour (Milkie & Warner, 2011), with children too often branded 'failures' (National Union of Teachers [NUT], 2014; BBC News, 2015b). Children with additional learning needs are at particular risk of developing mental health problems (Lindsay & Dockrell, 2012; Dickins, 2014). Children exposed to multiple risk factors have a significantly increased risk of developing poor mental well-being (Weare, 2010; DfE, 2014).

Mental health problems can lead to school absence, lower educational attainment and are associated with risky behaviours (DoH, 2014). Due to the links between mental health, academic success and life opportunities, schools are considered important settings for promoting mental well-being (Clausson & Berg, 2008; Cushman et al., 2011; Ekornes et al., 2012; WAG, 2012). Schools have an obligation to address aspects of mental health through the curriculum via Personal and Social Education (statutory in Wales) and Personal, Social and Health Education (non-statutory in England) and through engagement in the National Healthy Schools Scheme. Although involvement in the Scheme is not compulsory, schools must demonstrate through inspection regimes how they meet pupil well-being (Estyn, 2013; Ofsted, 2015). However, within the guidance documents for school inspections, no explicit reference is made to mental health. Instrumental in securing mental health into the school agenda is the consideration of mental well-being across a range of school policies (Hornby & Atkinson, 2003; Weare, 2010). Yet, whilst schools are required to have a statutory behaviour and discipline, special educational needs and curriculum policy, there is no specific requirement for schools to construct a mental health policy (Welsh Government [WG], 2013).

Fundamental to creating a system that supports the mental health of children and young people is a partnership approach to defining and meeting needs across universal, targeted and specialist services, through: promoting good mental well-being and resilience; preventing mental health problems from arising; early identification of need and intervention (WAG, 2012; DoH, 2014). Although schools are expected to take an active part, there is recognition that specialist agencies provide a level of care for young people whose needs cannot be met through school systems alone (Young Minds, 2014b; O'Hara, 2014). WAG (2012) acknowledge that the attitudes, values and skills of all front-line professionals with regard to

mental health issues require strengthening. Unfortunately, austerity cuts have resulted in reduced specialist services and a lack of funding to train school staff and to purchase appropriate resources, leaving schools struggling to meet the needs of pupils (Wales Audit Office and Healthcare Inspectorate Wales [WAO and HIE], 2009; O'Hara, 2014). Services shortages in Wales, has led to some schools calling for ambulances or the police where pupils' mental health needs are deemed to pose significant risk (BBC News, 2015a).

Contemporary health promotion within schools tends to draw upon the wellness model, which views all individuals as having mental health, positioning mental health as a positive concept (Weare & Markham, 2005; Weare, 2010). The holistic terms 'wellness' and 'well-being' acknowledge that different dimensions of health - physical, social, emotional and psychological - overlap and interrelate. However, Jorm (2000) warns of the risk of taking a global view of well-being without explicit reference being made to mental health due to the lack of communication about a child's *specific* difficulties and presenting behaviours. Davidson (2008) asserts there to be a lack of common terminology and understanding relating to mental health and well-being amongst professionals who work with children. This may lead to misunderstandings, resulting in inappropriate referrals and/or diagnoses, as well as leaving children's needs unaddressed or insufficiently met. McDougall (2011) examines misconceptions of mental health needs and mental problems being alike. A helpful concept is that of a continuum, with mental health at one end and severe mental illness at the other. As Prever (2006) advises, it is important that we help young people understand that we are all somewhere on that continuum and there will be times in our lives when we might require additional help. Tabloid coverage of mental health, however, frequently contributes to assumptions and stigma (Barber, 2012). This may explain the reluctance by some practitioners (Holmstrom, 2013) and parents (Time to Change, 2015b) to engage in related discussions; making it difficult for young people with mental health issues to talk about their situation. Stigma has a profound impact on the lives of children and young people; it affects friendships and school life, and it makes some want to give up on life (Time to Change, 2015a).

With regard to intervention strategies used to promote children's emotional well-being, some critics recommend that careful consideration be given. For example, Craig (2007), suggests how increased attention to developing self-esteem may lead to children becoming self-obsessed. Ecclestone (2014 and 2015) claims how such strategies can lead to the idea that all young people are psychologically and emotionally vulnerable. She warns that for some individuals this social construction may result in increased sensitivity to 'uncomfortable feelings' and 'stressful situations' regarding daily experiences, creating a self-fulfilling prophecy of need, as well as offering an opportunity to trivialise regular situations into anxiety-inducing, mental health issues, for their own advantage. Ecclestone (2014) calls for a philosophy which challenges the language of vulnerability and routine invitations to seek help for anxiety, by focusing more on building resilience and coping strategies among children and young people. There will, of course, be some school practitioners who believe such responsibility goes beyond their professional role and expertise (Ekornes et al., 2012).

Methods

This small scale exploratory study was conducted during the spring term of 2015. The focus was gaining insight into the experiences of school practitioners, on how children's mental health and well-being was understood, supported and promoted. 20 primary schools in North Wales were contacted during October, 2014 through to February, 2015. The aim was to get 40 questionnaires and 8-10 interviews completed. A letter outlining the purpose of the study, alongside a consent form, were distributed to head teachers. However, the results were disappointing; only 2 primary schools agreed to participate, despite follow-up phone calls.

A decision was made to contact secondary schools within the region to reflect the commitment made by the Welsh Government in supporting young people beyond primary school. However, the request was rejected by all 7 secondary schools contacted, including one which had been identified by the school counselling service. Explanations for the rejections to both primary and secondary schools related to time restrictions, although most commonly no reason was provided. The sensitive nature of the subject area, together with the stigma typically attached to mental health, may offer some explanation to the resistance. Consequently, this study focuses on 2 primary schools (School A and School B) and presents the views of 18 practitioners. According to Estyn (an independent body that inspects quality and standards in education and training in Wales), the schools, which cater for children aged 3-11 years, are considered to neither be advantaged or disadvantaged.

Participants were selected at the discretion of the head teachers; they consist of teachers, teaching assistants and additional learning needs co-ordinators. Before any research was undertaken, participants were informed of the research aims, how their responses would be used and made aware about their rights to withdraw from the study at any time. The self-completed questionnaire, which predominantly consisted of semi-structured questions, included: What words would you use to define the term mental health and well-being? What main factors influence children's mental health and well-being? What are the most common mental health issues experienced by children within your setting? What role should schools have in the promotion of children's mental health and well-being? What strategies do you use to promote children's mental well-being? Does anything prevent you from supporting children who are experiencing poor mental health? What training have you received in relation to children's mental health and well-being? In addition, 3 quantitative questions required participants to score their responses on a rating scale of 1 to 5; 5 being 'very confident/easy' and 1 'not at all confident/easy'. These questions were: How confident do you feel about detecting when children require additional support with their mental health? How confident do you feel about giving guidance and support for children experiencing mental health difficulties? How easy is it to access specialist support services for children facing mental ill health? The interviews which followed were based upon a similar set of questions to those contained within the questionnaire. This allowed further exploration of issues which had emerged and meant different versions of parallel phenomena could be related and analysed to more fully explain the complexities surrounding children's mental health and well-being. Interviews took place at the participants' workplace, they were manually recorded and lasted between 20 to 30 minutes.

The analytical approach drew on the concept of general inductive analysis (Thomas, 2006) where, through the coding of raw data which appeared to have implied meanings which related to the objectives of the study, led to categories. Comparisons were then made within and across categories to determine patterns, relationships and alternative perspectives, giving rise to emerging themes which were then compared to extant literature.

Results and discussion

This section of the paper presents the views of 18 practitioners: 9 teachers, 7 teaching assistants and 2 additional learning needs co-ordinators. 14 questionnaire responses are discussed, alongside data from 7 interviews. There is overlap as 3 participants engaged in both the questionnaire and interview process. Based on such a small sample, the results which follow do not claim to be characteristic of a larger sample. Rather, this exploratory study provides a rich, specific account of how children's mental health is understood, supported and promoted within 2 primary schools. It is hoped that this will encourage practitioners, functioning in comparable contexts, to reflect on their practice, leading to increased insight in this area.

Through critical analysis of data gathered, three central themes emerged: mental health discourse; mental health issues faced by children and; the role of the school practitioner. Issues within these themes will be considered in relation to core aims of contemporary mental health strategies: promoting resilience and well-being; preventing ill-health; early intervention (DoH, 2014) and; reducing stigma towards mental health conditions (Time for Change, 2015a).

Mental health discourse and the primary classroom

Most practitioners appeared to hold a social model of mental health with regards to the way they perceived the well-being of children to be the result of a complex interplay of forces linked to personal, social, economic and environmental factors. Practitioners offered a range of terms, associated with social, emotional, physical, intellectual and psychological dimensions, to describe mental health and well-being. Emotional aspects were most commonly referred to. Phrases used by practitioners included: being able to 'communicate feelings', 'cope with life challenges', being 'happy' and having 'positive self-esteem'. This corresponds to research undertaken by Ekornes et al., (2012) which also identified how school practitioners prefer to use terms such as 'emotional health' and 'well-being' because they are perceived to reduce the stigma associated with mental health. 'Social functioning' and being 'free from illness' were also used by practitioners to define characteristics of mental health. Throughout the interviews a medical concept of mental health was used regularly to describe children who were perceived to be emotionally needy and those who had additional learning needs. This highlights the tendency of school practitioners to revert to the deficit currency of 'difficulty, disaffection and dysfunctional' (Prever, 2006) to describe children who demonstrate more challenging needs and behaviours.

Practitioners were unanimous in the opinion that the term mental health was 'not suitable for use with children', although 3 respondents said the term was used in discussions held with colleagues and external professionals. Only 1 of the 14 participants who completed the questionnaire said she used the term mental health with children as this was terminology within the Healthy School Scheme. Reasons for non-usage centred on views that children would form negative interpretations, linked to illness or abnormality; that 'child friendly' language, which centred on emotions, was more appropriate and; how the stigma attached to mental health led to school practitioners using 'softer' terms associated with emotional well-being for children and parents. The fact that mental health was used to describe children with identified needs or when meeting with professionals suggests a medical discourse may still influence the perceptions of school practitioners, adding to the complexities that exist regarding the subject of mental health.

> The term mental health is not used in school. It is very much the 'elephant in the room'. Everyone is aware of it but we don't say anything. (School A, ALNCO)

> There is stigma attached to mental health. We don't use it with children. The term well-being is used as it's more accepting. (School A, TA 1)

> Parents take emotional health a lot easier. Mental health is only used when speaking with professionals. (School B, ALNCO)

> We don't use the term around children as they may interpret mental health as an illness. (School B, TA 1)

> Mental health is not an educational term. It is a medical diagnosis. (School B, T 1)

> Mental health suggests something is wrong with somebody, so I talk instead in terms of feelings and strategies. (School B, T 2)

Most significant is the comment '*It is very much the elephant in the room.*' This implies that although practitioners recognise mental health to be a pressing matter within classrooms, some feel children need to be sheltered from certain terms or issues. Perceptions that position mental health as 'abnormal' are not helpful. They risk perceiving children as having a problem that requires 'fixing', placing understanding of mental health within a negative paradigm rather than portraying mental health as a continuum, where most people during their life will require support with this aspect of well-being. Although research implies increased public awareness and open dialogue of mental health (Bor et al., 2014; Burton, 2014), this study as identified by Barber (2012), suggests that discussions are often avoided within the school context. In a report by the GGO (2015), 3 in 5 young women, aged 11 to 21, said that mental health is difficult to talk about; over half of the young women surveyed felt they did not know enough about mental health issues, that rarely was it considered as part of the school curriculum, and indicated that they would like to know more about where to get support.

Mental health issues experienced by children

8 out of the 14 practitioners completing the questionnaire identified anxiety as the main mental health issue faced by children. They believed anxiety among children was mainly due to one or more of the following factors: family breakdown; worries about being separated from parents; peer relations; transition to high school; and school work. Other mental health issues highlighted as being common among children included: depression; conduct disorders; phobias; autism; Attention Deficit Hyperactivity Disorder [ADHD] and low self-esteem. These conditions, which can cause distress and inhibit social and emotional development, offer parallels with other studies (Rothi et al., 2006; Halliwell et al., 2007; Dickins, 2014). Stability of home life and the role of parents were regular themes which emerged through the questionnaire (identified by 12 out of the 14 respondents) and interview discussions.

> Some children have very difficult behaviour, they cannot concentrate. Issues at home or worries about school work are possible influences. Some parents work long hours and don't spend much time with their children. Changes to family structures are particularly difficult for children. (School B, ALNCO)

Poverty (6); peer relationships (5); school ethos (4); low self-esteem (2); lack of outdoor stimulation (2); coping skills (2); additional learning needs (2); societal pressure to look or act in a particular way in order to fit in (1); lack of sleep and inability to concentrate due to increased exposure to technology (1); problems with school work (1); and bereavement (1) were also cited as issues that could have significant bearing on a child's mental health. There is nothing unusual about these findings, they are comparable to other studies which identify many of these factors as having significance on children's mental health (Lindsay & Dockrell 2012; Bor et al., 2014; Young Minds, 2014a). What was not directly identified by practitioners was the impact of bullying upon children's mental health despite this being a growing concern. More than a third of children, aged between 10 and 12, report being physically bullied in school and half excluded by their peers (The Children's Society, 2014). However, *relationships with peers*, cited by 5 practitioners, could have provided an indirect reference to this.

The role of the school practitioner

Although practitioners discussed the duty that schools have to play in promoting children's mental well-being, the only health-related frameworks they were able to identify were the Healthy Schools Scheme and the Student Assistance Programme [SAP]. Only 2 out of the 14 practitioners had knowledge of the Mental Health Strategy for Wales (WAG, 2012). One participant commented 'health and well-being strategies are often not fed into schools.' However, all participants believed, due to the knowledge school practitioners have of children's development and well-being that they are well placed to support children's mental well-being. 9 out of the 14 practitioners commented that the role of the school should be to provide a 'safe', 'caring' and 'supportive' environment.

> We provide children opportunities to build their self-esteem and share their feelings through circle time, PSE and specific programmes. (School A, T 2)

> Promoting mental health is part of our duty but only with the right support. Our role is to educate but we are doing a lot beyond education. Parents need to be empowered and supported more. (School A, ALNCO)

> Schools should provide a supportive environment where all children are valued and feel their worries will be listened to. (School B, TA 2)

> Schools can raise awareness of mental health issues so stigmas diminish for future generations. (School B, T 3)

> Schools play a crucial role in helping children to develop resilience and coping strategies. Early intervention can prevent mental health issues. (School B, TA 3)

> School can be a first port of call; a way of identifying need for intervention. We can bring in specialist agencies to address issues and involve parents. (School B, T 4)

Many practitioners referred to having a dual role with regard to children's well-being; to promote understanding of risk factors and to develop resilience among children, as well as working with parents and specialist agencies to provide early support and intervention for those with more complex needs. Although practitioners discussed the need to help children explore feelings and to develop resilience skills, less attention was placed on raising awareness of mental health issues. Again, this might indicate a reluctance to use medical terminology and explore mental health conditions in the fear of stigma but it could also signify a lack of practitioner understanding of more complex issues. DeBell et al. (2007) discuss how exploring sensitive health topics has been found to be overwhelming for practitioners due to some of the issues which may arise. Practitioners might be unwilling to engage in such discussions if they feel they have not been appropriately prepared and their understanding is inadequate (National Foundation for Educational Research [NFER], 2010; DOH, 2014). Alternatively, ALNCO (School A) illustrates how some practitioners may believe that there is only so much schools can do with regards to supporting children's mental health. Other studies highlight how some teachers consider the care role often goes beyond their capabilities as educationalists (Graham et al., 2010; Fulford, 2013). The challenge to drive-up educational standards has resulted in increased workloads; this risks conflicting against teachers' responsibility towards promoting pupil well-being (Rothwell et al., 2009).

Practitioners emphasised the need to work closely with parents and specialist agencies to ensure early intervention. Some practitioners discussed how they might be the first person to notice whether a child is experiencing mental health issues. Practitioners commented on

various strategies that were used to support pupil well-being. School B was in the process of employing a practitioner specifically for liaising with families about factors impacting upon children's health and well-being. One practitioner at School A said 'all schools should employ someone specifically trained to deal with children's mental health issues'. The School Counselling Strategy in Wales (DCELLS, 2008) has seen the employment of trained counsellors, predominantly within secondary schools. Whilst the benefits of this strategy are acknowledged (Rees, 2011), it is important that classroom practitioners do not lose sight of the role they can play, through daily interactions, of identifying difficulties children experience and knowing how to support them. This is would also be the case where family liaison or well-being officers are employed within primary schools. Some practitioners discussed the possibility of creating short courses for parents to raise awareness and empower them to meet the mental health needs of their children. As children's well-being and academic achievement can be significantly improved when parents and schools work together (Hornby & Witte, 2010; Milkie & Warner, 2011), it seems schools are more likely to promote mental health among their learners where there are policies in place which emphasise school and family partnerships.

Questionnaire respondents were asked whether *anything prevented them from supporting the mental health needs of pupils.* 11 out of the 14 practitioners answered 'no' to this question. Of the 3 practitioners who said 'yes' there were factors which prevented them from supporting pupils' needs, 1 cited this was due to a lack of personal knowledge of mental health, whilst 2 said it was because of limited resources within the local authority to provide specialist intervention. Practitioners highlighted how a lack of parental consent can also be a barrier, as some parents chose to exclude their children from well-being programmes such as SAP. The study illustrated how valued SAP was by practitioners for helping children to work through issues in their lives that could have bearing on their social, emotional and mental well-being. The SAP programme has been found to effective in helping children build self-esteem and resilience; competencies which enable young people to deal with conflict, solve problems, manage feelings and recover from setbacks (Carnwell & Baker, 2005; WAG, 2010). However, further understanding is required about the core character traits, attributes and behaviours that underpin resilience and emotional well-being throughout life (DoH, 2014).

Questionnaire respondents were also asked how confident they felt *in detecting when children require support with their mental health*. 8 out of the 14 practitioners felt 'confident' to 'moderately confident', 3 practitioners felt 'less confident' and 1 'not confident at all'. When asked how *confident they felt in giving advice and support to children experiencing mental health difficulties*, 10 practitioners felt 'confident' to 'moderately confident' and 4 practitioners felt 'not at all confident'. In the interviews some practitioners said they were not always sure of the best way to get support for children but they knew they could access colleagues, head teachers and educational psychologists for guidance. As the questions were related to mental health in general, it could be those practitioners who lacked confidence were concerned about supporting children with more severe needs. However, a study by Sisak *et al.* (2014) suggests that even when practitioners have a good level of knowledge of mental health, their confidence to provide practical guidance may present a barrier to meeting children's needs effectively.

Questionnaire respondents were invited to respond on *how easy they felt it was to access specialist services*. The majority of practitioners (10) found it 'easy' to 'moderately easy' to access services but 4 practitioners said it was 'not at all easy'. However, during the interviews many practitioners made frequent reference to the difficulty they had in accessing and securing early and appropriate professional support for children.

> There are long waiting lists and not enough resources. Support from CAMHS and other agencies is limited. (School A, T 3)

It's very difficult accessing services. They are over-stretched and lack funding. Only the really serious children get help. (School B, TA 3)

Therefore, although government policy calls for early intervention in addressing the mental well-being of children and young people, it seems that there are challenges in practice which are making this difficult. Financial cutbacks (Fulford, 2013; Young Minds, 2014c) and the volume of referrals to specialist services is delaying the support for some young people. Thus, it appears school practitioners are sometimes left coping with the complex mental health needs of pupils until appointments with specialist agencies become available. If children are concurrently exposed to multifaceted stressors, without obtaining appropriate and timely support, then their chances of developing poor mental health increases (Weare, 2010; DfE, 2014). This situation illustrates how vital it is that school practitioners have access to good quality mental health training if they are to effectively support the needs of their learners. However, the following comments show how some practitioners believed that a lack of training opportunities in mental health prevented the full execution of their role.

There is a total lack of training and understanding on my own part and other staff. I need more knowledge how to identify mental health issues, understanding of professional roles and how to promote mental well-being as a whole school policy. (School A, ALNCO)

I'd like training on how to identify and support children with specific mental health issues... (School A, T 5)

I've had no training in mental health, so I don't feel qualified to make a judgement about mental health or confident in supporting pupils. (School B, ALNCO)

9 out of the 14 questionnaire respondents had undertaken well-being training within the last four years. 5 participants said they had not received any training. Training courses attended by practitioners included: Student Assistance Programme [SAP] (4); child protection (3); autism awareness (3); behaviour management (4) and; Friends for Life (2). The duration of the courses varied from 3 days for SAP, to 2 hours for child protection and autism awareness. Although issues of child protection and behaviour management are valuable to the practitioner role, these courses are unlikely to address specific mental health issues. Considering the nature of some of the courses cited, it raises the question – 'to what extent have these practitioners been equipped to carry out their role in supporting children's mental well-being?' This may explain why 13 out of the 14 practitioners said they would welcome training that specifically related to mental health. Although SAP was commonly identified as a training opportunity that would be welcomed, practitioners said that SAP alone was not sufficient. Many practitioners wanted training that would help them to identify and support children with specific mental health issues such as: depression, low self-esteem and body image/eating disorders. Knowledge on the support services available, the role of specialist agencies and the skills needed to promote mental well-being as a whole school policy were also highlighted as areas for development. Unfortunately, the lack of training opportunities, due to austerity measures, together with geographical variations in the levels and types of training school practitioners receive related to mental health has been widely reported (National Advisory Council, 2011; Burton, 2014; O'Hara, 2014). It seems therefore that good intentions at policy level are at risk of failing to be delivered in practice, despite the school repeatedly being cited as a key place for promoting the health and well-being of children and young people.

Conclusion

Although this small-scale exploratory study makes no attempt to generalise, it has led to some thoughtful insight into school practitioners' perceptions and practices regarding supporting and promoting the mental well-being of pupils within the context of the primary classroom. Firstly, it appears that children may not be exposed to the term 'mental health' or introduced to 'specific mental health issues' despite this dimension of health being an element of the Healthy Schools Scheme. Practitioners offered broad interpretations to define mental health and identified topics they were addressing with children but these mainly related to emotional well-being. The comment '*It is very much the elephant in the room*' shows the reluctance of some practitioners to discuss mental health and mental illness with children. It is important that practitioners avoid seeing such discussions as awkward or taboo, or it may lead children into perceiving mental health issues as abnormal, something to fear and be kept hidden. Such reluctance may suggest gaps in practitioner knowledge and/or concern of creating negative conceptions among children. The findings of this study correlate with those of Barber's research (2012), to illustrate the powerful dominance of social stigma with regard to mental health, making any suggestions of a more open society towards this dimension of health questionable. Until school practitioners feel able to provide opportunities to openly discuss mental health terms and conditions with children, in a safe and respectful environment, societal stigma is likely to continue and the needs of young people risk remaining at best inappropriately supported or at worst unaddressed.

With regard to pupil well-being, practitioners identified anxiety as being the most common condition experienced by children, perhaps due to ever-increasing societal pressures. Many practitioners perceived issues with children's mental well-being to be due mainly to instability and inconsistencies within their home lives. Practitioners appeared attentive to the knowledge they felt they required in order to support children's mental health and the role they played in working with parents and external agencies. However, despite policy frameworks, such as the Mental Health Strategy for Wales, which seek to ensure school practitioners have sufficient knowledge and skills to support this aspect of a child's health, the participants within this study felt that training opportunities were lacking. Training relating to mental health for school staff has long been identified as a weakness (WAO & HIW, 2009; National Advisory Council, 2011; Burton, 2014; O'Hara, 2014). Many practitioners also referred to feeling frustrated about over-stretched specialist services, which left them addressing, often some very complex needs, as children waited to be referred. Children and young people should have the right to the support they need to promote good mental well-being at the earliest opportunity. In order for classroom practitioners to be able to play their part they require: the commitment of senior staff; effective school policies; access to appropriate training opportunities (courses which focus on the roots of difficult behaviour and signs of psychological/emotional distress); positive home school-relations; and 'readily available' specialist support. It is recommended that this support be in the form of a named pastoral worker, trained in mental health, who is based in the school, and whose responsibility involves leading whole school approaches, guiding teachers, assisting children and establishing a close working relationship between the school, parents and child counselling and mental health services.

In order to create a new era of openness and support, a change of philosophy is advised; one which makes mental health part of everyday conversation with children and young people; continues to understand the protective factors which make some children more able to cope with routine and significant life events; and improved teaching of mental health in schools. Schools most likely to be effective in achieving this are those that place mental health as a core aim; create a safe environment where pupils can build conducive relationships and form a positive view of themselves; provide opportunities to explore mental health, the impact of

stigma and develop resilience; intervene early to address underlying issues; and recognise when external support is necessary. However, whatever intervention strategies are implemented, there needs to be critical thought as to how an appropriate balance can be achieved between 'support and intervention' versus 'over-protection and the language of vulnerability' if we are to help equip children with the resilience and coping skills required to 'lead a world outside the self' (Ecclestone, 2014).

Words 6,061

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