School nurses' perspectives on managing mental health problems in children and young people.

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Aims and objectives. To explore the views of school nurses regarding mental health problems in young people and their potential for engaging in mental health work with this client group.
Background. Mental health problems in children and young people are an important public health issue. Universal children's services play a key role in identifying and managing these problems and, while school nurses have an important function in this work, little is known about their views on this aspect of their role.
Design. A qualitative research design employing focus group methodology.
Method. School nurses (n = 33) were purposively sampled from four school nursing teams in two English cities for a series of focus groups. The focus group data were audio-recorded, transcribed and subsequently analysed using 'framework'.
Results. Four principal themes emerged from the data. In these themes, school nurses were found to value their involvement with the mental health of young people, recognising this as an important area of practice. Several obstacles to their work in this area were identified: heavy workloads, professional rivalries, a lack of confidence and limited education and training opportunities. The importance of support from local specialist mental health teams was emphasised.
Conclusions. School nurses can be engaged in mental health work though, as public health specialists, their role should focus on health promotion, assessment, signposting and early intervention activities. To facilitate mental health work, school nurses are able to draw on established interpersonal skills and supportive networks; however, workload and a lack of confidence need to be managed and it is important that they are supported by constructive relationships with local specialist mental health teams.
Relevance to clinical practice. This study has implications for nurses and healthcare practitioners interested in enhancing the mental health of children and young people in school settings.

Key words: *children, education, focus groups, mental health, nursing, qualitative research, school nursing, schools, young people*

Introduction

Mental health problems in children and young people are a major public health issue. In the UK, as many as one in five children and young people will experience developmental, emotional or behavioural problems and approximately 10% will have a mental disorder that meets diagnostic criteria (Green et al. 2005). As mental health problems in the general population frequently commence in adolescence (Kessler et al. 2005), there is a strong case for embedding the skills of recognition and basic management into wider health and education services. Indeed, school-based services for early identification and intervention and for care coordination in primary care are advocated in the USA (Taras 2004) and in many other European countries (Braddick et al. 2009).

In the UK, child and adolescent mental health service provision ('CAMHS') exists under the auspices of a four-tier model that reflects increasing levels of specialisation and case complexity. Tier 1 encompasses anyone working in universal children's services (including teachers and school nurses); Tier 2 workers are the unidisciplinary specialists (such as psychologists) working in primary and community-oriented care; Tier 3 services are provided mainly by multidisciplinary teams working in outpatient (sometimes day care) services; Tier 4 provision – which equates largely with hospitalisation – is for the minority with the most complex needs (CAMHS Review, 2008). Primary-oriented care and community-oriented care are thus an inherent part of CAMHS, yet this provision is often overlooked. For many, CAMHS is synonymous with Tiers 3 and 4 or, at the very least, it begins at Tier 2. These higher tier services are often overstretched, with many having long waiting lists (Clarke et al. 2003, Etheridge 2004, CAMHS Review 2008). Moreover, in-patient (Tier 4) services are expensive, both for the service provider and for the families receiving the service (Jacobs et al. 2004).

There have been calls to enhance service provision at the lower tiers (NHS HAS 1995, Audit Commission 1999, CAMHS Review 2008). Schools often feature in these calls: they are, after all,

rooted in the community and are a normal part of childhood. Indeed, Appleton (2000) argues that schools are primary care CAMHS provision. However, while schools certainly have the potential to improve children's mental health, there is little clarity over who should take the lead. Those earmarked for the job have tended to be education rather than health professionals – teachers, school counsellors and educational psychologists, for example – and while few would question the need for interdisciplinary collaboration in children's services, it is odd not to see health professionals taking a lead on what is essentially a health issue.

Of the health professionals who could take the lead, school nurses are a natural choice. Unlike specialist CAMHS workers, they are part of the normal experience of growing up and are consequently more accessible and less stigmatising. They are a key aspect of universal health services, and surveys and consultations in the UK and elsewhere indicate that they have considerable involvement in identifying and addressing mental health issues (DeBell 2006, Haddad et al. 2010), an activity to which they would like to devote more time (Ball 2009).

Background

Reviews and guidelines from the UK (NICE 2005, 2008, 2009), other European nations (Stengard & Appelqvist-Schmidlechner 2010), Canada (Zuckerbrot et al. 2007) and the USA (Olin & Hoagwood 2002, AACAP, 2009) recommend developing the capacity and quality of school- and primary care-based support for common mental disorders, with school nurses being key to this activity. However, there is relatively little research concerning school nurses and mental health work. Although studies have been conducted in the UK's constituent countries and in Sweden and France, most work in this area has been undertaken in the USA. Puskar and Bernardo (2007), Bullock et al. (2002) and DeSocio et al. (2006), for example, provide evidence that school nurses can be successfully involved in mental health screening, promotion and early intervention activities.

In the UK, Leighton et al. (2003) undertook a small survey of school nurses together with a small-scale evaluation of a school nurse training programme in England, while Wilson et al. (2008) undertook a larger survey of health visitors and school nurses in Scotland. Both studies found a wide range of mental health concerns in school nurse caseloads including major mental health problems like psychosis, self-harm and eating disorders. Three studies examined regular contact with CAMHS professionals: Richardson and Partridge (2000) evaluated the provision of monthly consultations by CAMHS professionals to school nurse teams; Clarke et al. (2003) looked at the provision of psychologist-led monthly supervision and training sessions; and Chipman and Gooch (2003) examined a school-based, school nurse-led clinic for emotional and mental health issues that involved monthly supervision from CAMHS professionals. All three studies reported largely positive findings, as did Leighton et al.'s training programme. Moreover, in what is the closest to what might be called a patient outcome study, Stallard et al. (2007) explored the potential of using school nurses to facilitate a cognitive-behavioural programme designed to improve children's emotional health, finding statistically significant and sustained improvements in anxiety and self-esteem among the children who took part.

While school nurses are well placed for primary care level mental health work with young people and while the literature details some efforts to develop, quantify and evaluate this aspect of their role, there are also indications that there may be difficulties engaging school nurses in such work – not necessarily through a lack of willingness but through a lack of confidence or limited relevant training (Leighton et al. 2003, DeBell 2006, NISHYP 2006, Wilson et al. 2008). Pressures on time and the demands of other important public health issues like sexual health and healthy eating may also be obstacles (Ball 2009). The aim of this study was therefore to explore the views of school nurses regarding mental health problems in young people and their potential for engaging in mental health work with this client group.

Methods

Design

A qualitative focus group design was employed. Effective focus groups have 6–12 participants (Kitzinger 1995, Morgan 1996, Cŏté-Arsenault & Morrison-Beedy 1999), and key data can normally be elicited from three to four focus groups (Asbury 1995, Morgan 1996). The focus group topic guide was developed collaboratively by MH and SP following a review of the literature and consultation with school nurse experts.

Four school nursing teams were purposively sampled from two health districts in Greater London and two in Greater Manchester. Ethical approval was obtained from respective National Health Service (NHS) Research Ethics Committees in the two cities.

Data collection
In each of the four school nursing teams, a key contact known to the researchers invited school nurses to participate in a focus group specific to that team. Each focus group was scheduled for 6–12 participants, to last around an hour and to take place at a local team office. Most participants did not know the researchers prior to the study. The topic guide included questions and prompts about: knowledge and experiences of managing mental health problems in young people; ideas about support and treatment; views about the role of school nurses in relation to mental health problems; and obstacles to and ways of improving, how mental health problems might be managed in schools. The London focus groups were facilitated by TG and the Manchester groups by SP.

Analysis
Data analysis was guided by the five stages of 'framework' (Pope et al. 2000, Ritchie et al. 2003, Table 1). The focus group discussions were audio-recorded and transcribed verbatim. To enhance accuracy, the allotted researcher in each of the two sites listened to the recordings while concurrently reading each transcript. To begin with, initial themes and the corresponding content of each framework chart were coded independently by TG (London) and SP (Manchester), after which transcripts and initial charts were exchanged between the two sites. Group agreements and disagreements were used to explore relationships between and in themes. Coding differences were resolved through discussion. To add rigour, transcripts and charts were reviewed by an independent qualitative researcher in Manchester and by MH in London.

Results
Details of the participants are summarised in Table 2.
Following data analysis, four principle themes emerged from the data, each containing several subthemes (Table 3).

Theme 1: The mental health of children and young people
Subtheme 1.1: School nurses' knowledge of mental health

Participant awareness of mental health issues across all four groups was free of value judgements and empathic. Major areas of concern were self-harm, depression, substance misuse and eating disorders. Mental health was seen as a difficult concept to define, although many of the participants felt the stresses of school and home life and reactions to life events were implicated in the genesis of mental health problems. Interpersonal issues such as parental divorce, friendship problems and sexual identity were seen as sources of stress, exacerbated by the performance pressures on young people:

… these kids are under so much pressure... what do you need 13 GCSEs for? But that's what most kids are pressured to take... all these SATs [tests] that they do... no wonder kids are stressed. (MAN/FG2)

Table 1 Data analysis using the framework approach

Framework stage	Details
1. Data familiarisation	The audio recordings were listened to and the transcripts read several times
2. Identification of a thematic framework	The study's aims, topic guide and focus group data were used to draw out themes
3. Indexing	The thematic framework was further developed by assigning data to themes and subthemes
4. Charting	Microsoft Excel was used to chart the data with a single worksheet for each overarching theme. Subthemes were reflected in the worksheet columns, and worksheet rows reflected the individual focus groups
5. Mapping and interpretation	The charts from stage 4 were subsequently employed to map and interpret the data

Table 2 Details of the participants

	London groups	Manchester groups
Number of participants	20 (FG1 = 12; FG2 = 8)	13 (FG1 = 6; FG2 = 7)
Age ranges	31–60	23–60
Years experience in School Nursing	5–21 years	10 months–30 years
Range of NHS Pay Bands	5–7	5–7
Gender	100% females	100% females
Ethnicity	18 whites; 2 blacks	All whites

Adding to the difficulty in defining mental health, many participants mentioned that the distinction between behavioural problems and mental health problems was often blurred. Indeed, several participants in the London groups outlined how they often identified mental health problems through physical symptoms or behavioural signs such as aches and pains, fatigue and aggression.

Subtheme 1.2: School nurses' attitudes
Across all groups, attitudes towards children with mental health problems were unequivocally positive. Allied to this was a commitment to children's mental health, with most seeing mental health work as an inherent part of their work. Many felt particularly strongly about equity of opportunity and the necessity to encourage and raise expectations in young people. There was also a strong belief that young people should be listened to (see also **Subtheme 4.1**), taken seriously and be allowed a degree of control.

Attitudes towards parents, however, were somewhat resigned. While all of the participants understood the importance of involving parents, parents were sometimes seen as needy and often wanted instant changes in their child's behaviour. Across the two cities, participants reflected that when parents received appropriate advice, it was often not followed through, largely because they had difficulty seeing their part in the overall picture:

... they ask for help, you do the referral, it's accepted. They then get a questionnaire sent out to them... then when they read the questions it's too close to home for them, 'oh, you know, Johnny's OK, we won't bother'. (MAN/FG1)

... you can perhaps get them to the first appointment but then, once they get there and they realise that they're not going to just be focussing on the child; what really shakes a lot of parents is that 'they asked me about me'. (LON/FG1)

Subtheme 1.3: Stereotyping and stigma
Participants felt that the (negative) influence of stereotyping was evident on several different levels, from the stereotyping of those with mental health problems, to the stereotyping of nurses and what nurses do, to the stereotyping of children from particular groupings; for example, the Manchester participants felt that depression was often (erroneously) associated with the 'emo' youth subculture and, as drug problems were seen as almost routine in some schools or in certain subcultures, assumptions were also made about some young people in relation to drugs:

… I had a child once, found in a cemetery in the middle of the night.School were convinced, because she'd got black hair and black nails, she must have drug problems … But nobody had taken the time or the effort to ask her why she was there … She was there to speak to her brother who'd died 12 months earlier. Where would you go to speak to your brother? The cemetery! (MAN/FG1)

Most of the participants were aware of the stigma surrounding mental illness. Many felt that missed CAMHS appointments were often down to worries about the stigma of being labelled 'mad' or 'nuts', although the inconveniences involved in attending such specialist services (coming out of school and having to travel long distances, often on public transport) were also a factor.

Many thought that the title 'school nurse' was not helpful. In one of the London groups, the title was seen as a hindrance as it was associated with 'something being wrong'. Participants in one of the

Manchester groups preferred the title 'school health advisor' because it conveyed a more accurate representation of the role.

Table 3 The main themes and subthemes emerging from the data

Main theme	Subtheme
1. The mental health of children and young people	1.1. School nurses' knowledge of mental health 1.2. School nurses' attitudes 1.3. Stereotyping and stigma
2. Organisational issues	2.1. Relationships with CAMHS 2.2. Schools as places for mental health work
3. Barriers to doing mental health work	3.1. Lack of confidence 3.2. Education and training 3.3. Workload
4. Facilitators of doing mental health work	4.1. Good skills foundations 4.2. Supportive networks

CAMHS, child and adolescent mental health service provision.

Theme 2: Organisational issues

Subtheme 2.1: Relationships with CAMHS

The relationships participants had with CAMHS were mixed but generally, as might be expected, good relationships tended to be a facilitator of school nurses undertaking mental health work and poor relationships a barrier. Major irritants were referrals being rejected from CAMHS without explanation, long waiting times, scant feedback on the progress of children accepted by CAMHS and a lack of communication:

There is no actual relationship there between us which I think there needs to be because if the waiting list is 13 weeks that's quite some time and if they do go to CAMHS, we never hear what happens to them afterwards. There's no feedback. (LON/FG1)

In both cities, good relationships were reflected in CAMHS staff being available for advice and/or providing clinical supervision. Often good relationships boiled down to specific individuals and when those individuals left or there was a service reconfiguration, collaborative working tended to disintegrate. Most of the participants expected CAMHS staff to take a lead in offering mental health training, but often this did not happen (see **Subtheme 3.2**).

Subtheme 2.2: Schools as places for mental health work

Most of the participants in both cities agreed that schools were places where mental health work (especially mental health promotion) could take place, although the philosophy of the school, the attitudes of the school staff and individual relationships between school staff and school nurses could have a bearing on this. Professional tensions – especially with teachers – were evident in both cities though, as with the relationships with CAMHS, good relationships – which, again, often boiled down to specific individuals – were also evident:

It just depends on the teacher doesn't it? You know I have a very good relationship with the Year Nine Head... about the other years I have no idea... it depends on the particular member of staff. (LON/FG2)

The root of these tensions was often related to a communication problem or a lack of understanding of the school nurse role, and this could manifest in several ways. Participants complained about inappropriate facilities (e.g. rooms hidden away or unsuitable for seeing children in) of vague referrals from school staff that were more about the anxieties of the referrer (almost always a teacher) than the child and about issues over confidentiality and the sharing of information. One of the London groups, however, felt that school nurses had a responsibility to educate school staff about their roles and that, in doing so, professional tensions could be resolved.

In terms of the size, sex mix, educational philosophy and student profile of the schools serviced by the participants, there was a wide variability even in individual districts. In Manchester, some specific mental health problems (e.g. substance misuse and self-harm) were associated with particular

schools and one of the London groups referred to some schools as being 'needy'. Regardless of the type of school, there was a view that the general philosophy of the school and, particularly, the attitudes of staff could have an impact; for example, schools that prioritised league tables over student welfare were seen as poor when compared with those schools interested in emotional well-being or with good antibullying policies or good relationships with parents:

... a lot goes on league tables … one school in particular doesn't – wouldn't – admit they had a problem [with mental health issues] even if it were flagged up and they were standing on the roof shouting it to the hilltops, they would deny it. (MAN/FG2)

Theme 3: Barriers to doing mental health work
In addition to the barriers identified above (poor relationships with school staff and CAMHS), several additional barriers emerged from the data.

Subtheme 3.1: Lack of confidence
Lack of confidence was a common theme across all four groups, with many participants making explicit reference to it. The key issue seemed to be anxiety over 'doing it right' or 'saying the right things' rather than anxiety over the mental health work itself:

... well I said this but I'm not sure whether that was the right thing to say... it's just having that confidence that you are saying the right thing. (LON/FG1)

I don't think we're worried about doing it; I think we're worried about doing it wrong and we're worried about doing it badly; no qualms about doing it. (MAN/FG1)

Most participants were generally more confident with preventative work or the 'lesser' mental health problems – confidence was a particular issue with those problems (identified in **subtheme 1.1**) with a greater perceived degree of risk such as self-harm, substance misuse and eating disorders:

… [it's] the high end risk of mental health that I would feel most uncomfortable with, so the self harmers, the people who are depressed, the anxious children – they're where I'm totally out of my comfort zone. (MAN/FG2)

Subtheme 3.2: Education and training
Closely associated with the lack of confidence were issues relating to education and training. Lack of expertise, knowledge and training was cited as a barrier to doing mental health work in all of the groups. Most felt that training should be provided by CAMHS professionals and that it could be carried out in creative ways, such as allowing school nurses to 'shadow' CAMHS staff for a period of time (Manchester) or through using specific therapeutic models, such as cognitive-behavioural or solution-focussed therapy (London). Where specific training in mental health had been undertaken, it was largely seen as beneficial.

Subtheme 3.3: Workload
In both cities, workload was identified as one of the principal barriers to a greater involvement in mental health work:

... I think probably a lot of us would like to do this [mental health work] more but we are so busy that actually you just dip in and dip out really and don't ever do it justice. (LON/FG1)

Large caseloads were an issue for all groups. A wide variety of expectations and obligations were expected from school nurses including those relating to immunisations, sexual health, general health promotion and above all child protection. Because most school nurses are part-time and/or work only during term-time, this seemed to exacerbate workload pressures:

... we only usually have a five week block to work in and if you take two days out of that for [mandatory] training and you only work four days a week, you've lost quite a big chunk of your work time. (MAN/FG1)

Moreover, the term-time nature of their work also highlighted a problem in supporting children if school nurses and other agencies do not work collaboratively:

… coming up to summer time when you're working intensively with a young person that you see regularly... you've got six weeks then where they haven't got that support network or that contact … and I'm thinking what am I going to walk into when I walk back in in September? (MAN/FG2)

Theme 4: Facilitators of doing mental health work
Notwithstanding the barriers to school nurses' involvement in mental health work, several facilitators emerged from the data.

Subtheme 4.1: Good skills foundations
The participants had a repertoire of core skills, especially communication and interpersonal skills, and although they sometimes lacked confidence, these skills were fundamental to helping young people with mental health problems. Listening skills in particular were seen as vital:

[Responding to a prompt about the best way of supporting young people:] *Giving them the time; just listening.* (LON/FG1)

I've done quite a bit of that at my school, just listened to them. Sometimes that's all they want is someone to listen to. (MAN/FG1)

... what I always say is it's just to be there to listen, you know, they're on a one to one, they've got somebody's undivided attention. (MAN/FG2)

In addition, many participants felt that they were skilled at signposting young people to appropriate services (such as social services, CAMHS and sexual health services) but got frustrated when those referrals were rejected or when parental consent was deemed necessary.

Subtheme 4.2: Supportive networks
Existing supportive networks was an additional facilitator for some of the participants. While the support of CAMHS staff has already been considered (theme 2), clinical supervision and peer support were also singled out:

Because we're all based in one place we're very lucky... whenever you come back to the office they'll be somebody there you know and if you've had a particularly difficult chat with a young person there's usually somebody there that you can go back to and offload. (LON/ FG1)

Support models varied across the four groups. In some places, it was formal (clinical supervision); in others, informal (peer support). In some places, it was provided in-house (by a team leader with CAMHS expertise in one of the Manchester groups); in others, it was provided independently. However, in most places where supervision existed formally, CAMHS staff were involved and where it did not exist, participants generally thought that CAMHS staff should be involved.

Discussion
Study limitations
As a qualitative study involved a limited number of participants, it is difficult to generalise the findings outside of local contexts; though, similarities between the London and Manchester groups and to the existing literature suggest that the findings have, across England at least, a degree of 'transferability' (Lincoln & Guba 1985). The self-selecting nature of the participants could mean that only those with an interest in CAMHS attended the focus groups; consequently, the views of school nurses with little or no interest in CAMHS are unrepresented.

There was some inconsistency in the manner the focus groups were conducted in London and Manchester, notably that groups in the two cities were facilitated by different researchers. That the analysis was conducted jointly and reviewed independently by other researcher colleagues does, however, add rigour to the study. While some qualitative researchers argue that transcripts and emerging themes should be returned to participants for 'member checking' (Lincoln & Guba 1985), member checking was not carried out because it would have placed undue demands on the participants' already busy schedules (Barbour 2000).

The right skills foundations in the right environment
The key facilitators of school nurses engaging in mental health work are the good skills foundations school nurses have and the finding that schools are appropriate places to undertake mental health work. While most of the participants had only limited knowledge of mental health, they demonstrated a view of mental health that was largely positive and they clearly saw mental health work – mental health promotion, in particular – to be within their remit. Moreover, participants acknowledged the potential for stigma in mental health and were careful to avoid stigmatising the young people they worked with.

Confidentiality, understanding and trust are key factors underpinning the therapeutic relationship in CAMHS (Clarke et al. 2003, Freake et al. 2007, CAMHS Review 2008), and young people generally want non-patronising and non-judgemental advice (Gordon & Grant 1997). Positive attitudes are crucial in providing therapeutic relationships that are sensitive, confidential and trusting and on this factor alone school nurses score well. Children and young people also want to be listened to and given individual attention (Freake et al. 2007, CAMHS Review 2008) and the fact that school nurses see listening as a key attribute in the work they do bodes well for any future involvement in mental health work.

The World Health Organisation (WHO/HBSCF 2008) argues that because school is a universal experience, schools should play a significant part in influencing the mental health and well-being of young people. In the UK, young people want schools and colleges – much less stigmatising places than clinics and hospitals – to show more awareness of mental health issues and clearly see schools as convenient places to receive support, especially before the issue becomes a crisis (CAMHS Review 2008). The CAMHS Review notes, however, that some schools see their role in mental health in narrow terms perhaps because, as Adelman and Taylor (1999) comment, they see only those problems that are direct barriers to learning as within their remit. This view reflects some of the tensions between education and health services over the purpose of schools. Schools may be principally educational establishments, but as the CAMHS Review notes, there is a relationship between educational achievement and the mental health and psychological well-being of young people.

The participants' views generally concur with the sentiment that schools are places for mental health work, although it is clear that not all mental health work can or, indeed, should take place in schools. Indeed, the 'Healthy Schools' policy (DH/DCSF 2007) implies that the principal focus should be on mental health promotion and early intervention and preventative work.

Overcoming the barriers
On their own, the facilitators listed earlier are insufficient to engage school nurses in mental health work. They do, nevertheless, provide a solid foundation for involving school nurses in such work. To further the chances of engaging school nurses, the barriers – lack of confidence, unmet training needs and workload – need to be overcome.

The CAMHS Review (2008) acknowledges that confidence can be an issue for school nurses, and education and training is an issue that has been previously picked up in the literature, although often with regard to childcare professionals in general (NHS HAS 1995, Leighton et al. 2003, Etheridge 2004, Gowers et al. 2004, CAMHS Review 2008, WHO/HBSCF 2008, Wilson et al. 2008). Confidence and education are closely related, and it is likely that opportunities for formal education and training will also lead to enhanced confidence. How such education and training might be shaped can be determined from what the literature and the participants in this study have to say. First, as Clarke et al. (2003) and Chipman and Gooch (2003) note, CAMHS experts need to take the lead. Second, there needs to be clear and practical information about the specific mental health topics (such as eating disorders and self-harm) that concern school nurses (Leighton et al. 2003, NISHYP 2006, Wilson et al. 2008). Third, CAMHS experts need to support school nurses on a regular basis, preferably through a structured supervision system (Richardson & Partridge 2000, Chipman & Gooch 2003, Clarke et al. 2003, Leighton et al. 2003).

Professional rivalries, common among healthcare professions, can detract from effective healthcare delivery. These rivalries are usually related to a lack of understanding of the roles of others (Mandy et al. 2004). This could explain why the participants were occasionally dismissive of the attitudes and

performance of teachers and other school staff and why Etheridge (2004) found that school staff were often uncertain of what school nurses did or should do. It could also explain why some participants felt it was their responsibility – as school nurses – to educate schools about their roles. Furthermore, that teachers seem to experience similar anxieties to school nurses regarding children's mental health – anxieties over confidence, training, poor communication and the referral process (Etheridge 2004, Gowers et al. 2004) – merely reinforces the case for shared understanding.

As school staff are – as Tier 1 staff – notionally part of CAMHS, the relationship between CAMHS and those who work in schools needs to be particularly strong. The key to building this relationship seems to be joint working. Pettitt (2003), in a major report on joint working between schools and CAMHS, identifies several ways where joint working can be facilitated. Recommendations included opportunities for secondments between organisations, CAMHS staff spending time in schools (cf. a participant's suggestion that school nurses shadow CAMHS staff) and informal meetings, networking and team building. By establishing joint training initiatives, the building of good relationships could easily be coupled with the earlier call to improve education and training. Pettitt (2003) notes that joint training involving CAMHS and school staff works especially well in relation to health promotion and early intervention. Moreover, to alleviate interprofessional mistrust, joint training can also focus on systemic issues such as the differing roles and expertise of staff members, lines of communication, the referral process, confidentiality and consent.

While workload is an issue for school nurses, it is an issue that needs to be addressed more widely – by managers locally, by appropriate policy directives centrally and by professional nursing organisations. However, those planning developmental work or research with school nurses in the field of mental health need to be cognisant of the heavy workloads school nurses face and take care not to impose additional burdens on them merely because mental health work appears to be part of their remit. Additionally, as participants in this study and respondents to a recent survey of school nurses (Ball 2009) have pointed out, heavy workloads also preclude access to training opportunities.

Conclusion

School nurses can be engaged in mental health work with children and young people though, as public health specialists, their role should focus on health promotion, assessment, signposting and early intervention activities, and it should be supported by a constructive relationship with CAMHS. However, engagement is likely to be thwarted if there are insufficient education and training opportunities, professional rivalries and misunderstandings remain unresolved and if those wanting to engage school nurses fail to recognise the workload demands they are exposed to.

Moreover, while it seems that school nurses can make a (significant) contribution to young people's mental health, there is little empirical evidence regarding the level and type of mental health work they should or could be involved in. There are therefore ample opportunities for future research in this area.

Relevance to clinical practice

As this study has identified the facilitators of and potential barriers to, school nurses being involved in mental health work (along with potential solutions to the barriers), it has implications for nurses and healthcare practitioners interested in enhancing the mental health of children and young people in primary care and school settings.

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Contributions

Study design: SP, MH, AT; data collection and analysis: SP, TG, MH and manuscript preparation: SP, TG, MH, AT.

Conflict of interest

None.

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