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Supporting Young People's Mental Health: Reconceptualizing the Role of Schools or a Step Too far?

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This article provides an overview of the United Kingdom government's strategy for children's mental health in schools. Critique of the mental health policy document demonstrates that the government has adopted a clinical approach to resolving the mental health "crisis" among children and young people. We argue that a clinical solution, implemented in schools, is not based on robust evidence and that the policy reflects a medical model which positions children and young people with mental ill health through a deficit lens. We argue that the government should, instead, adopt a systemic response which directly addresses the underlying factors which cause mental ill health rather than implementing a clinical approach in schools. We argue that a clinical response at the level of the individual is not appropriate for most children and young people with mental ill health and that there needs to be an urgent review of policy.

Keywords: mental health, wellbeing, schools, education, special needs

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INTRODUCTION

This article provides an overview of the policy context in England in relation to the role of schools in supporting children and young people's mental health. In this article, we adopt the World Health Organisation (WHO), (2014) definition of mental health which focuses on mental health rather than mental illness: [. . .] a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Throughout this article we adopt the term "mental ill health" rather than "mental health problems" because we do not believe that mental health should be conceptualized as a problem. It is our belief that describing mental health as a problem perpetuates stigma in relation to mental health and we hold the view that mental health should not be stigmatized.

We conceptualize mental health as existing in a state of flux along a continuum which ranges from being mentally healthy to being mentally ill. Mental ill health is situated at the opposite end of the spectrum from being mentally healthy and individuals can move in both directions between both ends of the spectrum. Based on the WHO definition, individuals who experience mental ill health or mental illness are not able to cope with the usual stresses of life and are not able to be productive and make a contribution. However, this can be a temporary rather than a permanent state.

After outlining the mental health context in England, this article outlines the key strategies that the United Kingdom government has introduced to reduce the prevalence of mental ill health in England. The article then develops a critique of the policy, drawing on the biopsychosocial model of health and the literature on causation. Finally, we suggest some solutions to the mental health "crisis" which are underpinned by the theory and literature.

THE MENTAL HEALTH CONTEXT IN ENGLAND

Statistics suggest that approximately 850,000 children and young people have a clinically diagnosable mental health need (DfE/DoH, 2017) in the United Kingdom (United Kingdom). A clinically diagnosable mental health need is one which has been diagnosed by a health professional using agreed criteria. This equates to approximately one in ten. The prevalence of mental ill health increases as children move into adolescence and the types of mental ill health experienced can vary according to gender (DfE/DoH, 2017). For example, girls are more likely to experience anxiety and depression than boys and boys are more likely to demonstrate conduct disorders (DfE/DoH, 2017). Evidence suggests that young people who are living in care, those who are not engaged in education, employment or training and those who are lesbian, gay, bisexual and trans are at increased risk of developing mental ill health (DfE/DoH, 2017).

The prevalence of mental health is not specific to the United Kingdom. It is a global concern. However, in the United Kingdom and elsewhere, the destigmatization of mental health in recent years, along with increased awareness and understanding of mental health, may account for the increases in diagnoses, resulting in a crisis discourse. Regardless of statistics, attempts by governments to eradicate the stigma can be viewed positively because it has resulted in better identification and a willingness from individuals to reach out for support.

The causes of mental ill health in children, young people and adults are multifaceted. The biopsychosocial model of health (Engel, 1980) (see **Supplementary Figure S1**) demonstrates the contribution of biological, social and psychological factors which influence a person's health. Mental health is a component of overall health but overlaps between these factors can result in mental ill health. Individuals with disabilities are more likely to experience mental ill health (DfE/DoH, 2017). Risk factors are also present in schools, homes and communities (Glazzard, 2019). Children and young people who reside in areas of social deprivation experience greater likelihood of developing mental ill health (Mental Health Foundation, 2016). Those who experience parental conflict and abuse are also at greater risk (House of Commons, 2018) and attachment theory (Bowlby, 1958) is a seminal theory which has also contributed to our understanding of the relationship between insecure or non-existent attachments between a child and their primary carer and their mental health (Bowlby, 1958). School-related factors also play a role. There is a link between examination-related stress and specific mental health needs, including anxiety and depression (House of Commons, 2018). Additionally, the narrowing of the curriculum in secondary schools in recent years because of narrow measures of school effectiveness is also a contributory factor (House of Commons, 2018). Finally, bullying in schools is associated with poor mental health (Bradlow et al., 2017), with some young people being more at risk than others (Glazzard, 2019), particularly those who represent marginalized groups who experience often experience prejudice and discrimination as part of their daily lives (Meyer, 2003). These include young people with disabilities, those who are lesbian, gay, bisexual or trans and those with minority racial or ethnic identities.

Given the prevalence of research which has led to a better understanding of the causes of mental ill health, it is surprising that the United Kingdom government's mental health strategy does not appear to take causal factors into account. The problem of mental ill health can only be addressed if there is an understanding of causation. This point will be addressed later in this paper but suffice to say at this point that addressing the symptoms rather than the causes is a short-sighted policy. The government's Green Paper (DfE/DoH, 2017) emphasizes a range of within-child interventions rather than outlining the government's strategy for addressing the social factors which can cause mental ill health, including social deprivation and other adverse childhood experiences.

It is also important to emphasize that there is no magic bullet which will solve the mental health "crisis." The multiplicity of factors which cause mental ill health mean that a variety of solutions will be required which target the biological, social and psychological factors which result in mental ill health. In addition, given that the factors which cause mental ill health span various disciplines (for example, education, psychology, sociology and biology), it is likely that the solutions to mental ill health will not be found in a single discipline and therefore a single sector of the workforce. Instead, the solutions to mental ill health require a multidisciplinary approach which addresses the underlying factors which cause it in the first place.

MENTAL HEALTH POLICY IN ENGLAND

Back in 2017, the United Kingdom government released its five-year strategy for mental health, through the publication of its Green Paper, *Transforming Children and Young People's Mental Health Provision* (DfE/DoH, 2017). This was an exciting publication because it marked the government's commitment to addressing the mental health "crisis" in children and young people. The Prime Minister at the time, Theresa May, had referred to the problem of children's mental health as "one of the burning injustices of our time" (DfE/DoH, 2017, p.3), and the Green Paper was an attempt to correct this.

The Green Paper outlined a three-pillared approach to addressing children and young people's mental health. Firstly, the introduction of the role of designated senior leads for mental health in all schools marked the government's determination to ensure that mental health provision in schools was appropriately led and managed. Secondly, the government planned to introduce mental health support teams which would work directly in schools. This new group of health professionals would work alongside teachers by providing children with low-level clinical interventions, such as counseling and cognitive behavior therapy (CBT) within schools. The aim of this strategy was to ensure that young people receive swift clinical intervention within a non-clinical setting, thus ensuring that they gain access to rapid support and also helping to reduce already lengthy waiting lists to access National Health Service (NHS) clinical interventions. This strategy is currently being operationalized through the

introduction of professional training courses for "Education and Mental Health Practitioners." These were the mental health support teams that were outlined in the government's mental health strategy. However, this strategy is effectively a clinical model with focuses on interventions at the level of the individual child or young person. The strategy addresses the symptoms of mental ill health rather than the causes of it and perpetuates the view that there is a deficit within the child which needs to be addressed. Teachers are not trained to implement clinical interventions, so this approach provides children and young people with access to professionals who are trained to implement a range of low-level clinical interventions in school settings. However, this approach is potentially damaging because it is reflective of the medical model which locates the "deficit" or "problem" within the individual rather than locating the issues within broader social, cultural and political contexts. The argument in support of the model is that by reducing the pressure on already over-stretched mental health services, children and young people can gain access to support more rapidly within the context of their educational setting. Thirdly, the final pillar was to pilot reduced waiting times for specialist NHS services for children and young people with persistent and severe mental health needs.

The policy was a bold step in the right direction. It underlined the government's commitment to mental health, and it acknowledged the role that schools and colleges already played in supporting young people's mental health. However, there was a clear expectation that schools and colleges could take an even greater role:

Informed by widespread existing practice in the education sector and by a systematic review of existing evidence on the best ways to promote positive mental health for children and young people, we want to put schools and colleges at the heart of our efforts to intervene early and prevent problems escalating (DfE/DoH, 2017, p. 3, p. 3).

It is debatable whether schools should be required to plug the gaps in NHS services by extending their remit from education to health. Schools in the United Kingdom have, in recent years, broadened their remit from providing solely an education service, to focusing also on matters related to social care. Discourses in relation to safeguarding have reconceptualized the role of schools from merely providing children with a curriculum and supporting them through examinations, to institutions which serve to protect young people from societal risk. In addition, schools have also demonstrated a broader remit through developing initiatives which support parental literacy and numeracy and through developing community-related projects. At the same time, schools have also operated within a strict regime of accountability (Glazzard, 2019) through which measures of school effectiveness have been reduced to narrow performance indicators such as examination results (Glazzard, 2013). Schools and teachers are required not only to raise academic standards, but also to protect young people from harm and reduce the prevalence of mental ill health. This reconceptualization of the role of the teacher and the role of the school is necessary because Maslow's seminal work has highlighted how children and young people cannot learn effectively if their holistic needs are not met (Maslow, 1943) and more recent research has highlighted how children cannot thrive academically if they have mental ill health (Kieling et al., 2011). Addressing mental ill health in schools through clinical interventions will not necessarily guarantee that children and young people will not experience mental ill health given that they spend a greater proportion of their time in homes and communities which may be the sources of their mental ill health. In addition, it is important to remember that the primary role of schools is to educate the next generation. It seems ironic that, at the same time as supporting children's wellbeing, schools are being required to deliver a narrow curriculum (House of Commons, 2018) which privileges academic forms of knowledge, and subject children to high-stakes examinations, even though these can have a detrimental impact on young people's mental health.

Schools are therefore placed in a paradoxical situation. They are required to support children's mental health at the same time as subjecting young people to pedagogical approaches which can have an adverse effect on it. At the same time, the increased marketization of education through inspections, league tables, the public shaming of schools within a discourse of performativity (Ball, 2003) and a heavy emphasis on behaviourist approaches to regulate children's behavior (Glazzard, 2019), has not created an environment which supports positive mental health. Those most at risk within this neoliberal marketized system of education are, of course, those representing minority groups (Glazzard, 2019) and those from areas of social deprivation. Too often, these children become excluded from a mainstream system of education with does not meet their needs. Exclusion from mainstream environments can have a long-lasting adverse effect on young people's mental health (IPPR, 2017). It is therefore ironic that the United Kingdom government view schools as the solution to mental ill health, when in reality, at least for some children, their mental health needs arise because of their participation in education. The effectiveness of clinical models of mental health intervention which are outlined in the Green Paper may be reduced if children and young people are exposed to a narrow curriculum and an assessment system which labels too many as educational failures. In addition to models of clinical intervention, a systemic response is also required. This must include a broadening of the curriculum in all schools and a more inclusive assessment model which enables all young people to experience success. In addition, schools should prioritize developing positive school cultures which engender a sense of belonging and which positively affirm difference. In the absence of a systemic response, schools will continue to produce rather than solve mental ill health.

To survive within the marketized education system, teachers must focus on their core responsibilities, which include teaching the curriculum and assessing learning. It could be argued that policy initiatives which re-position teachers as mental health experts is just one step too far, on top of the educational responsibilities that a teacher must bear. Teachers are not health professionals. They are educators, first and foremost. Providing teachers and school leaders with training to support them to more effectively identify children and young people with mental health needs could be irresponsible and potentially dangerous. Teachers are not qualified to make a diagnosis of

mental ill health, but by identifying it, they are placing the child on the first step to diagnosis. Labels can have a detrimental effect on young people's sense of self and the adverse effects of negative labels can last a lifetime. In addition, labeling children as having "social, emotional and mental health needs" can adversely influence the way others view the child because labels can be stigmatizing even if they are accurately assigned. This is particularly significant during transitions when children move to new teachers or new schools. Viewing children through the lens of a label can be particularly damaging and placing children on clinical intervention programmes to support mental health can also be risky.

The Education Inspection Framework (Ofsted, 2019) also influences policy in schools. The latest version of the framework emphasizes the importance of schools providing children and young people with a mental health curriculum which supports them to be mentally healthy. This appears to be a wise decision, but guidance is currently lacking from central government in relation to what this curriculum might look like, who might be best to deliver it and when it should be introduced. It is our view that this curriculum is best delivered within the context of a whole-school approach to mental health which addresses aspects such as the role of a positive school culture and both for young people and for staff.

CRITICAL ANALYSIS OF THE POLICY

It is disappointing that the Green Paper (DfE/DoH, 2017) does not offer a definition of mental health. We conceptualize mental health as a dynamic attribute which falls along a continuum which ranges from being mentally healthy to mentally ill. There are numerous references throughout the document which conceptualize mental health as a "problem." However, framing mental health as a problem rather than acknowledging that mental health exists along a spectrum perpetuates, rather than eradicates, the stigma that is associated with mental health. The approach adopted by the government reflects a medical model of health. Within the Green Paper there are 26 references to the word "treatment" and 75 references referring to mental health as a "disorder." The government's positioning of mental health at the level of the individual is deeply problematic because this shifts the focus onto individual deficits and detracts attention away from the broader systemic factors which cause individuals to experience mental ill health. It also demonstrates a lack of understanding of the interaction between biological, social and psychological factors (the biopsychosocial model of health) which results in mental ill health. By situating mental health at the level of the individual, the government is effectively absolving its responsibility for addressing the social and environmental factors which result in children and young people experiencing mental ill health.

There are contradictions within the policy document. For example, the commitment to equality which is affirmed through the first statement below is effectively canceled out by the second statement which indicates that intervention and support will not be universal:

> *All young people* deserve the best start in life. But too often, young people with a mental health problem are not able to fulfill their potential (p. 2).
>
> We will roll out our new approach . . . to at least *a fifth to a quarter* of the country by the end of 2022/23 (p. 4).

We have used italics to add emphasis to the policy contradictions. It might be argued that the government's goal is less than ambitious although it could also be argued that this tentative approach reflects the need to roll out additional training to all teachers, which might not be realistic by 2022-23.

The emphasis on clinical interventions or treatments throughout the document is clear. However, clinical intervention at the level of the individual is not necessarily an appropriate form of intervention within educational settings. Most young people will benefit from a psychosocial approach which recognizes the important role that social connections and positive school environments can make to mental health. Children and young people thrive when they experience a sense of belonging and when they can learn in safe environments which are free of bullying, harassment and other forms of discrimination. Clinical interventions can result in deficit thinking and may cause individuals to believe that the problem resides in them rather than in the structures to which they are exposed. Removing young people from lessons to receive clinical interventions can also result in internal exclusion, negative associations and stigma.

Rather than focusing on treatment at the level of the individual, the government should urgently address the social and environmental factors which result in children and young people experiencing mental ill health. This includes taking urgent action to address poverty, child abuse and negative parent-child interactions. In addition, the government should, as a matter of urgency, review the curriculum offer in schools so that young people have an opportunity to access a broad, balanced and rich curriculum. Given the link between physical activity and mental health, school leaders should ensure that all young people have access to inclusive physical education and a mental health curriculum which helps them to develop their mental health literacy. Finally, the government should take urgent action to address the effects of examination stress by developing an approach to assessment which provides young people with a variety of modes of assessment and recognizes a broader range of achievements. Children in primary schools, whose strengths and talents lie outside academic disciplines, must have opportunities to demonstrate their achievements in a broader range of subjects so that they do not start their secondary education with low self-esteem and diminished confidence. A clinical model of intervention which operates at the level of the individual is likely to be ineffective if these broader systemic factors which cause poor mental health are not addressed.

CONCLUSION

In this paper we have argued that the United Kingdom government policy in relation to the role of schools in

supporting children's mental health reflects a clinical approach. We have argued that a clinical approach, which operates at the level of the individual, is not appropriate for most children with mental health needs. We have argued that the government should, instead, adopt a systemic response which directly addresses the underlying factors which cause mental ill health. Given that mental ill health is largely rooted in social circumstances, we have argued that the United Kingdom government should urgently address childhood poverty and other adverse childhood experiences which are linked with mental ill health. In the absence of a systemic response which addresses these social factors, schools can only hope to achieve limited progress in relation to mental health because children will continue to be influenced by factors in their homes and communities which are responsible for adversely affecting their mental health.

It is important to emphasize that we do not uniformly reject the tenets of the Green Paper. We have argued in this paper that the causes of mental ill health is rooted in individual/biological, social and psychological factors. We have argued that when these factors interact this can result in mental ill health. On the basis of this, it would seem reasonable to argue that different government agencies need to work together to address some of the serious, systemic problems in society which can result in mental ill health. Greater collaboration between education, health and social care departments at the level of policy and strategy would seem to be a logical recommendation, given the complex range of factors which are responsible for causation.

AUTHOR CONTRIBUTION

JG introduced the policy context and reviewed existing policy in England. SS and JG critiqued this policy in order to identify implications and offer discussion.

SUPPLEMENTARY MATERIAL

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/feduc.2020.607939/full#supplementary-material.

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