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Conditions for mental health in education: Towards *relational* practice

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Abstract

There are concerns globally about the emotional wellbeing and mental health of young people and in this paper a critical orientation comprises both theoretical and empirical data sources. The case is made that 1) the medical model of mental health - that of problem identification, diagnosis and medical treatment at the level of the individual - is not appropriate for the vast majority of children and young people in schools and 2) *relational* approaches would be more sensitive in responding to the complexity of the 'conditions' in the schools, homes and communities in which young people live. Articulations of these conditions are explored from the literature while we also draw on empirical data from part of an Evaluation of a school-based teacher-training programme in which interviewees and respondents too mapped out their own conditions for emotional wellbeing and mental health. We conclude with proposals for *relational* approaches which 1) acknowledge the links between affect, cognition and school climate and culture; 2) foreground mental health and poverty as impacting on young people's emotional wellbeing in their communities, families and schools; 3) attend to voice – provide spaces in which young people can develop their own 'preferred narratives' concerning emotional wellbeing and mental health.

Key words: education; mental health; relational networks; young people.

COVID – Not the only global pandemic?

Well before COVID-19, concerns had been growing globally in respect of mental health (Patel *et al*., 2007; WHO; 2015; OECD, 2017; Unicef, 2017; Siddique, 2018). In recent years, these concerns have been directed increasingly towards the mental health of children and young people, manifest in a raft of publications from governments and institutions, for example, the World Health Organization (WHO, 2010), the Australian Government (2019), the Department of Health and National Health Service England (DoH and NHS, 2015), the National Institute for Mental Health, USA (NIMH, 2018) and in New Zealand the Youth Parliament (2016). Research into the emotional wellbeing and mental health of children and young people is being conducted across many different cultural and national contexts, for example, China (Zhang and Du, 2018), India (Lai *et al.*, 2016), Iran (Salimi, Jafarkhani and Jamebozorg, 2017), Japan (Sekizaki *et al.,* 2017), Mexico (Bravo-Sanzana *et al.*, 2015) and South Africa (Mfidi, 2017).

Whilst there is debate around the intensity and demographic reach of mental ill health amongst young people, policy and research point to a sustained increase in the prevalence of mental ill health amongst young people, suggesting a wider, and growing, public health issue (Patalay and Gage, 2019; Deighton, Lereya, Casey, Patalay, Humphrey and Wolpert, 2019; NHS Digital, 2020). This view is reinforced by a worldwide growth in specific diagnoses such as attention deficit hyperactivity disorder (ADHD), attachment disorder, autism spectrum condition (ASC), depression, eating disorders as well as early-onset dementia and psychosis (WHO, 2010, 2019). Young people, of course, are victim to forms of harm and abuse which are themselves associated with mental health problems (Kisely *et al.*, 2018), for example, bullying (Currie *et. al.*, 2012; Mehta *et al.*, 2013), domestic violence (Holt, Buckley and Whelan, 2008), exposure to war and civil conflict (Pritchard and Choonara, 2017; Dimitry, 2012) and drug and gang culture (Gulliver, Griffiths and Christensen, 2010). There is evidence to suggest that more young people are experiencing anxiety, trauma and attempting suicide (APA, 2008; O'Connor *et al*., 2018) while in the UK the rise in the rate of young women reporting self-harm, for example, is a matter for public concern (Morgan *et al*., 2017). Outcomes can be serious for the young people affected, in some instances tragic, and each individual sufferer warrants clinical or service responses.

There is some research, however, which questions that acceptance of a massive pre-COVID rise in young people's mental health problems (Pitchforth *et al.*, 2018) while there is also research which challenges the blurring of the boundaries between a holistic approach to human wellbeing and a more sharply delineated medical / psychiatric arena of mental illness (Antaramian, Huebner, Hills and Valois, 2010, Patalay and Fitzsimmons, 2016). There are other critical voices who suggest that the rise of concern is allowing a therapeutic language and culture to be inserted inappropriately into schools (Ecclestone and Hayes, 2009). There are also educational researchers, however, who are just as concerned to ensure that mental illness shakes off the stigma to which it has long been attached (Allan, 2018) while others illuminate the ways in which mental health intersects with a range of human differences, not only in our schools but across our communities, for example, disability (Keesler, 2014; Liddiard, 2017), ethnicity (Rosen *et*

al., 2017), gender (Ussher, 2011; Bryant-Davies *et al.*, 2010), sexual orientation (Burton *et al.*, 2013) and young people in public care (Luke *et al*., 2014).

We need to make absolutely clear in this paper our support for the development of specialist services and responses to mental health and psychological harm. While mental health issues affect people at the level of individual experience, however, there is gathering evidence that the root causes and manifestation of the majority of mental health-related problems are affected by circumstances that lie beyond both the individual and the arena of medical or clinical health (WHO, 2016; Friedli, 2009; Cromby, Harper and Reavey, 2013; Read and Dillon, 2013; Pinderhughes, Davis and Williams, 2015; Thomas *et al*., 2020).

In this paper, therefore, we first of all explore some implications of inserting clinical discourse into education, which in the instance of mental health it achieves in the form of a 'medical model' with particular characteristics, practices and consequences (Laing, 1971). In the second empirical section of the paper we report on the ways in which we encouraged adult participants to construct the field of mental health in education for themselves, as part of our Evaluation of a school-based teacher-training programme delivered across selected urban schools. In the final section of the paper, we suggest principles for research, policy and practice in education based on key factors arising from those participant narratives and responses, in accord with the conditions and priorities for wellbeing and mental health they identify and which resonate with our theorizations and critiques of the medical model of mental health.

In mapping out some of the conditions for mental health practices in education in this paper, we have sought to evade traditional boundary disputes between the psychological (which ultimately usually invokes the individual) and the social. We have used the term *relational* as a means of encouraging more dynamic understandings of persons operating within fast-changing and inter-connected global, environmental and technological circumstances. A focus on relations or the *relational* can be found in education, for example, professional expertise (Edwards, 2005, 2011), power (Billington, 1996, 2006), learning (Hersted and Gergen, 2013; Billington, 2020) and evaluation (Gergen and Gill, 2020) but also in psychoanalysis too (Son, 2006; Mitchell, 2014) where the term can tend to invoke narrower conceptualizations of individual 'selves'. The *relational* envisaged in this paper moves beyond dyadic inter-subjectivities and links to uncertainties that have stubbornly persisted from the 19th. century scientific interest in association (Blackman, 2008) through to contemporary social constructionism as '…a process of coordination that precedes the very concept of the self' (Gergen, 2009: xv). The *relational networks* we propose connect with the theoretical (Latour, 2005) but also the practical in which our author experience (we are all either practising teachers or psychologists) suggests that the needs of the most vulnerable young people in our communities will not be met solely by individual psychologists, psychiatrists or therapists but by the networks of support that can be mobilized across communities, homes and schools.

The methodological approach in the paper is distinctive in juxtaposing critical theorizations with empirical data collection. Its significance lies in the opportunities it afforded professionals from local agencies and services (education and health), whole school staff including teachers as well as parents / carers to map out policy and service contexts that would best meet community and service-user aspirations and needs

regarding young people's emotional wellbeing and mental health. Our argument for *relational* approaches to mental health in education utilizes empirical research data as well as critical theorizations in order that we are better able to shed light on the contemporary medicalization and psychopathologization of young persons' lives. At the same time we aim to resist an individualising of what evidence suggests should more accurately be re-framed as a shared social, ethical, political and even scientific responsibility when working with young people who are experiencing distress.

The Medical Model of Mental Health in Education

The attention of mental health services has been turning to education. Schools are being targeted, for example, across Europe (European Union, 2017), Australia (Australian Government, 2014), Canada (Kutcher, Wei and Morgan, 2015), New Zealand (Cushman, Clelland and Hornby, 2011) and Finland (Puolakka *et al.*, 2011). In the UK there have been frequent pronouncements which are beginning to impact on policies and practices in schools (Public Health England, 2015; Frith, 2016; DoH and DfE, 2017; DoH and DfE, 2017a) and a host of other initiatives (e.g. Kendal, Callery and Keeley, 2011; Coombes *et al.,* 2013). While we understand and support aspects of such approaches, we suggest that there is an over-reliance in current initiatives, not only on medicalised understandings of the person but also on diagnostic performances, in particular, in the form of psychopathologies imposed at the level of the individual. Social models of health, psychology and mental health have questioned (Martinez *et al.*, 2011; Kvaale, Haslam and Gottdeiner, 2013; Callard, 2014) or even challenged the ways in which human differences are constantly being brought to account through the language of psychopathology, principally since that language invariably invokes deficit models of the individual with life-long consequences for any person identified during their childhood (Burman, 2017 [orig, 1994]; Coleman, 1999; Billington, 2000; Parker, 2005; Romme, Escher and Dillon, 2009; Timimi, Gardiner and McCabe, 2010; Frosh, 2014; Goodley and Runswick-Cole, 2016).

Resistances to the diagnostic / medical model of mental health face a constant battle to gain purchase, however, not least since they are pitted against huge economic resources circulating around the new technologies and pharmaceutics of modern medicine (Breggin, 2002; Mills, 2017). It can be argued that the current claims for an epidemic in young people's mental health problems have been, at least in part, a convenient vehicle for the resurgence of medicalized discourses of persons. In an alliance with market forces new generations of childhoods are being colonised into particular ways of thinking about themselves i.e. as dominated by psychopathologies and, potentially, the need for psychopharmacological solutions. During our Evaluation it became clear that the underlying premise of current health discourse being inserted into schools – ultimately that of problem identification, diagnosis and treatment at the level of the individual – is not appropriate for the vast majority of children and young people and we became alert to the insidious ways in which this medical model can conceal the impact of non-clinical circumstances upon mental health in communities.

The roles of schools and teachers in respect of the mental health of young people are currently being negotiated (Kidger *et al.*, 2010; Loades and Mastroyannopoulou, 2010; Reinke *et al*., 2011; Hopkins, 2014; O'Reilly *et al*., 2018) but, wherever implemented,

health interventions in schools are welcomed by many hard-pressed teachers since the projects bring with them new money and human resources. At the same time, these interventions also bring the promise of a potential solution to problems, which again are invariably located in individual young people. The scientific precision underlying the evidence behind such a promise is far from clear. We are also concerned, however, that inserting health models simplistically into education settings risks the acceleration of processes in which school communities, teachers and parents are, first of all infantilized in respect of their own supposed 'lack' of knowledge of young people and then somehow expected to act as the first line of defence against this perceived global mental health pandemic, the circumstances for which may yet change again depending on COVID-19 outcomes.

While again emphasizing the importance of services which meet the needs of those young people who are suffering trauma or distress, we need to think carefully about the implications of a widespread distribution of medicalized understandings of young people's wellbeing and mental health into the field of education. For there is compelling, long-standing evidence that mental health, wellbeing and learning are community activities and not mere deficits to be located in individual persons. Supporting arguments can be found, for example, across critical approaches to human subjectivity and psychology (Hollway, 1989; Sugarman, 2009), clinical psychology (Cromby, Harper and Reavey, 2013; Coles and Mannion, 2017), developmental and feminist psychology (Burman, 2017; Bird, 1999), educational psychology (Prilleltensky, 2014; Williams *et al*., 2017), the history and philosophy of science (Feyerabend, 1978; Hacking, 1995), psychosocial studies (Frosh, 2011; Corcoran, 2014), social constructionism (Gergen, 2015; McNamee *et al*., 2020) as well as educational and critical neuroscience (Immordino-Yang, 2016; Choudhury and Slaby, 2016; Billington, 2017).

While generated with great conviction and often received with enthusiasm, perhaps even relief, there is little evidence that the *a priori* deployment of a clinical language focussing primarily on diagnosis and medical treatment in relation to the emotional wellbeing and mental health of young people will succeed in its promise to provide an explanation for, and a solution to the dilemmas of everyday life in our communities, schools and classrooms. An open-ended delivery of mental health resources in schools at the level of the individual is a promise that cannot, and, arguably, should not be met. There is a problem for education, however, and we agree with the UK government's analysis of the injustices suffered by young people, 'Children with a persistent mental health problem face unequal chances in life. This is one of the burning injustices of our time' (DfE, 2017: 6).

In the next section, we draw on empirical data taken from just one part of a larger study of a mental health intervention in schools across one English city in which we adopted a social constructionist methodology (Nightingale and Cromby, 1999) to encourage participants to develop their own preferred ways of thinking about, and speaking about young people and their mental health relevant to education settings. Accounts obtained from local policy and service leads across education and health, and subsequently from parents / carers and whole school staff (in the form of interviews and questionnaire responses respectively), led us to question the appropriateness of a wholesale adoption by schools of a clinical attitude and, ultimately, to our proposal for a *relational* approach to the emotional wellbeing and mental health of young people in schools.

A school-based intervention (teacher-training)

Our team was commissioned to conduct a pre- and post-intervention Evaluation of a training programme being delivered to teachers by health professionals in respect of young people's emotional wellbeing and mental health in school settings in one English city (Billington *et al*, 2019). In this section it is not our intention to provide a comprehensive account of either the Evaluation or the training programme and there are distinctions to be made between the full Evaluation report, the teacher training programme and the empirical data incorporated within this paper.

We draw here upon just two data sets. Firstly, we utilize interview data captured at the very outset of the Evaluation and prior to delivery of the teacher training programme. Interviews were conducted with a wide range of professionals from across education and health sectors in the city and the themes identified (please see Table 1 below) were subsequently used as the basis for a questionnaire directed at school staff, parents and carers. The second data set utilized in this section draws upon participant responses to just the first question of that questionnaire (please see Figure 1 below), selected to support the case for an epistemology that recognizes non-clinical aetiologies when considering the mental health needs of children and young people.

Prior to any data collection phase, however, and during the preparatory stages of writing the initial competitive funding bid, we became aware of a wider context both for the Evaluation and for the teacher-training programme which was to affect our methodological decision-making. Despite the immense pressure of massive budget cuts in the region linked to a sustained economic austerity policy directive (Fell, 2019), the Local Authority and the local NHS had been working closely together for several years in the area of young people's mental health. There had been a series of initiatives in the city, some of which were still being conducted by different services in many, but not all, of the same schools receiving the teacher-training programme. Significant differences between schools had been identified by project commissioners suggesting the impact of different levels of teacher preparedness and it was clear that any claims in respect of the success or failure of the project's teacher training programme would be contaminated by other interventions, variable access to forms of data and differences in both delivery and context.

All schools possess their own unique history and community demographic which constitute just some of the conditions for the young people, their emotional wellbeing and mental health. Our approach, therefore, was to adopt a mixed-methods design which began with the accessing of generic data from education and health agencies. We noted in the health materials being taken into schools that there was little reference to the non-psychological factors associated with the emotional wellbeing and mental health of young people which are identified elsewhere in this paper. We argue that the exclusive deployment of clinical conceptualisations, while seemingly justifiable from a strictly health point of view, was to create at the outset a template for interrogating the field of young people's emotional wellbeing and mental health in schools which was incomplete.

Our collective experience as both practitioners and researchers (education and psychology) has exposed us to a range of situations as well as approaches towards the

mental health needs of young people that were not represented in the materials being disseminated in schools. We determined, therefore, that it was our ethical responsibility as independent evaluators to provide opportunities for participants to develop and articulate more nuanced approaches to young people's mental health that were not confined only to clinical accounts. As part of the first phase of our own primary data collection in the Evaluation, therefore, we resolved in the interviews not to impose on our participants either a medical language or any clinical understandings of young people but to create spaces in which the various contributors could speak about young people's wellbeing and mental health in language of their own choosing. This decision was methodologically significant, and it was one which took seriously the capacity of our participants to contribute more proactively to the knowledge-creating process i.e. in respect of young people's emotional wellbeing and mental health.

Initial semi-structured interviews (n=19) were conducted with senior policy makers and commissioners, service managers, clinicians, representatives of school leadership teams, teachers with specific pastoral or inclusion responsibilities and practitioners from across those agencies. The interviews were designed not only to elicit expectations regarding the teacher-training programme but to allow participants scope to explore issues of their own choosing, for example, to develop their own ways of talking about young people's emotional wellbeing and mental health in the form of their own 'preferred narratives' (White and Epston, 1990). This social constructionist methodology is sensitive to the manner in which all research and practice has a performative quality (Holzman, 2000) i.e. that words, questions and activities, for example, those of the researcher, constitute important variables affecting the data, analyses and results. Social constructionist methodology demands that professionals seek to devise ways of working *with*, rather than *on*, their clients as an ethical commitment and so we were particularly careful in the language used and questions we asked in order to avoid imposing our own terminology.

A core theoretical and ethical principle of the particular interview method was to enable interviewees to 'restore [their] agency' (Parker, 2005: 72) in respect of young people's mental health. Our aim, therefore, was to provide opportunities for the participants to develop their own thinking, hopefully as a precursor to making eventual policy contributions. Following these initial interviews, detailed transcriptions were made and recordings of the participant accounts were subjected to thematic analysis by three members of the team, separately in order to strengthen our confidence in respect of inter-rater reliability (Boyatzis, 1998; Braun and Clarke, 2006, 2013). The first and second authors then held a series of meetings during which the interview data and the themes were subject to further analysis and circulated to the rest of the team for comments. The team subsequently used the themes identified in the interview data to drive the second phase of the Evaluation which was to be a questionnaire with whole school staff, ~~and~~ parents and carers. This responsiveness to the interview data required an amended submission to the University's ethical review panel.

Perhaps one of the most striking features manifest throughout these first interviews (but evidenced during the whole of the study) was the extraordinary commitment of professionals to meeting what they perceived to be the emotional well-being and mental health needs of young people - within the executive bodies, the agencies and service leads across education, health and schools. There were to be many individuals, service

managers, clinicians, teachers and support staff who demonstrated dedication at levels far beyond those which might routinely be expected. This was, arguably, one of the most significant findings of our Evaluation for future policy and practice initiatives although this commitment and dedication of the professionals lay beyond positivist data collection measures as qualitative judgments. Such conclusions could, of course, ultimately support the argument for the development of *relational* approaches and evaluation in recognizing the value and importance of a human commitment to the success of any intervention when working with young people, their mental health and education.

It remained impossible for us to ignore though, the marked contrast between on the one hand, the language and ideas enunciated by professionals during these first phase interviews and, on the other, the restricted lexicon of the health materials being taken into schools that we had considered at the very beginning of our work. We were intrigued to find the extent to which, despite the opportunity offered during our interviews, there was little if any mention by professionals of specific medical diagnoses and there was an absence of a more obvious psychological language or orientation. The non-clinical themes arising in these initial interviews that we identified as being important across participant interviewee accounts were (not in order of frequency) –

Table 1 – *Phase 1 interviews with senior policy makers, commissioners, service managers, clinicians, representatives of school leadership teams, teachers with specific pastoral and/ or inclusion responsibilities and practitioners from across those agencies, policy–makers, service leads* [i.e. themes identified as having an impact on the wellbeing and mental health of young people]

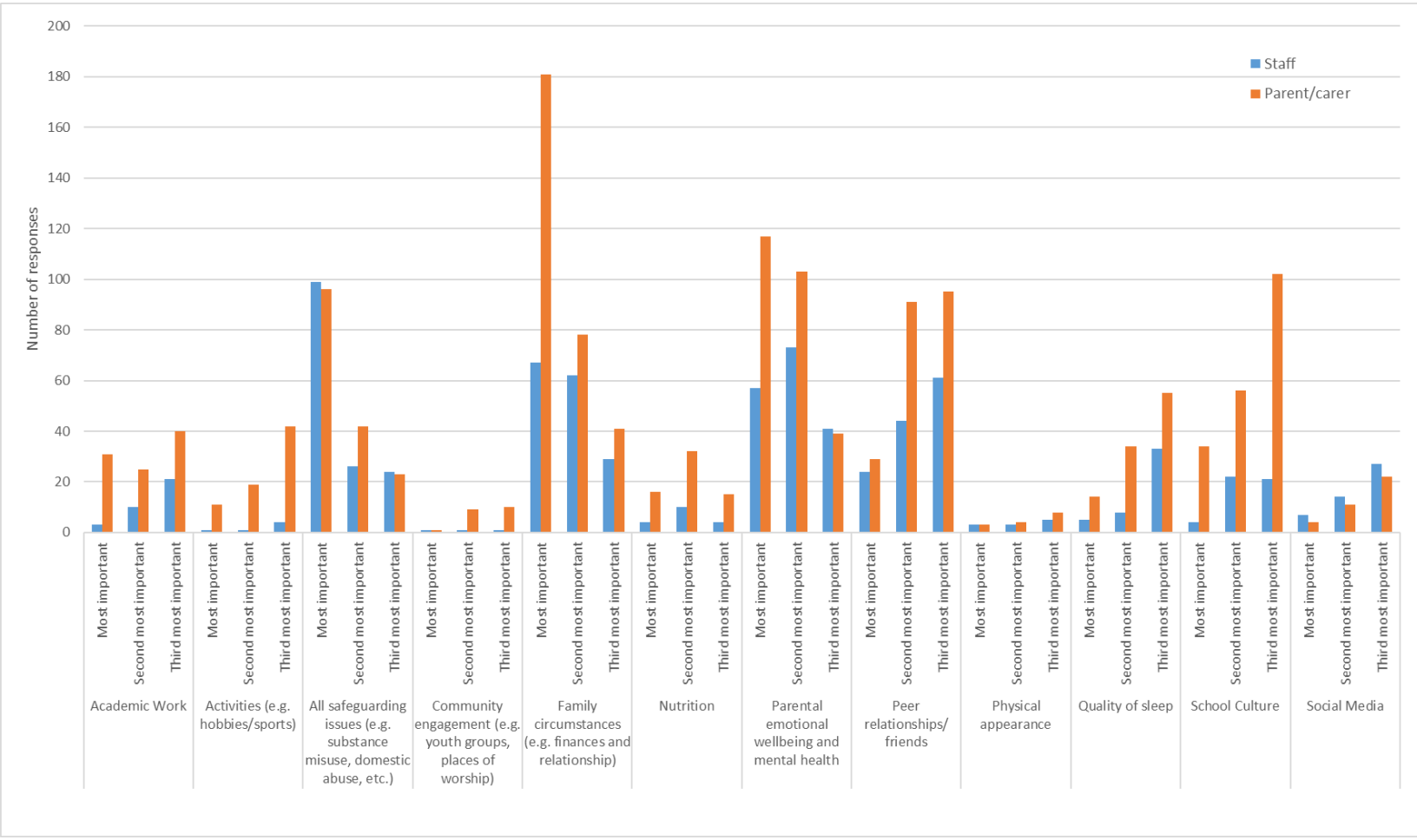
- academic work
- activities (e.g. hobbies/sports)
- all safeguarding issues (e.g. substance abuse, domestic abuse etc.)
- community engagement (e.g. youth groups, places of worship)
- family circumstances (e.g. finances and relationships)
- nutrition
- parental emotional wellbeing and mental health
- peer relationships / friends
- physical appearance
- quality of sleep
- school culture (aspects of the school environment which support young people and enable them to develop and flourish such as values, expectations and the way people treat each other i.e. including school climate)
- social media.

(Billington, Fogg, Lahmar and Gibson, 2019)

The language chosen by the interviewees located the mental health of young people firmly within non-medical contexts and non-psychological discourses. We decided, therefore, that it was our responsibility to the integrity of those interviewee accounts to embrace and build upon their evidence and use the themes they presented as the foundation upon which to construct the next phase of our Evaluation. The first and second authors held weekly meetings and began to devise a questionnaire for parents / carers and whole school staff, including teachers, in the participating schools. This process during the second phase of the Evaluation involved over twenty iterations, again shared with the rest of the team until we were confident that the questionnaire reflected the words and themes of the above initial interviewee accounts. The process enabled us to claim that the interview data were driving the theoretical, non-clinical foundations of the second Evaluation phase.

We decided to send out the questionnaires not only to the teachers receiving the training but to whole school staffs and parents / carers of children in those schools in order to access the widest possible relevant constituency (14 x primary, 1 x secondary). Questionnaires were made available either in hard copy or online and responses were received from 275 members of school staff and 517 parents. These were completed anonymously, mainly on-line and we were to deploy frequency counts and descriptive statistics only. There could be many details provided at this point but we re-iterate that neither the Evaluation, the teacher-training programme nor the full questionnaire responses are the primary focus of this paper. We choose instead to present responses to just ***one*** question from the questionnaire, the first question in which whole school staff and parents / carers were asked to rank, in order of importance, three of the themes identified by the interviewees during phase 1 (i.e. those in Table 1 above) that they perceived would have the greatest impact on a young person's wellbeing and mental health.

Figure 1



(Billington, Fogg, Lahmar and Gibson, 2019)

We make no claims in respect of any statistical precision but the respondent school staff and parents / carers above identified the following broad categories as impacting on young people's wellbeing and mental health, in order of approximate frequency:

- family circumstances (i.e. including finances and relationships)
- parental wellbeing and mental health
- safeguarding issues (e.g. substance misuse, domestic abuse)
- school culture (including school climate, peer and all other school-based relationships).

Free text spaces had been provided in the questionnaires to allow for additional or more nuanced responses to be made but again, respondents chose not to deploy medical language or refer to psychopathologies. When given the opportunity to express their views, whether during the initial interviews or in the questionnaires, Evaluation participants, policy makers, service leads, parents / carers or teachers, did not adopt a medical / clinical / psychologised terminology. Participants consistently chose instead to embed their accounts of young people's mental health in what we concluded were inherently social or what we would suggest could be considered more helpfully and accurately as *relational* circumstances.

Whilst accounts from young people's focus groups were incorporated within the full Evaluation report these were young people who had been pre-selected by professionals to perform particular roles across the city and its schools. As such the young people had already been exposed to language and understandings of mental health that adopted an exclusively clinical orientation. To provide opportunities for these young people to reflect and develop their own preferred language presented as a completely different project and outside the scope of our Evaluation. Prior to writing this paper, however, Evaluation materials were used to inform the development of a questionnaire for Primary School children that became part of PhD research (Gibson, Billington & Overton, forthcoming).

While continuing to acknowledge the urgent needs of all those young people who are in distress, we suggest that we need to find ways of listening to the voices of all those working in educational settings as part of a process in which they can focus upon and achieve solutions to what might more properly be considered the community, educational or *relational* problems that were identified in our Evaluation. What then, might be some of the conditions upon which a *relational* model of emotional wellbeing and mental health for schools could be based?

Conditions for a *Relational* Model of Mental Health in Education

Family circumstances, parental emotional wellbeing and mental health, child safeguarding issues and school climate and culture provide the conditions for emotional wellbeing and mental health for young people in education. They were not only identified by interviewees and prioritized by teacher and parent respondents during our Evaluation, they each feature strongly in the literature in which there is a positive correlation with adverse and potentially life-long outcomes in respect of the emotional wellbeing and

mental health of young people and their education (Hughes *et al.*, 2017; Marryat *et al*., 2018).

There are traditions within education, psychology and the social sciences which have long conceptualised the nature of all human functioning, our emotional wellbeing and mental health but our behaviour and learning too, as being, first of all, inter-connected and secondly, dependent on environmental 'conditions' '*…the faculty* [mind] *does not exist absolutely, but works under conditions; and the quest of the conditions* [author's italics] becomes the psychologist's most interesting task.' (James 2010 [orig.1890]: 1). William James, a principal founding figure in early institutionalized forms of western psychology, envisaged the functioning of individuals as contingent and we now utilize both theoretical and empirical resources drawn upon in previous sections of the paper as the evidence-base upon which to propose three key principles for research and practice which would form the starting points for a *relational* model of mental health in education

- to acknowledge the complex links between affect, cognition and school climate and culture i.e. including pedagogy and the curriculum
- to foreground mental health and poverty (but not excluding political, socio-cultural and other environmental circumstances) as impacting on young people's emotional wellbeing in their communities, families and schools (in-person and virtual)
- to attend to 'voice' – providing spaces in which young people, including those who are part of our most marginalized communities, can develop their own 'preferred narratives' concerning emotional wellbeing and mental health (but whole school staff and parents too).

Affect, cognition, school climate and culture

Not all young people have experienced unmanageable or enduring distress. Not all of those young people who have experienced such distress will wish this to be a focus of concern when at school. Young people's emotional lives will not necessarily impact either strongly or obviously on their educational achievements. Education, however, should not be performed in ways which ignore such possibilities.

'The internal battle between emotion and reason is one of the great narratives of Western civilization' (Barrett, 2017: xi). Education, and arguably much of western human science, has historically been constructed upon the basis of an ascetic, even mechanistic conceptualization of cognition (Ryle, 1949). The alliance of thinking and reason, to the exclusion of emotionality, has been enacted across psychology and the social sciences from their inception, at times brutally so (Galton, 1869), in ways which discriminate against and oppress all those forms of difference considered unacceptable, for example, according to disability, ethnicity, gender, sexual orientation or social class (Goodley, 2018; Chitty, 2007; Phoenix and Tizzard, 2002; Burman, 1997; Burton *et al*., 2013; Billington, 2000). The inter-connected approaches to learning and the psychology of persons envisaged by James and his pupil, the educationalist, John Dewey (1938), were often overwhelmed during the last century by dominant paradigms of behaviourism and cognitivism. Increasingly, however, questions concerning causality have required more complex modelling and the gaze of psychologists and social scientists has gradually fallen upon the links between learning and our other faculties, including emotion (Gardner, 1983; Goleman, 1995). For example, areas of neuroscientific research have in

recent decades highlighted the importance of our affective lives (Panskepp, 1998) and these trends began to impact on policy initiatives (Banerjee, Weare and Farr, 2014). Affective neuroscience is now offering models of feelings, but of thinking and learning too, that suggest not only that they are inter-connected neurologically (Damasio, 2000) but, together, constitute a new re-configuration of mental processes – emotion as an integral part of an expanded understanding of cognition (LeDoux, 1999). Our emotional lives, it has been suggested, could even reside within the very roots of our thinking, 'we feel, therefore we learn' (Immordino-Yang and Damasio, 2007: 3). This proposed reversal of a Cartesian rationalism and causation would have significant paradigmatic implications for educational practices.

Processes of thinking and learning, as the pinnacles of educational achievement, are now being regarded as inter-connected with feelings in ways not previously accepted (Damasio, 2012; Billington, 2017). Only psychoanalysis has been persistent in its exploration of these links between our emotionality and our cognitive functioning (Bion, 1962; Winnicott, 1971) but these have struggled to filter through into public debates with only rare exceptions - young people in public care (Wall, 1997) or the impact of colonialism on swathes of humanity (Fanon, 2008 [orig. 1952]). This inter-connectivity between feelings, thinking and learning, whether suggested by either psychoanalysts or affective neuroscience researchers, however, only seems to corroborate what participants in our Evaluation, school staff and parent / carer respondents, seem already to have known.

It is some years since the Division of Clinical Psychology Section of the British Psychological Society (BPS) produced a Position Paper urging their own 'paradigm shift' in the field of psychiatric diagnosis in order 'to support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors' (2013:9). The '*Power, Threat, Meaning Framework*' (PTMF), also published by the Clinical Psychology Division of the BPS (Johnstone *et al*., 2018) then suggested a means of operationalising that ambition of a paradigm shift in respect of adult services, and we propose in this paper that there could be a similar paradigm shift in approaches to supporting the emotional wellbeing and mental health of young people in schools. In challenging conventional approaches to psychiatry, PTMF drew upon a wide range of psychological theory which is critical of the medical model of mental health (BASF, 2014; Beresford *et al.*, 2016) and focused on the importance of, primarily family-based, trauma. Respondents to our Evaluation too had identified family circumstances as perhaps the most important contributory factor to a young person's sense of well-being and mental health, and identified, in particular, the significance of safeguarding issues. Relationships are clearly vital, whether at home or in school (Graham, Powell and Truscott, 2016; Early Intervention Foundation, 2017) but our respondents tended not to confine their narratives to the dyadic which in family work can too easily locate itself in an attachment theory focussed simplistically on the pathologization of mother-child relationships (Bowlby, 1979; Runswick-Cole and Ryan, 2019). Our participants seemed mindful of more complex family circumstances affecting a young person's wellbeing.

Many young people are unable to leave their distress at the school gates and pressure can build on schools to manage the situations that arise. The focus can often fall on young people's behaviour as opposed to their distress. Teachers and mentors themselves then

become vulnerable in emotionally charged situations as young people and members of staff alike become subject to unmanageable feelings and locked in cycles of a harmful distress. This is especially the case should the school climate, its ethos and culture, prove neither sufficiently sensitive nor robust to provide the *relational* conditions that support the wellbeing of all concerned (MacNeil, Prater and Busch, 2009; Reike, Aldridge and Afari, 2017). The positive impact of school climate and culture upon young people's learning and wellbeing has been known for many years (Hoy, 1990, Gonder, 1994). There has been a resurgence of interest in recent years, however (Voight and Maury, 2016), and there are convincing arguments that attention to school climate and culture would provide one important way in which education professionals could develop relational practices which support young people's mental health while at the same time resisting an unnecessary insertion of clinical language and practices into education (Gergen, 2009). The notion of 'trauma-informed schools' (Walkley and Cox, 2013) might be one step too far for some but participants and respondents in our Evaluation (in particular, parents / carers) identified school climate and culture as key contributory factors in supporting the emotional wellbeing and mental health of young people (Aldridge *et al*., 2016; Roffey, 2008).

Many members of school staff, however, are already actively supporting young people who are suffering the effects of trauma or other significant emotional and mental health needs (Wasserman *et al*., 2015; DoH and DfE, 2017b; Billington, 2018), performing on a daily basis what might even at times be described as a quasi-therapeutic role that other support and clinical services could not hope to emulate. *Relational networks*, often pivoting around individual members of school staff at crucial moments in a young person's life, defy quantification and generally remain unseen, unacknowledged and / or unappreciated, for example, within school league tables or inspection reports. The human value permeating such networks in school communities, however, notwithstanding its irreducibility to quantitative analyses, is vital within the *relational* conditions which, arguably, provide the most effective naturalistic form of intervention in supporting young people, as a first line of defence against any embryonic emotional wellbeing and mental health concerns (Rothi, Leavey and Best, 2008).

Mental health and poverty in young people's lives

'Children born into socioeconomically disadvantaged families suffer worse child well-being and its lifelong implications, in all societies, worldwide' (Pickett and Wilkinson, 2015: 539).

Not all young people who suffer economic poverty will experience mental health issues. Not all young people who suffer mental health issues will be economically poor. Nevertheless, there is again a positive correlation and a family's financial circumstances were identified by interviewees and prioritized by school staff and parent respondents as being a principal cause of young people's difficulties in wellbeing and mental health, a view which finds much support in the literature (Ha, 2009; Wilkinson & Pickett, 2010; Early Intervention Foundation, 2017; Mazzoli Smith and Todd, 2019; Moore *et al.*, 2020). Many of our participants recognized that the wellbeing of a young person relies on the support of family members, friends, school and extra-curricular staff or members of their community which is again, a view that finds support in the literature 'There is…strong evidence from DeStress [2019] that a great deal of distress within low income

communities is caused or exacerbated by social isolation and stigma. Where local community groups (often informal in nature) exist, they have been shown to act as powerful support mechanisms…' (Thomas *et al*., 2019: 21). Should the availability of these *relational* resources be restricted in the community, whether social or economic, evidence from both the literature and our Evaluation indicates that people are aware of the ways in which such deprivation impacts on wellbeing with potentially life-long outcomes. Any crisis in young people's mental health, therefore, should be seen to have been caused in the first instance, not by a dearth of comprehensive specialist services for young people in distress but by the impact of economic circumstances and government policies in either de-stabilizing or else reducing the availability of those supportive networks which underpin our communities. 'Poverty and deprivation are known to create and exacerbate mental distress (Rogers and Pilgrim 2014). Recent analyses demonstrate high levels of prescribing and use of psychoactive drugs in low-income communities' (Thomas *et al*., 2019: 2). Agency and service responses are often drawn to solutions in the form of resources and interventions which adopt the medical model of mental health. Clinical diagnostics on their own, however, serve as a means of concealing governmental culpability in depriving communities of the resources necessary to thrive and develop their own effective *relational networks* '…the medicalization of distress absolves those with power from taking responsibility for the injustices caused by on-going social, economic and health inequalities' (Thomas *et al*., 2019: 4).

Adopting the medical model of problem identification, diagnosis and treatment at the level of the individual, therefore, is not only wholly inappropriate for the majority of young people. It also serves to conceal the role, not only of government but of all those of us who work in agencies and services who do not take more fully into account the complex *relational* circumstances and conditions within which young people live, 'by pathologising individuals as having distinct and categorisable 'defects' within their brain or psychological functioning, mental health is viewed and treated in a disempowering apolitical vacuum, where the root causes of deprivation and social injustice that are known to sustain poverty and underpin the erosion of wellbeing become obscured (Shaw and Taplin 2007; Friedli and Stearn, 2015).' (Thomas *et al*., 2019:4). On its own, the medical model of mental health ignores the complex aetiology of distress in our communities and thus provides an incomplete template for understanding, and thereafter for devising potential solutions.

Not only is the impact of economic inequalities upon mental health obscured but the medical model encourages psychopathologization to become widespread through the circulation of psychological and clinical discourse. Young people's lives are unfolding, however, and should not be either clumsily or precipitately predicted. In particular, we need to avoid locking individual young people into mental health discourse which can too easily fail to detect any transience or potential and immerse them in a deterministic psychopathological discourse which, through the processes of 'classificatory looping,' can become internalized by the young person for a lifetime (Hacking, 2007). These processes can be very difficult to resist, however, given the material rewards that are often associated with diagnosis in the form of additional resources and schools and individual members of education staff are once again in the front-line of decision-making (Powell and Graham, 2017; NEA, 2018; O'Reilly *et al*., 2018; Reinke *et al*., 2018). The challenge for agencies and services when working with young people in education settings in the first instance is to eliminate all those possible causalities which scientific

investigation could more accurately attribute to the *relational* conditions in which young people live and then to devise interventions which acknowledge their ultimate dependency on the quality and strength of available *relational networks*.

'Voice' - listening to the (relational) experiences of young people

While focus groups were conducted with young people during our Evaluation, we consider the limited extent of young people's contributions to the empirical study to have constituted a serious methodological omission on our part. Agencies are grappling with the issue of how to engage with young people in respect of their mental health in fast-changing circumstances (Hollis *et al*., 2016; Anderson *et al.*, 2017) and we identified problems at each stage of our own Evaluation methodology. Problems too could be seen in the interventions, since from the initial government funding call onwards, the speed of the timeline made it difficult for project managers to consult fully with young people, for example, in respect of their ideas as to the content of any training programme for teachers i.e. what is it that young people would want teachers to know about their well-being and mental health?

There are clearly tensions in devising services, policies and practices which acknowledge that young people can be both knowledgeable agents in their own lives and yet vulnerable subjects requiring care and protection. This can be an especially difficult balance for schools to achieve and it was beyond our resources too. We were concerned that by exploring emotional wellbeing issues with young people we would run the risk of re-producing and circulating that incomplete template for mental health which would in its performance have risked committing harm i.e. by an inappropriate focus on psychological or clinical factors alone. The ethical processes around assent, confidentiality and representation demand that, whether as practitioner or researcher, we need to be theoretically sophisticated regarding issues of language, knowledge and power relations.

Social constructionist methodology deems that, from the moment of a first contact, whether in-person or even via information sheets and consent forms, we would as researchers have been constructing the discursive field of young people's mental health as part of the '…practices that systematically form the objects of which they speak' (Foucault, 1972: 49). PTMF provides just one example of an approach which demands that professionals understand how forms of epistemological violence can lead to a harmful neglect or harmful intervention and this is increasingly recognised in critically oriented adult mental health research and practice, the anti-psychiatry movement and Mad Studies in which service users/patients can now *'*....take part in the production of the official knowledge about madness and restore our epistemic injustice.' (Russo, 2016, in PTMF:74). This perspective can be even more difficult to establish in educational contexts, however, and it would have required far more time, negotiation and perhaps imagination in our Evaluation before we could have engaged with young people (none of whom we would have known), confident that we would have avoided committing any kind of harm.

While we conducted focus groups as part of the Evaluation we were concerned that we had insufficient time to give careful consideration to what we perceived to be the risks of perpetuating the 'epistemic injustice' (Fricker, 2007), its inherent tokenism or of failing to understand the implications of the kind of professionalism being demonstrated by

some young people in the sessions. The questionnaire designed for the later study (Gibson *et al*, ibid) enabled young people of primary school age to contribute to understandings of wellbeing in language of their own choosing and in a way that was more sensitive to the epistemological and ethical complexities involved than had been possible to achieve within the Evaluation.

Young people need to be consulted (Brown and Dixon, 2019) but if they are to believe that the benefits to trusting adults outweigh the risk, they will need to perceive that we have the conceptual tools to support them in expressing their own unique knowledge, while able to protect them from the consequences of being mis-understood and mis-represented. The need to develop good practice around 'voice' in educational contexts has been recognized elsewhere, for example, as a pre-requisite for the potential provision of therapeutic support in schools (Children's Commissioner, 2017) while one of the starting points in our other work with young people has been to ask ourselves the following five questions as part of ethical *relational* research and practice:

How do we speak **of** young people?
How do we speak **with** young people?
How do we write **about** young people?
How do we listen **to** young people?
How do we listen to ourselves (when working with young people)?
(Billington, 2006: 8).

Endnote

> *The factors associated with mental health…point toward environmental and social influences that can act as important risk and protective factors for young people's mental health. Capitalising on opportunities to provide children with supportive environments early may be key for ensuring good mental health for all children and young people*.
> Mental Health Foundation (2018)

Members of school communities across the world are currently reeling from the impact of COVID-19 and we are all in unknown territory in respect of the eventual implications for the lives of young people, members of staff and schools in the years ahead. We can perhaps see more clearly than ever, however, that while either suffered or enjoyed at the level of the individual, our experiences are ultimately contingent, inter-connected and thus fully *relational* within the prevailing community, school and family contexts in which we live.

Young people's 'voice', poverty as well as school climate and culture provide starting points for constructing the conditions for a *relational* model of mental health in education. An understanding of the *relational* incorporates not only personal relationships but cultural, economic and political circumstances while embracing the environment too as more broadly conceived, for example, in terms of its material fabric (e.g. housing, schools). Importantly, the *relational* attends also to those spaces in which young people especially will be negotiating the human interface with social media, evolving cyber-

technologies and the challenges posed by the changing natural world – their *relational networks* - in years to come (see Harper *et al*., 2016 for potential approaches to 'digital' solutions).

An ethical science of persons needs to accommodate the complexities of the emerging world with its new *relational* possibilities. This will require a paradigm shift in approaches to wellbeing, mental health and education which does not routinely ignore either distress or else the inequitable circumstances in which young people live and learn. Until we can develop a model of scientific inquiry which can embrace the complex inter-penetrability of our *relational* human being, however, it is our responsibility to avoid incarcerating young people in adult mental health categorizations or psychopathologies from which there will be little prospect of escape.

A critical understanding of the history of the western social sciences indicates strongly that, while medicalized discourse will continue to make important contributions to the wellbeing of individual young people, neither psychiatry nor psychology can be entrusted on their own with the mental health needs of all those young people who are distressed, especially those in communities who are most disadvantaged. Education should not relinquish responsibility in the area of young people's mental health, not least since young people depend on the day-upon-day commitments made by individual teachers, mentors and parents / carers. It is invariably their expertise and knowledge of the young persons that will sustain the *relational networks* long after other experts have had to move on.

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There are no conflicts of interest. Two of the authors, however, continue to practice as Educational and Child Psychologists.

Data availability statement
Research data are not shared.

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