

A critical consideration of 'mental health and wellbeing' in education: Thinking about school aims in terms of wellbeing

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Abstract

This paper examines ideas about mental health, wellbeing and school education to illustrate important issues in the relationship between mental health and education. The Covid crisis has amplified the pre-existing mental health problems of children and young people in England and recognition of the opportunities in schools to address these. The paper gives an overview of child and adolescent mental health services and how they position the role of schools. It examines prominent concepts of mental health and their relationship to wellbeing, setting this in a discussion of 'mentally healthy' schools, mental health in special educational needs and whole-school approaches. This analysis shows how the relationship between mental health and wellbeing has not been adequately worked out, using this as the basis for arguing for the dual-factor mental health model which separates mental illness/disorder from wellbeing as two related dimensions. The paper then translates the dual-factor model into a two-dimensional framework that represents the distinctive but related aims of school education (wellbeing promotion) and mental health services (preventing, coping, helping mental health difficulties).

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This framework involves a complex conception of wellbeing, with schools playing an important role in promoting wellbeing (beyond emotional wellbeing), tiered models and establishing school-wide social emotional learning. It is about a whole-school curriculum approach that involves considering what is to be learned and how it is taught. It contributes to a more nuanced concept of wellbeing that has a place for meaningful learning and challenge.

KEYWORDS

mental health, school education aims, special educational needs, wellbeing

Key insights**What is the main issue that the paper addresses?**

The main issue is about the uncertain relationships between mental health, wellbeing and school education aims. It is an issue about the broad purposes of schools with contemporary relevance. It relates to the design of education and health services.

What are the main insights that the paper provides?

The main insights of this paper involve questioning the unexamined use of the phrase 'mental health and wellbeing' with the proposal to adopt a dual-factor model that distinguishes between mental health and wellbeing. A broader concept of personal and social wellbeing is identified as central to school education aims.

INTRODUCTION

This paper examines some contemporary ideas about mental health, wellbeing and school education aims to illustrate important issues that bear on the relationship between mental health and education. Although the specific focus in this paper is on ideas and practices in England (e.g. Department for Education, 2019; Department of Health and Department for Education, 2017), the conclusions have wider international significance as schools internationally are called upon to meet the mental health needs of children and young people (WHO, 2017).

This focus on mental health provision within schools links to a general increase in the incidence of identified mental health problems amongst children and young people in England (Vizard et al., 2020). What has been represented as a mental health crisis (Thorley, 2016) is in the context of accounts of academic performance pressures within school (DfE, 2019). Current estimates are that 12.8% of children and young people (CYP) showed some evidence of mental disorder in 2017, with 5% having two or more mental disorders. (Sadler

et al., 2018). It was also estimated in the pre-Covid period that only 25% of CYP with a mental health problem accessed treatment (House of Commons, 2019). There is evidence of the Covid crisis worsening some mental health problems (Fox et al., 2020), but not all (Widnall et al., 2020), and reinforcing the perspective that schools have a central role.

This paper starts with an overview of the organisation of child and adolescent mental health services and how it positions the role of schools. It then examines prominent concepts of mental health and their relationship to wellbeing. This leads to a discussion of 'mentally healthy' schools, special educational needs (SEN) and the place of mental health in SEN whole-school approaches. This analysis recognises that mental health and wellbeing are linked but shows that how they relate has not been adequately worked out. The dual-factor model (Keyes, 2014) that separates mental illness/disorder from wellbeing as two related dimensions is used to connect wellbeing to school curriculum and aims. A fuller and nuanced conception of wellbeing is proposed as a way of thinking about what schools are for. The paper concludes with a model of the relationship between education and mental health services while recognising their distinctive goals.

SCHOOLS IN THE ORGANISATION OF CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

A public health model has been widely advocated internationally for mental health services (Power, 2009). This locates a broad range of interventions concerned with health promotion, prevention and support for wellbeing within mental health services. In England the National Health Service child and adolescent mental health service adopted a four-tier version of this public health model some years ago, conceptualised in the form of layers of a triangle (NHS, 1995; see Figure 1).

The layers in this tiered model represent the increasing intensity of intervention and treatment required for increasing severity of need. The triangular shape reflects the decreasing proportion of CYP at successive tiers.

Tier 1 services, called universal and applying to all CYP, are designed as preventative, with the aim of reducing the risk of mental health problems developing by promoting healthy behaviours and mitigating known risk factors. Tier 1 services, available in general services such as schools, children's centres and GP surgeries, are not necessarily delivered by mental-health specialists. Tier 2 services, called targeted, are for CYP who have been

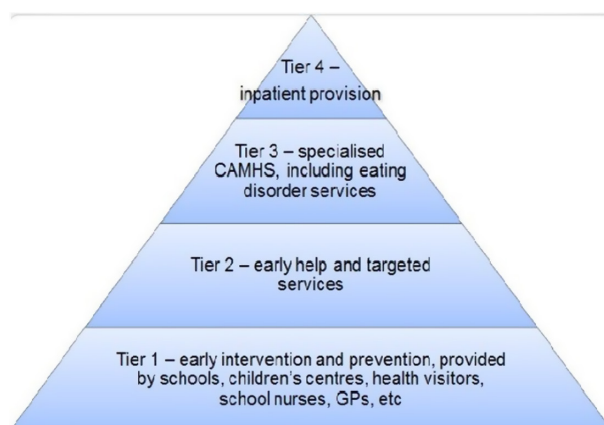


FIGURE 1 Four-tier child and adolescent mental services model [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com)]

identified as at risk of developing more severe mental health difficulties. They aim to intervene early to prevent 'emerging' or low-level mental health problems from worsening. These services can be delivered by a range of professionals in both universal and targeted settings in the community, including schools.

The more recent Thrive model is based on CYP needs in terms of types of inputs and their expected outcomes (Wolpert et al., 2014), and was developed in response to weaknesses of the tiered model. In Thrive, each grouping of need is equally important and to be given equal resource priority. Figure 2 shows the two sides of the same figure; the left describes the input that services offer to each group and the right describes the corresponding outcome state (Thorley, 2016).

The central sector in the Thrive model involves prevention and mental health promotion services, on the one side, and *thriving* as an outcome of these, on the other. This corresponds to tier 1 in the tiered model with its focus on community, including school mental health promotion and prevention work.

The four sectors represent groups of CYP who require distinctive services. One is located within the community including schools and involves self-management of temporary or mild difficulties which require one-off contacts to help children and families to help themselves, with a *coping* outcome (top-left sector). Education is the lead service which is talked about in terms of education/wellness, not in health/treatment terms. The next sector (top-right) involves interventions for CYP who will respond to evidence-informed interventions with *getting help* as the outcome. Health takes the lead and talk is of treatment/therapy. The third sector (bottom-right), an extension of the previous one, has *getting more help* as the outcome of services that are more intensive and take place in out-patient and in-patient settings. While the *getting more help* sector has marginal links to schools, the *getting help* sector has clear links through school-based helping and the last sector (bottom-left) also does, because it is about *getting risk support*. This is the outcome of services involved in managing a crisis response. The Thrive model recognises that there are no health treatments for some CYPs, who are risks to themselves and others. This group needs close inter-agency collaboration where social care might be the lead agency, with schools also involved. This might involve children with identified SEN, such as social-emotional and mental health (SEMH) difficulties, with a residential placement in a specialised setting or school.

It is also recognised that community mental health is not just a set of services to be referred into, but involves joined-up team work that supports other professionals (Department of Health, 2017), such as teachers in their school settings. It is also unclear whether the Thrive model is that different from the four-tier model. Although Thrive distinguishes between

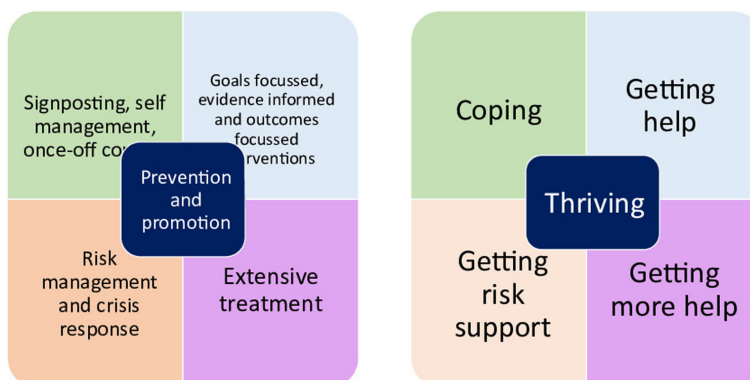


FIGURE 2 Thrive model (left panel as input and right panel as outcome state) [Colour figure can be viewed at wileyonlinelibrary.com]

inputs/services and outcomes with a focus on evidenced-based interventions, four of the five sectors of the Thrive model have links to tiers in the tiered model (thriving, coping, getting help and getting more help relate respectively to tiers 1–4). Despite Thrive recognising flexible services and inter-agency collaborations, it says little about the relationships between mental health, wellbeing and education, which will be examined now.

MENTAL HEALTH AND ITS RELATIONSHIP TO WELLBEING

At the centre of the argument in this paper is the relationship between what is meant by mental health and wellbeing in its UK use. The terms ‘mental health’ and ‘wellbeing’ are often used together, but without explaining their relationship (Ereaut & Whiting, 2008). For example, a well-known UK mental health voluntary organisation refers to CYP’s ‘mental health and well-being’ without details about their relationship (Young Minds, 2020). Another voluntary organisation focussing on ‘mentally healthy schools’ explains that:

your mental health affects how you feel, think and act. It refers to your emotional, psychological and social wellbeing. (Mentally Healthy Schools, 2020)

It continues:

Just as it’s important to look after your physical health, the same is true for your mental health. Your state of wellbeing affects how you cope with stress, relate to others, make choices, and play a part in your family, community, workplace and among your friends.

It is clear that mental health is being aligned with wellbeing – *mental health as wellbeing* – which is differentiated into emotional, psychological and social forms. Various consequences are then attributed to mental health as wellbeing, such as social emotional development and academic attainments. This *mental health as wellbeing* concept is the one proposed by the World Health Organization (WHO), when it states that mental health is a state of wellbeing in which:

- the individual realizes his or her own abilities,
- can cope with the normal stresses of life,
- can work productively and fruitfully, and
- is able to make a contribution to his or her community. (WHO, 2013, p. 6)

The WHO applies this concept of mental health to children by emphasising a developmental view about enabling full active participation in society, in these terms:

- having a positive sense of identity,
- ability to manage thoughts, emotions,
- build social relationships, and
- aptitude to learn and to acquire an education. (WHO, 2013, p. 6)

In this conception mental health is not just the absence of mental health disorders, difficulties or conditions, it has a positive meaning in terms of wellbeing. This has been referred to as positive mental health as distinct from negative mental health, which is also sometimes referred to as mental unwellness, mental illness or psychiatric or mental disorder (Schonfeld et al., 2017). This is the idea of a mental health spectrum which ranges from mentally healthy

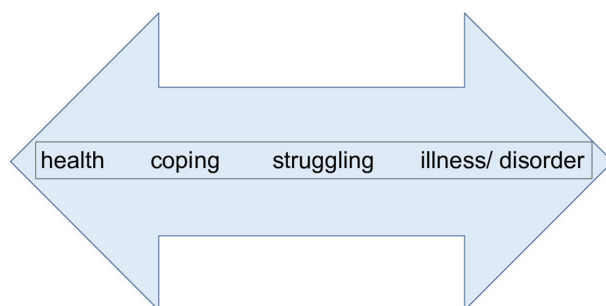


FIGURE 3 Mental health spectrum [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com)]

at one end through coping and struggling to being unwell or mentally ill/having a mental disorder at the other end (see [Figure 3](#): Mentally Healthy Schools, 2020).

Another way of representing this spectrum is to see the middle of the continuum, characterised as coping and struggling in [Figure 3](#), as involving mental health difficulties but not severe enough to be disorders, as diagnosed using some systematic medical diagnostic scheme, such as the International Classification of Diseases or the Diagnostic Statistical Manual. From this analysis, mental health as wellbeing can be seen as part of a one-dimensional model with positive mental health as wellbeing at one end and negative mental health as mental illness or psychiatric disorder at the other end. There is some affinity between this one-dimensional spectrum conception and the four-tier model ([Figure 1](#) above) of mental health services, with the tiers representing the positions along this spectrum.

There is an alternative conception of mental health–illness which considers mental health and wellbeing as a separate dimension from mental disorder or illness. In this conception there are two dimensions, a dual-factor model: (i) psychiatric disorder – no disorder; and (ii) high mental health (flourishing) – low mental health (languishing) (see [Figure 4](#)).

In this model, the mental health as wellbeing dimension is distinct from, but related to the mental illness/psychiatric disorder dimension (Keyes et al., 2002; Keyes, 2014). This means that it is possible for someone to be identified as having a mental health difficulty and be flourishing, on one hand, and on the other, for someone to be languishing without a psychiatric disorder. Other US research has underpinned this distinction between a mental health difficulties/disorders dimension and a mental health (wellbeing) dimension in adolescents (Antaramian et al., 2010; Moore et al., 2019). More recently, based on extensive UK studies of well-being, the Children's Society (2019) also concluded that: 'Children may thus have low subjective well-being without, and high subjective well-being despite a diagnosis of mental illness' (p. 13). There is also some endorsement of this dual-factor model by the UK Department of Health (2014).

The dual-factor model is not assumed to depend on a biomedical causal model, which sees that psychological distress can be understood as an illness/disorder originating in individual bodies. The high–low mental illness dimension is compatible with a bio-psycho-social model (Benning, 2015), which recognises the circumstances of people's lives (e.g. experiencing poverty, discrimination, abuse, trauma) as major causes of mental distress. Nevertheless, the bio-psycho-social causal model has been criticised for over-privileging the biological, the focus on pathology and the individual rather than relationships, community and culture, which are recognised by the Power Threat Meaning framework (Johnstone et al., 2018). However, this alternative Power Threat Meaning framework with its focus on social and material factors does recognise biological/genetic factors, while also accepting that some adaptations are less functional than others. The point that needs to be made here is that although the extent to which psychological distress is based on 'power imbalances'

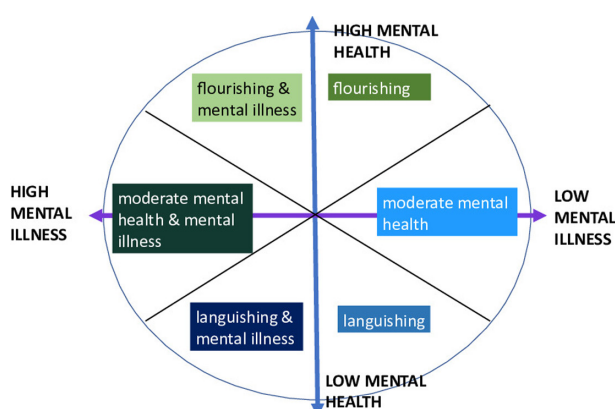


FIGURE 4 The dual-continua model of mental health and mental illness (Keyes, 2014) [Colour figure can be viewed at wileyonlinelibrary.com]

rather than ‘chemical imbalances’ (UNHRC, 2017, p. 19) is a continuing issue, it does not bear directly on the focus of this paper.

Despite the emphasis on a positive concept of mental health, there has been some scepticism about whether the widespread use of ‘mental health’ is just a euphemism for mental illness (Cattan & Tilford, 2006). Kendall-Taylor and Mikulak (2009) showed, for example, in a US interview study with prominent child mental health experts that they did not have a working concept of child mental health. These experts focussed on child mental illness, with little mention of what it means for children to have mental health. In a more recent Canadian study, Manwell et al. (2015) showed a lack of consensus about defining mental health through an international interdisciplinary expert dialogue. Most participants preferred the Canadian Public Health Agency (PHAC) (2006) definition to the WHO one (quoted above), with 30% considering that none were satisfactory. The PHAC definition was:

Mental health is the capacity of each and all of us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity. (p. i)

For the purposes of this paper the mental health dimension of the dual-factor model will be represented in terms of wellbeing. This is in keeping with the WHO and PHAC positions, as discussed above, about mental health as a state of wellbeing, as shown in Figure 5. This represents the dual-factor model as one of mental health difficulties and of wellbeing. Further reasons for this move will be explained in what follows.

CONCEPTIONS OF WELLBEING

Wellbeing is a term used pervasively in public and academic discourse, across different fields and disciplines. Ereaut and Whiting (2008) have charted its UK growth since the 1970s with different meanings projected on to it but with few commonalities, other than ‘it’s a good thing’. For some, the uncertainty about, and lack of critical analysis of wellbeing is framed as how wellbeing discourse is used and what it does (McLeod & Wright, 2016). For these authors wellbeing, from a critical discourse perspective, has become a key term with policy force. Ereaut and Whiting (2008) also suggest that wellbeing does not have a fixed meaning

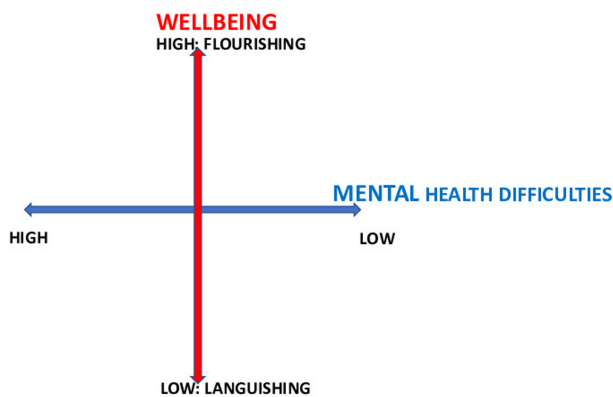


FIGURE 5 Dual-factor model of wellbeing and mental health difficulties [Colour figure can be viewed at wileyonlinelibrary.com]

as it is primarily a cultural judgement, like responses to questions, such as, ‘what makes a good life?’ As such, clarifying wellbeing involves basic philosophical positions, some of which will be discussed below.

From a contemporary positive psychology perspective, wellbeing is a complex concept with a distinction made between an objective version of wellbeing – having resources to meet basic needs in terms of social norms and values – and a subjective version of wellbeing which relates to subjective experiences. Subjective wellbeing is associated with many terms such as happiness and flourishing which are often used interchangeably. Within subjective wellbeing a distinction is made between a focus on emotions (hedonic wellbeing) and a focus on what is taken as the optimal functioning that makes for a ‘good life’ (eudaimonic wellbeing). Some models of wellbeing have integrated hedonic and eudaemonic forms, for example, the PERMA model, covering P for positive emotions, E for engagement, R for relationships, M for meaning and A for accomplishments (Seligman, 2011). Others have dealt with the complexity of wellbeing in a child protection context (Semanchin Jones et al., 2015).

However, these conceptions of wellbeing are mainly about individuals (see Figure 6). This has prompted a critique that this concept of wellbeing is too much about individual feeling and functioning and not enough about the social organisations and communities to which individuals belong. This indicates the need to include more collective indicators of social ties, as found in the ecological wellbeing framework (La Placa et al., 2013). Along similar lines, Taylor (2011) has criticised the pre-occupation with a wellbeing that is individualised and

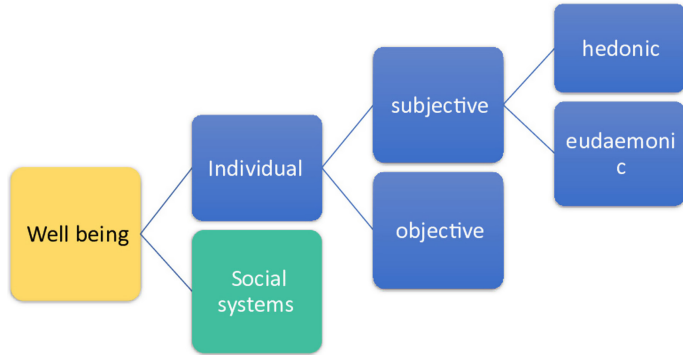


FIGURE 6 Types of wellbeing [Colour figure can be viewed at wileyonlinelibrary.com]

marketised, so detracting from the collective social provision of material conditions in which much individual wellbeing is lived. He presents a conception of wellbeing that is a process, not just an outcome, is relational and contextual. This is a critique of individualised wellbeing that is overly based on rational cognitive action, downplays emotions and overlooks those living in less than optimal conditions: those who live 'well enough' and do not meet the 'wellbeing ideal' (Edwards & Imrie, 2008). Schools clearly have a significant role in such an ecological/social and relational approach to wellbeing.

MENTALLY HEALTHY SCHOOLS AND SEN WHOLE-SCHOOL APPROACHES

Given the complexity of wellbeing, questions can be asked about its uncertain relationship to mental health, with its use as the unitary notion of 'mental health and wellbeing'. For instance, one leading UK voluntary organisation advocates for a whole-school approach in which 'positive mental health and wellbeing' values are fundamental to a school's mission and culture (Mentally Healthy Schools, 2020). Mental health is sometimes qualified by emotional health in the unitary 'mental health and wellbeing', as in Public Health England's (2015) promotion of a whole-school approach to support 'emotional health and wellbeing'. This is consistent with a social-emotional version of wellbeing that is also evident in the WHO (2013) formulation of mental health, as discussed above.

This emphasis on the social-emotional is also found in Government advice to English schools about adopting a whole-school approach to promote 'good mental wellbeing' (p. 3; DfE, 2018). This whole-school approach involves: (i) prevention, (ii) early identification, (iii) early support and (iv) access to external specialist support. Although this advice refers to the identification and provision for pupils with SEN in schools, it is not recognised that the two systems (mental health and SEN) are overlapping and interacting.

The whole-school mentally healthy school scheme tends to overlook the scope of the school SEN system, in which SEMH difficulties is a major area of SEN provision (section 3.25, DfE, 2018). The SEN system covers the range of learning difficulties and disabilities, currently organised under four areas: cognition and learning; sensory and motor; communication and interaction; and SEMH. About 2–3% of pupils are identified at the more severe level and have a statutory plan (being in both ordinary and special schools), while about 14% of pupils are identified at the School Support level (only in ordinary schools). Currently 17% of all pupils with a SEN in primary, secondary and special schools have their SEN related to SEMH difficulties. Overall, SEMH was the third most frequent area of SEN after moderate learning difficulties and speech, language and communication needs (DfE, 2019). These figures probably underestimate the extent of emotional and behaviour difficulties as they only represent where SEMH is the primary concern and not a secondary concern.

It is also significant that adopting the SEMH term represents the language of mental health difficulties that capture the full range of psychiatric disorders. The SEN Code of Practice (DfE & DoH, 2015) makes reference to anxiety disorders, attention deficit disorder, attention deficit hyperactive disorder and attachment disorder. Challenging, disruptive or disturbing behaviours are also recognised if they reflect mental health difficulties. This qualification acts to prevent everyday school behaviour problems from becoming a SEN. However, the SEMH category makes no reference to what have been called behaviour disorders, e.g. conduct and oppositional defiant disorders, which are part of most psychiatric classifications. This is another way in which the current meaning of the SEMH category emphasises the social-emotional aspects of mental health difficulties.

Despite these links between mental health and SEN, whole-school approaches framed in mental health and wellbeing terms are detached from whole-school approaches focused on

SEN, often called inclusive schools. This is despite similarities in the management of a mentally healthy school and SEN friendly or inclusive schools. Also, the DfE (2018) advice for a whole-school approach for promoting 'good mental wellbeing', as discussed above, involves tiers that resemble the four-tier child and adolescent mental health service model (NHS, 1995), but they are not connected. Where the school tiered model is distinctive is in being about school actions, programmes and ethos, that connect with other SEN areas, reflecting the responsiveness of school provision to diverse needs to promote inclusive schooling.

It is also notable that Government advice to English schools about whole-school approach tiers (prevention, identification and early support and access to specialist support; DfE, 2018) differs from the US use of the tiered model. The US use is based on a social-emotional and behaviour Response to Intervention model (see Figure 7 above). In the US model movement from one tier to another depends on student response to provision (intervention; Gresham, 2005; Pavri, 2010).

CURRICULUM AND SCHOOL AIMS PERSPECTIVE

This disconnection between mental health and SEN systems is partly about their distinct education and health service bases. Not only is the four-tier model (NHS, 1995) mostly difficulties focussed, but the Thrive model is vague about the 'thriving' sector (Wolpert et al., 2014). The thriving sector's reference to 'prevention' in 'prevention and promotion initiatives' is about mental health difficulties. However, it is less clear whether 'promotion' is about increasing knowledge, understanding and management of emotional and mental distress and/or promoting positive mental health and/or wellbeing? As the paper proceeds, the links of this unitary phrase 'prevention and promotion' to the above analysis of 'mental health and wellbeing', in terms of the dual-factor model will emerge.

Schools have historically been a setting for health promotion, which has more recently been about health education and a healthy school environment (the statutory English curriculum now includes health education). Comprehensive school health promotion programmes, such as the WHO's 'health promoting schools' initiatives, have been about schools strengthening their capacities as 'healthy settings for living, learning and working' (Parsons et al.,

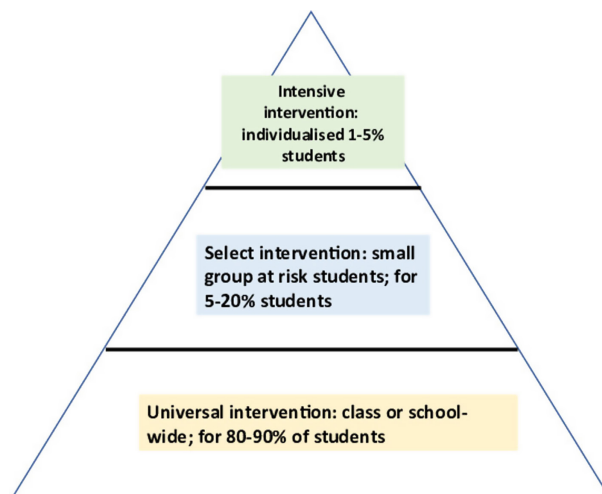


FIGURE 7 Social-emotional and behaviour RTI tiered model [Colour figure can be viewed at wileyonlinelibrary.com]

1996). Empirically these initiatives have adopted the broad WHO definition of health as physical, mental and social wellbeing (WHO, 2013), which has stretched the health concept beyond the traditional health interventions used in these 'health promotion' programmes. As Konu and Rimpela (2002) argue, these programmes have their conceptual basis in theories of health promotion not in concepts of wellbeing, a point that is relevant to presentations of social and emotional learning (SEL) as a public health approach to education (Greenberg et al., 2017).

There have also been substantial international research and development programmes about promoting the social and emotional well-being of CYP as an important determinant of their development (OECD, 2015). This has led to the development of the concept of and practices associated with SEL as a part of classroom and whole-school approaches (Humphrey, 2013; Oberle et al., 2016). However, with the historic prioritising of cognitive/academic programmes in schools, the social-emotional aspects of learning can become marginalised (Carmel & Cavioni, 2015). To counter these risks, Weare and Markham (2005) have advocated for the use of the terms 'emotional and social wellbeing' rather than 'mental health', even though they argue that schools need positive mental health models. Their concept of a whole-school approach (WSA) draws on elements of the health-promoting schools model (ethos, organisation, management, relationships and environment) as well as curriculum and pedagogic practices. Although they refer to evidence that WSAs have more positive outcomes when implemented for more than a year and when aimed at mental health promotion rather than preventing mental illness, they confine their ideas of promotion to a limited focus on social-emotional wellbeing. Nor do they deal with the gap between the evidence-based research being about single programmes rather than system-wide or WSAs.

This gap is recognised by Barry et al. (2017), who also address the challenges to integrating SEL programmes into routine school practices, e.g. competition in crowded curriculum, training and support for teachers to connect academic and SEL skills as part of everyday practice. In doing so they illustrate how a common set of evidence-based practices can inform implementing a WSA that is also based on student consultations. Hurry et al. (2021) also note that the evidence for WSA approaches in this field is mixed, probably because of poor implementation. They also recognise the two dimensions of mental health, but do not examine the basis or significance of these dimensions, despite their aim to review support for mental health and wellbeing from an educational perspective.

This paper goes further than the above authors in using the dual-factor model of mental health in two ways. The first is to link the distinction between the *prevention and remediation/helping mental health difficulties* with *health/medical aims* and the *promoting of wellbeing* with educational aims. The rest of this paper will elaborate on this linking. The second way is to argue that the mental health difficulties dimension has come to dominate the wellbeing dimension. This has been through the way that wellbeing, which is potentially the broader and richer concept, has come to be qualified by mental/emotional health, through framing it as 'mental health and wellbeing' or 'emotional wellbeing'. There are wider social and economic reasons for this domination, but it persists partly owing to an oversight and avoidance of thinking about the purposes of schooling, what schools are for and the role of more elaborate models of wellbeing in school education.

WELLBEING AS A WAY OF THINKING ABOUT WHAT SCHOOLS ARE FOR

There have been few attempts to examine empirically the aims of schooling in wellbeing terms. In one using policy discourse analysis and teacher interviews, Spratt (2016) studied the role of education for wellbeing by analysing a Scottish Government curriculum paper

which framed wellbeing in terms of 'health and wellbeing'. Wellbeing themes of physical health, social-emotional literacy and care were identified. Themes associated with flourishing, eudaimonic wellbeing, were not. The identified themes were framed as enabling the engagement with education, a condition for education, rather than wellbeing being an outcome of education. In contrast, teachers represented wellbeing as both a condition for engaging in education and as an outcome of teaching, e.g. through the choice of curriculum content. Wellbeing aims have, concluded Spratt (2016), important implications for the curriculum, teaching and learning.

From a theoretical perspective, Konu and Rimpela (2002), based on their critique of the linking of health with wellbeing in WSAs to health promotion and SEL, propose a model of wellbeing grounded in Allardt's Scandinavian based theory of welfare. In Nordic languages the word for welfare stands for wellbeing, so Allardt's theory is presented as being about wellbeing. Wellbeing is seen to change over time and to be judged in terms of basic human needs: material and non-material needs related to *having*, *loving* and *being*. From this a School Wellbeing Model is presented which links teaching and learning to wellbeing, which analyses these basic needs in terms of relevant school and personal conditions: having – school conditions; loving – social relationships; being – means of self-fulfilment; and health – health status. Konu and Rimpela's model is a rare illustration of how wellbeing broadly framed can have a central role in school programmes and not just as a condition for educational outcomes or as a peripheral agenda.

These sources show that thinking about the aims of schooling in wellbeing terms involves a broader concept of wellbeing as discussed above, one that goes beyond the limited mental health–social–emotional framing of wellbeing. In England, Peterson et al. (2014; see Figure 8) present a model of promoting CYP wellbeing in terms of their spiritual, moral, social and cultural (SMSC) development. The SMSC focus refers to an aspect of schooling that the English inspection agency (Ofsted) had been using in school inspections. What the Peterson SMSC model (Figure 8) offers is a broader concept of the development of student wellbeing in terms of practices in six areas that go beyond personal, social and health education (PSHE) as a subject of the taught curriculum to include school practices focussed on ethos, citizenship and student voice, and so representing a WSA. This is a model that reflects a broader concept of CYP wellbeing, as discussed above, but does still divide academic cognitive and non-cognitive goals and development.

This is where there is a need for further thinking about the role of schools to equip pupils to lead flourishing lives. This can be found in the philosophical tradition about the purposes of schools as promoting wellbeing (Kristjánsson, 2017; White, 2011). In this tradition schools are to promote the well-being of CYP based on a concept of wellbeing that White (2011) identifies as having two aspects: (i) meeting basic biological and other needs for self-respect and recognition; and (ii) the person as wholeheartedly and successfully engaged in activities and relationships that are intrinsically worthwhile. For White, education is about 'life building values' that give a meaning and purpose to life. However, there is no objective list of values, only some consensus within a culture which leaves room for different value weightings. Yet a life of wellbeing in an industrialised society involves autonomy to make choices between activities and relationships. So, an education for autonomous wellbeing implies that CYP be immersed in an adequate range of interesting activities and ways of life, which can be seen as the vital task for schools and other settings concerned with wellbeing. However, this task also involves expanding horizons beyond children's current interests to encompass what might be relevant to their later life interests, such as relationships with others which are central to wellbeing. So, the task of schools in this perspective goes further in extending the range of possible options in a vocational direction. With such extensions beyond current interests White sees some justification for some compulsory subjects, but this might also include activities like learning social communication and social skills. However, the key point

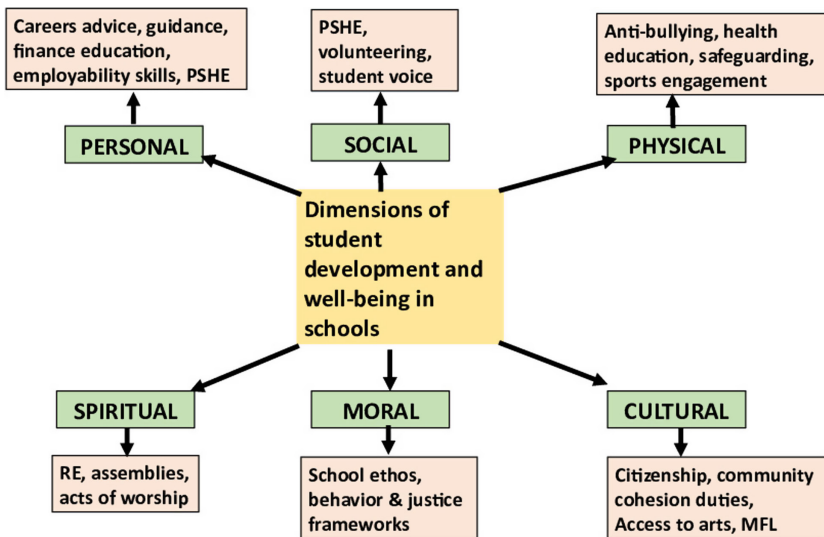


FIGURE 8 Model of spiritual, moral, social and cultural development (SMSC) in school (based on Peterson et al., 2014) [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com/doi/10.1111/berj.12111)]

is that this position reverses the current priorities for school curricula. An education for well-being would attend more fully to children's needs and their intrinsically chosen activities and less to a compulsory academic subject curriculum.

As Kristjánsson (2017) notes, this Aristotelian approach to schools promoting wellbeing as flourishing is not to be confounded with the recent emotional well-being perspective associated with self-esteem, emotional intelligence and mental health. This perspective has been linked to ideas of the emotionally vulnerable child, one criticised by Ecclestone and Hayes (2009) as a therapeutic turn in school education. In contrast, the flourishing perspective adopts a strength-based approach to student well-being, being about developing assets and enabling them to continue developing in a way related to eudaimonic aspects of wellbeing. This could allay traditionalist anxieties that wellbeing as flourishing is just about smuggling 'touchy-feeliness' into the classroom (Kristjánsson, 2017, p. 88). In relation to this point, Cigman (2012) has criticised the polarised thinking about the purposes of education, as about knowledge vs. enhancement, with enhancement understood as wellbeing. She sees this as leading to a radical but untenable position that school subjects are answerable to a wellbeing test. Cigman's concern is that those proposing a wellbeing enhancement position devalue and undervalue the knowledge disciplines, without realising that learners can come to value them intrinsically through a patient process of teaching and learning. However, it seems that what Cigman is criticising here is a hedonic version of wellbeing, rather than the wider notion that also includes eudaimonic aspects, as recognised by White (2011) and Kristjánsson (2017).

What a critique of the therapeutic turn ignores (Ecclestone & Rawdin, 2016) is that a rounded and balanced concept of wellbeing includes meaningful work and academic challenge and does not split the interconnections between the intellectual and the social-emotional aspects of learning (Thorburn, 2015). While there may be a difference of emphasis between the White and Cigman positions, there is potential for some common ground which would depend on a pluralist concept of school aims. One such account identifies three broad aims as proposed by Biesta (2019): (i) qualifications (knowledge, skills and understanding for navigating complex modern societies and for occupational purposes); (ii) socialisation (a sense of orientation to many traditions and practices that make up modern

societies and life); and (iii) subjectification (a concern for the student as subject of their own actions for their own wellbeing, but also as a democratic citizen who can make up their own mind and not simply follow orders). Subjectification expresses the German tradition of educational thinking known as *Bildung*, which is about CYP exploring their own individuality, with implications for wellbeing (Spratt, 2016). Seen as personal development guided by active reasoning, *Bildung* can be seen to counter an excessive socialising aspect of schooling (Brostrom, 2006). Qualifications might also undermine what is sought in terms of subjectification (Biesta, 2019). These three broad aims and their interactions provide a nuanced perspective on what schools are for and a basis for the development of personal and social wellbeing.

CONCLUSIONS

The paper concludes with the proposal that the dual-factor model of mental health difficulties and wellbeing (see Figure 5) has implications for clarifying the relationships between school education and mental health. This model implies that the terms 'mental health difficulties' and 'wellbeing', despite their relationship, should be framed as different. The former dimension is taken to refer to mental health difficulties and disorders, their prevention, support and treatment. The latter dimension is taken as the broader sense of wellbeing (see Figure 6) and related to a fundamental examination of what schools are for in terms of promoting wellbeing.

Figure 9 translates the two dimensions of the dual-factor model (wellbeing and mental health difficulties) into a two-dimensional framework that represents the distinctive aims of school education (wellbeing promotion) and mental health services (preventing, coping, helping mental health difficulties) relevant to an English context. So, school educational aims, along the vertical axis, are about promoting personal and social wellbeing (covering cognitive, physical personal/emotional, social, moral, spiritual and cultural areas). Mental health aims, along the horizontal axis, are about preventing, coping, helping mental health difficulties. Practices can be mapped in the space created by these axes. Practices which are between the promoting wellbeing axis and the diagonal are about school wellbeing aims, while practices which are between the preventing, coping, helping mental health difficulties axis and the diagonal are about health service aims. Those practices along the 45 degree dotted diagonal line reflect both wellbeing promotion and mental health preventing, coping and helping practices (e.g. school-based coping interventions; day and residential SEMH special schooling) – a merging of goals and services.

The practices identified above the diagonal in Figure 9 have been informed by Peterson et al.'s (2014) spiritual, moral, social and cultural model for the development of student wellbeing. This includes participative practices focussed on a school ethos of democratic citizenship and student voice, representing a holistic educational model within a whole-school approach. There are different ways of labelling and organising these practices, but what matters is the thinking about wellbeing which informs the practical design. Here two related philosophical traditions drawn on above are useful: the Aristotelian approach to schools promoting wellbeing as flourishing (Kristjánsson, 2017; White, 2011) and the German tradition of *Bildung*, in which CYPs explore their own individuality with implications for wellbeing (Biesta, 2019). Where these two traditions converge is on the importance of personal autonomy in underpinning wellbeing, but also that schools have other legitimate purposes that might undermine autonomy/subjectification. For White, there can be some justification for compulsory subjects, including, for example, the learning of social communication skills. For Biesta, school purposes also include socialisation and acquiring knowledge and skills, with these broad purposes potentially coming into tension with subjectification. How priorities are given to these broad school aims when they

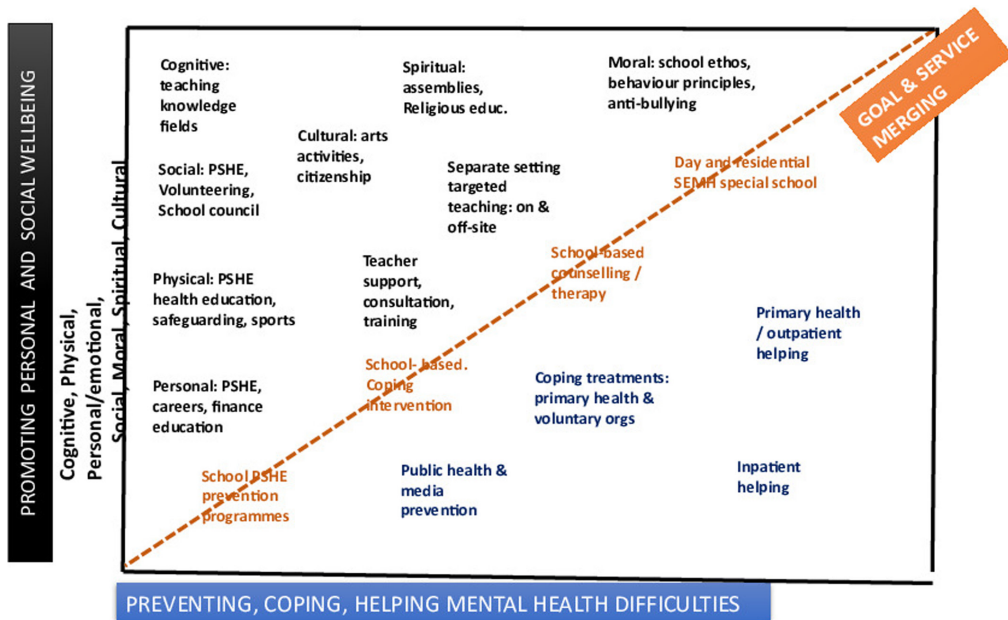


FIGURE 9 Relationships between promoting wellbeing and preventing /helping mental health difficulties [Colour figure can be viewed at wileyonlinelibrary.com]

interact is politically important. However, for the aims of this paper, the argument is to reclaim a broad concept of personal and social wellbeing as central to school education aims.

What this framework also provides is a broader conception of wellbeing that goes beyond narrower concepts of emotional wellbeing. In adopting the dual-factor model of mental health difficulties and positive mental health, the framework adapts it to include a broader social concept of wellbeing as flourishing that is linked to equity, social justice and personal dignity. In this way it replaces the language of positive mental health with the language of personal and social wellbeing and flourishing. In this sense the framework identifies the promotion of flourishing as central to school education and from an educational policy perspective it revives historic ideas about the purposes of schooling in terms of the development of society and individuals.

Keyes (2014), a leading proponent of the dual-factor model, has used evidence from a 10 year US longitudinal study to illustrate the influence of what he calls mental health promotion and protection (the wellbeing dimension) on mental health difficulties prevention and treatment (the mental health difficulties dimension of the dual-factor model). This study found that those whose flourishing declined over this period to a moderate level were just over three and a half times more likely to have a mental health difficulty after 10 years than those whose level of flourishing was sustained, other relevant factors being held constant. As Keyes argues:

The question is no longer whether we have any alternative to treatment for reducing mental illness – we do. ... The most important next step for researchers and practitioners is to discover how to get more people to stay or become flourishing. (Keyes, 2014, p. 190)

There is a key role for schools to promote wellbeing as flourishing, as argued above, but this is not just about a Response to Intervention tiered model as in Figure 7, or about establishing social emotional learning whole-school approaches, it is about a whole-school/curriculum approach

that involves considering what is learned and how it is taught and learned (e.g. Au & Kennedy, 2018). It is a framework that involves a rounded and nuanced concept of wellbeing that includes meaningful work and challenge. It also depends on a rounded and balanced approach to schooling that does not split the interactions between the intellectual and the social-emotional aspects of learning (Thorburn, 2015). Based on this it can be concluded that there is scope to further examine and develop these ideas through further empirical research in schools informed by the dual-factor model of wellbeing and mental health difficulties. There is also a renewed opportunity to lead and manage schools in terms of these broader ideas about wellbeing promotion.

ETHICS STATEMENT

Ethics approval was not required.

CONFLICT OF INTEREST

There is no conflict of interest.

DATA AVAILABILITY STATEMENT

There is no data to share.

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