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Work with Young People is Leading the Way in the New Paradigm for Mental Health

There has in recent years been copious discussion of new approaches to mental health, across all sectors. An attempt is being made to produce what is in effect nothing less than a major paradigm shift (Health Education Authority, 1997). This is a shift from the traditional medicalised approach, which is reductionist and problem- and usually illness-focused, and which has as its focus for enquiry and intervention the suffering individual. This model is being replaced by a wider, holistic and positive approach, which has as its outer parameter the promotion of positive wellness and is focused on understanding and changing the underlying psychosocial determinants of mental health. In this new paradigm, mental health promotion is no longer the province of medicine, or even the health services, but 'everyone's business'.

There has been much discussion of this new positive, social paradigm, but far less action to realise it in practice. Most work that goes under the banner of so-called 'mental health' tends to remain stuck in aspects of the old medicalised, illness-focused, individualistic paradigm.

Mental health promotion for young people has often been described as the 'Cinderella among Cinderellas' (Jezard, 2001), marginalised, under-resourced and of low status within mental health promotion, let alone in the health service. This marginalisation is generally thought to be a problem, as many contributors to this edition have pointed out. However, in some ways it has proved an advantage, as the lack of interest by those more in the

mainstream of mental health work has allowed mental health work with young people to flourish with a certain degree of isolation, and thus escape the domination by the medical profession and its attendant concepts of mental health that have dogged other sectors. Furthermore, the relatively circumscribed and controlled environment of the school has meant that work on mental health with young people has been able to make some progress in putting into practice aspects of the new paradigm in mental health that are proving harder to realise in other, less controllable contexts. The health-promoting school concept, described by Rowling in this issue, has been particularly key in helping to bring about fundamental change in health promotion for young people in some countries (Weare, 2000).

This commentary will therefore attempt to provide a certain antidote to the usual gloom and self-effacement shown by those who advocate on behalf of work in mental health and young people. It will examine various aspects of the new paradigm in mental health, explore ways in which mental health promotion for young people is making serious progress to implement the new paradigm in practice, and suggest ways in which other sectors might be informed by this example.

The new paradigm challenges the traditional Western approach to health, in which mind and body are conceived as separate, with mental health as very much the poor relation to physical health. Instead it takes a holistic approach, and one more familiar to Eastern views of health, in which

mental health is seen as integral, central and fundamental to the health and well-being of the individual, group and society. Perhaps because it is so evident to many who work with young people that their present and future physical health is indeed largely determined by aspects of their mental health (for example, their self-esteem and self-efficacy), schools have long put mental health at the centre of health and health promotion in a way that has not often been possible in other contexts.

The health-promoting school concept has always centralised the twin notions of the promotion of self-esteem and good relations with others in its criteria for a healthy school (WHO *et al*, 1993). So concrete proof of the recently coined maxim 'there is no health without mental health' is more likely to be found in school health promotion than elsewhere. Prioritising mental health has not always been as easy in other contexts in which the 'settings' approach has been applied, such as higher education (eg the health-promoting university), the workplace (eg the health-promoting hospital) and communities (eg healthy cities). Perhaps because mental health is more elusive and harder to translate into hard targets and indicators than physical health, these contexts have tended to find it easier to focus more on the promotion of physical health, usually through individual 'lifestyle' issues such as smoking cessation, exercise and diet.

The new paradigm stresses that the fundamental causes of mental ill-health, including the much discussed 'risk and resilience' factors, are at root social not individual. Some governments have made this link in their mental health policies and are attempting to tackle what are now seen as the underlying social determinants of mental health, such as poverty, unemployment, disaffection and social exclusion. Schools are realising that not only do they need to concern themselves with these underlying determinants, as the paper by Clarke and colleagues in this issue suggests, but also they need to apply the insights to their own operations, and look at the context they are providing as an organisation. Work on health-promoting schools has led the way in applying what Rowling in this issue terms the 'ecological' perspective. This ecological perspective is one which attempts to understand, and where necessary change, the dynamics of the whole organisation, including its management, ethos, relationships, physical environment and relations with the surrounding community, in order to facilitate health, rather than focusing on the mental states of the individuals within it (Parsons *et al*, 1996). Mental health promotion in other contexts has found it more difficult to focus on the whole organisation to the same extent. For example, in the workplace, perhaps because managers

have found it uncomfortable to refocus on themselves and the contexts they create, health promotion often remains largely fixated on the lifestyles of individual workers and, in so far as it considers mental health, sees it as the ability of the individual to 'manage stress.'

Perhaps one of the most striking features of the new paradigm is the frequent exhortation to take a 'positive' approach to mental health. The logical consequence of this is the use of 'universal' approaches to health promotion, in other words those which are aimed at the mental health of whole populations, not just those with problems. Such approaches are starting to be developed in school health promotion in some innovative whole-school programmes on mental health (including for example the Australian Mind Matters described in this issue by Hazell *et al*). If we include a consideration of whole-school approaches to what are in effect mental health, but which go under different names such as emotional literacy, emotional and social learning, personal and social education or Lifeskills (Weare, in press), such universal approaches are becoming fairly widespread. Meanwhile, in contrast much mental health work with the adult population tends to remain problem- and indeed usually illness-focused.

However the reasons for using universal approaches hold as good for the adult as for the young population. Universal approaches in schools have often been shown to be more effective than targeted ones, including in helping those with problems (Wells *et al*, 2001), and there is no reason to think the same would not apply in other contexts. Right across the whole population of all countries, mental health problems are both widespread and have a continuous/unimodal distribution. Targeting alone is therefore unlikely to be effective, as the cut-offs between those who have problems and those who do not are fairly arbitrary, and very many people who suffer from a problem to some extent will be ignored. Stigma is widely seen as a major block in working in mental health; it is far less stigmatising to work with everyone, which means that those with problems are more likely to use the services offered and feel positive about them than if they feel they are being singled out. Finally the principle of 'herd immunity' means that the more people in a community who are emotionally and socially competent, the easier it will be for them to help those with more acute problems (Stewart-Brown, 2000). So, for a variety of reasons, it is important that universal approaches are used more widely in the full range of sectors.

The new paradigm involves a shift from the medical view of mental health as a set of clinically defined disorders to a far broader, more inclusive and amorphous con-

cept of mental health. It thus becomes the concern of everyone, including not only a vast range of health, education and social work professions, but also all kinds of lay groups and interests, including people who are the target of interventions. This broader concept of mental health and the democratisation of its ownership bring with it enormous challenges of definition, which essentially boil down to the question of who defines what mental health is and how it should be promoted. The implications of this basic question are often not faced, however. At all levels and in all sectors we can see the tension between the impulse to 'get on with' what some see as the taken-for-granted task of promoting mental health and collecting data for the attendant evidence base, and the demands of others that we take a more critical perspective, and recognise that mental health promotion is a conceptually difficult, value-laden and highly controversial area (Tudor, 1996).

This tension remains unrecognised in much health promotion activity, which attempts both to be multi-sectoral and to proceed with traditional, largely medically defined problem- and illness-based definitions of what constitutes a mental health issue. In so doing it inevitably runs into the buffers when the various professional and lay parties involved find they do not subscribe to the same goals, or when the targets set for the collection of evaluation evidence do not match the aims of the activity. Finding ways first to recognise and then to resolve the major differences of definition that invariably crop up when we try to operate the new paradigm is one of the largest challenges that faces mental health promotion at present.

The various approaches to mental health promotion for young people taken in different parts of the world demonstrate starkly that there are distinctly different, usually ideologically driven, positions on what constitutes mental health. Many US and UK approaches to mental, emotional and social health in schools, including many of those under the banner of 'emotional intelligence' (Goleman, 1996), tend to define their goals in 'corporate' terms. They tend to take it for granted that to be mentally healthy is essentially to be an economically active producer and consumer, motivated by the long-term need to succeed on the promotion ladder by following direction, working steadily and avoiding risks and impulsive behaviour. This corporate model appears to be expanding its empire, for example into the newly capitalist countries of Russia and Eastern and Central Europe, but it does not go unchallenged. Certain European approaches, inspired particularly by the school system in Denmark (Brunn Jensen, 1997) and the vision of the World Health Organisation (WHO, 1997) emphasise instead autonomy, critical awareness,

empowerment, the building of ecologically sustainable and democratic communities and radical action for social change. It is important that the corporate model does not go unexamined and unchallenged, and that a plurality of concepts remain.

As well as the stark dichotomy described above, there are of course many other cultural variations on concepts of mental health and its promotion, as papers such as the one by Clauss-Ehlers and Lopez Levi on Latino young people in this edition demonstrate. Right across the sectors we need, as Rowling points out, to be aware of the assumptions that underlie interventions, and ensure that in our concern to help those with problems we do not pathologise, or impose solutions on different cultures and groups that are inappropriate to their needs.

Finally, the frequent emphasis in work that involves young people on the mental health needs of teachers and carers is a valuable pointer for ways forward in other sectors. In the school context considerable work has taken place on understanding and promoting the mental health needs of teachers. More challengingly, mental health promotion is now considering ways in which lack of self-awareness and lack of ease with mental and emotional matters may be causing some teachers to act defensively, because they find work on mental health personally threatening, and block the development of work in this area (Sharp, 2001). Other sectors could do well to think about the mental health needs and competences of those in control, such as managers, health care workers and politicians, who create the conditions that shape the mental health of groups, communities and society. There is a great need to 'refocus upwards' in our concerns, and critically examine and work on the mental health of those who 'run' society and who are able to hinder or facilitate attempts to create supportive environments and foster the mental well-being and emotional sensitivity of others. Taking such a genuinely holistic view of mental health, to include the policy makers as well as those for whom policies are made, is a challenge all sectors are only just beginning to face, but again mental health work with young people appears to be leading the way.

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