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A review of policies for adolescent mental health intervention in UK schools from the perspective of social governance

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Abstract. Adolescent mental health has become a global social governance issue. As one of the earliest countries to incorporate school-based mental health intervention into its national policy framework, the United Kingdom has undergone a policy evolution from "Universal CAMHS" to the "whole-school approach" and further to "Mental Health Support Teams". From the analytical perspective of social governance, this paper systematically reviews the theoretical foundations, institutional architecture, intervention pathways, and implementation effectiveness of UK policies on adolescent mental health intervention in schools. The study finds that the UK has established a tripartite intervention pattern of "external support systems—on-campus safeguarding strategies—digital empowerment", whose core experience lies in taking cross-sector collaboration as the institutional foundation, the "whole-school approach" as the practical paradigm, teachers as the key actors in early identification, and evidence-based evaluation as the quality assurance. However, structural tensions between funding cuts and professionalization demands, the contradiction between teachers' own mental health and their support capacity, and the problem of "increasing quantity but lagging quality" in intervention measures remain key bottlenecks constraining policy effectiveness. The UK experience provides important reference value for China in building a systematic, professional, and collaborative school mental health intervention system.

Keywords: social governance, UK, school mental health, intervention policy, whole-school approach

1. Introduction

Adolescent mental health is one of the core issues in global public governance, and the contradiction between its high prevalence and insufficient service provision has become a governance challenge commonly faced by countries worldwide. Globally, 10%–20% of adolescents experience varying degrees of mental health distress within a year, and most of them fail to receive timely and appropriate professional support [1]. Such problems not only impair adolescents' academic performance and social functioning but also extend into adulthood, giving rise to a series of problems such as employment barriers and difficulties in social integration, thereby driving up the long-term operating costs of public services. As a country that pioneered school-based mental health intervention, the UK has likewise seen a continuous rise in psychological problems in school settings.

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Based on survey data from the UK, Coates and Bingham pointed out that 78% of primary and secondary school teachers had encountered students with mental health distress in their work, and 14% of these cases involved self-harm ideation or related behaviors, highlighting the sustained pressure of demand for school mental health services [2].

As a typical field of public governance, adolescent mental health intervention in schools cannot be accomplished independently by a single department; its effective implementation requires the coordinated engagement of multiple actors, including education, health, local government, social organizations, and families, which is highly consistent with the core connotations of multi-actor participation, systemic construction, and precise provision emphasized by social governance theory. Since the beginning of the 21st century, the UK has gradually built a school mental health intervention policy system characterized by overall government coordination, frontline implementation by schools, professional support from the health system, and standard setting by professional organizations, forming a full-chain service model covering prevention, identification, intervention, and referral. Its evolutionary path and practical experience are of considerable value for comparative research. On this basis, from the perspective of social governance, this paper systematically reviews the evolution and institutional architecture of UK policies on adolescent mental health intervention in schools, analyzes their core implementation pathways and practical outcomes, reflects on the structural challenges in policy operation, and further distills implications for the development of China's school mental health governance system.

2. Policy evolution and institutional architecture

2.1. Policy shift from "universal services" to the "whole-school paradigm"

The institutionalization of school mental health intervention in the UK began with the green paper *Every Child Matters* issued by the Labour government in 2003. This policy, for the first time, established children's mental health as a priority of public services and put forward the core concept of "Universal Child and Adolescent Mental Health Services (Universal CAMHS)", advocating that mental health services should not be directed only at the minority with severe mental disorders but should cover all children and adolescents, spanning multiple tiers of services including health promotion, risk prevention, and early intervention. The *National Service Framework* introduced in 2004 further incorporated "mental health and psychological well-being" into the core standards system for children's services, clarifying the orientation that "children and adolescents' mental health is the shared responsibility of society as a whole".

After the coalition government came to power in 2010, the discourse of UK mental health policy shifted significantly. Through corpus analysis and critical discourse study, Callaghan et al. found that the frequency of expressions such as "children", "adolescents", and "CAMHS-specific services" in policy texts declined sharply, while the proportion of medicalized terms such as "mental illness" and "mental health problems" rose markedly; the policy positioning shifted from a specialized service framework for adolescents to a generic mental health governance system covering all age groups [3]. The core logic behind this shift is the "individualization" and "medicalization" of children and adolescents' psychological distress: the influence of socioeconomic factors on mental health was gradually downplayed, policy discourse placed greater emphasis on individual resilience and personal responsibility, and mental health problems were increasingly defined as medical issues requiring clinical intervention rather than public issues requiring systematic social responses.

Although the policy discourse shifted, the institutional framework of school mental health intervention in the UK did not dissolve; instead, it continued to iterate and optimize in the new governance context. In 2017, the UK Department of Health and the Department for Education jointly issued the green paper *Transforming*

Children and Young People's Mental Health Provision, planning an additional dedicated investment of 1.4 billion pounds over five years for the building of Mental Health Support Teams in schools, the strengthening of school mental health education, and the expansion of digital service channels. Based on policy evaluation, Foreman pointed out that the implementation effectiveness of school mental health policies highly depends on sustained dedicated funding guarantees and clear priority setting, and that policy design needs to balance service expansion with the planning of resource boundaries, so as to avoid structural contraction of service provision in non-priority areas [4].

2.2. The multi-actor collaborative external governance system

School mental health intervention in the UK exhibits typical polycentric governance features, forming a collaborative architecture in which the central government takes overall charge, professional institutions provide support, and localities carry out implementation. At the central level, the Department of Health and the Department for Education jointly formulate the top-level policy framework; National Health Service (NHS) England, under the Department of Health, coordinates the planning, layout, and funding allocation of mental health services, while the Department for Education is responsible for policy guidance and implementation supervision at the school level. At the regulatory level, the Office for Students supports universities and social institutions in carrying out innovative service practices through dedicated funding such as the "Mental Health Challenge Fund"; the Office of the Independent Adjudicator for Higher Education incorporates the quality of mental health service provision into its review of student rights disputes, using regulation to drive service implementation.

The health system is the core provider of professional school mental health services. The NHS and local health institutions at all levels undertake the professional diagnosis and treatment of students' mental illnesses. The *Five Year Forward View for Mental Health* released by the NHS in 2016 proposed the goals of shortening waiting periods for students' psychological diagnosis and treatment and promoting the connection of primary and specialist health services with schools; the long-term plan issued in 2019 further clarified the need to open up collaboration channels among the health, social security, education, and voluntary sectors. In practice, NHS professionals directly participate in the work of school health and well-being committees or go into schools to deliver mental health courses, forming institutionalized collaboration channels between the health and education systems.

Various professional organizations undertake the functions of knowledge intermediaries and standard providers in the policy system. The *Stepchange* policy framework released by Universities UK provides systematic guidance for the building of university mental health services; the Student Mental Health Association outputs specialized policy recommendations on scenarios such as dormitory management, tutor support, and peer mutual assistance; the Royal College of Psychiatrists provides professional grounds for policy optimization in the health and education systems from a clinical perspective.

2.3. The school-level internal support system

At the level of school-based governance, primary and secondary schools in the UK have formed an internal operating system of planning-led, team-based implementation, and cultural support. Xie's research shows that, in accordance with the statutory guidance of the UK Department for Education, most schools formulate independent dedicated mental health promotion plans, specifying core problem lists, standardized referral procedures, and family support schemes; schools set up dedicated mental health working teams, generally composed of a mental health lead, a special educational needs coordinator, school psychologists, and school doctors, to coordinate the implementation of mental health promotion affairs [5]. Meanwhile, schools regularly

conduct mental health training for teachers to improve their ability to identify and support students' psychological needs, and safeguard staff occupational well-being in accordance with the Workplace Wellbeing Charter, thereby ensuring the sustainability of school mental health intervention at the level of human resources.

3. Core intervention pathways and implementation mechanisms

3.1. The preventive intervention system of the "whole-school approach"

The "whole-school approach" is the most representative practical paradigm of school mental health intervention in the UK. Its core is to transcend the limitations of a single counseling room and integrate mental health promotion into all aspects of school culture, curriculum and teaching, management systems, and daily operations. This paradigm comprises six core dimensions: building a school atmosphere that supports positive learning and interpersonal development; creating a safe campus environment against bullying and violence; providing universal support to all students in conjunction with parent groups; offering targeted assistance to students at psychological risk; incorporating mental health policy into the school's overall governance framework; and providing teachers with specialized training and occupational support.

At the practical level, primary and secondary schools in the UK advance universal preventive education through the dual tracks of formal curricula and informal activities. The formal channel centers on Personal, Social, Health and Economic Education (PSHE) courses, systematically delivering skills teaching on emotion management and interpersonal communication, and designing thematic counseling courses for common psychological problems such as anxiety and depression; informal channels, through forms such as campus emotion charts, themed assemblies, parent forums, and mindfulness practice, permeate mental health promotion into daily school scenarios. Sapthiang et al.'s research on school-based mindfulness interventions shows that such universal programs can expand coverage through digital platforms, improving the accessibility of interventions while reducing service costs [6].

3.2. Early identification: the role and tension of teachers as "gatekeepers"

Under the whole-school governance framework, teachers stand at the forefront of early identification of students' mental health, undertaking the "gatekeeper" function of risk screening and initial support. Schools in the UK carry out risk identification mainly through three approaches: daily observation, information system analysis, and professional assessment. Teachers capture changes in students' emotions and behaviors through channels such as daily interaction, "worry boxes", and psychological hotlines; schools establish mental health information files for students, recording family background, academic performance, attendance, and other information to assist in judging students' psychological states; for students suspected of being at risk, professionals conduct formal assessments using standardized psychological measurement tools.

However, the implementation of the teacher role faces significant constraints of capability and conditions. Palmer et al.'s survey of 320 primary and secondary school teachers in the Birmingham area showed that 78.5% of respondents were currently under moderate or higher work stress, 91% of teachers had experienced moderate-to-high work stress in the past two years, and time pressure and workload overload were the most core sources of stress [7]. The high-stress state directly weakens teachers' willingness and capacity to invest in students' psychological support: some teachers, due to their own emotional exhaustion, actively avoid taking on additional duties such as after-school counseling, and even deliberately reduce contact with students during break time; only 17% of respondents had ever sought professional help for work stress, 23% of teachers coped with stress through smoking or drinking, and only 8.4% of teachers used psychological methods to regulate

their emotions. This study reveals a deep contradiction in school mental health governance: policies expect teachers to be the first line of defense for students' mental health, yet there is a significant gap between teachers' own mental health needs and the provision of support.

The actual effectiveness of training programs aimed at improving teachers' capabilities is also disputed. Anderson et al.'s systematic review showed that mental health training for teachers is significantly effective in improving knowledge reserves and cognitive attitudes, but the evidence at the level of changing teachers' actual helping behaviors is very limited; the only two relevant randomized controlled trials both found that training did not significantly increase teachers' actual support behaviors [8]. This means that improvements at the level of knowledge and attitudes are difficult to translate directly into effective intervention practice, and changes in teacher behavior are also constrained by multiple factors such as the school environment, time resources, and teachers' own psychological states.

3.3. Tiered intervention: the service chain from universal prevention to specialist referral

School mental health intervention in the UK has formed a clear three-tier service stratification: the first tier is universal prevention for all students, relying on curricula and campus activities to enhance overall psychological literacy; the second tier is targeted early intervention for students with mild to moderate psychological distress, including diverse forms such as school counseling, play therapy, art therapy, and peer support; the third tier is specialist referral, referring students with severe mental disorders to CAMHS for specialist clinical diagnosis and treatment.

School counseling is the core carrier of second-tier intervention, among which Place2Be is the largest charitable provider of school counseling in the UK, covering hundreds of primary and secondary schools. Toth et al. analyzed service data from 8,893 children receiving counseling in 291 primary schools and found that the core problems presented by children were, in order, generalized anxiety (73.1%), attention difficulties (71.3%), low self-esteem (70.6%), strained family relationships (67.2%), and emotional fluctuations (67.0%); 55% of children had at least one severe-level psychological problem, reflecting that a considerable proportion of students referred to school counseling already had relatively prominent psychological problems [9]. Daniunaite et al.'s evaluation of intervention effects among 3,222 primary school pupils receiving play therapy showed that pupils' total scores on the Strengths and Difficulties Questionnaire (SDQ) declined significantly after the intervention, with an effect size of $d = 0.48$, and the clinical symptoms of 50.3% of children improved, but 15.4% of children still showed symptom deterioration, reflecting the limitations of school-based intervention [10].

The operation of the referral mechanism also faces blockages. Neufeld et al.'s research showed that CAMHS rejected 23% of children and adolescents referred by general practitioners and teachers, and there is a significant gap between service access thresholds and actual needs [11]. A large number of students in the "middle ground"—that is, those with psychological distress who do not meet the diagnostic criteria for specialist services—can neither obtain CAMHS's clinical support nor are covered by schools' universal services, falling into a vacuum of service provision.

3.4. Digital transformation: innovative exploration of intervention models

In recent years, digital technology has gradually been integrated into all aspects of school mental health intervention, becoming an important support for service expansion and model innovation. The UK's exploration in the field of digital mental health provision covers multiple dimensions: first, optimizing psychological data collection tools to improve the precision and efficiency of surveys on students' psychological conditions through digital platforms; second, building a unified system for psychological state

assessment and data collection, and establishing regional databases of students' mental health; third, developing early warning tools that identify students at risk of psychological crisis by mining multi-dimensional data such as social media use, classroom participation, and library borrowing. Meanwhile, various online service platforms have developed rapidly, providing students with self-help learning resources, peer support channels, and service referral entry points, breaking the temporal and spatial limitations of offline services.

Lei Feng's research points out that digital interventions have significant advantages in expanding service coverage and reducing provision costs, but they can hardly fully replace face-to-face professional support, and may exacerbate service exclusion of disadvantaged student groups due to the digital divide; it is necessary to establish an effective linkage mechanism between technological tools and professional services to ensure the professionalism and fairness of digital services [12].

4. Evidence-based evaluation of intervention effects and practical controversies

One of the important features of the UK's school mental health intervention system is its emphasis on evidence-based practice, testing the effectiveness of intervention measures through large-scale empirical evaluations to provide grounds for policy optimization.

The randomized controlled trial conducted by Wolpert et al. on the UK's "Targeted Mental Health in Schools (TaMHS)" project is one of the largest empirical studies in this field [13]. Covering 8,480 children aged 8–9 in 266 primary schools, the study showed that the intervention significantly reduced the degree of behavioral difficulties among students at risk of behavioral problems, with an effect size of $d = 0.24$, but the improvement effect on emotional difficulties did not reach statistical significance. Meanwhile, the quality of collaboration between participating schools and local professional mental health institutions improved significantly, and the types of evidence-based interventions schools could provide became more diverse.

Evaluations of universal interventions, by contrast, have shown more complex results. The large-scale randomized controlled trial conducted by Sharpe et al. covered 14,690 students in 846 schools and evaluated the intervention effect of mental health self-help booklets on students; the results showed that the booklets had no significant impact on students' mental health levels, quality of life, or help-seeking behavior [14, 15]. This study raised prudent doubts about the "low-cost, wide-coverage" mental health promotion strategy, pointing out that policy-making needs to be based on rigorous evidence-based evaluation to avoid the blind promotion of intervention measures lacking empirical support.

On the whole, the effects of school mental health intervention in the UK show differentiated characteristics: the effects of targeted behavioral interventions are relatively clear, whereas the evidence for the effects of universal emotional promotion and self-help interventions remains insufficient; teacher training is significantly effective at the cognitive level but is difficult to translate into actual behavioral change and improvement of student development outcomes. This differentiation also reflects the complexity of school mental health intervention: intervention effects depend not only on the design of the program itself but are also moderated by multiple factors such as the implementation environment, personnel capabilities, and the characteristics of target groups.

5. Governance dilemmas and implications for China

5.1. Structural dilemmas of school mental health governance in the UK

First, the structural contradiction between funding provision and service demand. From 2010 to 2013, the UK's CAMHS budget was cut by 50 million pounds, an effective reduction of 6%, while demand for adolescent mental health services continued to climb during the same period. Available data show that in the 2014/2015 school year only 25% of children and adolescents with mental disorders had access to professional mental health services, a marked decline from 38% in the 2005/2006 school year; the contraction of funding directly weakened the accessibility of services.

Second, the gap in service provision in the "middle ground". As noted above, a large number of students in a subclinical state or with mild to moderate psychological distress neither meet CAMHS's specialist service access criteria nor need only support within the scope of universal school services. Although Mental Health Support Teams are by design intended to fill this gap, the low-intensity interventions they provide can hardly meet the complex needs of students with special educational needs, neurodiverse groups, and disadvantaged students, and significant loopholes remain in the articulation between service tiers.

Third, the structural shortage of professional personnel. The field of school mental health in the UK faces the systemic problem of insufficient supply of professionals, and the training scale of school counselors and educational psychologists falls far short of demand growth. Relevant surveys show that of the 24 schools surveyed, most had not included mental health in new staff induction training, and in some schools mental health support work was undertaken by non-professionals such as teaching assistants and librarians, making the quality of professional provision difficult to guarantee.

Fourth, the inherent tension of the teacher role. The implementation of teachers' "gatekeeper" function has always been constrained by their own work stress and mental health levels. Highly demanding work not only weakens teachers' capacity for psychological support but may also negatively affect students' mental health through negative teacher-student interactions, challenging the underlying logic of the "whole-school approach": if the school itself is an important source of teacher stress, then student mental health promotion that relies on teachers may fall into a self-defeating dilemma.

5.2. Implications for school mental health governance in China

First, build a cross-sector collaborative governance mechanism and consolidate institutional guarantees. The UK's practice shows that the effectiveness of school mental health governance highly depends on institutionalized collaboration among education, health, local government, and social organizations. China needs to accelerate the establishment of cross-sector coordination mechanisms, clarify the division of responsibilities among education, health, civil affairs, and other departments, open up referral channels between schools and medical institutions, break down departmental barriers, and form a governance pattern of collaborative co-governance by multiple actors.

Second, advance the implementation of the "whole-school" paradigm and strengthen prevention first. The core experience of the UK's "whole-school approach" is to upgrade mental health from a specialized intervention to an organic component of the school's overall governance, integrated into all scenarios of culture, curriculum, and management. China's school mental health development should transcend the limitation of "relying solely on the counseling room", incorporate mental health promotion into the school's overall development planning, run it through all aspects of curriculum and teaching, campus culture, management systems, and home-school cooperation, and promote the transformation from "after-the-fact remediation" to "before-the-fact prevention".

Third, attach importance to teachers' mental health and consolidate the human resource foundation for intervention. The high-stress state of UK teachers and its negative impact on their capacity to support students carry an important warning significance for China. While improving teachers' ability to identify psychological problems, it is necessary to simultaneously attend to teachers' own mental health needs, improve the occupational support system for teachers, reduce the risk of occupational burnout, and ensure the sustainability of the human resource foundation for school mental health intervention.

Fourth, establish an evidence-based evaluation mechanism to ensure intervention effectiveness. The UK's experience shows that not all intervention measures can achieve the expected results, and "low-cost" interventions lacking empirical support may cause a waste of resources. When promoting school mental health programs, China should establish a rigorous evidence-based evaluation system, conduct continuous evaluation of the effectiveness and safety of intervention measures, and avoid blindly promoting untested intervention models.

Fifth, prudently advance digital transformation, balancing efficiency and equity. Digital tools have outstanding advantages in expanding service coverage and improving service efficiency, but they also carry risks such as the digital divide and the replacement of professional services. In advancing the digitalization of mental health, China needs to reasonably position the auxiliary role of technology, ensure the effective connection between digital services and professional services, pay attention to the digital accessibility of disadvantaged student groups, and prevent technology from exacerbating inequity in services.

6. Conclusion

After more than two decades of evolution, UK policies on adolescent mental health intervention in schools have formed a governance system with the "whole-school approach" as the core concept, the tiered service system as the practical carrier, multi-actor collaboration as the institutional support, and digital innovation as the development driving force, providing an important practical sample for global school mental health governance. The core advantages of this system lie in its systematic and forward-looking nature: by embedding mental health promotion into the school's overall operation, it moves the governance threshold forward; by establishing institutionalized collaboration between the education and health systems, it opens up the service chain from prevention to diagnosis and treatment; and through the division of labor and collaboration among multiple actors, it activates resource advantages in various fields.

At the same time, it should also be seen that the UK's policy system still faces deep-seated structural contradictions: the tension between the continuous growth of service demand and the contraction of funding provision persists, the gap in provision in the "middle ground" between service tiers has yet to be filled, and the inherent paradox of the teacher role has not been fundamentally resolved. These contradictions essentially reflect the systemic characteristics of school mental health governance: its effectiveness depends not only on the design of intervention techniques themselves but is also constrained by broader social governance conditions such as public fiscal investment, teachers' occupational security, and the degree of social stigmatization.

For China, the UK's experience cannot simply be copied; rather, based on the local governance system and actual needs, China should absorb the UK's governance ideas of multi-actor collaboration, prevention first, and tiered intervention, break down departmental barriers, consolidate the human resource foundation, improve the evidence-based system, and gradually build a social governance system for adolescent school mental health adapted to China's national conditions, so as to truly achieve a balance between the universality and professionalism of mental health services.

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