Title: **From Targeted Interventions to Universal Approaches: Historicizing Wellbeing**

Authors: Katie Wright

Year: 2015

Publication: *Rethinking Youth Wellbeing: Critical Perspectives*

Funding: Australian Research Council Discovery Early Career Researcher Award DE140100060

DOI: 10.1007/978-981-287-188-6__12

Contact: Associate Professor Katie Wright
katie.wright@latrobe.edu.au

Full citation:

Wright, K 2015, From Targeted Interventions to Universal Approaches: Historicizing Wellbeing, in K Wright, J McLeod (ed.), *Rethinking Youth Wellbeing: Critical Perspectives*, Springer, Singapore, pp. 197-218.

From Targeted Interventions to Universal Approaches: Historicizing Wellbeing

Katie Wright

Abstract

Concern about high rates of mental health disorders amongst young people has underwritten a proliferation of social and educational policy aimed at improving youth wellbeing. This chapter examines educational concerns with mental health through a critical analysis of wellbeing as an object of educational policy and practice. It begins by considering the construction of mental health as an educational problem, in the past and in the present, and the policy solutions that have been developed in order to address this. It then explores how rising concern with the wellbeing of young people has fostered a shift from the historically narrow educational focus on targeted interventions – for students experiencing problems or identified as being at risk of mental health difficulties – to the more recent emphasis on universal approaches and preventative programs. The chapter concludes with some reflections on the seductive power of ideas of prevention and "psychological immunization" and considers the implications of this for contemporary educational policy and practice, and ultimately for understanding and promoting youth wellbeing.

Keywords

Educational policy. Mental health, Targeted interventions, Universal approaches, Youth wellbeing

From Targeted Interventions to Universal Approaches: Historicizing Wellbeing

Katie Wright

Introduction

Late in 2012, the Australian media reported with alarm that 10 % of children under 5 years of age experience mental health problems, and that a further 9 % of preschool aged children are at risk of developing a mental health disorder (Edwards and Martin 2012). This followed the announcement earlier that year of plans for the expansion of a federal government funded program, "The Healthy Kids Check", to provide screening for 3 year olds "for early signs of mental illness" (Stark 2012). The inclusion of measures to assess social and emotional development in the Healthy Kids Check is just one of a range of preventative strategies developed in recent years with the aim of improving the wellbeing and mental health of children and young people through interventions in primary health care, community and educational settings. For schools and early childhood centres, there are now frameworks for supporting mental health and wellbeing that cover the period from infancy through adolescence. MindMatters (2012), KidsMatter Primary (2012) and KidsMatter Early Childhood (2012) are prominent Australian examples in which prevention, early intervention and mental health promotion form a three-pronged approach to improving mental health and wellbeing in educational contexts.

Underpinning the development of these frameworks is recognition that mental health is "the single biggest health issue facing young Australians" today (headspace 2014). The idea that early intervention for children and young people who experience social, emotional or behavioural problems can prevent the development of mental health disorders in adolescence and adulthood is hardly new. Indeed since the early twentieth century, the value of early intervention has been widely endorsed and is now established orthodoxy. Educational settings have similarly long been regarded as key sites for the identification of a range of problems experienced by young people. Since the 1990s, however, the traditionally narrow focus on targeted interventions for young people diagnosed with disorders or considered "at risk" of developing problems, has been supplemented by the embrace of large-scale, universal preventative approaches aimed at improving the mental health and wellbeing of entire student populations.

In light of the prevalence of concerns about young people and the proliferation of policy directed towards improving youth mental health, it is timely to reflect critically on these matters. Guided by the provocation that examining the past offers a powerful way to defamiliarize the present, this chapter takes a broadly genealogical approach to analyzing the construction of mental health and wellbeing as an educational problem (Foucault 1984). The analysis draws from the field of critical policy studies,

a body of work which underscores how policies do not simply respond to social problems already formed and "out there", but actively "constitute the problems to which they seem to be responses" (Yeatman 1990, p. 158). This approach argues for the need to problematize rather than accept an a priori knowledge of a problem as it is represented in policy (Bacchi 2012; Ball 2012; Webb 2014). Problematizing wellbeing is not to suggest that educational concerns with the mental health of young people are necessarily misplaced. Rather, it is to illuminate the discursive construction of concepts like mental health and wellbeing and critically reflect on their effects. The analysis developed here, therefore, explores the interrelated processes by which mental health and wellbeing are constructed in official discourses, in turn are understood as problems *for* education, and the responses this generates, specifically, the development of school-based strategies and interventions.

A central aim of this chapter is to unsettle what is taken for granted in relation to both conceptions of wellbeing and how it is operationalized in educational contexts. This calls for examination of antecedent concerns with mental health. That is, to "understand the conditions that produce problems" (Webb 2014, p. 372), I suggest, requires historically situating the construction of problems as well as responses to them. In doing this, I draw on Bacchi's (2009) "what's the problem represented to be" (WPR) approach to policy analysis. WPR provides a useful conceptual and methodological framework for thinking critically about

mental health and wellbeing as a social ideal and an educational policy goal.

Focusing on two periods, the early decades of the twentieth century (1920s– 1930s) and the late twentieth century to the present (1990s–2010s), I examine dominant ideas about young people's psychological health and the remedial strate- gies developed on the basis of that knowledge. While extensive historical analysis is beyond the scope of the chapter, ideas and approaches to wellbeing and mental health are considered in relation to the historical conditions that have enabled particular ways of thinking about and responding to these issues. This involves exploration of the problem-solution nexus to show how prominent strategies have changed over time, from the remedial interventions characteristic of approaches during much of the twentieth century to the health promotion and preventative strategies that are dominant in schools today.

In light of recent scholarly critique of the possibilities of "psychological immunization" (Craig 2009), the final section of the chapter considers the powerful appeal of ideas of prevention and early intervention and reflects on the implications of embracing the pursuit of wellbeing as an educational aim. Critical questions that are raised include whether current approaches have overcome the deficiencies and pathologizing tendencies of past practices, the extent to which problems of mental health are conflated with social disadvantage, and the possibility that the

focus on wellbeing as a psychological issue may undermine the goal of actually achieving it. To begin an exploration of these matters, I turn first to the issue of "problem representation" (Bacchi 2012), beginning with the question of how mental health became an educational concern.

Mental Health as an Educational Problem

In the early twentieth century an important dimension of the New Education movement was the emphasis placed on developing scientific solutions to educational problems (McCallum 1990). Of the various influences that came to bear on the construction of mental health as an issue for schooling, the development of new understandings of children made possible by the fields of child study and psychology was central. By the interwar years in Australia there was much enthusiasm about the utility of the science of psychology for education, particularly through the application of "mental tests" and the establishment of psychological clinics (Wright 2012a). The fervor of psychology and mental testing was fuelled by excitement about the ability to measure intelligence, which provided a scientific way of identifying children of "subnormal", "normal" and "supernormal" ability (see for example, Miles 1921).

The scientific investigation of childhood, which itself was part of a broader rationalization of social life during the late nineteenth and early twentieth centuries (Reiger 1985), was

pivotal to the production of new normative understandings of the child. Of course the construction of abnormality is only possible alongside a conceptualization of what is "normal" and, as Turmel (2008) has noted, "a child is recognized as normal when categorized as such" (p. 13). This occurred first through the fields of paediatrics and public hygiene, and increasingly, during the first half of the twentieth century, through the discipline of psychology and the paradigm of developmentalism (Turmel 2008). It was within this broader context that the child became subject to various forms of categorization within educational settings, first with measurements of height and weight, and then assessments of intelligence. By the interwar years, mental testing had generated interest not only in normal and abnormal patterns of development but also in individual differences and "personality types". This resulted in an emergent view that "different types of children must be managed differently in order to avoid 'mental disease'" (Reiger 1985, p. 167). These ideas were, in turn, reflected in educational discourses that increasingly acknowledged the importance of psychology to schooling.

In 1930, for example, Mildred Muscio, school principal, women's activist and President of the National Council of Women of New South Wales (Foley and Fulloon 1986), presented a paper entitled "Some principles of education" at the Conference of the Australian Federation of University Women. In Muscio's view there were, overall, two aims of education: "the happy

development of the child and his or her usefulness to the community" (Muscio 1930, p. 73). To achieve these educational aims, she argued that "a child must be kept strong and well if he is to become a happy and useful citizen". However, "the psychological problem", according to Muscio, was a major issue confronting the modern teacher (p. 74). She advanced a progressive view of the role of schooling, particularly for girls, and criticized authoritarian forms of education that encouraged fear and in so doing were "often laying the seeds of future nervous troubles and mental ill-health" (p. 81).

Already by the early 1930s the discipline of psychology was recognized, as Muscio suggests, as having "revolutionized teaching" (p. 74). Muscio drew on psychology to advance a view of education as having the dual role of producing happy and useful citizens, which included recognition of women as equal members of society. While her paper provides an insight into how psychology buttressed a particular current of progressive educational thought of the time, it is useful to consider the broader context in which such ideas were circulating, in particular, the influence of the mental hygiene movement.

The period between the two world wars was a time of significant change in understandings of mental disorder and its treatment. This involved not only changing approaches to the treatment of major mental illness, but also recognition of less severe psychological problems and the utility of treatment across

the spectrum of disorders – from those classified as relatively minor to those at the more severe end. “Even more ambitiously”, as Thomson (1995) notes, “there was an expansion of interest in prevention of mental disorder and promotion of environmental conditions to encourage mental health among the normal population” (p. 283). These developments, which largely emanated from the United States but spread throughout the developed world, constituted key dimensions of the mental hygiene movement (Thomson 1995).

In Australia, enthusiasm for the principles of mental hygiene was reflected in the establishment of Mental Hygiene Councils in the early 1930s, which sought to replicate the work of the National Council for Mental Hygiene in Britain and the National Committee for Mental Hygiene in America. This included research, public education and the provision of treatment through clinical services. While mental deficiency and mental disease were undoubtedly cause for major concern, the mental hygiene movement advanced an optimistic view that mental health promotion and early intervention could prevent the onset, or at least curtail the prevalence and limit the severity, of mental illness. The aims and objectives as stated by the Victorian Council for Mental Hygiene (VCMH), established in 1930, throw light on both the contemporary situation and the aspirations for social change:

a) To improve the mental health of the community.

b) To give greater prominence to mental hygiene and allied subjects in the general education of the community, and to remove the popular prejudice against the word mental.
c) To study mental hygiene of child life in relation to parental responsibility and education.
d) To encourage scientific investigation into the causes of mental deficiency and acquired mental disorder with a view to their prevention and cure.
e) To improve the methods of diagnosis, treatment, and care of mental disorder and deficiency.
f) To study causation and prevention of mental disturbances arising from modern vocational activities.
g) To study the problems of delinquency and criminality.
h) To secure for psychology and psychiatry a position in medical education commensurate with their importance.
i) To serve as a liaison between all societies, associations, and other bodies interested in or concerned with mental hygiene, and, so far as this Council is able, to co-operate with them.
j) To co-operate with other State bodies having similar aims, and to become affiliated with the National Council for Mental Hygiene in Great Britain, and kindred societies in America and elsewhere. (VCMH 1931, p. 2)

I have included the aims and objectives of the VCMH in their entirety to illuminate the scope and range of concerns about

mental health and hygiene during the interwar years in Australia. It was within this context that mental health was constructed as a pressing concern for education, which in turn led to the establishment of the kind of school-based services and interventions that I consider below. Yet, what is striking in reviewing the VCMH's stated aims of almost a century ago is the extent to which many of the aspirations of the mental hygiene movement remain relevant today. While the terminology has changed, and anxieties about mental deficiency have receded, the goal of destigmatizing mental illness, the importance of public education and the critical role of early intervention remain high priorities.

As its objectives make clear, the VCMH recognized that a range of strategies was required if its goals were to be realized. An important one centred on the identification and treatment of "problem children". At the instigation of the VCMH, and with funding from the newly established Australian Council for Educational Research (ACER), an important research project was undertaken in Australia in the early 1930s. It sought to quantify the prevalence of "problem children" in Melbourne schools and delineate the behavioural and emotional abnormalities they exhibited (ACER 1931). As stated in the report that followed, the investigation aimed to produce an approximation of "the number of children in typical schools or institutions in Melbourne whose general behaviour or educational failure appeared to mark them out as cases calling for individual investigation and special

treatment" (Cunningham 1932, p. 75).

The study classified just over 14 % of school children as "showing abnormalities of physical, mental, educational, emotional or social development". Half of this number, some 7 % were considered to have "abnormalities of a serious or marked nature" (Cunningham 1932, p. 85). Just under 20 % of all reported abnormalities related to mental retardation, around 12 % were considered educational defects, and just over 14 % were deemed to be physical problems. The remainder – almost 54 % of so-called problem children – was classified as such in light of perceived personality defects (neurotic, hyperactive, emotional, egocentric), conduct disorders (truancy, delinquency, disciplinary problems) or because of unacceptable habits (nervousness, sexual deviations, sleepwalking) (Cunningham 1932, p. 82). Critically, the research indicated that both defects of personality and conduct disorders were more common than cases of mental retardation. Yet, while the total number of problem children was cause for concern, an optimistic tone was struck, with the report noting that unlike retardation, personality defects and conduct disorders were "relatively amenable to treatment" (Cunningham 1932, p. 83). It was thus recommended that a child guidance clinic be established in Melbourne in order to meet the needs of children requiring treatment for psychological and behavioural issues. The "problem children" study is an example of the kinds of investigations undertaken during the interwar years in Australia that contributed

to new understandings of childhood. Beyond a concern with atypical children, however, was recognition of the value of psychology and mental testing for education more broadly.[1] Indeed the classroom was recognized as one of the first sites to which emergent psychological knowledge could be usefully applied. This included understanding processes related to learning, memory, thinking and motivation as well as a new appreciation of individual differences and problems of "adjustment" (O'Neil 1987, p. 42). Institutional developments that made possible such emergent knowledges included the establishment of a psychological laboratory at the Melbourne Teachers' College in the first decade of the twentieth century, the introduction of intelligence tests in the 1910s, the appointment of psychologists in state education departments during the 1920s and the establishment of ACER in 1930 (see O'Neil 1987; Turtle 1993; Wright 2011a).

The founding of ACER in particular had a dramatic effect on the educational landscape in Australia, resulting in the development of a large research program, much of which was psychologically oriented (McLeod and Wright 2013). In addition, then, to drawing on international theories and research, there was a growing body of

[1] This is reflected in the range and number of studies funded by ACER in its first year of operation. Other projects included studies to investigate variations in the Intelligence Quotient (IQ) of subnormal children, mental tests for student teachers, class grouping and intelligence tests, mental tests for vocational guidance, the relative merits of mental and scholastic tests, tests of aptitude for teaching, standardization of intelligence tests, the prognostic value of intelligence tests in high school, and more (ACER 1931).

Australian studies to underpin educational reform efforts. This gave greater impetus to initiatives already underway and further buttressed the work of psychologists in education departments, especially in the area of mental testing and the classification of atypical children. Mental testing was particularly important in this regard, for it enabled the categorization of children based on a comparison of "mental" and "chronological" age, which in turn provided the basis for the classification and placement of children deemed to be "mentally retarded". Yet, while concerns about mental deficiency and educability loomed large, new understandings of mental health and mental ill-health were becoming increasingly influential, made possible by the production of new forms of specialized knowledge, particularly in the fields of psychology and psychiatry. It is the take up of this expert knowledge, as it pertained to children and young people, and its application in the domain of education during the interwar years, which I now consider.

The Development of Targeted Mental Health Interventions

The employment of psychologists in education departments across Australia in the 1920s (Turtle 1993) reflected the growing acceptance of psychological knowledge and its practical application, particularly for young people in schools. While much of the work of early educational psychologists involved mental testing as a measure of intelligence, there was also, importantly, an emerging interest during the interwar period in identifying children and adolescents who

appeared to have problems of "adjustment". Key to this were constructions of normality and abnormality in relation to both personality and conduct, and these underwrote educational understandings of problem children as well as the development of policy responses to child and adolescent mental health. To explore this, I turn now to official documentation from various state education departments in Australia, first examining reports from the state of South Australia, as an example of emerging ideas and approaches of this time.

In 1925 the South Australian Minister for Education reported on the appointment of a psychologist, whose work was designed "to meet both present requirements and future developments" (Halley 1926, p. 25). This included overseeing the development of special classes for "supernormal" and "subnormal" children and the training of teachers for these classes, the provision of vocational guidance, and the carrying out of "experimental work". However, the key task of the psychologist was to examine individual children and make recommendations to teachers in relation to pupils who were "retarded educationally", identified as "problem children" or deemed to be "delinquent". While the work of the psychologist was clearly wideranging, the predominant focus was on atypical children. As noted in the Report:

Dr Davey's work embraces the examination of exceptional children for the purposes of diagnosis, prognosis, and advice as to future teaching and training. She reports that "These children may

be those retarded in school work, they may be mentally dull and backward, they may be of an anti-social nature or possess delinquent tendencies, they are all those who in some way are maladjusted to their present environment of school, home or society". (1926, p. 26)

Explaining her work, Dr Davey noted that "the psychological examination is an individual one" and "no child is judged to be subnormal as the result of a mental test alone" (Halley 1926, p. 26). While developing ways of suitably educating "retarded children" comprised much of the work undertaken during the first years of her appointment, by the end of the 1920s the issue of psychological health had increasingly come to the fore. In the report for the year 1929, it was noted:

> Besides the individual work with the children of the Opportunity Classes, a number of teachers have asked for help in dealing with difficult children ::: It is often found that these temperamentally unstable children are those who, unless properly handled in school and home, become the delinquents of the future. Delinquency is now regarded by all cognizant with the problem as psychological—i.e., delinquency is a symptom of maladjustment to environment. It is therefore treatment and not punishment that is required. (Halley 1930, p. 31)

Growing awareness that behavioural problems should be remedied with psychological treatment was also reflected in the report of the following year, where it was noted that "among the children examined this year were more difficult and problem children than has normally been the case". Of delinquent children, the following comment was offered: "the need for psychological work with them becomes more and more apparent" (Halley 1931, p. 30).

The trend of increasing attention to mental health, alongside the growing demand for psychological services for "difficult" children, continued throughout the 1930s. Of the year 1936, the Chief Medical Officer of the South Australian Education Department commented: "It is interesting to note the increase in the number of parents who are seeking help ::: nearly twice that of any previous year (Christie 1937, p. 34). By the end of the 1930s, it was reported that there continued to be a steady growth in the number of enquiries from teachers, parents and guardians, particularly in relation to requests for "assistance with children whose behaviour is causing concern" (Christie 1940, p. 40).

The situation in other Australian states during this time varied according to the organizational arrangements of the respective education departments. Following the report, "Problem children in Melbourne schools" (Cunningham 1932), a child guidance clinic was established in Victoria. The clinic provided services for children and young people based on the American child guidance model, which included a multidisciplinary staff of psychiatrist, psychologist and social worker; it also offered vocational guidance services (Wright

2012b). However, while the Education Department in that state was supportive of the venture and promoted its services through its publication, The Education Gazette (e.g. Victoria 1934), it did not provide financial support. Indeed it was not until 1947, with the establishment of the Psychology and Guidance Branch, that extensive services were developed under the auspices of the Victorian Education Department (Waddington 1950).

The institutional base of psychological workers in education departments was critical to the development of school or educational-based services, as the situation in New South Wales (NSW) illustrates. In that state, a psychologist was appointed for a short period in the early 1920s (Turtle 1993) but it was with the appointment of Harold Wyndam as a Research Officer in the 1930s that psychological work at a departmental level effectively came into focus. Wyndam had a vision that psychology could transform education and he introduced schemes of mass IQ testing and a School Counselling Service during the 1930s (Hughes 2002). In 1936 a Child Guidance Clinic was established, institutionalizing an educational commitment to "problem children" and mental health. In contrast to the School Counselling Service, concerned with educational guidance and placement, the Child Guidance Clinic was established for the diagnosis and treatment of children with social, emotional and behavioural problems. School personnel could refer children to the clinic who exhibited "nervous symptoms", those suffering from "personality disorders" and those "showing behaviour disorders" (New South Wales Department of Education c. 1936).

By the late 1930s, the NSW Department of Education had considerable infrastructure for the identification and treatment of problem children. While it was not typical of approaches across Australia at that time, it did reflect a model that was widely supported across the nation, in principle if not in practice. It is important to acknowledge in this regard the considerable obstacle that economic conditions posed. While the interwar period was an especially fruitful time in the generation of new ideas, and much educational research was made possible by the endowment from the Carnegie Corporation to ACER, the economic Depression prevented the realization of many educational aspirations of this time, including a fuller provision of psychological and clinical services. As a result, there was something of a disjuncture between the widespread support and enthusiasm for the principles of child guidance on the one hand, and the provision of clinical services on the other (Phillips 1946; Wright 2012b).

With this in mind, it is useful to look to at the NSW Child Guidance Clinic as an ideal model of education-based clinically informed practice. A variety of problems was identified in children referred to the clinic, including “nervous symptoms” and “personality disorders”, and a range of treatment options offered. These included the “full treatment service” of medical and psychological evaluation, home visits from a social worker, and possibly therapy. The clinic also offered an “advice and partial treatment service” (Burton 1939, p. 22), as well as diagnostic and consultation services, mainly in the case of children referred from the Child Welfare Department. While space

prohibits a fuller discussion of the form that educational liaison and clinical services took, for the purposes of this discussion it is sufficient to note that the clinic operated on a model of early intervention. The philosophy governing this approach was that early treatment both assists with the present difficulties of "maladjusted children" and plays a vital role in preventing future problems, particularly mental illness and delinquency. In calling for an expansion of services, the psychologist at the child guidance clinic argued that "one of the main difficulties in all remedial work along lines of personality comes from the failure of the specialist to treat children soon enough" (Burton 1939, p. 261).

Before considering both divergences and continuities with regard to mental health discourses of the interwar period and the rise of wellbeing discourses in education more recently, it is instructive to reflect briefly upon established critiques of educational psychology during its formative years in the early to mid-twentieth century. A central concern, and one that remains relevant to today, is with the dividing practices of categorization and classification – based on normative conceptualizations of childhood, intelligence and development – that psychology ushered in. Children were (and still are) effectively codified in relation to their "proximity to normalcy" (Gleason 1999) and educational differences based on the disadvantages of social class were (and still are) individualized and legitimized (McCallum 1990).

On the one hand, emerging forms of classification marked out a

new and highly visible population of "abnormal" children, separating them from the "normal" population, with the inevitable detrimental effects that exclusion and marginalization entails, including the psychological and subjective effects of the internalization of deficient categories. Yet as I have argued previously (Wright 2011a), the emphasis on psychological classification and expanding categories of abnormality or debility can obscure the complexity of these processes, and indeed the ways in which such categories have also worked in the interests of disadvantaged children who have benefited from the help of trained professionals or differentiated classes or alternative curricula. While there remains much to be critical of, it is important to recognize that alongside the dangers of pathologization, the provision of remedial assistance and other forms of support has immeasurably helped the lives of some children.

The value of early intervention, as noted at the beginning of this chapter, continues to be a key feature of contemporary approaches to both mental health treatment and the promotion of youth wellbeing. However, while some continuities may readily be identified in relation to initiatives developed during the interwar years and those that are prevalent today, there are also major differences that warrant explication. In the following section I consider how a marked increase in concerns about youth mental health, which arose in the context of a growing body of research evidence during the late twentieth century, fostered the shift from a rather narrow focus on interventions for problem children to a much broader promotion of mental health and wellbeing.

Current initiatives involve not only early intervention but increasingly emphasize universal approaches that focus on prevention and health promotion for entire student populations. This reflects, in part, a broadening of ideas about early intervention and how to achieve the best outcomes. However, as the aims of the Victorian Council for Mental Hygiene make clear, many of these ideas are not new. What has changed markedly is the intensification of concerns about youth mental health, a growing body of research documenting this problem and new approaches to mental health promotion, particularly those informed by positive psychology. This has taken place within the wider social context of increasing acceptance of the importance of psychological health, greater levels of openness about psychological problems, and recognition of the value of psychological intervention (Wright 2011a). Within the educational sphere, these changes have led to an embrace of the idea that education has a key role in promoting wellbeing, not simply providing remedial services for young people experiencing educational, social or psychological problems.

The Rise of Universal Approaches to Promote Wellbeing

By the end of the twentieth century, both in Australia and internationally, the state of young people's mental health was recognized as a major social and public health issue. It is now widely accepted that mental health disorders are the leading cause of disability in young people globally and a major health issue affecting young Australians today (Gore et al. 2011; Sawyer et al. 2007). Prevalence

rates indicate that mental health difficulties steadily increase from childhood through adolescence and into early adulthood. It is estimated that between 7 % and 14 % of children aged 4–12 years experience mental health problems; this increases to 19 % for young people aged 13–17 years, and rises again, up to 27 %, for young adults aged 18–24 (McGorry et al. 2007). Other studies suggest that one third of all young people experience "moderate to high psychological distress" (Muir et al. 2009, p. 17) while still others suggest "the prevalence of a more general malaise" amongst half of all young people (Eckersley et al. 2006, p. 7).

An important question raised by these figures is whether there has been an actual increase in mental health problems, or whether increasing levels of psychological literacy and awareness have led to higher rates of identification of social and emotional problems and a greater number of diagnoses of disorders. This is a contentious issue, and one that is fraught with epistemological difficulties. Certainly in the medical and psychological fields, there is broad consensus that during the second half of the twentieth century, there was a marked increase in mental health problems. As Twenge (2011) notes: "Almost all of the available evidence suggests a sharp rise in anxiety, depression, and mental health issues among Western youth between the early twentieth century and the early 1990s" (p. 469). In light of the prevalence rates cited above, the importance of schooling in the lives of young people and research linking social and emotional wellbeing with successful learning outcomes (Durlak et al. 2011), mental health is now an issue of central concern for education systems.

In the preceding section I pointed to some early developments in Australia, noting that historically, educational concerns with youth mental health largely took the form of the provision of clinical services for young people identified as "troubled" or "difficult". As the discussion above indicates, the value of early intervention has long been emphasized, supported by the widely accepted principle that problems can be mitigated if identified and treated early. This philosophy underwrote a problem-focused strategy. By the 1990s, however, there was a major shift in social and educational policy, with the embrace of more proactive, universal and preventative approaches.

An important backdrop to this development was the rise of positive psychology as a new branch of the discipline. It has been instrumental in broadening the remit of psychological research to include "the scientific study of positive human functioning and flourishing" (Compton and Hoffman 2013, p. 2). Positive psychology has appreciably reshaped the ways in which mental health is understood in educational contexts, and it has been central to the development of ideas around wellbeing. Another important development was the launch in 1995 of the World Health Organization's (WHO) "Global school health initiative", which reflected an emerging consensus that schools had an important role to play in health promotion (WHO 2014a). Since this time, there has been a proliferation of policy at all levels of government and across the health and education sectors, aimed at improving social and emotional wellbeing and youth mental health.

Before examining policy responses and the dominant forms that educational interventions have taken in recent years, it is important to note that by the late twentieth century, there was also, more broadly, increasing attention to the social and emotional domains of learning. By the 1970s, statements of educational aims in Australia begin to include aspirations for the development of the individual and the exploration of feelings (Barcan 1993). An overt concern with the psychological and emotional development of the child saw policies in some states mandate that schools should provide a caring and supportive environment, because this was recognized as important to children's capacity to learn (Victoria 1984).

During the 1980s and 1990s, there was considerable enthusiasm about the promotion of self-esteem. The Hobart Declaration on Schooling (AEC 1989), for example, named the development of self-confidence, optimism, and high self-esteem second in its list of educational objectives. And this was reaffirmed a decade later with the Adelaide Declaration on National Goals for Schooling in the Twenty-first Century (MCEETYA 1999). There has, however, been a shift away from the idea that simply boosting self-esteem will lead to improved outcomes – either in terms of academic performance or mental and emotional health. In the present era, promoting more holistic notions of mental health and wellbeing is considered a useful strategy. This is reflected, for example, in the 2008 Melbourne Declaration on Educational Goals for Young Australians, which asserts that schools play a vital role in promoting the wellbeing of young Australians (MCEETYA 2008). And this sentiment continues

to underpin policy approaches at both the state and federal levels.

Frameworks and strategies that take a universal approach to promoting mental health and wellbeing have constituted the dominant educational policy response since the 1990s. In the late 1990s, the now prominent MindMatters (2012) framework was developed for secondary schools and trialed across Australia "in recognition of the need to address the mental health and wellbeing of young Australians" (p. 1). While issues of implementation are not the focus of this chapter, it is instructive to note that by 2010, it was estimated that almost all Australian schools were "aware of MindMatters", with 65 % of secondary schools using it as a "key resource" and 38 % using it as "their main organizer for mental health promotion, prevention and early intervention" (MindMatters 2012, p. 2). The MindMatters framework has also been taken up in a number of other countries, including the USA, Germany, Switzerland and Ireland (Mullet et al. 2004).

The overarching philosophy, as articulated in the 2012 iteration of the framework, is that: "Mental health and wellbeing is a school's business" (MindMatters 2012 p. 8). It strongly advocates the position that schools are a key site for the promotion of mental health and wellbeing and offers strategies for schools to achieve this. This includes developing "a positive climate of mental health and wellbeing", being "proactive in the promotion of mental health and wellbeing for all students", supporting prevention and providing "early

intervention initiatives for young people with mental health and wellbeing challenges" (p. 1). The goals of the framework are summarized as follows:

> MindMatters adopts a universal school-based mental health promotion, prevention and early intervention approach. Such an approach targets the entire school population with the goals of enhancing strengths so as to reduce the risk of later problem outcomes and/or to increase prospects for positive development. Prevention strategies can be universal, selective or targeted and are designed to identify and counter risk factors. Intervention strategies are aimed at students who have some risk factors, mental health difficulties, or who have diagnosable disorders. (MindMatters 2012, p. 2)

The whole school approach encompassed in frameworks like MindMatters employs a range of strategies for preventing and managing problems of mental health and wellbeing. The bringing together of mental health promotion, prevention and early intervention reflects a tripartite best practice model. MindMatters also embraces the three key dimensions of the WHO Health Promoting Schools Initiative (WHO 2014b): a focus on school ethos and environment, curriculum, and internal and external partnerships. Key components of this include professional development for staff to ensure adequate knowledge and awareness of potential problems, curriculum initiatives such as health and values education, and attempts to cultivate school environments

that make young people feel safe and valued. Fostering an ethos within the school in which help-seeking is supported is also critical, as is early intervention for "young people with mental health and wellbeing challenges" (MindMatters 2012, p. 1).

School staff are encouraged to monitor all students for signs of distress, identify students who may be at risk of mental health or wellbeing difficulties, and discuss young people who elicit concern with other members of staff. This involves teachers reading particular behaviours as potential indicators of mental health problems. As in primary and secondary schools, this is also a feature of approaches in early childhood settings. Indeed, central to the ethos of preventative approaches is that very young children are ideal candidates for early intervention. As a result, screening programs to identify early signs of emotional, social and developmental problems, and frameworks to promote good mental health for all children in educational and care settings have been developed (KidsMatter EC 2012). Before exploring the provocative idea of "psychological immunization" and its promise of prevention, I conclude this section on universal approaches by briefly examining some notable developments in early education settings.

Following the success of MindMatters, KidsMatter Primary was developed in the mid-2000s, with KidsMatter Early Childhood (EC) following in 2010. The rollout of these frameworks, first for adolescents then primary school-aged children and most recently for preschool aged children, reflects the acceptance of early intervention

as a guiding principle in the promotion of mental health and wellbeing, even for infants. A key assumption underlying KidsMatter EC is that "mental health problems exist and can be identified in early childhood" and that "certain risk factors" for depressive and anxiety symptoms are "present before 6 months of age" (KidsMatter EC 2012, p. 2). It is based on a "positive psychology philosophy" that aims to "improve the mental health and wellbeing of children from birth to school age", reduce mental health difficulties and "achieve greater support" for children experiencing mental health problems (p. 6). The framework includes four main components: creating a sense of community; developing children's social and emotional skills; working with parents and carers; and helping children who experience mental health issues. KidsMatter EC recognizes early childhood as critical to the development of wellbeing throughout life and identifies protective and risk factors that affect mental health. Strengthening "protective factors", for example, by fostering positive relationships and attachments, intentionally teaching social and emotional skills and promoting self-esteem, is the primary approach to mitigating "risk factors" (KidsMatter EC 2012).

The shift in emphasis from targeted approaches and early intervention for identified problems to the embrace of broader health promotion and preventative strategies signals a major change. In the current educational landscape there is considerable effort directed towards the development of frameworks, programs and interventions to improve mental health at a population level. Within this context, it is difficult to question taken for granted "truths", for example, that

universal approaches to fostering wellbeing may prevent future mental health problems or that focusing on the development of social and emotional skills leads to better educational outcomes. It is also difficult to pose critical questions, such as the possibility that strategies aimed at promoting wellbeing could lead to undesirable outcomes. In the preceding sections, I have explored the rise of wellbeing and antecedents to current concerns about youth mental health by contrasting developments in the early decades of the twentieth century with more recent approaches. In seeking to problematize discourses of mental health and wellbeing I have focused on illuminating the "conditions and registers in which problems and solutions have been articulated" (Webb 2014, p. 369). In what follows, I consider what is left unproblematic in constructions of mental health and wellbeing and how these matters may be thought about differently (cf. Bacchi 2012).

Psychological Immunization and the Promise of Prevention

Promoting the mental health and wellbeing of young people now sits alongside traditional educational aims of knowledge acquisition, vocational preparation and the development of citizenship (Wright 2011b). The benefits of adopting policies and practices to achieve this are often assumed to be self-evident, with little questioning of dominant approaches. Yet, as critical policy studies remind, there are sound reasons to consider all educational policies and practices with caution, even those that have worthy aspirations and appear incontrovertibly to be in the best interests of students. This not only includes attention to issues such as the gap between policy and

practice but also, importantly, consideration of how inequalities or disadvantage may be reproduced, despite intentions to the contrary, and being alert to unintended consequences that may arise from the adoption of particular policies (Young et al. 2010). Alongside this, critiques of the therapeutic turn in education raise important questions about the effects of strategies aimed at promoting social and emotional skills and personal dispositions regarded as essential for wellbeing (Ecclestone 2012).

An important issue that arises from this analysis is that the concept of wellbeing is itself poorly defined (Amerijckx and Humblet 2013; Watson et al. 2012). It may be taken to simply mean "being well". However, its frequent coupling with mental health (i.e. "mental health and wellbeing"), prominent in much contemporary policy, suggests that wellbeing is often conceptualized in relation to psychological health. Certainly, it encompasses physical health as well, and indeed part of the appeal of wellbeing as a concept is that it not only overcomes some of the stigma carried by a term like mental health but it also reflects an embrace of notions of flourishing or optimal functioning, ideas that have gained prominence with the rise of positive psychology. Nevertheless, despite the extent to which it may be an all-encompassing term, the alignment of wellbeing with mental health means that the focus on improving wellbeing is often implicitly framed in terms of enhancing mental health or improving problems of poor mental health. Indeed, in a review of the literature on child wellbeing, Amerijckx and Humblet (2013) suggest that there is an "oddly pathogenic approach" to wellbeing; that is, much research

on wellbeing has followed a pathogenesis model in which states reflecting the antithesis to wellbeing are foregrounded and investigated rather than the focus being on wellbeing itself (p. 1).

To extend this analysis a little further, while mental ill-health may be one problem that the promotion of wellbeing seeks to address, it is not the only problem. As it is an amorphous concept that reflects an idealized state of being, the range of problems to which the promotion of wellbeing may be drawn upon as a solution is left open. As noted above, wellbeing is increasingly linked to successful learning outcomes and academic engagement (Durlak et al. 2011; Watson et al. 2012). While this is strongly reflected in contemporary educational policy, it is useful to remember that this view has only risen to prominence since the late twentieth century, and has now become something of a taken for granted truth. Social and emotional learning, for example, is a highly influential model for conceptualizing the processes associated with the acquisition of skills and knowledge (Zins et al. 2004, 2007). The development of social and emotional skills, moreover, is considered important for being a "good student, citizen and worker" and deemed to play a key role in minimizing "risky behaviours" (CASEL 2014). Earlier, I examined how mental health became an educational problem by looking back to the early decades of the twentieth century; a central part of this story being the embrace of contemporary medical and psychological knowledges that provided normative understandings of what constituted child (mental) health (Turmel 2008). More recently, positive psychology has played a major part in the rise of wellbeing, both as a concept and in the idea that

promoting wellbeing can prevent the development of mental health problems.

There is, as Webb (2014) notes, "a pervasive logic that maintains educational problems can be solved in, with, or through policy" (p. 364). Certainly, the value of prevention has long been recognized, not only in educational contexts; expressions such as "an ounce of prevention is worth a pound of cure" and "a stitch in time saves nine", attest to the accepted common sense of preventative approaches. In the field of mental health, what is now referred to as "the science of early intervention" takes various forms, from biomedical models to more psychologically or socially oriented approaches (Slee et al. 2011, p. 38). Arguments supporting early intervention are advanced in relation to the physical, psychological and social benefits of intervening early. However, strong economic arguments, framed largely in terms of cost-benefit analysis, are also commonly used to demonstrate that there are considerable returns on investments made early in children's lives. Such a view posits that schools are "ideal entry points" for interventions that address mental health (Slee et al. 2011, p. 39). In recent years, this has seen the expansion of the parameters of early intervention, both in terms of the remit of what may be achieved (i.e., preventing mental illness by treating problems early), and the populations to which preventative efforts and the promotion of psychological health can be extended (i.e. infants and very young children).

There is clearly a demonstrable benefit to be derived from

intervening before minor problems develop into major ones. Yet, how this is actually done in schools and other educational settings is an area fraught with difficulties. To return briefly to the MindMatters (2012) and KidsMatter EC (2012) frameworks, an important strategy for teachers and early childhood educators is that of "observation"; that is, staff are encouraged to be on the lookout for indicators of mental health difficulties in babies, children and adolescents. While it may be argued that this has long formed part of the pastoral work of teachers and carers, the systematic monitoring of young people, informed by indicators of psychological risk and distress, raises a number of issues.

For babies and young children, signs and risk factors include "pessimistic thinking styles", "impulsivity", "low IQ", "low self-esteem", "poor social and emotional skills" and "socioeconomic disadvantage" (KidsMatter EC 2012, p. 9). Deviations from normal patterns of development form one concern, indeed a highly psychologized one, but so does the problem of social disadvantage. Similarly, for adolescents, MindMatters (2012) offers a list of indicators for high school staff to help them assess whether students are in need of support for their mental health and wellbeing. These include some clearly worrying signs, such as "thinking about death, suicide or self harm", "stealing, vandalism and risk taking behaviour", and "abuse of drugs or alcohol". But they also include indicators such as being lethargic or having lots of energy, changes in eating patterns and changes in academic performance or interest (MindMatters 2012, p. 99). Certainly, these may be signs of problems with mental health or wellbeing. However, what must also be considered are the risks that

arise from this kind of surveillance and the potential for pathologizing variability in the behaviour, personality and disposition of infants, children and adolescents. Especially important in this regard is the extent to which social disadvantage becomes normatively tied to the risk for developing mental health problems (Graham 2012; Harwood and Allan 2014).

There are also more practical issues to consider, such as the distribution of finite resources, a perennial issue for education systems. With regard to current approaches to improving wellbeing, in recent years this has involved funding directed towards whole school as well as targeted programs. This raises questions about need and the effectiveness of interventions that aim to foster wellbeing through universal approaches. A recently published systematic review (Kidger et al. 2012) suggests that there is limited evidence to support claims that the school environment – a key focus of many approaches – affects student mental health. What this analysis does affirm, however, is not surprising: that is, that students' perceptions of teacher support and feelings of being connected to school are associated with better emotional health.

Importantly, current approaches also have a much broader aim than early intervention and the prevention of mental illness. For educational philosopher, Ruth Cigman (2012), the promotion of wellbeing is a central part of the contemporary enhancement agenda, which "aims to enhance so called positive emotions in children

(optimism, resilience, confidence, curiosity, motivation, self-discipline, self-esteem, etc.) and inhibit negative ones" (p. 449). While Cigman argues, not surprisingly, that there are aspects of this to be welcomed, she cautions against the dangers of this type of polarized thinking, that is, the notion that some emotions are positive and some are negative, which is characteristic of positive psychology and is reproduced in educational policy that aims to improve wellbeing. Moreover, she warns of the potential of wellbeing being caught up in the contemporary climate of neoliberal accountability. In short, should young people be "answerable to a wellbeing test", and what happens to those who "fail"? (Cigman 2012, p. 450).

Finally, an implicit assumption in positive psychology and in approaches to promoting wellbeing is the idea of "psychological immunization" and the concomitant promise of "inoculating young people against depression" (Craig 2009). Yet there is little evidence, according to Carol Craig of the UK's Centre for Confidence and Wellbeing, that the effects of programs aiming to promote wellbeing are long lasting. She raises a variety of concerns about unintended consequences, including the privileging of the psychological at the expense of the physical; exercise, she notes, is a natural "anti-depressant". In her view: "Making movement an integral part of school life may have a more beneficial effect than psychological programmes" (p. 20). There is also the question of the extent to which the promotion of wellbeing may lead to self-absorption. Educational programs that aimed to improve self-esteem, popular in the 1990s especially, are now criticized for leading to an epidemic of narcissism

(Stout 2000; Twenge and Campbell 2013). Might similar or related arguments be leveled at wellbeing in the future?

Concluding Remarks

Examining antecedents to current concerns with youth wellbeing – and the institutional changes that have accompanied them in the form of new ideas and programs – provides a way of historicizing and defamiliarizing present day educational approaches. The contemporary focus on wellbeing, in other words, is part of a longer history of educational concerns with the social, emotional and psychological development of young people (McLeod and Wright 2013). While my empirical analysis has focused on Australia, it reflects a more general international trend. In the first half of the twentieth century there are discernable similarities to some of the aspects that characterize educational directions today; yet there are also important differences. While the story of this development is complex, it is a reasonable generalization to say that over the course of the twentieth century there was a significant expansion of programs that aimed to assist young people with learning and other academic problems, but also with social and psychological problems. Moreover, if one takes a comparative look at the early and the late twentieth century, what is striking is the shift that occurs from a narrow focus on interventions for "problem children", to universal interventions and programs with the aim of improving social and emotional skills – and psychological health more broadly – for the entire population of young people.

Central to this has been the development of new understandings of child and adolescent mental health, alongside widespread views by the late twentieth century that mental health was a major social problem for advanced economies. These have underwritten concerns about youth wellbeing, and to a large extent, provided the rationale for developing universal approaches as a key strategy to address this issue. It is important to recognize, however, that the growing body of research on mental health disorders does not simply document an existing problem. It also plays a central role in the way that the problem itself is constructed. In other words, the production of psychiatric and psychological knowledge frames the ways in which mental health is understood, both in professional contexts and by the broader public, and forms the basis from which solutions or policies aimed at addressing the problem are developed.

Importantly, the same period that saw mental health acknowledged as a pressing social problem also saw the rise of positive psychology. Positive psychology has taken a leading role in developing solutions that can be applied in educational contexts, notably, through the promotion of student wellbeing. It promises a more holistic, less pathological, approach. Yet, the ways in which notions of wellbeing are taken up in contemporary educational frameworks suggest that wellbeing is largely a proxy for mental health and that the "solutions" continue to be largely individualized. Moreover, there remains considerable potential for pathologization, and particularly worrying in this regard are the ways in which social

and structural disadvantage are situated as problematic for mental health.

Youth wellbeing is clearly a complex issue. Not only is it widely regarded as a pressing social problem, but it also presents interpretive and definitional challenges with regard to what wellbeing constitutes, the question of its relationship to mental health and how appropriate the concept is as an educational aim and as an organizing framework for interventions to improve the lives of young people. I conclude, therefore, not with a definitive response or an evaluation of the historical shifts I have documented, but with a series of provocations that emerge from the foregoing analysis. From a conceptual or sociological standpoint, we may ask: What does the contemporary focus on youth wellbeing as a key aspiration say about our society today, and perhaps more importantly, what does it say about the enduring anxieties that we face in relation to young people?

Important questions are also raised from critical perspectives informed by principles of justice and social equity: To what extent does the focus on wellbeing, vis-à-vis older concerns with welfare, detract from what are the actual social determinants of wellbeing and the need to address those – not least of which is enduring social disadvantage? In examining contemporary school-based approaches it is important to also acknowledge the seemingly inexorable rise of diagnosable disorders and lay understandings that shape educational attitudes towards mental health problems. This leads one to speculate on the overall impact of positive psychology and the rise of wellbeing

as a central concern of education. A key question here is whether these more holistic concepts and processes have led to a diminishment of the individualizing and dividing practices of categorization and the tendencies towards pathologization in educational psychology in the past. Or whether these practices have simply re-emerged, albeit in a rather different guise, in the form of wellbeing discourses.

References

ACER. (1931). *Australian council for educational research annual report*, 1930–31. Melbourne: Brown, Prior & Co.

AEC. (1989). *The Hobart declaration on schooling*. Hobart: Australian Education Council. Amerijckx, G., & Humblet, P. C. (2013). Child well-being: What does it mean? *Children & Society*. doi:10.1111/chso.12003.

Bacchi, C. (2009). *Analysing policy: What's the problem represented to be?* Sydney: Pearson Education.

Bacchi, C. (2012). Introducing "what's the problem represented to be?" Approach. In A. Bletsas & C. Beasley (Eds.), *Engaging with Carol Bacchi: Strategic interventions and exchanges* (pp. 21–24). Adelaide: University of Adelaide Press.

Ball, S. (2012). *Global education Inc.: New policy networks and the neo-liberal imaginary*. London: Routledge.

Barcan, A. (1993). *Sociological theory and educational reality: Education and society in Australia since 1949*. Sydney: NSW University Press.

Burton, N. W. (1939). *The child guidance clinic: A critical survey.* Unpublished M.A. thesis, The University of Sydney, Sydney.

CASEL. (2014). *What is social and emotional learning?* Chicago: Collaborative for Academic, Social, and Emotional Learning.

Christie, W. (1937). Report of the Principal Medical Officer. In South Australia, *Report of the Minister of Education, 1936*, Appendix E (pp. 32–35). Adelaide: Government Printer.

Christie, W. (1940). Report of the Principal Medical Officer. In South Australia, *Report of the Minister of Education, 1939*, Appendix G (pp. 38–42). Adelaide: Government Printer.

Cigman, R. (2012). We need to talk about well-being. *Research Papers in Education, 27*(4), 449–462.

Compton, W. C., & Hoffman, E. (2013). *Positive psychology: The science of happiness and flourishing* (2nd ed.). Belmont: Cengage Learning.

Craig, C. (2009). *Well-being in schools: The curious case of the tail wagging the dog?* Glasgow: Centre for Confidence and Well-being.

Cunningham, K. S. (1932). *Problem children in Melbourne schools* (Australian educational studies, First series, pp. 75–85). Melbourne: Melbourne University Press.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405–432.

Ecclestone, K. (2012). Emotional well-being in education policy and practice: The need for interdisciplinary perspectives and a sociological imagination. *Research Papers in Education, 27*(4), 383–387.

Eckersley, R., Wierenga, A., & Wyn, J. (2006). *Flashpoints and signposts: Pathways to success and wellbeing for Australia's young people*. Melbourne: Youth Research Centre, The University of Melbourne.

Edwards, V., & Martin, S. (2012, December 24). Preschool mental health toll at 10pc. *The Australian*. Retrieved from www.theaustralian.com.au/news/health-science/preschool-mental-health-toll-at-10pc/story-e6frg8y6-1226542726397#

Foley, M., & Fulloon, G. (1986). Muscio, Florence Mildred (1882–1964). In *Australian dictionary of biography*. Canberra: Australian National University. Retrieved from adb.anu.edu.au/biography/muscio-florence-mildred-7715

Foucault, M. (1984). Nietzsche, genealogy, history. In P. Rabinow (Ed.), *The Foucault reader* (pp. 76–100). New York: Pantheon Books.

Gleason, M. (1999). *Normalizing the ideal: Psychology, schooling, and the family in postwar Canada*. Toronto:

University of Toronto Press.
Gore, F. M., Bloem, P. J. N., Patton, G. C., Ferguson, J., Joseph, V., Coffey, C., Sawyer, S. M., & Mathers, C. D. (2011). Global burden of disease in young people aged 10–24 years: A systematic analysis. *Lancet, 377*(9783), 2093–2102.
Graham, L. J. (2012). Disproportionate over-representation of indigenous students in New South Wales government special schools. *Cambridge Journal of Education, 42*(2), 163–176.
Halley, G. (1926). Report of the Principal Medical Officer. In South Australia, *Report of the Minister of Education, 1925*, Appendix E (pp. 24–28). Adelaide: Government Printer.
Halley, G. (1930). Report of the Principal Medical Officer. In South Australia, *Report of the Minister of Education, 1929*, Appendix E (pp. 29–31). Adelaide: Government Printer.
Halley, G. (1931). Report of the Principal Medical Officer. In South Australia, *Report of the Minister of Education, 1930*, Appendix E (pp. 29–31). Adelaide: Government Printer.
Harwood, V., & Allan, J. (2014). *Psychopathology at school: Theorizing mental disorders in education*. New York: Routledge.
headspace. (2014). *headspace: National youth mental health foundation*. Commonwealth of Australia: Department of Health and Ageing. Retrieved from www.headspace.org.au/about-headspace/what-we-do/why-headspace
Hughes, J. P. (2002). Harold Wyndham and educational reform in Australia, 1925–1968. *Education Research and Perspectives, 29*(1), 1–268.
Kidger, J., Araya, R., Donovan, J., & Gunnell, D. (2012). The effect of the school environment on the emotional health of adolescents: A systematic review. *Pediatrics, 129*(5), 925–949.
KidsMatter. (2012). *KidsMatter: Australian primary school mental health initiative*. Commonwealth of Australia: Department of Health and Ageing.
KidsMatter EC. (2012). *KidsMatter early childhood mental health initiative: An overview*.
Commonwealth of Australia: Department of Health and Ageing.
McCallum, D. (1990). *The social production of merit: Education, psychology, and politics in Australia, 1900–1950*. London: Falmer Press.

MCEETYA. (1999). *The Adelaide declaration on national goals for schooling in the twenty-first century*. Canberra: Ministerial Council on Education, Employment, Training and Youth Affairs.

MCEETYA. (2008). *The Melbourne declaration on educational goals for young Australians*. Melbourne: Ministerial Council on Education, Employment, Training and Youth Affairs.

McGorry, P. D., Purcell, R., Hickie, I. B., & Jorm, A. F. (2007). Investing in youth mental health is a best buy: The logic and plan for achieving early intervention in youth mental health in Australia. *Medical Journal of Australia, 187*(7), S5–S7.

McLeod, J., & Wright, K. (2013). Education for citizenship: Transnational expertise, curriculum reform and psychological knowledge in 1930s Australia. *History of Education Review, 42*(2), 170–184.

Miles, J. A. (1921, March 4). Education in America: The psychological clinic. *The West Australian*, p. 6.

MindMatters. (2012). *Whole school matters: A whole school approach to mental health and wellbeing. Draft.* Commonwealth of Australia: Department of Health and Ageing.

Muir, K., Mullan, K., Powell, A., Flaxman, S., Thompson, D., & Griffiths, M. (2009). *State of Australia's young people: A report on the social, economic, health and family lives of young people*. Canberra: Commonwealth of Australia.

Mullet, E., Evans, S., & Weist, M. (2004). A whole school approach to mental health promotion: The Australian MindMatters program. In C. S. Clauss-Ehlers & M. D. Weist (Eds.), *Community planning to foster resilience in children* (pp. 297–309). New York: Springer.

Muscio, M. (1930). Some principles of education. *The Australian Quarterly, 2*(5), 73–86.

New South Wales Department of Education (c. 1936). Memorandum to head teachers: Establishment of child guidance clinic. School Medical Service. In N.W. Burton (1939), *The child guidance clinic*. Unpublished M.A. thesis. The University of Sydney, Sydney.

O'Neil, W. M. (1987). *A century of psychology in Australia*. Sydney: Sydney University Press.

Phillips, A. R. (1946, April 23–26). The approach to child guidance in Victoria. *The Hospital Magazine*.

Reiger, K. (1985). *The disenchantment of the home: Modernizing the Australian family, 1880– 1940*. Melbourne: Oxford University Press.

Sawyer, M. G., Miller-Lewis, L. R., & Clark, J. J. (2007). The mental health of 13–17 year-olds in Australia: Findings from the national survey of mental health and well-being. *Journal of Youth and Adolescence, 36*(2), 185–194.

Slee, P. T., Dixon, K., & Askell-Williams, H. (2011). Whole-school mental health promotion in Australia. *The International Journal of Emotional Education, 3*(2), 37–49.

Stark, J. (2012, June 12). Preschool mental health checks. *The Sydney Morning Herald*. Retrieved from www.smh.com.au/national/health/preschool-mental-health-checks-20120609- 202qd.html

Stout, M. (2000). *The feel-good curriculum: The dumbing-down of America's kids in the name of self-esteem.* Cambridge: Da Capo Press.

Thomson, M. (1995). Mental hygiene as an international movement. In P. Weindling (Ed.), *International health organisations and movements, 1918–1939* (pp. 283–304). Cambridge: Cambridge University Press.

Turmel, A. (2008). *A historical sociology of childhood: Developmental thinking, categorization and graphic visualization*. Cambridge: Cambridge University Press.

Turtle, A. M. (1993). The short-lived appointment of the first New South Wales government psychologist, Dr Lorna Hodgkinson. *Australian Historical Studies, 25*(101), 569–588.

Twenge, J. M. (2011). Generational differences in mental health: Are children and adolescents suffering more, or less? *American Journal of Orthopsychiatry, 81*(4), 469–472.

Twenge, J. M., & Campbell, W. K. (2013). *The narcissism epidemic: Living in the age of entitlement*. New York: Atria Books.

VCMH. (1931). *First annual report, 1930–1931*. Melbourne: Victorian Council for Mental Hygiene.

Victoria. Department of Education. (1934, June 25). Vocational and child guidance centre: Free Services. *Education Gazette and*

Teachers' Aid, p. 212.

Victoria. Department of Education. (1984). *Curriculum development and planning in Victoria* (Ministerial paper No. 6). Melbourne: Government of Victoria.

Waddington, D. M. (1950). *Review of education in Australia, 1940–1948*. Melbourne: Melbourne University Press.

Watson, D., Emery, C., & Bayliss, P. (2012). *Children's social and emotional wellbeing in schools: A critical perspective*. Bristol: The Policy Press.

Webb, P. T. (2014). Policy problematization. *International Journal of Qualitative Studies in Education, 27*(3), 364–376.

WHO. (2014a). *Global school health initiative*. Geneva: World Health Organization. Retrieved from http://www.who.int/school_youth_health/gshi/en/

WHO. (2014b). *What is a health promoting school?* Geneva: World Health Organization. Retrieved from http://www.who.int/school_youth_health/gshi/hps/en/

Wright, K. (2011a). *The rise of the therapeutic society: Psychological knowledge & the contradic- tions of cultural change*. Washington, DC: New Academia.

Wright, K. (2011b). *The therapeutic school: Historicizing debate about policy & practice*. Newcastle: Refereed Proceedings of the Australian Sociological Association.

Wright, K. (2012a). "To see through Johnny and to see Johnny through": The guidance movement in interwar Australia. *Journal of Educational Administration and History, 44*(4), 317–337.

Wright, K. (2012b). "Help for wayward children": Child guidance in 1930s Australia. *History of Education Review, 41*(1), 4–19.

Yeatman, A. (1990). *Bureaucrats, technocrats, femocrats: Essays on the contemporary Australian state*. Sydney: Allen & Unwin.

Young, M., Diem, S., Lee, P-L., Mansfield, K., & Welton, A. (2010). *Understanding critical policy analysis*. Paper Presented at the annual meeting of the American Educational Research Association. Denver.

Zins, J. E., Weissberg, R. P., Wang, M. C., & Walberg, H. J. (Eds.) (2004). *Building academic success on social and emotional learning: What does the research say?* New York: Teachers College Press.

Zins, J. E., Bloodworth, M. R., Weissberg, R. P., & Walberg, H. J. (2007). The scientific base linking social and emotional learning to school success. *Journal of Educational and Psychological Consultation, 17*(2–3), 191–210.