


ORIGINAL ARTICLE

Mental health services in the school environment—Future visions using a phenomenographic approach

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Abstract

Aims and objectives: First, to describe the variation in stakeholders' perceptions related to the desirable mental health services in school environments. Second, to construct alternative future visions based on these perceptions. Finally, to describe stakeholders' perceptions about the actions needed to reach such an ideal state.

Background: The increased need for mental health care has challenged the role of schools and school health care in the area of mental health services for those of school-age. There is a need for future visions and comprehensive statements concerning the mental health services provided in the school environment.

Design: The study was undertaken in Finland, between February 2020 and February 2021. Qualitative individual interviews were conducted with 15 professional stakeholders and focus group interviews with 10 stakeholders advocating for adolescents or parents.

Method: The study was conducted with the phenomenographic approach using a visioning methodology. The study is reported following the COREQ checklist.

Result: Four alternative future visions were formulated based on the perceptions of the stakeholders. They emphasised different aspects: (1) non-medicalising the school environment, (2) early and extensive intervention by school nurses enabled by work distribution with mental health specialists, (3) a multiprofessional team providing help on overall health questions and (4) a focusing of the services on mental disorders. Necessary changes were identified at the micro-, mezzo- and macro-level.

Conclusion: The future visions are based on opposite perceptions related to the mission and focus of school health care. One extreme emphasises overall health promotion for everyone, while the other accentuates treatment for those suffering from mental disorders. The former may lead to inadequate help for mental health problems and the latter insufficient help for other health problems.

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Relevance to clinical practice: This study contributes alternative future visions, promotes strategic planning and helps to clarify the future role of school nurses.

KEYWORDS

mental health, phenomenography, public health nurse, school health care, school nurse

1 | INTRODUCTION

Mental health problems are the top-five common causes of YLD (years lived with disability) among adolescents (WHO, 2021a). People with these problems are often referred to special mental health units, but according to political guidelines, mental health services (MHSs) should be an integrated part of the general health services, such as school health care (SHC) (Vorma et al., 2020, WHO, 2021a). The position of school nurses (SNs) is not clear or obvious among other professionals (Dahl & Crawford, 2018) in respect of their role in MHSs for school pupils (Granrud et al., 2019, Anttila et al., 2020). The increased need for mental healthcare among the school-aged population (Sourander et al., 2016, Gyllenberg et al., 2018) has provoked the need to evolve the MHSs provided in the school environment and to readdress the duties of SNs in the future. The stakeholders (i.e., persons affecting or being affected by the given situation or action) are important participants in the process of creating a future vision. Visions, that is, the descriptions of a desirable state in the future, can promote change and, moreover, generate effective strategic planning. (Ziegler 1991, cited in O'Brien & Meadows, 2001). In this study, we examine and describe the variation of stakeholders' perceptions related to the desirable MHSs in the school environment and construct alternative future visions based on these perceptions. Using the results, it would be possible to clarify the role of SNs and to develop more effective services.

1.1 | Background

According to a recent WHO report, SHC is essential, but currently plays an inadequate part in the MHSs of children and adolescents (WHO, 2021a). Almost every fourth school-aged person has symptoms of mental health problems (Patel et al., 2007) and as many as 15% of the population are diagnosed with a mental disorder before the age of 18 years (Dalsgaard et al., 2020). Mental health problems have been linked to: substance abuse problems, low educational achievements (Patel et al., 2007), lack of education and employment (Ringbom et al., 2022) and higher mortality (Wahlbeck et al., 2011); it is also the costliest children's condition in society (Soni, 2014). Suicide is the sorrowful end to this list, as it is still one of the leading causes of death among 15–19-year-old (WHO, 2021a).

SHC is provided worldwide, but the quality of the services vary (WHO, 2021a). Contrary to many other countries (WHO, 2021a), the SHC in Finland is a well organised, integrated and high-quality service (Grym & Borgermans, 2018). In Finland, SNs are

What does this paper contribute to the wider global clinical community?

- The future vision of desirable MHSs in the school environment is not clear or harmonious.
- The perceptions of the stakeholders vary in relation to fundamental questions, such as the desirable provider of treatment for mental disorders, the mission and focus of school healthcare and the principal values.
- Changes are necessary to reach the ideal state of mental health services in the school environment at the micro-, mezzo- and macro-level.

registered public health nurses with a Bachelor of Health Care in Public Health Nursing (240 ECTS credits) from a University of Applied Sciences (Government Decree 1129/2014). The Finnish legislation regulates the work of SNs; they are required to provide health examinations, including the promotion of mental health, at least once a year. Moreover, they must inspect health and safety in the school community and study environment, provide special support if needed and provide health care counselling. The extensive health examinations are conducted in the 1st, 5th and 8th grade with an emphasis on the well-being of the whole family and collaboration with doctors and teachers. (Government Decree 338/2011). Thus, the promotion of mental health is a statutory part of the work of Finnish SNs (Government Decree 338/2011), and it should also include the prevention of mental health problems (Health Care Act 1326/2010). Worldwide, the WHO has stated that promotion and prevention are an essential part of all SHC activities (WHO, 2021a).

School-based mental health promotion seems to be beneficial (O'Connor et al., 2017; Sakellari et al., 2021) and preventive interventions have proved to be cost-effective (Feldman et al., 2020; Vartiainen et al., 2021). In the mental health field, promotion and prevention are interrelated and overlap but nevertheless distinct concepts. Promotion of mental health is usually associated with mental well-being and positive mental health, while prevention emphasises the perspective of illness. (Tamminen et al., 2016.) The latter is usually divided into universal, selective and indicated prevention. The target group of universal prevention is the entire population, while selective prevention targets individuals with a higher risk of disorders than average, and indicated prevention focuses on individuals with foreshadowing signs or symptoms of disorders, although still below diagnostic level. (Gordon, 1983).

Promotion and prevention targeted at those of school-age can be actualised by different professionals, such as teachers, psychologists or SNs (Feldman et al., 2020). The already existing mental health problems consume more than 25% of the working hours of SNs (Moen & Skundberg-Kletthagen, 2017). SNs need to have competence not only for promotion and prevention but also concerning the treatment of mental health issues (Putkuri et al., 2021). In Finland, the treatment of mental disorders is not a statutory part of the SHC in comprehensive schools (Government Decree 338/2011). However, despite the current legislation, Finnish SNs and social workers in many schools are currently trained in two treatment methods suitable in school settings: Cool Kids for anxiety (Mifsud & Rapee, 2005) and IPC (interpersonal counselling) for depression (Parhiala et al., 2020). Promising results have indicated that SNs are able to decrease students' symptoms of mental health problems (Ginsburg et al., 2019, Parhiala et al., 2020) with structured interventions and a sense of good self-efficacy (Caron et al., 2022). The implementation of treatment in school settings seems to be challenging; the barriers identified are, for example, the competence of the staff, the logistics of the educational activities (Gee et al., 2021) and problems in collaboration with other professionals in the schools (Granrud et al., 2019). The implementation of treatment methods as a part of the work of SNs has also met numerous difficulties, that is, unstructured procedures, lack of coordination and collaboration, the uncertainty of SNs concerning their competence and scarce resources (Ranta et al., 2018).

In summary, there is a considerable need to regenerate MHSs for children and adolescents. The role of SHC and SNs as a part of the solution is unclear and ambiguous. An earlier study that examined suggestions for future MHSs in the school environment, from the perspective of the SNs themselves, indicated the need for more personalised services and more resources to provide these services (Anttila et al., 2020). To the best of our knowledge, there are no previous studies exploring stakeholders' perceptions related to the desirable state of MHSs in the school environment. Thus, we examined their perceptions and based on these, constructed alternative future visions. We also examined stakeholders' perceptions regarding the actions needed to reach the ideal state. The research questions in this study were as follows: (1) What are the alternative future visions concerning the desirable state of MHSs in the school environment? and (2) What are the stakeholders' perceptions about the actions needed to reach the ideal state?

2 | METHOD

2.1 | Design

The ontological and epistemological base of this study was constructivism, where the nature of the truth is a construction in which multiple various realities are concurrently possible. This is a common view in qualitative research. In the philosophy of science, realism or post-positivistic realism is a dominant paradigm. For scientific realism, truth as correspondence is the only truth there is, and science should

create exact pictures of the objective reality. This kind of truth is considered the ultimate criterion of scientific validity. According to scientific realism, the entities exist objectively and mind-independently. In constructivism, science finds or creates subjectively different kinds of interpretations of the world (Huttunen & Kakkori, 2020).

This study was conducted with a phenomenographic approach, which is applicable when exploring the various, individual perceptions and conceptions of the study participants and allows various realities to be concurrent (Marton, 1988). In phenomenography, the researcher is interested in the second-order perspectives, that is, not how something really is but rather how the phenomena are conceived (Marton, 1988, Sjöström & Dahlgren, 2002). Although phenomenography was developed within educational research, it is also suitable for nursing research (Sjöström & Dahlgren, 2002, Granrud et al., 2019). Marton (1988) described the idea of phenomenographic research as follows: 'Phenomenography is a research method adapted for mapping the qualitatively different ways in which people experience, conceptualize, perceive, and understand various aspects of the world around them. ... [P]henomenography investigates the qualitatively different ways in which people experience or think about various phenomena'. In this study, the phenomenon is understood according to the definition of the Finnish Innovation Fund Sitra (2021) as a situation affected by a background of several independent factors. The examined phenomenon is the MHSs in the school environment.

The consolidated criteria for reporting qualitative research (COREQ) checklist was used to guide the reportage of the study (File S1; Tong et al., 2007).

2.2 | Recruitment and data collection

The eligible participants for this study were recruited with snowball sampling method. They were adult (at least 18 years old) individuals who could affect or could be affected by the work of SNs or individuals with a special interest in the work of SNs (i.e., the stakeholders). The participants were not required to have personal experience of the MHSs provided in school environments, but perceptions regarding the issue were required and considered sufficient (Marton, 1988). Potential participants from different organisations in Finland were contacted via e-mail by the first author (TP). They were given information about the study and asked to participate. The first author established a time for the interview with those interested in participating. After the interview, the participants were asked to name other potential participants.

Semi-structured interviews are the preferred method in phenomenographic research (Marton, 1988, Sjöström & Dahlgren, 2002), and in this study these were conducted by the first author (TP) between February 2020 and February 2021. Advocates from the NGOs of the adolescents or parents were interviewed in two focus groups in order to create diversity through interaction. All the specialists were interviewed individually in order to gather more in-depth information. Five individual interviews were held as live meetings and the

remainder via remote access because of the COVID19-pandemic. The participants in the focus groups knew each other beforehand, which may have helped discussions via remote access. The discussion in the focus groups was very self-guided using a dialogical method, and the interviewer (TP) maintained a quite passive role.

The interview guide (Table 1) was designed based on five dimensions of visioning: (1) Analysis of the current situation, (2) assessment of the external environment, (3) identification of the desired future state, (4) connection of the future to the present state and (5) testing the vision (O'Brien & Meadows, 2001). The fifth dimension, testing the vision, was not used in this study. In the interviews, the questions focused on the ways the participants saw and understand the phenomenon (the second-order perspective). One pilot interview was conducted with a specialist in mental health in December 2019, and minor changes were made to the guide based on this. The pilot interview was not included in the analysis.

Focus group interviews lasted for about 1h and individual interviews from half an hour to 1h. The stakeholders were informed about the topics of the interview beforehand via e-mail. All stakeholders were asked the same entry questions concerning each topic, and then, according to the answers, the interviews continued in a reflective way (Marton, 1988, Sjöström & Dahlgren, 2002). The interviews were audio-recorded with the permission of the participants and transcribed verbatim in Finnish.

2.3 | Data analysis

First author (TP) analysed the data in an inductive way with a phenomenographic approach to obtain qualitative variations in stakeholders' perceptions (Marton, 1988). The other author (AA) checked the analysis at the end of the process. The nVivo12 qualitative analysis software was used to help the analysis. At first, the transcribed interviews were read through in order to obtain a general view of the collected data. The preliminary aim was to describe a variation of perceptions related to the role of SNs, but when re-reading the data, a larger picture began to emerge about the desired MHSs in

school environments. Therefore, all sentences describing the desirable MHSs in the school environment were selected for further processing, and the sentences describing the work or competence of SNs in detail were omitted from the analysis. The transcriptions were re-read several times to ensure all adequate perceptions were captured. The excerpts answering the research questions formed a pool of meaning. Instead of concentrating on the contexts of individual participants, the main focus was given to the broader context of the pool of meaning. The meaningful statements from all the interviews were grouped based on a similarity of meaning. Each group was named so as to describe the identified perception. (Sjöström & Dahlgren, 2002.)

Following this, we searched for any possible themes appearing among the perceptions. The identified perceptions representing a particular aspect were grouped and abstracted into categories of description. The categories of descriptions constitute the results of the research (i.e., the variation), not the essence of the meaning (such as categories, for example, in phenomenology). (Sjöström & Dahlgren, 2002.) The dimensions of the visioning guided the analysis; the categories of description were organised into those describing either the current state, desirable state or actions needed. The process was repeated with the sentences describing participants' perceptions related to actions needed to reach the ideal state. Finally, the outcome space was formulated from the categories of the descriptions (i.e., qualitatively different ways of experiencing the phenomenon). The outcome space illustrates the structural relationships between the categories of descriptions (Åkerlind, 2012).

2.4 | Ethical considerations

The study was conducted following the WMA Declaration of Helsinki (WMA, 2013) and national guidelines of The Finnish Advisory Board on Research Integrity (TENK) (2012). A favourable statement from the Ethics Committee of the University of Turku was obtained before data collection (statement 5/2020, 24.2.2020). Approvals for the

The dimension of visioning	Topics of the interview	Entry questions
<ul style="list-style-type: none"> Analysis of the current situation 	Topic 1: The current state of MHSs in school health services	<i>What are the mental health services that school nurses currently provide?</i>
<ul style="list-style-type: none"> Identification of desired future state 	Topic 2: Desired MHSs in school healthcare in the future	<i>What are the mental health services that school nurses should provide in the 2020s?</i>
<ul style="list-style-type: none"> Assessment of the external environment 	Topic 3: Barriers to the vision	<i>What are the greatest barriers that will hinder the future vision from becoming true?</i>
<ul style="list-style-type: none"> Connection of the future to the present state 	Topic 4: Identification of necessary competencies needed for the vision	<i>What competencies should school nurses have to achieve this future vision?</i>

TABLE 1 Interview guide

study, where necessary, were obtained beforehand from the participating organisations. All participants were informed before the data collection about the details of the study, and that participation was completely voluntary. Each participant gave their written informed consent to participate in the study. The data were reported, so that the participants could not be identified.

3 | RESULTS

We identified eight descriptive categories related to MHSs in the school environment. One of them described the current state, four of them the desirable state of MHSs in the school environment, and three of them necessary changes at different levels. The future visions were constructed by combining the content of four categories describing the desirable state of MHS in the school environment.

3.1 | Participants

Among the participants were advocates of adolescents and parents, and specialists in SHC or mental health (Table 2). There were participants from the micro-, macho-, mezzo-, macro- and meta-level. The micro-level (i.e., local level) participants ($n = 10$) were advocates from two non-governmental organisations (NGOs) for adolescents and one NGO representing parents; their ages varied from 28 to 59 years. Other participants were specialists as regard SHC ($n = 9$) or mental health ($n = 6$); their ages varied from 36 to 62 years and the length of their working experience in the area of SHC or mental health varied from 7 months to 30 years.

The participants involved in the macho-level (i.e., leadership level) ($n = 3$) worked as the head of a unit in SHC. The participants at the mezzo-level (i.e., organisational level) ($n = 3$), were comprised of a consultative psychiatric nurse, the head of MHSs and an adjunct professor. The macro-level (i.e., national level) participants ($n = 4$) worked as ministerial advisers, senior specialists or medical superintendents working within the ministry. The meta-level (i.e., abstract level) participants ($n = 5$) were chairs of professional organisations, senior lecturers in public health nursing or scientific researchers.

TABLE 2 Sample characteristics

Participants ($n = 25$)	Micro-level	Macho-level	Mezzo-level	Macro-level	Meta-level	Age:	Working experience:
Advocate of adolescents ($n = 4$)	$n = 4$					28–51 years (mean 37 years)	
Advocate of parents ($n = 6$)	$n = 6$					39–59 years (mean 49 years)	
Specialist of SHC ($n = 9$)		$n = 3$	$n = 1$	$n = 2$	$n = 3$	36–62 years (mean 52 years)	7 months–30 years (mean 15 years)
Specialist of MHSs ($n = 6$)			$n = 2$	$n = 2$	$n = 2$	44–58 years (mean 49 years)	6–30 years (mean 17 years)

3.2 | Current state

Visioning started with the identification of the current state. Stakeholders named several problems in the current MHSs provided to school-aged persons. The services were seen as insufficient, unavailable and diverse (Table 3). The services in primary healthcare were seen as scarce or completely missing. Collaboration between the different professionals was deemed to be lacking. Help for mental health problems was not offered at a sufficiently early stage or when needed. Stakeholders emphasised that waiting lists were too long, especially for specialised healthcare. The help provided for the school-aged population as regards mental health issues was dependent on the person, the schools and the municipality; stakeholders described huge differences both in the internal school services and those external to the schools.

The problem with the mental health services for children and adolescents as a whole is the fact that there is practically no therapy on the basic level.

P1

Getting into psychiatric specialist medical care is also difficult.

P5

It does vary a lot already on the municipal level, so what can the school nurse even offer.

G17

3.3 | Alternative visions

Four alternative future visions (Figure 1) were formulated based on stakeholders' perceptions regarding the topic. The perceptions about the desired provider of treatment in primary healthcare, the mission and focus of SHC, and the principal values behind the opinions were variable. The perceptions articulated by stakeholders were separated from the context of an individual interview and the focus was placed only on the meaning of each perception (Åkerlind, 2012). The visions do not exactly represent the perceptions of specific

stakeholders (Table 4), because most of the stakeholders had no complete solutions to provide.

3.3.1 | Vision 1: Non-medicalising school environment focusing on promotion and the mental health of the community

In the first vision, the providers of mental health treatment were envisaged as being external to the school environment, for example, in child guidance and family counselling centres. It was argued that the treatment of any disorder should only be provided outside of the schools. In contrast, health aspects and actions at the community level were seen to be central regarding the school environment. The third sector was also mentioned as a significant operator who should be invited more often to conduct mental health work with schools. In this scenario, the mission of SHC in the future was promotion and prevention for every pupil. Providing health examinations for everyone was seen as having a crucial role in the work of SNs. The focus of

SHC was considered to be more holistic than fragmented; the most important issue was to support both the physical and mental wellbeing of pupils and their family. Mental health should be impacted by actions provided at the community level rather than at the individual level.

The practical treatment work, this more intense mental health work, treatment for mental health should be offered in primary health care or in specialist medical care, if the situation is serious.

P2

I find it important that school health care and student welfare services, in my opinion, are a part of a bigger unit, which means that the health, entire age group, and the promotional work would always remain as the starting points.

P11

TABLE 3 Stakeholders' perceptions about the current state of MHSs provided for school-aged persons

Descriptive category	Identified perceptions
Current state	<ul style="list-style-type: none"> • Insufficient mental health services • Unavailable mental health services • Diverse mental health services

One of the principal values in this scenario was non-medicalising, that is, aspiration to avoid pathologising symptoms related to normal development or life situations. In addition, mental health was seen as equal to physical health. Therefore, if treatment is provided for some diseases in the school environment, there should be treatment for others as well. This undesirable scenario may lead to a situation where schools transform into medical centers, perhaps providing treatment

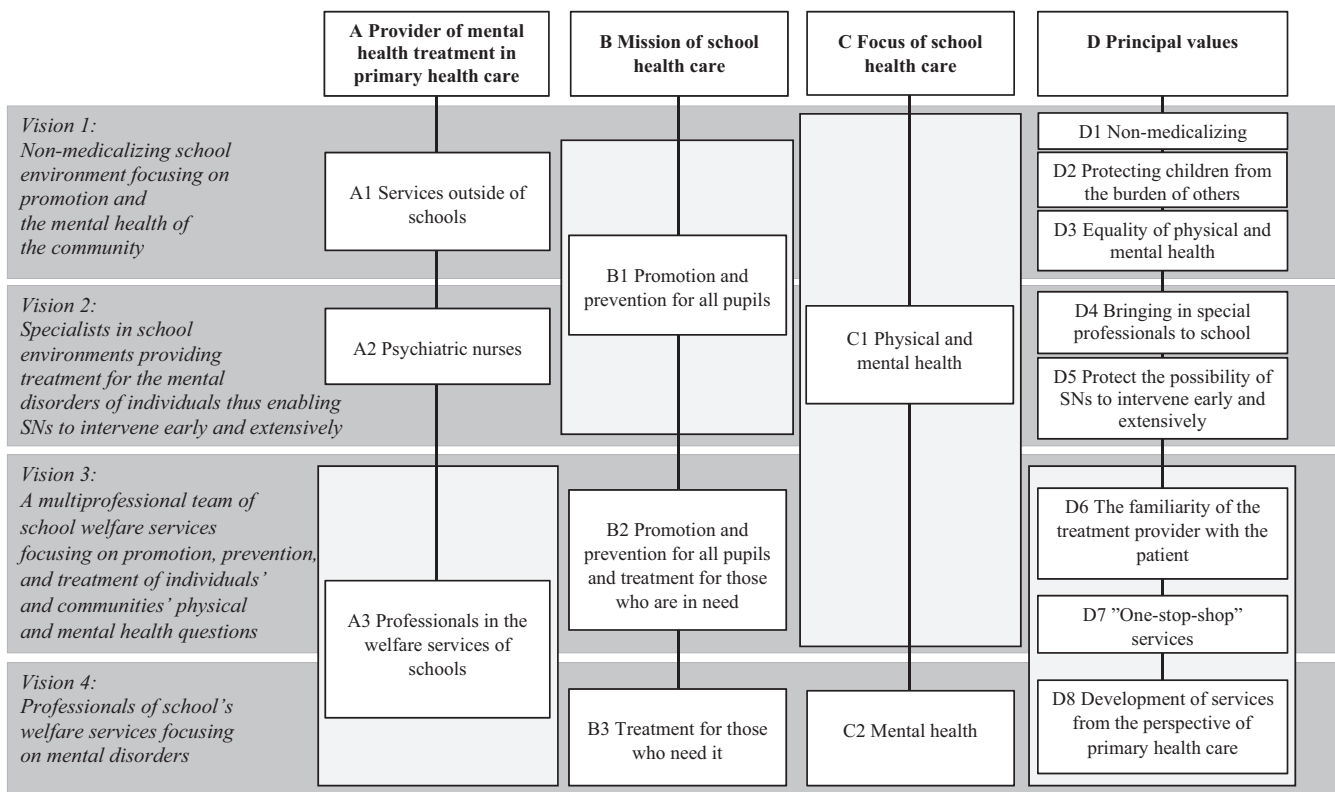


FIGURE 1 Outcome space: Alternative visions about MHSs in the school environment

TABLE 4 Stakeholders' perceptions concerning desirable mental health services in the school environment

Descriptive categories	Identified perceptions
Provider of mental health treatment	<ul style="list-style-type: none"> • Services outside of schools • Psychiatric nurses • Professionals in the welfare services of schools
The mission of school health care	<ul style="list-style-type: none"> • Promotion and prevention for all pupils • Promotion and prevention for all pupils and treatment for those who are in need • Treatment for those who need it
The focus of services in school health care	<ul style="list-style-type: none"> • Physical and mental health • Mental health
Principal values	<ul style="list-style-type: none"> • Non-medicalising • Equality of physical and mental health • Protecting children from the burden of others • Bringing in special professionals to school • Protect the possibility of SNs to intervene early and extensively • The familiarity of the treatment provider with the patient • 'One-stop-shop' services • Development of services from the perspective of primary health care

for depression as well as diabetes. In this situation, SNs will not have sufficient time for promotion and prevention.

Since all of that, now we can see a lot of this, for example, in adolescent psychiatry, we have noticed that these ordinary, daily things have turned into mental health issues.

P13

If all treatment regarding this one issue is to become the responsibility of school health care, it raises the question, why all the rest cannot be dealt with in there as well.

P5

The third essential value was to protect children from assuming the burden of other people or communities. It is frequently found that the symptoms behind the problems of a child or adolescent lie in difficulties in the family. For this reason, there is no point in providing treatment only for the child. On the other hand, the treatment of the whole family within a school environment is not reasonable either. However, parents always have a significant role, and they should be involved in supporting their child. Behind the symptoms may also be problems within the community or society, that is, a poor social climate within the class or pressure to study and be successful. Similarly, in this situation intervening with regard to the cause is more sensible than only trying to cure the consequence.

We should not create these systems and schemes that in some way start to encourage or add to the way we see problems and issues as issues, symptoms, illnesses, and diagnoses of the individual. We are loading the shoulders of an individual with things that would in reality be the responsibility of a community or a group. Or

we force the children and adolescents to carry things that belong to us adults either at home or at school.

P11

3.3.2 | Vision 2: Specialists in school environments providing treatment for the mental disorders of individuals thus enabling SNs to intervene early and extensively

In the second vision, the providers of mental health treatment were envisaged to be mental health specialists working in a school environment, or to be more precise, psychiatric nurses from primary or specialised healthcare. In this vision, the mission of SHC in the future was also promotion and prevention but achieved by health examinations being provided for every pupil. It was seen as crucial that the school health professionals worked proactively, seeking pupils with potential risks or signs of problems. The focus of SHC was the same as in vision one, that is, physical and mental wellbeing. However, the roles of SNs and doctors were more uncertain; the stakeholders spoke about close collaboration between SHC and these specialists, but also about the necessity for a strict distribution and allocation of their work.

Should we add more resources specifically to recruiting psychiatric nurses, who could utilise these methods, meaning that the school nurses could focus more on the promotional work of mental health?

G16

Children and adolescents form a unit within themselves. They have a physical, mental, social, and spiritual unit. Everything is connected.

P2

The principal values in this vision were to bring special professionals to the pupils' ordinary environment, whilst also retaining the possibilities of SNs to intervene extensively at an early stage. One of the priorities was to avoid sending pupils to different places to receive help. Responsibility for treatment was seen as a threat to the other work tasks of SNs; hence, the stakeholders supporting this scenario did not want SNs to provide treatment. Offering health examinations to every pupil as well as other regular meetings with the pupils were seen as essential in an SN's work. In these meetings, SNs could become sufficiently familiar with pupils, so that they would feel confident enough come and talk about their problems. Moreover, regular meetings would normalise visits to SNs, and this would also assist in lowering the threshold for help-seeking.

The adolescent can remain in the school community and the services are brought into that community.

P7

We already know that the nurses are the primary people the children will reach out to at school. That is such a precious thing, and it should not be threatened in any way.

P3

3.3.3 | Vision 3: A multiprofessional team of school welfare services focusing on promotion, prevention and treatment of individuals' and communities' physical and mental health questions

In the third vision, the providers of mental health treatment were envisaged to be a multi-professional team composed of members of professionals already working in schools. The team should include an SN, a doctor, a psychologist and a social worker, and they should have the same clients and the same superior. The mission of SHC was to provide promotion and prevention for all pupils and to provide treatment for mental disorders when needed. The focus of SHC was the same as in the earlier visions, that is, physical and mental wellbeing.

Student welfare services should be unified into one multidisciplinary service with shared customers. Then, as a team, a social worker, a psychologist, and the operators of school health care could treat those pupils.

P3.

In my opinion, the key would be offering low-threshold support for mental health and psycho-social support, and these therapeutic interventions.

P10

One of the principal values in this vision was the MHS providers' familiarity with the pupil and knowledge of the pupils' circumstances in school. The school was mentioned to be an important developmental environment; hence, awareness of this should also be used when providing treatment for mental health problems. Secondly, the stakeholders considered the so-called 'one-stop-shop' services as highly important. They wanted to avoid situations where pupils receive help for somatic problems from one person and mental problems from another. The third principal value was to pay attention to the viewpoint and proficiency of primary health care when designing MHSs for school-aged children and adolescents.

It would require, of course, extremely fluent cooperation with all other operators in the sector of student welfare, so that we are not faced again with the problem where we become too sectorised and staying in our own boxes in a way.

P5

I do see this as a threat, that they think, that people in specialist medical care think that they can develop these basic-level services without involving people at the basic-level at all.

P3

3.3.4 | Vision 4: Professionals of school's welfare services focusing on mental disorders

In the fourth vision, the providers of mental health treatment were envisaged to be the same people as in the third vision, but now working independently. In this vision, the mission of SHC was to provide treatment for mental disorders; health examinations should be offered only when necessary. The focus of SHC was different than any of the other visions as the mental health issues were seen as central. Some of the stakeholders even thought that mental health should take preference over physical health. The usefulness of health examinations was doubted, and their content was described as simply routine information discussed with every pupil in the same way. Offering health examinations only for pupils with some problems may release more time for MHSs. These services should include treatment interventions for mild and moderate mental disorders. A number of the stakeholders said that there should also be psychotherapy available in schools.

School health care should also be capable of this basic-level mental health work and also execute and provide treatment.

G16

Do we need those measurements and this somatic monitoring so much and so often. Or should we

TABLE 5 Stakeholders' perceptions about necessary changes to reach the ideal state

Descriptive categories	Identified perceptions
Necessary changes at micro-level	<ul style="list-style-type: none"> • Strengthening the attitude of solidarity • Improvement of competence • Intensify working with digitalization
Necessary changes at mezzo-level	<ul style="list-style-type: none"> • Ease the flow of the distribution of work and multi-professional cooperation • Modelling the procedures • The development of mental health services outside of schools • Bringing psychiatric nurses into schools • Ensuring supervision of work • Regeneration of the management
Necessary changes at macro-level	<ul style="list-style-type: none"> • Reformation of legislation <ul style="list-style-type: none"> • an obligatory limit on the number of pupils • deregulating the health examinations provided for everyone • making obtaining treatment for mental health problems a statutory part of SHC • Increasing the resources • Taking mental health into account when organising education

really give more space and leeway for mental health issues?

P10

The principal values in this vision were the same as in the third vision, that is, the familiarity of the treatment provider with the patient, 'one-stop-shop' services and development of services from the perspective of primary health care.

It would be so odd to start to deal with these things somewhere, under a completely strange person, who does not know the school context of a specific child.

P3

3.4 | Courses of actions needed to reach the ideal state

The stakeholders' perceptions varied regarding the necessary changes to reach the ideal state of MHSs in school environments. The changes suggested were not specific to any particular vision. For clarity and confirmability, the desired changes were simply allocated into micro-, mezzo- and macro-levels (Table 5).

3.4.1 | Necessary changes at the micro-level

Strengthening the attitude of solidarity means that mental health issues should be the responsibility of every adult in schools. According to this perception, it was harmful to think that mental health issues are only the responsibility of some specialists and special places. Some stakeholders related that even normal problems, such as problems in social relationships, have been outsourced to psychiatric special healthcare. Moreover, professionals in different places have provided repetitive assessments, instead of an alleviation of

symptoms and treatment of disorders. Shifting the responsibility to others should be stopped and every adult should be self-reliant enough to provide help for children and adolescents. The third sector should also be involved and should take part in the mental health work in the school environment.

This is not work for one professional: this belongs to everyone, and it does not require any magic skills.

G17

Improvement of competence was emphasised by many participants. The competence of both SNs and doctors in mental health issues was seen as insufficient. There was a need for continuous and systematic training, especially concerning evidence-based methods. In addition, among the participants, it was also noted that singular methods do not help for every situation and there is also a need for wider competence. In addition to treatment methods, there was also a desire for methods directed to the prevention of problems and the assessment of symptoms.

The studies of a nurse should include even more elements on mental health work and prevention, the kind of work you can do as a nurse.

P2

Intensify working with digitalisation included three issues: (1) lowering the threshold of help-seeking, (2) more effective use of working time and (3) increasing the use of digitalised resources. Stakeholders suggested the use of electronic scheduling, remote meetings and messaging apps to lower the threshold of help-seeking. With the digitalised questionnaires and electronic automated health education, it could be possible to release more working time to mental health issues. The use of digitalised MHSs already available should also be increased. These kinds of services are, for example, the self-help programmes provided by specialised psychiatric healthcare via the internet.

The digital screening could be used to identify those who are in more need of a talk.

P4

3.4.2 | Necessary changes at the mezzo-level

Ease of the flow of distribution of work and multi-professional cooperation was seen as an essential change. The job descriptions of professionals related to mental health were seen as obscure and somewhat overlapping. Stakeholders asked for clarity in the distribution of work between professionals in schools (i.e., SNs, school psychologists and social workers) and between primary healthcare and psychiatric special healthcare. If psychiatric nurses are working in schools, a clear definition of the distribution of work between their work and the SNs work was needed. Cooperation among professionals should be solid and smooth. Problems were seen in the cooperation between SNs and physicians, but also in a wider context among professionals in the schools with other professionals outside the schools. Several concrete examples of such problems were given, such as, ignorance about the content of the jobs of other professions, broken transmissions of information and too high confidentiality between professionals. There were also problems with workspaces; free rooms for all professionals were not always available; so, they did not see each other as they had to alternate their working hours in the same rooms.

I think the cooperation with other personnel in student welfare is quite essential. So, it needs to be clear. Clear distribution of work, so that people do not get stuck in a limbo.

P5

The modelling of the procedures was also one of the critical changes needed. Stakeholders wanted to ensure goal-directed and systematic working by means of modelling. According to the stakeholders, there was a need for predefined content and targets, as well as systematic monitoring concerning the impact of the help provided, especially in the work of SNs. In addition, regional agreements about the use of questionnaires aiming to assess symptoms and methods aiming to improve mental health was seen as important. More structure was needed for treatment processes; currently, it is unclear and changeable as to who should go where to obtain treatment for mental health problems. The stakeholders hoped that in the future regional procedures would extend all the way from primary healthcare to special healthcare, making cooperation smoother.

Everything is leaning on this, like planning something together. Like a process description, a local model on how to act.

P10

The development of mental health services outside of schools, especially in primary healthcare, was one of the necessary changes that the stakeholders mentioned. A number of the participants reasoned that mental health treatment should only be provided outside of schools. However, the lack of primary health care facilities where pupils can receive help was seen as a major problem in the field. In addition, the need for MHSs outside of schools was justified through the perception that some pupils and teachers want to avoid office visits during school days. For this reason, the need for appointments in evening times was also mentioned. Organising mental health treatment only in a school environment was also seen as a threat to pupils seeking help, especially if the pupils have problems relating to the person named as the treatment provider in a school.

And yeah, these basic health care, development of health centre services.

P2

Introducing psychiatric nurses into schools was one suggested solution to the problem. Several of the participants saw psychiatric nurses working in or visiting the school environment as a principal solution while others protested against them. The working model based on this vision is already in use in some municipalities. Those who have some experience of this, said that it has helped SNs' work and made the process of obtaining help quicker for mental health problems. However, they also talked about problems in the collaboration between professionals. There was also a fear of sectorising services; a different box for every purpose may lead to situations where peoples' needs are not met holistically.

I wish that in the future, school and student health care includes these psychers. I don't mean that they [pupils and students] would become mental health, like, they will not become customers of psychiatry or anything like that. It would still be school health care, where adolescents could go and talk about their feelings when they are anxious, when school feels bad.

P13

Ensuring supervision of work and other support was mentioned as essential. The participants wanted to reinforce the fact that the supervision of work is a statutory part of mental health work and also important when related to possible new methods. A regional coordinator for new methods was also seen as necessary and aimed at avoiding situations where the new methods and procedures are abandoned over time. More consultative support was needed for SNs, especially from specialised healthcare, but also from the psychiatric nurses who might work in the schools. In the stakeholders' opinion, SNs also needed more support from their colleagues and superiors.

There should be adequate access to professional guidance and consultation opportunities.

P10.

An essential change regarding the regeneration of management was to start to lead these services as a unit. Currently, separate managers for every profession are hampering seamless and coherent services for those suffering from mental health problems. The stakeholders worried that this will lead to a game of ping pong scenario with people being referred from one service to another. They also talked about resistance to change among managers and required management to be more goal-directed, integrated and supportive of new procedures.

The difficulties of cooperation are caused by not leading these services as a unit. These services have been produced by different sectors.

G16.

3.4.3 | Necessary changes at macro-level

Reformation of legislation was seen as essential from three perspectives. First, in respect of resources, there was a need to obtain an obligatory limit for the number of pupils per SN instead of the current recommendation. Second, there was an expectation that health examinations of the whole age group could be transformed into being provided only when specifically needed. With this amendment, the desire was to obtain more time and space for pupils' mental health issues. Third, a change of legislation was seen as crucial in order to establish the treatment of mental health problems as a statutory part of SHC. The stakeholders had the perception that because treatment is nowadays excluded, there are no SN resources reserved for the treatment of mental health problems.

The law does not directly define the number of pupils and children per nurse.

P8

This inspection has suddenly gone above everything else because it is the one thing that is easy to measure, and therefore, this law and decree that applies to school health care should all be renewed.

P4

I wish that the legislation would be changed so that the school health care must also include therapeutic liability.

P10

Increasing the resources was one of the most obvious necessary changes identified: The stakeholders mentioned it in every interview. The need to increase resources of SNs was justified through with the fact that health examinations take the majority of SNs' working hours and there is no time for mental health issues, not even for promotion and prevention. Providing treatment for mental disorders was seen

impossible with the current resources. An increase in competence or the number of mental health interventions was described as pointless if SNs have no time to meet pupils. The number of school doctors was also one of the stakeholders' concerns. According to the participants, scarce resources of competent and committed physicians undermines the quality of SHC. It also burdens SNs when they no longer have the support of a professional partner (i.e., the school doctor). Moreover, the scarce number of school psychologists was also mentioned.

Now there is a great ruckus over these intervention methods. It is as if these methods would help someone even if the nurse does not have the time to perform them.

P11

Taking mental health into account when organising education included perceptions regarding both the curriculum and everyday work in a school environment. The suggested concrete proposals for change were, for example, decreasing the number of pupils in a class and increasing the education of mental health skills, such as emotional and social interaction skills. Mental wellbeing should also be considered in the architecture of school buildings, for example, this could help in the matter of noise and a peaceful environment for learning.

Smaller student groups are also a form of mental health treatment.

P2

4 | DISCUSSION

The stakeholders' perceptions related to the desirable state of MHSs in the school environment were variable. Four alternative future visions were constructed based on these perceptions. In these visions, the desired provider of treatment varied from being someone outside the school, to psychiatric nurse visiting the school or professionals within the welfare services of the school. The mission and focus of school health care varied from overall health promotion to treatment of mental disorders. Moreover, the principal values behind each vision were numerous and various. As our results show, there is a lack of agreement concerning the essential elements of SHC. Our results also introduce several suggested actions for reaching the ideal state in MHSs in the school environment.

4.1 | Alternative visions

Vision 1 has two important aspects of note. First, when speaking of the school-aged population it is essential to emphasise non-medicalisation and to remember that many symptoms can also be a part of normal development and not a sign of mental health problems. Second, it is necessary to consider the root causes of malaise and to direct the interventions correctly. The basis of this vision was equality

between physical and mental health, because there is no treatment for other diseases in schools there should be no treatment for mental disorders either. However, most mental disorders begin in the school-age period (Patel et al., 2007), and they are the most common cause of disability retirement in Finland (Finnish Centre for Pensions, 2021). On the contrary, this prognosis can improve with adequate help (Patel et al., 2007). Unfortunately, the ongoing COVID19-pandemic has significantly increased depressive and anxiety symptoms in children and adolescents (Racine et al., 2021) and the risk of suicide, especially among female adolescents (Mayne et al., 2021). For these reasons, it is not wise to fully equate mental health problems with physical problems when contemplating the content of SHC services.

The main difference between Visions 2 and 3 is the position of SNs. In Vision 2 SNs are quite passive providing space for mental health specialists. In Vision 3, the SNs are an active part of a multi-professional team providing promotion, prevention and treatment. The main weakness in Vision 2 is the difficulty of making a distinction, in practice, between promotion and treatment. Mental health promotion should be provided to all individuals, despite their mental health status or diagnosis. Moreover, preventive interventions should be targeted towards both people with and without risks or symptoms of mental disorders (Vartiainen et al., 2021). Too strict a segregation of promotion, prevention and treatment may lead to situations where a child or adolescent is transferred back and forth from one place to other.

Vision 4 advocates treatment over promotion and prevention. Conversely, health promotion is a cornerstone in the profession of SNs (WHO, 2021a), and the focus on mental health issues should be in promotion, prevention and early interventions, according to the political strategies and guidelines (Vorma et al., 2020, WHO, 2021b). According to earlier research, promotive interventions are beneficial (O'Connor et al., 2017; Sakellari et al., 2021) and preventive interventions cost-effective (Feldman et al., 2020; Vartiainen et al., 2021). The results of our study tend to indicate that these interventions are underused. The large review made of the global WHO guidance documents supports this conjecture, as it identified essential or suitable mental health interventions in SHC that were only related to screening, assessment, referral or support, but no interventions regarding promotion or prevention (WHO, 2021a). Thus, there is need to clarify the opportunities of SNs to conduct promotive and preventive mental health work in an evidence-based, systematic and goal-directed way. This vision also favours mental health over physical health. Although mental health difficulties are one of the central health problems in those of school-age, they are not the only problem (WHO, 2021a). If a focus is placed on the treatment of mental disorders in the school environment, the promotive, preventive and holistic services may suffer.

4.2 | Courses of actions needed to approach future vision

In our study, necessary changes to reach the ideal situation were identified, at the micro- mezzo- and macro-level. Most were not specific

to a particular vision, but further discussion about the necessary changes related to each vision is possible. The suggested micro-level changes can be seen to be beneficial in every vision. Nevertheless, *The attitude of solidarity in mental health issues* is more related to Vision 1 and to the salutogenic approach. Consistent with our findings related to the other necessary changes at this level, Sakellari et al. (2021) reported promising results in their study concerning the use of digital interventions in mental health issues in school settings. The need for an improvement in competence in mental health issues has also been reported earlier (see for example Gee et al., 2021). The new methods of treatment and the competence to use them have been a frequently mentioned solution to the mental health crisis. However, according to the Finnish research conducted by Parhiala et al., 2020, the routine work that SNs provide in an intensive and focused way was demonstrated to be probably as feasible, acceptable and effective a form of treatment for depression as the IPC method.

In this study, many changes at the organisational level (i.e., mezzo-level) were suggested. One of these was *The development of mental health services outside of schools*, and it is strongly related to Vision 1 which suggests allowing the treatment of mental disorders to be external to the schools. In turn, *Bringing psychiatric nurses into schools*, is strongly related to Vision 2. The other suggestions were more general and functional in every vision. The problems behind these suggestions have also been identified in previous studies. For example, Savolainen et al. (2021) reported deficiencies in multi-professional collaboration between organisations; Dahl & Crawford (2018) discussed the overlapping roles of SNs and other professionals in schools and Gee et al. (2021) described the lack of supervision in the work of SNs. According to the legislation, 'Provision of mental health services requires an effective system for supervision of the work' (Mental Health Act 1116/1990), and therefore, supervision must be guaranteed for all professionals providing promotion, prevention or treatment of mental health issues.

Participants in this study also raised the issue that there is a need for considerable macro-level changes. Most of these recommendations were not specific to any particular vision. By contrast, two of the legislative changes suggested, *Deregulating the health examinations provided for everyone* and *Making obtaining treatment for mental health problems a statutory part of SHC*, were strongly related to Visions 3 and 4 aiming to enable the treatment of mental disorders in SHC. In respect of the former, the health examinations provided for everyone were seen as low-value care by some participants in this study. It can be argued that limiting the health examinations would be the correct de-implementation strategy only if the care is proven to be (cost)ineffective or more harmful than beneficial (Verkerk et al., 2018). Interventions provided in SHC appeared to have been effective, but evidence about the effectiveness of routinely delivered SHC, such as health examinations, is poor according to a recent systematic review (Levinson et al., 2019). It is worthwhile to note that Finland has one of the best health care systems (GBD, 2018) and overall well-being (Ruggeri et al., 2020) in the world, and also a good ranking in healthy life expectancy (GBD, 2016). Although there is no scientific evidence

about the impact of the regular health examinations included in Finland's unique child health clinics and SHC system which have been in operation for over 100 years in these results, it might be one of the explanations. Therefore, limiting health examinations is not a strategy to be considered if there is no sound evidence about its ineffectiveness (Verkerk et al., 2018).

However, many stakeholders emphasised that the current way in which health examinations are conducted, and more broadly the overall work of SNs, is inefficient. The common reasons for this inefficient care are ineffectual organisations and a lack of cooperation (Verkerk et al., 2018); the same problems that participants also mentioned in this study. According to Verkerk et al. (2018), a suitable de-implementation strategy for inefficient care is lean thinking, that is, eliminating wasteful practices and improving efficiency. The results of this study include three suggested changes aiming to 'lean' the process: (1) *Ease the flow of the distribution of the work and improve the multi-professional cooperation*, (2) *Modelling procedures* and (3) *Intensifying the work with digitalisation*. These three are potential ways to obtain more space for mental health questions in SHC and improve MHSs in the school environment.

4.3 | Limitations and strengths

This study has many strengths and some limitations which are discussed according to the criteria introduced by Lincoln and Guba (1985). To ensure dependability, every participant was asked the same entry questions. Representative quotations from every identified perception and precise description of the analysis were reported (Åkerlind, 2012). Supporting confirmability, the results were consistent with earlier studies. A purposive sample, involving a heterogeneous group of stakeholders from different contexts, and a suitable data collection method strengthened the credibility as well as reaching data saturation. Data saturation was reached when there was no new variation found in the participant's responses.

Only one researcher (TP) analysed the data. For a dialogic reliability check, another researcher (AA) read the whole data and checked the analysis, and the research group discussed the results and reached a consensus (Åkerlind 2012). The researcher's pre-understanding may limit the credibility. On the contrary, the logical structure of outcome space always reflects not only the data itself but also the professional judgement of the researcher (Åkerlind, 2012). The researcher (TP) was aware of her background and its possible influence on analysis. The study was conducted in a Finnish context where the work of SNs, and also education and legislation, are somewhat different from other countries. This should be considered when assessing transferability.

5 | CONCLUSION

The future visions of MHSs in the school environment are based on distinct and even opposite perceptions related to the mission of

SHC. One extreme emphasises overall health promotion for everyone, and the other treatment for those suffering from mental disorders. Selection of a desirable vision is challenging: the former may lead to inadequate help for mental health problems and the latter insufficient help for other problems.

6 | RELEVANCE TO CLINICAL PRACTICE

Mental health questions and possible ways to organise and provide MHSs are a crucial global problem. The decision-makers in politics and health care organisations need information and knowledge about different ways to solve the global mental health crisis. This study not only contributes alternative future visions but also promotes strategic planning with in-depth knowledge about stakeholder's perceptions behind these various visions. It also helps to clarify role of SNs in the future. Furthermore, it presents several suggestions about how to reach an ideal state for MHSs in the school environment. Further studies are needed about the perceptions of children and adolescents regarding MHSs in the school environment.

AUTHOR CONTRIBUTIONS

Study design: TP, ML, CL, AS, AA; data collection: TP; data analysis: TP, AA, and manuscript preparation: TP, ML, CL, AS, RH, AA.

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CONFLICT OF INTEREST

The authors report no conflict of interest.

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions.

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