frontiers | Frontiers in Education

TYPE Original Research
PUBLISHED 12 January 2026
DOI 10.3389/feduc.2025.1743129

OPEN ACCESS

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RECEIVED 10 November 2025
REVISED 08 December 2025
ACCEPTED 10 December 2025
PUBLISHED 12 January 2026

CITATION
Howard K and Moore D (2026) School-based mental health support for children with English as an additional language.
Front. Educ. 10:1743129.
doi: 10.3389/feduc.2025.1743129

School-based mental health support for children with English as an additional language

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Introduction: Over 20% of school children in England speak English as an additional language (EAL), a figure that is increasing each year. Given an unrelated increase in the prevalence of mental health difficulties among young people, the number of multilingual children in England experiencing mental health difficulties is inevitably on the rise. With growing support in England for mental health services to be embedded into educational settings and delivered by educational mental health practitioners (EMHPs), this article investigates school-based mental health support in England for children with EAL.
Methods: Fourteen EMHPs who administer low-intensity psychological therapies to EAL pupils in schools were interviewed and data were analysed using a critical realist-orientated thematic analysis.
Results: Results suggest that school-based mental health interventions in England may be less accessible for EAL pupils than their monolingual peers. Along with cultural differences and mental health-related stigma, some aspects of therapy were 'lost in translation'. This affected both the accessibility and the effectiveness of support in schools, from identification to treatment.
Discussion: Navigating multilingualism in therapeutic interventions with young people is complex. Greater linguistic flexibility, including more choice over the language(s) used in psychotherapeutic interventions, is pivotal to improving mental healthcare for children with EAL.

KEYWORDS

accessibility, linguistic diversity, mental health, mutilingualism, school

1 Introduction

Over 20% of the school population in England speak English as an additional language (EAL) (Lindorff et al., 2025). This figure is growing year on year and increasingly includes refugees and asylum-seekers. This rise in linguistic diversity is reflected in classrooms across the world, primarily fuelled by increased international migration and globalisation (Bonnet and Siemund, 2018). In England and internationally, there has also been an increase in the prevalence of mental disorders among children and young people (Newlove-Delgado, 2022; Piao et al., 2022). Within the context of this 'global public health crisis' (McGorry et al., 2022), it follows that an increasing number of those young people experiencing mental health difficulties may be multilingual. Little is known, however, about access to mental health interventions for children and young people from multilingual backgrounds, and, in particular, those who have recently arrived in England and speak little English. This is of significant concern given the growing focus on psychotherapeutic interventions (i.e., 'talking therapies' like cognitive-behavioural therapy (CBT)) that rely primarily on language to identify and treat mental health difficulties. This article therefore explores the accessibility of mental health interventions delivered in English for children and young people who speak English as an additional language.

Given that EAL pupils are defined primarily by their linguistic profile, research into the experiences of this group tends to focus on academic achievement and the development of their English language proficiency (e.g., Lindorff et al., 2025). However, EAL students are more than the languages they speak. Indeed, there is significant linguistic, academic, social, cultural, and ethnic heterogeneity within the EAL population, which can render the label problematic (Arnot et al., 2014). While not all pupils from minoritised ethnic backgrounds have English as an *additional* language (for many it is their *first* or *only* language) and not all EAL pupils are from minoritised ethnic backgrounds, there is significant overlap between these two umbrella groups. Similarly, while not all EAL pupils are first generation migrants, the majority come from migrant backgrounds. Despite these overlaps, mental health research has focused attention on the prevalence and treatment of young migrants (e.g., McMahon et al., 2017) and children from minoritised ethnic groups (e.g., Dogra et al., 2012) rather than EAL pupils, perhaps due to the linguistic emphasis of the term 'EAL' By doing so, there is a risk that research overlooks the centrality of language competence in the effectiveness of psychological therapies.

Existing research on both migrant and minoritised ethnic groups suggest that these populations of young people are more likely to be at risk of experiencing mental health difficulties (Alegria et al., 2010; McMahon et al., 2017) and yet face greater individual and systemic barriers to accessing mental healthcare (Bansal et al., 2022; Colucci et al., 2015). Although consideration of accessibility is under-researched, especially for migrants (Howard et al., 2024), key barriers include: a lack of trust in services (Finnigan et al., 2022); stigma around mental health (Baak et al., 2020); cultural misalignment in services (Faheem, 2023); acculturative stressors (Ellis et al., 2013); and biases in the recognition of mental health needs (Guo et al., 2014). A more culturally responsive approach to mental healthcare is likely to reduce disparities in access (Meléndez Guevara et al., 2021).

Linguistic differences are also often cited as a factor in access difficulties for migrant groups (Krystallidou et al., 2024; Rousseau and Frounfelker, 2019) but are rarely the focus of research. Studies on multilingualism in therapeutic interventions with children and young people are particularly scarce (Serrani, 2023). Effective language practices in therapy depend first on multilingualism being identified and secondly supported throughout the therapeutic process (Costa, 2010; Rolland et al., 2017). This is because emotional expression is often preferred in multilinguals' 'first' language, or languages acquired early in life (Dewaele, 2011; Dewaele and Costa, 2013; Pavlenko, 2004), even though additional languages can serve a distancing function in therapy, known as the detachment effect (Marcos, 1976). Taken together, allowing recipients of therapy to code-switch, that is, move between their languages, facilitates a more comprehensive and authentic self-expression among multilinguals (Dewaele and Costa, 2013).

Nevertheless, an underlying assumption persists that therapy is a monolingual activity (Rolland et al., 2017, 2021). Such monolingual norms are also ubiquitous in school settings in England where multilingualism is often viewed as problematic (Evans et al., 2016) and where the implementation of monolingual policies can be discriminatory and divisive (Welply, 2023). Such practices and attitudes stand in contrast to research findings that encouraging children's use of their home language(s) may have positive effects on their mental health and wellbeing (Müller et al., 2020), although family relationships often play a moderating role in the relationship between home language maintenance and mental health (Kilpi-Jakonen and Kwon, 2023).

1.1 The current study

Schools are increasingly considered effective sites for the delivery of mental health interventions for children and young people (Fazel and Soneson, 2023), despite challenges in implementation and scope (Ellins et al., 2024). In 2017 the UK government's Green paper *Transforming Children and Young People's Mental Health* announced the first wave of mental health support teams (MHSTs) in schools across England (Department of Health and Department for Education, 2017). Initially 58 "Trailblazer" teams were commissioned, by mid-2025 NHS England reported 700 teams. Their remit is to foster mental health promotion (e.g., universal interventions, whole school approaches) and provide targeted support to those with mental health difficulties (e.g., through evidence-based psychological therapies delivered by educational mental health practitioners (EMHPs)). Despite being broadly well received by schools, geographical disparities persist in the provision of mental health support as less than half of schools and colleges have access to MHSTs (Mundy et al., 2025).

Schools may be especially well placed to serve the mental health needs of children from culturally and linguistically diverse backgrounds as they are arguably less stigmatising spaces and can provide a platform for the integration of different services (Baak et al., 2020; Fazel et al., 2016). However, concerns have been raised that the Green Paper initiative failed to address cultural diversity among young people, drawing instead on overly Western-centric understandings of mental health (Cox and McDonald, 2020). This critique aligns with a recent evaluation of the MHST programme that found gaps in provision for children from minoritised ethnic backgrounds and who had English as an additional language (Mundy et al., 2025). Current school-based mental health support may therefore be inaccessible to some, or many, young people from multilingual backgrounds in England because interventions are reliant on good proficiency in English. Drawing on interview data with EMHPs who deliver mental health interventions in schools in England, this study sought to address the following research questions:

1) How effective are psychological therapies perceived to be for EAL pupils?
2) What influences EAL pupils' access to school-based mental health (SBMH) support?
3) How could SBMH provision for EAL pupils be improved?

2 Methods

2.1 Study design

Qualitative research on child and adolescent mental health is increasingly considered imperative to understanding experiences, intervention, and accessibility (Sonuga-Barke, 2024). This study was underpinned by a critical realist (CR) philosophical framework, concerned with the interplay between social structures and human agency (Bhaskar, 2008). CR engages with causal explanations of events and experiences, making it useful for qualitative research that investigates social problems and their solutions (Fletcher, 2017). As such, a critical realist approach to thematic analysis (Fryer, 2022) was deemed apposite to the aims of the study, which sought to go beyond

identifying patterns among participants' experiences of events, by exploring underlying causal mechanisms in relation to EAL pupils' access to school-based mental health support. The study's design and implementation adhered to the Standards for Reporting Qualitative Research (SRQR; O'Brien et al., 2014).

2.2 Participants

Fourteen educational mental health practitioners (EMHPs) who deliver school-based mental health support to EAL pupils were included in this study (Table 1). Two participants described their role as 'education wellbeing practitioners', reflecting regional differences. Half of participants spoke one or more languages in addition to English. Participants worked in a range of schools across different regions in England with varying numbers of EAL pupils (Table 1).

2.3 Ethics statement

This study was granted ethical approval by the researchers' University ethics committee (University of Exeter Research Ethics Committee [528365]) and by the Health Research Authority (23/HRA/1700). Participants were recruited through study information sheets emailed to Mental Health Support Teams (MHSTs) in England and could take part in the study if they a) were currently working as an EMHP, and b) had experience of working with EAL pupils. Participants contacted the first author then gave their informed consent to participate.

2.4 Procedure

Semi-structured interviews were conducted by the first author with 14 educational mental health practitioners (EMHPs) between June and September 2023. This method was selected to gain preliminary understandings of the experiences and perspectives of EMHPs on the accessibility of school-based mental health support for pupils who have EAL. The interview schedule (see Supplementary materials) was informed by relevant studies on practitioner and clinician perspectives of multilingualism in the context of mental health support (e.g., Costa, 2010; Jones, 2018). Questions were divided into five sections: (1) EMHP role; (2) Identification, referrals and assessment; (3) Targeted interventions; (4) Universal interventions; (5) Recommendations for improving access for multilingual children and young people.

Two EMHPs who were not participants were consulted on the suitability and accessibility of the interview schedule before interviews began and changes were made as a result of their feedback. Specifically, questions related to parental consent and involvement, and cultural competence were added and/or clarified.

The mean interview length was 46 min 41 s (range 38 m 06 s–54 m 28 s) and all interviews took place online. An explanation of the study aims and procedures was provided prior to the interview and participants were offered a chance to ask questions both before and after the interview. Interview data was audio recorded. Following transcription, all identifiable information was redacted, and transcripts were stored securely.

2.5 Data analysis

Data in this study were analysed using a critical realist approach to thematic analysis as outlined by Fryer (2022). This approach is underpinned by a tripartite focus on experiences, events, and causes (Bhaskar, 2008; Fryer, 2022). Following an initial process of re-reading the transcripts to become familiar with the data, 271 initial codes were developed inductively across the 14 transcripts. An iterative process of standardisation (bringing together similar codes) and consolidation (adopting a more general or theoretical term to describe the code) then took place (Fryer, 2022), leading to a reduction in codes, first to 158, and then to 138. The first researcher then returned to the transcripts to check the descriptive and interpretative validity of the

TABLE 1 Participant characteristics.

Participant	Gender	Percentage of EAL pupils in school	Role	Speaks other languages?
1	Female	80%	EMHP	Yes
2	Female	10%	EWP	Yes
3	Female	Unsure	EMHP	Yes
4	Female	20–30%	EWP	No
5	Female	Unsure	EMHP	Yes
6	Female	School dependent	EMHP	Yes
7	Female	35%	EMHP	No
8	Female	50%	EMHP	No
9	Female	Almost 100%	EMHP	No
10	Female	70–80%	EMHP	No
11	Female	School dependent	EMHP	No
12	Female	School dependent	EMHP	No
13	Female	Over 50%	EMHP	Yes
14	Female	School dependent	EMHP	Yes

codes (Wiltshire and Ronkainen, 2021) and pivot to a more deductive lens that draws on existing theory and knowledge (Fryer, 2022). This process resulted in a further synthesis and re-naming of codes. Detailed notes of this process were kept to increase trustworthiness (Nowell et al., 2017). Broader patterns of meaning were identified across initial themes, leading to the defining and naming of themes and subthemes congruent with the study's research questions. To further enhance trustworthiness, the first author re-read and organised excerpts from each theme and subtheme to ensure empirical adequacy (Wiltshire and Ronkainen, 2021) and theme development was discussed and refined with the second author.

3 Results

Three overarching themes and seven subthemes were identified as part of the critical realist thematic analysis (Table 2).

3.1 Navigating multilingualism in psychotherapy

3.1.1 "Lost in translation"?

All participants discussed the impact of multilingualism in the school-based mental health support they provided to EAL pupils. Some practitioners were eager to normalise and celebrate multilingualism, inferring that they considered multilingualism an asset, not a deficit. Similarly, one practitioner noted that, while not their primary aim, psychotherapeutic interventions may provide further opportunities for EAL pupils to develop their English proficiency outside the classroom:

> *"It's another opportunity to speak in English, a different area of English."*

However, more commonly described were linguistic challenges faced by EAL pupils when participating in psychological therapies, particularly when discussing emotions in their non-native language. Practitioners highlighted how linguistic differences restricted EAL pupils' inclusion and engagement in psychotherapeutic interventions.

TABLE 2 Overview of themes and subthemes.

Themes	Sub-themes
1) Navigating multilingualism in psychotherapy	a) "Lost in translation"? b) Perceived effectiveness of psychotherapies for EAL pupils
2) SBMH support is less accessible for EAL pupils	a) EAL pupils are less likely to be identified for SBMH support b) Stigma and cultural difference c) Difficulties for newly arrived pupils
3) Linguistic flexibility is central to cultural responsiveness	a) Linguistically flexible delivery increases access b) Linguistic flexibility relies on collaboration

For instance, some acknowledged the additional cognitive load in switching between languages:

> *"It's having that emotional literacy to even name those feelings in their first language, never mind them trying to translate that in their head to another language. It's hugely complicated to be able to do that"*

In line with 'first language primacy' (Pavlenko, 2004), EMHPs considered how multilinguals may be more inclined to use their home language to discuss mental health:

> *"I think most people, when they're really expressing their deepest thoughts, they revert to their mother language"*

As a result, many practitioners discussed difficulties in deciphering EAL pupils' understanding of key concepts during interventions and the frequent occurrence of conversations being 'lost in translation'. For example, one practitioner noted that:

> *"Like panic attacks and things that don't have a direct translation. I remember the interpreter thought we were talking about asthma attacks for a whole session, and then it turned out it was panic attacks"*

More concerning still, one practitioner discussed a case of 'lost in translation' pertaining to risk. An EAL pupil with limited English proficiency had used the phrase 'I do not want to be here', which was quickly highlighted as potential suicidal ideation and escalated. In fact, the young person was indicating they did not want to be in school. This example epitomises the experiences of several practitioners who noted that EAL pupils often received less comprehensive mental health support than their non-EAL peers due to misunderstandings and miscommunication.

Practitioners noted how the lack of a 'direct translation' for key terms also made it more difficult for young people to discuss the support with their families in their home language, resulting in reduced parental input. Accordingly, language barriers tended to influence the attendance and engagement of EAL pupils and their families:

> *"Trying to learn in a different language is tiring… so I can completely understand this young person's lack of engagement"*

> *"They're going to be terrified coming into an assessment with a practitioner who doesn't speak any language that they speak"*

If EAL pupils have difficulty understanding the practitioner or feel misunderstood in psychotherapeutic interventions, then it is possible that support intended to alleviate mental health difficulties might exacerbate the problems it seeks to address. Nevertheless, some practitioners noted that many EAL pupils had a high level of English proficiency, and that often interventions required no or little adaptation for linguistic reasons. Instead, for some, language barriers tended to be more prominent among the parents of EAL pupils:

> *"Working with the young person doesn't present that many challenges. But working with the parents is where it becomes a little*

> *bit more tricky, because most of the parents have a lower level of English"*

Practitioners reported that language barriers for EAL parents resulted in lower engagement and attendance, including less support with intervention-related homework. The reliance on written materials was identified as particularly problematic for parents. Consequently, a more frequent drop-out rate among EAL families was reported.

Most practitioners emphasised how translation and interpretation were key vehicles to improving access:

> *"If you don't have the translated resources and materials, it's very difficult to make it accessible"*

Several EMHPs highlighted how the presence of an interpreter or translated materials not only supported understanding and communication, but also made EAL pupils, their families, and practitioners feel more confident. However, many of the practitioners reported that there were no or limited translated materials (i.e., referral forms, information for parents, intervention resources, etc.) available to share with EAL pupils and their families.

For some, access to interpreters during interventions was limited and for those who were able to access interpretation, several challenges emerged. First, EMHPs reported logistical barriers such as scheduling interventions, additional administrative work, and longer sessions and/or treatment. Some practitioners raised concerns about what and how information was being communicated by interpreters, especially given the predominant view that interpreters had not received specific mental health training. However, participants expressed a preference for formal interpretation rather than the commonplace 'informal' reliance on family members or school staff, which raised ethical concerns about confidentiality for practitioners and pupils alike:

> *"I wasn't 100% comfortable with using a member of staff to do the translation because how impartial is that translation when I have absolutely no experience of Urdu and I do not 100% know whether what I'm saying is being translated accurately?"*

Others highlighted the cost of translation and interpretation as a barrier:

> *"I asked to get the whole behaviour intervention for parents translated because about three quarters of the parents I work with are from Somalia. It was too expensive"*

3.1.2 Perceived effectiveness of psychotherapies for EAL pupils

EMHPs were generally sceptical that psychological therapies were as effective for EAL pupils as their monolingual counterparts, citing the inherent reliance on the English language as the medium for therapy as a central barrier:

> *"If you were looking at full evidence-based interventions, in my personal opinion, I think it would be more successful with a young person without EAL"*

> *"This young person just wasn't speaking, and I thought maybe they are just really anxious. It turned out she couldn't understand anything I was saying"*

Others noted that certain interventions were more effective than others, depending on the type and amount of language required and the ease of adaptation. However, there was little consensus about which interventions were more effective. For instance, while one practitioner considered a 'worry management' intervention more suitable for EAL pupils because it is less manualised, another suggested that difficulties conceptualising hypothetical and practical worries among non-EAL pupils were compounded for EAL pupils. In a similar vein, there were mixed views of the effectiveness of 'graded exposure' therapy for EAL pupils. Some EMHPs considered it to be more effective than other interventions because it follows a repetitive structure that is likely to suit children with less English proficiency. Others believed it is less effective because it relies heavily on parental involvement, making it less feasible for some EAL families. Some practitioners highlighted that 'cognitive restructuring' interventions might be more difficult for EAL pupils who would first need to identify the language(s) of their thoughts.

Establishing a strong therapeutic alliance between the practitioner and the young person is central to the efficacy of psychotherapeutic interventions. Some practitioners commented that the therapeutic alliance is *'potentially easier to build it with someone who speaks fully your language'*, which may further diminish the accessibility of English-only psychotherapies for EAL pupils. The therapeutic alliance may also be affected by the presence of an interpreter:

> *"You kind of want them to translate word for word, but also that then loses that therapeutic alliance"*

3.2 SBMH support is less accessible for EAL pupils

There was a clear sense among EMHPs that mental health support in schools was less accessible for EAL pupils, by dint of factors beyond the linguistic ones outlined above, notably due to slower identification of needs, and cultural differences and stigma.

3.2.1 EAL pupils are less likely to be identified for SBMH support

Practitioners indicated that EAL pupils may go unidentified or be identified later than non-EAL pupils. Several participants noted that the referrals they received did not match the demographics of the school, i.e., the percentage of EAL referrals received by the MHST was much lower than the percentage of EAL pupils in the school:

> *"I think the referrals we get just aren't representative at all"*

> *"There are noticeably more different nationalities and backgrounds coming into the area, but this is yet to be shown in our referrals"*

Some practitioners inferred that EAL was not a priority among MHSTs, e.g., *"I really do not think it is much on people's radar at all."* This was reflected in the fact that several practitioners mentioned that linguistic diversity or EAL did not feature on referral forms. As such, practitioners often did not know the linguistic profile of pupils before meeting them, which sometimes resulted in communication issues at the initial assessment.

EMHPs suggested that EAL pupils were less likely to be referred to their services and suggested a range of reasons for this trend. First, some suggested that language was an explicit barrier to access:

> *"If that young person doesn't have the English to tell a member of staff in school that they are struggling, then they don't get brought to referral meetings"*

Second, practitioners noted that EAL parents were less likely to discuss mental health concerns with the school due to linguistic and cultural differences (and many referral processes rely on parental input):

> *"Parents aren't gonna speak to school about these problems because they don't trust the school with the added language barrier"*

> *"They [the parents] did not wanna speak to anyone about mental health because they had a lot of fear and stigma around what might happen"*

Third, referrals may also take longer while school staff decipher whether a pupil's communication is the result of their language proficiency or an underlying mental health problem. This is particularly pertinent for newly arrived pupils, whose mental health difficulties might be masked by low levels of English proficiency or attributed to difficulties with adjustment:

> *"If you've got a child that's withdrawn, you could easily think they're just struggling to interact because of the language barrier"*

Fourth, practitioners highlighted the importance of well-established teacher-pupil relationships as the basis of referrals, and there was an assumption that teachers had less developed relationships with their EAL pupils:

> *"If English is not your first language, often not having a relationship with the member of staff can be a barrier to receiving support"*

3.2.2 Stigma and cultural differences

EMHPs also considered school-based mental health support to be culturally inaccessible for EAL pupils. Although more prevalent among parents than pupils, EMHPs described a 'shame factor' associated with mental health among specific minoritised ethnic groups, which served as a prevalent barrier to access. As such, practitioners often found gaining parental consent difficult:

> *"Mental health is a taboo; parents they might not want their children to be identified as having a mental health problem"*

> *"There are young people that schools just don't even bother trying to refer because they're not gonna get consent anyway"*

While mental health-related stigma was often described as generational and not as common among young people themselves, practitioners noted that many EAL pupils were concerned about talking to their parents about mental health or the support available. Participants discussed how a predominantly westernised view of mental health and therapeutic intervention often made mental health support culturally inaccessible. For instance, several EMHPs noted how cultural mismatch of values impacted access:

> *"For some young people, their culture and their religion is more a priority than their mental health"*

More specifically, practitioners reported that ideas of independence and rewards systems in some parenting interventions were culturally inappropriate. EMHPs also identified how gaps in their own cultural knowledge and understanding may inadvertently create further barriers to access for certain religious groups:

> *"I have gaps in my knowledge and understanding of how to support Muslim children with therapy…. that is a big gap to that therapeutic relationship."*

In tandem with the stigma of mental health was a distrust in services and schools among EAL families:

> *"There's such a distrust of services, "white coats" syndrome. It's very difficult to get someone to be open around that. And if there is a language issue as well, then that would kind of close the door to them having that access."*

3.2.3 Difficulties for newly arrived pupils

While EMHPs broadly implied that mental health support in schools was less accessible for all EAL pupils, this was particularly the case for those who had recently arrived in England. Although some practitioners argued that newly arrived pupils, and refugees in particular, may require more specialist mental healthcare, this population may face additional barriers to SBMH support in terms of disclosing their needs:

> *"If a young person's come here illegally or if they've come here in a very traumatic way, they're not gonna disclose that. So they might not access that mental health support"*

Similarly, practitioners reflected on newly arrived children requiring a period of time for acculturation and language learning before mental health needs can be identified. Some described acculturative stressors and uncertainty as further barriers to help-seeking while others suggested that a pupil's 'embeddedness' within the community (and, in turn, their ethnic community's embeddedness within society) played a role in how likely they would be to access support.

3.3 Linguistic flexibility is central to cultural responsiveness

Linguistic flexibility—allowing multilingualism to be acknowledged and embraced in therapeutic interactions—was highlighted by EMHPs as a mechanism by which to improve

access for EAL pupils. Practitioners noted how a more linguistically flexible approach might help to make psychological therapies more culturally responsive, although such an approach would be contingent on collaboration with parents, other EMHPs, schools, mental health services and, crucially, the young people themselves.

3.3.1 Linguistically flexible delivery increases access

Several recommendations emerged related to offering more linguistically flexible approaches to assessments and interventions. First, EMHPs stressed the need to give young people choices about the language(s) in which support is provided:

> *"Giving them the choice: 'What would you prefer?' At the moment they don't have the choice"*

For some, linguistic flexibility was about ensuring that translation and interpretation was available for all EAL pupils. However, others argued that instead of delivering interventions via an interpreter, offering psychotherapies in EAL pupils' preferred language would be best practice:

> *"What would be absolutely gold standard would be someone who can natively speak the language that the young person can speak, but is also a qualified low-intensity CBT practitioner"*

In this vein, one multilingual practitioner spoke about her experiences delivering interventions in different languages when needed, while another suggested that a nationwide specialist multilingual MHST that could be accessed remotely could help to meet the needs of EAL pupils. Alongside this, a central directory of translated resources that could be shared across MHSTs was identified as crucial to improving access to psychological therapies for EAL pupils.

EMHPs suggested further strategies to create more linguistically flexible, and therefore more culturally responsive, delivery. These included avoiding jargon, checking understanding, repetition, simplifying language, and using concrete examples. Many stressed the difficulty posed by heavily manualised interventions and instead recommended reducing written content. Audio books and translated chapter summaries were also discussed as ways of overcoming the volume of manualised content. Some suggested adopting other means of communication (visual, physical movement, etc.) to mitigate the focus on language. Indeed, enhancing linguistically flexibility also incorporates *"more creative approaches that move away from needing language."* Strategies to increase access that were less reliant on language included the use of videos, online polling, drawing and art, feelings wheels, etc.

Depending on the intervention type, group work was further identified by some practitioners as a means of increasing access for EAL pupils, not only because it facilitated a crucial sense of belonging, but because it enables peers to support each other in understanding concepts and translation:

> *"If there is a child that doesn't quite understand, there might be a peer that could support them"*

3.3.2 Linguistic flexibility relies on collaboration

Collaboration emerged as a key mechanism for improving linguistic flexibility in SBMH support. In particular, collaborative service design with EAL pupils themselves was considered central to improving the access to support:

> *"Getting more young people [with EAL] who have access to the MHST to say what they found difficult or what they found helpful"*

Consultation and collaboration with schools, external clinical services (including Child and Adolescent Mental Health services), and families were also highlighted as pivotal to increasing linguistically flexible delivery. Practitioners identified trust in, and awareness of, school-based mental health services among EAL families as a key mechanism for improving cultural responsiveness. They suggested this could be achieved through outreach activities, such as coffee mornings and EAL parents' forums, and through roles, such as parent community workers and cultural brokers.

The role of the EMHP in working with communities was also recognised. Many practitioners commented on the importance of support from members of their MHST or wider service, including through supervision, case-based discussions, and drawing on the experiences of team members from different linguistic and cultural backgrounds. Accordingly, representation within services emerged as crucial:

> *"The more you can increase the diversity of the workforce so that there are some natural translating abilities within your school and MHST, the better"*

> *"By chance that we had a member of the team who spoke Bengali. So it goes to show it's important that your team reflects the diversity in the place that you work"*

Others noted that it was best practice to pair children with practitioners from the same linguistic or cultural background:

> *"Within our team we have colleagues who speak different languages, and therefore we tend to allocate those colleagues to that particular child"*

Many of the EMHPs involved in the study spoke other languages themselves and/or came from different cultural and ethnic backgrounds. These practitioners spoke of the benefits of linguistic and cultural diversity within the EMHP workforce, most notably an ability to empathise with EAL pupils:

> *"The young person and parent felt very relieved when they found out 'there is someone who we can talk to, who we can relate to'"*

> *"I understand how difficult it can be to try and get help and you can't express yourself. So I feel that it's vital for our service to have these additional languages."*

> *"Because I've got that voice… I have credibility to be able to say 'it's not actually what you think it is' [referring to EAL parents' views of SBMH]"*

Finally, practitioners noted the importance of continuing professional development to improve their confidence and competence in working with EAL pupils. Ideas included further service-wide training specifically on EAL, more time to reflect on practice and adapt resources, and consolidated platforms to share ideas and resources among EMHPs nationally.

4 Discussion

The findings of this study indicate that pupils who speak English as an additional language face several barriers in accessing school-based mental health support in England and that such support is perceived to be less effective for this group than for their monolingual counterparts. The results concur with previous findings that current support may lack cultural responsiveness (Colucci et al., 2015), which in turn, inhibits the identification of mental health needs among children from different cultural backgrounds (Baak et al., 2020; Guo et al., 2014). However, our analysis presents novel findings about the major role played by language in access to psychological therapies in schools. Educational mental health practitioners acknowledged that language barriers restrict access to, and engagement with, mental health interventions among EAL pupils and their parents. Written information was identified as a particular barrier, as found by Baker et al. (2019). Some aspects of therapy were 'lost in translation'; at best, such misunderstandings served to weaken the therapeutic alliance or lessen the impact of the intervention, at worst, they had implications for the safety of the young person. It is therefore unsurprising that EAL pupils may receive suboptimal mental healthcare, as reflected in previous studies with similar populations (Kamran et al., 2022; Pandey et al., 2021).

These findings call into question the efficacy of language-reliant psychological therapies for children with limited proficiency in the dominant educational or societal language. EMHPs underscored the need for increased linguistic flexibility in the delivery of mental health interventions. Such flexibility includes increasing access to translation and interpretation, reducing the volume of linguistic input (both spoken and written), and giving EAL pupils a choice about the language(s) of delivery, i.e., interventions could be delivered by a low-intensity CBT practitioner who speaks their home language. Interestingly, the possibility of code-switching or drawing on children's full linguistic repertoires in therapy, highlighted as best practice in previous studies (Dewaele and Costa, 2013; Rolland et al., 2021), was not considered by EMHPs in this study, perhaps due to the practical restraints of bilingual implementation within a stretched and inherently monolingual system.

The findings indicate that to enhance cultural responsiveness in SBMH support, there is a need for greater awareness of multilingualism and its possible impact on young people's presentation of mental health difficulties, both among school staff referring to mental health services and practitioners delivering interventions. This reflects previous calls to identify and actively support multilingualism in psychological therapies (Costa, 2010; Rolland et al., 2021). There was not consensus on which interventions were perceived as the most or least effective for EAL pupils, but there was a sense that interventions could be more linguistically flexible by relying less on spoken and written language (including in manuals) and instead harnessing creative, non-linguistic means of communication where possible. Practitioners also recommended key communication strategies when working with EAL pupils and their families, such as simplifying language, checking understanding, and using visual cues, all of which are hallmarks of EAL pedagogy (Hall, 2019).

While translation and interpretation were held up as possible solutions to language barriers, especially when working with parents, they were by no means a panacea. A range of logistical, ethical, and communicative barriers were identified in relation to interpretation and translation. For example, concerns were raised about the impact of interpretation on the therapeutic alliance. As in Pandey et al. (2021), practitioners also cautioned against family members taking on interpreting roles and expressed the need for interpreters to have mental health training (Krystallidou et al., 2024).

It was clear from the findings of this study that language barriers were only one part of the picture. Indeed, SBMH support was deemed less accessible for EAL pupils for reasons beyond language. The initial identification of mental health difficulties, cultural differences and stigma, and the unique experiences of newly arrived children were identified as contributors to limited access. Participants in this study agreed that EAL pupils were less likely to be referred to SBMH services, and many asserted that the referrals they received did not match the demographics of their school population, echoing previous findings about an under-identification of mental health needs among children with lower English proficiency (Ngwakongnwi et al., 2011). Teaching staff having less established relationships with EAL pupils, reluctance from some parents, and less 'embeddedness' within the community were cited as reasons for this trend. Following identification, EMHPs described a cultural dissonance in the therapeutic process (Faheem, 2023), which also diminished the effectiveness of SBMH interventions.

Adopting intersectional (Crenshaw, 1989; Kern et al., 2020) and interactional (Fazel and Soneson, 2023) approaches to school-based mental healthcare that integrate language and culture will likely be an important step in improving the accessibility of school-based mental health support for multilingual students. This will involve acknowledging that multilingualism is an important facet of EAL pupils' identities, which not only influences therapeutic processes but also can contribute to positive wellbeing (Müller et al., 2020). Working collaboratively with young people in the design and implementation of SBMH support reflects practitioners' recommendations in this study and previous research (Gee et al., 2021), and determining their language preferences will be equally imperative. Given that support may be particularly inaccessible to EAL parents, as noted by EMHPs who reported language barriers and stigma limiting parental engagement, greater awareness of how language proficiency influences parental involvement and more effective collaboration between schools, mental health support teams, and families will help to improve access and build trust in services (Finnigan et al., 2022; Howard et al., 2024).

5 Conclusion

Drawing these threads together, our interviews with EMHPs revealed that EAL pupils are not a homogenous group (Welply, 2023);

they have varying language proficiencies and home languages, different ethnicities, fluctuating strengths and needs, and many have different pre- and post-migratory contexts. Increasing access to psychological therapies for EAL pupils will therefore mean placing more emphasis on linguistic flexibility as practitioners in this study consistently highlighted the need for language choice, reduced reliance on written materials, and creative strategies to overcome language barriers.

While solutions need to be attentive to specific contexts, some key broader policy considerations also emerged from our analysis. EMHPs called for a nationwide specialist multilingual mental health support team, staffed by multilingual qualified practitioners who can offer psychotherapeutic interventions to EAL pupils in different languages (albeit online), and a directory of translated materials. Participants noted that pairing pupils with practitioners who share their linguistic or cultural background improved trust and engagement. Greater representation of different cultures and languages within MHSTs would also serve to increase access and enable young people to be supported by practitioners who share their cultural or linguistic background (Faheem, 2023). These recommendations build on the study's themes of linguistic flexibility and cultural responsiveness, which practitioners identified as central to improving SBMH provision.

A critical realist approach to thematic analysis (Fryer, 2022) helped to identify and examine the underlying causal mechanisms at play in EAL pupils' access to school-based mental health support. We acknowledge that we cannot fully understand the experiences of mental healthcare among EAL pupils without consulting the population themselves. Future research should therefore address this current gap by gathering the perspectives of EAL pupils themselves. Research should also examine the effectiveness of school-based interventions for multilingual children and young people.

Underpinned by an asset-based approach to multilingualism (Cunningham, 2019), we call for a renewed focus among researchers, practitioners, and policymakers to understand and address language barriers for multilingual children and young people in accessing mental healthcare not only in schools but in clinical settings too. Our findings demonstrate that linguistic flexibility–operationalised by language choice, creative strategies, and collaboration–is central to achieving this goal.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by University of Exeter Research Ethics Committee [528365] and Health Research Authority (23/HRA/1700). The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

KH: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing. DM: Conceptualization, Formal analysis, Validation, Writing – review & editing.

Funding

The author(s) declared that financial support was received for this work and/or its publication. KH received funding from the British Academy Early Career Research Network (BA ECRN Seed Funding 06) for this work.

Acknowledgments

The authors are grateful to the Educational Mental Health Practitioners who participated in this study.

Conflict of interest

The author(s) declared that this work was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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