REFORM POLICY

A revolution in mindset

Addressing the youth mental health crisis after the pandemic

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#reformhealth

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The arguments and any errors that remain are the authors' and the authors' alone.

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About

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About *Reform* Policy

***Reform* Policy** are in-depth research reports focusing on a specific challenge facing public services. They provide a detailed and evidence-based examination of the issues and put forward implementable recommendations to government, public sector bodies and other key stakeholders to help deliver better public services for all.

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Forewords

Rt Hon Baroness Morgan of Cotes

When I arrived at the Department for Education, totally unexpectedly in July 2014, I was asked what my priorities would be. One immediately obvious area to focus on was the mental health and wellbeing of children and young people and the role that our schools could play in supporting this. I was clear that schools could not do this on their own – they needed the support and engagement of their NHS colleagues, and I was pleased to work with the then Health Secretary, Jeremy Hunt, on this.

It is good to see *Reform*'s report recognising the work behind our 2015 'Future in Mind' paper and the money allocated in the 2015 Budget. But we clearly have a long way still to go to see real and long-lasting improvements.

I was also clear that building resilience, learning how to deal with adversity, and the importance of 'emotional regulation' as covered in this *Reform* report are also important skills that young people should learn during their school years. I talked about this in the context of 'character education'. Here it is referred to as 'social and emotional learning' – the name isn't so important but the building of resilience and the prevention of poor mental health amongst our young people does deserve renewed attention.

As this *Reform* report records, there has undoubtedly been work done by successive governments on young people's mental health. And there is a recognition that the last two years of the pandemic have imposed even greater pressures on our young people. And yet we are still short of data, consistent policies that work and enough trained young people's mental health practitioners. Expanding the role of PSHE and the need for teachers to receive training on mental health, wellbeing and resilience are key suggestions here which I'm delighted to support.

As ever, the *Reform* team offer practical ideas that would make a real difference. I believe they will be broadly supported, and I hope they will be speedily adopted by policy makers. As the report makes clear we simply cannot afford, as a nation, not to step in and to prevent any further deterioration in the mental health of the next generation.

Rt Hon Baroness Morgan of Cotes
Former Secretary of State for Education (2014 - 2016)

Kate Green MP

Even before the COVID-19 pandemic, concerns about young people's mental health and wellbeing were growing. But after March 2020, as we began to come to terms with the impact of lockdown, disruption to social and family life, and lost learning, I was struck again and again by how often parents, teachers and young people themselves raised mental wellbeing as the top priority for children's recovery.

This report therefore comes at a highly opportune moment, and is packed full of practical suggestions that will be widely welcomed. It starts by recognising, however, that first we must understand the scale and trajectory of the challenge.

In Greater Manchester, where my constituency is located, the #BeeWell initiative launched last year asked pupils in secondary schools across the city region about their wellbeing, providing information for school leaders, charities, businesses, other local actors and policy makers to provide appropriate support services and make immediate improvements.

But many have called for a national system of assessment and monitoring of young people's wellbeing, and *Reform*'s report is unequivocal in emphasising the importance of robust and systematic data. We need data to plan provision, to know what's working – and to ensure the issue remains in the spotlight.

Of course, young people themselves have often told us what they consider they need, and here too the report echoes what I hear from my young constituents. They want effective, well-taught PHSE given appropriate recognition in the curriculum. They want ready access to confidential support. And they want their voices to be heard, and their experiences taken account of.

I hope they'll agree with me that the report responds to their pleas, setting out ideas around improving the teaching and status of PHSE, the establishment of community hubs, and the co-production with young people of appropriate indicators and performance measures. Agency and autonomy are important for wellbeing, and it is really welcome to see the role of young people in setting the agenda recognised and given practical expression.

Despite all the pressures and challenges they face, the young people I meet are optimistic and have high aspirations for their future. Securing their wellbeing is important in order for them to live a good and happy childhood, and achieve their aspirations. But it's also important for every one of us – to ensure our society and economy flourish. This report makes crystal clear why young people's wellbeing must be 'everyone's business'. I hope policy makers will take its recommendations to heart: our young people deserve it.

Kate Green MP

Former Shadow Secretary of State for Education (2020 - 2021)

Recommendations

Recommendation 1: NHS Digital, or its successor body, should immediately commission a comprehensive national survey using the methodology employed in the 2004 and 2017 *Mental Health of Children and Young People in England* surveys to establish current rates of probable mental health disorder in the aftermath of the pandemic. Follow-up surveys should be conducted at least every three years after the publication of this survey so that progress can be tracked over time.

Recommendation 2: NHS England should urgently revise the access and treatment targets established in *Implementing the Five Year Forward View on Mental Health* in line with updated prevalence estimates. Until reliable estimates are established, targets should be updated to 2017 estimates.

Recommendation 3: The Government should accept the recommendation of the Health and Social Care Committee and provide funding for the roll out of community mental health hubs throughout the country. A ring-fenced budget should be provided to upper tier local authorities for this purpose, proportionate to the number of young people in the local area. These hubs should be co-designed with local communities to ensure they meet local needs.

Recommendation 4: The Government's upcoming cross-departmental mental health strategy should include a dedicated section on improving young people's mental health, with specific, costed recommendations for prevention and early intervention.

Recommendation 5: The Department for Education, working with the Department of Health and Social Care, should design and roll out a standardised survey for assessing wellbeing and mental health among young people in schools. Data from this survey should be used by schools to monitor overall levels of wellbeing, to identify pupils who would benefit from additional support, and to track progress over time. The Department for Education should use the data to track trends in young people's mental health, as well as to identify and share best practice from schools.

Recommendation 6: The Teaching Regulatory Agency, in collaboration with the Department for Education, should work to ensure that all providers of initial teacher training have modules and specialist routes for teaching PSHE. This should be aimed at creating expertise for teaching PSHE in schools, rather than a new 'PSHE teacher' role.

Recommendation 7: PSHE should be transformed into a universal, timetabled lesson, which is allocated a minimum of an hour a week, underpinned by a social and emotional learning curriculum. This would involve teaching skills such as emotional regulation and self-control that will enable pupils to proactively respond to physical, social and health issues as they arise.

Recommendation 8: NHS Digital should urgently collect standardised, outcomes-based data from the Mental Health Support Team rollout, and publish this data in an accessible form in the Mental Health Services Data Set. For the purposes of evaluation, NHS Digital or its successor body should be permitted to access relevant extracts from the National Pupil Database to determine the extent to which Mental Health Support Teams are addressing long-standing inequalities in access to school-based mental health support.

Recommendation 9: The Department for Education, working with the Department of Health and Social Care, should urgently commission a comprehensive evaluation of Mental Health Support Teams using the standardised, outcomes-based data. This evaluation should also consider whether the availability of other forms of in-school support has been impacted by the rollout of Mental Health Support Teams.

Recommendation 10: Health Education England should publish a workforce retention plan that addresses the lack of vertical progression for Education Mental Health Practitioners while creating in-school support for pupils who fall between the gap of low-level interventions and Children and Young People's Mental Health Services. This should include the creation of a Band 6/7 Senior Education Mental Health Practitioner role, capable of treating moderate to severe mental health conditions, such as eating disorders and self-harm.

Introduction

The COVID-19 pandemic has taken a significant toll on the mental health and wellbeing of the nation. Many have had to cope with the loss of family members, friends and loved ones; and many more have struggled with the social isolation and disruption caused by national lockdowns.

The mental health impacts of the pandemic have been particularly severe for teenagers. Adolescence is a period in which people go through life-defining experiences – from forging formative relationships and life-long friendships to developing skills and capabilities that shape their adulthood.

Yet for most teenagers, the last two years have been defined by disruptions to everyday routines, the loss of opportunities to learn and develop skills, and a curtailing of chances to socialise and develop into independent young adults. Many have been left feeling isolated, despondent, and anxious about the future. Alarming trends in the data on young people's mental health are clear to see. In late 2021, more than one in six 11-19-year-olds had a probable mental health condition, compared to one in nine before the pandemic.[1]

However, the mental health of young people was deteriorating long before COVID-19.[2] Rates of self-harm, eating disorders, and mental health conditions have continued to tick upwards and support services have failed to keep up. Despite promises by successive governments to "revolutionise" mental health support, too many young people remain unsupported in the current system.[3]

Failure to support young people's mental health comes at an enormous cost to individuals and governments. At an individual level, failing to support mental health leads to unnecessary misery, limits opportunity, and saps potential. For governments, short-term inaction in this vital area brings far greater long-term costs in the form of acute healthcare spending, benefit payments and foregone tax revenues. Just in 2017, the direct cost to government of benefits paid to individuals who were out of work with poor mental health was £10 billion.[4]

[1] NHS Digital, *Mental Health of Children and Young People in England 2021 - Wave 2 Follow up to the 2017 Survey*, 2021.
[2] Ibid.
[3] Prime Minister's Office, 10 Downing Street, Department of Health and Social Care, NHS England, The Rt Hon David Cameron, and The Rt Hon Jeremy Hunt MP, 'Prime Minister Pledges a Revolution in Mental Health Treatment', Webpage, 11 January 2016.
[4] Paul Farmer and Dennis Stevenson, *Thriving at Work: The Independent Review of Mental Health and Employers*, 2017.

As the direct impacts of the pandemic begin to recede, the Government must act quickly to stem the long tail of mental ill health. More importantly, it must seize the opportunity to rethink its approach to mental health and develop a sustainable system that ensures no young person is left behind.

1. The need for action

The aftermath of the pandemic provides an opportunity for the Government to reshape its approach to supporting young people's mental health. The last two years have shone a much-needed spotlight on the shortcomings of current provision and a broad consensus exists to put young people's wellbeing at the heart of the recovery.

1.1 Boosting wellbeing, supporting mental health

As the Health and Social Care Secretary Sajid Javid rightly noted "as we all look to rebuild after the pandemic, one of the best ways to forge a happier, a fairer and a more prosperous society is a relentless focus on mental health."[5] It is now time for words to be matched by bold action.

To build a sustainable mental health system and transform outcomes for young people, policy makers must focus both on boosting wellbeing and supporting good mental health. The terms 'mental health' and 'wellbeing' are often used interchangeably, but important distinctions exist between the two (see Figure 1).

Figure 1: Wellbeing and mental health

Wellbeing: "Wellbeing, put simply, is about 'how we are doing' as individuals…personal wellbeing is a particularly important dimension which we define as how satisfied we are with our lives, our sense that what we do in life is worthwhile."[6]

Mental health: "A state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[7] While there is more to good mental health than avoiding mental illness, the presence or absence of mental illness is an important indicator of mental health.

Mental illness: "Mental illnesses or mental health disorders are illnesses that affects that way people think, feel, behave, or interact with others."[8] Mental illnesses are identified according to formal diagnostic criteria.

[5] Department of Health and Social Care, 'Mental Health: A Decade of Change in Just 2 Years', Webpage, October 2021.
[6] What Works Centre for Wellbeing, 'What Is Wellbeing?', Webpage, 2021.
[7] World Health Organization, 'Mental Health: Strengthening Our Response', Webpage, 2018.
[8] Mental Health Foundation 'What Are Mental Health Problems?', Webpage, 2021.

Despite the important distinctions between wellbeing and mental health, the two are closely related – low levels of wellbeing are strongly correlated with poor mental health and vice versa. For this reason, actions that attempt to boost wellbeing are likely to have a positive impact on mental health, and more effectively addressing mental illness is likely to improve wellbeing.

1.2 A focus on young people

Living with poor mental health or low levels of wellbeing at any age can be debilitating. However, there is good reason to place particular attention on the mental health and wellbeing of teenagers.

Firstly, adolescence is a period of rapid biological and social change. Adolescence is characterised by rapid and dynamic brain development and is the period in which an individual acquires the physical, emotional, and social resources that are the foundation for health and wellbeing later in life.

Relatedly, adolescence is a crucial period for the onset of mental illness: at least a third of all mental health conditions develop before the age of 14 and almost half by the age of 18.[9] The peak age of diagnosis for all mental health conditions is roughly 14.5 years and conditions with a major long-term impact such as eating disorders, anxiety disorders and obsessive-compulsive disorder are all well established by late adolescence.[10]

Secondly, adolescence is a crucial stage for intervention to prevent long-term costs associated with poor wellbeing and mental ill health (see Section 1.4). Although adolescents become increasingly independent as they move into adulthood, educational settings, and the ongoing support they receive from families and carers mean that significant levers are available to policy makers.

Finally, compared to other life stages such as old age and early childhood, adolescence has until recently been a period of relatively limited focus in health policy making.[11] Given the vital importance of adolescence in shaping life chances and future health needs, far greater attention needs to be paid to the mental health and wellbeing of this group.

[9] Marco Solmi et al., 'Age at Onset of Mental Disorders Worldwide: Large-Scale Meta-Analysis of 192 Epidemiological Studies', *Molecular Psychiatry* 27 (June 2021): 281-295.
[10] Ibid.
[11] George C Patton et al., 'Our Future: A Lancet Commission on Adolescent Health and Wellbeing', *The Lancet* 387 (May 2016). 2423–78.

1.3 Taking stock: how are young people doing?

Assessing existing policy approaches and establishing priority areas for attention and investment relies on establishing the current state of young people's mental health and wellbeing.

As this paper makes clear, despite encouraging progress in recent years, much more needs to be done to develop a clear national picture of mental health and wellbeing needs. What data is available should be a cause of deep concern.

1.3.1 Wellbeing and mental health before COVID-19

The events of the last two years have clearly had a significant impact on the wellbeing and mental health of young people; however, this was deteriorating long before the pandemic. Decreases in young people's subjective sense of wellbeing and increases in probable rates of mental illness are both well reflected in available data.

A range of indicators document marked decline in young people's wellbeing in recent years. Since 2010, The Children's Society's annual *Good Childhood Report* has tracked rates of subjective wellbeing by surveying young people (aged 10 to 15) on their sense of life satisfaction (their happiness with life as a whole). Between 2010-2020, there was a marked decrease in children's "happiness with life as a whole", from an average of 8.2 points out of 10 to an average of 7.75.[12] Young people's satisfaction with key aspects of life including their school, their appearance, and their friendships has also been in decline over this period.[13]

According to data collected by the Programme for International Student Assessment (PISA) in 2018 on the wellbeing of 15-year-olds, the UK ranked last out of 24 European countries on the proportion of this cohort reporting high life satisfaction, last on the mean life satisfaction of people in this age group, and last on the percentage of respondents agreeing that they had a "positive sense of purpose in life".[14] Alarmingly, the UK also experienced the highest drop in mean life satisfaction among 15-year-olds between 2015-2018.[15]

Deterioration in wellbeing has been matched by increasing rates of mental ill health over the same period. NHS Digital's *Mental Health of Children and Young People in England* survey series provides the most comprehensive national level data on young people's

[12] The Children's Society, *The Good Childhood Report, 2021*, 2021.
[13] Ibid.
[14] Angela Donkin, 'PISA 2018: What We Have Learned about Children's Life Satisfaction', *Schools Week*, 5 December 2019.
[15] The Children's Society, *The Good Childhood Report 2020*, 2020.

mental health.[16] Unfortunately, data collection has been infrequent, and no comprehensive survey was carried out between 2004 and 2017. However, the survey gives a good sense of the rising challenge of mental ill health among young people.

This survey series makes use of parent, child and teacher questionnaires and incorporates a range of diagnostic assessment tools to assess the prevalence of four condition types – emotional disorders, behavioural disorders, hyperactivity disorders, and other disorders – and the risk factors with which they are associated. Figure 2 outlines these disorder types.

Figure 2: Types of mental health condition

Emotional disorders: the most common type of condition in young people, emotional disorders include anxiety disorders (characterised by fear and worry), depressive disorders (characterised by sadness, loss of interest and energy, and low self-esteem), and mania and bipolar affective disorder.

Behavioural (conduct) disorders: a group of disorders characterised by repetitive and persistent patterns of disruptive and violent behaviours in which the rights of others and social norms or rules are violated.

Hyperactivity disorders: a group of disorders characterised by inattention, impulsivity, and hyperactivity. The most common example of a hyperactivity disorder is hyperkinetic disorder, the severe form of attention deficit hyperactivity disorder (ADHD).

Other disorders: these include autism spectrum disorders, eating disorders and tic disorders.

Source: NHS Digital, Mental Health of Children and Young People in England, 2017, 2018

The data shows that between 2004 and 2017, the percentage of 11-16-year-olds with a probable mental health disorder rose from 11.5 per cent to 14.4 per cent. A significant rise in emotional disorders is responsible for the overall increase in disorders – in this period the prevalence of emotional disorders almost doubled, from 5.0 per cent to 9.0 per cent.[17]

The 2004 survey did not include adolescents aged from 17-19, meaning identifying a trend in late adolescence is not possible. However, in the 2017 survey, the rate of probable mental disorders in this age group was over one in six (16.9 per cent), and the rate of emotional disorders was more than one in seven (14.9 per cent).

[16] NHS Digital, *Mental Health of Children and Young People in England, 2017*; Currently, NHS Digital is set to merge into NHS England's Transformation Directorate. Although details of this merger are yet to be finalised, there will be a successor body responsible for collecting and evaluating data on the mental health of children and young people in England.
[17] Ibid.

Alongside poor and declining mental health and wellbeing, the severity of mental health needs among young people is also cause for major concern. In the case of self-harm, an indicator of severe mental health need, alarming trends were developing before the pandemic.

Using data from the Adult Psychiatric Morbidity Survey, a National Institute for Health Research study found that the number of older adolescents and young adults (16-24) engaging in non-suicidal self-harm more than tripled, from 6.5 per cent to 19.7 per cent between 2000-2014.[18]

Data from the Millennium Cohort Study, a national survey of teenagers born in 2000-2, shows that in 2018-9 almost a quarter (24 per cent) of 17-year-olds reported self-harming in the previous 12-month period and 7.4 per cent had attempted suicide at least once in their lifetime.[19] Rates of self-harming had increased from 23 per cent to 28 per cent in females and more than doubled from 9 per cent to 20 per cent among males from the last time the cohort was surveyed three years earlier.[20]

By early 2020, before the pandemic hit, young people were significantly less happy with life than a decade earlier, and in comparison with those living in other high-income countries. Mental health conditions, particularly emotional disorders such as depression and anxiety, were increasing in prevalence and severity.

1.3.2 The impact of COVID-19

COVID-19 brought severe upheaval to the lives of young people. School closures and changes to assessment disrupted young people's education, lockdown restrictions affected young people's ability to socialise with friends, and protracted, close contact with family in some cases led to a deterioration of personal relationships.[21] Put simply, pandemic restrictions increased risk factors for poor mental health and wellbeing – social isolation, family dysfunction, and disrupted learning – and undermined the protective factors that help young people manage their mental health – regular contact with adults outside the home, routine and purpose, and independent social activity.[22]

As interviewees for this paper noted, the full effects of the pandemic on young people's mental health may take years to understand. However, early evidence suggests that the pandemic has had a sizeable impact on young people's mental health.

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[18] Sally McManus et al., 'Prevalence of Non-Suicidal Self-Harm and Service Contact in England, 2000-2014: Repeated Cross-Sectional Surveys of the General Population', *The Lancet Psychiatry* 6, no. 7 (July 2019): 573–81.
[19] Praveetha Patalay and Emla Fitzsimmons, *Mental Ill-Health at Age 17 in the UK: Prevalence of and Inequalities in Psychological Distress, Self-Harm and Attempted Suicide* (UCL Centre for Longitudinal Studies, 2020).
[20] Ibid.
[21] OECD, 'Young People's Mental Health Has Declined Significantly since the Onset of the COVID-19 Crisis', Webpage, 12 May 2021.
[22] Ibid.

Two follow up studies were carried out among participants in the NHS's 2017 *Mental Health of Children and Young People in England* survey firstly in July 2020 and then in February-March 2021. The data for these surveys was collected online and via telephone and used a more limited diagnostic measurement, making comparisons with 2017 imperfect.[23] However, both surveys show a marked increase in mental ill health among young people. In the February-March 2021 survey, 17.7 per cent of 11-16-year olds had a probable mental disorder, up from 14.4 per cent in 2017.[24] Of particular concern, among young women aged 17-19, the rate of probable mental health disorders stands at almost 1 in 4 (24.8 per cent).[25]

The pandemic has had a particularly significant effect on young people with existing mental health conditions. Decreasing access to mental health care and other support services, social isolation and loneliness, and disruption to stabilising routines have all taken their toll.

NHS Digital data suggests that a quarter of 11-16-year-olds and more than a third of 17-23-year-olds living with a probable mental health disorder felt that pandemic restrictions had made their life "much worse".[26] Similarly, a four-wave survey conducted by the charity YoungMinds found that among a cohort of 13-25-year-olds already living with mental health conditions, 80 per cent agreed that the pandemic had made their mental health worse and 67 per cent believed that the pandemic would have a long-term negative effect on their mental health.[27]

The combined effect of increasing rates of mental ill health and worsening symptom severity have led to large increases in forecasts for future demand for mental health services. According to modelling by the Centre for Mental Health, 1.5 million children and young people will need new or additional support for depression, anxiety, post-traumatic disorders, and other mental health difficulties in the coming years.[28]

As the direct impacts of the COVID-19 pandemic begin to recede, and the Government finds itself confronted by worrying increases in the rate of mental ill health, urgent action is needed to place young people's mental health and wellbeing at the heart of recovery plans.

[23] Tracy Williams et al., *Mental Health of Children and Young People in England, 2021: Survey Design and Methods*, 2021.
[24] NHS Digital, *Mental Health of Children and Young People in England 2021 - Wave 2 Follow up to the 2017 Survey*.
[25] Ibid.
[26] Ibid.
[27] YoungMinds, *The Impact of Covid-19 on Young People with Mental Health Needs: Survey 4 - February 2021*, 2021.
[28] Centre for Mental Health, 'Covid-19 and the Nation's Mental Health: May 2021', Webpage, 12 May 2021.

1.4 The cost of inaction

Increases in mental health prevalence and decreases in young people's wellbeing over time should, in and of themselves, be cause for major concern among policy makers. Mental ill health and poor wellbeing hugely undermine young people's quality of life. They reduce enjoyment of everyday activities, make learning and participating socially more difficult, and affect young people's relationships with those around them.

However, there is also a strong economic case for improving support for wellbeing and mental health in adolescence. The cumulative effects of inaction on mental health and wellbeing challenges in this age group are large and avoidable costs to individuals and the public purse. As a recent overview of the long-term costs of mental illness makes clear: "to neglect mental illness in young people is not only morally unacceptable, but also an enormous economic mistake."[29]

1.4.1 Costs to individuals

Poor adolescent mental health and wellbeing is associated with significant short and long-term costs to individuals.[30]

In the first instance, those experiencing mental health difficulties during adolescence are far more likely to experience mental health difficulties in adulthood. International evidence suggests that depression in adolescence was associated with between four- and seven-fold increases in the odds of adult depression.[31] Failure to intervene effectively in adolescence is therefore associated with mental health difficulties across the life course.

Secondly, mental ill health at this age has major implications for educational attainment and employment outcomes. A recent National Centre for Social Research study found that, controlling for factors such as poverty and child-parent relationship status, young people living with mental health conditions were twice as likely to not reach the benchmark of five GCSE grades at A*-C (or 9-4).[32]

In the longer term, mental ill health in adolescence is associated with a decreased likelihood of moving into employment or further education. A 2020 UK-wide study found

[29] Martin Knapp et al., *Youth Mental Health: New Economic Evidence* (PSSRU, 2016).
[30] For a detailed overview, see: Aleisha Clarke and Katie Lovewell, *Adolescent Mental Health Evidence Brief 2: The Relationship between Emotional and Behavioural Problems in Adolescence and Adult Outcomes* (Early Intervention Foundation, 2021).
[31] Kiyuri Naicker et al., 'Social, Demographic, and Health Outcomes in the 10 Years Following Adolescent Depression', *Journal of Adolescent Health* 52, no. 5 (May 2013): 533-38.
[32] Neil R. Smith et al., 'Adolescent Mental Health Difficulties and Educational Attainment: Findings from the UK Household Longitudinal Study', *BMJ Open* 11, no. 7 (July 2020): 1-10.

that adolescents reporting high depressive symptoms had a five-fold increased risk of not being in education, employment or training (NEET) at 24.[33]

1.4.2 Costs to public services

Alongside these consequences for the life chances of individuals, poor adolescent mental health is also associated with significant long-term costs on the public purse.

The total estimated cost of mental ill health on England's economy is £100 billion each year – approximately 5 per cent of GDP.[34] Poor mental health is the leading cause of worklessness and sickness absence in the country, and, in turn, the biggest driver of spending on out-of-work benefits.[35] Given the early age of onset of lifelong mental health conditions, investing in preventing mental ill health at a young age and intervening early where it does emerge is crucial for mitigating enormous long-term costs.

A systematic evaluation of available evidence on the direct economic impacts of mental health in young people found that those living with mental health issues between the ages of 16-25 were twice as likely to be in receipt of out-of-work benefits than those without mental health issues, were eight times more likely to have contact with criminal justice services, and be far greater users of medical and social care services.[36]

Modelling the effects of depression, research by the Intergenerational Foundation finds that government loses a total of £2.9 billion due to decreased tax revenue and greater use of publicly funded services amongst a single birth cohort of people living with the condition between the ages of 16-40.[37]

1.4.3 An unequal burden

The gross costs of mental ill health and low wellbeing in adolescence to individuals and public services require urgent attention. Yet they are not shared equally. Young people growing up in low-income households, in troubled families, or with parents living with mental health conditions are all significantly more likely to experience mental ill health.

[33] José A. López-López et al., 'Trajectories of Depressive Symptoms and Adult Educational and Employment Outcomes', *BJPsych Open* 6, no. 1 (December 2019): 1–8.
[34] David McDaid and A-La Park, *The Economic Case for Investing in the Prevention of Mental Health Conditions in the UK* (Mental Health Foundation, 2022).
[35] Nick O'Shea and Andy Bell, *A Spending Review for Wellbeing* (Centre for Mental Health, 2020).
[36] Knapp et al., *Youth Mental Health: New Economic Evidence*.
[37] Melissa Bui, *Costing Young Minds: The Fiscal Consequences of the Lack of Spending on Young Adult Mental Health* (Intergenerational Foundation, 2020).

Low-income households

Young people living in the lowest income households are twice as likely to live with a probable mental health condition than those in the highest income households.[38] Data from the Millennium Cohort Study shows that the 17-year-olds from the most disadvantaged quintile had almost twice the rates of attempted suicide (12 per cent) compared with those in the most advantaged quintile.[39]

Family Status

The effects of family and parental status on young people's mental health are well documented.[40] According to recent Office for National Statistics analysis, 11-16-year-olds living in families that experience "unhealthy functioning" are more than twice (25 per cent) as likely to have a probable mental health condition than those living in families that have "healthy functioning" (11 per cent).[41]

Parental mental health is also a strong determinant of poor mental health in young people – those living with a parent with poor mental health are almost 3 times more likely (30 per cent) to have a mental health condition than those without (11 per cent).[42]

Vulnerable young people

Several groups of young people are especially vulnerable to poor mental health in adolescence. Young people affected by adverse childhood experience such as abuse and neglect, family breakdown and exposure to domestic violence are significantly more likely to develop mental health conditions.[43] Relatedly, 'looked-after' young people – those taken into care by their local authority – are far more likely to live with poor mental health. The National Institute for Care Excellence estimates that 45 per cent of looked-after young people have a probable mental health condition, a number that climbs to 72 per cent for those living in residential care.[44]

The effects of disadvantage on the mental health of young people were clear to see even before COVID-19. However, the effects of pandemic restrictions are likely to have further strengthened the link between disadvantage and mental ill health – school closures, reduced access to core public services, and increased financial instability have had the greatest impacts among the least advantaged.[45]

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[38] Katherine Sadler et al., *Mental Health of Children and Young People in England, 2017: Summary of Key Findings* (NHS Digital, 2018).
[39] Patalay and Fitzsimmons, *Mental Ill-Health at Age 17 in the UK: Prevalence of and Inequalities in Psychological Distress, Self-Harm and Attempted Suicide*.
[40] Office for National Statistics, 'Children Whose Families Struggle to Get on Are More Likely to Have Mental Disorders', Webpage, 26 March 2019.
[41] Ibid.
[42] Ibid.
[43] Kirsten Asmussen et al., *Adverse Childhood Experiences: What We Know, What We Don't Know, and What Should Happen Next* (Early Intervention Foundation, 2020).
[44] National Institute for Health and Care Excellence, *Looked after Children and Young People: NICE Guideline*, 2021.
[45] The Children's Society, *The Impact of COVID-19 on Children and Young People*, 2021.

As part of its Levelling Up Strategy, the Government has committed to spreading opportunity and improving the life chances of all young people.[46] For it to succeed, tackling mental health inequalities must play a key role.

[46] HM Government, *Levelling up the United Kingdom*, 2022.

2. Meeting the challenge

Governments have long been aware of the deterioration in young people's mental health and wellbeing and the long-term costs of inaction. Few have been short of ambition.

In 2016, then Prime Minister David Cameron promised a "revolution in mental health treatment", with a specific focus on children and young people.[47] The following year, Prime Minister Theresa May pledged to "employ the power of government as a force for good to transform the way we deal with mental health problems" and ensure that all "children and young people get the help and support they need and deserve".[48]

However, ambitious intentions have not been matched by adequate investment and strategy. Progress has been made in improving access to and the quality of mental health services, but this has been outstripped by the increasing prevalence of mental ill health. A new approach is needed to meet this growing challenge and deliver the current Education Secretary Nadhim Zahawi's pledge to put mental health and wellbeing "at the centre of everything we do".[49]

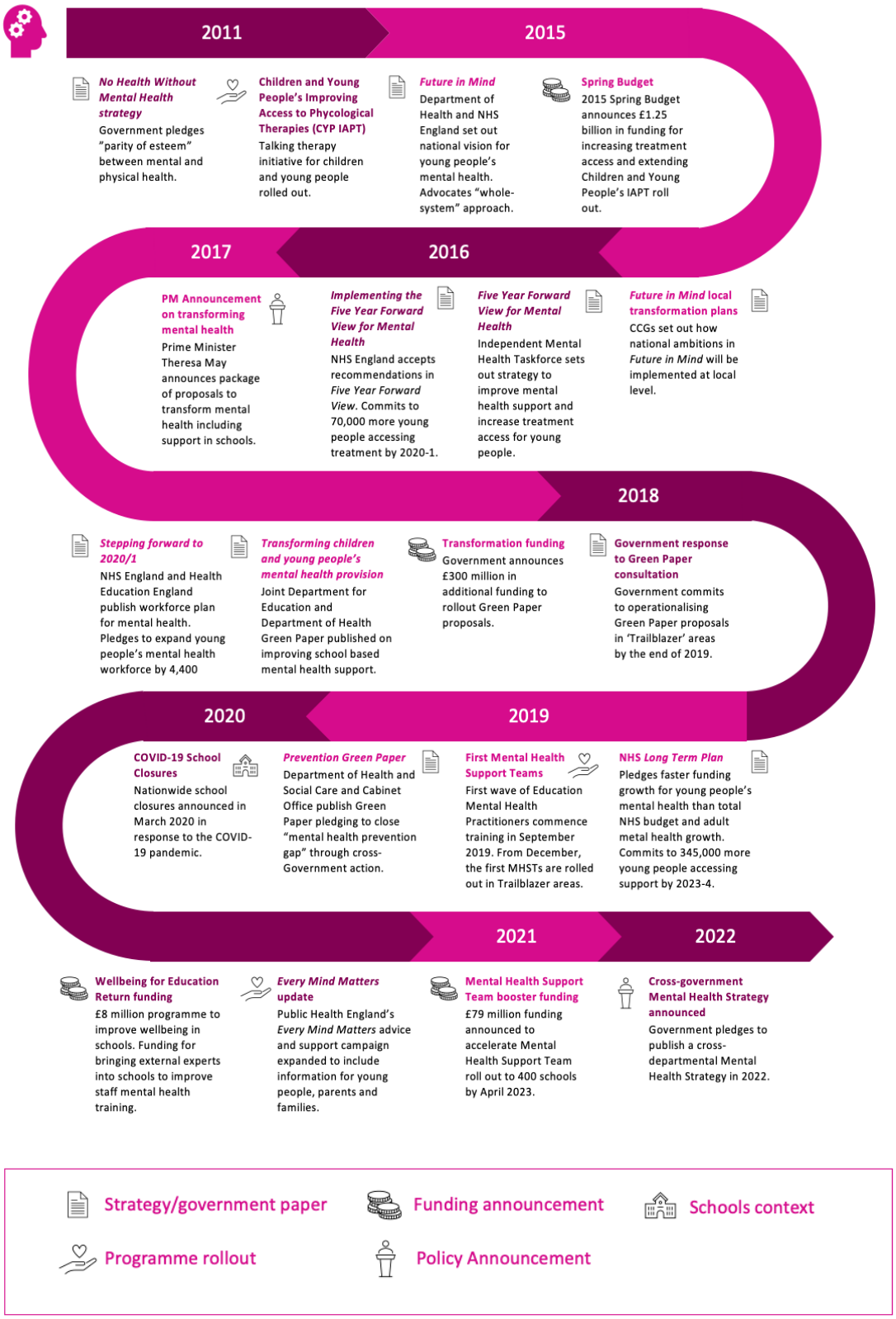
2.1 The story so far

In 2011, the Department of Health's *No Health Without Mental Health* strategy pledged to achieve "parity of esteem between mental and physical health" and emphasised the importance of "promoting good mental health and intervening early, particularly in the crucial childhood and teenage years".[50]

Since this time, a range of policy initiatives have been launched to achieve these aims. Figure 3 presents a timeline of major policy initiatives to improve young people's mental health over the past decade.

[47] Prime Minister's Office, 10 Downing Street, Department of Health and Social Care, NHS England, The Rt Hon David Cameron, and The Rt Hon Jeremy Hunt MP, 'Prime Minister Pledges a Revolution in Mental Health Treatment'.
[48] Rt Hon Theresa May, 'Prime Minister Unveils Plans to Transform Mental Health Support', Press Release, 9 January 2017.
[49] John Roberts, 'Zahawi: I'll Put Wellbeing at Heart of Schools Policy', *TES Magazine*, 9 October 2021.
[50] Department of Health and Social Care, *No Health Without Mental Health: A Cross-Government Outcomes Strategy*, 2011.

Figure 3: Timeline of young people's mental health policy



Young people's mental health policy initiatives in this period have attempted to achieve three key objectives:

- Improving access to and the quality of mental health care
- Enhancing the role of schools in boosting wellbeing and delivering mental health interventions
- Developing cross-governmental prevention strategies

Some progress has been made in each of these areas, but the level of focus and resources devoted to this challenge are so far insufficient to meet the high and growing levels of need. Importantly, initiatives to boost wellbeing and prevent mental ill health remain secondary to those which seek to bolster clinical models of support. Progress made on all three objectives is considered below.

2.1.1 Playing catch-up in CYPMHS

Efforts to address deteriorating adolescent mental health have focused predominantly on increasing access to clinical support through Children and Young People's Mental Health Services (CYPMHS).[51]

CYPMHS has long been considered a "Cinderella service within a Cinderella service".[52] Low prioritisation has historically led to underinvestment in mental health compared to physical health – despite accounting for around a quarter (23 per cent) of the total burden of disease in England, mental health services account for just over 11 per cent of healthcare expenditure.[53] In turn, spending on CYPMHS only accounts for around 6.5 per cent of spending on mental health services, or less than 1 per cent of NHS England's overall budget.[54]

Low levels of investment in CYPMHS, coupled with high levels of demand for support, have caused care to be rationed in two key ways: through the setting of high access thresholds and the development of long waiting lists.[55] For this reason, many young people who might benefit from clinical support continue to miss out – the so-called treatment gap between the number of young people with a probable mental health condition and those in contact with CYPMHS.[56] Additionally, many young people find

[51] Elizabeth Parkin and Rob Long, *Support for Children and Young People's Mental Health*, 2021., previously referred to as Child and Adolescent Mental Health Services (CAMHS).
[52] Rebecca Collins et al., 'Participation in Developing Youth Mental Health Services: "Cinderella Service" to Service Re-Design' 16, no. 4 (2017): 159–68.
[53] NHS England, *NHS Mental Health Dashboard: Q1 2021/22*, 2021.
[54] Children's Commissioner for England, *Briefing on Children's Mental Health Services, 2020-1*, 2022.
[55] House of Commons Health and Social Care Committee, *Children and Young People's Mental Health, Eighth Report of Session 2021-22*, HC 17 (London: The Stationery Office, 2021).
[56] Whitney Crenna-Jennings and Jo Hutchinson, *Access to Child and Adolescent Mental Health Services in 2019* (Education Policy Institute, 2020).

themselves unable to access care until they have reached a state of crisis, or find their condition deteriorating as they wait for treatment.[57]

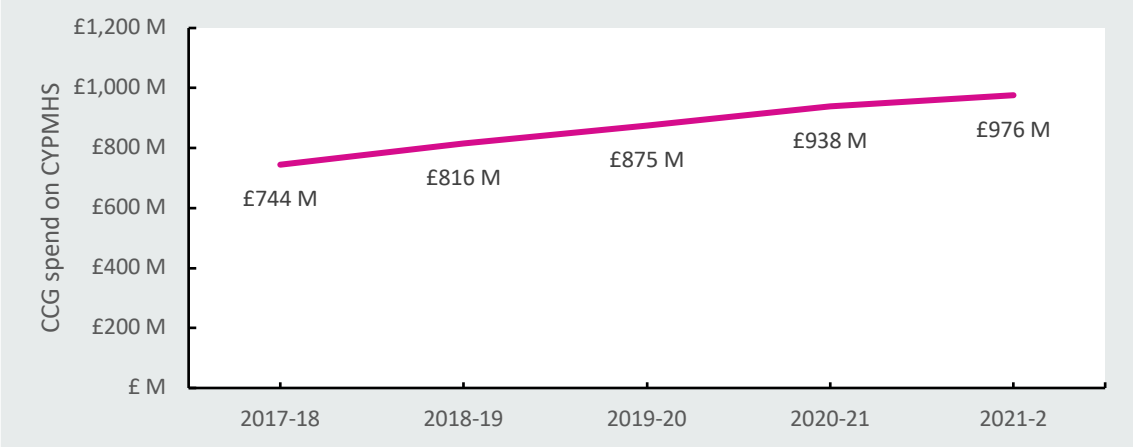
To address these challenges, governments in the last decade have sought to increase the capacity of CYPMHS in two ways: boosting funding to specialist services and developing a dedicated talking therapy workforce.

Boosting CYPMHS funding

Allocating more funding to specialist CYPMHS, which deal with more severe mental health needs, has been a priority for successive governments. In the 2015 budget, the then Chancellor announced that £1.25 billion would be provided over 5 years to introduce new access standards for CYMPHS and build capacity to care for an additional 110,000 children and young people by 2020-1.

CYPMHS was also a priority area in the 2019 *Long Term Plan*, which committed to provide support for 345,000 additional children and young people by 2024. The *Long Term Plan* additionally pledged that the budget for children and young people's mental health services would grow as a proportion of all mental health services, which itself would also be growing at a faster rate than the overall NHS budget.[58] Though historic reporting of spending on CYPMHS has been patchy and inconsistent, since data has been reliably reported as part of the *Five Year Forward View for Mental Health Dashboard* from 2017 onwards, spending has grown consistently (See Figure 4).

Figure 4: CYPMHS funding from 2016-7 to 2021-2 (real terms in 2021 prices)



Source: NHS England, *NHS Mental Health Dashboard, Q4 2017-Q2 2022*

[57] House of Commons Health and Social Care Committee, *Children and Young People's Mental Health, Eighth Report of Session 2021-22*.
[58] NHS England, *NHS Long Term Plan*, 2019.

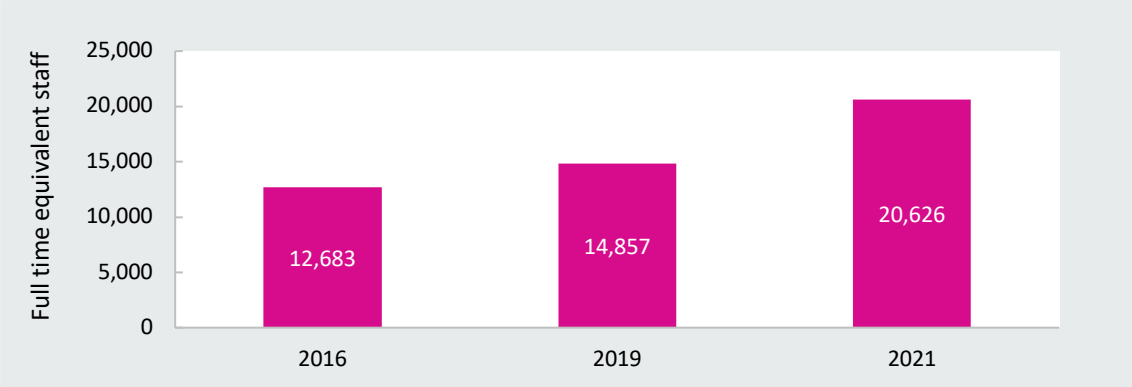
Improving access to talking therapies

Alongside efforts to increase capacity in existing specialist services, policy makers have also focused on developing a workforce trained to deliver talking therapy interventions to address mild to moderate mental health needs. This change is a welcome one – talking therapies such as Cognitive Behavioural Therapy (CBT) have a strong evidence base and are highly effective in addressing mild to moderate anxiety and depressive disorders, which have increased at a particularly high rate in recent years.[59]

Since 2011, efforts to increase access to this kind of support has centred on the rollout of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT). To facilitate the launch of CYP IAPT, £60 million was initially set aside for the period from 2011-2016, to train staff already working in CYPMHS, local authorities, and non-government organisations to train to deliver talking therapies.[60] This programme was bolstered by an additional £118 million of investment in the 2015 Budget and by 2018, the programme had been rolled out across all of England.[61]

As well as up-skilling the existing CYPMHS workforce to provide talking therapies, since 2017 policy makers have focused on increasing the overall size of the workforce by developing two dedicated CYP IAPT training programmes for community-based Child Wellbeing Practitioners (CWPs) and school-based Education Mental Health Practitioners (EMHPs). These roles are intended to provide early intervention therapies in areas where young people are most likely to turn for support – youth services and schools. Attempts at workforce expansion have proven successful with the workforce almost doubling between 2016-2021.[62]

Figure 5: CYPMHS workforce growth from 2016 to 2021

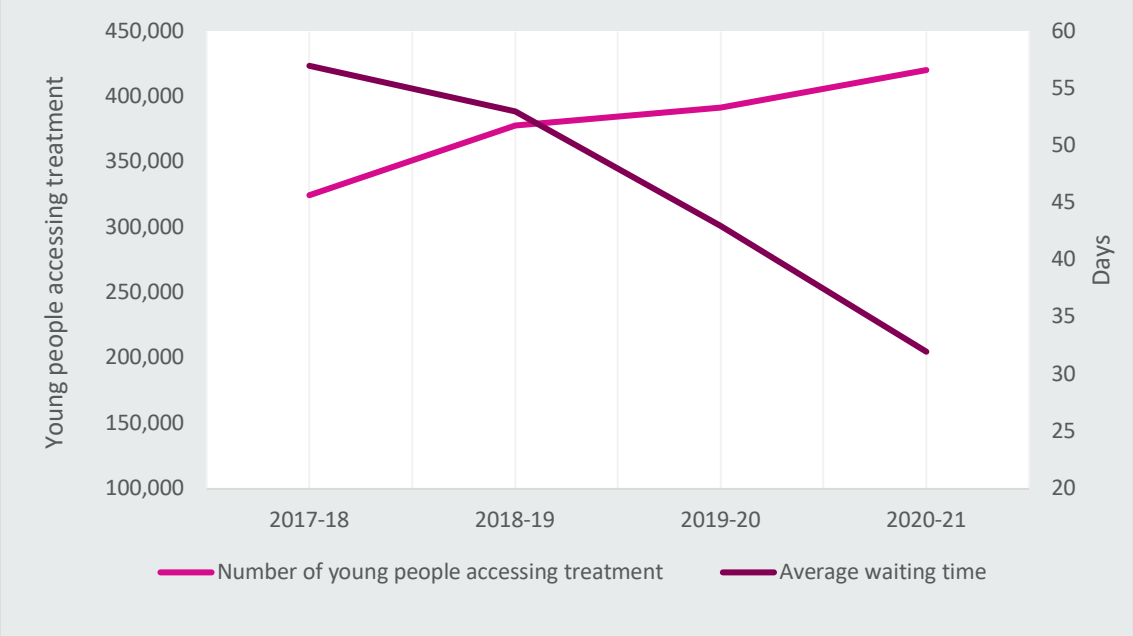


Source: HEE, *CYPMHS Workforce Survey 2021*

[59] Aleisha Clarke et al., *Adolescent Mental Health: A Systematic Review on the Effectiveness of School-Based Interventions* (Early Intervention Foundation, 2021).
[60] Department of Health, *Talking Therapies: A Four-Year Plan of Action*, 2011.
[61] HM Treasury, *Budget 2015*, 2015.
[62] Health Education England, *Children and Young People's Mental Health Services Workforce Report for Health Education England*, 2021.

As can be seen in Figure 6, additional funding to CYMPHS and the growth in both the specialist and CYP IAPT workforce has increased the number of young people in contact with support services and reduced waiting times for care. Figure 6 shows the increasing number of young people in contact with CYMPHS and the reduction in average wait times between referral and entering into treatment in recent years.

Figure 6: Number of young people in contact with CYPMHS and average wait length



Source: Children's Commissioner, *The state of children's mental health services 2020-1*

This shows real and welcome progress: greater access to treatment and a decline in long waits means more young people are receiving timely care. Yet despite these improvements, increasing demand has meant that progress has been insufficient to address the large gap between those living with diagnosable conditions and those in contact with CYPMHS.

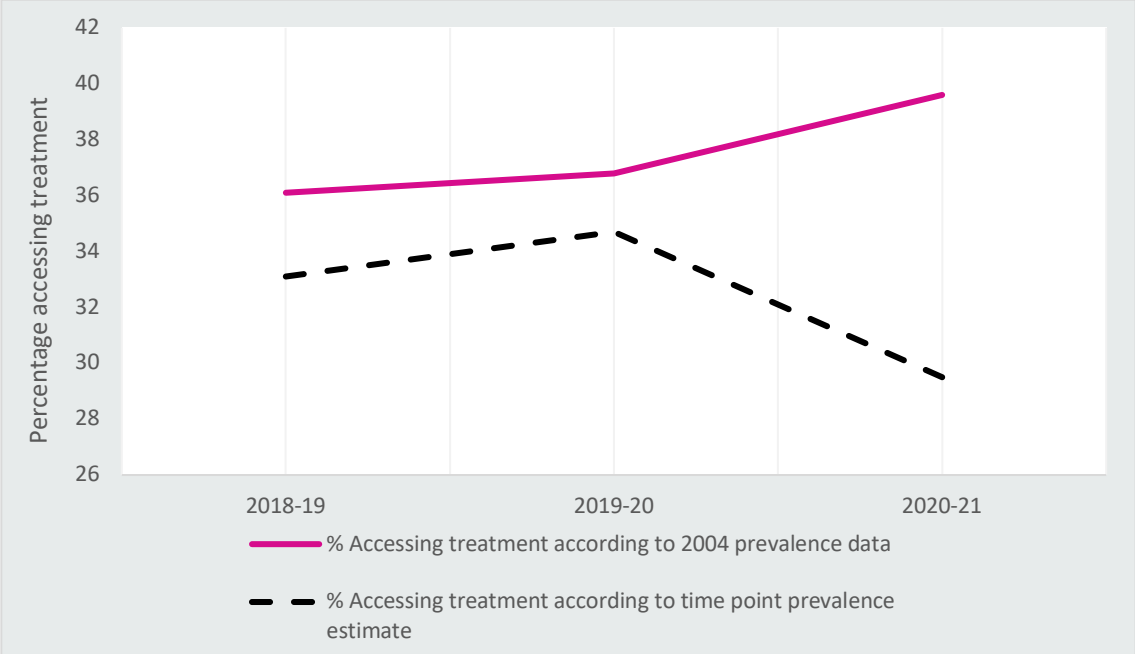
In 2016, NHS England set itself a modest target: 35 per cent of those living with a diagnosable mental health need should be in contact with CYPMHS.[63] However, in assessing progress towards closing the treatment gap, NHS England continues to rely on prevalence figures recorded in 2004, rather than those updated after more recent national surveys in 2017, 2020 and 2021.[64] This is clearly unacceptable.

[63] NHS England, *Implementing the Five Year Forward View For Mental Health*, 2016.
[64] NHS Digital, *Mental Health of Children and Young People in England 2021 - Wave 2 Follow up to the 2017 Survey*.

Though NHS England acknowledged in *Implementing the Five Year Forward View for Mental Health* that changes in prevalence would affect the size of the treatment gap and that targets might need to be revised accordingly, no such revision has taken place.[65]

Given the known increase in prevalence of mental health conditions in this period, relying on out-of-date survey data suggests that CYPMHS are far closer to closing the treatment gap than is, in reality, the case. Figure 7 shows the number of young people in contact with mental health services in relation to updated estimates of the level of need in the population.[66]

Figure 7: Share of young people with a diagnosable condition accessing treatment updated to current prevalence estimates



Source: NHS England, *NHS Mental Health Dashboard Q4 2018-Q4 2021*

To better plan services and allocate resources, it is essential that comprehensive national level data on need is collected, evaluated, and used to benchmark progress. Interviewees for this paper noted that the data collected in the 2020 and 2021 *Mental Health of Children and Young People* surveys should be treated with some caution. Pandemic constraints on in-depth, face-to-face interviewing meant that data was collected in a less rigorous way than in previous national surveys.[67] Additionally, others argued that data collected during the pandemic may have led to a temporary surge in young people experiencing mental ill health which should level out in its aftermath.

[65] NHS England, *Implementing the Five Year Forward View For Mental Health*. 2016.
[66] Care Quality Commission, *Review of Children and Young People's Mental Health Services: Phase One Report*, 2017.
[67] Williams et al., *Mental Health of Children and Young People in England, 2021: Survey Design and Methods*.

Nonetheless, as previously discussed evidence has long indicated an increase in condition prevalence. Now that the constraints that made robust data collection difficult during the pandemic have abated and a degree of normality has returned to the lives of young people, it is vital that a nationally representative survey is carried out to identify overall levels of need.

Recommendation 1: NHS Digital, or its successor body, should immediately commission a comprehensive national survey using the methodology employed in the 2004 and 2017 *Mental Health of Children and Young People in England* surveys to establish current rates of probable mental health disorder in the aftermath of the pandemic. Follow-up surveys should be conducted at least every three years after the publication of this survey so that progress can be tracked over time.

Once updated figures have been published, these should form the baseline against which future treatment targets are set. Given access targets are currently set against data collected almost two decades ago, re-benchmarking targets is long overdue and necessary to ensure that young people who would benefit from clinical support are not being left behind.

Recommendation 2: NHS England should urgently revise the access and treatment targets established in *Implementing the Five Year Forward View on Mental Health* in line with updated prevalence estimates. Until reliable estimates are established, targets should be updated to 2017 estimates.

2.1.2 Enhancing school-based support

School-based mental health promotion and early intervention strategies have long been a focus of policy makers. As universal settings with close, long-term relationships with young people, schools have been considered an important site for interventions to promote wellbeing, identify mental health needs, and intervene early to support young people with mild to moderate needs.

Since the National Healthy Schools Programme was launched in 1999, schools have been encouraged to take a "whole school approach" to mental wellbeing through their curricula, extra-curricular activities and pastoral systems, and a range of initiatives in the early 2000s sought to embed this agenda.[68]

[68] Sandie Schagen et al., 'Evaluating the Impact of the National Healthy School Standard: Using National Datasets', *Health Education Research* 20, no. 6 (December 2005): 688–96.

After 2015, school-based mental health support re-emerged as a central policy focus. In that year, NHS England and the Department of Health published *Future in Mind* which stressed the role of schools in boosting wellbeing, providing targeted support to young people with mild to moderate needs, and directing those who require more specialist support to appropriate services.[69] These ambitions were bolstered by the publication of a joint Department of Health and Department for Education Green Paper in 2017, *Transforming Children and Young People's Mental Health Provision*.[70]

Chapter 3 considers progress made in relation to school-based wellbeing promotion and mental health support in detail, but it is not yet clear that policy in this area is optimally set to significantly improve mental health outcomes.

2.1.3 Focusing on prevention and early intervention

Given historically low levels of investment, increasing funding and staff numbers in CYPMHS to improve access to specialist support must remain a policy priority. Yet attempting to meet deteriorating mental ill health through enhanced clinical support alone is not a sustainable approach. For this reason, policy makers have emphasised the need to reduce rather than simply meet demand for specialist mental health services through public health interventions. Developing cross-cutting local prevention and early intervention strategies has been the key initiative in this area.

Cross-cutting local prevention strategies

While budgets and responsibility for commissioning CYPMHS sit with NHS Clinical Commissioning Groups (CCGs), services that play a preventative role – children's social care, youth services and public health teams – are the responsibility of local authorities. Developing joined-up approaches to prevention between local authorities and the NHS has therefore been a central focus of policy.

A number of initiatives have attempted to galvanise joint working on prevention. *Future in Mind* called on CCGs to work with partners in local government and the third sector to produce transformation plans covering the "whole spectrum of services for children and young people's mental health" including prevention and promotion activities.[71] These local transformation plans were incorporated into the *Five Year Forward View* programme following its launch in 2016.

[69] Department of Health, *Future in Mind: Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing*, 2015.
[70] Department of Health and Department for Education, *Transforming Children and Young People's Mental Health Provision: A Green Paper*, 2017.
[71] Department of Health, *Future in Mind: Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing*.

The importance of local level prevention was re-affirmed with the launch of Public Health England's Prevention Concordat for Better Mental Health in August 2017. The Concordat called on local authorities, NHS organisations, and third sector and independent providers of mental health services to commit to taking a "public mental health informed approach to prevention".[72] Signatories to the Concordat are expected to develop plans in line with seven agreed statements on preventing mental ill health and are in turn provided with resources and guidance on implementing cost-effective prevention and promotion approaches.[73]

Encouraging joint-working on prevention is a positive development – building a sustainable system requires working collectively to tackle the drivers of mental ill health and intervene before clinical treatment is necessary. However, it is unclear that policy initiatives in this area have been successful in shifting the dial towards prevention and early intervention.

In the first instance, a lack of data makes tracking prevention and early intervention spending and performance difficult. While NHS England and CCGs have significantly improved data collection on CYPMHS in recent years, this is not apparent in the case of local authority commissioned services. Concerns about limited data in this area were raised as early as 2014, when the Health Select Committee called on the Department of Health to carry out an audit of local authority commissioned early intervention services. In 2018, the National Audit Office reiterated this call, noting that information on non-NHS mental health spending was "very limited" and that "neither the Department nor any of its arm's-length bodies can monitor whether preventative services are reducing demand for specialised services."[74] Comprehensive auditing in this area is yet to occur.

The limited data that is available on non-NHS mental health spending suggests the policy priority of shifting resources towards prevention and early intervention has been inconsistent in practice. Using information obtained through a Statutory Information Request under Section 2F of the Children's Act 2004, the Children's Commissioner found that prevention and early intervention spending had grown by 17 per cent in real terms between 2016-17 and 2018-19, from £181 million to £220 million.[75] Roughly half of this spending came from Local Authorities and half from NHS CCGs. However, national level increases masked worrying regional variation – more than 6 in 10 (59 per cent) areas saw real terms decreases in Local Authority spending per child on preventative and early access services.[76]

Efforts to increase spending in this area have been hampered by two barriers: budgetary limitations and failures in target setting.

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[72] Public Health England, 'Prevention Concordat for Better Mental Health', Webpage, December 2020.
[73] Public Health England, *Prevention Concordat Consensus Statement Update: Draft for Consultation*, 2021.
[74] National Audit Office, *Improving Children and Young People's Mental Health Services*, 2018.
[75] Children's Commissioner for England, *Early Access to Mental Health Support*, 2019.
[76] Ibid.

Firstly, the relevant budgets at local level – the ring-fenced public health grant and largely non-ring-fenced funding for children's social care have either declined in real terms or been outstripped by growth in demand in recent years. The public health grant has been reduced by 24 per cent on a real terms per capita basis since 2015-6, and public health spending on children's services has declined by 5 per cent in this period.[77] While children's social services spending has been largely protected in recent years, significant increases in demand for high cost, late intervention services such as care placements mean that budgets available to fund preventative and early intervention services are limited.

Spending has therefore followed a "rule of rescue" logic – late intervention, crisis services have tended to be prioritised at the expense of prevention and early intervention.[78] Indeed, analysis by ProBono Economics notes a 48 per cent decrease in spending on early intervention services, including those related to mental health, between 2010-11 and 2019-20.[79]

Secondly, while a range of targets have been set to increase spending and improve access to CYPMHS, this has not been the case in relation to prevention and early intervention. Relevant targets on prevention and early intervention are not set for local authorities and CCG spending is targeted towards increasing access to mental health treatment rather than reducing demand for it in the first place.[80] An emphasis on treatment targets and an absence of prevention targets therefore risks moving the system further away from its stated preventative focus.

While increasing prevention and early intervention activities in schools may help close the prevention gap, it is not clear that current spending arrangements and target setting are geared towards system change. As the recent Health and Social Care Select Committee report on young people's mental health makes clear, "radical steps" must still be taken to shift the focus in mental health towards prevention and early intervention.[81]

2.2 The road ahead

Given the major role that schools and education settings are envisioned to play in providing mental health support going forward, this paper focuses on how to optimise school-based approaches. However, many interviewees reflected on the valuable role

[77] The Health Foundation, 'Why Greater Investment in the Public Health Grant Should Be a Priority', Webpage, 5 October 2021.
[78] Stephen Rocks, Mina Fazel, and Apostolos Tsiachristas, 'Variation in Spend on Young Mental Health across Clinical Commissioning Groups in England: A Cross-Sectional Observational Study', *BMJ Open* 9, no. 10 (August 2019): 1–8.
[79] Max Williams and Jon Franklin, *Children and Young People's Services: Spending 2010-11 to 2019-20* (Pro Bono Economics, 2021).
[80] House of Commons Health and Social Care Committee, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's Progress against Its Policy Commitments in the Area of Mental Health Services in England, Second Special Report of Session, 2021-2*, HC 612 (London: The Stationery Office, 2021).
[81] Ibid.

that community support and digital technology can play in providing holistic support to young people. The remainder of this chapter considers these areas in turn.

2.2.1 Building community support

Improving community-based support for mild to moderate mental health needs has been a key focus of mental health campaigning organisations and the youth sector in recent years.[82]

Rolling out open-access early support hubs built on the Youth Information, Advice and Counselling Services (YIACS) model has been the key proposal in this area.[83] YIACS organisations provide holistic wellbeing support and provide mental health counselling alongside advice services to help young people with educational, social and occupational needs. A mix of clinical staff, youth workers and volunteers tend to be co-located under one roof and most YIACS organisations operate drop-in programmes where young people can access support without referrals from schools or medical practitioners.[84]

YIACS organisations are already established throughout England. Figure 8 gives the example of the Liverpool-based Young Person's Advisory Service (YPAS) which runs three community hubs in the city.

Figure 8: The YPAS community hub model

YPAS is a Liverpool-based charity which provides a range of support, wellbeing and therapeutic services for children and young people. Alongside providing support in schools, YPAS runs three community hubs in the city. YPAS's model of holistic support provides wellbeing and mental health therapy alongside wider social services. As well as one to one and group-based therapy and counselling, young people can access advice on benefits, housing and accommodation, debt management and budgeting, employment, and life skills. They can also make use of education support services, seek help with drug and alcohol issues and access laundry and shower facilities.

Source: Interview with YPAS

Interviewees pointed out that this model of support has a number of distinct advantages. Community counselling has a strong evidence base – the percentage of young people

[82] Nick O'Shea and Zoë McHayle, *Time for Action: Investing in Comprehensive Mental Health Support for Children and Young People* (Centre for Mental Health, 2021).
[83] Youth Access, 'The YIACS Model', Webpage, 2021.
[84] Ibid.

showing levels of reliable improvement and clinically significant change in their mental health after using YIACS services is comparable to that in CYPMHS.[85]

This model also plays an important role in increasing access to help for groups who underutilise school-based support and CYMPHS – research suggests that BAME young people are far more likely to make use of community services than those provided in other settings.[86]

Finally, YIACS-based community services provide holistic support which can tackle the drivers of poor mental health. Interviewees for this paper argued that while providing access to evidence-based mental health treatment for a larger number of young people was vital, 'over medicalising' support remained a risk. Understanding young people's needs in the round and providing holistic support including, but not limited to, clinical treatment is key to building a system that works for young people.

The Health and Social Care Select Committee's recent report on young people's mental health recommended that the Department of Health and Social Care should roll out open access models to every area of the country to complement available school-based and clinical support, [87] a commitment that the Centre for Mental Health estimates would cost £103 million each year.[88]

Interviewees for this paper reflected that expanding this form of support would be a welcome initiative. However, many noted that scaling up this approach nationally risked losing the responsiveness to local need that underpinned the success of existing hubs. Interviewees also pointed out the importance of involving young people and their families in the design of local services to ensure they were best tailored to community need.

For these reasons, responsibility for any national rollout would better sit with local authorities than the Department of Health and Social Care, given the proximity of the former to the communities they serve and the aspiration to move away from clinical models of support. A ring-fenced funding pot should be provided by central government to ensure that local authorities can provide community mental health hubs.

[85] Charlie Duncan et al., 'Counselling for Young People and Young Adults in the Voluntary and Community Sector: An Overview of the Demographic Profile of Clients and Outcomes', *Psychology and Psychotherapy: Theory, Research and Practice* 93, no. 1 (December 2018): 36–53.
[86] Ibid.
[87] House of Commons Health and Social Care Committee, *Children and Young People's Mental Health, Eighth Report of Session 2021-22*.
[88] Nick O'Shea and Zoë McHayle, *Time for Action: Investing in Comprehensive Mental Health Support for Children and Young People*.

Recommendation 3: The Government should accept the recommendation of the Health and Social Care Committee and provide funding for the roll out of community mental health hubs throughout the country. A ring-fenced budget should be provided to upper tier local authorities for this purpose, proportionate to the number of young people in the local area. These hubs should be co-designed with local communities to ensure they meet local needs.

2.2.2 A new role for technology

An increasing proportion of young people's lives are spent online and almost all have grown up as 'digital natives' – with constant access to smartphones, the internet and other technologies.[89]

As a result, young people expect and are increasingly turning to digital technologies and services for mental health and wellbeing support.[90] As these services can be delivered remotely, they have huge potential to transform when and where young people access support, and to enable anonymity, which protects young people's identity and helps reduce the stigma associated with help-seeking.

Digital technologies can be applied in a variety of ways to support young people's mental health and wellbeing – from online CBT and mindfulness apps to AI-assisted virtual counselling and symptom assessment tools.[91] Although concerns have been raised about levels of engagement and user satisfaction in the case of some digital mental health tools, there is a growing evidence base for using digital tools as a complement to existing support.[92]

Digital approaches provide potential solutions to three key challenges in supporting the mental health of young people: offering 24 hour access, providing treatment remotely, and enabling a certain degree of anonymity and confidentiality.

Offering a lifeline

Mental health needs can arise at any time – however, only a small number of conventional support services are available out-of-hours, meaning young people can be left feeling like they have no one to talk to.[93] Digital services, which can recruit volunteers,

[89] Sonia Livingstone et al., *Children's Online Activities, Risks and Safety* (UK Council for Child Internet Safety and Department for Digital, Culture, Media & Sport, 2017).
[90] Claire Wilkins, Oli Kelly-Dean, and Angela Kail, *Charities, Young People and Digital Mental Health Services*, 2019.
[91] World Economic Forum, *Empowering 8 Billion Minds: Enabling Better Mental Health for All via the Ethical Adoption of Technologies*, 2019.
[92] Aleisha M Clarke, 'Implementing Universal and Targeted Mental Health Promotion Interventions in Schools', in *Implementing Mental Health Promotion*, Ed. Margaret M. Barry, Aleisha M. Clarke, Inge Petersen, and Rachel Jenkins (Cham, Switzerland: Springer, 2019).
[93] Shout, *Half a Million Conversations through a Pandemic: The Power of Text for Providing 24/7 Digital Mental Health Support* (Mental Health Innovations, 2021).

and employ staff in different time zones, therefore have a key role to play. A report by the Mental Health Foundation, for example, finds that young people most often access digital helplines late at night or in the evening.[94]

The immediate support provided by a digital helpline can also be vital for de-escalating a mental health crisis when conventional support is unavailable or when there is a surge in the number of young people needing support in response to a particular news story, event, or announcement. A 2021 report by Mental Health Innovations on the digital text service Shout, for example, found "large spikes in conversations … in the moment following a tragic event" – with the service handling 200 per cent as many conversations on 3rd November 2020 following the announcement of a second national lockdown.[95] Figure 9 details Shout's approach to providing 24 hour mental health support for young people.

Figure 9: Shout 85258

Shout 85258 is a free, anonymous texting service available to anyone in the UK. It is developed by the charity Mental Health Innovations, which specialises in how technology can be used to improve mental health. By employing staff and volunteers in the UK and New Zealand (GMT+13), Shout is able to offer 24 hour support to young people struggling with their mental health and wellbeing, and has so far hosted over a million conversations.

Data collected during the pandemic found that most conversations hosted by Shout take place after midnight, whilst suicidal ideation is the main reason young people access the service. Over half of young people who use Shout say they "didn't feel they have anyone else to talk to".

Source: Interview with Mental Health Innovations

Widening Access

With high levels of regional variation in waiting times for young people to enter CYPMHS treatment – from 6 days in the Castle Point CCG to nearly 81 days in the Cannock Chase CCG – digital services have unique potential to provide instantaneous support across the country and so contribute to the wellbeing of young people everywhere.[96] Remotely accessed, digital support can especially benefit those in remote and rural communities, who may be unable to reach in-person support themselves, or request transport from a parent or carer.

[94] Kirsten Morgan, Lauren Chakkalackal, and Eva Cyhlarova, *Life Lines: Evaluation of Mental Health Helplines* (Mental Health Foundation, 2012).
[95] Shout, *Half a Million Conversations through a Pandemic: The Power of Text for Providing 24/7 Digital Mental Health Support*.
[96] Children's Commissioner for England, *Briefing on Children's Mental Health Services, 2020-1*.

Reducing stigma

The perceived anonymity offered by many digital services and technologies means they have huge potential to reduce stigma and make support available to young people who would not feel comfortable, or able, to discuss their difficulties with anyone else. This disinhibiting effect can also prompt young people to disclose their difficulties at a faster rate than in face-to-face sessions, and to discuss topics that carry more stigma.[97] For example, 38 per cent of the young people who use the text service Shout 85258 say they have never spoken to anyone else about their mental health (see Figure 9).[98]

Although interviewees stressed the potential of technology across each of these areas, they also cautioned against digital solutions being seen as a 'silver bullet' replacement to conventional forms of support, and emphasised that young people should be able to choose from a range of services. Digital services can effectively complement in-person support, increase mental health support capacity, and create a less stigmatised access point for those unable to turn for help at home, in school, and in the community. However, some young people also find themselves excluded from digital support – for example, due to concerns about confidentiality when using digital services at home, or because of poor digital literacy and access to technology.

2.2.3 A systemic approach

Interviewees for this paper reflected on the fact that past policy making in relation to young people's mental health support has been disjointed and unsystematic. Building a system that meets the needs of young people requires looking beyond formal statutory services provided through the NHS or in schools to a wider range of support.

The recent announcement that a long-term, cross-government strategy on mental health with a specific focus on prevention and early intervention will be developed in 2022 provides an opportunity to build a holistic approach to mental health.[99] It is important that this strategy pays sufficient attention to the needs of young people and considers support offered in the community and online as well as in existing statutory services.

Recommendation 4: The Government's upcoming cross-departmental mental health strategy should include a dedicated section on improving young people's mental health, with specific, costed recommendations for prevention and early intervention.

[97] Youth Access, *Going Digital: A Beginner's Guide to Adding Online Support to Your Young People's Mental Health and Wellbeing Service*, 2017.
[98] Shout, *Half a Million Conversations through a Pandemic: The Power of Text for Providing 24/7 Digital Mental Health Support*.
[99] Gillian Keegan, 'Health Update: Statement Made on 10 February 2022' (HCWS609, 10 February 2022).

3. Enhancing the role of schools

Schools and educational settings have a vital part to play in promoting the mental health of young people. As universal services in contact with almost every young person, sites of formative relationship building, and settings for developing core life skills, schools can contribute to mental health in three key ways:

1) Monitoring and identifying the wellbeing and mental health needs of pupils
2) Promoting positive wellbeing and preventing mental health difficulties
3) Providing a setting for early intervention for mental health difficulties

3.1 Progress so far

Given the importance of educational settings for promoting wellbeing, preventing mental ill health, and managing existing mental health needs, encouraging schools to take on greater responsibility for mental health and providing them with the resources needed to do so has been a significant focus of policy makers in recent years.[100]

As noted above, the 2015 report *Future in Mind* stressed the importance of taking a whole-school approach to wellbeing and focused on the role of schools in promoting mental health, providing early support, and building resilience and emotional regulation in young people.[101]

The direction of travel set out by *Future in Mind* was reinforced by the publication of the 2017 Green Paper, *Transforming Children and Young People's Mental Health Provision*. In this Green Paper, the then Government made three core commitments:

- To provide direct clinical support in schools through NHS funded, school-based Mental Health Support Teams (MHSTs)
- To incentivise schools to nominate a designated senior mental health lead responsible for working with staff, pupils and parents to shape a whole-school approach to mental health
- To trial a four-week waiting time standard for access to specialist support[102]

[100] National Children's Bureau, *Mental Health and Emotional Wellbeing in Schools: Policy Context Briefing*, 2014.
[101] Department of Health, *Future in Mind: Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing*.
[102] Department of Health and Department for Education, *Transforming Children and Young People's Mental Health Provision: A Green Paper*.

The commitments in the Green Paper were supported by £300 million of investment, the vast majority of which was earmarked for the rollout of MHSTs (£215 million). During the pandemic, the Government committed a further £79 million to the MHST programme to ensure a quicker pace of rollout.[103]

Figure 10 summarises the key proposals of the 2017 Green Paper and the progress made in achieving its targets. A lack of reported data on some of the Green Paper's core targets makes evaluating its success difficult, a point to which this report later turns.

Figure 10: Summary of 2017 Green Paper proposals and progress made

Policy	Aim	Progress so far
Incentivise every school and college to identify and train a Designated Senior Mental Health Lead (DSMHL).	Every school and college has a DSMHL with access to high-quality training, who oversees the implementation of a "whole-school approach" to mental health, provides basic advice to staff and students, and signposts to services as needed by the end of 2025.	As of June 2021, 84 per cent of schools report having a DSMHL. However, there is no publicly available data on the number of DSMHLs who have accessed training for the role.[104]
Fund the rollout of Mental Health Support Teams (MHSTs), comprised of specially trained staff who provide schools with extra capacity to intervene early, and to support those with mild to moderate mental health needs.	A fifth to a quarter of the country has a MHST by the end of 2022-23, with the rollout occurring in waves – accompanied by an evaluation of their effectiveness focusing on the outcomes of the interventions they offer.	Fully operational teams cover 15 per cent of the school-aged population and are expected to reach a fifth to a quarter of the population a year ahead of schedule, in 2022. The NHS anticipates that 35 per cent of students will have access to a MHST by 2023.[105]

[103] Department of Health and Social Care, '£79 Million to Boost Mental Health Support for Children and Young People', Press Release, 5 March 2021.
[104] Department for Education, *COVID-19 School Snapshot Panel: Findings from the June Survey*, 2021.
[105] Claire Murdoch, *Update on Mental Health Services* (NHS England, 2021); The Green Paper aim for a fifth to a quarter of the country to have a MHST by the end of 2022-2023 is measured by the NHS in terms of the percentage of the "school-aged population" who are covered by a fully operational MHST.

Trial a four-week waiting time for access to specialist Children and Young People's Mental Health Services (CYPMHS).	Every young person who needs to can access CYPMHS within four weeks.	There is no publicly available data on the number of CCGs that are meeting the four-week waiting time.

As Figure 10 makes clear, progress across different areas of the 2017 Green Paper has been inconsistent – a lack of data hampers our ability to assess take up of the DSMHL position and training, whilst progress to achieving the 4-week wait time standard is not measured in NHS data sets. This means that almost £400 million has been allocated to a programme for which there is no publicly available data on two of the three metrics of progress made.

In the case of MHSTs, while the increased pace of rollout has been broadly welcomed, both at the time of the Green Paper's publication and in subsequent evaluations, their limited coverage has been criticised for not going far enough in meeting young people's needs. Even according to estimates that the rollout is ahead of schedule, 65 per cent of secondary pupils will not have access to an MHST in 2023.[106] Indeed, a joint report by the Health and Education Select Committees in 2018 argued that the then Government strategy in this area "lack(ed) ambition and will provide no help to the majority of those children who desperately need it".[107]

Section 3.3 will consider barriers to rolling out MHSTs in further detail, but maximising the impact of this rollout relies on significant improvement taking place in the way that schools identify mental health needs, promote wellbeing and prevent mental ill health, and work with other services to ensure young people are supported in the most effective way.[108]

3.2 Identifying mental health needs

For schools to support the mental health of pupils, effective procedures must be in place to monitor overall levels of wellbeing, and to identify those at heightened risk of

[106] Murdoch, *Update on Mental Health Services*.
[107] House of Commons Education and Health and Social Care Committees, The Government's Green Paper on mental health: failing a generation, First Joint Report of the Education and Health and Social Care Committees of Session 2017-19, HC642 (London: Stationery Office, 2018).
[108] Jo Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report* (BRACE Rapid Evaluation Centre and the Policy Innovation and Evaluation Research Unit, 2021).

developing mental health conditions and those in need of more specialised support. Monitoring also allows schools to evaluate the efficacy of programmes to boost wellbeing and prevent mental ill health. Robust and consistent data collection has been identified as a central tenet of a whole school approach to mental health and wellbeing, but current approaches leave schools and policy makers with an incomplete picture of need and an inadequate basis on which to plan support.[109]

3.2.1 How do schools monitor wellbeing and mental health?

According to a 2017 Department for Education survey of schools' mental health support, most secondary schools conduct some form of monitoring or screening.[110]

The most common way schools monitor pupils' mental health and wellbeing is through ad-hoc identification by teaching staff, which 83 per cent of secondary schools claim to use.[111] Ad-hoc identification tends to involve teachers monitoring students' behaviour and temperament, and encouraging students to self-report mental health and wellbeing needs.

Identifying wellbeing and mental health needs using screening tools of any kind is uncommon: only a quarter of secondary schools use targeted screening, and even fewer (13 per cent) use universal screening programmes.[112] Of those schools using screening tools, nearly half (48 per cent) claim they use "bespoke" or in-house surveys when identifying pupil wellbeing and mental ill health.[113]

The Government has recently issued guidance on monitoring wellbeing and directs schools towards a range of free online information including the Anna Freud Centre's *Healthy Schools* toolkit.[114] However, as no survey on schools' approach in this area has been carried out since 2017 – despite mental health in schools being a priority for Government – it is not possible to know whether changes have occurred in the ways schools monitor wellbeing since that time.

[109] Department of Health, *Future in Mind: Promoting, Protecting and Improving Our Children and Young People's Mental Health and Wellbeing*.
[110] Lydia Marshall et al., *Supporting Mental Health in Schools and Colleges: Quantitative Survey* (Department for Education, 2017).
[111] Ibid.
[112] Ibid.
[113] Ibid.
[114] Anna Freud National Centre for Children and Families, 'Mental Health Toolkit for Schools', Webpage, 2020.

3.2.2 Limitations of the current approach

Interviewees expressed concern that methods currently used to collect information were limiting the identification of mental health and wellbeing need in schools and resulting in lower data quality overall.

The reliance of schools on ad-hoc identification is a significant cause for concern. In the first instance, teachers are often ill-equipped to identify mental health needs. Almost three quarters of teachers say they received no guidance on identifying mental health needs in their initial teacher training, [115] and only a third of teachers say they would feel confident recognising mental health needs from the way their pupils behave.[116]

Additionally, while teachers are better equipped to identify potential wellbeing and mental health concerns in young people who externalise their needs (those whose temperament and behaviour changes in response to changes in wellbeing) – they struggle to identify difficulties among those who internalise needs (withdrawing from educational and social activities, and in some cases actively concealing symptoms of poor mental health).

Many interviewees for this paper stressed that young people most at risk, particularly those engaging in self-harm or developing eating disorders, tended to internalise their conditions. Relying on teacher identification alone therefore risks failing to identify significant need, never mind being able to intervene early.

Survey-based screening tools may provide a more reliable metric for identifying need, yet challenges exist in this area too. Bespoke surveys used by schools tend to lack a strong evidence base and make comparisons between school settings impossible.

Limited data and poor data quality in this area has a number of negative impacts: many young people with support needs go unidentified or are identified late; support cannot be effectively targeted at groups that would benefit from it most; and policy makers and schools both lack reliable baselines to track whether approaches to boosting wellbeing make a difference over time.

Schools have huge potential to intervene early and prevent mental disorders from escalating, yet unless they have effective means of identification, this potential will not be realised.

[115] Anna McShane, Carla Munnelly, and Ed Dorrell, *Fixing a Failing System: Rethinking Mental Health Support in Schools for the Post-Covid Generation* (The Coalition for Youth Mental Health in Schools, 2021).
[116] Place2Be, 'Place2Be Launches Free Online Training Programme for 50,000 UK Teachers', Press Release, 2020.

3.2.3 The way forward

The quality of data schools collect on mental health is key to planning and implementing improvements to mental health support, both at a school and system-level. As described, high-quality data can improve schools' ability to identify young people who are struggling and offer early intervention. At a system-level, it supports more accurate comparisons between schools, sharing of best practice, evaluation of what works, and more targeted resource allocation.

Though Department for Education guidance exists on effective wellbeing monitoring in schools, developing a standardised metric would provide valuable information to policy makers and allow schools to reliably track their progress over time. The Office for National Statistics has conducted population wellbeing surveys since 2011 and the Department for Education should consult with them in designing a standardised survey.

A consistent regional approach to wellbeing data collection is already taking place in Greater Manchester through the #BeeWell programme (Figure 11). Similar approaches have also taken place internationally – in the Netherlands, Finland, and South Australia.

Figure 11: The #BeeWell programme in Greater Manchester

#BeeWell is a wellbeing programme led by the University of Manchester, the Anna Freud Centre and the Greater Manchester Combined Authority. Designed in partnership with young people, #BeeWell began to survey the wellbeing of pupils in secondary schools across Greater Manchester in Autumn 2021 and will continue to do so annually for the next three years. It is the first wellbeing survey in the UK which seeks to cover all secondary schools in a city-region.

The survey is completed by young people online and includes questions on three core domains of wellbeing: meaning, control and purpose in life; self-understanding; and emotions. Questions posed in this section include whether young people have been "feeling relaxed", "thinking clearly", and "dealing with problems well".

The survey also asks questions aimed at measuring six core drivers of wellbeing: health and routines; hobbies and entertainment; relationships; school; environment and society; and perceptions of the future. These questions include how often young people are physically active, spend time on creative hobbies, and if they feel supported by their friends. Data from the #BeeWell survey will be fed back to school leaders, charities, businesses, other local actors and policy makers to provide appropriate support services and make immediate improvements.

Source: #BeeWell, 'About us', *Webpage*, 2021

Interviewees for this paper argued that producing a standardised national survey would have benefits for schools – helping identify wellbeing needs early and in a more evidence-based way – and policy makers – allowing change over time and the efficacy of policy to be more effectively tracked. Survey methods used should contain a range of wellbeing indicators co-produced with young people themselves, as well as more generic diagnostic tools used in existing approaches to mental health screening.

Recommendation 5: The Department for Education, working with the Department of Health and Social Care, should design and roll out a standardised survey for assessing wellbeing and mental health among young people. Data from this survey should be used by schools to monitor overall levels of wellbeing to identify pupils who would benefit from additional support and to track progress over time. The Department for Education should use the data to track trends in young people's mental health as well as identify and share best practice from schools.

3.3 Promoting wellbeing and preventing mental ill health

Data on wellbeing can be effectively used by schools to design programmes to promote wellbeing, prevent mental ill health, and provide additional support to those who would benefit from it. Wellbeing can be promoted and supported through a school's pastoral system, curricular and extra-curricular activities which offer opportunities for pupils to learn skills including resilience and emotional regulation, and engagement with parents and families.

Although many determinants of wellbeing lie beyond the school setting, and prevention alone will not eliminate mental ill health, investing in school-based prevention is highly cost-effective. A Centre for Mental Health report finds that whole-school interventions designed to instil pro-social behaviour and address drivers of mental ill health have a benefit-cost ratio of 27 to 1.[117]

Boosting promotion and prevention activities in schools is vital to improving outcomes for young people and reducing reliance on expensive, late-intervention clinical services. However, existing approaches to prevention and promotion are yet to realise their full potential.

[117] Lorraine Khan, Michael Parsonage, and Jessica Stubbs, *Investing in Children's Mental Health: A Review of Evidence of the Costs and Benefits of Increased Service Provision* (Centre for Mental Health, 2018).

3.3.1 An inadequate approach

Questions of Quality

Much of the focus on school-based promotion and prevention has been directed towards the teaching of Physical, Social and Health Education (PSHE). Since September 2021, there has been a statutory requirement for secondary schools to include PSHE in their curriculum.[118] Yet there is no minimum requirement for the number of timetabled PSHE lessons a school is expected to deliver. Interviewees, among them teachers, explained that this means PSHE is held in lower esteem than other subjects – often being poorly planned and implemented, and taught in one-off, irregular sessions.

This is reflected in the comprehensive review of PSHE teaching published by Ofsted in 2013, which found the subject was being inadequately taught in 40 per cent of English schools.[119] A more recent Ofsted report, published in 2021, similarly finds that young people "were seldom positive of their PSHE lessons", and felt lessons were not "relevant to the reality of their lives".[120] The report identifies specific issues with PSHE delivery in schools, such as weak implementation, teachers not feeling prepared to teach outside of their subject specialism, and senior leadership teams (SLTs) not valuing the subject's importance.[121]

Since most schools do not formally evaluate their PSHE teaching, and few survey their pupils regarding PSHE, it is difficult to determine the extent to which these weaknesses undermine the current approach to school-based promotion and prevention.[122]

Indeed, a survey carried out by Ofsted in 2013 found that, in 67 per cent of secondary schools, evaluation of the outcomes delivered by PSHE was deficient.[123] A more recent report, published by the Department for Education in 2021, finds "variation in the ways and extent to which schools went about … evaluating the delivery of their PSHE education curriculum".[124]

Poor training

The low quality of PSHE is compounded by the lack of subject-specific training available. For example, there is no route for PSHE-specific training in initial teacher training (ITT); and, as previously stated, three quarters of teachers say they received no training to

[118] Department for Education, 'Introduction: Relationships Education, Relationships and Sex Education (RSE) and Health Education', Webpage, 2019.
[119] Ofsted, *Not yet Good Enough: Personal, Social, Health and Economic Education in Schools*, 2013.
[120] Ofsted, 'Review of Sexual Abuse in Schools and Colleges', Webpage, 2021.
[121] Ibid.
[122] Department for Education, Ipsos MORI, and PSHE Association, *Relationships Education, RSE and Health Education: School Practice in Early Adopter Schools*, 2021.
[123] Ofsted, *Not yet Good Enough: Personal, Social, Health and Economic Education in Schools*.
[124] Department for Education, Ipsos MORI, and PSHE Association, *Relationships Education, RSE and Health Education: School Practice in Early Adopter Schools*.

support mental health in their ITT. [125] A survey by Public First also finds that around two thirds of teachers responsible for PSHE do not feel adequately trained to deliver it.[126]

A 2021 DfE report explains that, given the lack of training available for teaching PSHE, teachers often fall into the subject by being involved in related roles (such as pastoral support), or come from completely unrelated roles, and are therefore "less comfortable or confident" teaching PSHE.[127]

While existing training in this area is deficient,[128] strikingly, roughly a quarter of teachers say that were the route available they would have chosen to specialise in PSHE for ITT.[129] This preference is even more common among new teachers (with under five years teaching experience), nearly half of whom would have chosen to specialise in PSHE. Ensuring teachers are properly equipped to build social and emotional skills through ITT is thus part of the solution to addressing the current deficiencies.

Recommendation 6: The Teaching Regulatory Agency, in collaboration with the Department for Education, should work to ensure that all providers of initial teacher training have modules and specialist routes for teaching PSHE. This should be aimed at creating expertise for teaching PSHE in schools, rather than a new 'PSHE teacher' role.

3.3.2 From knowledge to skills acquisition

To truly realise the benefits of PSHE teaching time, however, the contents of the curriculum must also be overhauled. In 2020, statutory guidance on teaching PSHE was updated to include more of a focus on mental health and wellbeing in secondary schools. In particular, this guidance stressed that young people should know the effects healthy and unhealthy relationships can have on wellbeing; the link between physical and mental health; and signs of some of the most common mental health conditions, such as anxiety and depression.[130]

While these are all vital for young people to understand, this represented a continuation of the focus PSHE has on teaching knowledge, rather than skills such as emotional regulation and self-control. The new statutory guidance states that pupils "need

[125] McShane, Munnelly, and Dorrell, *Fixing a Failing System: Rethinking Mental Health Support in Schools for the Post-Covid Generation*.
[126] Ibid.
[127] Department for Education, Ipsos MORI, and PSHE Association, *Relationships Education, RSE and Health Education: School Practice in Early Adopter Schools*.
[128] Loic Menzies et al., *Why Teach?* (The Centre for Education & Youth, 2015).
[129] McShane, Munnelly, and Dorrell, *Fixing a Failing System: Rethinking Mental Health Support in Schools for the Post-Covid Generation*.
[130] Department for Education, 'Introduction: Relationships Education, Relationships and Sex Education (RSE) and Health Education'.

knowledge … to make informed decisions about their wellbeing" and that "Effective teaching will ensure core knowledge is broken down into units of manageable size".[131] Knowledge, however, is of limited worth without the capabilities to act on it.

Interviewees for this paper and a range of international evidence suggests that wellbeing promotion and preventing mental ill health is most effective when it is focused on developing skills rather than acquiring knowledge. Whilst young people benefit from possessing strong mental health literacy, being able to cope with adversity and possessing emotional regulation leads to much greater improvements in mental health and wellbeing over time (for ideas on how to measure these traits, see Figure 11 on the #BeeWell programme in Greater Manchester).[132]

In this regard, a particularly strong evidence base exists for using social and emotional learning (SEL) programmes. Teaching skills such as emotional regulation and self-control is shown to improve long-term outcomes in physical and mental health, even after accounting for household income and family background.[133] Figure 12 presents an example of a particularly effective international SEL based programme, the Dutch Skills for Life (S4L) course.

Figure 12: Dutch Skills for Life (S4L)

The Dutch Skills for Life (S4L) programme is a universal programme adopting a social and emotional learning approach to supporting young people's mental health and wellbeing. It consists of 26 modules taught over two years, with underlying principles designed to teach pupils general skills such as interpersonal problem-solving, critical thinking and emotional regulation.

These skills are then applied through lessons to specific problem situations within themes, including substance abuse, conflicts, gossip, bullying and sexuality. The programme is delivered through a combination of role-plays, discussion, feedback, social reinforcement, and extended practice – by teachers who receive three days of general and curriculum-specific training. It is shown to significantly improve students' self-efficacy after a 20-month follow-up, particularly among students with lower educational levels, and those at risk of developing mental health and behavioural difficulties.

Source: Aleisha Clarke, Miriam Sorgenfrei, James Mulcahy, Pippa Davie, Claire Friedrich, and Tom McBride, *Adolescent Mental Health: A systematic review of the effectiveness of school-based interventions* (Early Intervention Foundation, 2021)

[131] Ibid.
[132] Alissa Goodman et al., *Social and Emotional Skills in Childhood and Their Long-Term Effects on Adult Life* (UCL Institute of Education, Cabinet Office, Social Mobility & Child Poverty Commission and the Early Intervention Foundation, 2015).
[133] Moffitt Terrie E. et al., 'A Gradient of Childhood Self-Control Predicts Health, Wealth, and Public Safety,' Proceedings of the National Academy of Sciences 108, no. 7 (January 2011): 2693-2698.

In particular, programmes that teach self-control reduce the likelihood that young people will engage in specific risk behaviours associated with worse physical and mental health outcomes in adulthood, such as smoking, risky sexual behaviour, alcohol, and substance misuse.[134]

Teaching emotional regulation has been shown to deliver lifelong improvements in wellbeing.[135] Interviewees explained that a wider focus on wellbeing, as well as preventing mental health difficulties, is a central feature of SEL programmes – which also helps to ensure young people do not feel medicalised by school-based approaches.

Interviewees also explained that the distinction between schools choosing to pursue wellbeing or academic attainment is a false one. Instead, good mental health underpins young people's engagement in school, which is an important determinant of academic success. A meta-analysis carried out in 2011, for example, found that SEL programmes resulted in improved academic attainment that was "equivalent to an 11-percentile point gain in achievement".[136]

While SEL principles can underpin teaching across the curriculum and schools' approach to pastoral care, given existing requirements on teaching PSHE and the interest many schools have taken in improving its delivery, SEL principles should be embedded the heart of the PSHE curriculum. This has two benefits: firstly, SEL programmes are an inexpensive way to improve wellbeing and mental health broadly; secondly, they equip young people with the life skills needed to succeed beyond school.

Recommendation 7: PSHE should be transformed into a universal, timetabled lesson, which is allocated a minimum of an hour a week, underpinned by a social and emotional learning curriculum. This would involve teaching skills such as emotional regulation and self-control that will enable pupils to proactively respond to physical, social and health issues as they arise.

3.4 Early intervention for mental health difficulties

Promoting wellbeing and preventing mental health conditions developing is key to improving outcomes for young people and reducing reliance on specialist clinical support. However, regardless of the success of prevention programmes, some young people will develop mental health support needs. Early identification and intervention can

[134] Stephanie Waddell and Aliesha Clarke, *Social and Emotional Learning: Supporting Children and Young People's Mental Health* (Early Intervention Foundation, 2017).
[135] Moffitt Terrie E. et al., 'A Gradient of Childhood Self-Control Predicts Health, Wealth, and Public Safety'.
[136] Joseph A. Durlak et al., 'The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions', *Child Development* 82, no. 1 (January 2011): 405–32.

make a dramatic difference to preventing escalation, achieving improved mental health outcomes, and reducing costs associated with high-intensity treatments.

3.4.1 The MHST rollout

Early intervention has rightly been a major long-term policy focus and received a welcome, significant boost following the publication of the 2017 Green Paper. While roughly 61 per cent of schools provided some form of counselling before the Green Paper,[137] school-based support was of variable quality and often failed to meet high levels of demand.[138] For this reason, young people with support needs tended to have their conditions managed in primary care or required support from more specialised CYPMHS.[139]

MHSTs, the central commitment of the 2017 Green Paper, are designed to provide specific extra capacity in schools for early intervention and have become the primary focus for scaling this up.

MHSTs are funded through NHS England CCGs and are linked to a set number of primary and secondary schools in a local area. They are typically staffed by four Education Mental Health Practitioners (EMHP), a new role in the CYP IAPT programme, and are supervised by local CYPMHS staff. EMHPs receive 12 months of university-based training, including work placements in schools, colleges, and pupil referral units.[140]

EMHPs are tasked with three core roles – working collaboratively with educational institutions to support a whole-school approach to mental health, delivering evidence-based talking therapies to young people with mild to moderate needs, and signposting young people to more specialised support where necessary. Interviewees for this paper working in schools with MHSTs in place and an interim evaluation of the programme reflected on the fact that providing one-to-one talking therapies constituted the bulk of EMHPs workload.[141]

As noted above, a broad consensus exists that the original targets of rolling out MHSTs to only a fifth to a quarter of schools were under-ambitious, and that if the Government was serious about providing support to all young people, it would need to scale-up the availability of its offer.[142] By leaving three quarters of schools without the care MHSTs offer, millions of young people are being left unserved.

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[137] Marshall et al., *Supporting Mental Health in Schools and Colleges: Quantitative Survey*.
[138] Clarissa White et al., *Supporting Mental Health in Schools and Colleges: Qualitative Case Studies* (Department for Education, 2017).
[139] Ibid.
[140] NHS England, 'Education Mental Health Practitioner', Webpage, 2021.
[141] Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report*.
[142] House of Commons Education and Health and Social Care Committees, *The Government's Green Paper on Mental Health: Failing a Generation*.

To ensure MHSTs are best fulfilling their purpose in providing early support for young people, a number of other issues must also be addressed: the quality of data on which to evaluate the programme, the skills mix of EMHPs, and the retention of staff in the system.

3.4.2 Data-led evaluation

In 2021, an early evaluation of the MHST rollout was completed by the NIHR-funded BRACE Rapid Evaluation Centre and Policy Innovation and Evaluation Research Unit.[143] The evaluation noted the positive effect this programme was having in schools, including young people reporting good experiences interacting with MHSTs, and the development of more proactive cultures around mental health and wellbeing.[144]

Teachers interviewed for this paper also reflected they would be "devastated" to lose the support of the MHST based in their school; and that EMHPs had increased their school's capacity to intervene early to help young people with mild to moderate mental health needs, where previously they would have been reliant on CYPMHS.

However, significant concerns exist over the availability of high-quality data to monitor the effectiveness of the programme. Absence of high-quality data has been a perennial barrier to improving mental health support for young people. For example, a National Audit Office report from 2016 finds that "understanding progress is significantly hindered by a lack of data"; and where data is collected, there are "concerns about [its] consistency and accuracy".[145]

The lack of high-quality, publicly available data on whether MHSTs have improved pupils' mental health and wellbeing was a recurring theme in interviews. Partly this is because quarterly reporting on MHST data was suspended during the pandemic – as part of the NHS-wide pause on non-essential monitoring.[146] However, as the interim evaluation of the MHST rollout notes, many sites do not even have the correct infrastructure needed to record data and track the progress made in schools.[147]

Three categories of data are essential for measuring the success of the MHST rollout:

- Outcomes data (similar to the data already used in IAPT reporting) to assess the impact of interventions on young people's mental health, such as whether young people have "reliably recovered" from poor mental health (i.e. have moved from requiring clinical support to no longer requiring clinical support).

[143] Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report*.
[144] Ibid.
[145] National Audit Office, *Mental Health Services: Preparations for Improving Access*, 2016.
[146] Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report*.
[147] Ibid.

- Data on whether the availability of other forms of in-school support has changed following the rollout of MHSTs.
- Access rates for under-represented groups, for instance BAME and LGBT young people who have historically underutilised mental health support.[148]

So far, reliable data is unavailable on all three metrics. This is highlighted in a November 2021 report by the Health and Social Care Committee which states, "there is little to no publicly available data on the impact that existing Mental Health Support Teams have had on the mental health of children and young people who are accessing them".[149]

Evaluating Outcomes

MHSTs are expected to collect and report data on person-centred outcomes, such as young people's experience of care given, which is then reported through NHS Digital's Mental Health Services Dataset. However, the only publicly available data on MHSTs relates to access rates and waiting times for treatment. This data provides an incomplete and potentially misleading picture of whether MHSTs are succeeding for young people – whilst high access rates may suggest young people have better access to the support they need, it could also indicate an increase in the prevalence of mental health conditions.[150]

Access data also fails to measure whether young people's wellbeing and mental health is improved by receiving an MHST's support. Hence, until data on outcomes is collected and published, government cannot assess whether the programme represents good value for money. As a Health and Social Care Committee report rightly points out, using access to treatment as a barometer of MHST success risks "hitting the target, [but] missing the point".[151]

Promising regional data is emerging in this area. Information shared by Professor Peter Fuggle, joint Lead at University College London for the CYP-IAPT programme, reveals that EMHP-delivered interventions in schools in London and the South East have achieved similar rates of recovery and mental health improvement as existing CYPMHS services.[152]

However, national level outcomes data is required to determine the effectiveness of MHSTs in every location they have been rolled out. Providing this information will help

[148] Claudia Cooper et al., 'Ethnic Inequalities in the Use of Health Services for Common Mental Disorders in England', *Social Psychiatry and Psychiatric Epidemiology* 48, no. 5 (May 2013): 685-692.
[149] House of Commons Health and Social Care Committee, *Children and Young People's Mental Health, Eighth Report of Session 2021-22*.
[150] NHS England, *Mental Health Support Teams for Children and Young People in Education: A Manual*, 2019.
[151] House of Commons Health and Social Care Committee, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's Progress against Its Policy Commitments in the Area of Mental Health Services in England, Second Special Report of Session, 2021-2*.
[152] Information kindly shared by Professor Peter Fuggle, UCL.

provide evidence of the cost-effectiveness of accelerating the MHST programme, as has often been called for.

Assessing impacts on other forms of support

A concern raised in early evaluations of the MHST rollout was that, since some EMHPs had been recruited from local NHS children and young people's services, accelerating the rollout could create "knock-on staffing problems for those services".[153] In the context of ongoing attempts to expand the CYPMHS workforce (see Section 2.1.1), not having data in this crucial area hampers the Government's ability to get a full picture of future workforce requirements.

Moreover, written evidence to the Health and Social Care Committee in 2021 suggests the MHST rollout may have impacted on other areas of in-school mental health support.[154] While MHSTs are funded through NHS England, other forms of in-school support such as counselling are funded locally through the NHS, local authorities or schools themselves – for example, using their pupil premium budget.[155] In 2017, 93 per cent of schools used their own budgets to fund counselling provision.[156]

Concern has therefore been raised that some schools, in the interest of saving money, have not re-employed counsellors in the hope "MHSTs would backfill these roles".[157] Although baseline data was collected in 2017, showing that 84 per cent of secondary schools employed counselling services, no data has been collected since to assess whether the MHST rollout has affected in-school counselling provision.[158]

This is particularly concerning as the then Government's response to the 2017 Green Paper consultation clearly states, "It is essential that [support] teams build on and increase support already in place, for example high quality counselling services in schools".[159] However, without updated baseline data on the provision of in-school counselling, this cannot be known – making it difficult to evaluate whether young people have access to the right balance of in-school support.

Monitoring Access

Monitoring the characteristics of students in contact with MHSTs would help policy makers and school staff determine whether or not groups historically underserved by

[153] Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report.*
[154] British Association for Counselling and Psychotherapy, *Children and Young People's Mental Health: Written Evidence by the British Association for Counselling and Psychotherapy (CYP0081)* (Health and Social Care Committee, 2021).
[155] Aaron Kulakiewicz and Nerys Roberts, *Provision of School-Based Counselling Services* (House of Commons Library, 2021).
[156] Marshall et al., *Supporting Mental Health in Schools and Colleges: Quantitative Survey*.
[157] British Association for Counselling and Psychotherapy, *Children and Young People's Mental Health: Written Evidence by the British Association for Counselling and Psychotherapy (CYP0081)*.
[158] Marshall et al., *Supporting Mental Health in Schools and Colleges: Quantitative Survey*.
[159] Department of Health and Social Care and Department for Education, *Government Response to the Consultation on Transforming Children and Young People's Mental Health Provision: A Green Paper and Next Steps* (London, 2018).

mental health support were benefiting from the programme's rollout. Much of the relevant information to determine this is contained in the Department for Education controlled National Pupil Database (NPD), which has been described as "one of the richest data sets in the world" and contains information on a range of relevant pupil characteristics, from household income to ethnicity.[160] Some small-scale attempts have been made to link this database with NHS mental health data, but this is yet to occur at a national level.[161]

Interviewees reflected that a permanent link between these datasets may contravene existing data protection regulation. However, for the purposes of evaluation, NHS Digital should be permitted to access relevant extracts from the NPD to ensure that all groups are benefiting from the service.

The Government has committed almost £400 million to the MHST programme and it is now the central pillar of its strategy to intervene early to support young people's mental health. However, in the absence of publicly available, high-quality data on the outcomes MHSTs achieve, the Government's ability to make informed decisions regarding their continued rollout is significantly weakened.

Recommendation 8: NHS Digital should urgently collect standardised, outcomes-based data from the MHST rollout, and publish this data in an accessible form in the Mental Health Services Data Set. For the purposes of evaluation, NHS Digital or its successor body should be permitted to access relevant extracts from the National Pupil Database to determine the extent to which Mental Health Support Teams are addressing long-standing inequalities in access to school-based mental health support.

Recommendation 9: The Department for Education, working with the Department of Health and Social Care, should urgently commission a comprehensive evaluation of Mental Health Support Teams using the standardised, outcomes-based data. This evaluation should also consider whether the availability of other forms of in-school support has been impacted by the rollout of Mental Health Support Teams.

3.4.3 Developing a skilled workforce

The other barriers that remain to be addressed in the MHST rollout relate to workforce, which has been described by an expert panel to the Health and Social Care Committee

[160] Department for Education, 'Apply for Department for Education (DfE) Personal Data', Webpage, 7 January 2022.
[161] Karen Laura Mansfield et al., 'Five Models for Child and Adolescent Data Linkage in the UK: A Review of Existing and Proposed Methods', *Evidence Based Mental Health* 23 (January 2020): 39-44.

as the "single biggest threat to national ambitions to improve mental health".[162] In particular, important questions remain over the skills mix of the existing workforce and strategies for retaining EMHPs in the long run.

Interviewees for this paper and the interim evaluation of the MHST programme noted that currently MHSTs were unable to support a so-called 'missing middle' of students, whose needs were too significant to be met in schools but not significant enough to meet high thresholds for CYPMHS care.[163] Eating disorders often fit into this category of need. As documented in Section 1.3.1, recent years have seen marked and worrying increases in demand for healthcare services to treat disordered eating.[164]

EMHPs are not trained in providing support for these disorders, meaning that responsibility for intervention falls almost entirely on CYPMHS.[165] As the prevalence of mental health conditions increases, though, so too does the threshold for CYPMHS access. This is because increased demand on services means treatment is rationed to those with the most severe need – a CQC report in 2018 quotes GPs telling young people to "pretend things are worse than they are", to increase their chances of getting access to CYPMHS.[166]

This leads to an increase in the number of rejected referrals which the CQC report says causes "blockages further down the system".[167] Interviewees explained that this results in young people with high needs often finding themselves bounced between services until their symptoms escalate or free capacity exists in CYPMHS.

While young people engaging in severe self-harm and experiencing disordered eating require specialist support, school-based early intervention can play an important role in managing these conditions and reducing symptom escalation. Expanding the training offered to EMHPs and allowing those with more experience to take on high-intensity therapy responsibilities could play a crucial role.

Allowing EMHPs to take on greater responsibilities can help address another core challenge for the MHST rollout: workforce retention. Retention was raised as a concern both by interviewees and in early evaluations of the MHST trailblazer sites.[168] Despite the popularity of the EMHP role, staff turnover has reportedly been high.[169]

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[162] House of Commons Health and Social Care Committee, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's Progress against Its Policy Commitments in the Area of Mental Health Services in England, Second Special Report of Session, 2021-2*.
[163] Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report*.
[164] Lukasz Cybulski et al., 'Temporal Trends in Annual Incidence Rates for Psychiatric Disorders and Self-Harm among Children and Adolescents in the UK, 2003–2018', *BMC Psychiatry* 21, no. 1 (May 2021): 1-12.
[165] House of Commons Health and Social Care Committee, *Children and Young People's Mental Health, Eighth Report of Session 2021-22*.
[166] Care Quality Commission, *Are We Listening? Review of Children and Young People's Mental Health Services (Phase Two Supporting Documentation: Qualitative Analysis)*, 2018.
[167] Ibid.
[168] Ellins et al., *Early Evaluation of the Children and Young People's Mental Health Trailblazer Programme: Interim Report*.
[169] Ibid.

One potential reason is that the EMHP role is seen as a stepping stone for progression into advanced careers, such as clinical psychology. While fully trained EMHPs are appointed at NHS pay band 5, school nurses and clinical psychologist trainees are appointed at the higher pay band 6, making these obvious professions to move on to. The risks of this situation were anticipated by the National Collaborating Centre for Mental Health (NCCMH), who stated in 2020 that a lack of progression opportunities "both vertically and horizontally" was likely to "impact retention".[170]

Developing a career progression structure for EMHPs that would involve them taking on higher levels of responsibility over time and moving into a new senior EMHP role at a higher pay band could help address both challenges. To increase retention of EMHPs, a 2021 report by the expert panel to the Health and Social Care Committee explains "an established career structure that recognises increased competence" could "incentivise staff to remain in the workforce".[171]

A similar reform has been implemented in the adult psychological profession.[172] In the adult IAPT workforce, the role equivalent to an EMHP, the 'psychological wellbeing practitioner' is supported by a more senior staff member, known as a 'senior psychological wellbeing practitioner', who specialises in treating more complex mental health conditions, and is appointed at a higher pay band.

Following this reform, staff retention in the adult IAPT workforce was described by a 2018 NCCMH review as "generally good",[173] and the number of low intensity (EMHP equivalent) adult IAPT staff increased 46 per cent (from 2804 to 4100) between 2019-2021.[174]

Recommendation 10: Health Education England should publish a workforce retention plan that addresses the lack of vertical progression for Education Mental Health Practitioners while creating in-school support for pupils who fall between the gap of low-level interventions and Children and Young People's Mental Health Services. This should include the creation of a Band 6/7 Senior Education Mental Health Practitioner role, capable of treating moderate to severe mental health conditions, such as eating disorders and self-harm.

[170] Juliane Läng, *Final Report: Maximising Efficiency in Psychological Professions' Training Routes* (National Collaborating Centre for Mental Health (NCCMH), 2020).
[171] House of Commons Health and Social Care Committee, *The Health and Social Care Committee's Expert Panel: Evaluation of the Government's Progress against Its Policy Commitments in the Area of Mental Health Services in England, Second Special Report of Session, 2021-2*.
[172] Health Education England, *Adult IAPT Workforce Census 2021: National Report February 2022*, 2022.
[173] *The Improving Access to Psychological Therapies Manual: Appendices and Helpful Resources* (NHS, 2018).
[174] Health Education England, *Adult IAPT Workforce Census 2021: National Report February 2022*.

Conclusion

Young people's mental health and wellbeing were deteriorating long before the COVID-19 pandemic. However, the events of the last two years have proven especially difficult for young people. They have made major sacrifices to mitigate the spread of a disease whose direct health effects on them were, for the most part, limited.

Interruptions to learning and education have left many concerned about their future prospects. Many have missed out on formative life experiences, opportunities to socialise with friends, and crucial adolescent rites of passage. For those already living with mental health conditions, pandemic restrictions have made accessing support more difficult and often exacerbated the risk factors that led to poor mental health in the first place. The mental health and wellbeing effects of the pandemic are only beginning to be calculated.

As the direct effects of the pandemic begin to recede, we owe it to young people to put their mental health and wellbeing at the heart of the recovery. This will require increasing access to and improving support already available through CYPMHS and schools, but also looking beyond statutory services to develop a truly joined-up approach to young people's mental health and wellbeing that prioritises prevention and early intervention, rather than picking up the pieces of crisis.

The costs of bringing about change may be significant. However, the costs of inaction are far higher – poorer quality of life for young people, reduced life chances, particularly for the most disadvantaged, and unsustainable long-term costs on public services.

Government must seize the initiative and forge a new path to make young people's mental health everyone's business. Doing so will transform lives in the short term and pay dividends in the long run.

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