Written evidence submitted by UCL Institute of Education (CYP0038)

1. Introduction

We are research experts in educational, developmental, and social psychology and a clinical expert in eating disorders from the **Department of Psychology and Human Development** at the **UCL Institute of Education** - the largest UK university centre in education and social sciences research ranking #1 in the 2014 Research Excellence Framework.

Our written evidence is based on our expertise and focuses on:

- Provision of mental health support in schools
- Provision of support for young people with eating disorders
- Wider changes needed in the system, and to what extent it should be reformed in favour of a model that focuses on early intervention in children and young people's mental health to prevent more severe illness developing

Our recommendations arise from existing inefficiencies identified in the system that are exacerbated by the COVID-19 pandemic:

- Sharp decrease in children's mental wellbeing has resulted in an increased demand for mental health services for children. This demand is unlikely to be met by current already stretched provision; alternative solutions need to be found (see **3.1**).

- A key, related issue is the increase in cases of eating disorders (see **3.2**). **During the pandemic, referrals to specialist CAMHS have quadrupled. With most children not in school, there are reduced opportunities for teachers to observe symptoms and refer on**, **so it is likely that many new, and exacerbations of known, cases are missed**, meaning longer duration of untreated illness. This is a problem because longer illness duration is associated with poorer long-term prognosis.[1] For many **people with eating disorders, symptoms have worsened during the pandemic**; and are likely to affect up to 15% of young women and up to 5.5% of young men in high-income countries.[1]

- Prior to the pandemic, mental health referrals to CAMHS through schools were primarily identified by teachers using the standardised but brief Strength and Difficulties Questionnaire – **cut-offs differed across schools and were not standardised which meant many children with difficulties not meeting the cut-offs were missed.** Further, our research shows that children who do not meet clinical cut-offs also need help and if untreated over a prolonged period, can develop more severe mental illnesses in adulthood (see **3.3**).

2. Recommendations

In light of the evidence below, we suggest that the government considers the following solutions to address the increased demand on CAMHS and meet children and young people's mental health needs:

2.1 Schools should be better supported to provide a central part of mental wellbeing provision.

With the right support and effective school preventive interventions, schools are well-placed to help children and young people, leading to long-term financial savings across society as lower need for mental health service access, hospitalisation, additional support as well as costs related to future crimes not committed (see 3.1).

2.2 Teachers should be equipped with mental health first aid knowledge.

Teachers are key contact persons who can flag concerns in children's mental wellbeing and can refer on to appropriate professionals. Providing continuing professional development and support for teachers at all levels would help them recognise and support children with eating disorders and mental health issues who miss clinical thresholds (see 3.2. and 3.3). Failing to provide accurate teacher training would result in children not being referred and shorten children's life chances.

2.3 DHSC/NHS should develop a central online hub with credible mental health resources which explain the current referral system in order to expedite children's access to healthcare experts.

A low-cost virtual platform ensures that teachers are not burdened with providing mental health support to students and students in need can access help from specialist healthcare quickly (see 3.2).

2.4 Regular mental health assessment for all school children should be made part of the school curriculum.

Current assessment of children's cognitive and physical health falls short of mental health and is a disservice to young people. Understanding children's mental health and its developmental can highlight those who do not yet meet clinical threshold or show up on academic performance indicators but are suffering and are at-high risk for mental illness in adulthood (see 3.1. and 3.3).

3. Evidence

- Children and young people have been hard hit by the pandemic. **Our survey on parents of children with Special Educational Needs and typically developing siblings reported increased levels of anxiety and worries about health, social relationships, and school closures in both groups of children.[2]**

- In another large global survey (N=1829), we found that **young people aged 18-34 years were worse off across all mental health indicators**: anxiety, depression, aggression, sleep, social mistrust, and stress due to COVID, compared with their older counterparts (55y+) during the first lockdown (March-July 2020) and sustained effects during lockdown two and three.[3]

- **Our studies also show that UK's poorest communities will be most affected following further economic shock.[4]** The pandemic has clearly set back this year's goal of having more than 70,000 children and young people (0-25 years) access mental health services in line with the *Five Year Forward View for Mental Health (2016)*. A reassessment of young people's mental health- particularly those in low socioeconomic neighbourhoods – is urgently needed.

- **The pandemic is a stressor which has both increased the risk of disordered eating and eating disorders** (due to disruption to daily routines, sleeping patterns, access to outdoor activities

and increased access to social media) **and decreased factors that usually offer some protection** (e.g. social support). Under- and over-eating are maladaptive coping strategies that temporarily give the perception of feeling more in control of an out-of-control situation, such as a pandemic.

3.1 Provision of mental health support in schools

3.1.1 Schools are not just places where children learn, they are also hubs of expertise in terms of social care and health support. COVID-19 has brought this into sharp focus: we have seen that schools provide essential lifelines for families in terms of meals, provide wellbeing classes in terms of PE and after school sports clubs. Importantly, evidence from a systematic review suggests that sport-based interventions can improve mental health outcomes.[5]

3.1.2 Schools are also already a hub for support for children with Special Educational Needs and Disabilities (SEND). Schools work closely with a range of specialist service providers within the local authority and Clinical Commissioning Groups as well as other providers (e.g. Patient Advice and Liaison Services; Family Information Service) and most schools are informed about local authority support and thus can signpost parents or make referrals when needed.

3.1.3 New initiatives like Mental Health Support Teams and Place2Be have placed schools at the frontline of providing mental health support for children in need. **Our COVID research highlights the importance of schools for families in terms of mental health support. In our survey of over 400 families, parents reported that schools provide a structure and routine that is important for children's overall wellbeing and a place for children to socialise and develop friendships.** Schools also provide important support for parents during times of crises; parents reported increased anxiety with the loss of this support because of school and activity centres' closures.

3.1.4 Mental Health Support Teams and Place2Be is making steady progress upwards of 30% of children with mental health issues having access to services. However, this relies on children knowing when to seek help, which is often unlikely to happen and difficult for children to judge.[6]

3.1.5 Over 20% of teachers reported specific gaps in terms of continued professional development, especially with regards to supporting mental health issues in children with SEND.[7]

3.1.6 Prioritising a whole-school approach that promotes teacher-student relations will allow teachers to detect mental health issues early on, in addition to student-individual approaches will provide a more preventative approach to severe mental illnesses.

3.1.7 Student-individual approaches rely on an understanding of students and their mental health needs in a school as well as an understanding of how these needs can be addressed. This requires that schools regularly audit the mental health needs of students, provide staff with the required training, and to put systems in place to work with external specialist providers to meet these needs.

3.2 Provision of support for young people with eating disorders

3.2.1 The government has recognised the seriousness of these illnesses which typically start in adolescence around the age of 15 and require early detection, intervention and specialist treatment.

3.2.2 Dedicated, community-based outpatient specialist eating disorder services have been shown to improve outcomes and to be cost effective in comparison to generic services and most young people with eating disorders (70-90%) can be treated as outpatients. The specialist eating disorder services for children and adolescents (CEDS-CYP) are multidisciplinary teams available around the country.

3.2.3 The National Collaborating Centre for Mental Health and NHS England (2015) publication stipulated that any child or adolescent with a known or suspected eating disorder should receive treatment within a maximum for 4 weeks from their first contact with a designated healthcare professional, like their GP. Urgent cases where the child or adolescent is rapidly losing weight and showing serious physical health concerns (see Junior MARSIPAN) should be seen by a special eating disorder team within a week. In emergency cases where life is at risk, a specialist eating disorder team should be contacted and will provide support within 24 hours.

3.2.4 Good progress has been made towards these targets thanks to £30million of additional government funding annually between 2014-18 into specialist child and adolescent eating disorder services to help achieve these waiting time and access standards. This additional funding continued with a further £22million of additional investment between 2019 and 2021 through the NHS Long Term Plan, with the money being directed through Clinical Commissioning Groups. Specialist training and supervision was provided by expert teams to up-skill clinical teams around the country so that children and young people can access evidence-based treatment, such as Family Based Treatment for their eating disorder.

3.2.5 In NHS England and NHS Improvement's *2019 Guidance for Adult Eating Disorder Services and Community Eating Disorder Services* documents (National Collaborating Centre for Mental Health), information is provided to support the delivery of integrated services which utilise intensive day care options to reduce admissions and length of stay where an admission is require for medical stabilisation. Further, these documents aim to outline how young adults can transition seamlessly from child and adolescent services into adult care where this is needed.

3.2.6 **Schools, through links with local CEDS-CYP are vital in the early detection and referral of potential cases**, meaning that they support early intervention efforts and help young people access the services described above.

3.3. The wider changes needed in the system, and to what extent it should be reformed in favour of a model that focuses on early intervention in children and young people's mental health to prevent more severe illness developing

3.3.1 Over half of all mental health conditions start by 14 years of age. Many adult mental health illnesses have roots in childhood and childhood mental health issues precede adult mental illnesses. For example, 20% of children with schizophrenia-like traits are diagnosed with schizophrenia as adults, and about 20% of children who are persistently suspicious of others – the most common symptom of schizophrenia – report concurrent childhood psychopathology, hostile attributions, and being victims of bullying 12-months later.[6,8]

3.3.2 Children's life chances are shortened without early intervention. **Prioritising regular mental health assessment in school children can inform the development of school interventions that reduces later crime.**[9] Evidence suggests that an equivalent £546,919 is saved after 1.5years and £63.3million annually for psychosis programmes. Untreated childhood problems can predate more costly and disabling mental illnesses in adulthood like psychosis, anxiety, and antisocial behaviours.

- Our evidence for early mental health assessments stems from international samples and large UK birth cohort studies of school-aged children. For example, 8-10% of children aged 3-14 years suffer from internalising (anxiety, depression) and externalising (aggression, callousness, hyperactivity/distractibility) yet do not have a clinical diagnosis and predict later mood disorder. [10-12] As many as two-thirds of children experience socio-demographic and family risk-factors associated with mental health difficulties in adolescence, and poorer cognitive and academic outcomes.[13]

- 3-to-11-year-olds with internalising/externalising problem behaviours are at greater risk for poor long-term outcomes including self-harm, depression and drug use, compared to those without.[12,14]

- Mother-reports of children's mental health at 3-16 years predict psychotic-like experiences in adults.[15] Poor peer relationships, low self-esteem, and adversity/neglect in childhood are key areas for intervention; these mediate psychotic-like experiences and aggressive behaviours in adolescence[16] and predict psychotic-like experiences and antisocial criminal behaviours in adulthood.[17]

- Still, another study of community-residing children found that early stressful life events can increase levels of internalising symptoms in late childhood.[18]

3.3.3 **Early mental health assessment has the potential to reduce late diagnoses of adult illnesses, as well as developmental disorders**. For example, 75% of children with a late (secondary school) autism diagnosis were reported as having significant emotional/behavioural/social problems at school entry by a parent or teacher.[19]

3.3.4 Worldwide estimates of 10%-20% of children experiencing mental health issues is likely to be an under-estimation that is not grounded in regular mental health assessment. **Our studies show that children with poor mental health and attenuated symptoms of psychosis are silent sufferers who do not receive help[6].** These same children are performing equally well as their peers on key school cognitive measures and assessments of physical health and intellectual performance yet may fall through the cracks without regular mental health assessment and support.

3.3.5 The current school referral process to CAMHS is not fit-for-purposes as it is not standardised across schools such that in different schools, children with the same level of difficulties may or may not meet threshold to access clinical services. **While regular assessments are in place for physical and cognitive academic progress in schools, little is in place for young people's mental health in the short or longer term – a key area of concern, further exacerbated by the pandemic.**

3.3.6 With regards to eating disorders, readily available resources such as school policies on eating disorders and psychoeducation can be assembled in an online hub and promoted

within schools. SENCOs should engage with local mental health services to identify specialist referral pathways if these are not yet known or established. During the planned school Catch-Up sessions in 2021, facilitators should be briefed on the signs and symptoms of eating disorders through accessing training available from Beat, the UK's eating disorder charity. School staff can increase their confidence in acting where they observe a concern by using resources developed by Beat. The government should plan for additional investment into specialist services who are seeing increases in the number and severity of new cases.

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