

Health and Social Care Committee Education Committee

Oral evidence: [Children and Young People's Mental Health](#), HC 239

Wednesday 14 October 2026

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Health and Social Care Committee members present: Layla Moran (Chair); Jen Craft; Josh Fenton-Glynn; Andrew George; Joe Robertson; Gregory Stafford.

Education Committee members present: Helen Hayes (Chair); Sureena Brackenridge; Jodie Gosling; Darren Paffey; Mark Sowards; Peter Swallow; Caroline Voaden.

Layla Moran took the Chair.

Questions 221 - 294

Witnesses

I: Professor Peter Fonagy, Chair, Independent Review into Mental Health Conditions, ADHD and Autism; Professor Gillian Baird, Vice-Chair, Independent Review into Mental Health Conditions, ADHD and Autism.

Examination of witnesses

Witnesses: Professor Gillian Baird and Professor Peter Fonagy.

Q221 Chair: Welcome to this joint session of the Health and Social Care and Education Select Committees. This is the fourth session of our inquiry into young people and children's mental health services. It is a delight to have with us today Professor Peter Fonagy and Professor Gillian Baird of the now infamous Fonagy review. It has been a week since it has come out, and it has been very widely reported.

Can I start by asking a very simple question? How did you come to be the one to be asked to do this review? What is your background, so that those who may be less familiar with it understand the expertise that you bring to bear on this area?

Professor Fonagy: Thank you for asking, and thank you for having us here. We are really pleased to be able to present to you. By background,



HOUSE OF COMMONS

I am a clinical psychologist. I have been working in child mental health for four decades, which is quite a long time. Since 2011, I have been senior clinical adviser to NHS England in the child mental health policy team. I have really enjoyed it. That is probably the reason why I was asked—I was familiar with the system and had clinical experience that seemed appropriate to the task.

Professor Baird: I was asked to be co-vice chair with Professor Sir Simon Wessely, who is not with us today but whom I suspect many of you know. By way of background, I am a paediatrician. I specialised in paediatric neurodisability and was a consultant running a large service at Guy's and St Thomas' for rather more years than Peter has been. I was also much involved in NICE and various guidelines and research into areas relevant to this review.

Q222 **Chair:** People can read the over-600-page report too, if they want to, but, Professor Fonagy, could you very briefly outline the top recommendations that you made? While you do that, could you underline the recommendations that you think are the low-hanging fruit, and which ones you think might be more challenging to implement?

Professor Fonagy: The low-hanging fruit will be a little bit challenging, but I will try. The review proposes a radically different model of managing children's mental health. It is a shift from a diagnosis-led system, where people have to wait to get a diagnosis in order to get support, to a system where, as soon as they present with a need, that need gets addressed and they are then prioritised for a diagnosis if needed, but in the hope that in many instances it will not be. This means that they would receive support earlier in relation to what they actually need, because, surprisingly, diagnosis does not tell you what people need. After you have a diagnosis, it still needs to be figured out what it is that you require. That seemed to us illogical. I emphasise that diagnostic assessment and specialist services remain essential in this system. We are not trying to downgrade the service. It needs to be protected and strengthened.

We called for a number of other changes, which are perhaps ambitious. A stronger focus on prevention, a public health approach to wellbeing, and tackling the social and environmental drivers that we identified for the increasing prevalence of common mental disorders, particularly in children and young people but across all ages, seemed to us to be important.

We also identified that the current system was incompatible with delivering effective prevention. The system that we are proposing is far more aligned to a system where targeted prevention is aligned with offering support at the point when people present with need. We argued that we need to create conditions for people to stay well rather than relying predominantly on specialist services.



HOUSE OF COMMONS

There are just a couple more things that are really essential to our logic. This has been recommended because of the very high level of co-occurrence of neurodevelopmental disorders and common mental disorders.

Q223 **Chair:** What do you mean specifically by that? Just break it down for a non-clinician like me.

Professor Fonagy: For a non-clinician, it is that a person who is diagnosed with ADHD or autism is likely, in the majority of cases, to also have common mental disorders of anxiety, depression or self-harm, or an eating disorder. That means that, in order to deal effectively with both common mental disorders that carry with them traits of autism and other neurodevelopmental problems such as ADHD, it is essential that the assessments occur as part of a single system. That does not mean it is the same assessment or a single assessment, but it does mean that it is an integrated assessment.

At the moment, people get put on one of three pathways, as I am sure you know. That is an inefficient system. That sometimes requires people to be assessed a number of times and wait on a number of waiting lists before they acquire a diagnosis.

There are other things that we recommended that we will perhaps come around to being able to talk about.

Chair: Thank you for that. I have a constituent who has been on a CAMHS waiting list for an autism diagnosis for seven years. They are now 15. The time has passed to help them in their schooling. I am sure every MP here and many listening will relate to that.

Q224 **Peter Swallow:** One of the experiences we all have as local MPs is exactly as Layla describes there, hearing from families who are very distressed that their young people are not getting the support that they need.

Another thing that we will all be familiar with is others telling us that it is all down to the snowflake generation, and that the mental health crisis we are seeing in our young people is because they just are not resilient enough. Your report rejects that idea. Could you perhaps just explain why you reached that conclusion and the evidence that lies behind that?

Professor Fonagy: You asked two questions. I will answer the second one and maybe turn to Professor Baird to answer the first. The "snowflake generation" is an insult to young people. I challenge all of you here to cope with the pressures that young people are under and to sustain the quality of childhood and young adulthood that you all were privileged to experience.

You did not have two major categories of pressures. One is increased stress. I can go into detail in relation to this, but increased stress is financial; that is well known. It is about insecure work, unaffordable rents



and so on. Also, there is increased stress in terms of social media and social comparisons that are incessant, and educational pressures. We have evidence for that. Again, I can go into that, but it seems that young people are less well protected and less well supported. That is the second category of issues.

It is recorded that they have a lower sense of belonging to their schools. They do not feel that they belong, but it is not just schools. There has been a 73% reduction in youth services that are funded by local authorities since 2011. They do not have other young people to go to.

Finally, in terms of the lack of protection, I want to mention what we found particularly important, which is the opportunity for recovery, which is unstructured play. That is not just about youth clubs, but just being able to sleep. If you have social media that keeps you awake, stops you from sleeping and reduces face-to-face interactions, you will have less capacity to cope.

When you and I were young, we had friends. We went to see friends when we were in trouble. If that is taken away and replaced by mobile phones, they have greater stress and less support. I would reject the idea that it is a snowflake generation.

Professor Baird: The other question was particularly about waiting lists.

Peter Swallow: That was more of a flavour to get into the question. We will come back to that.

Chair: We will be coming back to waiting lists. Fear not.

Q225 **Peter Swallow:** I do not want to steal anyone else's thunder on that question. Really, I just wanted to follow up on a very helpful answer about this idea of a snowflake generation being an insulting narrative. Why do you think it has gained such traction despite the lack of evidence for it? How do we combat it?

Professor Fonagy: I am going outside the report slightly and now expressing my personal views. This is not so much about me, because I am on the other side of this, but looking at you, most of you are of a generation that was brought up believing that your future would be better than your parents'. The current generation are convinced, and rightly so, that they will not have the opportunities that their parents had.

That sense of hopelessness has been demonstrated. This is an empirical fact. That is part of their beliefs, but it is also part of our beliefs about them. It is an enormously powerful influence, but it also makes us feel somewhat guilty in relation to them. Therefore, it is much easier for us to say they are a snowflake generation than for us to say, "Actually, we have really messed it up for them, and it is our fault."

If you think back, covid was the first time that I can remember when our generation, the adult generation, brought in a way of adjusting to a



major health crisis that advantaged adults and disadvantaged children and young people. Mostly, the priority is given to the new generation, but for whatever reason—I am not here to blame anyone—we decided that our health was more important than theirs.

Q226 Peter Swallow: That is a profoundly challenging answer. It is challenging to all of us here. I just briefly reflect that, with AI coming down the track as well, it is not at risk of getting easier.

The other prevailing narrative that we hear a lot is that the rise in need reflects better diagnosis and identification of mental ill health by practitioners. That is perhaps slightly less of a pernicious myth, but nevertheless it is one that you also rejected in your report. Could you again just say a little about how you came to that conclusion?

Professor Baird: The first thing to say is that there is no evidence of overdiagnosis. We did not find evidence. To some extent, the studies have not been done. Nobody has taken a very large number of people with one diagnosis and had another group of people then examine them to see whether they would come to the same conclusion. That would be the obvious way to answer this question. Despite a huge amount of anecdote, report and opinion, there was no evidence, and this is a highly evidence-based review.

We did find evidence of misdiagnosis, where somebody would have a diagnosis of one condition and another condition was not recognised that might better explain their difficulties. This comes back to the co-occurrence, which is a central feature of the review.

The obvious examples are with eating disorders; only more recently are people recognising that many of those affected have autism as well, which has an influence on the management of the condition. You could be diagnosed with autism when somebody else might think that your major problem was ADHD or anxiety or another mental health problem. The way in which services are so often organised as single-diagnosis pathways means that you go for an assessment where the answer is, "Yes you do have this," or "No, you do not," and then you may have to rejoin a completely different pathway for an integrated assessment of what the main problems might be.

The other thing is that, when we looked at the number of people with a common mental disorder such as anxiety or depression, you might think the first thing would be that perhaps people have much milder problems these days. That is not what the evidence found. The evidence found that the level of impairment was as high or sometimes higher. The symptoms were causing greater impairment, so it is not a milder problem.

There are various other possible explanations for why the number of people with a diagnosis of ADHD or autism might be rising. I am happy to go into those, but there may be some other questions about those. There is a broader understanding of some of these difficulties. There have been



diagnostic criteria changes. Of course, while the underlying traits, features and symptoms of neurodevelopmental conditions are heavily genetically influenced, the impairment that people experience is a result of the interaction of genetic predisposition with environment.

Q227 Caroline Voaden: I would now like to talk a little bit about the drivers of mental distress that you refer to in the report. You talked about several things including emotional pressure, social media, economic uncertainty and reduced social connectedness. I notice, Professor Fonagy, that you have already talked about social media. You refer quite a lot to sleep in the report. We know that sleep is really important to good health. Being on phones late at night is a real barrier to good sleep.

Is it possible for you to quantify the extent to which each of these pressures is driving demand, where you think the main focus should be, and where the priority should be in the Government's response?

Professor Fonagy: That is a brilliant question. As with all brilliant questions, I cannot answer it. There is an honest reason why I cannot answer it, which is that they are interacting. If influences interact, it is very hard to see which came first: the egg or the chicken.

There are three things that I can say with confidence. One is that, as I have already said, they are not making it up, but the language has changed. Awareness of mental disorder has changed so that it has become a psychological language. The same level of distress that a person might feel today is more likely to drive them towards getting mental health support than it used to. That may seem like a negative, but it is actually a positive because we can help these people.

In terms of the drivers, there is a lot of negative content on social media and I do not want to minimise that. I do not want to be an apologist for social media, but it displaces things that are protective rather than simply causing harm.

I am mentioning that because of the second part of your question, about what the Government can do. By banning social media broadly, we cannot achieve quite as much, because the same distress that drives people towards social media and to seek answers from social media will still be there even if you ban it, except with less support.

It is really important that the good things that it displaces can be encouraged and supported. For example, if social media displaces physical exercise, we can encourage it. If social media displaces face-to-face interactions, we can create situations where they are enhanced. If it causes problems with sleep, we can have good ways of dealing with sleep problems. You cannot force people to go to sleep, but you can put on an alarm clock and make them wake up, which is a very simple measure of dealing with sleep disorder that we have used for a number of years.

I have one final thing, which touches on the earlier point that I made. One thing that we could all do in relation to discouraging children from



overusing social media is to use our own social media less. The number of people who are engaged with their cell phones rather than face-to-face interactions over meals is appalling. Of course, it sets a model for young people because they are there to learn from us. Human beings learn by looking at adults and seeing what they do. If we set an appalling model, can we be surprised that they do appalling things?

Q228 Caroline Voaden: There is quite a movement now for delaying the purchase of smartphones for children going into secondary school, and not having one at 11, but pushing it back. Do you think that just not having a device until young people are older would perhaps make them more resilient?

Professor Fonagy: Young people are very resilient, remarkably so, but at the same time I want to emphasise that they are also shrewd. Any attempt at some kind of Government injunction to deprive them of something that they feel that they need is less likely to be successful than we hope. We can do a great deal to change social norms and expectations on them, and to emphasise, as I said, activities that are displaced by social media.

I do a lot of advising parents about how they should bring up their children, and there is one piece of advice that I give above all: stop criticising your child and notice when they do something that you want them to do; reinforce and encourage that. We need to be less spiteful and less depriving in our approach to young people, and far more encouraging. That is a general shift that your advice to Government could probably take forward.

Q229 Caroline Voaden: Last, I have a private Members' Bill about outdoor education.

Professor Fonagy: Thank you for that.

Caroline Voaden: I believe that getting children outside is a very cheap way of improving children's mental health, sense of belonging, wellbeing and all of that. Could you tell us how important you think it is for children to be outside more and to be in nature?

Professor Fonagy: The reduction of green space correlates positively with the increase in mental health issues for young people and the decrease in wellbeing. I am sure you are very familiar with those statistics.

Obviously, being outside is an opportunity. This is irrelevant, but my father, in order to enhance my resilience, made me wear short trousers throughout winter. That was in Hungary, in a continental climate. I do not think it made me more resilient. It is not about being exposed; it is the opportunities that it brings with it, which is communication with other young people.



From age 8 through to age 11 or 12, there is a shift in the interests of young people from their parents as the primary influence to other young people being the primary influence. If we deprive them of having that opportunity, we deprive them of the major way that their genes have enabled them to integrate with modern culture. You are doing God's work.

Q230 Gregory Stafford: Thank you for the evidence so far. It has been quite difficult for me because in one breath I agree with everything you say, and then you say something else that I fundamentally disagree with. It has been interesting, but I totally agree with you on the covid point. Locking our children away was probably the worst thing we did, and we should never do that again.

Before I go on to my main questions, I want to clarify something you seem to be suggesting, which I have not heard before. You seem to be suggesting that a number of societal factors are having a significant impact on diagnoses of people's mental health. This then begs the question that, if those societal factors are removed or improved, are you saying that people who have been diagnosed with ADHD could, for want of a better phrase, get better?

Professor Fonagy: As Professor Baird very eloquently explained, any neurodevelopmental disorder such as ADHD is a combination of biological predisposition and environmental pressures. If you live in an environment that is stressful, it will bring forth traits that you have that you were born with.

Q231 Gregory Stafford: If I can drill down into that, for example, I am someone with light skin and red hair—well, it used to be red. I have a genetic predisposition to skin cancer because of those factors, but if I do not go out in the sun or I put factor 50 on all the time, I am less likely to get skin cancer.

Am I being very reductive in this? Are you saying that you might have a predisposition to ADHD but, if the societal factors are vastly improved, not in every case but in some cases, you would not develop ADHD? I am using non-medical language here. It is not a disease; it is a condition. It is a multifactorial condition. I am trying to understand what you are saying here.

Professor Fonagy: I am saying that it is a continuum. It is not something that you either have or do not have. I will turn to the local expert here to answer the question, but let me just emphasise one thing. Maybe you could give one of your favourite examples on this.

"Attention deficit" is actually a misnomer; it is attention regulation that is the problem. Hyperactivity is a way that people with ADHD cope with the problem of attention regulation. For example, the subjective inner restlessness they feel is reduced by hyperactivity. It is a continuum, as indeed most disorders are, between environmental and situational demand. When the disadvantages in mental abilities become disabling, it



HOUSE OF COMMONS

is more difficult to cope with the demands of modern life, and you struggle more. That moves you over to a threshold that is, ultimately, arbitrarily defined.

Q232 Gregory Stafford: Yes, and I am not in any way trying to suggest that the condition does not exist. I fully accept that it absolutely does. As we would do with anything, I am trying to look at how we prevent and cure. We have talked a lot about how we diagnose and how we deal with that diagnosis, but we do not seem to talk, in these areas, about prevention and cure. Maybe that is for another time.

Professor Fonagy: There is a very good example that Professor Baird can give.

Professor Baird: I will certainly try to move that forward slightly, because it is helpful to consider a dynamic interaction between genetic predisposition and environmental circumstances. For ADHD particularly, the demands for attention and the demands on the executive function will make more manifest.

First of all, here is a figure. If you have a common mental disorder and are aged 16 to 24—that is anxiety or depression—60% will screen positive for autism traits and for inattention or traits of ADHD. That brings up the likelihood that the dynamic interaction with the environment will occur, that the problems will become more manifest, and that you will probably come into a diagnostic category.

The example that Peter was referring to that is sometimes a helpful way to think about this is with type 2 diabetes. Type 2 diabetes is a well-described medical condition with a genetic predisposition. If a combination of the genetic predisposition, lifestyle and particular features, such as being overweight, all come together, your blood sugar is in difficulties because of the insulin resistance. The diagnosis of diabetes becomes manifest. If you reduce the lifestyle factors and the obesity, the diabetes can disappear, but if you have that combination of problems for long enough, you get secondary effects, so you will get a cumulative impact that then has secondary effects that are much more difficult to diminish. Is that helpful?

Q233 Gregory Stafford: That is certainly an interesting example. I have some other questions on the paper that I am going to go into, but perhaps we can come back to it at another point.

Professor Baird: I hope that was a sufficient example of the sort of principle that one could apply. It is a hypothesis, but it has some merit.

Q234 Gregory Stafford: Thank you very much. Moving on to some of your recommendations, in recommendation 5, you essentially looked at a complete overhaul of the commissioning, funding, oversight of the system, et cetera. What changes do you propose to improve the ADHD and autism diagnostic and treatment pathways? Specifically, which change do you think would have the greatest impact on improving the



waiting times?

Professor Baird: The most important is to integrate the mental health and neurodevelopmental disorder assessment so that, if you have problems and you come in for assessment, you will be having an assessment of all the possible contributory factors. If you have one problem, you are so much more likely to have another. To miss that then has a huge impact on the level and appropriateness of support that you are likely to achieve.

That is going to be one of the most important things that we can do, rather than these separate pathways. A huge amount of duplication is currently going on. People have an assessment in one place, then in another. There is a lot of duplication. Integration, both of assessment and then of services following that, is one of the most important recommendations that will help.

Q235 **Gregory Stafford:** In terms of that balance, are you suggesting that changing how the support is accessed and delivered is a greater priority, for example, than just increasing capacity overall? They are both important, but that is your view.

Professor Baird: Yes, absolutely. If all you did was to increase capacity, you would not do a very good job at all. The system as it stands at the moment is not the right one for meeting people's needs early and then providing appropriate and comprehensive assessment.

Q236 **Gregory Stafford:** What do the Government or the NHS need to do to provide this "no wrong door" access? What are the practical steps?

Professor Fonagy: There are several. The first one that should be emphasised is changing the sequence from a sequence that is, "Wait, assess, diagnose, support," to something that is, "Recognise need, then understand need, then begin support, then establish diagnosis where it changes, and then review and adapt as needed."

This is a radical change that has been implemented in a number of places. As we cite in our review, we try to seem original, but we are not. This has been discovered. It only works though, as is also documented in the review, if it is sufficiently well supported. To have a needs-based system without adequate support creates a problem rather than solving one.

We are asking for two things. One is further resources to support that needs-based system. The second is a reorganisation that is more efficient than anything that is in place now. The combination of the two will ultimately lead to a reduction in cost because of earlier intervention.

At the moment, we have a system where you gatekeep in order to be able not to treat. With children and young people particularly, if you wait long enough, the treatments that we have are not helpful. It is setting thresholds at a level where you can no longer intervene effectively. It is a



HOUSE OF COMMONS

particularly mindless thing to do. It is understandable, but all the evidence is that moving support earlier makes the treatments that we have far more effective. If you wait even for two weeks, the likelihood of a condition getting worse is something like 20%; if you wait for six months, it is 75%. Reducing waiting lists is really a key part of what we are recommending.

Q237 Gregory Stafford: This is a really specific question. On the CQC regulation recommendation, what is your reasoning behind the thought of banning public advertising for NHS-funded assessment? Where is the evidence there?

Professor Fonagy: It is very simple. You have a system where people are incentivised by the number of diagnoses they do, and you enable them to drive up demand through advertising, which the NHS has to pay for. That is an avoidable problem.

Gregory Stafford: Demand is driven up, but previously you said that levels of diagnosis had not gone up.

Chair: We are going to come back to this.

Gregory Stafford: Keep that thought, and I will leave it there. Thank you very much.

Chair: Josh Fenton-Glynn might well go down this rabbit hole. Thank you for setting it up.

Q238 Josh Fenton-Glynn: Before I pick up on that particular rabbit hole, I want to go back to a rabbit hole that you had at the start of your conversation with Greg. It was quite interesting talking about how culture and education culture has probably led to a rise in diagnosis. I thought I was back in an A-Level psychology class talking about the social model of disability again, but I wonder if there is a factor that, since Michael Gove, education has been more focused on a specific, strict type of education while society has moved in a different direction in terms of the education economy, and whether that has led to more people being likely to present with ADHD symptoms in an education environment?

Professor Baird: Yes is the answer. The changes meant that people felt that the only way that they could get support was through diagnosis. The number of EHCPs—the education, health and care plans—just went up like that after 2014.

Also, diagnoses changed; that is the other interesting feature. We have talked a little bit about co-occurrence and the importance of not just thinking about things in terms of single diagnoses. In 2016, for example, the proportion of people with a special educational need who had a learning disability was something like 15%. That halved by 2025, whereas the autism has gone like that. It is not only the number going up, but the contents.



Q239 **Josh Fenton-Glynn:** Just to clarify, what would a classic learning disability be as compared to autism?

Professor Baird: A general learning disability means having intellectual disability across the board. The number of pupils diagnosed with that has gone down, whereas other diagnoses have gone up. The main answer to your question is that after 2014 there was a change.

Q240 **Josh Fenton-Glynn:** That was in terms of both the classification of what got support and the way that the general education system works.

Professor Baird: Sheer numbers and the classification, yes.

Q241 **Josh Fenton-Glynn:** It seems to be the case that people just do not feel they can get support another way. If I look at my local ICB, West Yorkshire, the cost of the neurodiversity service has risen from £3 million in 2022-23 to £25 million in 2025-26, which is clearly unsustainable. Do you think that the model that you suggest, having support before diagnosis, would make a significant difference to that?

Professor Fonagy: We would not have suggested it if we did not think it did. People ask us sometimes if we are optimistic about change and whether some of this is going to be implemented. Our response to that is that, unless there is change, we are going to have such a catastrophic set of problems that change is inevitable.

The question is how we can change. What we are suggesting here is a feasible, practical pathway that has been tested and shown to work, which is early intervention linked to prevention. The costs are so high and the processes involved are so frequently bidirectional that the solutions that we propose actually cause the problems later down the line.

I cannot mention the person, but in one of the media encounters that we have had recently since the release, a person presenting to me said, "I just had my child assessed. It was privately done. It was a 20-minute assessment of the child, a one-hour assessment of us as parents, we got the diagnosis of autism and that was it. Now what do we do?"

Q242 **Josh Fenton-Glynn:** Fundamentally, that is what this comes down to. There is a lot of problematising lots of people going through these assessments, as if they are the problem, but at the centre of that is usually a parent who is worried that their kid is not getting the support they need for education.

Professor Fonagy: Yes, absolutely.

Q243 **Josh Fenton-Glynn:** Ultimately, that is where it is falling down. I wonder if you think a rising tide would lift all boats in some of this. If we assessed need rather than disability, would that not be better for all children going through an education system, not simply those children who happen to cross the line into neurodivergence?



HOUSE OF COMMONS

Professor Fonagy: Yes, absolutely. At the moment, we are in a system that defines children and young people in terms of their limitations. We should be in a system that describes them in terms of their potential. If that change was made systematically across the board, instead of problems, there would be opportunities for enhancing an individual's capacity.

That means focusing on their functioning, which is linked to need. You meet them where the limitations in their function are. You support them, and suddenly the problem changes.

Q244 **Josh Fenton-Glynn:** That comes back to the earlier discussion about whether society disables them. Of course it does, because it focuses on what they cannot do.

Professor Fonagy: I can give you a nice clinical example at some point, but maybe we do not have time for that.

Q245 **Josh Fenton-Glynn:** The Right to Choose assessment is something that every Member of Parliament with an inbox has come across. This is the idea that people have a right to choose to have a private assessment after a certain time. In West Yorkshire, there is a two-year minimum wait for that. I use that example just because it is my local ICB so it is closer to me. That is over 10% of someone's educational experience. Is Right to Choose working as a model?

Professor Fonagy: It is important to say that we did not recommend abolishing Right to Choose, but we did recommend prioritisation. At the moment, as Professor Baird said, there is a major issue in relation to the population changing for those who meet criteria. Parents are not looking for a label; parents are looking to help their child to deal with the challenges that the child faces. If we change the system so that what it offers is support for the parents, Right to Choose becomes an irrelevance except for in the cases where it is not.

Professor Baird: You will be familiar with this from your own ICBs. In terms of the proportion of their resource that is currently going to Right to Choose, the costs of that are far higher than perhaps the NHS cost would be. It then means that there is nothing available to support the families afterwards.

You cannot possibly blame parents. They are doing the right thing for their child. They want a diagnosis. They think it will help. Of course, they are going to do whatever they possibly can in order to get that, but it is not followed by anything. You can find that, "I have my diagnosis. My child has autism and may be non-verbal. What is going to follow?" They fall into a hole. That is not the way to manage these situations.

Q246 **Josh Fenton-Glynn:** A lot of the private providers have an incentive to find people who have those issues. Do you think more needs to be done to regulate the private providers to make sure that they are coming out with good results? I think I know the answer to this.



Professor Fonagy: That is a major recommendation that we have. It needs to be something that is probably developed by NICE and then implemented with CQC oversight. It is a very simple thing. It applies to most conditions. Why not this one?

Josh Fenton-Glynn: I suspect that will be in this Committee's recommendations as well.

Q247 **Jen Craft:** This is a very brief supplementary. I declare an interest as the chair of the all-party parliamentary group on learning disability. I was fascinated to hear that learning disability diagnoses have halved. Do you think part of that could potentially play into the misdiagnosis, around autism particularly? Maybe people are seeing that as the route to go through to get support for their child, and that is, in fact, perhaps obscuring an underlying learning disability

Professor Baird: Yes, I do. It is also probably obscuring underlying difficulties of a variety of sorts, such as speech and language impairment and other specific learning difficulties such as dyslexia. There are a number of conditions that co-exist. If you do not look for them, they can be overlooked. Of course, our report was particularly about the combination of common mental disorders, severe anxiety and the neurodevelopmental disorders. They are all interlinked.

Q248 **Chair:** Thank you. That sets me up very well for the questions I want to ask. I might give you a slight break, Professor Fonagy, and direct them at Professor Baird, because they are about data and the underlying data about misdiagnosis, overdiagnosis and so on. You touched on it earlier.

In your report, you talk about how the balance of risks of underdiagnosis, misdiagnosis and overdiagnosis may be changing. You then say that you need more evidence to be able to determine whether or not and how this is changing over time. From your perspective, what should we be recommending to Government that they do now as a matter of course to make sure that that evidence base exists for where we are now? What needs to happen moving forwards so that we can check whether these interventions or any others are working?

Professor Baird: First of all, we have some good evidence, which the report refers to, in the Adult Psychiatric Morbidity Survey, which was done relatively recently, in 2024. When it came to conditions such as autism and ADHD, there is no recent population survey in England, which was the geographic area that was the focus of our report, since 2017. We are relying, therefore, for information on population prevalence, on rather old data.

Q249 **Chair:** Is that because it did not happen due to covid, or is it just that it is ad hoc commissioned by Government? Is this something that just needs to be commissioned more regularly on a rolling basis? I wanted to understand.



HOUSE OF COMMONS

Professor Baird: That is absolutely right; it is the latter. There have been attempts to do so. It is a recommendation. That would make a huge difference if we had that regularly, yes.

Q250 **Chair:** What would need to happen? It simply needs commissioning and money, presumably.

Professor Baird: Commissioning, yes, and a certain amount of money, but not a vast amount. People are ready, willing and just waiting and very much hoping that that is going to follow.

Q251 **Chair:** You have answered most of this, but I just want to make sure we have not missed any points. You say that misdiagnosis can particularly do harm. Professor Fonagy, you nodded most emphatically. Can you describe what harm it is that we are potentially doing with misdiagnoses? What would stop misdiagnoses from happening?

Professor Fonagy: Imagine a young person who does not want to go to school, wakes up in the morning already exhausted, and complains about attention problems but also complains of an overwhelming experience they have in social contexts in school.

The parents are obviously out of their mind with anxiety. They go and the child gets referred, because of complaining of attention problems, to the ADHD pathway for assessment. That child, while waiting on the pathway, gets more anxious and the problems get worse.

If we intervened in terms of addressing the attention problems by getting that child to sit closer to the teacher, to get written instructions, and to have the available, simple anxiety reduction that mental health support teams can deliver, it may well be that the attention problems would quieten, and that you would not have that difficulty.

The harm that it does is that the problems that are most likely to be resolvable are not addressed in a timely manner; they get worse as a consequence of waiting. That is very simple. Misdiagnosis is not simply making a mistake; it is missing an opportunity for effective intervention.

Q252 **Chair:** That is because of the delay, primarily.

Professor Fonagy: It is because of the delay. If the child gets put on, say, stimulant medication because the anxiety reduction treatment did not deal with it, you are still in a situation where you have put many of the ways of addressing that child's problem already in place, so you are more likely to be successful. Missing the diagnosis of anxiety in that case is a major problem, and that probably happens quite a bit, as Professor Baird explained, because of the way that mental health problems can drive it.

Q253 **Chair:** In that example, is that not underdiagnosis, because there is a condition that has not been diagnosed as part of it, or is that a misdiagnosis because, in fact, that child does not have ADHD? You say



HOUSE OF COMMONS

that they are co-occurrent, but I am trying to pin it down for the sake of the parents watching who are now worried that their child who is on medication, for example, may not need to be. Can you try to unpick it for their sake?

Professor Fonagy: If they were put on medication, I am not saying that that is unlikely. All the evidence that we have suggests that people put on medication and diagnosed now have problems as profound as they ever did, as Professor Baird mentioned.

I am saying that there may be others for whom, as Professor Baird described, we are missing the opportunity to intervene in a dynamic interaction between environmental pressures and genetic predisposition, in a way that may be able to afford the possibility of dealing with the problem before medication and diagnosis.

Q254 **Chair:** What do you say to parents who want a diagnosis to better understand how to help their children? I have had many in my own surgery who say, "I do not know if my child is or is not, but I want the diagnosis because that will give me a toolkit to better help them." Is that a good thing to do or a bad thing to do, or both?

Professor Fonagy: It is a wonderful thing to do, but there are two things. I can tell that Professor Baird is dying to come in here but, if I can just say one thing, the toolkit should not be sitting behind a diagnosis; the toolkit should be there, delivered by the NHS. That is one of our recommendations. It is not just about an awareness toolkit, but an action-oriented toolkit should be there.

Chair: You mentioned twice, particularly in recommendations 2 and 3, AI-enabled shared needs assessments and priority frameworks. Then again, in recommendation 3, you mention digitally enabled mental health and neurodevelopment assessments and support. As a Committee, we are taking a particular interest in that digital strand of the NHS. I wondered if you could point us at good practice where this is happening. My concern was that you said this because AI will solve all problems. You are evidence-based, so I am confident that that is not what happened, but could you point us to the best practice so that we can help the NHS to do this further and faster?

Professor Fonagy: There are three quite different jobs that digital, more broadly, could do. The first is, as we were touching on, information and support that is more specific. Parents do this already. They go to ChatGPT and say, "How do I deal with this?", and sometimes ChatGPT answers in a sensible way; sometimes it does not. The NHS could do a much better job of giving better advice in that way.

Secondly, digital tools are very helpful in assessing people's needs more efficiently. We are very clear about it: AI describes; the clinician decides. There is a clinician sitting behind that.

Q255 **Chair:** Does this model already exist, or is this a model that you are



HOUSE OF COMMONS

hoping will exist one day?

Professor Fonagy: It needs to be vastly improved.

Q256 **Chair:** Who is doing it?

Professor Fonagy: We are not.

Q257 **Chair:** ChatGPT is one end of the spectrum.

Professor Baird: There are some examples.

Q258 **Chair:** Are they from other countries?

Professor Baird: Yes. There are some examples, particularly in different places. A far more integrated system is required. A lot of places are using digital in some areas.

Q259 **Chair:** Is that in the UK?

Professor Baird: Yes, in the UK. There are some in south London, for example. We had a fantastic look around the Maudsley Hospital. I believe the Scottish Government are looking for exactly this. Of course, they have the possibility of then extending it across the whole of Scotland. There are a number of different places where it is in part, but insufficiently. We are suggesting that the information section should be a nationwide system.

Q260 **Joe Robertson:** Professor Fonagy, you say that there is no evidence of a substantial overdiagnosis in conditions such as ADHD and autism, yet your own report identifies a population prevalence of autism in young people of about 1.2%, but a diagnosis that has increased to over 4%. That does not include waiting lists. How is that anything other than evidence of overdiagnosis, based just on your figures?

Professor Fonagy: What we said was that we have no evidence of overdiagnosis at scale.

Q261 **Joe Robertson:** You identify that the population prevalence of autism in young people is 1.2%, but the diagnosis rate is over 4%, which is increasing further with a big waiting list. That seems to me evidence of overdiagnosis, when nearly four times as many young people are being diagnosed as the population prevalence.

Professor Fonagy: This is a really important point, and I am really grateful for you raising it. Overdiagnosis implies that there is nothing wrong with that person: that the diagnosis is applied, but there is nothing wrong with them. We find absolutely no evidence of that.

We find that it may be that some of those 4% are misdiagnosed, as Professor Baird has already pointed out. We find no evidence that there is a group of people who are presenting and there is nothing wrong with them. "Overdiagnosis" is a very unfortunate pejorative term that indicates that people are presenting with problems that they do not have. All the evidence that we have is that the risk of misdiagnosis is increased,



which your example covers, but at the moment there no evidence for overdiagnosis.

What we do point out is that there is a warning sign in the figures that we present. Unless the system is changed, it is almost inevitable that the problem of overdiagnosis will arise. For example, with young people in the adolescent age group, the prevalence of ADHD has reached the level at which all the figures that we have available suggest the population prevalence should be, at which point the administrative prevalence, the number of diagnoses, should have levelled off.

Q262 **Joe Robertson:** It has not levelled off. If the population prevalence of autism in young people is 1.2% and diagnosis rates have climbed above 4%, it seems a problem if it cannot be asserted—it can be disputed—that that is an overdiagnosis. It could be re-explained as a misdiagnosis, but for autism itself those are the figures. I cannot see how that can be anything other than an overdiagnosis. What support is then required for people who are being overdiagnosed is a separate and very valid conversation, but you seem to be asserting a lack of overdiagnosis when your figures say something different.

Professor Baird: There are several things about your proposition, which is a very good one. The first thing to say is exactly my response to Layla's question, which is that there simply has not been a recent population prevalence study.

Q263 **Joe Robertson:** You quoted data from 2017.

Professor Baird: Yes, 2017 was the last one. We do not know whether the population prevalence has changed. You may have thought that it would be impossible, if it was a substantially genetically predisposed condition, that it would rise, but that is not the case. You could have a rise for the reasons that I outlined earlier. We do not know what the population prevalence is. We are making a comparison between now, in 2025-26, with figures that were available probably just before 2017. That is one thing.

The second thing is—I will turn to ADHD because we have rather better figures about that, and exactly the same situation pertains to ADHD—the population prevalence is, again, from 2017. We have projected forwards from the previous figures to a possible population prevalence of 3.8%, but diagnosis in some groups of children and adolescents is already at that level or a little bit higher.

We know that when the DSM-5—the *Diagnostic and Statistical Manual of Mental Disorders*, the classification system that we all rely on for diagnosis—was rewritten and published in 2013, there were changes in the conceptualisation of ADHD. There were specific changes for ADHD that raised the possible population prevalence by 2% in adults and 3% in children. The way in which people are understanding these conditions has



HOUSE OF COMMONS

changed. You are using a population prevalence in this country of 2017 on a slightly changing base.

In autism, we do not have quite the same detailed figures to give you about what happened when the changes were made in the DSM-5, but there has been far greater recognition in girls and women and the numbers of diagnoses have then increased.

Q264 **Joe Robertson:** That does help, although I notice that the data up until 2017 allows you to conclude that there has been no substantial change in the prevalence up until that point.

Professor Baird: That is perfectly correct for the data up until 2017.

Q265 **Joe Robertson:** Can I ask about support for those with these sorts of conditions? Support is given through education, health and welfare. I will put a proposition to you. There has been an oversupply of money to deal with an issue particularly in welfare, rather than the therapeutic health or educational support. Is that your view? Does it at least need to be explored whether the right support is being given and whether there may have been an overemphasis on money to families rather than health and educational support in community environments?

Professor Baird: I am not quite sure where the vast amount of money came from, Mr Robertson.

Q266 **Joe Robertson:** I am sorry. I will spell it out. I mean money being provided via the welfare system, through PIP and DLA, rather than community health support or appropriate support in schools.

Professor Baird: There are varying levels of support that are required at different stages of a child's life. The most important thing we want to emphasise is that there is a developmental accumulation of problems, if you do not deal with something early enough. Putting in money for early support is absolutely vital. Yes, we also need more focused support for the particular therapeutic approaches that we have outlined in the report, for which there is a good evidence base.

With regard to your later question about PIP and so on and so forth, that is not what our study was about at all. We were looking at prevalence, what evidence we had for interventions, what works and what does not work.

Q267 **Darren Paffey:** If, as you suggest and as a lot of the reviews around the SEND system in education are proposing, we should be moving to much earlier intervention and having a support-first system instead of a diagnosis-first system, what should that support look like? Is it the same kinds of interventions that typically currently have to wait until after diagnosis? Is it different or lower-level interventions?

Lots of the parents who I have spoken to fear that, if they are going to get support first, it is going to be going on a course or it is going to be online or sporadic rather than feeling that, if they get a diagnosis, they



HOUSE OF COMMONS

will get a robust package of interventions. What do you see as being the difference, if we make that shift?

Professor Fonagy: That was a concern that was expressed to us by lived experience partners, and it is a concern that we share. The important qualification is that we know what works. In this country, we have a remarkably good system for identifying the best health interventions that can be applied. That is defined by NICE. I know of no other country in the western world where that is available.

We are very clear that there is a real gap at the moment between what NICE recommends and what is offered even after a diagnosis. The gap can be eye-watering. Yes, you could probably reduce the intensity of the intervention, if it were applied earlier, but this cannot be something that is not tested and recommended by NICE.

However, we also recommend that we should be contemplating a set of interventions that is broader than health. It is partly education, partly welfare and partly youth justice and MOJ. This needs to be a cross-Government initiative that has early intervention and prevention of increased problems at its heart.

If I can plead for one thing for your wonderful cross-departmental Select Committee to recommend, it would be to broaden it even further. It should not just be education and health; it should extend to welfare. These systems need to work in an integrated and aligned way to achieve the objectives that we know need to be achieved, much of which is really not rocket science.

Education, I am really pleased to say, is moving towards that. We need to align health with education and the recommendations that education is coming up with in terms of SEND reforms. Education is coming up with one set of understanding about what need is and one language for what need is; health comes up with another set of definitions of what need is. Unless we align health and education, we will be back in the same catastrophic position. If you can persuade these Government Departments to work together to arrive at a single definition of need, you will have done something useful.

If that is aligned with welfare, which already works in principle, not in terms of diagnosis but in terms of need, that would be the ideal. I hope your joint Select Committee can achieve that.

Q268 **Darren Paffey:** If I am hearing you right, your suggestion is that NICE has to stay in control of what the interventions are. We have a process at the moment whereby schools are going to be reimagined as much more inclusive and needs will be met in mainstream for many, preserving specialists for the most complex needs. NICE and health need to be involved in designing what those educational environments and interventions are. Is that right?



HOUSE OF COMMONS

Professor Fonagy: The way we put it is that health is the steward. If you are the steward for anything, you do not define, but you oversee and ensure that good practice is implemented. I hope that is possible. The NICE ADHD guidelines already make many recommendations that are to do with education, except education feels that they need not be followed because they have been made by NICE and they are all to do with health.

Q269 **Jodie Gosling:** We have talked a lot about the harm that is being done on current waiting lists. You described it as a mindless thing to do, making people wait for that threshold while complexity increases and the chance of irreversible issues increases. What safeguards are needed to ensure that any move to needs-based support does not weaken access to specialist support, reasonable adjustments and statutory entitlements?

Professor Baird: It is certainly a concern and one that has been very well articulated to us, as Peter says.

There are several levels to that. The way in which it is organised will also make a very big difference. For example, we have been talking about integrating services. If you can integrate support services as close to home as possible—to a large extent, this fits with the devolution agenda of the present Government—if you have them there and people can see that they are actually working for them, that dissipates a great deal of the concern.

There is a job of work to be done about enhancing parental trust in how the education system is going to manage that. They are very well aware of that because at the moment—you have articulated this—parents generally feel like they are not going to get anywhere without a diagnosis. Equally, parents understand that diagnosis alone is not working for them. It is not getting them the support that they require.

One example is ADHD. The opportunity to move from a diagnosis of ADHD to implementing a very specific treatment, first of all a psychosocial intervention, which is the number-one treatment, and, secondly, a medication intervention, has halved since covid. There is no follow-through at the moment. It is going to be in the doing of it and how the doing is organised that it is going to work best.

Q270 **Jodie Gosling:** Are there any interventions that you feel are inappropriate before a diagnosis?

Professor Fonagy: I would say medication.

Professor Baird: Medication before diagnosis, yes. Indeed, yes.

Q271 **Jodie Gosling:** To what extent do you think that people with co-occurring conditions require different support and different pathways rather than those presenting with a single condition?

Professor Baird: The vast majority have more than one condition. Half of the people with a common mental disorder are going to have two or



HOUSE OF COMMONS

more conditions. It is the rule rather than the exception. It is a question of finding what the co-occurring condition is and treating it appropriately.

To go back to one of the earlier points, in the discussion about how the dynamic environmental interaction is making things more obvious, I definitely do not want to ever suggest that people do not have very significant problems with each of these individual diagnoses. People have very significant autism and very significant learning difficulties, but it is the combination; it is when they come together.

About 4% of young people will have combined difficulties with lifelong impact. Whatever you do, it will go on affecting them. They and their families need a very particular form of support. In general, that has been less available to them because of the huge waiting lists. They just have to join a waiting list like everybody else. It is one of the reasons why we have proposed a very careful prioritisation based on complexity and risk.

Q272 Jodie Gosling: Should services be designed around individual diagnosis criteria or categories or the wider pattern of needs?

Professor Fonagy: One of the difficulties with the current system and indeed with NICE, which I very strongly support as an arm of the health service, is that it is based on single diagnoses. That needs to be changed. It needs to change because of what Professor Baird said about the prevalence of co-occurrence. Single diagnostic pathways are probably unhelpful in general.

That does not mean single problems cannot or should not be dealt with in turn, but it needs to be a multidisciplinary team. The team around the child should represent the appropriate addressing of the problem of co-occurrence. I would very much hope that in those new neighbourhood services that Professor Baird was talking about we will have mental health and physical health co-represented because of the co-occurrence of physical health problems in many children, which at the moment is completely separate.

Q273 Jodie Gosling: You have touched on the breadth of experience in the services that need to be involved, but who should be responsible for co-ordinating the support for individuals with complex and overlapping needs? Moving past school into employment, what does that look like for employers?

Professor Fonagy: Who should be in charge matters less than somebody being in charge. We have problems where there is dissipation of responsibility.

It is not a problem for the system to be organised in a way that can be specific to a local system. It does not need to be a national model that is implemented. It can fit that local system and the prevalence that occurs within that system, which widely varies because of a whole range of social factors. It is appropriate to a locality, but at the same time it is integrated and coherently organised.



HOUSE OF COMMONS

All the parts are there in the current system. What we are recommending is co-ordinating them in a more efficient way. The co-ordination should come locally, but that means leadership. If there is no leadership, the service will fail.

Q274 Jodie Gosling: Of course, one of the aims is to increase participation of work, especially for people with multiple conditions. What support are employers going to need from Government and that leadership in order to make that effective?

Professor Fonagy: The same principles apply. At the moment we have a system, which you are well familiar with, that in a way incentivises disability. We need to have a system where employers are supported in enabling and supporting, rather than simply signing off. The same thing needs to apply. At the moment, doctors do not give advice to employers about what can be done with this person that might help them. They give advice that they are unfit to work. That is a limited way of dealing with it.

The principle that we are recommending for education applies equally to employment. It should be focused on need and supporting that need. Employers need to be supported in supporting needs.

Professor Baird: That means understanding the barriers to perhaps being able to participate. Coming back to your original question about single diagnosis, that is where understanding a particular diagnosis can have an impact.

For example, somebody with autism may have a very marked reaction to the sensory environment. Although anxiety may be mixed in with it, that is different from simply feeling anxious and thus avoidant. For the sensory environment, if it is effortful to manage that, you might need longer periods of recovery rather than the avoidance that might come with an anxiety. There are subtleties that need to be borne in mind.

In school, it is very helpful to understand the particular profiles that people present and understand, therefore, how their particular difficulties impact. In autism, you might have learning difficulties, extreme anxiety associated with it or a demand avoidance profile. There are a variety of different ways in which children interact with the environment that need to be understood and then they can be helped individually.

Q275 Chair: Can I quickly pick up on the point about a demand avoidance profile? We have had a question from a clinician, Professor Baird, who wrote to you about this. Are we talking about the same thing? Is PDA the same thing?

Professor Baird: Yes.

Q276 Chair: I believe that the report says that the evidence for PDA is clinically contested. This professional said to us that, at the same time, the 2021 NICE guidance, which she believes you were in fact involved in drafting, specifically says that PDA is a subset of autism. Her concern was that this



HOUSE OF COMMONS

is a mixed message to clinicians, who are looking at the report and trying to do the best they can for the families who are coming to their door. It feels to her slightly at odds with the fact that NICE says that PDA does exist and is not clinically contested. Could you clear that up for the clinician who wrote to us, please?

Professor Baird: Yes. The way in which most clinicians work is to follow the international classification systems, particularly the diagnostic statistical manual, called the DSM, or the ICD international classifications by the WHO. They have particular diagnoses.

When we were compiling this particular report, we were using the standard classification systems for different diagnoses. That is in chapter 9. There are a number of situations that are clinically very important but do not necessarily come into the DSM or the ICD. Challenging behaviour is one of them. This is a common problem in young people. They have a combination of severe learning difficulties, often autism as well, and challenging behaviour. Challenging behaviour is not a diagnosis in itself.

We separated, therefore, a list of conditions that are important but not in the classification systems. That is where PDA comes into our report. As a recognised way of behaving, yes, clinicians will be familiar with it and NICE guidelines can be followed. I hope that is helpful.

Chair: I am sure we will be told if not.

Q277 **Sureena Brackenridge:** My questions will be around schools and family support. We have heard time and again—it has come through clearly in the report—that there very much needs to be a needs-led system rather than young people with their parents facing excruciating waits and feeling like they are in an abyss or a void when they are trying to get the support that they need.

What is the role of a school in terms of ensuring that needs are identified as early as possible so that they are addressed appropriately before waiting for that rubber stamp or label of a diagnosis?

Professor Fonagy: That is excellent. I am really pleased to be able to say that the current SEND reforms are very much in line with developing those strategies. Many of the things that we know work for neurodevelopmental conditions are not clinical but are best implemented in the context of education.

There is a very well-known study, the OxWell Student Survey, that asks young people, "What is helpful in your mental health need?" They prioritise family and friends, but immediately afterwards they put school. Way down the line comes child and adolescent mental health services. That really underscores the importance of how much schools can do.

Importantly, there are limitations, and I just want to underscore those. Special educational needs, particularly EHCPs, in terms of looking at the evidence, have not quite delivered in the way that people had hoped. The



outcomes, even despite greater investment, have not improved. It is hard to assess, but we know that the major influence of mental health prevalence are things such as school climate.

You have vast differences between two schools in the same demographic area in terms of mental health prevalence. That is understandable in terms of the climate of that school. For example, we know that teacher distress generates pupil distress. It is important that we address that.

Children also often mask their discomfort at school. Many children who I have worked with, who are regarded by their teachers as doing just fine, are really difficult at home.

What we need to do is integrate a sensitivity to a child's problems with education far better. Mental health support teams, which I had something to do with establishing, is a step in that direction.

- Q278 **Sureena Brackenridge:** As a former school leader, I recognise a lot of what you have just shared. What more can mental health support teams do? Dedicated and caring teachers and wider school staff, the whole pastoral team, et cetera, cannot and should not replace the specialist health teams that are there. What more can mental health support teams do in schools?

Professor Fonagy: Again, you would do us an enormous favour if you were to agree with us that increasing the competence and increasing the complexity of problems that mental health support teams can deal with is a major way of dealing with the group of children who do not meet criteria for specialist intervention but exceed the current capacity of mental health support teams. It is sometimes called the "missing middle".

If you can empower mental health support teams, which you could do, to deliver the interventions that we know work in a timely way in the context of schools, you would improve the outcome of schools quite broadly. At the moment, even though mental health support teams are being rolled out, they are somewhat underpowered. They do not deal with the missing middle.

- Q279 **Sureena Brackenridge:** That goes back to the point that you made earlier about how the Education Department is sometimes working in a silo away from with the Health Department. They are at different positions on that journey. They are heading in the same direction, but greater collaboration is needed. Professor Baird, is there anything you wish to add?

Professor Baird: I totally agree. You have it absolutely right. There are a number of interventions that at small scale are shown to be very effective and could be increased. There are specific treatments for anxiety in school. Noticing earlier and instituting those would make a huge difference in the avoidance of school and people not wanting to go to school.



HOUSE OF COMMONS

We are also concerned—no doubt the Education Department is too—about the 1.5% of children who are not attending school for a whole variety of reasons. There is much to be done.

It is one reason why we have been very supportive of neighbourhood hubs, which bring together the people who could further support in school. This is the expert at hand, as the education reforms have it. These could be mental health professionals who could help run behaviour programmes for parents, help with the anxiety inputs and so on.

They would also have specialisms in autism, just as they have specialisms in being deaf, visually impaired and so on. It would all be co-located in neighbourhood sections, which would enhance very considerably this integration that we think is absolutely vital.

- Q280 **Sureena Brackenridge:** You have just answered my follow-on question, which was about mental health not stopping at the school gate and what more could be done to support families to access the support that they need. Neighbourhood hubs with specialist support is key.

Professor Baird: That is absolutely right.

- Q281 **Jen Craft:** I am now going to turn to look at the proposed SEND reforms a little more widely. I noted with interest that your recommendations seem to focus quite a lot on taking a more holistic approach to these common conditions and perhaps not seeing things in silos. For example, I noticed that you warned that the SEND reforms will fail if the health and education services do not develop a shared approach, particularly around the language for assessing need. Would you be okay to speak a little bit further on that? Particularly, how could the health services see their role not just in terms of medical interventions?

Professor Fonagy: We raised four conditions that are required in order for the SEND reforms to succeed. One is shared language. Investment is another one. That touches on what you are raising. We also need to have specialist advice and we need to have parental confidence in the system.

What is required, most of us would agree, is a model where parents can be confident that their child is not being deprived of the support that they need in order to thrive in that school.

- Q282 **Jen Craft:** Should things be seen through a lens of educational attainment or wellbeing or should we be looking at something else entirely?

Professor Fonagy: One of the things that we are very hopeful will be adopted is a common metric for understanding benefit from services. At the moment, health measures symptoms at the same time as education measures educational attainment. Believe it or not, there are some people who do very well in education who are quite unhappy.



HOUSE OF COMMONS

You need to have an alignment of objectives based around what we call participation. Participation is when people feel like they belong to the school. It is as much a wellbeing issue as much as anything else. In education, sadly, young people less and less feel that they belong, but that is not an issue that schools are assessed on.

Q283 Jen Craft: I noticed this in your review. You said that education itself can contribute to distress through factors such as the lack of belonging. We have been talking a little bit around the social model of disability as well. In their current guise, can schools be a risk factor for people who are predisposed to ADHD and autism?

Professor Fonagy: Can I just be very clear about this? Although children link their unhappiness to school, that is not necessarily a development that has occurred recently. There have been children who have linked their unhappiness to school since time immemorial. It is really an easy mistake to make to blame schools.

As Professor Baird mentioned, there have been some changes in schools, but the focus has moved to performance in a particular modality that may indeed create pressures on a particular population of children. To me, broadening that is a no-brainer. Schools are trying to do their best. I would be very unhappy if any part of our report was read as trying to blame schools for the problems.

There are problems that could be changed. There are aspects of schools that could be changed that would reduce the problems, but that is in relation to broadening the parameters that are used to evaluate education in this country.

Q284 Jen Craft: Professor Baird, perhaps I can turn to you on a similar vein. I do not necessarily mean that schools are to blame as such, but you mentioned some of the changes to the way that the education system is set up. To use your analogy earlier, for people who are predisposed to autism or ADHD, could the way that schools focus on particular things, such as certain types of educational attainment or attendance metrics, be exacerbating some of these issues?

Professor Baird: There is no doubt that, when we look at the evidence, around exam time people's anxiety rises, but then generally it comes down again. There are certainly those specific aspects.

The important thing is that people need to feel they are succeeding, do they not? They need to feel that there is something in which they are being successful. Schools have a really difficult job, but, given the range of what people are able to experience and engage in, they need to have something that people are good at and can do. Those positivities are extremely helpful and necessary.

People do comment on various aspects of school, which some of them have struggled with, but I totally concur with Peter. Overall, people have always found some things very difficult about school. Adolescence is a



time when people are really trying to discover themselves. That sense of belonging and the opportunities for the rest and recovery that Peter has emphasised throughout the report are really the most important factors in learning how to manage social relationships and the interactions with the outside world. That is really some of the job that needs to be enhanced.

Q285 Jen Craft: I do not envy anyone for being a teenage girl; I hated it. If we move on to the wider SEND reviews and proposals—we touched on this a little bit—one of the key things that we have taken quite a lot of evidence on is the lack of health representation around the table when it comes to either planning individual educational health and care plans or commissioning SEND services. Time and again, we have taken evidence that they are just not there; they do not play their part. It is a systemic issue rather than a variation in any particular regional area.

How should we ensure that that changes? How do we make sure that health see their role as being more than just, “We need to improve our diagnostic time frame”?

This is very interesting, but I note that the focus of my local area seems to be on improving the delay in diagnostics rather than maybe holistically looking at how they support the wider system. How do we get them to do that?

Professor Baird: The model that we propose of local neighbourhoods, using examples where it is already happening, would be really very helpful indeed. The next is commissioning and having integrated commissioning, so that people are organised and that that is their job. Again, it should be as close to home as possible. Those would be the main two drivers that you have going forward.

Professor Fonagy: Can I add two others to it on either end? First, we should be commissioning for outcomes, rather than commissioning for the performance of actions that may or may not be successful. We need to commission for outcome, where “outcome” is defined as participation.

The other, which touches on what Gillian mentioned, is understanding that health is responsible for improving understanding. I cannot think of a better example than understanding behavioural problems. Health has a better understanding of why behavioural problems emerge in children than education does, which has to deal with it much more in terms of the core class. If health was at the table, it could provide better ways of managing problem behaviours in children, either via help supporting parents, which I personally believe is the most effective mode, or, as we know, supporting teachers and teaching assistants in managing behaviour better.

To take one example, we developed the model of a family school—Pears Family School at the Anna Freud Centre—where we bring parents into the school to observe how to manage their child’s behaviour better from teachers and from assistant teachers. Embedded in that are supporters of



HOUSE OF COMMONS

the teachers to manage the child's behaviour. This is children with diagnoses of autism or severe OCD. These are children who have been excluded from other schools. Integrating the wisdom is the answer.

Q286 **Jen Craft:** Do health services see that as part of their role? Do they embrace that?

Professor Fonagy: They are not commissioned to. They are not commissioned to, so why would they see it as part of their role?

Q287 **Jen Craft:** They do have a duty on prevention and public health.

Professor Fonagy: They do not. I do not believe that they do. That is not a CAMHS—

Q288 **Jen Craft:** It seems that you are saying that there is definitely something that could be done centrally in terms of articulating that health does have this role in prevention, increasing knowledge and increasing education for both teachers and parents.

Professor Fonagy: Yes.

Q289 **Jen Craft:** You will be aware that the statutory responsibility for the delivery of education, health and care plans currently falls solely on local authorities. We have taken some evidence about putting a similar duty on health bodies.

Indeed, I tabled an amendment that was supported by both of our Committees to the recent Health Bill to place an equivalent duty on ICBs or health trusts to deliver that health plan to give them that real onus and owning of the issue. Is that something that would be helpful?

Professor Fonagy: It could not be otherwise.

Jen Craft: On that very helpful note, I will go back to the Chair.

Chair: That is really helpful.

Q290 **Helen Hayes:** I would like to push you a little bit on some of the practicalities of delivery, building on the questions that Jen has asked already.

The conversation that we have had today will be enormously frustrating for many of the stakeholders that my Committee works with within education. Some of the things that you have said imply that schools can just do things. If you are working in the education sector as it is at the moment, they are under a whole range of pressures that stem from their own accountabilities and what they are tasked with doing that would make it very difficult for them to do things. It is hard to overstate the extent to which both the education sector and local authorities are tearing their hair out with the health system.

We can all look—and we do on our Committees—at examples of good practice, who is doing things well, how things should be and what we can



HOUSE OF COMMONS

learn from, but this will boil down to accountability. It boils down to what people are measured against and what they are required to do. We do not have that for health at the moment in relation to the delivery of support for neurodivergent children and children with mental health difficulties in schools.

We have been talking about this agenda for 25 years. We have been talking about co-commissioning. We have ICBs, which are supposed to have local authorities at the table, though their voice is extremely weak. They are supposed to do joint commissioning. These things are supposed to happen, and yet they do not.

I would just make a plea that we move the conversation on from how things should be and hypothetically can be, and indeed are in some circumstances where things are done well, to how we arrange the system in its fundamental accountabilities to deliver the things that we know children need in education because that is the thing that is not happening at the moment.

Professor Fonagy: I believe that is beyond our remit. I believe the Government are responsible for doing that. We can and we do recommend a commissioning system that is mindful of exactly those things. An integrated system is the only system that could possibly work and meet the mental health crisis that we see in young people at the moment. We could not agree with you more.

I would not want to in any way underestimate the pressures that schools are under. I hope that I have not tried to shift the blame, but I would not want to underestimate the pressure that those working in child and adolescent mental health care are under either. When you have two bodies that talk poorly to each other, it is very easy to blame the other for not doing their job properly.

The conversation needs to change. It needs to start with a common language around the needs of families, children and young people and shared responsibility for those needs being met. Unless you do that and you invest sufficient resources for that to be delivered in a timely way, when it is needed, as soon as the problems present, you will not deal with this problem.

Professor Baird: It is co-location. Co-location as local as possible would make a big difference.

Q291 **Helen Hayes:** My second practicality is around expertise. We would agree with you—this inquiry has heard a significant amount of evidence on this—about the missing middle who are in education, whose mental health needs are not currently met through mental health support teams. That requires a change in the expertise within mental health support teams, because their current remit is mild to moderate mental health needs. The children who we describe as being within the missing middle have a more severe need stopping short of requiring CAMHS interventions.



Can you say what you think is needed in terms of the level of expertise in mental health support teams and perhaps what that might look like in terms of a change in the workforce required?

Professor Fonagy: We are quite explicit about that in the review, but let me just set the record straight. Although they are supposed to do mild to moderate mental health support teams, the objective reality is that they do moderate to severe and they deal with the co-occurrence. Most of the children referred have a diagnosis of neurodevelopmental conditions in addition to mental health conditions. All the other data that we have supports that.

Mental health support teams at the moment do more than what they were originally designed to do. The system needs to change for there to be better training in cognitive behavioural therapy, eating disorders, post-traumatic stress disorder and a whole range of systems. This is something that personally, with a different hat, I recommended three or four years ago. It has not been possible so far. If you can add your voice to this, maybe jointly we will be successful.

At the moment, the initiative has been to spread this to all schools and include all schools. We have been successful at that. In the case of anxiety, mental health support teams are remarkably successful. They may not be dealing with everything that you want to deal with, but those who meet clinical levels of anxiety are dealt with successfully over 50% of the time. That is from a study that we recently published on 23,000 children, if I remember correctly. It does deliver, but it could do a hell of a lot better.

Q292 **Helen Hayes:** I have a final question. My Committee has had a lot to say about how we think that prevalence in the classroom at the moment is about 20%. We think that about four or five children in every classroom, in every school right across the country, have some type of neurodivergence, special educational need or disability, and yet our education system is fundamentally not designed for those children.

We know the Government want to shift towards inclusive mainstream schools that can better meet the needs of all the children who are in the classroom. We want all children to thrive in education. There should not be any conflict between high standards and meeting the needs of children who have neurodivergence in the classroom because those children are a part of our population of people whose needs we are seeking to serve.

What does an inclusive mainstream system look like from the perspective of your expertise? How should the Government be defining that as they seek to implement their SEND reforms?

Professor Baird: It does slightly depend on the age group of the children. Let us start with the preschool and the way in which it is possible to integrate and have inclusion at that stage while also defining the problems that the children are going to experience as they move on.



HOUSE OF COMMONS

It is not that any system has shown that you can accurately screen everybody and expect to get 100% sensitivity and specificity. You cannot. By the time children are starting at five or six, you can have a very good idea of some of the biggest problems that they are going to get and they should already be in a system of parental support. You will know about the success of Sure Start and how one really needs to get back into having early support hubs and bringing families with you.

By the time you get into primary school, different problems may become manifest. That is the time when inclusion should be possible, if you make the modifications that, again, an understanding of the individual pupil will bring.

I totally support your aim of trying to insist that local hubs have expertise that is able, from health as well as education, to investigate such children and support the school with an understanding of what they need or do not need.

The next cliff edge tends to be entering into secondary school. Again, we do not have really good properly integrated systems of planning for individual children who are likely to need additional support as they move from that stage to secondary and then on to further education. Peter, I am sure, has other visions.

Professor Fonagy: I just want to put in a word for higher education, universities. Universities are also facing pressure in accommodating people who now increasingly come with neurodiverse conditions. The sad fact is that, as far as we can tell, the accommodations that universities offer are totally without value.

Chair: Please go slightly further into that statement.

Professor Fonagy: These accommodations do not effectively deal with the issues. The problem seems to be that universities fall into an accountability vacuum. You are absolutely right that in schools, right up to university, there is scrutiny, but there is no proper exploration of university provision.

There is no input of the kind that Gillian was talking about from health into universities. Universities try to manage as best they can. You would not expect a university to deal with brain scans. They do not install a scanner so that they can deal with possible brain damage, but they are expected to deal with neurodiversity and they are not well equipped to do so. If you could point to that, that would be helpful.

Q293 **Chair:** We are about to lose quorum, but I have one extremely fast final question. I appreciate that this is asking you to pick among your children. This review comes as a whole, but, if there were one single most impactful recommendation that these two Committees could make together to help to implement your review, what would it be, Professor Fonagy?



HOUSE OF COMMONS

Professor Fonagy: I have written mine out; I could send it to you. It is bringing services together around the needs of children, young people and families. That reduces fragmentation and makes support easier to access.

Q294 **Chair:** Do you agree with that?

Professor Baird: I totally agree.

Professor Fonagy: Family hubs come into that. We need neighbourhood family hubs and integrated models. It is something that enables us to overcome the fragmentation that has stopped us from delivering what ensures mental health, which are three simple things: people, place and purpose. You need relationships with people, places where you can benefit from that social support, and purpose in your life. Education is a major purpose. Let us hope that we can do better for children and young people than we have been able to do over the past 20 years.

Chair: That is a good place to stop. Thank you very much.