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Health and Social Care Select Committee and Education Select Committee Inquiry into Children and Young People's Mental Health

We are two professionals specialising in child and young people's mental health, working directly with schools and/or Mental Health Support Teams in Derby city. I Michelle Robinson am the Derby City Public Health Manager for Children and Young People's Mental Health and Wellbeing, with decades of experience working in schools and/or child and young people's public health. I, Professor Frances Maratos, am a Chartered Psychologist and Research Professor specialising in Affective Science and Wellbeing, with decades of research, grants and publications in the topics of: child and adolescent wellbeing; child and adolescent wellbeing measurement; and child and adolescent wellbeing intervention effectiveness.

The role of education and community settings in support and delivery

Education and community settings are central to the mental health system for children and young people, acting as universal access points with daily reach into young people's lives. From a public health perspective, they are uniquely positioned not only to identify and respond to need, but also to prevent the development of mental health difficulties through the promotion of protective factors and reduction of risk factors.

However, current delivery remains weighted toward reactive support, rather than a whole-system, preventative model.

How effectively are education and community providers identifying and responding to children and young people's mental health needs?

Education settings are often the first point of identification for children and young people experiencing mental health difficulties, and there have been notable improvements in awareness, confidence, and willingness among staff to respond. However, overall effectiveness remains variable and constrained by wider system pressures. Identification tends to be stronger for visible or behavioural presentations of need, while internalised difficulties — such as anxiety, low mood, and emotional distress — are more likely to go unrecognised, particularly in the absence of systematic screening and help-seeking processes (Soneson et al., 2020). Responses across education and community settings are frequently reactive rather than preventative, often occurring only once difficulties escalate.

A key challenge is the persistent "missing middle", where children's needs are too complex for universal or school-based provision but do not meet thresholds for specialist services such as Child and Adolescent Mental Health Services. While Mental Health Support Teams (MHSTs) have expanded support for mild to moderate difficulties, coverage remains incomplete, and many children still fall into this gap. This includes those with emerging or fluctuating needs, children whose social environment is not conducive to effective intervention, and those awaiting neurodevelopmental assessments, where delays can prevent timely support. Without targeted

provision for this group, children's difficulties may escalate, placing additional pressure on both education settings and specialist services.

From a public health perspective, this reflects a system that remains overly focused on downstream intervention rather than addressing the upstream determinants of mental health. Effective mental health promotion requires addressing risk factors such as poverty, adverse childhood experiences, social isolation, and academic pressure while actively strengthening protective factors, including resilience, stable relationships, school connectedness, and emotional literacy. The evidence is clear that school connectedness, the extent to which young people feel cared for, supported, and included, predicts fewer internalising and externalising problems and greater positive mental health over time**,** and can buffer the effects of adversity on mental health (Diggs, Deniz & Toseeb, 2025). Furthermore, studies show that school connectedness and broader climatic factors are associated with better wellbeing and fewer mental health difficulties, supporting the role of educational environments in prevention (Aldridge & McChesney, 2018). Embedding this preventative, system-wide approach across education and community settings would reduce the likelihood of children developing more serious difficulties and ease pressure on early intervention and specialist services.

What role should education staff play, and what support is needed?

Staff in education settings should play a clearly defined but bounded role within a wider system in supporting children and young people's mental health. Critically, schools should not be expected to serve as the primary provider of mental health services, but they are uniquely positioned to provide the environment, relationships, and structure that support protective factors and resilience. Education staff play a vital role in enabling a whole-school approach (an evidence-informed framework designed to promote positive mental health and prevent difficulties across the student population), which encompasses an inclusive and supportive school culture where children feel valued and a sense of belonging, embedding high-quality PSHE and social-emotional learning (SEL) which helps foster children's resilience, emotional literacy, coping strategies, self-awareness, healthy relationships, and overall mental wellbeing, and ensuring that children with emerging needs are identified early and supported effectively. Evidence shows that whole-school and school climate approaches are linked to better mental health, reduced emotional and behavioural difficulties, and stronger protective factors among students (Aldridge & McChesney, 2018; Singla et al., 2021).

Currently, many schools lack the funding, infrastructure, and support required to ensure consistent and high-quality delivery of mental health provision. As a result, interventions may be implemented inconsistently or without sufficient fidelity, limiting their effectiveness. Research indicates that even 'evidence-based' programmes can be ineffective or potentially harmful if delivered poorly, without adequate training, or in a school environment where pupils do not feel safe or supported (Mackenzie & Williams, 2018; Montagne et al., 2025).

The impact of such interventions is maximised only when schools have the capacity, training, and robust quality assurance mechanisms in place to support safe and consistent delivery of proven materials and interventions. This level of support is not currently replicated at scale, despite earlier national programmes such as the National Healthy Schools Programme demonstrating the value of *on-the-ground, expert support and structured monitoring* in helping schools embed whole-school practice (informal evaluation evidence from the Healthy Schools Programme toolkit).

In the absence of such infrastructure, while the preferred approach would be the provision of sustained, on-the-ground support and quality assurance, at a minimum schools must be provided with clear guidance on what constitutes 'evidenced' or 'evidence-based' provision**,** alongside access

to appropriately trained staff, ongoing support, and sufficient funding, to ensure interventions are delivered safely, consistently, and with demonstrable impact. Systematic research confirms that training, supervision, and implementation support are core predictors of intervention effectiveness in school mental health work (Durlak et al., 2011).

In summary, education staff are essential to embedding a whole-school approach that promotes positive mental health, prevents difficulties, and strengthens protective factors; but to be effective this requires clear guidance, evidenced interventions, trained staff, adequate funding, and robust quality assurance mechanisms to ensure all children benefit equitably.

Additionally, regarding evidenced (vs. evidenced-based) interventions and approaches, we have suggested in a further submission- Maratos, Lancaster, Robinson, Williams & Howells (AUE029629)- a model for quality assurance of school-based provision. This is because the word 'evidenced-based' has become a confusing buzz word. It is a word banded about by providers no matter how reputable they are, or what scientific evidence they have to support their program/intervention efficacy.

How do inspection and accountability frameworks such as Ofsted, the Office for Students or DfE guidance support or hinder education settings in prioritising mental health provision and should any changes be made?

Inspection and accountability frameworks, including Ofsted, the Office for Students, and Department for Education (DfE) guidance, recognise the importance of mental health and wellbeing and, in principle, provide a supportive policy context for schools and education settings to prioritise this area (DfE guidance on promoting and supporting mental health and wellbeing in schools and colleges). Ofsted's refreshed Education Inspection Framework explicitly requires inspectors to assess pupils' mental health and wellbeing within the *Personal Development* judgement, including expectations around how schools evidence support in this area (Mentally Healthy Schools, 2023).

However, in practice, the impact of these frameworks is often limited and inconsistent**.** While inspectors may check that schools have systems to manage identified needs, they do not always have clear benchmarks for what 'good' mental health provision looks like**,** or the evidence they should expect to see. This includes limited guidance on the role of the Designated Senior Mental Health Lead, implementation of a whole-school approach**,** and the use of 'evidence-based' interventions or measurable outcomes in pupil wellbeing. Research on school-based mental health provision in the UK highlights that much provision offered by secondary schools is not robustly evaluated or linked to pupil mental health outcomes**,** and there is a pressing need to improve the evaluation and recording of what is delivered in practice (Garside et al., 2021). In addition, even statutory elements like PSHE require high-quality implementation, training, and integration if they are to impact emotional wellbeing and resilience meaningfully (Montagne et al., 2025; Maratos, 2025; the PSHE Association, 2017).

While statutory requirements, such as the inclusion of PSHE education, represent a positive step, the lack of consistent depth, scrutiny, and accountability means that delivery is often variable and ad hoc. PSHE is not typically subject to the same level of inspection focus or academic weighting as other core subjects, and it is not a formal qualification. As a result, it can be deprioritised within crowded curricula, with delivery often dependent on staff confidence, interest, and available time rather than a consistent, high-quality standard. This limits its potential as a key vehicle for developing life skills, resilience, emotional literacy, and overall wellbeing**,** which are critical for supporting children and young people to become active, healthy citizens who reach their full potential (PSHE Association evidence and research).

Similarly, while frameworks reference wellbeing and safeguarding, there is no strong or explicit requirement to evidence a comprehensive whole-school approach to mental health**,** including prevention and relational culture. Implementation is therefore often dependent on individual school leadership priorities and capacity, creating inequity between settings and missing opportunities to embed preventative, public health approaches. There is also limited alignment between accountability expectations and the realities of school capacity, including workforce pressures, retention challenges, and competing priorities. Schools are often expected to take on additional responsibilities without the time, training, or resources needed to implement them effectively, making it difficult for senior staff to drive and sustain a high-quality whole-school approach.

To strengthen the role of inspection and accountability frameworks, it is important to provide greater emphasis and clarity on mental health and wellbeing**,** including explicit expectations around leadership and the implementation of a whole-school approach including the use of evidenced (cf. 'evidenced-based') interventions and outcome measurement (DfE guidance; Cary & Webb, 2025). Frameworks should support consistent evaluation of the quality and impact of PSHE and social-emotional learning (SEL), rather than focusing solely on their presence. Clearer alignment between policy expectations and the resources, training, and workforce capacity required to deliver high-quality provision is also needed. Stronger mechanisms for accountability and quality assurance are essential to ensure that mental health support is implemented effectively, equitably, and with demonstrable positive impact on children and young people's wellbeing.

In summary, while current frameworks acknowledge the importance of mental health, they do not yet provide sufficient leverage or consistency to ensure that all education settings prioritise and deliver high-quality provision. Strengthening accountability, while aligning it with appropriate support, infrastructure, and resources, would enable schools to embed preventative, whole-system approaches and deliver consistent, evidenced (cf. 'evidenced-based') mental health support**.**

What is required to achieve the governments manifesto commitments on provision of mental health support in schools and colleges?

A fundamental limitation of current policy is its predominant focus on responding to identified mental health needs, rather than preventing difficulties from developing in the first place**.** While it is vital that education settings and community partners are equipped to support children and young people whose needs have already manifested, a system designed primarily around *deficit responses* –i.e., *a deficit-model of mental-health* - risks overlooking opportunities to build protective, preventive environments**.** Many mental health difficulties in childhood and adolescence emerge through cumulative exposure to risk factors such as adversity, trauma, exclusion, and social isolation; proactive, universal strategies are therefore required to strengthen wellbeing and resource build (i*.e., the application of a strength-based approach/mode*) before difficulties escalate.

The whole-school approach (WSA) offers an evidence-informed framework designed to support prevention and positive mental health across the whole student population. A growing body of research shows that aspects of the school climate and culture including safety, connectedness, peer support, and a sense of belonging are associated with better mental health and emotional wellbeing in children and adolescents (Aldridge & McChesney, 2018; Singla et al., 2021). For example, longitudinal research has found that young people who reported a more positive school climate were more likely to experience reduced emotional and conduct problems and improved mental wellbeing over time (Wong et al., 2021). In a large-scale cross-sectional Scottish study, feeling safe and connected to school, and having strong peer support, were found to be protective factors for mental and emotional wellbeing during key transitions from primary to secondary school (Long et al., 2020). Further recent research demonstrates that teaching children scientifically sound emotion

literacy and physiology, as well as kindness and compassion, prevents increases in anxiety and increases prosocial behaviours, as well as positively impacts teacher wellbeing (Maratos et al., 2024). Meta-analytic evidence also indicates that school connectedness has a protective relationship with adolescent mental health and other risk behaviours**,** supporting the preventive value of relational environments (Rose et al., 2024).

In contrast, components of the current accountability landscape, such as a strong focus on attendance metrics without accompanying relational support, can inadvertently contribute to fractured relationships between schools and families. Emerging data from the UK show that mental health concerns are now one of the leading reasons for parents choosing elective home education**,** reflecting that some families feel mainstream schools are unable to meet their child's social-emotional and mental health needs (The Times, 2023). This trend may be symptomatic of relational breakdowns**,** where children do not feel safe, supported, and connected within school environments - feelings that research links with poorer emotional wellbeing and engagement (Aldridge & McChesney, 2018).

To truly promote mental health and prevent difficulties from emerging, policy and practice must move beyond a predominantly reactive, deficit-focused model toward a relationship-centred, preventive and strength-based system. This includes investing in a whole-school approach that prioritises a supportive culture, connectedness, and belonging, ensuring that accountability frameworks support these aims rather than inadvertently undermining them. Realising this shift would enable all students to benefit from environments that not only respond to need but actively strengthen protective factors, reduce risk, and support sustained engagement with education and community life.

To what extent does the rollout of Education Mental Health Practitioners and Mental Health Support Teams support in delivering on this commitment?

The rollout of Education Mental Health Practitioners (EMHPs) and Mental Health Support Teams (MHSTs) partially supports the government's commitment to improving children and young people's mental health, but its effectiveness varies across different functions. MHSTs have been particularly successful in delivering targeted, 'evidence-based' interventions**,** including both 1:1 and group support for pupils experiencing mild to moderate mental health difficulties, ensuring that needs are identified early and supported effectively (NHS England, 2021).

In contrast, their contribution to the whole-school, preventative approach is more limited. In practice, support often consists of discrete activities, such as delivering workshops on anxiety for parents, rather than facilitating schools to embed a whole-school mental health model systematically and/or providing sustained guidance to lead strategic whole-school change. While these activities can enhance wellbeing, they do not build long-term capacity, culture, or systems within the school. As suggested above, evidence shows that whole-school and school climate approaches are linked to better mental health outcomes, reduced emotional and behavioural difficulties, and stronger protective factors among students. Early evaluations and local service specifications from Integrated Care Boards indicate that MHST performance data is dominated by outputs such as the number of pupils seen or interventions delivered, with limited metrics assessing whole-school impact or preventative outcomes (Ellins et al., 2023). To our knowledge, there is also limited longitudinal or large-scale research demonstrating that MHSTs systematically embed whole-school approaches, suggesting that the preventative, systemic ambition of the model remains underdeveloped. Arguably, the whole-school approach should be MHSTs' 'bread and butter,' because if teams focused on embedding preventative systems, there would likely be fewer referrals

for targeted interventions, reducing the need to constantly respond to urgent cases and enabling a more sustainable, proactive model of school mental health support.

Service targets and performance expectations further reinforce this focus on reactive work, as the metrics set for teams emphasise outputs rather than the long-term impact of the whole-school approach. Consequently, while MHSTs contribute meaningfully to targeted early support, they only partially realise the preventative, public health-oriented ambitions of the whole-school model (see also CYPMHC, 2025). Additionally, as Ellins et al., (2023) reported in their national evaluation of MHSTs, a lack of clarity at all levels regarding the scope and purpose of MHSTs specifically, calls into question their effectiveness of efficacious mental-health provision and implementation

April 2026