Young people's mental and emotional health

Trajectories and drivers in childhood and adolescence

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Prince's Trust

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Acknowledgements

Grace Breen is the Senior Policy and Public Affairs Manager at The Prince's Trust, and carried out the focus groups to support this research. As a part of her role Grace leads on education policy for The Prince's Trust, with the team also covering issues including youth employment and skills. Prior to joining The Prince's Trust, Grace worked at the Confederation of British Industry covering education and skills policy.

This report is supported by Tesco. The partnership between Tesco and The Prince's Trust supports young people in schools, as well as helping them to find employment through employability courses and work placements. As a part of the ongoing partnership, this research has enabled the development of new mental health and wellbeing resources for schools across the UK alongside additional mental health training for school support staff on Tesco-funded programmes with The Prince's Trust. The research will also form the foundation of a new health and wellbeing programme that Tesco is building to support the wellbeing of young people coming to work for them.

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The Education Policy Institute is an independent, impartial, and evidence-based research institute that promotes high quality education outcomes, regardless of social background. We achieve this through data-led analysis, innovative research and high-profile events.

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Through our research, we provide insight, commentary, and a constructive critique of education policy in England – shedding light on what is working and where further progress needs to be made. Our research and analysis span a young person's journey from the early years through to entry to the labour market.

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Our experienced and dedicated team works closely with academics, think tanks, and other research foundations and charities to shape the policy agenda.

About the Prince's Trust

The Prince's Trust helps young people all over the UK to build their confidence and skills and supports them into jobs, education and training.

Founded by The Prince of Wales in 1976, the charity supports 11- to 30-year-olds who are unemployed, struggling at school and at risk of exclusion.

Many of the young people helped by The Trust's youth support workers and mentors are in or leaving care, facing issues such as homelessness, mental health problems, or have been in trouble with the law. The courses offered by The Trust give young people the practical and financial support needed to stabilise their lives, helping develop self-esteem and skills for work.

Three in four young people supported by The Prince's Trust move into work, education or training. The Trust has helped over a million young people to date.

Further information about The Prince's Trust is available at princes-trust.org.uk or on 0800 842 842.

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Foreword: Education Policy Institute

Over recent years there has been an improved understanding of the importance of good emotional and mental health, alongside growing concern about the apparently increasing prevalence of mental health problems in society.

Children's mental and emotional health is understood to be a major issue - because of the number of children who experience problems; the potential impacts of this on health, education and longer-term outcomes; and the strong association between mental health problems in childhood and in adulthood.

Mental health and wellbeing among children is therefore a major research priority for EPI, and in this report we seek to use a detailed quantitative survey, supported by qualitative work, to track the prevalence of mental health issues through childhood and to seek to identify the underlying drivers of emotional and mental health problems.

This report shows the scale and importance of this issue, helps identify some of the key causal factors, and sets out a series of policy recommendations.

We are very grateful to the Princes Trust and to Tesco PLC for making this project possible. We welcome feedback on the methodologies and conclusions of this report, which will help inform and shape our future work programme in this area.

Rt. Hon. David Laws

Executive Chairman, Education Policy Institute

Foreword: The Prince's Trust

The transition from childhood to adolescence can be a turbulent time, and the findings of this report underline why addressing and supporting young people's mental health will only become more crucial as the impact of the pandemic unfolds.

Young people continue to be among the hardest hit by the pandemic, so it is more important than ever that they can access support with their mental health during this critical time in their lives.

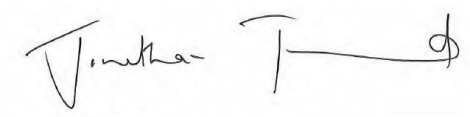
In particular, the decline in young people's wellbeing and self-esteem as they go into their mid-late teens, shows the need for early intervention and ongoing support to prevent future harm and potential mental health crises.

Working with partners like Tesco, we are able to use the findings of this research to inform and influence the mental health support we provide young people through schools - ensuring they get the essential support they need.

At The Prince's Trust we see the damage poor mental health can have on a young person's life, impacting their education, subsequent employment and overall life chances. It is only by working together, in partnership with government and schools, that we can tackle the issues highlighted by this research and prevent scarring this generation's future.

We are pleased to have partnered with the Education Policy Institute on this important and timely piece of research and are thankful to Tesco for their ongoing support.

Jonathan Townsend



UK Chief Executive of The Prince's Trust

Executive summary

This report investigates how mental and emotional health (MEH) changes as children move into and through adolescence, as well as the individual-, family-, school- and area-level factors that drive positive and poor MEH. To supplement the quantitative analysis, virtual focus groups were conducted with young people aged 14 to 16. These had a mixture of genders, backgrounds and experiences related to mental health.

Given the known rise in prevalence of mental illness from childhood to adolescence, particularly in girls, this analysis aims to dig more deeply into young people's mental health and wellbeing in this period of life. Poor mental health in adolescence is strongly associated with poor mental health in adulthood, which, in turn, can affect relationships, societal engagement and productivity. Since the arrival of Covid-19, the prevalence of probable mental disorders has risen substantially to one in six young people, from one in nine in 2017. [1] In response, the government has announced a new £500m funding package focused on children and young people's mental health services, yet this amounts to less than £250 per young person with a diagnosable disorder and is unlikely to make a significant difference.

For the quantitative analysis, we use data on approximately 5,000 young people born around the year 2000 and living in England, surveyed through the Millennium Cohort Study. At ages 11, 14 and 17, young people were asked to rate their wellbeing, or how happy they were in different areas of their lives; their self-esteem, or how much value they placed on themselves; and their levels of psychological distress, or how often they experienced depressive symptoms such as feeling worthless or hopeless. We compare these responses across ages and test the relationship between a range of social factors and these outcomes in early and late adolescence. The focus group discussions were conducted virtually in November 2020.

Part 1: Mental and emotional health from childhood through adolescence

On different measures of mental and emotional health, the transition from childhood to adolescence marks a decline:

- Personal wellbeing drops, on average, as children move from primary into secondary school, and continues to drop as children move through secondary school. **As children get older, the drop in median wellbeing scores is greater for girls than for boys.** While the majority of young people remain at least moderately happy with their families, friends, school, and personal appearance as they move into secondary school, the proportion of girls who are unhappy in each of these areas rises. This is particularly stark in the area of happiness with personal appearance: **around one in seven girls report being unhappy with the way they look at the end of primary school, rising to almost one in three by age 14**.
- Similarly, self-esteem falls on average as children move into adolescence, staying broadly similar for girls as they move into late adolescence and continuing to fall for boys. **In focus groups, young people highlighted the transition to secondary school as being particularly hard on their self-esteem due to increased concerns about being judged and not fitting in.**
- We see a corresponding rise in levels of psychological distress through adolescence, with girls starting off at age 14 with higher psychological distress scores and, on average, seeing a larger rise in levels of psychological distress as they move into late adolescence. **Young**

people we spoke with highlighted an increase in levels of worry and pressure as they moved through secondary school.

- We find that as children move into adolescence, self-esteem is more strongly correlated with both wellbeing and levels of psychological distress, suggesting that **as young people get older, how they see and value themselves becomes more closely tied to how they feel about their lives generally.** This is of particular concern for girls, a significant proportion of whom struggle with body image issues and lower self-esteem.

Part 2: Drivers of young people's mental and emotional health

We examined the impact of a range of characteristics and experiences in childhood on young people's mental and emotional health through adolescence. The factors below were found to have independent and statistically significant effects on MEH in models controlling for all other factors:

- We find a graded relationship between **family income** and all three outcomes through adolescence: young people's mental and emotional health scores are worse the lower down their family is on the income scale. We also find that **children's feelings about their family's socioeconomic circumstances** – wishing they could afford more and feeling poorer compared to their peers – are associated in a graded fashion with both lower wellbeing and higher levels of psychological distress, while feeling poorer than peers is also associated with lower self-esteem. These findings highlight the impact of localised inequality and perceptions of inequality, beyond absolute measures of socio-economic circumstances, for young people's mental health.

- Health and activities in childhood, including physical activity and social media habits, are important for all three outcomes. Engaging in physical activity was found to be more important for boys' mental and emotional health in early adolescence than girls', with a graded relationship between **frequency of exercise** and scores on all three outcomes for 14-year-old boys; at age 17, we find a graded relationship with frequency of exercise in both girls and boys. **Heavy social media** use is associated with worse scores on all outcomes in girls age 14 and 17, but only worse wellbeing for boys at age 14. In a model controlling for pre-existing levels of self-esteem and wellbeing, we find that low levels of physical activity remain associated with low self-esteem and wellbeing scores in girls and boys through adolescence, while heavy social media use contributes to low self-esteem and wellbeing in girls, and wellbeing in boys at age 14. In focus groups, young people highlighted the positive and negative aspects of social media. While girls tended to focus on the negative impact on body image, boys felt that the images they saw on social media platforms could be aspirational. **Being overweight** in childhood is also found to be associated with worse MEH outcomes for both boys and girls, showing a lasting impact of negative body image and related social interactions throughout adolescence.

- The social dimension of life, including quality of relationships with parents and peers, is highly important for young people's mental and emotional health. **Being bullied in childhood** has strong and lasting effects on both boys' and girls' mental and emotional health through adolescence. **Frequent arguing with parents** is linked to lower wellbeing at age 17, while at age 14 it is associated with both worse wellbeing and higher psychological distress. Controlling for academic ability, being **placed in the bottom stream** in primary school is associated with slightly lower self-esteem scores in boys at age 14, but not girls, supporting

existing evidence of the socially stigmatising effect of being placed in low performance streams. Young people spoke about how relationships can affect mental health in positive and negative way: open and supportive relationships are beneficial, while rocky relationships with family and friends can be damaging.

- Family health and wellbeing is also highly important for young people's MEH. **Poor maternal health** is predictive of worse scores on all three outcomes in both girls and boys at age 14, and **maternal depression in infancy** is associated with higher levels of psychological distress in girls at age 17.
- Wider community factors were found to play a role as well. Throughout adolescence, girls who **feel unsafe in their neighbourhood** were found to be at increased risk of worse wellbeing and higher levels of psychological distress.

Policy recommendations

As most lifelong mental health issues are seeded in adolescence and early adulthood, it is clear that any strategy to reduce the burden of mental ill-health for the population as a whole should prioritise interventions in this early period of life.

An effective strategy requires expanding current thinking beyond mental healthcare. Focusing primarily on specialist care is a reactive approach to illness once it has developed, at which point interventions are more costly and less likely to be effective. In the case of mental illness, as with chronic physical health issues, many conditions can only be managed once they are established.

Given our findings and the existing evidence base that the conditions in which children live, go to school and play are highly important for mental and emotional health, policymakers should redirect focus to prevention, through targeting these wider determinants of mental health, and early intervention, to prevent difficulties from turning into chronic illness.

Based on this research, and in light of the risk of the pandemic leading to a further deterioration of young people's mental health and wellbeing, the Education Policy Institute have developed the following recommendations for the UK government. The Prince's Trust will endeavour to work in partnership with government and schools to take these recommendations forward, where appropriate. These recommendations are presented broadly in order of more contained action to larger, cross-government policies likely to result in long-term positive change. The government should:

- **Release a £650m post-pandemic wellbeing funding package to schools to match academic catch-up funding.** The number of children with a probable mental illness has risen to one in six since the advent of the pandemic; a substantial number will be struggling with their mental health but fail to meet diagnostic thresholds. Beyond pandemic-related stress, known drivers of poor mental and emotional health, including financial insecurity and limited social support, have been exacerbated by the lockdown and school closures. The current policy focus in schools is on academic catch-up but remedial wellbeing work will be necessary to achieve this catch-up, alongside investment in socio-emotional development interventions. The wellbeing funding should be targeted to schools with disadvantaged intakes and a high proportion of children with special educational needs and disabilities. A £650m package would allow schools, where required, to hire additional staff to deliver

mental health support to pupils and teaching staff, run interventions to address socio-emotional skills' gaps, improve links with local CAMHS, and deliver training to teachers.

- **Build on existing mental health content in the Health Education and Relationships and Sex Education curriculum.** This should help young people to understand how different characteristics, identities, and backgrounds, and existing stereotypes around these, can affect their mental and emotional health, including beliefs about themselves. It should cover the impact of conventional beauty standards spread by advertising and on social media platforms on body image, particularly for girls, and address the stigma young people may face for having different body types or gender expressions. Evidence-based techniques to support good mental health and reduce psychological distress, such as mindfulness, should be promoted. Pathways to access different types of support should be clearly laid out. Schools should be advised to engage with parents and carers to ensure they are equipped with the same knowledge. Where relevant, schools should be encouraged to work with external organisations with expertise in this area to enhance delivery. Research into the adolescent brain shows that young people are particularly susceptible to peer influence, and our analysis highlights the importance of the peer environment to good mental health, wellbeing and self-esteem. Maximising mental and emotional health literacy amongst young people will equip them with the tools to support not only their mental and emotional wellbeing, but that of their peers as well.

- **Improve the capacity of school leaders and teachers to support children with mental and emotional health needs. School leaders should be encouraged to spend time in alternative provision (AP) settings as part of ongoing CPD or prior to entering into a leadership role.** The majority of young people in AP struggle with mental or emotional health difficulties. It is crucial for leaders to know how to best support children with additional needs, including how to employ trauma-informed approaches in the classroom, and to be able to cascade this knowledge to teaching staff. Survey findings show that many teachers do not feel equipped to deal with pupils' mental and emotional health issues.[2] While it is not the job of teachers to provide mental healthcare, given the proportion of children who struggle with their mental health it is inevitable that most teachers will encounter these issues in the classroom. **As such, local Mental Health Support Teams, currently being piloted in a number of areas, should be required to deliver training to school staff to ensure that mental health support is embedded across the school community.** Schools are the most important, non-stigmatised setting where young people can seek advice and support, and policymakers must ensure leaders and teachers are equipped to offer it.

- **Develop an evidence-based policy to prevent and tackle bullying with clear plans for funding, delivery and accountability.** This could involve more evidence-based guidance from DfE for schools on preventing and tackling bullying – guidance that should be statutory to comply with Equalities legislation when bullying is based on protected characteristics, such as race, gender or (dis)ability – and/or changes to Ofsted's inspection framework. Evidence shows that interventions which create understanding of and accountability for harm caused by bullying are more effective than punitive action: these include anti-bias training, bystander intervention training, peer support programmes and restorative approaches.[3]

- **Publish a plan for rollout of a four-week waiting time for specialist mental healthcare across the country including clear details on funding and staffing requirements.** Increasing

access to timely care must continue to be a priority for those children who need it, and the government should make clear when and how all children in the country will be able to quickly access the treatment they need.

- **Ensure that all young people have access to options for engaging in physical activity, including non-competitive activities, in their local area and commission research, working with diverse young people, to identify scalable interventions to increase activity among children and adolescents.** This research should include a critical assessment of how physical education is currently delivered in schools and address the areas that require improvement.
- **Increase funding to local mental health providers to allow them to better identify and work together to support children with needs which do not meet diagnostic thresholds.** Current thresholds for access to specialist mental health treatment are high meaning that many children have to reach a crisis point before they are able to access care. A system focused on identifying difficulties early and providing sustained support to prevent them from worsening would reduce the suffering of young people and their families as well as the high costs of more complex interventions.
- **Develop a cross-government and cross-sector strategy to reduce family poverty and ensure young people feel safe in their communities.** Given the social gradient in mental and emotional health, this would reduce the burden of mental illness and poor wellbeing in the population as a whole. Poverty, which has risen amongst families with children in the last decade, leads to worse health generally and increases the need for more costly, late interventions putting pressure on squeezed health services.[4] Given the high and rising number of families in in-work poverty, this action must go beyond getting people into work.[5]

Introduction and background

In the last five years, there has been growing government recognition of the need to radically improve mental health services, particularly ease of access to support for children and young people (CYP). In 2015, the NHS committed £1.6bn to 2020/21 to 'transform' child and adolescent mental health services (CAMHS). Yet progress against targets remains difficult to gauge as published data is insufficient to paint a clear picture of the state of CAMHS and how it is changing.

What is clear is that need continues to surpass available support. While the number of young people able to access mental healthcare is growing, it remains around a third of all CYP in the country with a diagnosable mental illness. Between a quarter and third of young people referred to CAMHS do not meet criteria for access to treatment.[6,7] It is unclear whether alternative services for these young people, as well as those struggling with poor mental health or wellbeing who are never referred for specialist care, are available across the country. EPI research has found that many local authorities have cut child and family wellbeing support services over the last decade.[8]

In 2017, the first prevalence data in more than a decade was released confirming anectodal reports and showing a rise in the prevalence of diagnosable mental illness from approximately one in ten young people (aged five to sixteen-years old) in 1999 to one in nine in 2017.[9] Potential drivers of this increase often cited include the rise of digital technologies such as social media and increased academic pressure. Since the arrival of Covid-19, the prevalence of probable mental disorders has risen substantially to one in six young people.[1] In response, the government announced a new £500m package focused on children and young people's mental health services, yet this amounts to less than £250 per young person with a diagnosable disorder and is unlikely to make a sustainable difference.

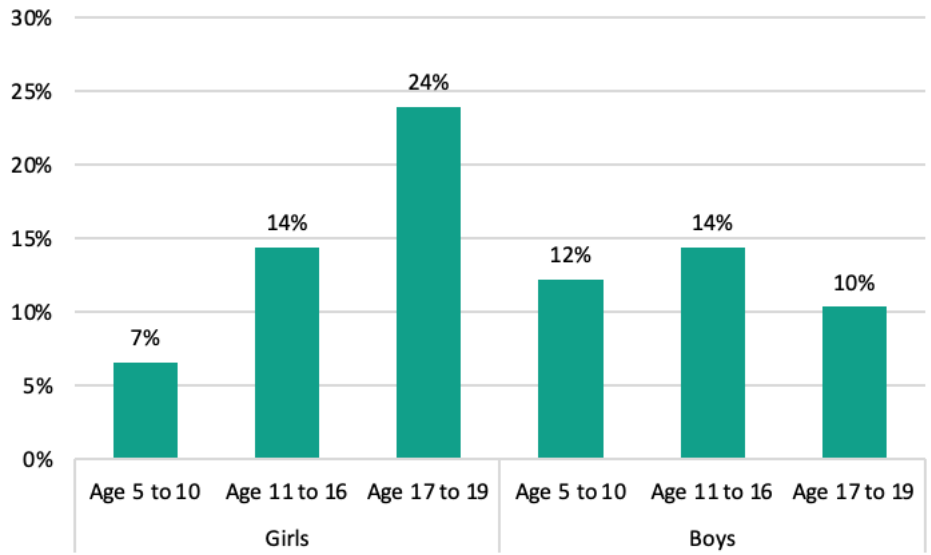
Alongside their focus on improving the availability and quality of specialist care, policymakers have acknowledged that early intervention and prevention are necessary parts of any effective strategy to reduce the burden of mental ill-health in young people.[10] But these have received much less focus and fewer resources in practice than specialist care. Since 2018, the Government has been piloting new mental health support teams working with groups of schools and colleges to support young people's mental health but it remains unclear when they will be rolled out across the country.

Mental health in childhood and adolescence

Most lifelong mental health issues develop early in life: estimates vary, but at least 50 per cent by age 14 and 75 per cent by age 24.[11]

Prior to the pandemic, national prevalence data shows that from childhood to adolescence, the proportion of young people with a probable disorder increases, and in later adolescence, continues to increase for girls while dropping slightly for boys. As seen in Figure 1, at primary school age (five- to ten-years old), this stands at seven per cent of girls and 12 per cent of boys, at secondary school age (11- to 16-year olds), at 14 per cent for both girls and boys, and in later adolescence (17- to 19-years old) at 24 per cent for girls and 10 per cent for boys.[9]

Figure 1. Prevalence of probable mental illness in young people in England



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

While the policy response has been primarily focused on diagnosable mental disorders, mental health is more than the absence of illness. According to the World Health Organisation (WHO), mental health is 'a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'

Some have pointed out gaps in the WHO definition, including that it does not account for the dynamic nature of mental health through different stages of life. For example, many adolescents go through a period of emotional turbulence, or of being shy or socially uncomfortable, and have yet to master a skill or subject area.[12] Furthermore, it ignores that 'poor' mental health is a rational reaction to certain social, economic and political contexts, such as being an asylum seeker fleeing political violence or being incarcerated, a point which highlights the importance of living conditions for mental health.

Regardless of any gaps, there appears to be growing recognition by policymakers that outcomes beyond mental illness should be tracked. In 2018, DfE began publishing an annual 'State of the Nation' report which brings together the evidence on children and young people's wellbeing.[13] The latest report shows that young people in England, while less happy than those in other countries, continue to be mostly satisfied with their lives in 2020. It is less clear from existing evidence how wellbeing changes as children move from childhood through adolescence, a period during which mental illness becomes more common.

There is considerably less focus, by both policymakers and researchers, on the other components of mental health listed in the WHO definition. Despite this, evidence shows a clear link between low self-esteem, or placing low value on oneself, and psychological distress in young people, and that high self-esteem is protective against the development of poor psychological health.[14] Existing research into self-esteem across the lifespan in earlier generations shows a dip in adolescence particularly for girls.[15]

In this report we adopt a broad view of mental health in young people. We look at levels of personal wellbeing, self-esteem and psychological distress. For clarity, we use the term 'mental and emotional

health' to refer to all three outcomes. We rely on young people's reports about their own mental and emotional health at all ages rather than parent reports as existing research shows discrepancies between the two.[16,17] We look at these outcomes at the end of primary school (childhood), at Key Stage 3 (early adolescence) and after GCSEs (late adolescence). We do not examine all aspects mentioned in the WHO definition but still aim to paint a more complete picture of mental health through this period.

Drivers of children and young people's mental and emotional health

Mental health is determined by both biological, psychological and social factors, often working in tandem. However the specific causes of most mental disorders are not well understood. What we do know is that the environment into which children are born and grow up is crucial for their psychological and emotional development.

Most research on social drivers is focused on psychological distress or mental illness as the outcome, with a smaller body of evidence on wellbeing, and little existing research into determinants of self-esteem. Research is conclusive that worse socio-economic circumstances (SEC) predict mental illness in young people, with some evidence in adults suggesting low SEC is linked to poor self-esteem.[18,19] Existing research using data from the Millennium Cohort Study on children throughout the UK has found that, in addition to relatively low family income, unhappiness with family socio-economic position and being bullied are significant predictors of higher depressive symptoms scores and lower wellbeing scores in early adolescence.[17] Both quantitative and qualitative studies consistently identify relationships with family and friends as key for wellbeing.[20] Maternal mental health is strongly associated with child mental health, while maternal mental health problems in very early life are linked with poor child development outcomes, which can have a lasting impact on psychological and emotional functioning.[21, 22] Wider factors, including school and neighbourhood conditions, also play a role, with some evidence linking positive teacher-pupil relationships to better mental health outcomes, ability streaming to the stigmatisation of children in bottom streams, and experiencing an exclusion and feeling unsafe in the community to worse outcomes.[18, 23-25] There is also some evidence suggesting that the same social factors may be differentially related to wellbeing and mental ill-health for girls and boys, as well as at different ages.[26]

Gaps in the current policy response

Experts agree that good health and wellbeing in adolescence is key for the development of emotional and cognitive skills, the completion of education and transition to employment, civic engagement and the formation of lifelong relationships.[27] In addition, the foundations that determine health throughout life, and that of future generations, are laid down in this period: adolescents are the next generation to parent, and their health and wellbeing reserves can determine the healthy start to life they provide for their children.

Mental ill-health is highly costly to individuals and society as a whole: it predicts worse physical health, lower productivity and lifelong earnings, and shorter life expectancy, along with higher healthcare and social services costs. [28-30] Research shows that mental and emotional health are also strongly related to educational attainment and suggests that low self-esteem may play an important role in the disadvantage achievement gap.[31]

Yet, this evidence is not reflected in the current policy response. Past governments have been overwhelmingly focused on specialist care, specifically increasing access to treatment and reducing

waiting times. Even so, while at least half of adult mental health conditions are established by adolescence, only 8.75 per cent of NHS mental health funding goes to children and young people.[32] On early intervention, it remains unclear when local Mental Health Support Teams, currently being piloted in a handful of areas, will be rolled out to all schools and colleges and to what extent they will improve their capacity to identify difficulties and support children across the country.

As the number of children requiring treatment continues to exceed available provision, and is likely to rise as a result of the pandemic, improving access to support for those with difficulties should continue to be a priority for the government.

However, as mental and emotional health is strongly influenced by the social and economic environment in which children and young people live, many problems could be prevented from developing at all. A more cost-effective, long-term strategy would redirect focus and resources to prevention.[33] This requires policies which comprehensively target the upstream determinants of poor mental health and low wellbeing amongst young people. Research identifying these determinants opens up opportunities for universal interventions of this kind.

As well as tracking changes to mental and emotional health through adolescence, this report investigates the factors – from individual characteristics and habits, to family health and wellbeing, to experiences in primary school, to wider community factors – which drive poor and positive mental and emotional health in young people.

Data and methodology

Quantitative data

We use data from the Millennium Cohort Study (MCS), a nationally representative longitudinal cohort study of children born between 1 September 2000 and 31 August 2001 in England and Wales, and between 24 November 2000 and 11 January 2002 in Scotland and Northern Ireland. The MCS came out of a renewed interest in child wellbeing in the late 1990s and was developed as a multidisciplinary survey which could capture the influence of early family context on child development and outcomes throughout childhood, into adolescence and subsequently through adulthood.

The MCS is clustered by electoral wards and is disproportionately stratified to over-represent areas with a high percentage of ethnic minority and socio-economically disadvantaged children. This analysis uses data on children living in England at ages 11, 14 and 17, as well as some data from earlier waves (age 9 months, age 7) on some variables in the regression models.

The MCS received ethical approval from the South West and London Multi-Centre Research Ethics Committees, UK. All carers gave their informed consent. The anonymised data was accessed through the UK Data Service where it is publicly available.

Outcomes

We look at three components of mental and emotional health at ages 11, 14 and age 17: wellbeing, self-esteem and psychological distress.

At age 11, wellbeing is measured with a set of questions about happiness in six areas of life and self-esteem using a subset of questions from the Shortened Rosenberg Self-Esteem Scale on positive feelings about self and self in relation to others. Children did not report on their levels of psychological distress at age 11. At age 14, wellbeing and self-esteem are measured using the same scales as at age 11 and psychological distress using the Short Mood and Feelings Questionnaire. At age 17, psychological distress is measured using the Kessler-6 scale, wellbeing with the Short Warwick Emotional Mental Wellbeing Scale and self-esteem with the same measure as at earlier ages. More information on these measures is available in the text boxes below.

Wellbeing

At ages 11 and 14, children were asked how happy they were with their appearance, family, friends, school, schoolwork and life. Responses were scored on a seven-point Likert scale ranging from 'completely happy' to 'not at all happy'. At age 17, young people were asked about general feelings of wellbeing – e.g. their level of optimism, feeling close to others, feeling relaxed in their lives – using the validated Short Warwick Emotional Mental Wellbeing Scale. Responses were scored on a five-point Likert Scale.

Self-esteem

At all three ages, children were asked about their feelings about themselves and themselves in relation to their peers using the validated Shortened Rosenberg Self-Esteem Scale, scored on a four-point Likert scale with responses ranging from 'strongly agree' to 'strongly disagree'.

Psychological distress

At age 14, young people were asked about their recent feelings and actions using the Short Mood and Feelings Questionnaire. Thirteen questions were answered on a three -item Likert scale: 'not true', 'sometimes true' and 'true'. At age 17, young people were asked about recent depressive symptoms using the Kessler-6 scale and responses were scored on a five-point Likert scale. Both scales are validated for use in this age group.

Overall scores for the three outcome were aggregated from responses to each item. For the box charts in part 1, we standardised and rescaled aggregate outcome scores to a zero-to-20-point scale to compare change over time. In part 2, we used standardised aggregate scores for each outcome to allow for comparison of regression coefficients across outcomes.

Drivers

Model 1 (base model): gender + ethnicity + family income (demographic information)

We run three models to examine the effect of drivers on each of our three outcomes at ages 14 and 17 separately.

Model 1 is our base model and controls for the effect of gender, ethnicity and family income.

A limitation of our analysis is that our ethnicity variable is simplified into broad categories (White, Pakistani or Bangladeshi, Black or Black British, Indian, mixed, 'other') due to small sizes of some ethnic groups in our study sample, meaning findings may not be applicable to all sub-groups.

We use family income quintiles as our measure of socio-economic circumstances (SEC).

Model 2: demographic information + individual and family characteristics

We then added in the following factors to the model. This information was recorded at age 11, unless otherwise specified:

- weight status (according to World Health Organisation cut-offs for body mass index)
- chronic illness in childhood

- frequency of physical activity at age 11 for models looking at outcomes at age 14, and at age 14 for models looking at outcomes at age 17
- time spent on social media at age 11 for models looking at outcomes at age 14, and at age 14 for models looking at outcomes at age 17
- perceived socio-economic position (SEP). Children were asked if their family was richer, poorer or about the same as their friends'. They were also asked how strongly they agreed with the statement 'I wish my family could afford more'.
- living in a single-parent home
- maternal depression in infancy
- maternal general health
- quality of the young person's relationship with their parents: parents reported on how frequently they 'battled' with their child
- cognitive ability: to generate a cognitive index score, we combined young people's scores on measures of reading, pattern construction and maths at age 7. We used principal components analysis to generate an overall indicator of cognitive ability.
- number of siblings

Model 3 (full model): demographic information + individual and family characteristics + peer and community factors

We then added in wider factors and experiences to the models. Given evidence showing a link between the quality of teacher-pupil relationships and wellbeing, we tested whether teacher characteristics that might plausibly affect relationships were significantly predictive of worse mental health outcomes. We only tested the relationship with experiences in primary school and outcomes at age 14, due to the high proportion of missing data which could impact the results of our analysis (see 'Analysis' section for more information):

- teacher qualifications
- teacher years of experience
- whether the young person experienced a fixed term exclusion in primary school
- whether the young person was streamed in primary and, if so, the stream in which were they placed
- how often they argued with friends
- how often they were bullied in primary school
- how safe the young person felt in their neighbourhood
- whether they had access to green space in their neighbourhood

Analysis

In our sample of 5,002 young people in England with complete data on the wellbeing, self-esteem and psychological distress scores at ages 11, 14 and 17, we had complete data on demographics (gender and ethnicity) and socio-economic circumstances (family income). We did not find statistically significant differences in mean wellbeing, self-esteem or psychological distress scores of participants with complete outcome data at all three ages and those missing this data. We therefore excluded cases missing outcome data at ages 14 and 17 from the analysis. We were missing less than 5 per cent of data on other predictors, and approximately 30 per cent of responses on school data; this data was provided by teachers who completed mail-in surveys rather than participating in in-

person interviews which contributed to the relatively low response rate. In order to include cases in the analysis missing data on the drivers, we imputed missing values. Forty imputed data sets were created for the analysis.

A limitation of this approach is that we do not know the characteristics of the schools and teachers for whom we are missing data. If these schools and their teaching workforces differ significantly along the characteristics we examine as drivers, for example, they have a disproportionately high number of teachers with few years of experience, this could affect the results of our analysis. Findings on the impact of school factors should therefore be interpreted with caution.

All analyses account for the design of the MCS and include weights. In Part 1, we present aggregate outcome scores for wellbeing, self-esteem and psychological distress at ages 11, 14 and 17, for the sample as a whole and separately by gender. We also present the strength of the correlation between different areas of wellbeing and self-esteem at age 11, areas of wellbeing, self-esteem and psychological distress at age 14, and wellbeing, self-esteem and psychological distress at age 17. In Part 2, we present results from weighted regression analyses separately for each outcome at ages 14 and 17. We also present results from separate models for girls and for boys, based on results showing an improvement in model fit when including interactions with gender. Finally, we present results from analyses of wellbeing and self-esteem at ages 14 and 17, controlling for pre-existing wellbeing and self-esteem scores to test if drivers account for any change in these outcomes through adolescence.

Focus groups

To supplement the quantitative analysis, we conducted focus group discussions with young people in secondary schools. Due to the Covid-19 pandemic and school closures, we were only able to run these groups virtually in two secondary schools, one in Cheshire and one in Greater Manchester. The groups had a mixture of genders, backgrounds, and experiences with their mental health and the mental healthcare system, and ranged in age from 14- to 16-years old. The overall aim of the focus groups was to better understand young peoples' perspectives on mental and emotional health, their views on the current support systems in place and their ideas for change. The sessions lasted between two and three hours.

Findings from the focus groups are organised thematically and presented throughout the report in green text boxes.

Part 1: Mental and emotional health from childhood through adolescence

In part 1, we look at changes in mental and emotional health as children get older and the relationship between the different components of MEH.

In focus groups, young people spoke about mental health being more than psychological distress and about not feeling equipped to discuss mental health issues.

'I feel like when people hear the words mental health they just think about depression and anxiety, but there's so much more to it'

'You don't know how you feel because you've not been taught a way to explain it'

'You feel like you're letting your friends down because you don't know how to help them'

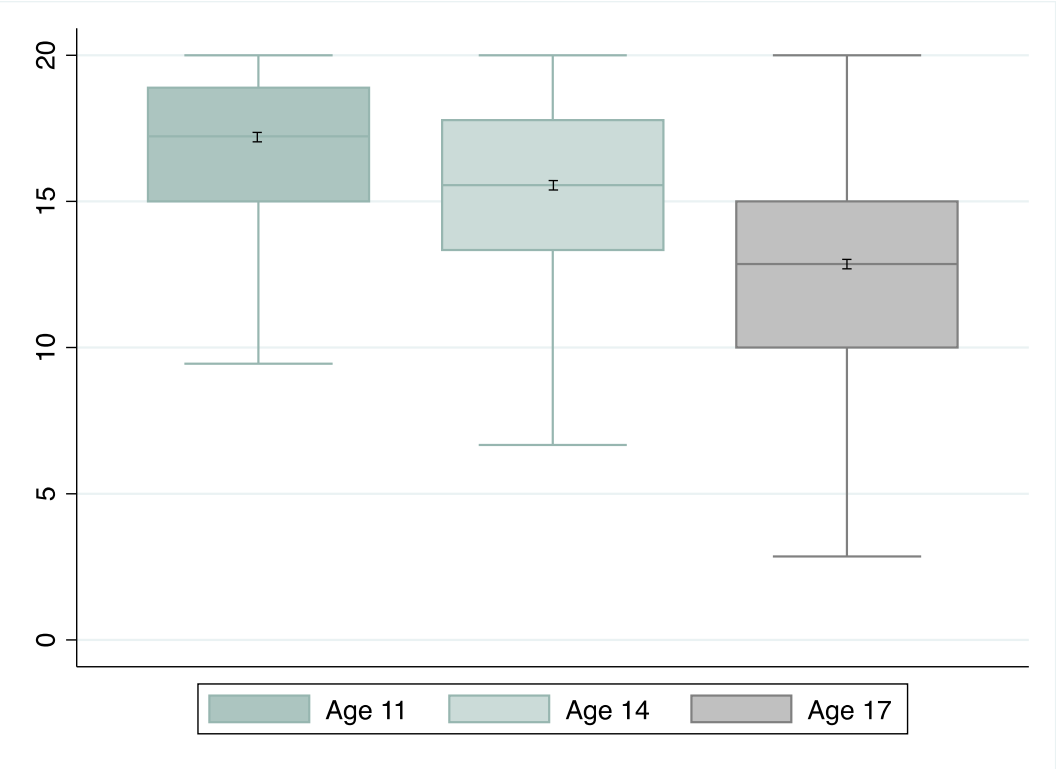
'As a kid you're just trying to figure out what's going on in your head'

Wellbeing in primary through secondary school

Figure 1.1. shows the spread of wellbeing scores at ages 11, 14 and 17. A high score indicates a high level of wellbeing and a low score indicates low wellbeing. The middle line represents the median score at each age, while the top and bottom of the boxes represents the 25th and 75th percentiles of scores respectively.

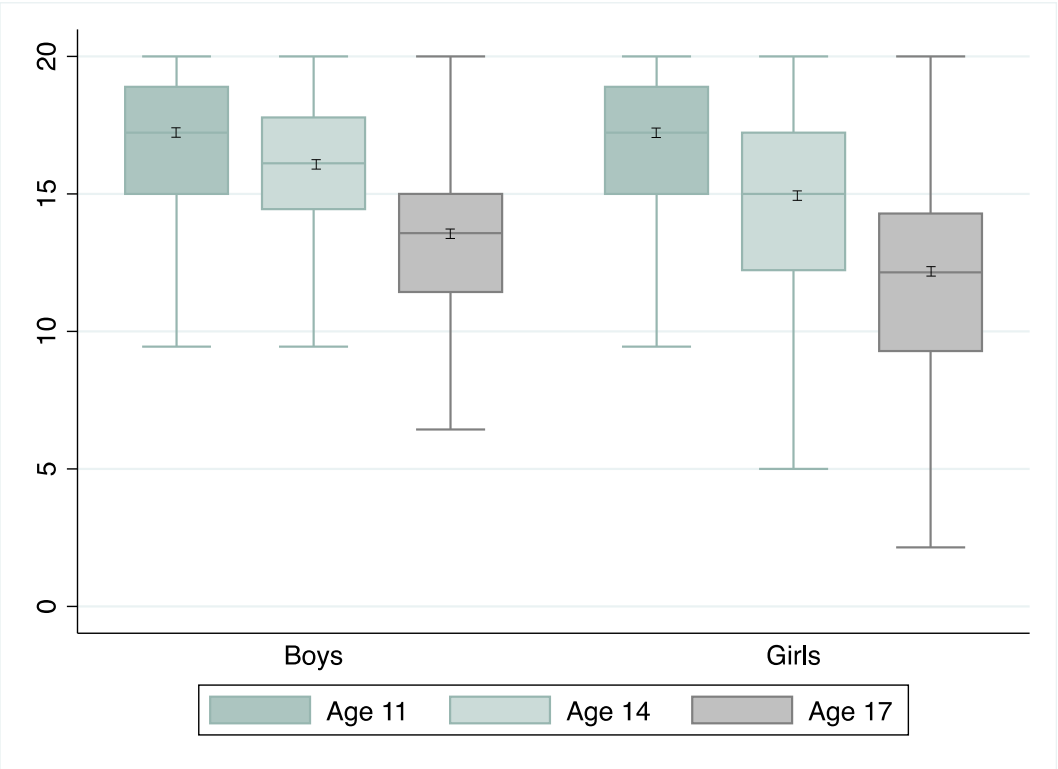
As seen in Figure 1.1, wellbeing falls on average as children age. At the end of primary school, the majority of children have high levels of wellbeing. Average wellbeing scores drop by secondary school, and by post-GCSE age, most young people have satisfactory wellbeing scores, the lowest, on average, of the three ages.

Figure 1.1 Change in wellbeing scores from childhood through adolescence



As seen in Figure 1.2, the drop in wellbeing differs by gender and is larger for girls. Girls start with a slightly higher median wellbeing score at age 11 and have a lower median score at ages 14 and 17 compared to boys. Scores remain concentrated toward the higher end of the scale throughout, showing that the majority of young people continue to have at least satisfactory wellbeing scores.

Figure 1.2 Change in wellbeing scores from childhood through adolescence by gender



The young people did not speak explicitly about experiences of the gender divide in mental and emotional health that emerges at the beginning of adolescence. They discussed how girls and boys tend to approach the subject of mental health differently, with stigma around sharing one's mental health struggles and fear of being judged by male peers more of a barrier for boys.

'Girls are more open and more prone to talk about how they feel – but boys are more bottled up'

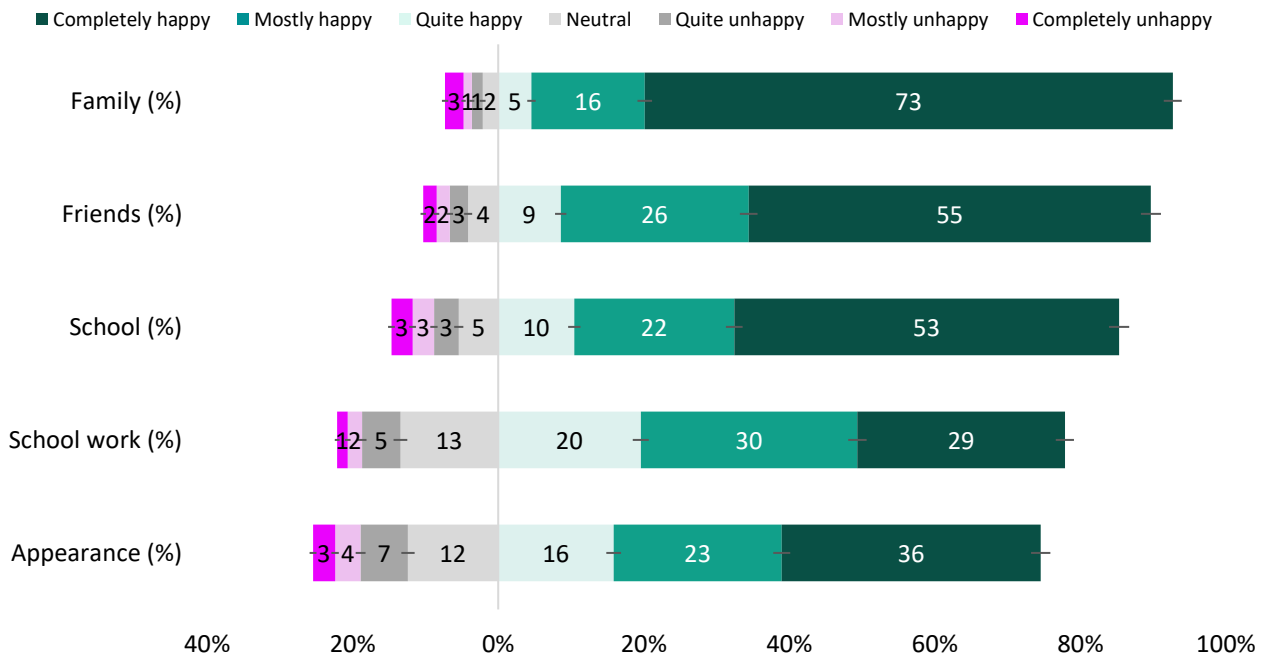
'[Boys] begin to open up as they get older. As a kid they're like "oh I need to be [masculine]", but as they get older they realise that bottling it up is no good.'

Change in areas of wellbeing between primary and secondary school

This section looks at changes in different areas of wellbeing as children transition from primary to secondary school.

As seen in Figure 1.3, the large majority of children finish primary school happy in all areas of their lives, in particular with their families, friends, and school. Fewer, but still at least three quarters, are happy with their schoolwork and appearance.

Figure 1.3 Wellbeing at the end of primary school in different areas of life



Note: percentages may exceed 100% due to rounding

As children move into secondary school, there is a drop in the proportion who are completely happy, but the majority remain mostly or quite happy in all areas of life (Figure 1.4). Meanwhile the proportion who are ambivalent or unhappy increases in all areas of life, particularly in areas of schoolwork and personal appearance. This corresponds to the drop seen in self-esteem in this period; the transition to adolescence is accompanied by growing self-consciousness and worse feelings about the self.

In focus groups, young people spoke about the transition from childhood to adolescence as a time when their experiences with mental and emotional health changed: they felt there was more to worry about as they got older and that challenges, including academic and exam pressure, grew as they moved through secondary school. Others spoke about developing more understanding of their own emotions at older ages and being more open about their mental health as a result.

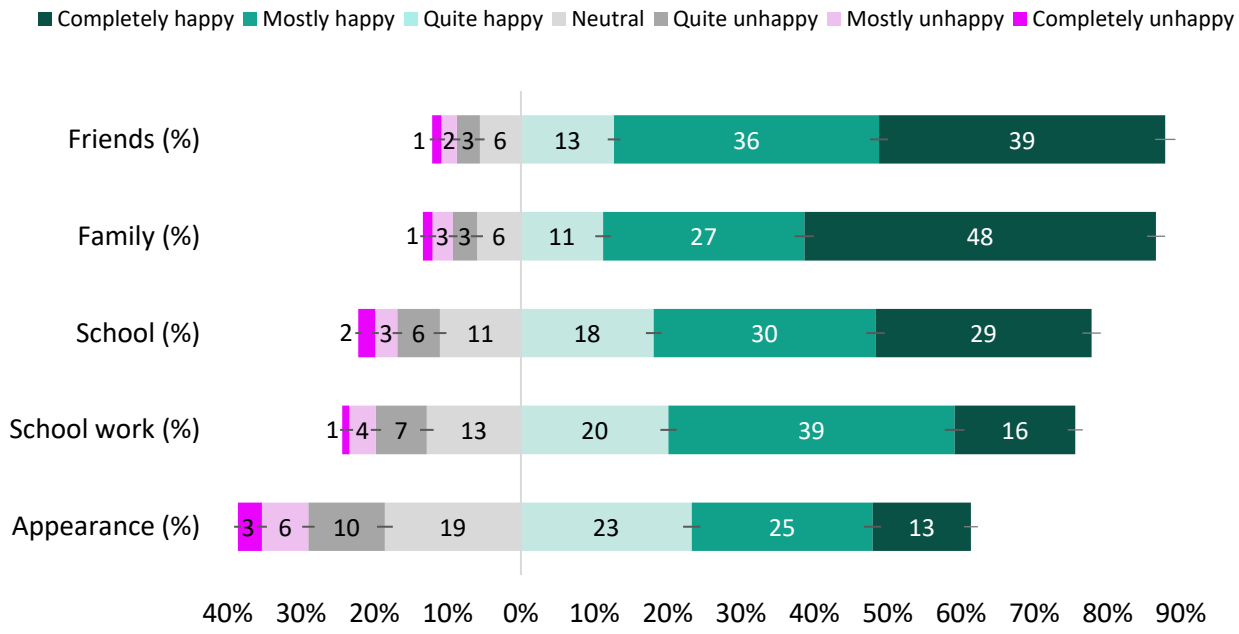
'In primary school everything is black and white in your head'

'In primary and year 7 and 8, you have no care in the world and then after that it gets worse'

'If you asked everyone in year 9, 10 and 11 if they're happy themselves, barely anyone would say 'yes' and be confident about it'

'Sometimes you set yourself goals that you know you can't achieve – pushing yourself over the limit, and that has a massive impact on your mind because you're always thinking I could be doing better'

Figure 1.4 Wellbeing in secondary school in different areas of life

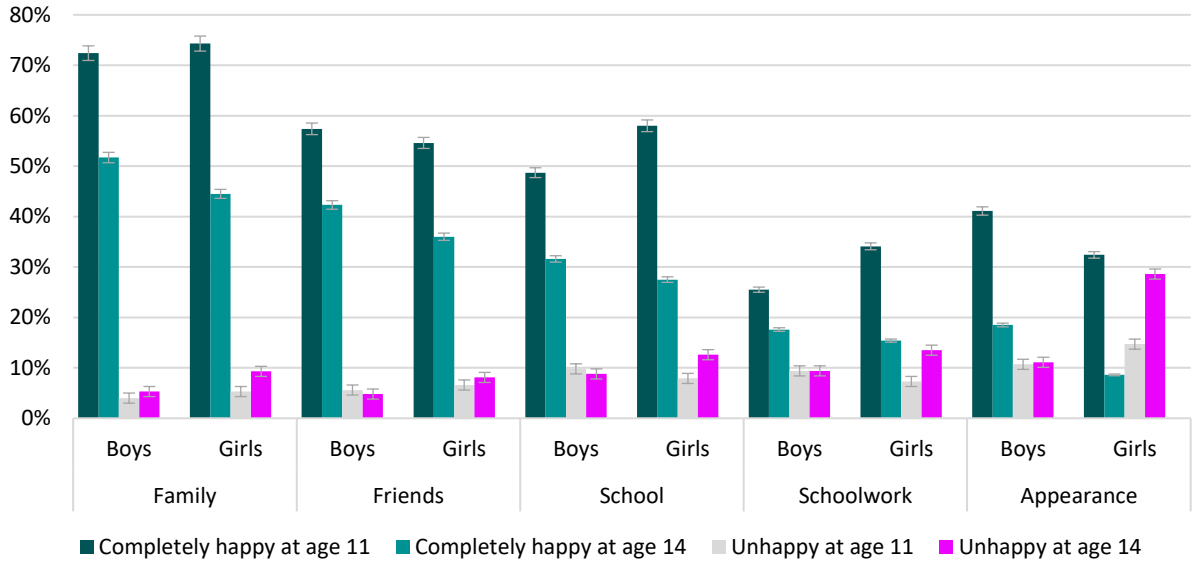


Note: percentages may exceed 100% due to rounding

While we see a drop in average wellbeing in all areas of life for both boys and girls, the size of this drop varies by area and gender as seen in Figure 1.5. Generally, the increase in proportion who are

unhappy in different areas of life is greater for girls and is most pronounced in the areas of schoolwork and appearance. The proportion of girls unhappy with their schoolwork doubles from 7 per cent to 14 percent from primary to secondary school, while remaining static at 9 per cent for boys. Similar proportions of boys and girls are unhappy with their looks (11 per cent and 15 per cent respectively), but this stays constant for boys as they move into adolescence and rises to 29 per cent for girls.

Figure 1.5 Changes to areas of wellbeing from primary to secondary school by gender



Young people were not asked to rate their happiness in different areas of life at age 17 so we are unable to look at changes through secondary school.

In focus groups, young people expressed different beliefs about generational differences in how the subject of mental health is approached.

'Adults can be more open-minded than children'

'People our age are more open to talking about it. A lot of adults grew up in a time where you just had to "get over it".'

'You're more willing to talk about it as you get older, as more experience means you know what's going on'

Self-esteem in primary through secondary school

We see a similar, but less pronounced, drop in self-esteem as children move into and through adolescence (Figure 1.6). Most of the fall in self-esteem happens between childhood and adolescence, although scores are generally more concentrated towards the low end of the scale at age 17 compared to age 14.

Figure 1.6 Self-esteem scores from childhood through adolescence

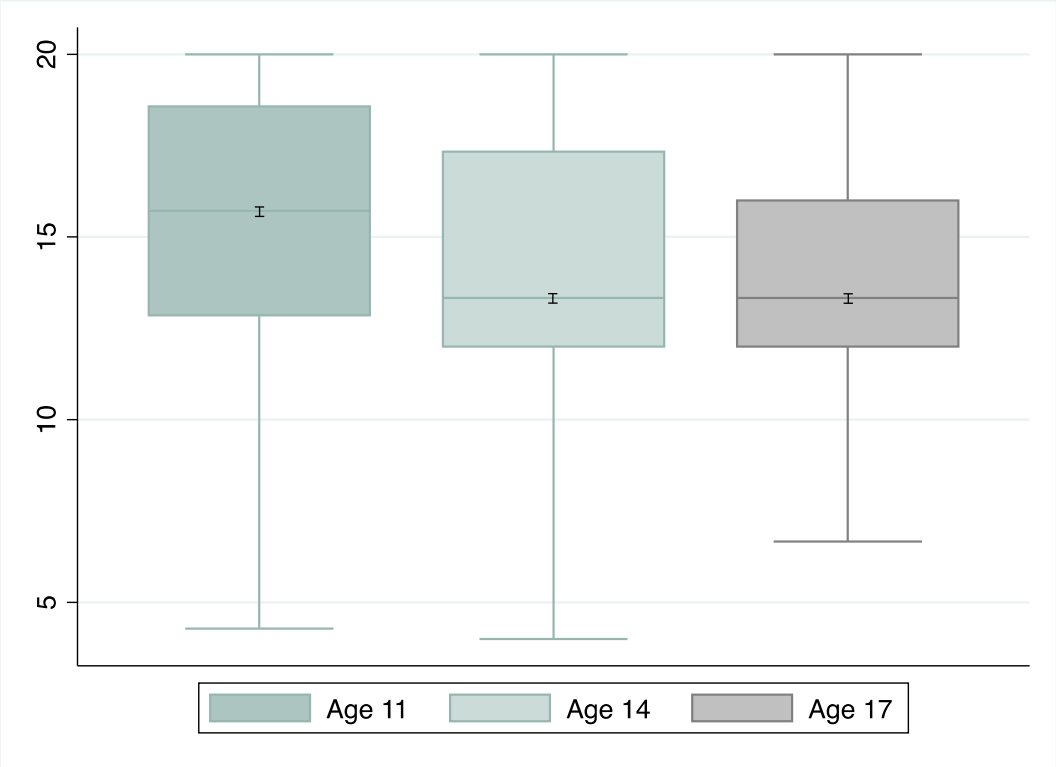
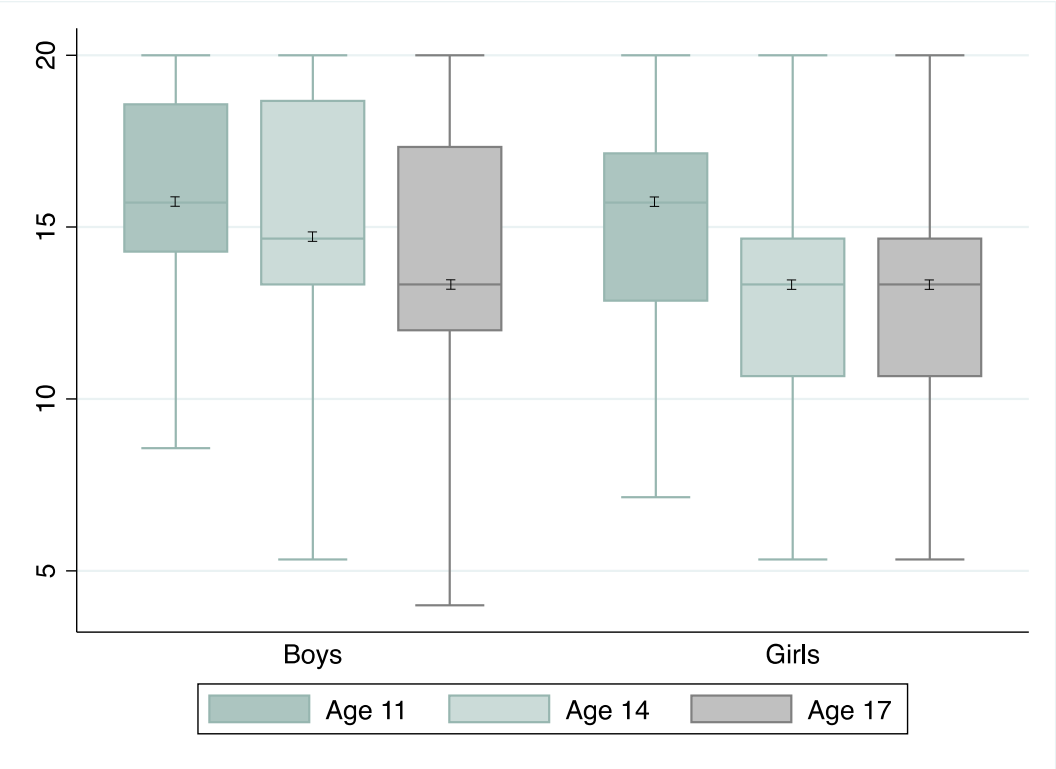


Figure 1.7 shows the change in self-esteem for boys and girls separately as they move from primary through secondary school. We find a more precipitous drop in self-esteem for girls than for boys from ages 11 to 14. Between ages 14 and 17, boys' scores continue to fall, on average, while girls' self-esteem appears to remain broadly stable.

Figure 1.7 Change in self-esteem scores from childhood through adolescence by gender



Young people highlighted challenges with self-esteem as they moved from primary to secondary school, including 'caring more about what other people think of you', as well as the difficulty of navigating relationships with peers. They talked about a 'standard' they felt they had to fit and concerns about being laughed at and called names, including for caring about their schoolwork and grades.

'As soon as you get to high school there's people making comments about you'

'It's very easy to [judge] other people, especially if you're insecure about yourself'

'If you care about your work, it's seen as embarrassing'

Levels of psychological distress through secondary school

We see a corresponding rise in levels of psychological distress as young people move through adolescence (Figure 1.8). This rise is larger for girls, who start off with higher levels of distress at age 14, on average (Figure 1.9).

Figure 1.8 Change in psychological distress scores through adolescence

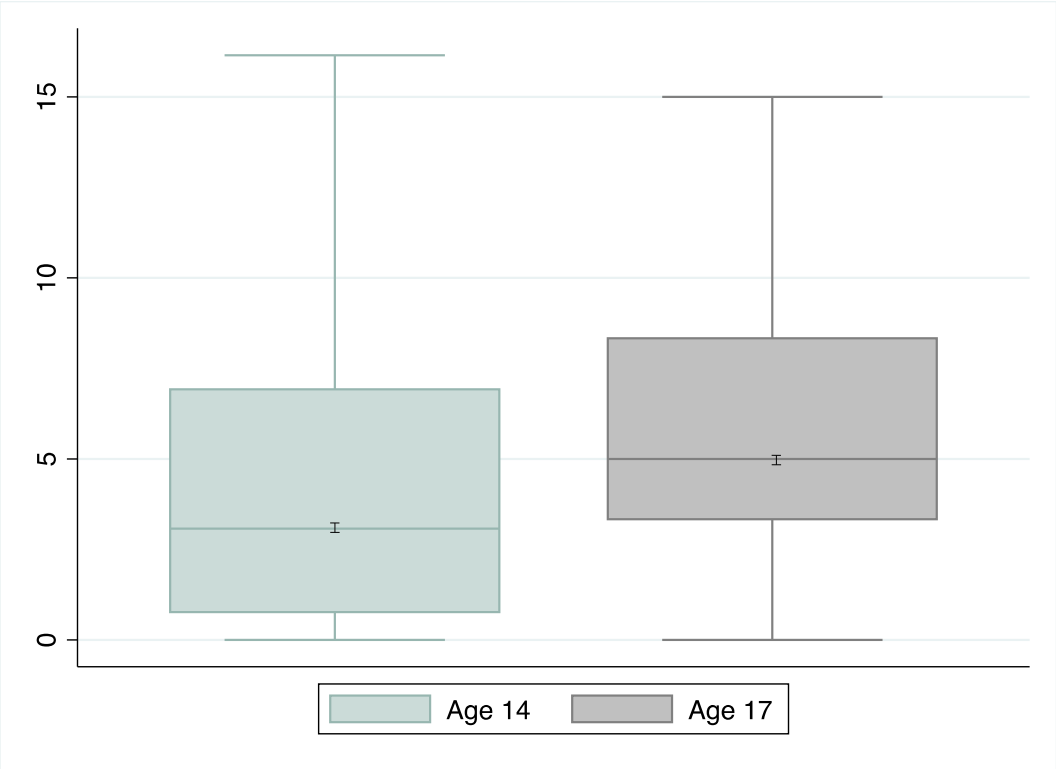
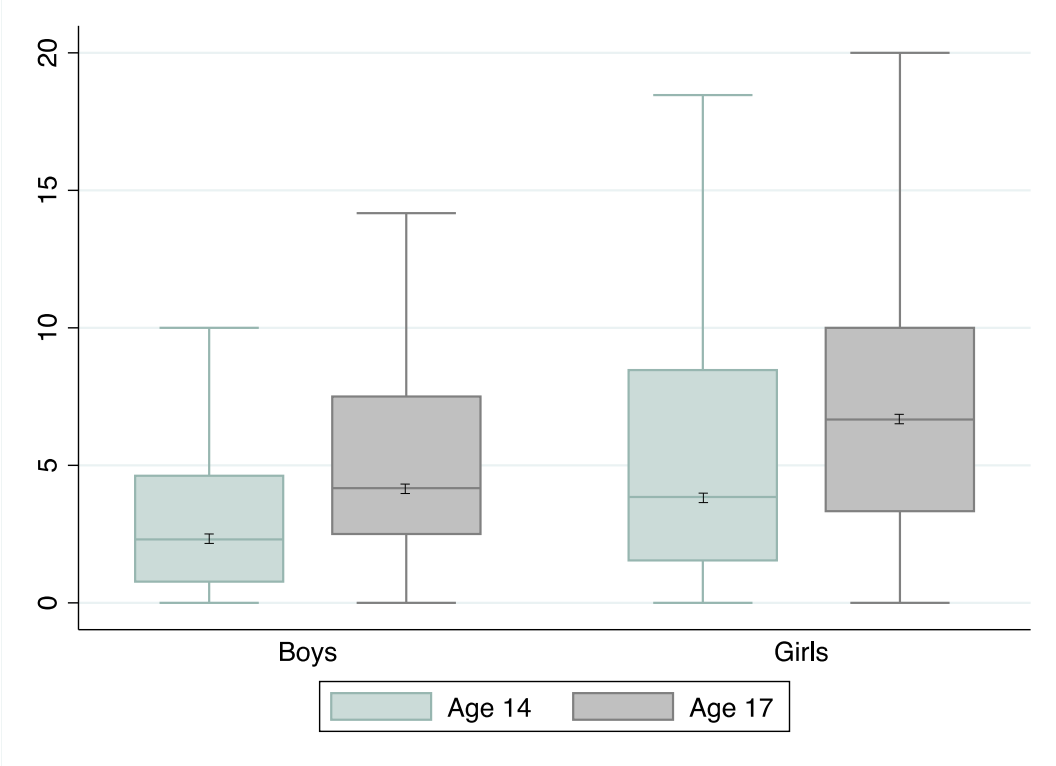


Figure 1.9 Change in psychological distress scores in adolescence by gender



The relationship between wellbeing, self-esteem and psychological distress in childhood and adolescence

Figures 1.10 and 1.11 show the strength of the relationship (correlation) between areas of wellbeing, self-esteem and psychological distress at ages 11 and 14. The bubbles show correlation coefficients between 0 and 1 or -1, and the closer the value to 1 or -1, the closer to a perfect correlation between the factors in question. A perfect correlation means that an increase or decrease in variable A always predicts the same directional change for variable B. Darker colours indicate stronger correlations.

The young people spoke about the importance of mental health in this period:

'It can affect everything in your whole life -- your relationships with family and friends, and your schoolwork and how you apply yourself'

'[Mental health is] one of the main things that can impact your life if it's not looked after properly'

Figure 1.10 The relationship between areas of wellbeing and self-esteem at age 11

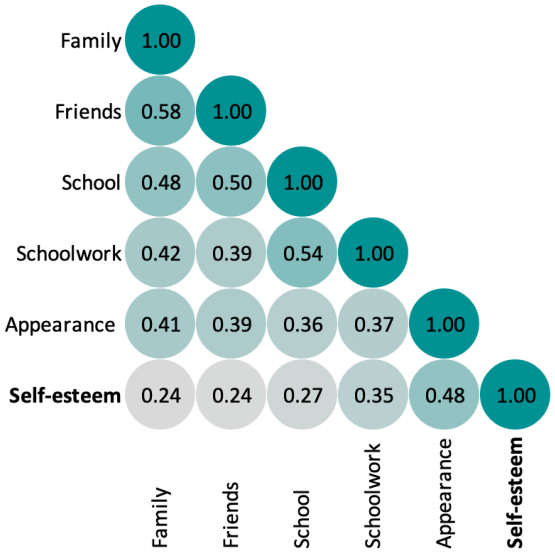
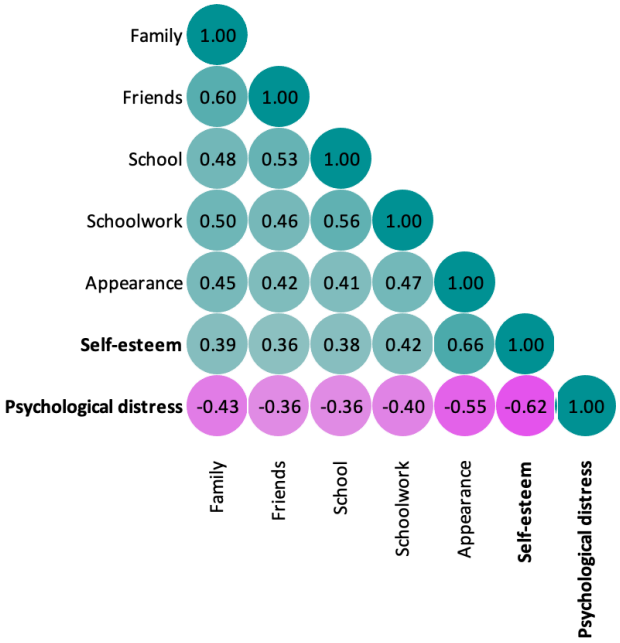


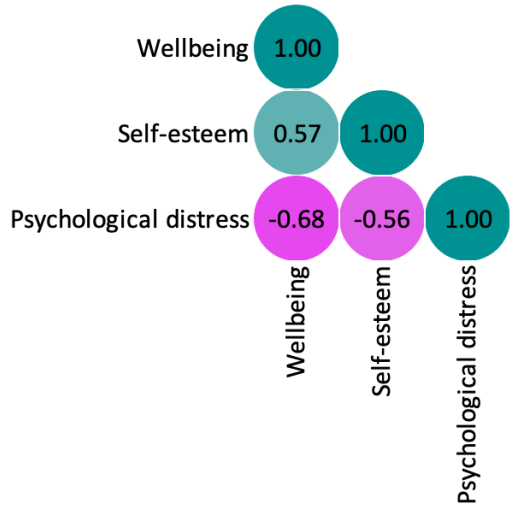
Figure 1.11 The relationship between areas of wellbeing, self-esteem and psychological distress at age 14



We find that areas of happiness and self-esteem are weakly related at age 11, as shown by the light-coloured bubbles along the bottom of the chart. How children feel about themselves is not strongly related to how they feel about different areas of their life. Happiness with one's appearance is the only area of wellbeing which shows a modest correlation with self-esteem. Areas of wellbeing are generally weakly correlated with one another, except for a moderately strong correlation between happiness with friends and happiness with family and a moderate correlation between friends and school, indicating that school is an important social space for children.

At age 14, happiness in all areas is more strongly, yet still moderately, correlated with both self-esteem and levels of psychological distress, compared to age 11 (Figure 1.11). The exception to this is how happy a young person is with their appearance which is strongly related to self-esteem, and moderately (negatively) correlated with psychological distress. Self-esteem and psychological distress are also moderately strongly, negatively correlated, meaning that a high self-esteem score is linked to lower levels of psychological distress. These findings suggest that as children get older, how they see and value themselves, and how they feel about themselves in relation to others, becomes more closely tied to how they feel about their lives generally.

Figure 1.12 The relationship between wellbeing, self-esteem and psychological distress at age 17



Wellbeing and psychological distress are more strongly correlated at age 17 (Figure 1.12), but this is likely related to the different measures used at this age. Self-esteem has a similar moderate negative correlation with psychological distress at ages 14 and 17, despite a different measure of the latter being used. Regardless of measures, there are moderate associations between the different components of mental health, but not complete overlap; the same is true for other ages. This means while scores on these outcomes are related, they do not fully predict one another.

Young people shared different attitudes and experiences around accessing support for mental health issues, with some feeling more wary of accessing support if they felt they didn't have a reason to feel poorly. Young people felt it was not ideal that they were unable to access support without their parents' help or knowledge.

'The thing with CAMHS is waiting lists and feeling as if your problems aren't good enough almost, like you've not got it as bad as others'

'*There's lots of support open for younger people'*

'If you are looking for that professional support it is very hard to get it as a young person… you have to go with family, it's not like you can reach [it] by yourself.'

'The only way you can get help with your mental health is through your parents'

'There doesn't need to be a reason for people to feel sad. You don't need a reason for it to be valid'

Part 2: Drivers of mental and emotional health in adolescence

We examine the relationship between aspects of children and young people's lives and their mental and emotional health in early and late adolescence. We start with simple models adjusting for gender, ethnicity and family income (base model). We then add in individual and family factors (model 2), followed by school and community factors (full model). All models apart from base models also control for cognitive ability and number of siblings, but these are not included in the charts. We run models for each of the three outcomes at ages 14 and 17. We then split these models by gender to examine the differential impact of factors on girls' versus boys' mental and emotional health. Finally, we run models controlling for pre-existing self-esteem and wellbeing for these outcomes at ages 14 and 17, to isolate the impact of drivers on changes to self-esteem and wellbeing through adolescence (Annex).

Drivers of wellbeing, self-esteem and psychological distress at age 14

Figure 2.1 presents a model adjusting for gender, ethnicity and socio-economic circumstances (SEC), as represented by family income, for each outcome at age 14. The black dots represent the effect size of each factor, or how much the mean of each outcome score changes given a change in the factor in question, while holding other variables in the model constant. A negative effect means that the factor in question is associated with a lower score, a positive effect that the factor is associated with a higher score. Factors with dots along the middle line are the comparison groups, e.g. when looking at the impact of gender, we are comparing girls to boys. The bars show 95% confidence intervals (an effect is statistically significant if the bar does not cross the middle line).

In a simple model controlling for only gender, ethnicity and socio-economic circumstances (SEC), female gender is strongly predictive of lower wellbeing, lower self-esteem and higher levels of psychological distress, as seen in Part 1. Young people of Indian, Pakistani or Bangladeshi heritage are found to be at lower risk of poor mental and emotional health, with Black and Black British ethnicity also associated with higher self-esteem and lower psychological distress scores. This corresponds with national mental illness prevalence data which shows a lower rate of probable disorders amongst minority ethnic young people.[9]

We see a graded relationship between family income and all three outcomes: lower family income is associated with worse wellbeing and self-esteem and higher levels of psychological distress.

Figure 2.1 Demographic and socio-economic drivers of mental and emotional health at age 14 (base model)

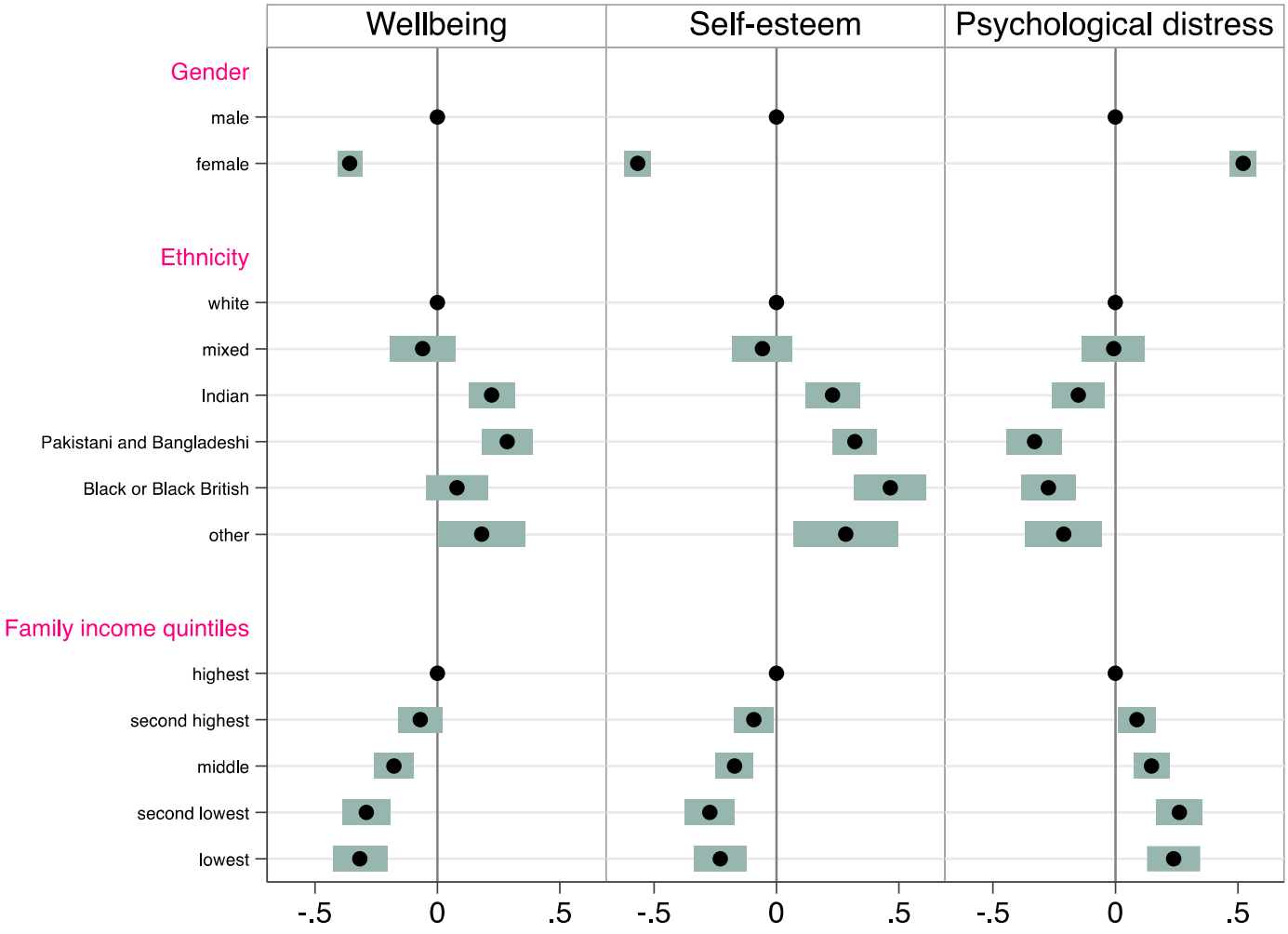


Figure 2.2 presents findings from model 2 which includes individual and family factors. We see that the relationships between our three outcomes and gender and ethnicity hold after the addition of these factors, but the effect of family income is partially attenuated – meaning it works partially through these other factors.

We find that how a child feels about their family's socioeconomic circumstances – wishing they could afford more and feeling poorer compared to their peers – is associated in a graded fashion with lower wellbeing and higher levels of psychological distress, while feeling poorer than peers is also associated with lower self-esteem, showing the importance of relative social standing beyond absolute measures of socioeconomic position.

Physical health status in childhood is significantly associated with mental and emotional health. Having a chronic illness is associated with a lower wellbeing score in this early adolescent period but does not appear to have an effect on self-esteem or psychological distress. Being overweight is associated with worse scores on all three outcomes.

Habits and activities are also important: frequent social media use in childhood is associated with worse wellbeing and psychological distress scores, but not self-esteem scores. Very infrequent social

media use was also associated with lower wellbeing, indicating that social media engagement in childhood may be a proxy for general social engagement which we know to be important for wellbeing. Physical activity is very clearly associated with all three outcomes, in a graded fashion: the less physical activity a child engaged in, the worse their wellbeing, self-esteem and levels of psychological distress at age 14.

We do not find a significant effect of living in a home with a single parent, when adjusting for family income and other factors. We do find that maternal mental and physical health are related to a young person's mental and emotional health: worse maternal health is linked to poorer scores in all three areas. We also looked at the impact of maternal depression in very early years of life and did not find a significant effect at age 14. Arguing frequently with parents is associated with lower wellbeing and higher levels of psychological distress, with no significant effect on self-esteem.

Figure 2.3 presents findings from the final model with includes teacher, peer and community factors. The impact of individual and family factors remains largely unchanged. Additionally, we find that being in the bottom stream in primary school is associated with worse self-esteem scores at age 14. We did not find a statistically significant association between the other factors in primary school we looked at and our outcomes at age 14. As discussed in the methodology section, one limitation of this analysis is the substantial number of cases missing school and teacher data which could affect results. Additionally, the very small number of children who experience a fixed term exclusion in primary school could be a reason why we did not detect an effect.

We find that being bullied in childhood is associated in a graded way with all the outcomes, meaning that the more frequently a child is bullied, the worse their outcomes at age 14. This is particularly clear for wellbeing; the more often a child was bullied in childhood, the more likely they have low wellbeing at age 14. We find a less clear association with the quality of friendships and our outcomes; it appears that arguing with friends is predictive of lower wellbeing and self-esteem and higher psychological distress, but the association is not significant at every level. Finally we find that feeling unsafe in one's neighbourhood is associated with worse wellbeing and higher psychological distress, but not self-esteem.

Young people spoke about factors they considered important for their mental health. They highlighted the importance of balancing different aspects of their life.

'Growing up, people might not have had enough money and might have struggled – and that might have affected their mental health.'

'Families can be on both sides [have negative and positive impacts for mental health]'

'Everything can go either way – if you have a good relationship with your siblings and parents and you're open with each other, that can make you happier – but if it's the other way around that can affect you badly'

Figure 2.2 Demographic, socio-economic, individual- and family-level drivers of mental and emotional health at age 14 (model 2)

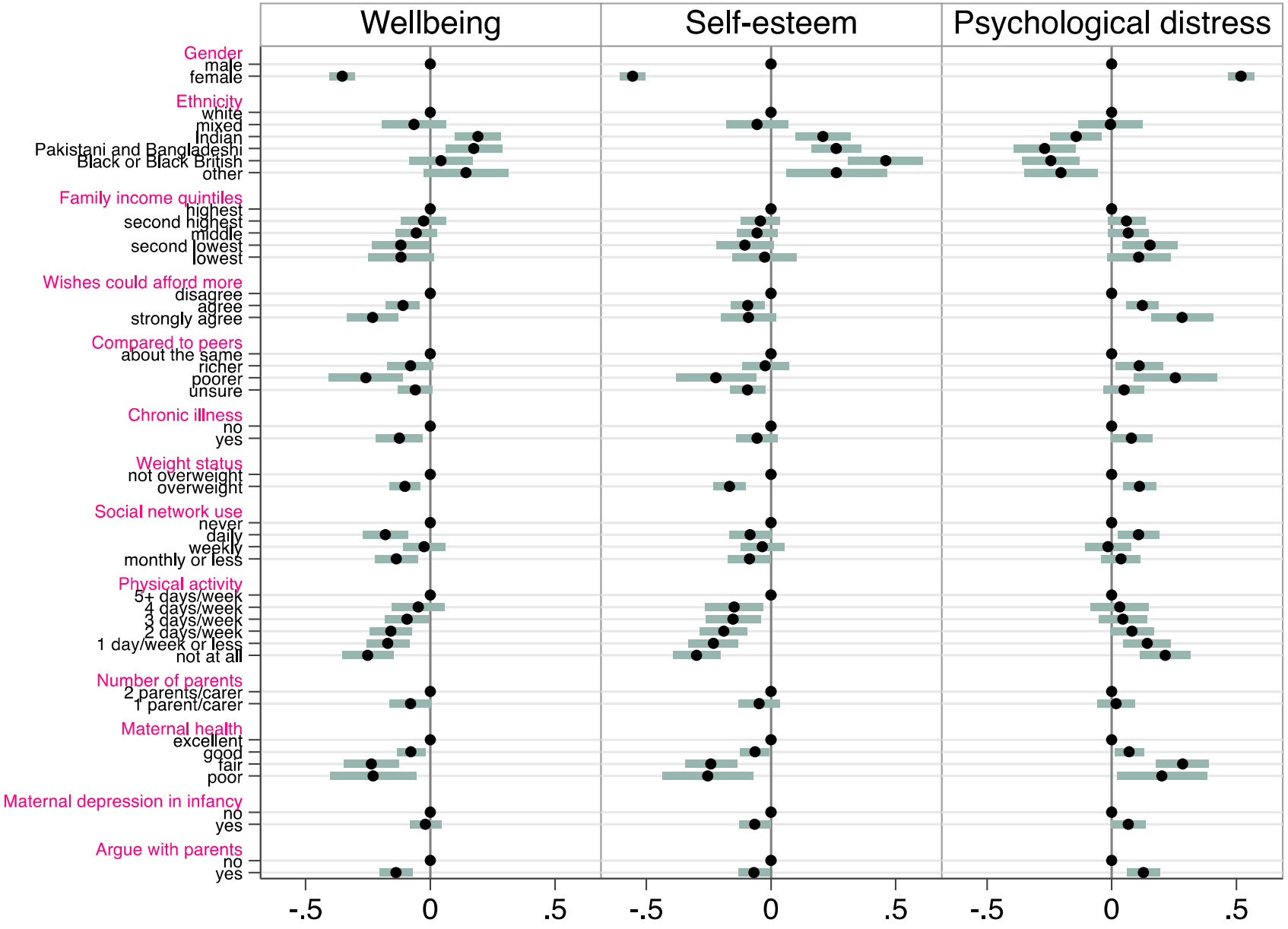
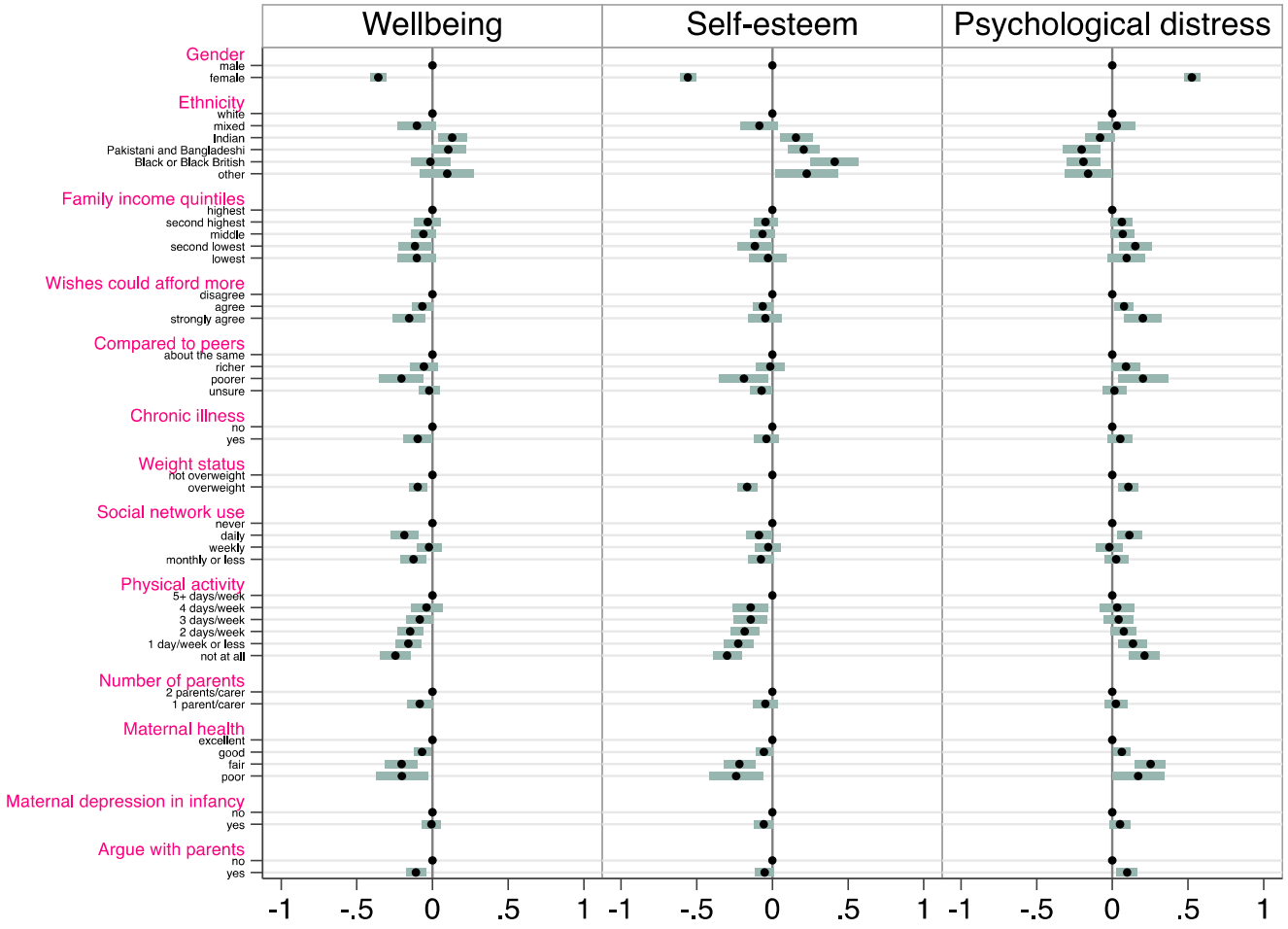
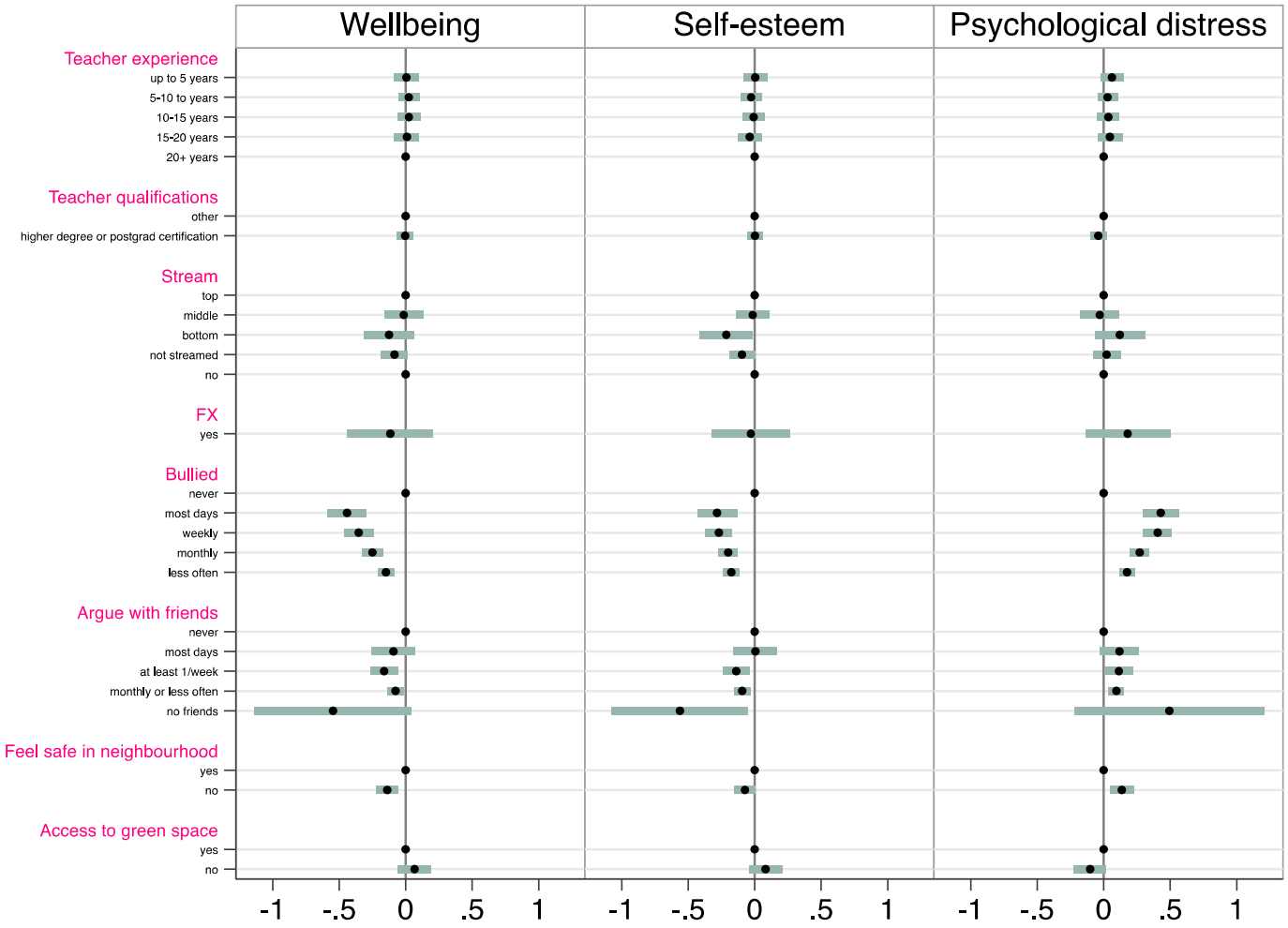


Figure 2.3 Demographic, socio-economic, individual-, family-, school- and community-level drivers of mental and emotional health at age 14 (full model; continued on next page)




Wellbeing
Self-esteem
Psychological distress
Teacher experience
up to 5 years
5-10 to years
10-15 years
15-20 years
20+ years
Teacher qualifications
other
higher degree or postgrad certification
Stream
top
middle
bottom
not streamed
no
FX
yes
Bullied
never
most days
weekly
monthly
less often
Argue with friends
never
most days
at least 1/week
monthly or less often
no friends
Feel safe in neighbourhood
yes
no
Access to green space
yes
no
-1
-.5
0
.5
1

The young people spoke extensively about social media, highlighting both the negative and positive aspects for mental and emotional health. While this discussion was dominated by the female participants, the boys also agreed with the statements including those around body image. They did however suggest that some of the pressure being created could be aspirational – underlining the difference in experience. The young people also acknowledged the importance of controlling how you use social media to limit negative impacts.

'Social media can have quite a drastic impact on mental health'

'Beauty standards and what other people think, and [what] other people look like, can make you think that's how you're meant to look'

'You can meet people online – I have loads of online friends. Sometimes it's easier to talk to people online rather than in real life'

'People younger than us on social media don't know what's real and what's not'

'*Comments on social media can be vile – people are vile to each other. It's the same in school – people do make comments on people's bodies'*

'There's so much going on – and if you don't have social media you can't see what's actually happened'

'On social media it's easy to sort of like build a life – like a fake life and make it seem like everything's perfect'

'There's people in our year that I compare myself to'

'Rumours on social media can lead to bullying'

'At the same time, it's how you use it and what you choose to see'

Drivers of wellbeing, self-esteem and psychological distress at age 17

We ran the same models for our outcomes at age 17, except we looked at the impact of social media use and physical activity at age 14 rather than in childhood. In addition, to simplify the model, we removed the school-level variables from the model, given the relatively weak or lack of associations at age 14.

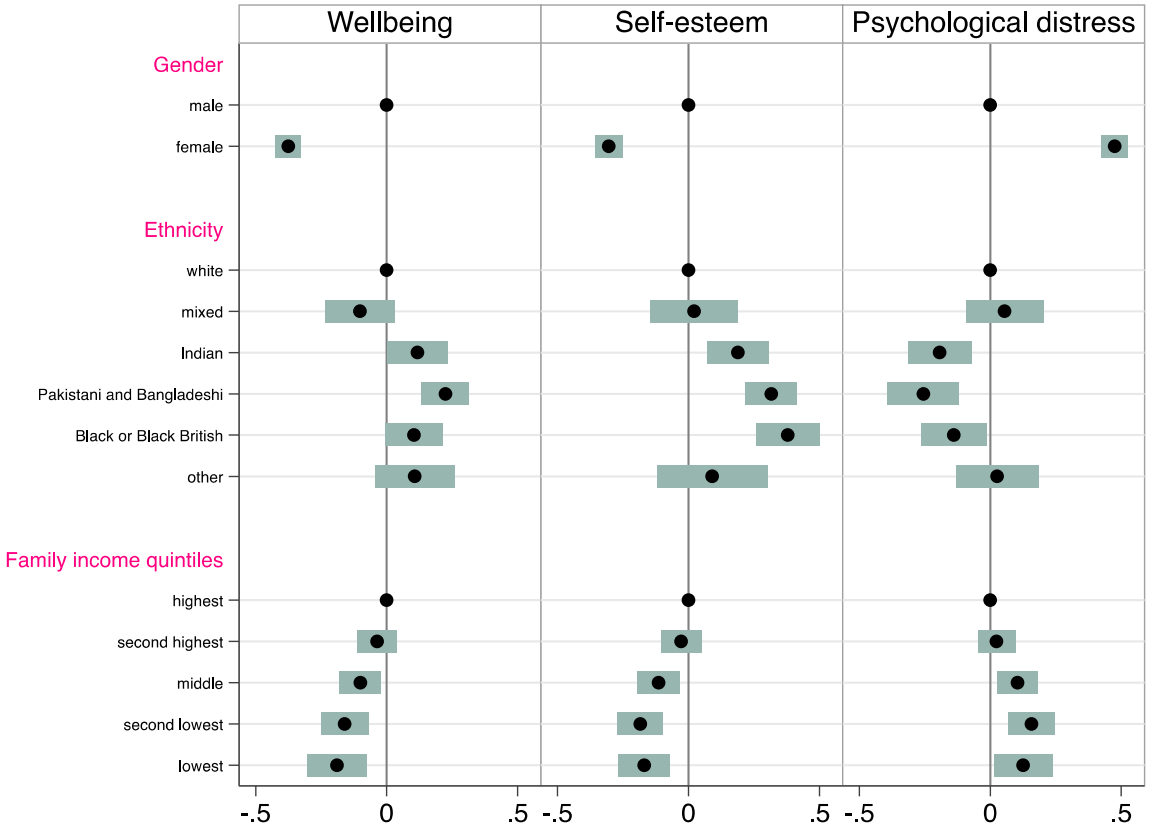
Figure 2.4 presents a simple model adjusting for gender, ethnicity and family income. We find a similar relationship between these factors and wellbeing, self-esteem and psychological distress at age 17 as at age 14.

The young people spoke about the links between mental and physical health.

'If a person is struggling mentally it can [affect] their body physically too – like with their daily routine'

'When your mental health is low, you can lack motivation to exercise'

Figure 2.4 Demographic and socio-economic drivers of mental and emotional health at age 17 (base model)



Broadly, the same factors are important for mental and emotional health at age 17 as at age 14 (Figures 2.5 and 2.6).

Perception of socio-economic circumstances in childhood continues to have an impact on wellbeing and psychological distress at age 17, although not self-esteem. Having a chronic illness in childhood is linked to lower self-esteem and higher psychological distress at age 17, while being overweight is linked to lower self-esteem. We find a significant relationship between heavy social media use at age 14 and worse self-esteem and higher psychological distress at age 17. We do not find a similar relationship between heavy social media use and wellbeing, contrary to findings at age 14. We also find a graded relationship with physical activity, similar to age 14. Worse maternal health is predictive of higher psychological distress at age 17; while not statistically significant at all levels, we also find an association with worse wellbeing and self-esteem scores. Contrary to the findings for young people age 14, we find an association with maternal depression in infancy and higher psychological distress at age 17. Frequent arguing with parents is linked to lower wellbeing at age 17, while at age 14 it is associated with both worse wellbeing and higher psychological distress. Peer factors continue to have an effect in later adolescence, with experiences of bullying particularly strongly associated with psychological distress. Feeling unsafe in the neighbourhood also has a negative impact on wellbeing and psychological distress, while lacking access to green space in childhood is associated with worse wellbeing at age 17.

Figure 2.5 Demographic, socio-economic, individual- and family-level drivers of mental and emotional health at age 17 (model 2)

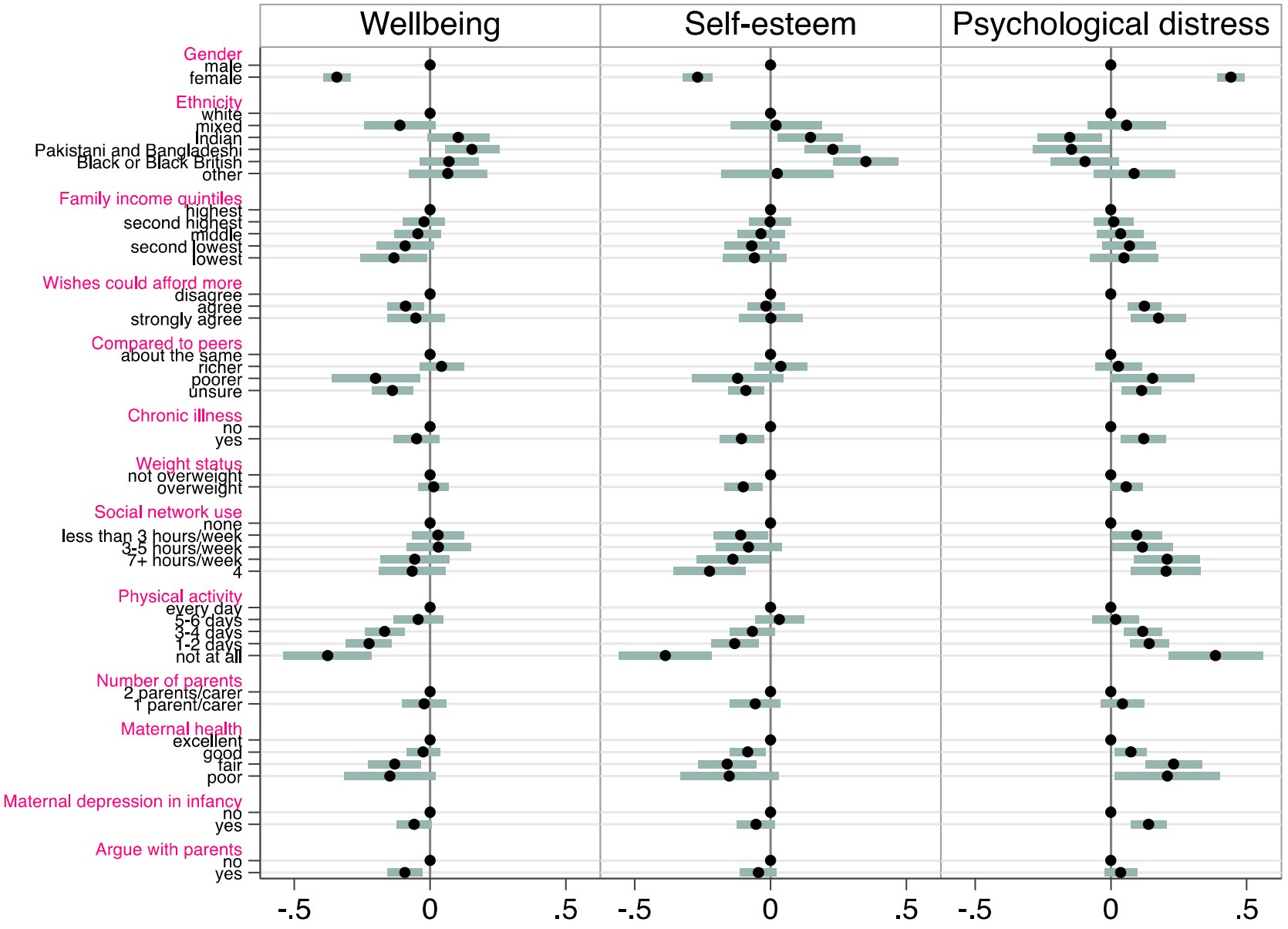
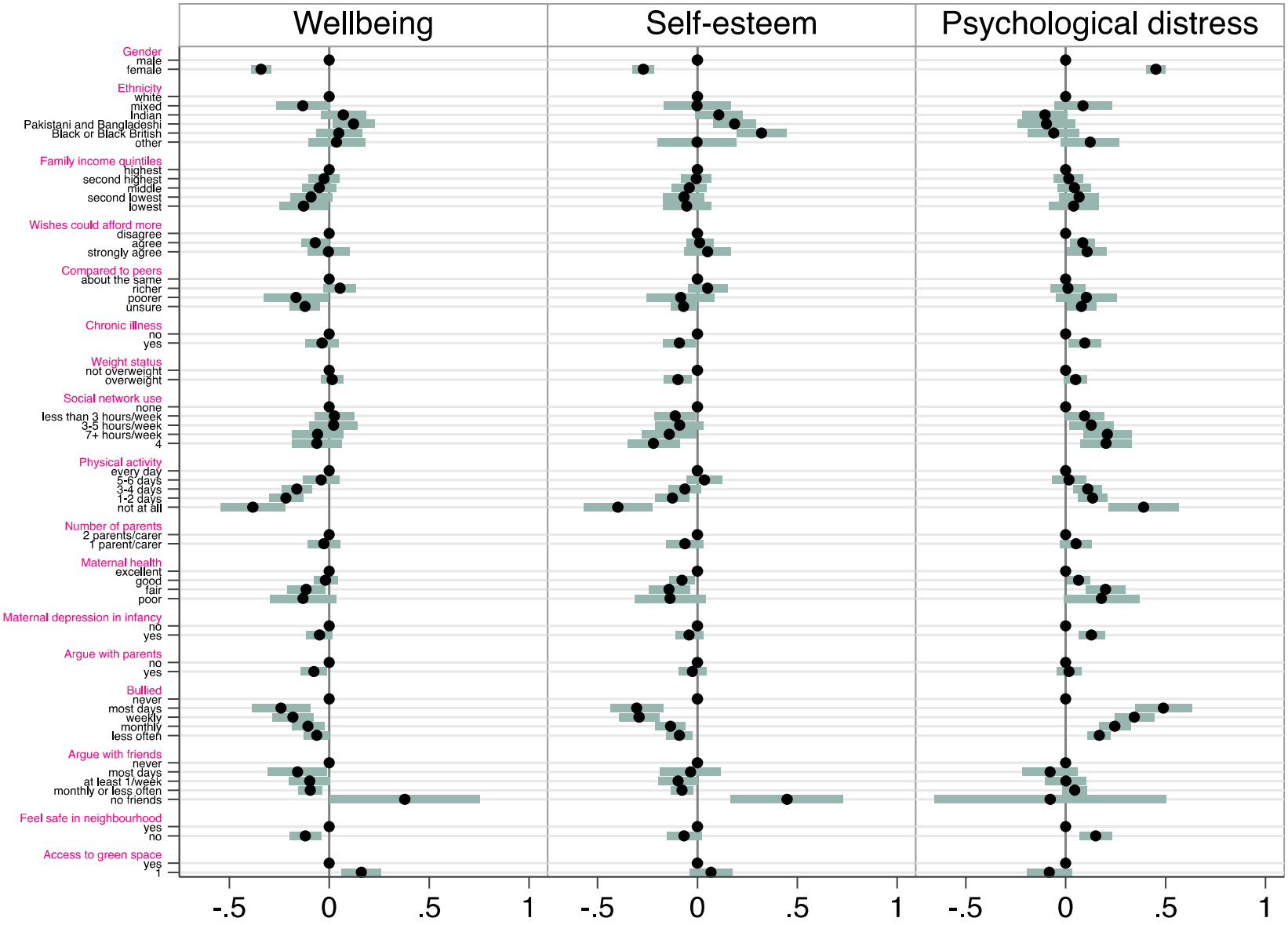


Figure 2.6 Demographic, socio-economic, individual-, family- and community-level drivers of mental and emotional health at age 17 (full model)



Gender differences

Given the gender differences in mental and emotional health in adolescence, and the significance of gender interaction terms in the model, we generated results separately by gender (Figures 2.7 to 2.10). We find substantial differences in the effect of factors on girls' and boys' mental and emotional health.

We find that the graded relationship with income is apparent primarily in girls at both ages, although we see a social gradient, albeit not a statistically significant one, in boys' psychological distress scores at age 14 and wellbeing scores at age 17. Perceptions of socio-economic position are also more important for girls' mental and emotional health at age 14.

Being overweight is associated with poorer scores on all three outcomes for girls at age 14, and poorer self-esteem and higher psychological distress for boys.

Daily social media use is associated with worse score on all outcomes in girls age 14, but only worse wellbeing for boys at age 14. Physical activity appears to be more important for boys' mental and emotional health in early adolescence, with a graded relationship between frequency of exercise and scores on all three outcomes at age 14; at age 17, we see a graded relationship in both girls and boys.

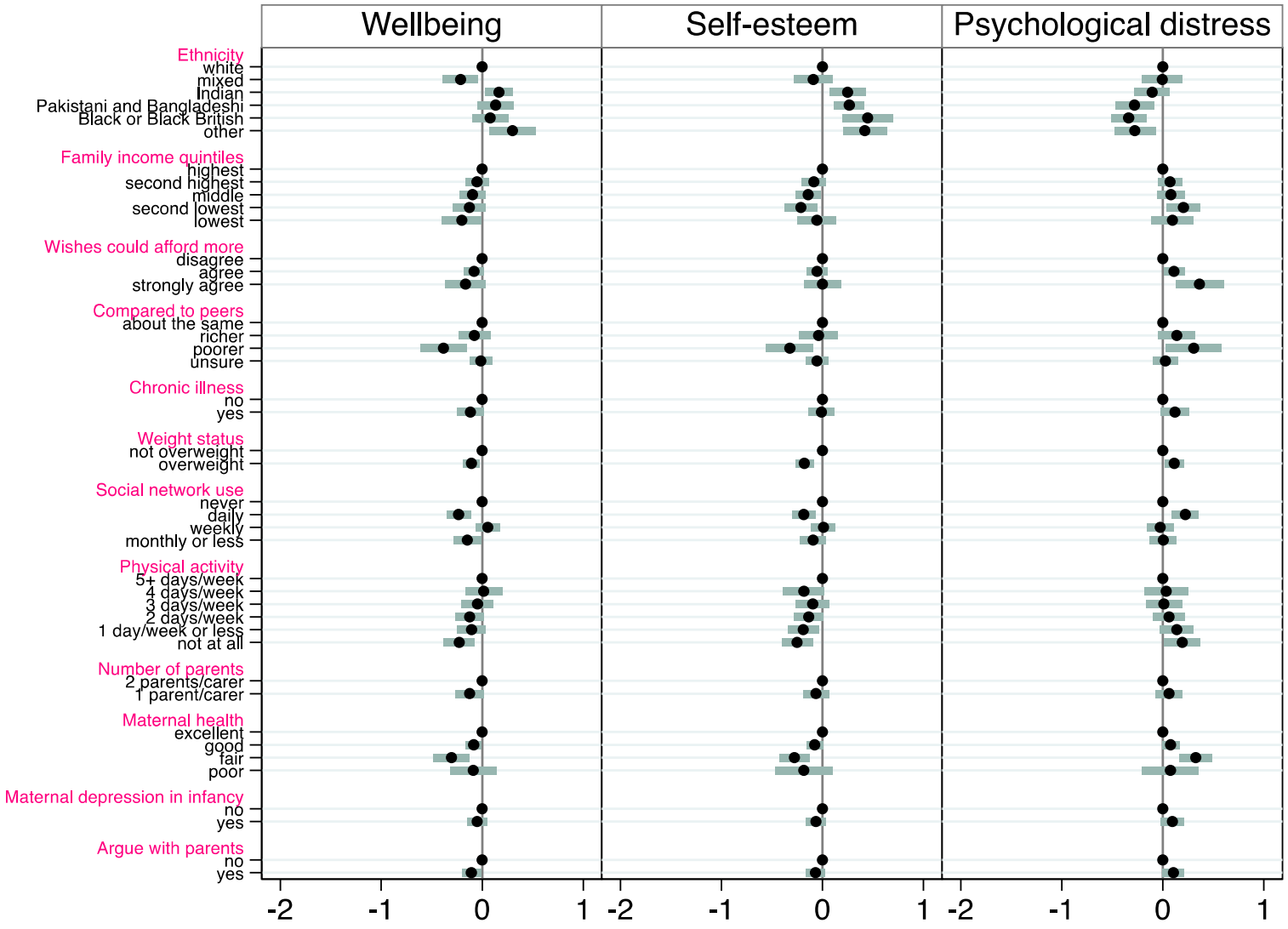
Poor maternal health is predictive of worse scores on all three outcomes in both girls and boys in early adolescence, and maternal depression in infancy is associated with girls' psychological distress level at age 17. Frequent arguments with parents are associated with lower wellbeing in boys age 14 and lower wellbeing in girls age 17.

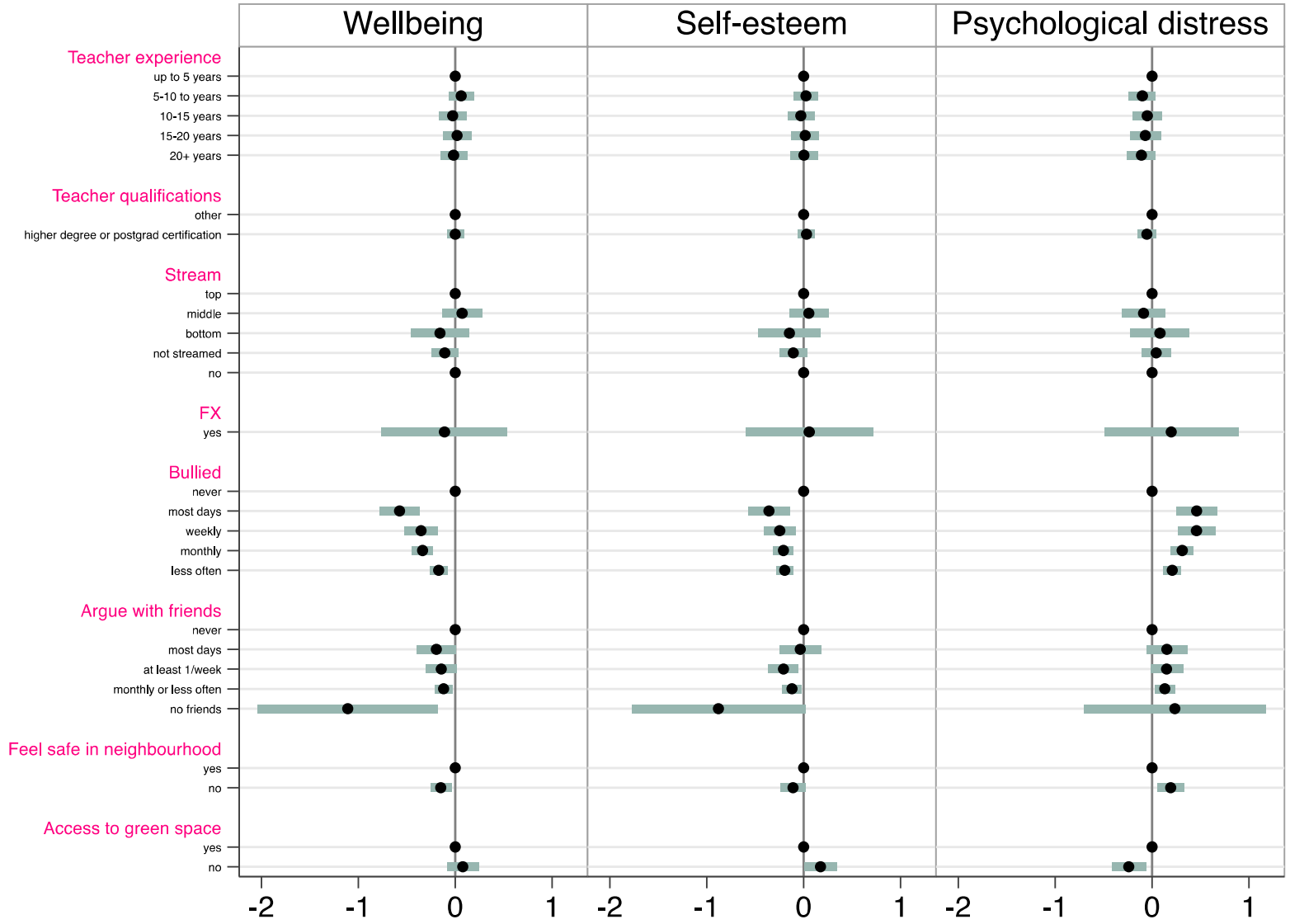
Placement in a low stream in primary school appears to be particularly significant for boys' self-esteem, while experiences of bullying in childhood are important throughout adolescence for both boys and girls.

At both ages 14 and 17, feeling unsafe in one's neighbourhood is significantly predictive of worse wellbeing and higher psychological distress for girls only.

We also ran models looking at self-esteem and wellbeing at ages 14 and 17, separately by gender, controlling for pre-existing levels of self-esteem and wellbeing to identify factors associated with the change in these outcomes in adolescence (Annex 1). We were unable to do the same for psychological distress as children were not asked to report on their psychological state at age 11. Broadly speaking, the same factors remain associated with worse self-esteem and wellbeing scores. Notably, we find that heavy social media use remains associated with low wellbeing in both boys and girls at age 14, girls at age 17, as well as low self-esteem in girls at both ages. We also find that low levels of physical activity remain predictive of low wellbeing and self-esteem for both boys and girls through adolescence. This suggests that regardless of a young person's pre-existing emotional health status, heavy social media use and low levels of physical activity are linked to worse wellbeing and self-esteem as young people get older.

Figure 2.7: Full model girls age 14 (continued on next page)




Wellbeing
Self-esteem
Psychological distress
Teacher experience
up to 5 years
5-10 to years
10-15 years
15-20 years
20+ years
Teacher qualifications
other
higher degree or postgrad certification
Stream
top
middle
bottom
not streamed
no
FX
yes
Bullied
never
most days
weekly
monthly
less often
Argue with friends
never
most days
at least 1/week
monthly or less often
no friends
Feel safe in neighbourhood
yes
no
Access to green space
yes
no
-2
-1
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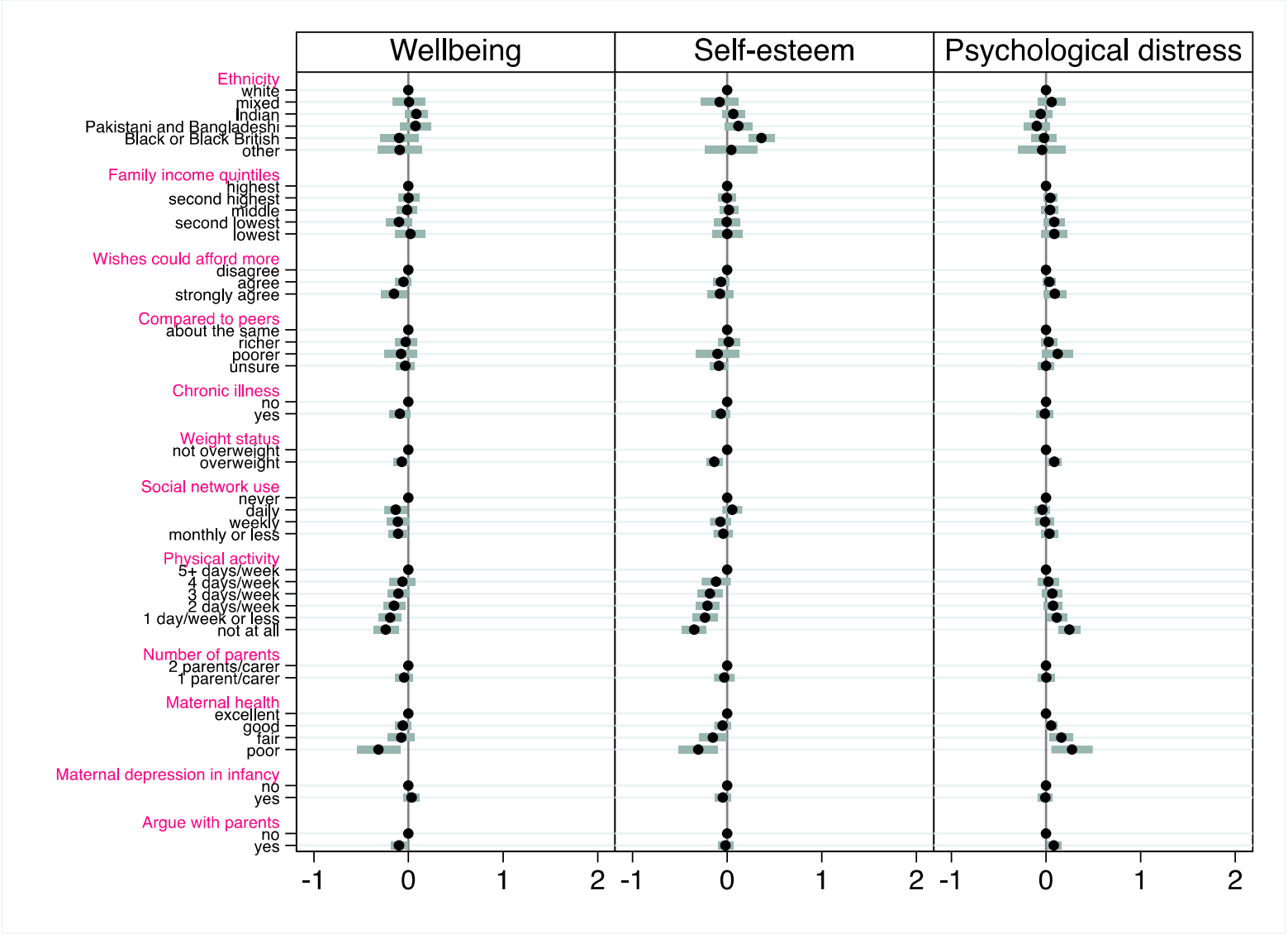
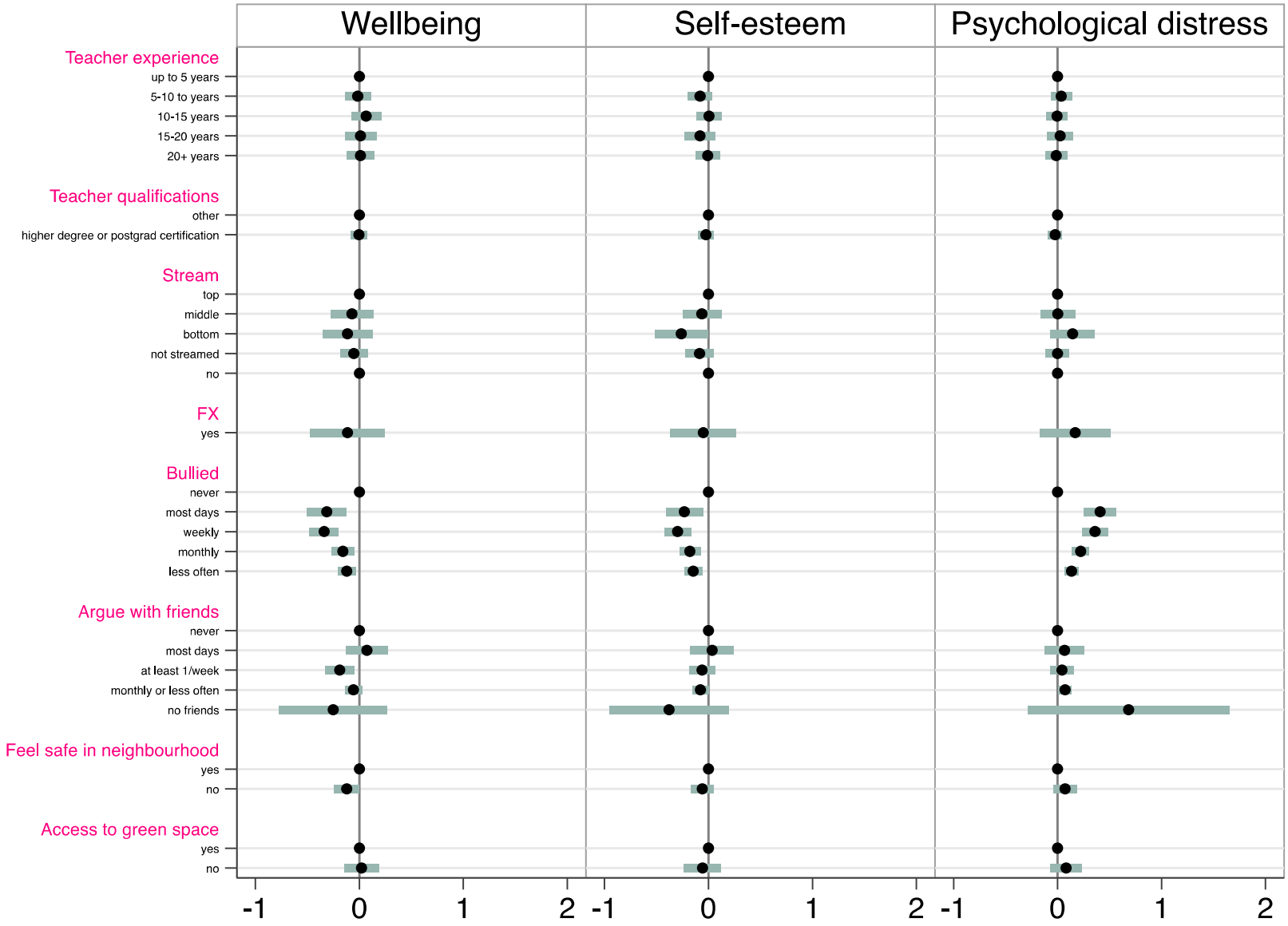
1

Figure 2.8 Full model boys age 14 (continued on next page)

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15-20 years
20+ years
Teacher qualifications
other
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most days
weekly
monthly
less often
Argue with friends
never
most days
at least 1/week
monthly or less often
no friends
Feel safe in neighbourhood
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Access to green space
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Figure 2.9: Full model for girls at age 17

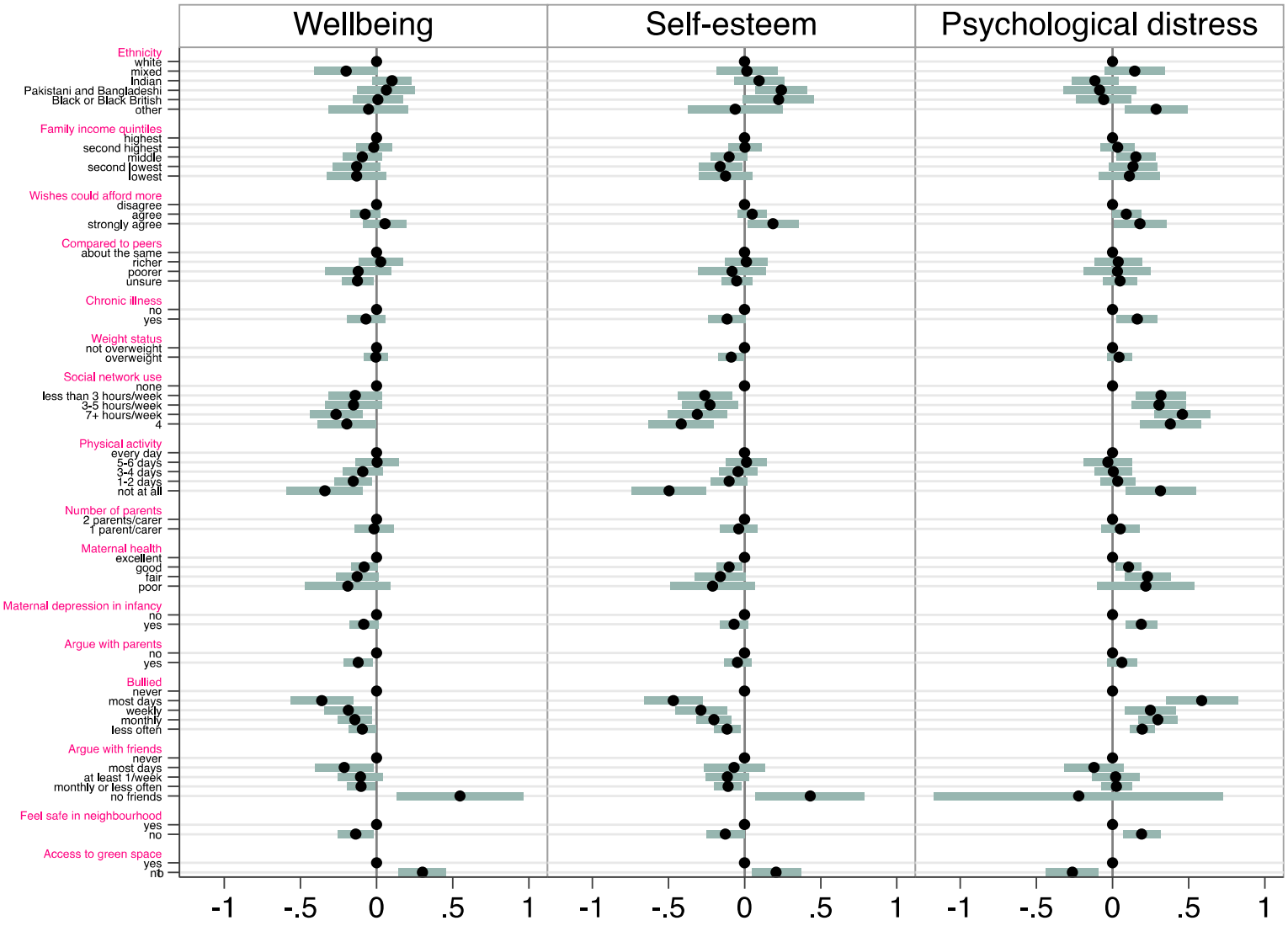
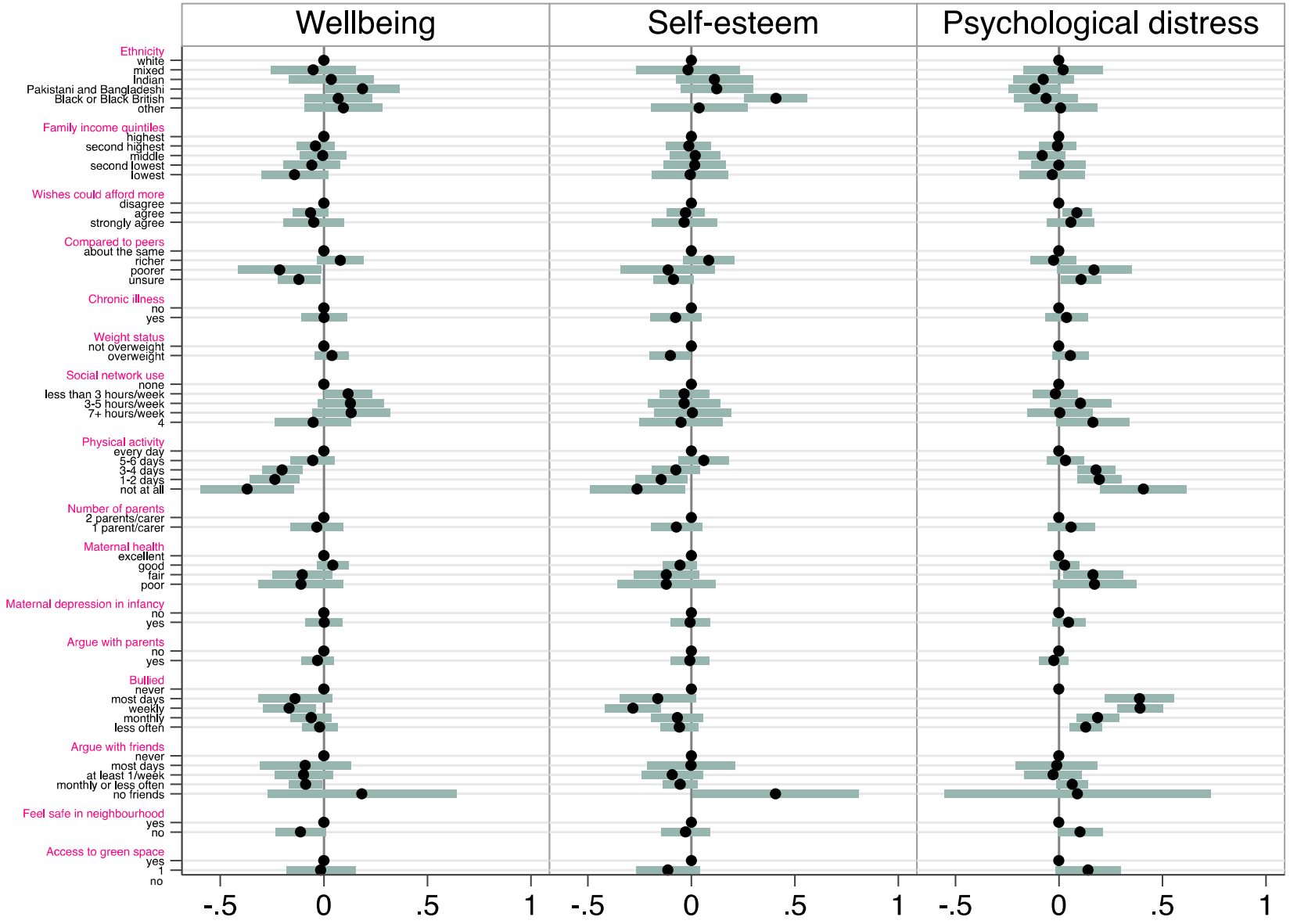


Figure 2.10: Full model for boys at age 17



Conclusion and policy recommendations

The transition from childhood to adolescence is a turning point for mental and emotional health, especially for girls. As most lifelong mental health issues are seeded in adolescence and early adulthood, it is clear that any strategy to reduce the burden of mental ill-health for the population as a whole should prioritise interventions in this early period of life.

An effective strategy requires expanding current thinking beyond mental healthcare. Focusing primarily on specialist care means a reactive approach to illness once it has developed, at which point interventions are more costly and less likely to be effective. In the case of mental illness, as with chronic physical health issues, many conditions can only be managed once they are established.

Policymakers should refocus on prevention and early intervention, and expand current thinking around these approaches. While mental health support teams will possibly be a step in the right direction, the risk is that these are seen as ticking this box, when it is unclear exactly what role they will play or when all children across the country will benefit from them.

Prevention is about creating the conditions that are conducive to healthy psychological development and functioning for children and young people. This means policies that go beyond the mental health sector to include economic and social factors, the upstream determinants of mental health – also known as a **mental health in all policies** approach.

The findings of our analysis add to the existing body of evidence showing that targeting socio-economic factors would have an impact on young people's mental health. We find that socio-economic circumstances, according to both objective measures and children's perceptions of their family's position on the socio-economic ladder, are strongly predictive of both mental and emotional health.

Our findings also confirm the importance of the social dimension of life – including young people's relationships with their parents and peers – and show the lasting impact of social experiences in childhood, particularly bullying, on adolescent mental health. The quality of family relationships has been shown to be affected by financial stress, suggesting that policies targeting socio-economic factors could also have an impact on these important drivers of young people's mental health and wellbeing.[34,35] We know from existing research into adolescent brain development that peer influence is particularly strong in this period of life, and further research on policy action to harness this to support young people's wellbeing is necessary.

Our findings also confirm the importance of habits including physical activity and social media use. As social media has become a fully integrated part of young people's lives, we must ensure that young people are equipped with the tools to engage with it in ways that do not adversely affect their mental health.

Investing in the prevention of mental health issues, through targeting upstream determinants, is likely to have a knock-on effect in other areas. Existing research shows that mental health is strongly, and possibly causally, related to educational attainment.[36] This means that young people's mental health is a mechanism through which intergenerational social inequity can be transmitted. The gender divide in mental and emotional health as young people enter working age, particularly in areas of self-esteem, raises questions about the extent to which this contributes to the gender pay gap. The Lancet Commission on Adolescent Mental Health and Wellbeing calls the promotion of

education and health 'synergistic goals': health and wellbeing interventions boost educational attainment while educational attainment, and the opportunities it provides, boosts health and wellbeing.[31]

The young people we spoke with showed a clear desire for change to the current approach. Several indicated that more attention should be paid to mental health starting in primary school.

'Schools should be more aware of these things and have more training'

'If school helped us out about and gave us suggestions of different things we could do to take action for ourselves that would be good.'

'[Government] should spend money on more space[s] for young people'

'They should discuss it more in school. It would be helpful to have a separate subject on mental health. It should be taught from primary school'

[In primary school,] there was anti-bullying stuff, but there was never a big emphasis on how your actions can make others feel. Talking about it would [normalise it] because you do it from a young age.'

'[We should be] educating teachers, parents, kids, everyone'

'Kids should know who to talk to and that they're allowed to – and if they're not taught that it gets worse'

'I think it is important that schools talk about [mental health] and give you support, because that's where young people spend most of their time'

Based on this research, and in light of the risk of the pandemic leading to a deterioration of young people's mental health and wellbeing, the Education Policy Institute have developed the following recommendations for the UK government. The Prince's Trust will endeavour to work in partnership with government and schools to take these recommendations forward, where appropriate. Recommendations are presented in order of more contained action to larger, cross-government policies likely to result in long-term positive change. The government should:

Release a £650m wellbeing funding package to schools to match academic catch-up funding. The number of children with a probable mental illness has risen to one in six since the advent of the pandemic; a substantial number will be struggling with their mental health but fail to meet diagnostic thresholds. Beyond pandemic-related stress, known drivers of poor mental and emotional health, including financial insecurity and limited social support, have been exacerbated by the lockdown, its economic fallout and school closures. The current policy focus in schools is on academic catch-up but remedial wellbeing work will be necessary to achieve this catch-up, alongside investment in socio-emotional development interventions. The wellbeing funding should be targeted to schools with disadvantaged intakes and a high proportion of children with special educational needs and disabilities. A £650m package would allow schools, where required, to hire additional staff to deliver mental health support to pupils and teaching staff, run interventions to address socio-emotional skills' gaps, improve links with local CAMHS, and deliver training to teachers.

Publish a plan for rollout of a four-week waiting time for specialist mental healthcare across the country including clear details about funding and staffing requirements. Increasing access to timely care must continue to be a priority for those children who need it, and the government should make clear when and how all children in the country will be able to quickly access the treatment they need.

Build on existing mental health content in the Health Education and Relationships and Sex Education curriculum. This should help young people to understand how different characteristics, identities, and backgrounds, and existing stereotypes about these, can affect mental and emotional health. It should cover the impact of conventional beauty standards spread by advertising and on social media platforms on body image, particularly for girls, and address the stigma young people may face for having different body types or gender expression. Evidence-based techniques to support good mental health and reduce psychological distress, such as mindfulness, should be promoted. Pathways to access different types of support should be clearly laid out. Schools should be advised to engage with parents and carers to ensure they are equipped with the same knowledge. Where relevant, schools should be encouraged to work with external organisations with expertise in this area to enhance delivery. Given the importance of peer influence in this period, maximising mental and emotional health literacy amongst young people will equip them with the tools to support not only their mental and emotional wellbeing, but that of their peers as well.

Improve the capacity of school leaders and teachers to support children with mental and emotional health needs. School leaders should be encouraged to spend time in alternative provision (AP) settings as part of ongoing CPD or prior to entering into a leadership role. The majority of young people in AP struggle with mental or emotional health difficulties. It is crucial for leaders to know how to best support children with additional needs including how to employ trauma-informed approaches in the classroom, and to be able to cascade this knowledge to teaching staff. Survey findings show that many teachers do not feel equipped to deal with pupils' mental and emotional health issues.[2] While it is not the job of teachers to provide mental healthcare, given the proportion of children who struggle with their mental health it is inevitable that most will encounter these issues in the classroom. **As such, local Mental Health Support Teams should deliver training in all areas to school staff to ensure that mental health support is embedded across the school community.** Schools are the most important, non-stigmatised setting where young people can seek advice and support, and policymakers must ensure leaders and teachers are equipped to offer it.

Develop an evidence-informed policy to tackle bullying including clear plans for funding, delivery and accountability. This could involve more evidence-based guidance from DfE for schools on preventing and tackling bullying – guidance that should be statutory to comply with Equalities legislation when bullying is based on protected characteristics, such as race, gender or (dis)ability – and/or changes to Ofsted's inspection framework. Evidence shows that interventions which create understanding of and accountability for harm caused by bullying are more effective than punitive action: these include anti-bias training, bystander intervention training, peer support programmes and restorative approaches.[3]

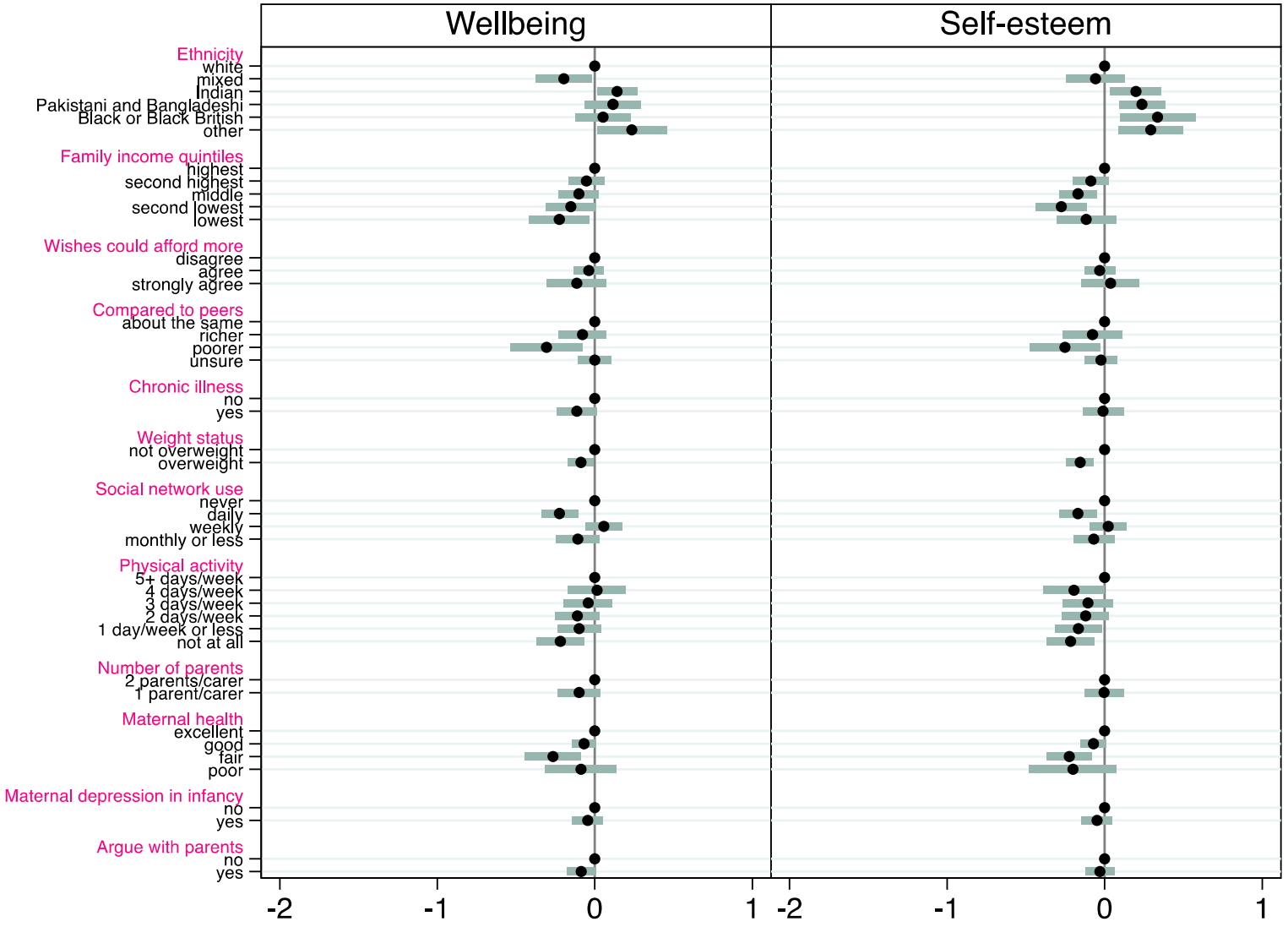
Ensure that all young people have access to options for engaging in physical activity, including non-competitive activities, in their local area. Commission research, working with diverse young people, to identify scalable interventions to increase activity among children and adolescents. This research should include a critical assessment of how physical education is currently delivered in schools and address the areas that require improvement.

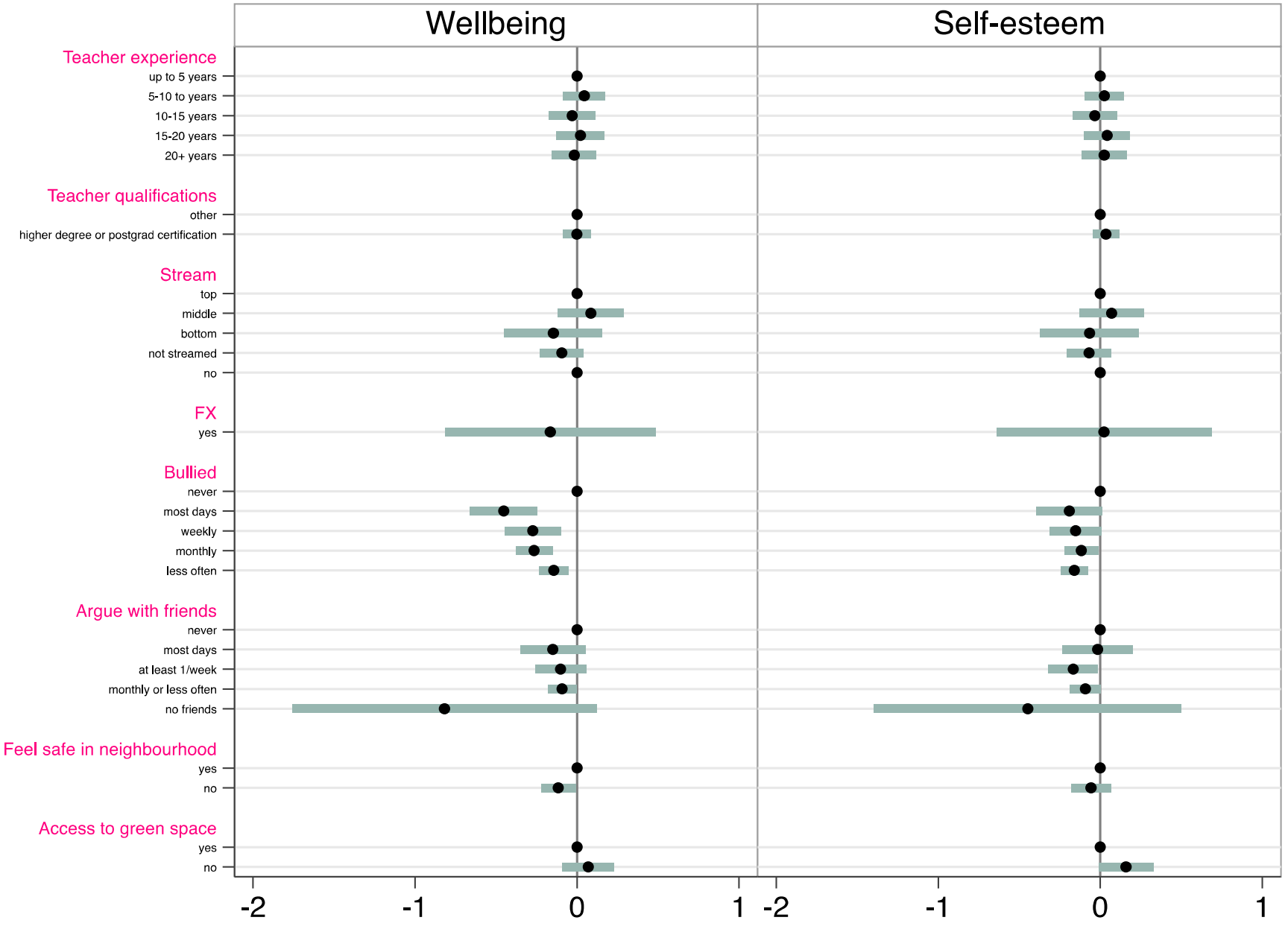
Increase funding to local mental health providers to allow them to better identify and work together to support children with needs which do not meet diagnostic thresholds. Current thresholds for access to specialist mental health treatment are high meaning that many children have to reach a crisis point before they are able to access care. A system focused on identifying difficulties early and providing sustained support to prevent them from worsening would reduce the suffering of young people and their families as well as the high costs of more complex interventions.

Develop a cross-government and cross-sector strategy to reduce family poverty and ensure young people feel safe in their communities. Given the social gradient in mental and emotional health for young people as well as adults, the strong links between poor mental health in adolescence and adult mental health problems, and the interconnectedness of parental and child mental health, this would reduce the burden of mental illness and poor wellbeing in the population as a whole. Poverty, which has risen amongst families with children in the last decade, leads to worse population health generally and increases the need for more costly, late intervention putting pressure on squeezed health services.[4] Given the high and rising number of families living in in-work poverty, this strategy must go beyond getting people into work.[5]

Annex: Factors associated with the change in wellbeing and self-esteem scores through adolescence

Figure A1. Drivers of wellbeing and self-esteem in girls age 14, controlling for childhood wellbeing and self-esteem (continued on next page)




Wellbeing
Self-esteem
Teacher experience
up to 5 years
5-10 to years
10-15 years
15-20 years
20+ years
Teacher qualifications
other
higher degree or postgrad certification
Stream
top
middle
bottom
not streamed
no
FX
yes
Bullied
never
most days
weekly
monthly
less often
Argue with friends
never
most days
at least 1/week
monthly or less often
no friends
Feel safe in neighbourhood
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Access to green space
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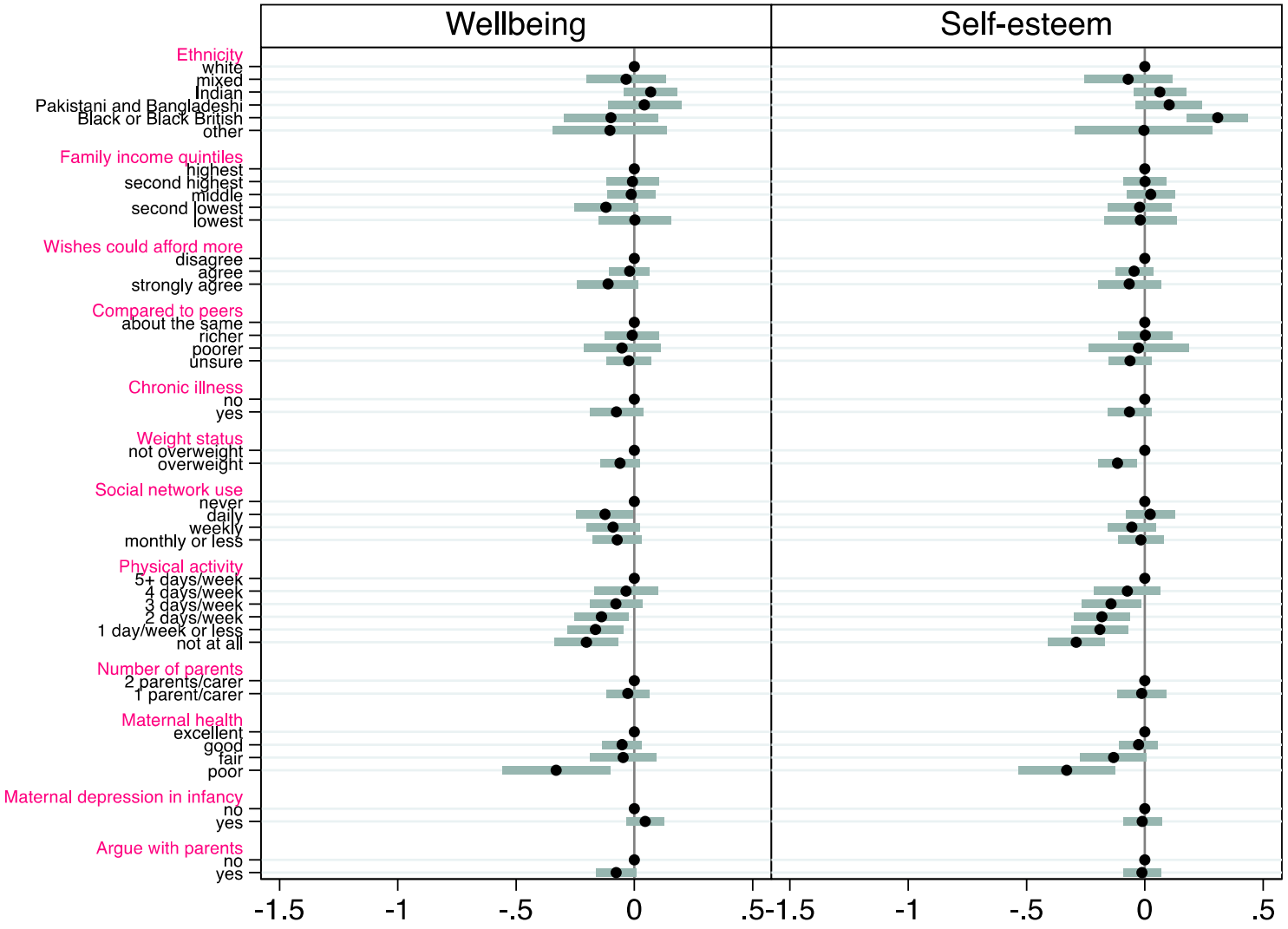
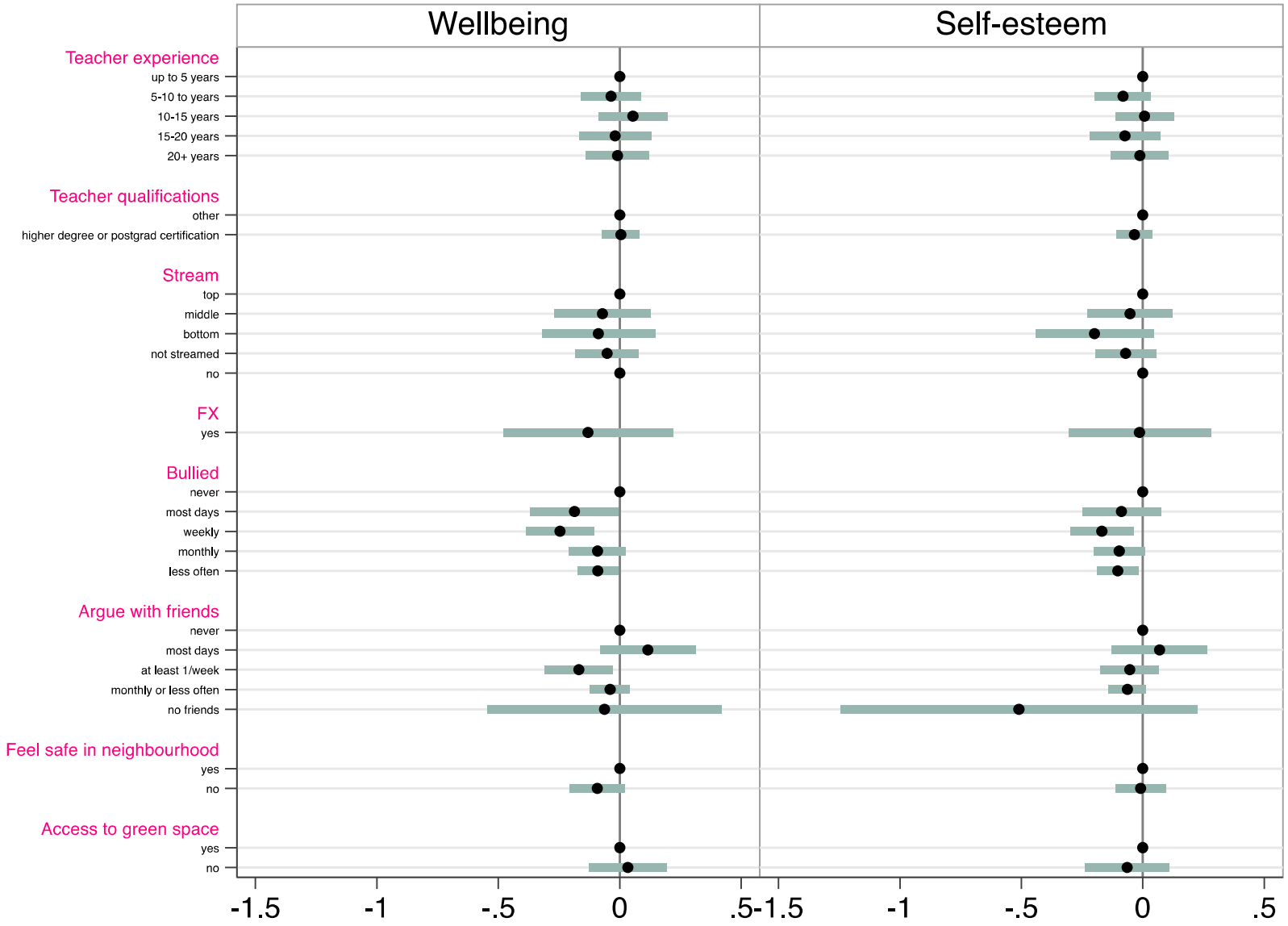
Figure A2. Drivers of wellbeing and self-esteem in boys age 14, controlling for childhood wellbeing and self-esteem (continued on next page)




Wellbeing
Self-esteem
Teacher experience
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20+ years
Teacher qualifications
other
higher degree or postgrad certification
Stream
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most days
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monthly or less often
no friends
Feel safe in neighbourhood
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Access to green space
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Figure A3. Drivers of wellbeing and self-esteem in girls age 17, controlling for childhood wellbeing and self-esteem

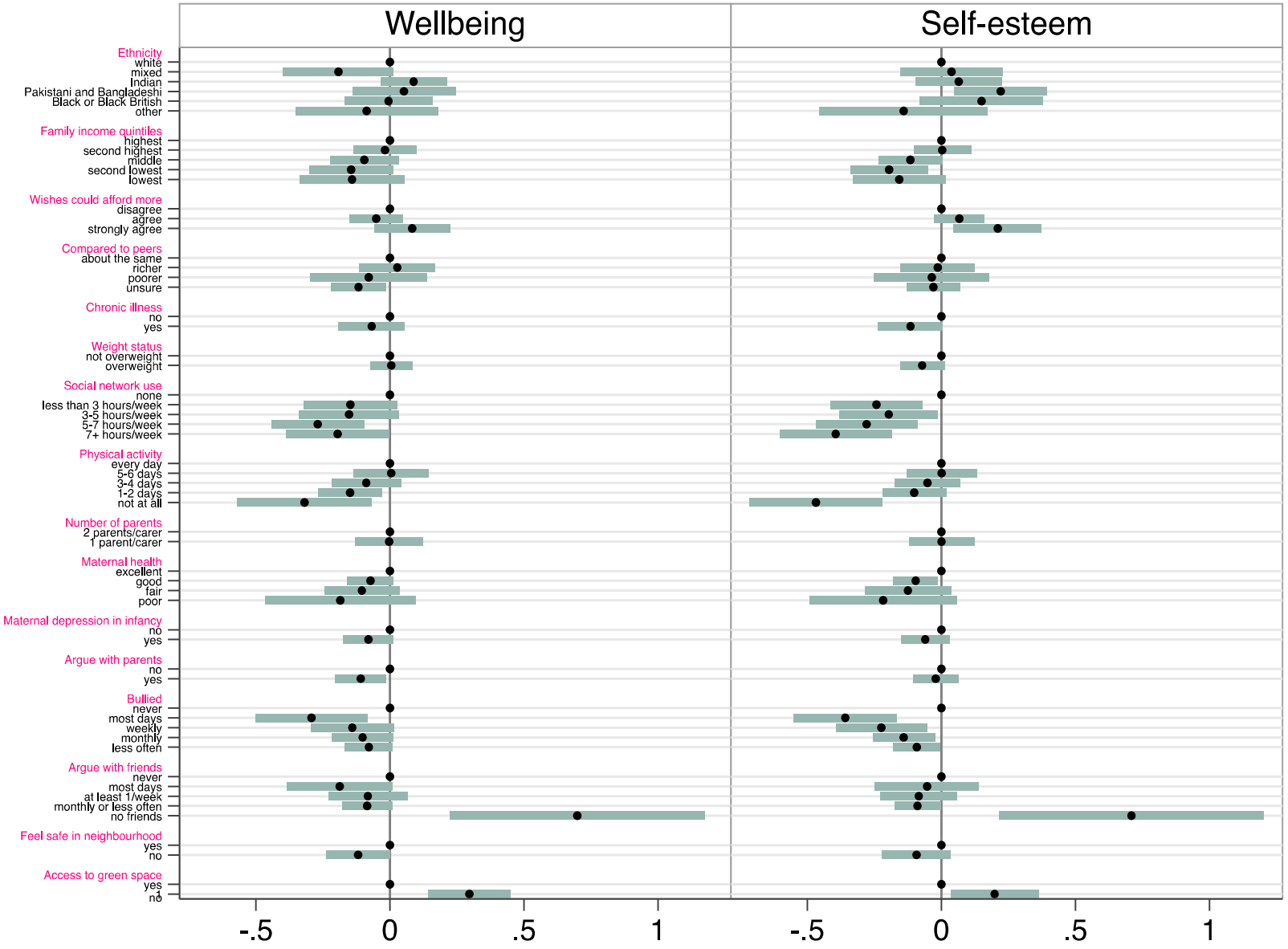
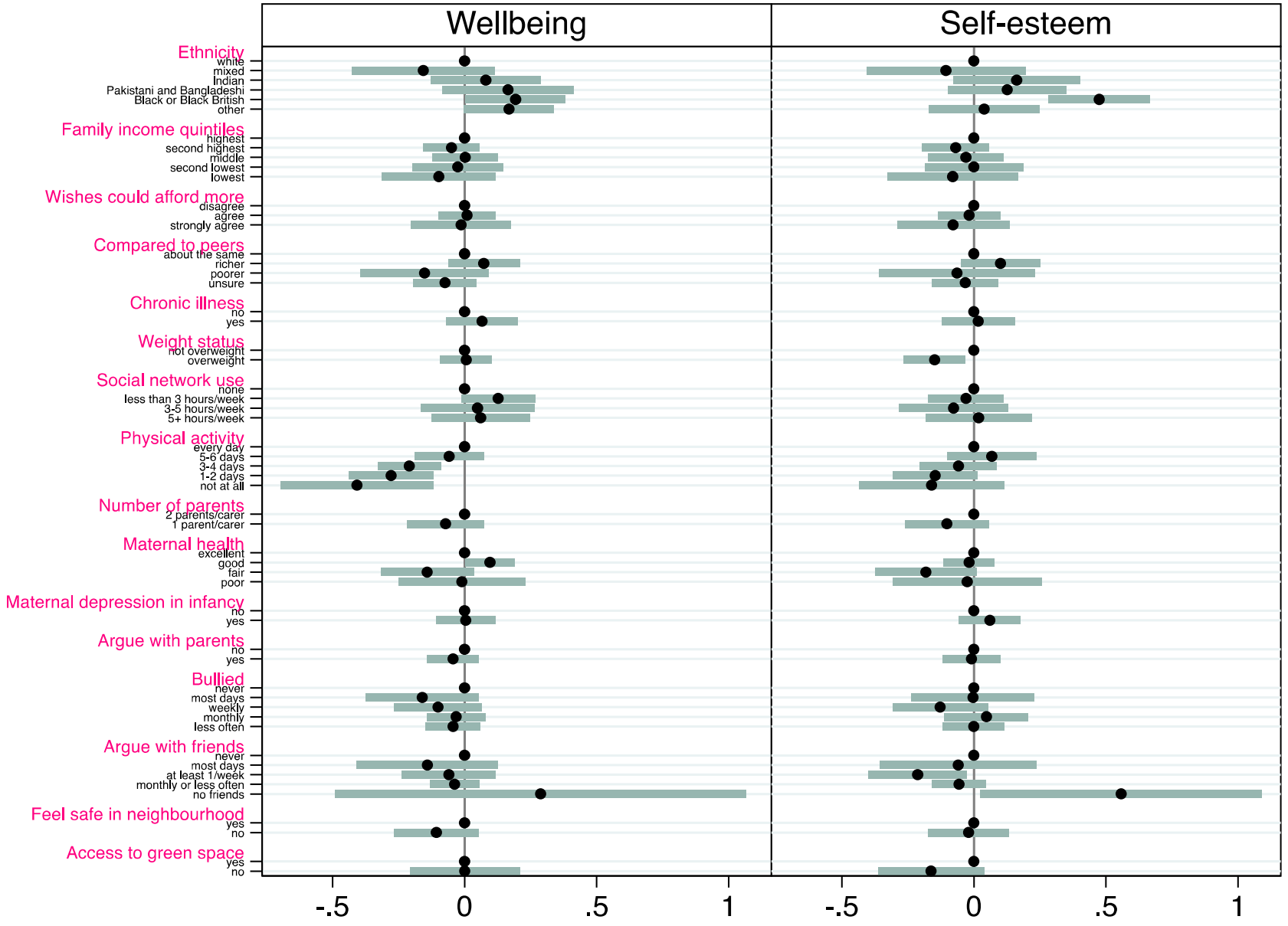


Figure A4. Drivers of wellbeing and self-esteem in boys age 17, controlling for childhood wellbeing and self-esteem



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