HeadStart national evaluation final report

Supporting the mental health and wellbeing of children and young people: the role of HeadStart

May 2023

COMMUNITY FUND

Evidence Based Practice Unit

A partnership of

Anna Freud

UCL

Contents

Collaborators

CORC Child Outcomes Research Consortium

An Anna Freud project

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Executive summary

Background

In recent years we have witnessed an escalation in mental health problems for children and young people and a corresponding decrease in wellbeing. Young people themselves have identified mental health as an area of concern that they believe requires more prominence and greater investment.

What was HeadStart?

HeadStart was a six-year, £67.4 million National Lottery funded programme set up by The National Lottery Community Fund, the largest funder of community activity in the UK. It aimed to explore and test new ways to improve the mental health and wellbeing of young people aged 10–16 and prevent serious mental health issues from developing. To do this, six local-authority-led HeadStart partnerships in Blackpool, Cornwall, Hull, Kent, Newham and Wolverhampton worked with local young people, schools, families, charities, community services and public services to make young people's mental health and wellbeing everybody's business. The programme was designed to test and learn – to try new approaches and be innovative – with the intention being to sustain and embed effective approaches locally. The HeadStart programme ended in July 2022.

This report

This report describes the reach, implementation and impact of the programme, and our learning about the nature of mental health and wellbeing in children and young people and what influences it.

Approach

Because HeadStart was a complex programme involving many different activities across multiple sites, the evaluation took a multi-strand approach. It incorporated large-scale quantitative data collection in the form of self-report surveys from children and young people; qualitative interviews with young people, programme staff, school staff and parents; and nested summative evaluations[a] of selected interventions. The key areas of investigation for the evaluation are broadly stated below:

To find out the **nature of the problem (context and need):** what was the level and type of existing mental health need in HeadStart areas?

To find out **what help looks like (implementation and reach):** what did HeadStart areas focus on and deliver, and to whom?

To find out **whether HeadStart had a positive impact on the mental health and wellbeing of children and young people (impact):** did those receiving HeadStart support experience improvement in their mental health and wellbeing over the period of the programme? If improvements were detected, for whom, under what conditions and to what extent did HeadStart contribute to these changes?

Findings

Context and need

Data from the large-scale self-report survey indicated that experiencing a mental health difficulty was quite common among young people, with 42.5% experiencing some kind of mental health difficulty at any one time. These difficulties were more common in older young people and more common in girls than boys. Over the early adolescent period our survey data showed a general decline in young people's mental health and that this was predominantly driven by girls' mental health deteriorating markedly.

In addition to gender and age, we identified a number of risk factors that increased the likelihood that young people would experience a mental health problem. These included having special educational needs, being from a low-income family and being considered as in need of extra help or protection (having child in need [CIN] status). Findings indicated that it was not just the nature but the number

a) robust assessments of the impact of a number of HeadStart interventions in isolation, using randomised control trials (RCTS) or quasi-experimental designs

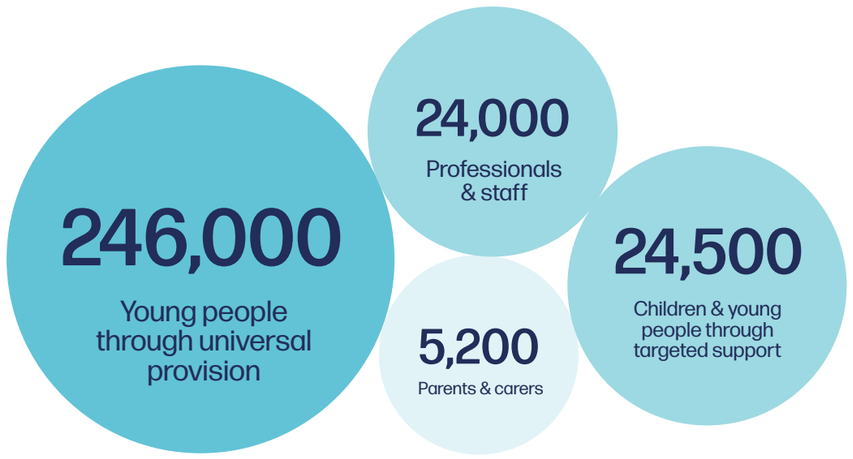
of risk factors that young people experienced that has a significant bearing on their mental health, showing a cumulative effect of challenges, circumstances and experiences. The quantitative and qualitative research also highlighted a range of protective factors that reduced the risk of experiencing a mental health problem. Key protective factors included having multiple and trusted sources of support (e.g., from family, friends and school), being able to successfully regulate emotions and having low levels of stress.

Our data also showed that mental health and wellbeing are related but distinct constructs meaning that while there was a strong relationship between the two, it was possible to experience mental health problems while also experiencing positive wellbeing and, similarly, to experience poor wellbeing but not have significant mental health problems.

Our qualitative research showed a range of approaches young people took to help them cope in the face of challenges to their mental health and wellbeing. Frequently this involved turning to trusted others for support, drawing on different people depending on what was troubling them. Young people also engaged in positive thinking and favourite activities or hobbies (e.g., creative activities and reading books) which could help them feel better and/or distract them from their concerns.

Implementation and reach

HeadStart reached 24,500 children and young people through targeted support, 246,000 young people through universal provision and 5,200 parents and carers. Over 24,000 professionals and staff across school, local authority and community settings have been trained in ways to support young people's mental health and wellbeing.[b]



b) Reach figures for the HeadStart programme (July 2016- July 2022) based on data reported to the Fund by HeadStart partnerships

HeadStart partnerships included both targeted and universal support in their approaches to supporting young people. Universal support is provision that is accessed by, not just on offer to, all young people in a given population. This could include, for example, training for school staff in understanding mental health and how to identify vulnerable pupils. In HeadStart schools, every pupil received at least one universal intervention during the programme. Some partnerships also offered interventions that they termed 'universal plus' – interventions that were made universally available but not everyone would have made use of. Targeted support, on the other hand, refers to interventions offered to select groups of young people who meet the criteria for needing additional help with their mental health and/or wellbeing. The kinds of targeted activities offered through HeadStart included professionally-led resilience training, therapy or counselling delivered on a group or one-to-one basis, parent or carer support, building relationships and connections, training for professionals, creative and physical activity to improve mental health and online support.

HeadStart partnerships experienced challenges around the implementation of the programme but were able to share useful learning as a result. For example, in order to successfully gain traction, interventions need to be sympathetic to existing practices and principles in schools and local communities, as well as the preferences of young people. In terms of wider challenges, the coronavirus pandemic had a significant impact on programme delivery with referrals slowing down, some types of support having to adapt their delivery mode significantly (often to virtual delivery) and others stopping altogether. Overall, the findings illustrate the ways in which preventive programmes like HeadStart can adapt and play a valuable part in reaching new areas of need during periods of major challenge.

In terms of sustaining HeadStart practices beyond the life of the programme, HeadStart partnerships told us that integrating with local services and fitting within existing systems as far as possible were crucial, as was developing key relationships and getting buy-in at a senior level (especially in schools).

Impact

Young people, parents and school staff all gave accounts of the benefits they perceived of HeadStart support. However, looking across the programme as a whole using our large-scale survey data, we could not identify a statistically significant impact of either the targeted or universal HeadStart support on young people's mental health and

wellbeing. This may have been due to challenges in establishing comparison groups against which to compare our HeadStart sample. It also may have been because the mixture of practices rolled out as part of this 'test and learn' programme included both interventions that did and did not achieve a significant impact. In support of this, our nested summative evaluations did indicate some effective interventions delivered through HeadStart, and some that were less effective or that needed sufficient engagement to achieve positive outcomes.

In terms of school outcomes, in the early stages of the programme we found a reduction in the rates of exclusion in schools that were in HeadStart areas compared to those that were not. We did not find any evidence that being in a HeadStart area had a positive impact on young people's attendance or attainment at school.

Findings across our qualitative studies illustrate the range of ways HeadStart had a positive impact on young people's mental health and wellbeing from the perspectives of young people themselves, school staff and parents. These studies also identified, to a lesser extent, some areas of possible improvement for HeadStart interventions. Through our qualitative investigation focusing on young people's active involvement in programme delivery, young people told us about a range of benefits they had experienced through their participation roles. These included improvements in young people's resilience, confidence and wellbeing, the development of social-emotional skills, and fostering agency, voice, and power.

Our qualitative evaluation work with HeadStart staff and local area stakeholders highlighted that HeadStart had facilitated collaboration and improved joined-up working at a local area and systems level, raised the profile of young people's wellbeing and the importance of preventing the onset of mental health difficulties, and addressed gaps in support for young people, parents and carers, and staff in school and community settings.

Conclusions and implications

Taken together, our findings illustrate the extensive reach of HeadStart within the six partnership areas and the range of influences the programme has had – from systemic changes across local areas and changes in school practices, to benefits described by young people, parents and school staff. While the programme-wide quantitative analysis did not show a net improvement in mental health and wellbeing for all those in contact with the programme, the lack of a comparison group limited our scope to robustly investigate impact.

Our summative evaluations did point to a number of effective practices, especially when engagement with these interventions was sustained over a longer period of time. We also observed some positive effects on wider school outcomes – specifically, a reduction in school exclusions during the early stages of the programme. Furthermore, the range of benefits described by young people, parents and school staff often extended beyond those measured by the evaluation survey.

The HeadStart programme provides many examples of how we might reconceptualise models of support for young people's mental health and wellbeing, particularly in terms of prevention and early intervention. It was clear from both quantitative and qualitative studies that young people's mental health often varies based on their own lived experiences and identities and that some challenges young people experience can make mental health difficulties more likely. This suggests that careful thought should be given to how we identify those in need of support – not only taking into account their level of mental health difficulties, but also the degree of risk and challenge they are exposed to in their lives. While it was clear that HeadStart's targeted interventions were aimed at those with high need and that some innovative models were used to identify those who would benefit from support, there were also indications that some young people who might have benefitted from help didn't receive it.

Our findings also indicate that young people experiencing high levels of risk coupled with a lack of social support might have quite different support needs compared to young people who can access informal support from family, school and friends. While the latter may only require short-term, focused support to manage a mental health problem, the former may need more intensive or sustained help, drawing on multiple sources of support. HeadStart, as a multi-layered, complex intervention embedded across the system, provides more opportunities for young people to experience multiple sources of support. We suggest that this embedded, system-wide approach is a promising area for further development.

The programme has also yielded rich learning about evaluating complex programmes. These kinds of evaluations should draw from multiple sources of information. This includes many of the features that were built into the HeadStart evaluation – for instance, local evaluations embedded in the design of local programmes, an emphasis on young people's, parents' and carers' perspectives, and national evaluation drawing on new data collected from intervention sites, and data from existing administrative datasets (such as those routinely collected in schools). Further improvements to the HeadStart evaluation could have been achieved by building in a robust comparison group from the outset of the programme, with non-

delivery sites collecting the same data as delivery sites; and by having a greater focus on data quality, especially in terms which interventions are delivered to whom and how.

Newer approaches to examining routine data provided us with valuable insights around the relationship between the programme and wider academic outcomes. For researchers evaluating complex programmes in future, a greater emphasis on building in comparison groups using a wider range of administrative datasets (e.g., health and social care data) might also be beneficial. Finally, context and implementation are important aspects of success in any intervention. Active monitoring and evaluation of the support on offer in mental health and wellbeing programmes is therefore important, to ensure it is having the desired impact.

Outputs and publications from the HeadStart learning programme can be found here: https://www.annafreud.org/research/past-research-projects/the-headstart-learning-programme/

Introduction

Context

When the HeadStart programme was commissioned in 2016 and began its delivery in 2017, there was evidence that children's mental health and wellbeing in the UK had been getting slowly but incrementally worse for a number of years.[1] The increase was consistent with the picture across a number of countries[2-4] and corresponded with an incremental drop in personal wellbeing.[5] The increase in mental health need was coupled with growing strain felt by specialist child and adolescent mental health services (CAMHS) and non-statutory services.[6-9] The mental health needs of children and young people were vastly outstripping the support available, leading to many waiting a long time for services or not receiving support at all.[10; 11] Young people themselves echoed these concerns, identifying mental health as a key issue.[12; 13] The coronavirus pandemic has compounded mental health challenges, with recent figures showing an escalation in the proportion of young people experiencing a 'probable mental disorder' from 12% pre-pandemic to around 17% during and after the pandemic.[14; 15]

About this report

The aim of this report is to lay out the findings of the national evaluation of the HeadStart programme and our learning from this work. It brings together findings from over 60 research studies and publications we have delivered during the six-year evaluation of HeadStart. The sections of this report describe in detail the reach, implementation and impact of the programme and our learning about the nature of mental health and wellbeing in children and young people and what influences it. We also present our analysis of the key programme outcomes and an overview of our key messages based on learning from the programme.

This report will be of interest to:

- funders, to inform future programmes
- those responsible for commissioning and developing services for young people, in terms of who might benefit most from support and what kind of support is valued by young people
- staff in school and community settings, in terms of their role in supporting young people's mental health
- researchers, in terms of evaluating complex interventions.

The HeadStart programme

HeadStart was a six-year, £67.4 million programme which started in 2016, set up by The National Lottery Community Fund (TNLCF). By investing in six regional partnerships across England – Blackpool, Cornwall, Hull, Kent, Newham and Wolverhampton – HeadStart broadly aimed to explore and test new ways to improve the mental health and wellbeing of children and young people aged 10–16 and prevent serious mental health issues from developing. To do this, the local-authority-led partnerships worked with local young people, schools, families, charities, and community and public services. As a 'test and learn' programme, HeadStart ended in July 2022, with the intention being to sustain and embed effective HeadStart approaches locally.

Overall, between 2016 and 2022, the six partnerships supported over 246,000 young people and 5,200 parents and carers through HeadStart

interventions. Over 24,000 professionals and staff were trained across school, local authority and community settings. And the partnerships engaged with over 1,000 community-based organisations to develop and deliver the HeadStart programme.[c]

According to TNLCF, participating local authorities were selected on the following basis:

- There were significant risk factors for mental health problems locally (e.g., high levels of deprivation, high levels of existing mental ill-health)
- Strong partnerships (e.g., between the local authority and the voluntary sector, or between the NHS and the local authority) already existed or could be easily established
- A health and wellbeing board, one or more clinical commissioning groups and one or more Healthwatches were in place

A range of local authorities were selected to increase the opportunity to test and learn across diverse contexts. The most important factor in selecting the six areas was the quality of their strategies and the level of involvement from children and young people.

The six partnerships developed, commissioned, delivered and evaluated portfolios of support for young people, co-designed with young people between 2016 and 2022. For more information on individual partnership approaches, see Appendix 5. These portfolios included a range of interventions and were tailored to local need but were underpinned by a set of common principles.

Local packages of support aimed to:

- focus on the prevention of and early intervention in the development of mental health problems
- be multi-component, including not only universal and targeted support for young people but also building up support from a range of sources (e.g., from school, peers, family and the community)
- take an ecological, systemic approach
- encourage local ownership
- prioritise participation (i.e., place young people at the very centre of programme design).

c) Reach figures for the HeadStart programme (July 2016- July 2022) based on data reported to the Fund by HeadStart partnerships

In line with the programme requirement of 'proportionate universalism', all partnerships delivered both universal support (e.g., training staff in schools to recognise early signs of mental health problems) and targeted support (e.g., one-to-one counselling or peer support sessions). This meant that all children and young people received some element of universal support through school and community activity to build their wellbeing and emotional resilience, and those who were experiencing – or at risk of experiencing – mental health problems were offered additional support. One young person described this combined approach as "everyone gets something but some get more than others," according to need. The majority of the interventions were directed towards children and young people, but a small number were also designed for parents and carers. Most interventions aimed to enhance skills and change behaviours and attitudes that are important in young people's social and emotional lives.

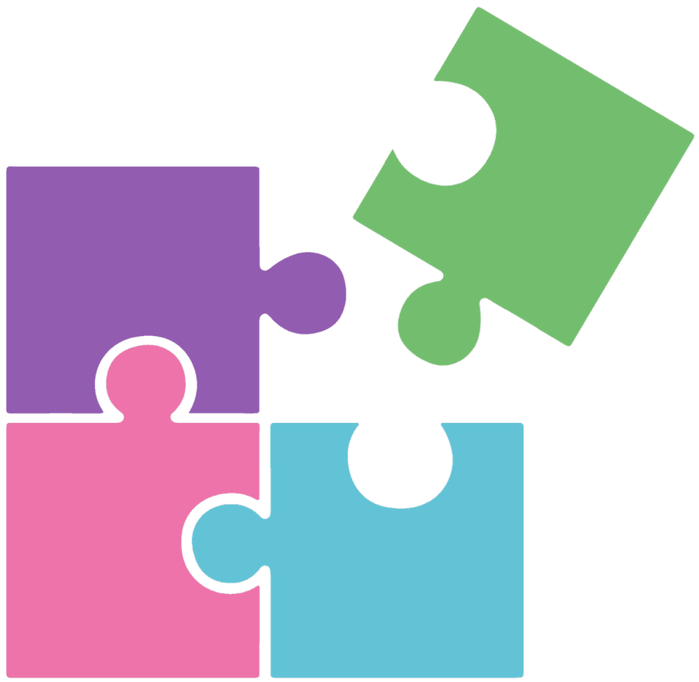
Despite these underlying commonalities, each HeadStart partnership implemented different types of interventions. For example, among many other interventions HeadStart Hull developed a Mark of Excellence (MoE) to help schools think about the way they provide support for children and young people's mental health. Schools were supported by HeadStart Hull's policy and practice officers to work towards the MoE. HeadStart Kernow (in Cornwall) had a particular focus on workforce development. HeadStart Kernow and its delivery partner, Trauma Informed Schools UK, undertook training which was delivered to school staff. HeadStart Blackpool offered support around the transition from primary to secondary school with their Moving on Up intervention; activities included mentoring, linking the young person with a trusted adult in their new school and advocating for the young person and their family.

Partnerships also provided community-based support. For example, among many other interventions HeadStart Newham offered Creative and Sporting Activities, a group activity course (e.g. dance, sport, music and creative arts) delivered by specialist facilitators. In addition to offering whole school approaches built around the HeadStart Resilience Toolkit, HeadStart Kent provided community-based interventions such as Intensive Mentoring, in which resilience mentors helped young people to build resilience to enable them to better deal with day-to-day issues and setbacks in life. Finally, HeadStart Wolverhampton created the Getting Ahead programme – residential and experience days outside of the school environment to support young people's resilience.

As mentioned earlier in this report, a key principle of HeadStart was the recognition of young people as competent citizens within society and the belief that their opinions and views should hold value and influence the systems they are a part of. The participation of young people in

local strategy development, the delivery of interventions and services and programme legacy was an expectation of, and priority for, all of the HeadStart partnerships.

Finally, TNLCF designed HeadStart as a ‘test and learn’ programme. This gave partnerships the opportunity to trial potential solutions to mental health problems with young people locally, to measure success and to respond iteratively and dynamically. Ultimately it was intended that this approach would lead to the best fit in terms of young people’s needs. It was also important to TNLCF to be able to share learning about the HeadStart test and learn approach and its implementation over the long term “so that HeadStart can contribute to the debate about increased investment in adolescent mental health prevention.”



Logic model

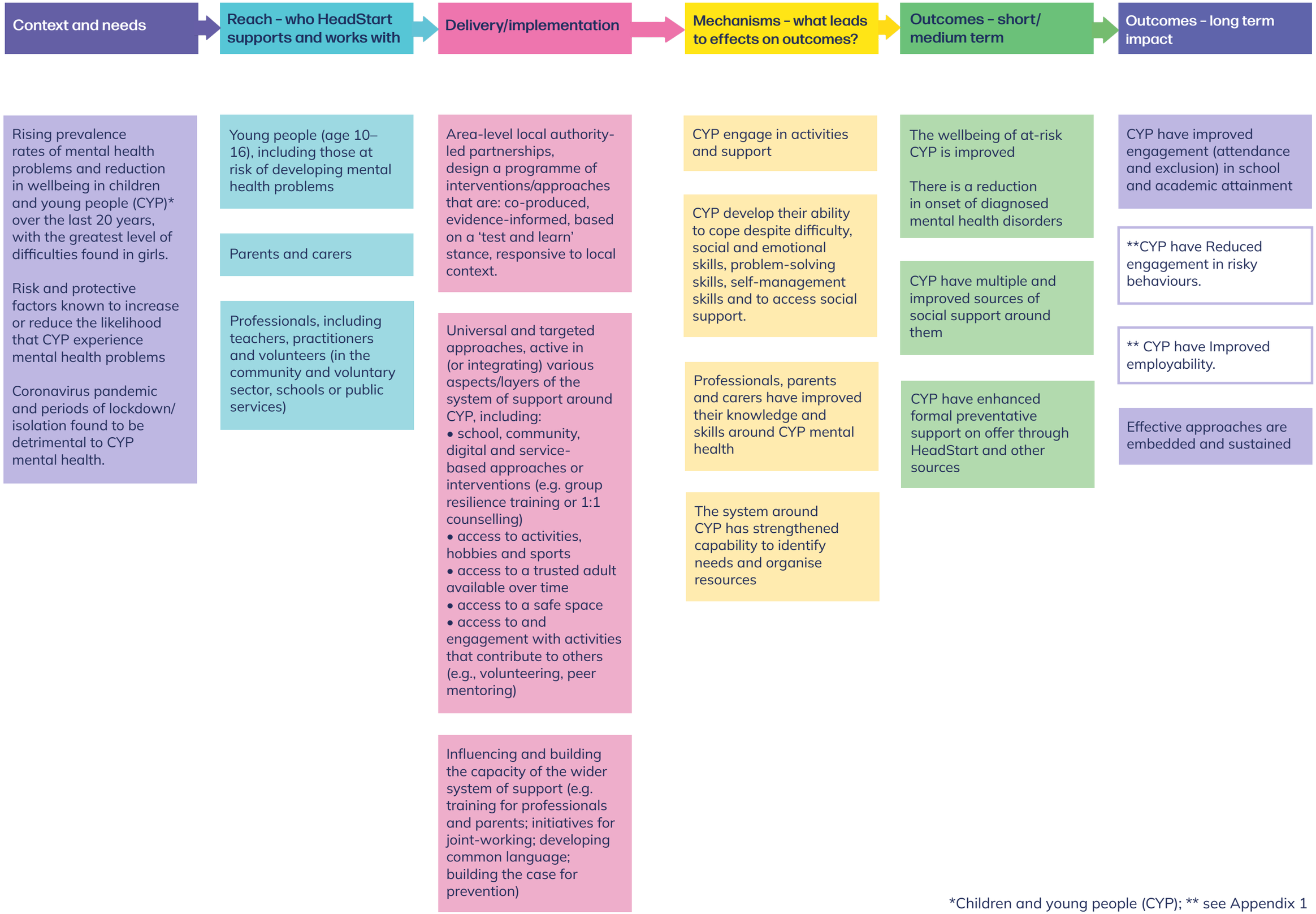
Figure 1. depicts the logic model for HeadStart. It outlines how and under what circumstances HeadStart activities were expected to achieve the programme’s anticipated short- and long-term outcomes. This logic model informed the evaluation approach.

The logic model should be understood with contextual factors in mind (see ‘Context’ section), which will have influenced various stages of this model.

There is also a set of assumptions held implicitly, for this logic to work:

- Young people’s basic needs are already met.
- Acute crisis support is available for young people who need it.
- Statutory and voluntary services exist with sufficient resources and can work together.
- Interventions are delivered to the quality expected.
- Young people sufficiently engage with interventions.
- Participation is a valuable and necessary approach to developing quality interventions and young people/schools/services/parents and carers have the skills and willingness to come up with solutions to youth mental health issues.

Figure 1. HeadStart logic model



*Children and young people (CYP); ** see Appendix 1

The national evaluation

The Learning Team

The Learning Team was appointed in 2016 to carry out the national evaluation of the HeadStart programme. The Learning Team was a consortium led by Professor Jessica Deighton at the Evidence Based Practice Unit (UCL and Anna Freud) and comprised the following organisations, who collaborated for all or part of the evaluation programme:

- The Child Outcomes Research Consortium (CORC; a project of Anna Freud)
- Manchester Institute of Education
- London School of Economics (LSE)
- Common Room

Evaluation aims and questions

Broadly, the national evaluation had the following aims:

- To find out the nature of the problem (context and need): what was the level and type of existing mental health need in HeadStart areas?
- To find out what help looked like (implementation and reach): what did HeadStart areas focus on and deliver, and to whom?
- To find out whether HeadStart had a positive impact on the mental health and wellbeing of children and young people (impact): did those receiving HeadStart support experience improvement in their mental health and wellbeing over the period of the programme? If improvements were detected, for whom, under what conditions and to what extent did HeadStart contribute to these changes.

The research aims were explored through the research questions, listed in Table 1. Some questions were established from the outset, while others were added in response to the evolving nature of the programme and events, such as the coronavirus pandemic. The research questions are structured in the report against three sections and collectively help to tell the 'story' of HeadStart.

Table 1. Research questions

Section	Research question
Context and need regarding young people's mental health and wellbeing	1. What risk and protective factors did young people at HeadStart schools identify experiencing in relation to their mental health and wellbeing? How does this vary for different groups (including by gender)?
	2. What problems/difficulties did these young people describe experiencing and how do these change over time?
	3. What has the impact of the coronavirus pandemic been on young people's mental health and wellbeing?
	4. What factors did young people at HeadStart schools identify as being helpful or unhelpful in relation to dealing with their problems/difficulties?
	5. Who did HeadStart work with and what did they receive?
Reach, implementation and delivery of HeadStart	6. What did young people describe as being helpful and unhelpful about the support they received?
	7.What were the successes and challenges (for HeadStart staff and schools) in implementing the HeadStart programme? What lessons were learned along the way?
	8. How did the coronavirus pandemic affect HeadStart partnerships and the delivery of support to young people?
	9. What did young people identify as being the outcomes or impact of support that they receive, from HeadStart or elsewhere? How does this change over time?
Impact of HeadStart	10. Is the mental wellbeing of young people, receiving and/or having received 'HeadStart', improving? Can we, at least, ascertain that it is not deteriorating?
	11. Is the onset of diagnosable mental health conditions among young people, receiving and/or having received 'HeadStart', reducing?
	12. Is the academic attainment of young people, receiving and/or having received 'HeadStart', improving?
	13. Is the academic engagement of young people, receiving and/or having received 'HeadStart', improving?
	14. How did HeadStart partnerships seek to sustain or embed good practices and support for young people's mental health beyond the programme?
	15. What have been parents' and carers' experiences and perceptions of the impact of HeadStart?
	16. How were young people involved in HeadStart, and what have we learned about the role and impact of youth participation?

The scope of the national evaluation was to evaluate HeadStart support across the six partnerships. Alongside the national evaluation, the HeadStart partnerships carried out local evaluations in their own areas, sometimes commissioning university evaluation teams as collaborators. You can find links to local evaluation websites in Appendix 5. Whereas the local evaluations focused on exploring the benefits of the programme at a local area level, by design the national evaluation was much broader in aim and focus.

There are multiple challenges that accompany the evaluation of such a complex, large-scale programme, and these were compounded by obstacles that arose during the coronavirus pandemic. We discuss these challenges in detail in our section 'Overall strengths and limitations of the national evaluation'.

Evaluation approach

Our evaluation took a multi-layered approach, appropriate to a large, complex programme, to build the evidence from a range of sources. We pursued three key strands of evidence – quantitative, qualitative and nested summative studies – on the basis that collectively, these strands would capture the information needed to answer our research questions. The methods contained in the three strands are summarised below. For more detail on each strand see Appendix 1. Consistent with the principles of HeadStart, the Learning Team engaged young people in the research and evaluation of HeadStart throughout the programme. For much of the programme, we did this through local partnership groups and networks. Latterly, we established a HeadStart National Young People's Group to increase our direct engagement with young people.

Quantitative approach

The six HeadStart partnerships implemented a wide range of interventions in terms of who they were aimed at, what they were trying to achieve, delivery mechanism and implementation. This meant that we needed a common measurement framework to measure the effectiveness of HeadStart across all the target populations and a standardised approach to collecting information. To this end the quantitative arm of the evaluation drew on four sources of data:

1. **The Wellbeing Measurement Framework (WMF)**: a large-scale pupil survey delivered year-on-year in schools in all six partnerships (over 30,000 young people in the first year of data collection). The WMF is a set of validated questionnaires to be completed by young people, designed to not only capture indicators of young people's wellbeing and mental health problems (outcomes), but also to capture the mechanisms that we know (from the literature) explain the relationship between internal and external risk factors and young people's outcomes. See Appendix 1 for a full list of constructs, relevant subscales and data collection schedules. We captured data from two samples:

    a. A longitudinal sample of young people who first completed the survey as Year 7 pupils in 2017. We followed up with these young people each year until they completed secondary school in Year 11. See Appendix 1 for sample sizes achieved each year.

    b. A 'repeated snapshot' group – Year 9 pupils completed the survey every year between 2017 and 2021 (i.e., a new Year 9 group completed the survey each year).

    These two samples allowed us not only to observe changes in the same children over time but also to examine change in the same age group over time, which can address issues of co-occurring developmental changes.

2. **Pupil background information:** demographic information about young people who completed the WMF (e.g., gender, ethnicity and eligibility for free school meals [FSM]) as well as fields related to school outcomes such as absenteeism, attainment and exclusions, retrieved from the National Pupil Database (NPD). For the full list of fields we requested and the coverage of the NPD data (percentage of young people with NPD data), see Appendix 1.

3. **The Template for Intervention Description and Intervention (TIDieR):** a template completed annually by partnerships, providing key pieces of information about each intervention being delivered.

4. **Who Got What (WGW):** a template completed annually by partnerships, providing information about which young people received which intervention.

Qualitative approach

The qualitative arm of the evaluation explored, in-depth, the experiences of three groups:

1. **Young people:** a qualitative, longitudinal design, consisting of semi-structured interviews with the same cohort of young people once per year over the original five-year period of the HeadStart programme (starting in 2017 with 82 young people; please see Appendix 1 for

sample sizes at each data collection point). We aimed to explore young people's experiences of coping and receiving support for difficult situations and their experiences of HeadStart, as well as coping strategies and other sources of social and professional support more broadly.

2. **HeadStart staff and stakeholders:** a series of studies using interviews or focus groups, concentrating on different elements of HeadStart staff members' and stakeholders' experiences of the programme (e.g., how systems change and sustainability are being approached and school staff members' experiences of HeadStart).

3. **Parents:** a small number of interviews conducted with parents who had been involved in different types of HeadStart support. We explored their experiences of taking part, their perceptions of the impact of the interventions and their suggestions for improvement.

The total number of interviewees for each group is detailed in Appendix 1, along with interview topic guides and demographic information about the longitudinal young people's group.

Summative evaluations

The Learning Team designed the summative strand of the evaluation to provide robust assessments of the impact of a number of HeadStart interventions in isolation. This strand aimed to complement the large-scale quantitative and qualitative evaluation approaches, which looked at the impact or experiences of HeadStart interventions collectively across all six partnerships. We used randomised control trials (or, where this was not possible, quasi-experimental trials) in the summative strand, drawing on annual WMF data wherever possible. The Learning Team completed three summative evaluations of interventions in HeadStart Newham: (1) Team Social Action (TSA), a targeted, group-based intervention that was implemented by HeadStart schools; (2) More than Mentors (MtM), a targeted cross-age peer mentoring intervention implemented by HeadStart schools; and (3) Bounce Back, a school-based small group mental health intervention working to improve core resilience skills.

Other evaluation activities

The Learning Team also supported the partnerships to conduct their own economic analyses and engaged children and young people in HeadStart research and evaluation. Again, more detail about the evaluation approach can be found in Appendix 1.

Findings

In this part of the report, we present the key findings at the start of the relevant section. We synthesise the findings in these sections and provide references to the original publications where the findings can be explored in more detail. Each section concludes with a short discussion, including the implications of the findings and reflections on strengths and limitations of the approach taken.

Context and need

As well as examining the delivery and impact of the HeadStart programme, the Learning Team's research provided an opportunity to better understand children and young people's mental health and wellbeing. In this section we look at findings about the prevalence of mental health problems, factors associated with risk of or protection from experiencing poor mental health, and the natural coping strategies used by young people when they are experiencing difficulties. While we present our findings as simply as possible, the factors surrounding young people's mental health are complex and our understanding of it is ever evolving. As such, interpreting findings is not always straightforward. In this section we aim to explain our findings in the context of this complexity.

Summary of findings

- The prevalence of mental health problems across schools in England may be higher relative to previous estimates; around two in five young people aged 11-12 years reported experiencing some kind of mental health problem
- In Year 7 (age 11-12 years), young people described experiencing a range of problems that impact upon their mental health or wellbeing, with the most prevalent issues being fights and arguments with their peers
- Young people with access to multiple sources of support described better wellbeing and being better able to cope in the face of risk than young people with uncertain sources of support
- There was a general trend of increasing mental health difficulties and declining wellbeing during the early (age 11–12) to mid-adolescent

(age 13–14) years. We found that this trend was predominantly driven by girls, as boys had a fairly stable level of difficulties and wellbeing over time.
- In Year 7, girls reported significantly more support than boys from home, school, the community and their peers. This pattern appeared to change as young people grew older. By year 9 boys' and girls' perceptions of social support had converged somewhat (become more similar), with the exception of peer support where girls continued to perceive more support than boys.
- Mental health and wellbeing are related but distinct constructs and should therefore be considered in tandem (not as one) in thinking about how to most effectively support young people
- Managing anger and coping with difficult relationships with family members and peers appeared to be important areas of need for some young people
- Reported coping strategies and support can vary according to adolescent gender, levels of adversity experienced in life, and the resources that adolescents have available within their contexts.
- Girls' mental health and wellbeing appears to have been more adversely effected by the pandemic than boys'.

Prevalence of mental health difficulties

Over the past five years we have learnt a lot about the prevalence of mental health problems in children and young people, with estimates currently suggesting around one in six children and young people experience a mental disorder.[17] However, at the beginning of the HeadStart programme our research was able to provide insight at a time when there was little up-to-date information about prevalence.

Early analyses of our HeadStart data, collected from 28,160 young people in Year 7 and Year 9 using the 2017 baseline Strengths and Difficulties Questionnaire (SDQ), gave us an overall idea of the prevalence across the four areas (or 'domains') of mental health problems measured in this age group. 18.4% of young people indicated that they were experiencing[18] high levels of emotional problems, 18.5% indicated that they were experiencing high levels of conduct problems,[d] 25.3% indicated that they were experiencing high levels of inattention/hyperactivity problems and 7.3% indicated that they were experiencing high levels of peer relationship problems. 42.5% scored above threshold for any one of the following three problem scales: emotional symptoms, conduct problems or inattention/hyperactivity. These findings suggested that the extent of mental health difficulties in young people across many schools in England was much greater than previous estimates, with around two in five young people scoring in the high range for emotional problems, conduct problems and hyperactivity. However, findings were consistent with an escalating trend in recent years for young people's mental health.

Inattention/hyperactivity problems were particularly high in this [10] HeadStart sample compared to other areas of mental health difficulty measured, especially peer problems which appear to be relatively low level on average.

Young people's experiences

Through our qualitative interviews with young people in Year 7 (N = 63; average age 11.9 years), we heard young people's own descriptions of what they found challenging to their mental health and wellbeing. They described experiencing a range of problems, the most prevalent being fights and arguments with peers.[19] Young people also spoke about having fights and arguments with their parents and siblings, which could be similarly distressing, and alluded to the various sources of strain that their families were under, which sometimes took a toll on both themselves and their families. In terms of their experiences of difficult emotions, young people most often described explosive angry outbursts, which were difficult to control, and referred to their (sometimes chronic) worries and fears. In relation to school life, young people described their struggles academically (e.g., with particular subjects) and behaviourally.

Risk factors

Risk factors are characteristics or circumstances which mean that certain young people will be more likely to experience mental health problems. We carried out additional quantitative analysis on the baseline survey data from 28,160 young people gathered in 2017 and found many similarities across different types of mental health problems in terms of associated risk factors.[18] We found that several characteristics increased the likelihood of young people experiencing emotional problems, conduct problems, peer relationship problems and

d) That is, they scored above the SDQ 'abnormal' threshold.

hyperactivity. These were:

- having Special Educational Needs (SEN)
- being from a low-income household (FSM eligibility)
- being in the older year group (with the exception of peer problems)
- being a child in need of extra protection (having CIN status; with the exception of emotional problems)

Other characteristics, such as being female, made it more likely that young people reported emotional problems, while being male increased the likelihood of experiencing conduct problems. This finding was echoed in qualitative interviews with young people – girls tended to describe experiencing emotional problems more often, whereas boys tended to describe more behavioural problems.[19] In terms of ethnicity, relative to the White ethnic group (as the largest ethnic grouping in the sample): being Asian significantly reduced the odds of experiencing any of the four mental health problems that our analysis focused on, and being Black significantly reduced the odds of experiencing all mental health problems, except conduct problems, for which the odds were comparable with being White.[e] [18]

In the final year of data collection, we introduced some questions into the WMF about gender identity. Data from these additional questions (see Appendix 1 for full list of questions and response options) were from young people in Year 11. By combining the two questions related to gender identity (young people's own description of their gender identity, and whether they reported their gender being the same as their sex registered at birth), we created five broad groupings (cisgender man or boy, cisgender woman or girl, transgender, non-binary and questioning). We found that cisgender men or boys reported the highest level of wellbeing, whereas young people who were questioning their gender identity reported the lowest level of wellbeing. Questioning and non-binary young people had the highest levels of total difficulty and emotional difficulty scores, while cisgender men or boys reported the lowest level of total and emotional difficulty scores. Conduct problems were the highest for transgender participants and lowest for cisgender women or girls. Perceived stress was reported to be most prevalent among questioning participants and lowest for cisgender men or boys.

We also investigated how young people with different gender identities perceive social support. By perceived social support we mean how much support we feel is available from our relationships with people around us, and the adequacy of this support. We found that cisgender young people perceived having the most social support from community and peers in comparison to other sources of support. When it comes to support at school and home, young people questioning their identity reported receiving the most support. On the other hand, of all the gender identity groupings transgender young people reported receiving the least support from each source (home, community, school and peers).

Alongside this quantitative investigation of risk factors, we explored other possible influences (positive and negative) on young people's mental health and wellbeing through qualitative investigations. During our first annual wave of qualitative data collection in 2017, pupil interview responses sometimes contained rich information about the causes of emotional distress (interviews with 32 young people aged 11–12 years included reference to this). We found that young people's perceived causes for their emotional distress fell into five distinct categories:[23]

Perceived lack of control. Young people in this group indicated that they are affected by situations and feelings that they perceive to be out of their control. For example, feeling controlled by people in their lives, and not feeling in control over how they or other people feel or act.

Unfair treatment. Young people in this group felt as though they are treated differently from others and perceived this treatment to be unfair, which led to feelings of emotional distress.

The actions and judgements of others as the catalyst. Young people in this group tended to describe the actions or the perceived judgement of others as causal factors for their emotional distress.

Concerns for self and others. Young people in this group indicated that concern for others causes them distress – this may be their friends, family or strangers they hear about on the news. They were also concerned with their own wellbeing and how their actions or feelings could affect other people.

Self as cause. Young people in this group saw themselves as having a causal role in their emotional distress. The problems that they face were not, in general, seen as a cause for emotional distress. Rather, these young people ascribed the way in which they deal with their problems as the cause of their distress.

e) While these results may seem surprising given that those from minoritised ethnic groups may be likely to experience more stressors, such as racism or social disadvantage, findings are consistent with previous studies.10 Exactly why this pattern of findings occurs is not clear though some studies point to other protective factors, such as social support, being more prevalent for some ethnic groups.20; 21 Others suggest cultural differences in mental health stigma and how mental health problems might be described may also play a role.22

Protective factors

Alongside the rich insights from the interviews about perceived causes of emotional distress, the quantitative data aided our understanding about the personal skills, characteristics and support networks reported in Year 7 which may work to protect children and young people from developing mental health problems in Year 8[24] (N = 3,500). We found that the following factors were associated with fewer mental health problems:

- stronger problem-solving skills
- having goals and aspirations
- better emotion regulation
- prosocial behaviour (actions intended to help others)
- lower levels of perceived stress
- stronger support from family, peers and the community
- more active participation in the community, at home and in school.

Through both our quantitative and qualitative research, we took a more in-depth look at the role of social support in bolstering young people's wellbeing (as a protective factor). Analysis of survey data from 10,888 young people in Year 7 and Year 9 told us that perceived support from home, school, peers and the community were all significantly positively correlated with subjective wellbeing.[f] [25] In other words, strong perceived support from various sources seems to be related to better wellbeing (but the relationship is not necessarily causal).

Furthermore, from interviews with 63 young people (aged 9–12 years) we found a relationship between the number of sources of support available to young people, the stability of that support and their wellbeing.[26] Specifically, we found that there was clear variety at the outset of HeadStart in the types and extent of the support drawn on or available to young people from various sources. In their interview responses, young people with access to 'multiple sources of support' described better wellbeing and being better able to cope in the face of risk than young people with 'uncertain sources of support' or those who relied on 'self-initiated forms of support' (that is, those typically using their own strategies for dealing with difficulties before drawing on school or parental support). While exposure to risk varied, most young people had experienced at least some level of risk to their wellbeing.

Finally, we found differences between boys and girls in the strength of support perceived by young people.[25] In Year 7, girls reported significantly more support than boys from home, school, the community and their peers. This pattern, which appeared to change as young people grew older, is discussed later in this report (see section 'Gender differences').

f) Subjective wellbeing means feeling generally good about life, feeling able to deal with problems well and feeling positive about the future.

Mental health and wellbeing – related but distinct

As well as mental health problems, we were interested in quantitatively exploring the construct of wellbeing and whether the same risk and protective factors for mental health would have a bearing on young people's wellbeing. Often, mental health problems and wellbeing are conceived of as opposite ends of the same spectrum and it is assumed that the presence of one necessarily means the absence of the other. However, this is not always the case – some people who experience mental health problems at the same time report good wellbeing (and vice versa).

We looked into the extent of overlap between the factors that predict mental health and those that predict wellbeing and found that half of the predictors we explored were related to both mental health and wellbeing (e.g., gender or emotion regulation). Other variables were associated with one and not the other (e.g., peer support – see Table 3). This suggests that mental health and wellbeing are related but distinct constructs and should therefore be considered in tandem (but separately) in thinking about how to support children and young people most effectively.

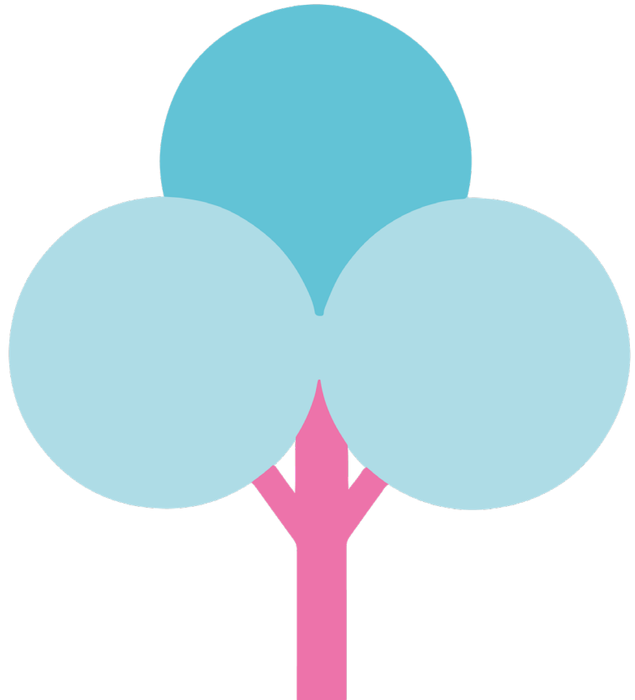
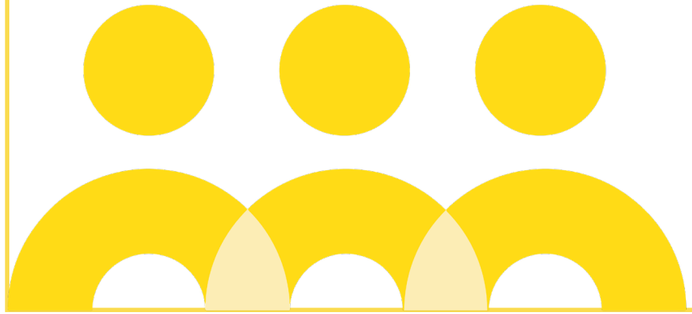


Table 3. Variables associated with mental health only, wellbeing only, and both mental health and wellbeing[24]

Variables associated with mental health only	Variables associated with wellbeing only	Variables associated with both mental health and wellbeing
Child in Need (CIN) status	prosocial behaviour	gender
empathy	peer support	being Asian or Black (compared to being White)
school connection	community connection	being from a mixed ethnic background (compared to being White)
	participation in community life	special education needs
	participation in home and school life	FSM eligibility
		problem solving
		goals and aspirations
		emotion regulation
		perceived stress
		family connection



Strategies for coping

Through qualitative interviews with young people, we also gained insight into the range of strategies they described for coping.[19; 27; 28] These strategies included engaging in positive thinking and activities that made them feel better; disengaging from problems by ignoring them, forgetting them and being distracted; and accepting and getting used to difficult situations. Young people also talked about the various sources of support that they had or could access. The majority described their parents or carers, friends and school staff as being important individuals they could draw on for comfort, advice, distraction and instrumental support; for example, to intervene in incidents of bullying.

The coping strategies mentioned by young people were not drawn on in isolation. They often described drawing on multiple strategies. For example, they described using activities (such as reading books) as a distraction from their problems and mentioned engaging in strategies for emotion regulation (such as use of a stress ball). Understanding young people's use of coping strategies (whether helpful or not) helps to highlight how programmes like HeadStart can seek to influence and strengthen the resources that young people are already using to handle difficulties in life.[27]

We also found differences in the coping strategies described by girls and boys. More girls described drawing on creative activities, perseverance, and support from family members.[27] In addition, young people who reported experiencing more difficulty in life described using coping strategies like self-defence and self-harm, were reluctant or unable to seek support from their parents or carers, and perceived limitations in their use of particular coping strategies and support from school staff and professionals.[28]

Cumulative risk

The existing literature suggests that early exposure to 'cumulative risk' – an indicator that counts the number of risk factors experienced (e.g., low academic attainment, having special educational needs and disability [SEND], adverse childhood experiences, caregiving responsibilities, poverty) is associated with later emotional symptoms in adolescents. However, to the best of our knowledge, no research has yet reported the nature of this association (i.e., whether cumulative risk exposure is a direct or indirect predictor of emotional symptoms). We conducted additional quantitative analysis to explore the direct and indirect effects of cumulative risk exposure on adolescents' wellbeing and emotional symptoms.

To do this, we created a measure of cumulative risk and looked at the relationship between this and changes in emotional difficulties over time. In a sample of 19,159 young people, we found that, on average, the more risk factors young people experienced, the more their emotional difficulties increased over time. We also found that the impact of this cumulative risk marker on emotional difficulties was at least partly explained by the level of stress young people reported experiencing during this time. The findings suggest, therefore, that it isn't just the nature of the risk factor experienced that is important but also the number of risk factors that young people are experiencing that matters. Findings also suggest that where it isn't possible to reduce the risk experienced by young people, supporting them to manage the stress they are experiencing, in the context of this risk, may help reduce their emotional difficulties.

Risk, protection and change over time

To get a sense of the scale and nature of change in young people's experiences of difficult situations and emotions and the support received, we analysed qualitative interviews conducted with young people across the six HeadStart areas in year one (2017 or 2018; age 9–12) and year two (2018 or 2019; age 10–13) of the HeadStart programme.[29] We found clear variability in young people's experiences of life and support over the first two years.

Young people who had had broadly positive experiences in their lives over time often referred to having supportive, relatively unproblematic situations and relationships with their family, friends and/or school. In our earlier analysis we identified three groups of young people in terms of the social support available to them (multiple sources of support, uncertain sources of support and self-initiated forms of support; see section 'Protective factors'). A higher proportion of the young people who had had broadly positive experiences over time had also been classified in our earlier analysis as having multiple sources of support in the first year of HeadStart,[26] perhaps indicating relative stability in support over time in some cases.

By contrast, young people who had experienced improvement in some areas of their lives and deterioration or difficulty in others, or who had been experiencing real challenges over time, often talked about the problems they had been experiencing with their family, friends, school and/or emotions. In particular, managing anger and coping with difficult relationships with family members and peers appeared to be important areas of need for some young people. A higher proportion of these young people had been classified in our earlier analysis as having uncertain sources of support in the first year of HeadStart, perhaps indicating relative instability in support over time in some cases.

We also explored change over the first two years of the HeadStart programme in terms of young people's lived experiences of risk and protective factors, and the types and extent of the support drawn on or available to young people from various sources.[30] We identified both continuity and change between year one and year two in the membership of the three groups (multiple sources of support, uncertain sources of support and self-initiated forms of support). Of the young people who shifted group, 40% moved in a positive direction towards having more effective protective factors (e.g., they moved from having uncertain sources of support to having multiple sources of support) and 10% moved towards having fewer and less effective protective factors (e.g., they moved from having multiple sources of support to having uncertain sources of support). This indicates that while some young people felt more supported by the second year of the HeadStart programme, others felt less supported. This suggests that regularly checking in with young people about the support available to them, and how useful they are finding that support, is an important task for the adults in young people's lives.

Differences between boys and girls over time

We explored differences in the mental health and wellbeing of boys and girls over time using both the quantitative and qualitative longitudinal data. We found that the general decline in young people's mental health over the early adolescent period was predominantly driven by a decline in girls' mental health.

Using the longitudinal survey data, we found that, looking at the sample as a whole (N= 8,612), there was a general trend of increasing mental health difficulties and declining wellbeing over time. During the early (age 11–12) to mid-adolescent (age 13–14) period, young people were more likely to experience emotional difficulties, behavioural difficulties and hyperactivity/inattention difficulties as they got older. This pattern of declining mental health and wellbeing throughout adolescence is well documented and is developmentally typical.[31] Young people's difficulties with peer relationships remained relatively stable over the same time frame.

However, gender difference analyses also showed that the increases in mental health difficulties and decline in subjective wellbeing during early- to mid-adolescence were largely driven by an overall deterioration for girls, as boys had a fairly stable level of difficulties and wellbeing over time. Even after accounting for sociodemographic factors (i.e., ethnicity and eligibility for FSM, SEN status and English as an additional language), internal protective factors (i.e., problem solving, goals and aspirations, and empathy) and external protective factors (i.e., family connection, school connection and peer support), there was a marked gender difference in mental health difficulties and wellbeing over time:

Emotional difficulties. The average emotional difficulty level for girls was already higher than boys at the age of 11–12 years and continued to increase year on year, whereas boys' emotional difficulties remained relatively stable over time.

Behavioural difficulties. During early adolescence, on average boys were more likely to experience behavioural difficulties than girls, but boys' behavioural difficulties were relatively stable over time. On the other hand, girls' level of behavioural difficulties increased to almost to the same level as boys by mid-adolescence.

Hyperactivity/inattention. While boys' average hyperactivity/inattention level stayed relatively stable, girls' levels increased year on year.

Peer problems. There were no significant differences in peer problem scores between boys and girls during early adolescence, but girls were more likely to experience peer problems by mid-adolescence than boys.

Wellbeing. At age 11–12 years, girls had slightly (but significantly) lower subjective wellbeing than boys, and girls' wellbeing further deteriorated year on year.

We also saw some differences in the kinds of difficulties boys and girls experienced that challenged their mental health and wellbeing.[19] In our qualitative interviews with young people (aged 9–12 years), a higher proportion of boys described experiencing explosive anger, lack of friends, struggles with learning and behaviour at school and perceived victimisation by teachers. On the other hand, a higher proportion of girls described feelings of worry and fear and a lack of confidence. These findings are consistent with our early survey findings, suggesting that boys tend to externalise their psychological distress to be expressed as behaviour, whereas girls tend to internalise it, leading to distressing emotions.

Some gender differences were also evident in factors that might protect mental health and wellbeing. We know from our earlier qualitative work that young people regard social support as an important tool in maintaining good mental health and wellbeing.[26] We used our survey data pertaining to the strength of support from others to see whether it might account for some of the decline in young people's mental health from early- to mid-adolescence. We found that perceived social support did decline overall over this period, but in different ways for boys and girls and for each source of support.[25]

In Year 7, relative to boys, girls reported higher levels of home, school, peer and community support. However, by Year 9 perceptions of social support had converged somewhat. Boys and girls perceived similar levels of home and community support, but boys were now reporting greater support from school. Peer support, on the other hand, remained relatively stable over this period despite marginal declines for all young people. Girls continued to perceive more support from their peers than boys. Although this type of analysis did not directly link declining mental health and social support, we learnt that young people's perceptions of social support can change in certain respects over the same period (Year 7 to Year 9) and that the picture is somewhat complex.

Young people's experiences of the coronavirus pandemic

We explored young people's responses to survey questions about their feelings, worries and experiences during the coronavirus pandemic lockdown (see Appendix 1 for a list of questions). We also explored whether there were any differences in girls' and boys' responses to these questions. Compared to boys, girls were more

likely to have negative feelings such as anger, frustration, sadness, loneliness, worry, anxiousness and helplessness in response to the pandemic. Compared to boys, girls also worried more about their family's health, their friends' health, their own health, the amount of money their family had, attending school, schoolwork, leaving their house, missing out on things and their future. On the other hand, girls were better at sleeping well and concentrating; they also enjoyed learning at home, spending time at home and spending time with family more than boys during the lockdown.

We also investigated if young people's mental health and wellbeing had suffered during the pandemic. To do this we capitalised on two longitudinal cohorts that had been created during the evaluation. Both cohorts completed the WMF when they were in Year 7 and Year 9; for the first cohort this period (2017-2019) fell before the pandemic occurred and the second cohort was exposed to the coronavirus pandemic between the baseline and follow-up assessments (January-June 2019 and November 2020-July 2020). This meant that the first cohort could act as a control group (i.e. a 'typical' adolescent period). Young people who experienced the coronavirus pandemic had a greater decline in emotional difficulties and wellbeing over early adolescence compared to earlier groups of young people at a similar age in 2019 who had not experienced the pandemic. If coronavirus pandemic hadn't occurred, there would have been 2% fewer adolescents with high emotional difficulties. We did not find an effect of exposure to the pandemic on behavioural difficulties. We also found that girls might have been more impacted by the coronavirus pandemic than boys, with girls exposed to the pandemic showing greater emotional and behavioural difficulties, and lower wellbeing than boys.

Discussion: young people's mental health and wellbeing

In 2017, we found that the prevalence of mental health problems in the HeadStart sample was high relative to previous estimates: around two in five young people aged 11–12 years reported experiencing some kind of mental health problem. There are several factors to consider in interpreting this finding.

First, it's important to remember the context in which local authorities were invited into the programme. Local authorities were not randomly selected to participate in the programme and so their populations of young people are not nationally representative. Furthermore, participating local authority partnerships were asked to select schools to involve in their programmes. One of the criteria for selection was need – another reason why the HeadStart data may not be nationally representative. Finally, the SDQ, while a widely used population screening tool, is brief and therefore limited in its measurement properties. This gives way to the possibility of false positives (i.e., identification of mental health problems where there are none) and false negatives (i.e., no identification of mental health problems where these do in fact exist), particularly in the younger age range. Nevertheless, it remains the most feasible and practical means for large-scale school-based population estimates.[18]

Despite these limitations, our prevalence estimates do correspond to the picture emerging from concurrent research of increasing mental health problems among young people in the UK.[1;32] Several factors have been suggested as contributing to this rise in mental health problems including the impact of austerity,[33] experiences of increasing academic pressures,[34] reduced rates of sleep[36] and increased use of social media.[37]

Building on this, in line with other studies,[32] , the story that unfolded over the first three years of the HeadStart programme (2017–2019) was one of deteriorating mental health and wellbeing for young people overall as they moved into mid-adolescence, especially for girls. In fact, the level of difficulty among boys remained fairly stable over this time. Even after accounting for sociodemographic factors and internal and external protective factors, there was a marked gender difference in mental health difficulties and wellbeing over this early adolescent period.

Through our qualitative work, strong, multifaceted support systems emerged as important protective factors and young people reported poorer wellbeing when support was lacking or inconsistent. This is in line with research indicating that higher levels of social support play either a buffering or direct role in diminishing stress appraisal and response thereby decreasing distress or ameliorating health and wellbeing.[39]
Our findings bring attention to the kinds of support systems (i.e., support from home, community, peers and school) that a young person may have contact with and the strength of their links with those systems. Young people with multiple sources of support had strong links with many systems, whereas young people with uncertain or self-initiated sources of support had less reliable links with systems. Our findings suggest that when identifying those in need of early intervention for mental health and wellbeing, targeting young people with few protective factors and/or support systems may be as important as targeting those exposed to risks.

Similarly, we concluded that while experience of a particular risk factor, such as parental divorce, might seem to be problematic and a source of distress for some young people, this was not always the case for others. Findings like this remind us that exposure to a risk factor does not necessarily negatively affect wellbeing, suggesting that targeted support may be of greatest benefit those who experience a negative impact on their wellbeing following exposure to a particular risk factor.

Knowledge of the ways in which particular risk factors can negatively affect wellbeing could usefully inform the content of targeted support. To some extent, many of the findings in this section around perceived causes of emotional distress and preferred sources of support are linked to people in different contexts (e.g., in school, at home and in the media) who young people already interact with. This should be kept in mind when designing support for young people. For example, there may be a number of practical solutions that preventive programmes like HeadStart could develop in order to reduce emotional distress, such as empowering young people to speak out when they feel that they are being treated unfairly, as well as encouraging those in young people's lives to actively listen and effectively respond to their concerns.

Considerations around the role of social support in helping young people's mental health and wellbeing are also particularly relevant in the aftermath of the coronavirus pandemic and the long periods of isolation and time away from school that it brought. Indeed, previous research has shown that low support was associated with higher prevalence of depression and anxiety symptoms.[40]

Our qualitative findings about the variability evident in young people's experiences of life and support invite reflection on the extent to which young people in need are being identified for support, are receiving or engaging with support and are getting what they need from support. This includes both formal sources of support, like HeadStart, and informal sources of support, like family and friends. More sustained early intervention may be needed for some young people. Moreover, preventive interventions could usefully include family, school and individual components to bolster young people's contextual and internal resources.

Implementation and reach

In this section, we collate and summarise analysis that speaks to the implementation and reach of HeadStart support. This includes findings about the types of targeted interventions offered through HeadStart, the reach of HeadStart support, findings about and what young people found helpful and the challenges and facilitators in terms of delivery. We also cover the programme's response to the coronavirus pandemic.

Summary of findings

- Alongside universal interventions, which reached everyone, 76 different targeted interventions were delivered across the six partnerships.
- The majority of young people draw on support from their parents or carers, friends and school staff, depending on what is troubling them.
- The findings indicate that it is important for young people to have a trusted person who is available to talk to about their problems with if they need to.
- Young people told us that they use various techniques and strategies to deal with their problems on their own or to distract themselves from their problems.
- For staff working in HeadStart partnerships, HeadStart's ability to fit into schools' existing systems and processes was crucial to working successfully with schools, as was senior leadership team (SLT) buy-in.
- From school staff members' perspectives, HeadStart principles seem likely to live on in schools beyond the funding period of the programme but this will rely on embedding HeadStart learning within school structures, having ongoing access to HeadStart resources and, crucially, providing schools with the capability to cascade training to other staff.
- The experiences of young people in HeadStart showed that it is crucial that support takes place at a time and location that is suitable and accessible for young people to facilitate attendance.
- During the coronavirus pandemic, adapting HeadStart support for virtual delivery led to more widespread acceptance of different forms of delivery as viable alternatives to in-person provision. HeadStart staff were able to reach even more young people than they had prior to the pandemic because of this newfound flexibility.

How many people did HeadStart support?

Between 2016/17 and 2020/21:[g]

24,500
children and young people received targeted support

over **246,000**
young people received universal provision

5,200
parents and carers were supported

over **24,000**
staff were trained

What did HeadStart offer (targeted support)?

As well as universal interventions, partnerships offered additional support to young people who were experiencing – or at risk of experiencing – mental health challenges. The majority of targeted interventions were directed towards children and young people themselves, while others supported the staff and professionals that worked with them, or their parents or carers. Between 2016/17-18/19, partnerships told us that they delivered 76 different targeted interventions between them. Analysis showed that the interventions broadly fell into ten different types:

1. **Professionally-led resilience training, therapy or counselling delivered on a group basis** (n= 19; e.g., HeadStart Wolverhampton's Work Ready programme).

2. **Being connected with and establishing a long-term relationship with a trusted person in the community or school** (n= 12; e.g., HeadStart Kent's Intensive Mentoring programme).

3. **Training for professionals** (n= 12; e.g., HeadStart Newham's Academic Resilience Approach – Whole School Work).

4. **Professionally-led resilience training, therapy or counselling delivered on a one-to-one basis** (n= 11; e.g., HeadStart Kernow's Facilitator Direct intervention).

5. **Creative and physical activity to improve mental health** (n= 9; e.g., HeadStart Hull's Play Ranger project).

6. **Parent or carer support** (n= 8; e.g., HeadStart Hull's Parent Peer Mentoring project).

7. **Online support** (n= 2; e.g., Kooth in HeadStart Newham).

8. **Assessment** (n= 1; e.g., HeadStart Kent's Resilience Conversations).

9. **Engagement – active contribution by young people** (n= 1; e.g., HeadStart Blackpool's youth engagement)

10. **Reflective spaces** (n= 1; e.g., HeadStart Kent's Safe Spaces).

The most commonly delivered intervention type was individual or group support to young people delivered by professionals. Mentoring-type approaches (e.g., forming relationships with a trusted person in community or school) and training for professionals or school staff who support young people were the next most common type of approach.

Although, we know from our qualitative interviews with young people that not all young people who were experiencing challenges reported receiving HeadStart support, on average young people who received any type of targeted intervention were more likely to have higher mental health difficulty scores (emotional, behavioural or total difficulties) and lower wellbeing scores compared to those who did not receive any targeted intervention. These findings suggest that HeadStart support was reaching a population of young people who had more significant needs than the general population, which was exactly the intention for the targeted support.

g) Reach figures for the HeadStart programme (July 2016- July 2022) based on data reported to the Fund by HeadStart partnerships

What did young people and parents find helpful or unhelpful about the support?

Across our studies exploring young people's experiences of support,[19; 26-29; 41] HeadStart was assumed to be just one part of a broader system of social or professional support that young people may seek. From our interviews with young people (age 9–12 years), we found that the majority described drawing on support from their parents or carers, friends and school staff for comfort, advice, distraction and instrumental support, for example to intervene in situations of bullying.[19; 27] In general, young people described how they turned to different people for support at different times, depending on what was troubling them.[27] Issues that they viewed as being more personal or sensitive, for instance, were better discussed with a parent or carer than with others. School staff were often seen as being in the best position to deal with difficult situations that arose at school but not always. Young people found that that teachers could sometimes be too busy, and that support seeking could be problematic in school when they were labelled as a 'snitch' by peers or if teachers had to break confidentiality.[27; 28]

We also found that some young people prefered to handle difficulties themselves, without drawing on support.[26]

Across our studies exploring young people's experiences of HeadStart support,[19; 27; 29; 41; 42] young people told us what was helpful (or less helpful) about the support that they had received from HeadStart.

Some examples are:

- gaining resources, techniques, and advice for managing emotions (e.g., stress balls, breathing or counting techniques, writing down or drawing feelings, apps and help with how to think positively)
- learning how to handle family and peer difficulties and relationships
- gaining help with managing behaviour at school (e.g., goal setting)
- having fun and enjoying support (e.g., doing creative, digital, outdoor and extracurricular activities, working collaboratively in group or team activities, playing games, going on a residential trip, doing something new or different and having food in sessions)
- feeling listened to, understood and taken seriously
- getting things off your chest, letting your feelings out or releasing a weight off your shoulders by talking about emotions or problems
- improving confidence and socialising more as a result of meeting new people in group activities or developing social skills.
- being able to relate to others involved in support, such as peers in group sessions who had had similar life experiences to them, or peer mentors who were of a similar age.

Young people also told us what was less helpful or could be improved about the support that they had received from HeadStart.

Examples include:

- feeling uncomfortable working with some peers in group sessions, such as older peers or those who misbehaved
- concerns about trust, including worrying that peer mentors would tell others about your problems
- perceiving the location of support as unsafe, too far away or too expensive to get to
- being unable to attend sessions (e.g., if it disrupts after school activities, means that you miss schoolwork, or clashes with detention)
- finding the content of sessions boring (e.g., when it is repetitive)
- finding that difficult emotions or situations returned, continued or got worse when support ended.

Often, these factors were common across the range of HeadStart interventions received by the young people we interviewed, with few intervention-specific differences identified.

We also asked parents what they found helpful or otherwise about HeadStart support.[43] That is, a small number of interventions were aimed at or included parents and carers and we invited a small sample of parents who had been involved in three HeadStart interventions to take part in qualitative interviews about their experiences. Parents described several helpful elements of the support that they and their children had received: having positive interactions with HeadStart staff, including staff being friendly and caring, and receiving helpful feedback about how their children were getting on; enjoying activities, appreciating the informal, discussion-based format of sessions, and being given resources to revisit information when needed; and learning from and connecting with other parents and carers.

In terms of less helpful elements of support: content was not always covered in enough depth; not all content was relevant for all families; and the coronavirus pandemic had disrupted support, in terms of sessions moving online. However, some parents felt that online sessions

were more accessible than in-person sessions. Parents suggested that interventions could be improved through the inclusion of additional or follow-up sessions; refining content (e.g., to include signposting to additional support); HeadStart staff providing more feedback about how their children were getting on and advice about how to help their children themselves; and devoting more time to strengthening peer relationships between parents and carers in sessions.

Implementing HeadStart: what worked well and what was challenging?

Implementing complex programmes like HeadStart is a challenging task, and it can sometimes be hard for those not directly involved in the programme to understand what this delivery entailed. Understanding the delivery of a programme can provide insight into its future impact and the factors that may moderate this impact. During the early set-up phase of the programme we explored HeadStart staff members' perceptions of the challenges that they and their partnership had encountered so far in relation to programme delivery, challenges they anticipated in the future and the solutions they suggested for overcoming these challenges.[44] We identified some common themes across 22 interviews with HeadStart staff members:

1. Working with schools – suggested solutions included establishing good working relationships with schools (e.g., by ensuring regular communication and having a dedicated schools lead) and providing a flexible and broad programme offer to schools.

2. Managing burden on staff time and capacity due to the scale of HeadStart – suggested solutions included recognising the limits as to how far the programme could be rolled out within the partnership (e.g., rolling it out in select areas rather than across the whole region).

3. Managing contextual issues – for example, suggested solutions for managing within the economic climate included ensuring that programme development did not rely on local services that may not be there in the future.

4. Reaching sustainability – suggested solutions included use of 'train the trainers' models for workforce development.

5. Duplication of services that were already available for young people and families in the area – suggested solutions included having a clear system for identification, referral and signposting to support for young people who fell within HeadStart's remit, rather than within the remit of CAMHS.

6. Delays to delivery – suggested solutions included initiating processes around staff recruitment, commissioning and approval of decisions as early as possible.

7. Working with external providers – suggested solutions included holding regular meetings with external providers and establishing frequent, open communication channels.

8. Identification of young people for targeted support – suggested solutions included involving schools in the design of identification tools and referral pathways.

9. Measuring impact or conducting an effective local evaluation (critical for HeadStart's 'test and learn' approach) – suggested solutions included simplifying data collection and management to minimise the burden on schools and organisations, and potentially employing someone specifically to work in this area.

What were school staff members' perspectives on HeadStart implementation?

Many HeadStart interventions relied on the buy-in and actions of schools involved. In late 2019 and early 2020 (mid-implementation), we explored the perspectives and experiences of staff members working at schools delivering and implementing HeadStart activities[45] We interviewed 13 members of school staff representing a range of job roles (before the initial coronavirus pandemic lockdown). Overall, school staff perceived that:

1. HeadStart was showing indications of positive impact, including in changes to their schools' ethos, priorities, policies and curriculum regarding supporting young people's mental health and wellbeing; improvements in staff skills, communication and wellbeing; and improvements in young people's resilience, confidence and wellbeing

2. implementation of HeadStart interventions and changes were facilitated by the degree to which HeadStart had met the needs, environment and ethos of their school; staff buy-in and enthusiasm for HeadStart; and supportive relationships with HeadStart staff teams

3. the challenges to implementation included young people, parents and carers and school staff not always engaging with HeadStart; lack of capacity within schools to implement HeadStart; and limitations in the availability and reach of HeadStart support.

Changes to programme delivery in response to the coronavirus pandemic

The coronavirus pandemic started early in 2020, at the mid-way point of the HeadStart programme and research. It created significant disruptions to delivery and evaluation with limited face-to-face contact and the closure of schools to most pupils (implemented as part of the UK government's strategy to prevent the spread of the virus). We invited partnership staff to attend a video call discussion about HeadStart delivery during the coronavirus pandemic. Programme leads, strategic leads, local evaluation leads and the leads of particular areas of HeadStart activity (such as co-production) joined this discussion.[46]

Partnership staff unanimously described this period as a challenging time, but also a time when HeadStart skills, experience and resources were in high demand across the community. Overall, they described needing to be responsive and flexible as a programme. The impact of the pandemic varied between partnerships, with some stopping delivery of certain types of activity altogether. Referrals decreased for all or some interventions during the early stages of lockdown, increasing again over the course of lockdown. Reasons suggested for the initial reduction in referrals included the closure of schools to many pupils, and seeking help becoming less of a priority as families and schools adjusted to coronavirus restrictions.

Working with schools particularly required sensitivity during this time. Schools' engagement with HeadStart reduced during the earlier stages of lockdown as they grappled with the very immediate challenges in their contexts. Partnership staff described being worried about school staff wellbeing and not wanting to overburden them.

In terms of delivery, HeadStart staff described adapting their interventions, resources and activities to be delivered or accessed virtually (but of course, not all types of activity can be adapted in this way). This was a learning curve for both those delivering and accessing support, but ultimately led to a more widespread acceptance of different forms of delivery as viable alternatives to in-person provision. Indeed, HeadStart staff reported that they had been able to reach even more young people than they had before the pandemic because of the newfound flexibility in delivery. But virtual programme delivery had drawbacks too; not all young people had access to technology or a private space at home, and they experienced technology failures from time to time.

Finally, those who joined the discussion also described how new areas of need had arisen as a result of the pandemic, such as anxieties around isolation and loneliness, families accessing basic resources (e.g., food), and families experiencing job losses. In response, partnerships developed new resources and delivered additional activities.

Overall, our findings provided insight into the ways HeadStart adapted during this period of crisis, highlighting the factors that facilitated this adaptation as well as the opportunities that arose for a preventative programme like HeadStart at a time when support for young people's mental health and wellbeing was in such demand.

Young people's participation in HeadStart (young people in the lead)

A key principle embedded across HeadStart was that young people were central to local strategy development, delivery of interventions and services and programme legacy. The Learning Team reviewed aspects of participation throughout the programme, disseminating practice and learning.

We considered different models of participation to inform a review of participation activity across the six partnerships.[47] Our review was based on the 'matrix of participation'[48] and an expansion of the 'ladder of participation',[49] as we felt that these conceptualisations most effectively captured the breadth and diversity of the participation activities that the partnerships had delivered. All of the activities we reviewed avoided the 'non-participation' categories (manipulation, decoration and tokenism) identified by Hart,[49] therefore all were all authentic forms of participation.

Our review [50] highlighted the wide range of participation activities that the HeadStart partnerships delivered. It showed that although most

activities offered were adult initiated, there had been many opportunities for young people to initiate and direct activity. The partnerships provided opportunities for young people to be involved in one-off and short-term initiatives as well as extended opportunities such as membership of advisory panels.

We shared these findings with the HeadStart National Young People's Group who reported that they had enjoyed and valued participation opportunities. They highlighted that they had felt listened to and that there had been good balance to the decision-making responsibility.

We also reviewed the engagement of young people in research and evaluation[51] and found that young people in HeadStart were involved in research in a range of ways: reviewing learning and shaping actions, influencing and determining research questions, carrying out research and providing feedback. According to partnerships, this helped to ensure that their research topics were important to young people and helped to develop ways of working that may have been different to those usually considered by adults. Considering research findings with young people led to more informed decisions around service improvement and a deeper understanding of young people's emotional health and wellbeing. This fulfilled ethical and moral obligations for young people to influence services that are designed for their benefit and provided opportunities for them to develop new skills. We found that although the partnerships had experienced challenges in implementing this activity, all were able to describe benefits of involving young people in this way.

We also carried out a qualitative study of participation in HeadStart, interviewing young people and staff from across the partnerships and focusing on the benefits and challenges of collaborating on the creation of mental health interventions in school and community spaces.[52] In terms of staff perceptions of the positive impact of collaboration in HeadStart, themes included: increased awareness and understanding of young peoples' needs; trusting in young peoples' abilities; noticing improvements in young people's wellbeing and; developing outputs that addressed the current needs of youth in their communities.

In terms of young people's perceptions of the positive impact of collaboration in HeadStart, themes included: a culture of collaboration emphasising safety, support, inclusivity, and authenticity; working on their own self-development and wellbeing; giving back to their community; and creating outputs that were youth-led and youth-friendly. Staff and young people highlighted the strong relationships that were built between them as both a benefit of the collaboration experience and as a factor which contributed to fruitful collaboration efforts.

Staff members and young people also addressed potential barriers to collaboration, including: limited time and resources; tokenistic involvement of young people from outside partners; and the disruption of the coronavirus pandemic causing a shift to an online modality for collaboration. Both staff members and young people suggested that prolonged funding for HeadStart would be welcomed and in some cases necessary for collaboration efforts to continue within their locality. Further recommendations for effective collaboration include: involving young people in collaboration efforts from the start of a project or campaign; being transparent and honest in communicating the ways that young people can contribute; and putting in checks and balances to safeguard against tokenistic involvement of young people with outside organisations.

Local economic analysis

This strand of the Learning Team's work focused on supporting partnerships to capture information about value for money that could be used to inform plans and decisions about the future sustainability of their programmes. There was no formal economic evaluation of HeadStart at a national level. Specialist expertise was provided by the LSE Personal Social Services Research Unit (PSSRU), who developed a methodological and data framework for the economic evaluation of HeadStart and a modelling tool and template that local partnerships could use to assess the economic impact of their approaches.[53] See Appendix 1 and LSE's final report for more detail.

All of the HeadStart partnerships captured some unit cost information using the approach and template devised, and in some instances HeadStart partnerships brought this together with impact data to use the model in full to identify savings, value for money or a 'break-even' point for particular interventions.

There were, however, a number of factors that limited use of the economic impact model. HeadStart partnerships found the process time consuming and there were some types of programme delivery for which it was difficult to attribute costs or impacts, particularly within the timeframe of the programme. Some technical aspects of the model were also demanding for local teams too, please see Appendix 1 for the detail about these challenges.

We also carried out a qualitative exploration into partnerships' collection and use of cost unit data in HeadStart towards the end of 2019 and start of 2020 (mid-implementation of the programme); from this we

drew out a range of learning points relating to the implementation of economic evaluation approaches in cross-system approaches. This work highlighted how, to a local partnership, the utility of any given approach to assessing value for money relates to the context and purposes of its use.[54] For example, the initial economic evaluation tool was, in the round, not felt to be compatible with the multi-layered, test and learn structure of the HeadStart programme. That is, HeadStart was composed of multiple different types of support provision which did not translate easily into specific units of cost needed for the economic tool.

Discussion: implementation and reach

The breadth and volume of support on offer and the reach of the support across the six HeadStart partnerships was striking. In this section we have brought together multiple perspectives on the implementation and delivery of a large-scale, long-term programme like HeadStart, including young people who had accessed HeadStart support, young people who had been involved in the development of mental health support, HeadStart partnership staff and staff working in schools in HeadStart areas.

Despite variation in partnerships' approaches to rolling out HeadStart support there were many shared challenges. From the perspective of staff working within the HeadStart partnerships, the most common of these were working with schools, staff capacity, contextual issues and achieving sustainability. In addition to these challenges, which emerged at various points during programme implementation and delivery, from 2020 onward the partnerships had to grapple with the unanticipated and significant obstacles presented by the coronavirus pandemic.

We learned that working with schools to deliver HeadStart support to young people is a nuanced process. HeadStart staff members considered it important to recognise that every school is different and has different needs and to ensure that HeadStart systems fit with existing systems and processes in schools. Staff recommended involving school staff representatives in the development of the HeadStart identification and referral pathways from the beginning, to ensure that processes fit with schools' established procedures as far as possible. In order to drive the cultural shift within schools, having school Senior Leadership Team (SLT) buy-in and dedicated HeadStart staff time for building strong relationships with schools were felt to be crucial.

Building on learning around the distinct needs and contexts of different schools, HeadStart activities often involved being sympathetic to the local and cultural context and working alongside schools when implementing support. All providers, such as charities, community and public services, delivering the interventions should understand the needs of particular communities (including languages spoken). Interviewees also emphasised the importance of ensuring that the development of the programme did not rely on services that may not survive in a climate of economic uncertainty.

In terms of the longevity of HeadStart support beyond the funding period, programmes as a whole need to integrate with services in the local area (including schools) and, where possible, upskill the workforce to build capacity within the existing system. From school staff members' perspectives, HeadStart principles seem likely to live on in schools beyond the funding period of the programme. This will rely on embedding HeadStart learning within school structures, having ongoing access to HeadStart resources and, crucially, providing schools with the capability to cascade training to other staff.

As mentioned previously, a completely unanticipated challenge to programme delivery encountered by HeadStart partnerships was the coronavirus pandemic. Despite the significant disruption brought by the onset of the coronavirus pandemic, it also seems to have played a role in emphasising the importance and prominence of HeadStart within local areas. Likewise, the findings provide insight into the ways in which preventive programmes like HeadStart can adapt during periods of major challenge. In this particular instance, the coronavirus pandemic brought to the forefront the need to invest in training, preparation and access regarding virtual delivery of support services. Effective preventive programme delivery most likely now requires a mixed model of in-person and remote support provision going forward. Collectively this may serve to strengthen the HeadStart legacy.

Our qualitative work with young people themselves provided rich learning about factors to consider in trying to engage them in support. The range of experiences described by young people shows how support programmes can be engaged with and perceived differently – young people like and don't like different aspects of the same experiences. For instance, some young people like having a peer mentor as they feel they can relate to their experiences, whereas others struggle to trust a peer mentor and would prefer to have an adult to speak to. Moreover, our finding that not all young people reported receiving HeadStart support suggests that schools' and programmes' strategies for identifying young people in need of support and engaging young people with support may need to be continually reviewed and refined as part of developing practice.

We also learned that most young people tend to turn to different people for support at different times depending on what was troubling them, most commonly their parents or carers, friends, siblings, and school staff. These findings indicate the importance for young people of having someone who they trust available to talk to about their problems if they need to. Individuals working or interacting with young people could simply check with young people whether they have someone in their lives with whom they can talk. Formal support provision for young people could (where appropriate) highlight and draw on the support that young people may already get from these sources. Similarly, contact with trusted individuals could be enhanced by large-scale training for those in contact with young people around how to help when a young person approaches you with problems or difficulties. As well as turning to people around them, we also know that young people use various techniques and strategies for cheering themselves up, distracting themselves from their problems, and helping them to move past a difficult situation or feeling. This could indicate the utility of the provision of time for young people to do the things that relax them, that they enjoy, or that can make them feel better, such as reading a book or drawing. Where possible this could be facilitated through approaches such as a brief time-out outside of normal breaktimes during the school day.

Just as it is crucial to work with schools' existing procedures to ensure maximum engagement, we also learned that it is crucial that support takes place at a time and location that is suitable and accessible for young people. The findings point to the importance of collaborating with young people to co-design support, as well as remaining curious and asking young people about what they think of the support they are receiving, whether it is helping, and what may be preventing them from accessing the support they need.

Indeed, our findings show how collaboration with young people can contribute to positive impacts for both the individuals involved in creating outputs and for developing youth-friendly and youth-focused programmes. The findings provide suggestions for how HeadStart, and other programmes like it, could incorporate youth collaboration in the future to ensure that young people have both voice and influence in programmes intended to address their mental health and wellbeing.

The findings covered in this section should be considered with a handful of caveats in mind. First, there was some ambiguity in separating HeadStart from non-HeadStart support in both the minds of school staff and young people. As the programme went on, the level of integration of HeadStart within schools and local areas also made it more difficult to draw meaningful distinctions between what constituted HeadStart and non-HeadStart support. Similarly, it was not always clear from young people's perspectives whether a particular staff member, lesson, or intervention was directly funded through HeadStart. Second, the study to understand implementation in schools drew from interviews with 13 school staff members from schools recruited to take part by the partnerships. This means that the findings reflect the perceptions and experiences of a small intentionally selected sample of school staff members.

Finally, as part of the focus on how best to embed and ultimately sustain HeadStart approaches, the Learning Team supported partnerships to assess the economic impact of their local approaches. This experience highlighted the limitations of using a standardised method for cost data analysis in the context of a complex, real world, multi-area-level programme like HeadStart. To maximise buy-in, it is important to involve implementers in the design of economic evaluation tools and manage the time burden that the use of such tools can present for programme implementers.

The Impact of HeadStart

In this section we consider the role of HeadStart support (both universal and targeted) in improving young people's mental health and wellbeing, as well as their academic outcomes (attainment, attendance and exclusion). We also consider how the programme has influenced the wider system in each of the local areas. To do this we draw on survey and interview data from young people themselves, as well as the perceptions of parents and HeadStart staff members. Some studies compared quantitative data about young people who took part in HeadStart with young people who did not, to see whether participating in HeadStart improved their mental health and wellbeing, or academic outcomes. For the full methodological details please see Appendix 1. Some additional quantitative analysis which was not published elsewhere is included in detail in Appendix 3, for those with an interest in the analysis and detailed findings.

Summary of findings

- Looking across the programme, we could not identify a statistically significant overall impact of either the targeted or universal HeadStart support on young people's mental health and wellbeing. There may be several reasons for these findings, including the availability of reliable data or comparison groups.

- Studies of individual interventions did indicate some effective interventions delivered through HeadStart, and some that were less effective.

- The level of young people's engagement with support can make a huge difference on the impact of an intervention's effectiveness.

- We identified a reduction in rates of exclusion in HeadStart schools in 2016/17 when compared to schools in non-HeadStart areas of the country. We estimate that HeadStart prevented about 800 students from experiencing a school exclusion in 2016/17.

- While our findings showed a decrease in exclusion rates, it cannot tell us about the reasons for the decline. The decline might have been due to initial improvements in school policies regarding the management of exclusions, changes in young people's attitudes or behaviours at school, or a combination of the two.

- We did not find any evidence of positive impact on young people's attendance or attainment at school,

- Findings across our qualitative studies exploring young people's experiences of HeadStart support illustrated the range of ways HeadStart had a positive impact on young people's mental health and wellbeing. Their perspectives were echoed by school staff.

- Qualitative studies also identified some areas of negative impact, albeit to a lesser extent, including young people feeling bored or stressed by session content.

Impact on mental health and wellbeing

Impact of universal support

Universal support is provision that is accessed by, not just on offer to, all young people in a given population. In HeadStart this meant all pupils in HeadStart schools receiving enhanced mental health or wellbeing provision. This could include, for example, training for school staff in understanding mental health and how to identify vulnerable pupils, or a review of the school's approach to promoting and supporting good mental health. In HeadStart schools, every pupil received at least one universal intervention during the programme.

Exploring the contribution of universal interventions across the entire HeadStart programme presented a challenge because all pupils in HeadStart schools received some sort of universal support, and because there was a lack of comparison 'non-HeadStart' schools. As such, in order to examine the impact of the universal support we focused on one HeadStart partnership, Kent, where a phased roll-out of universal support offered the opportunity for comparison between schools. Not all schools in Kent were part of the HeadStart intervention programme in year one; each year more schools were added to the programme. All schools, however, took part in the annual survey (the Wellbeing Measurement Framework) from the beginning as part of the national evaluation. This implementation approach created natural control groups which allowed us to look at the impact of HeadStart universal support. Overall, we could discern no significant effect of HeadStart universal interventions on young people's mental health and wellbeing. We consider the possible reasons for this at the end of this section.

Impact of targeted support

In this context targeted support refers to interventions offered to select groups of young people who meet the criteria for needing additional help with their mental health or wellbeing. These young people may have been identified as already showing signs of mental health problems or being at particular risk of developing mental health problems in the future. We investigated the impact of targeted HeadStart interventions in three ways.

Firstly, using the longitudinal sample, we compared survey data from young people who received targeted interventions (at least once over the five years) to that of young people who did not receive any targeted intervention. We found that the mental health difficulties scores of young people who received targeted interventions were significantly

higher at each timepoint compared to those who did not receive targeted interventions. This indicated that in general, targeted support was reaching those 'most in need'. We did not find any difference in the trajectory of young people's mental health or wellbeing scores between those who received targeted interventions and those who did not. In other words, we did not find any evidence that the interventions improved the mental health or wellbeing of those that received them. We found that the emotional difficulties of all young people significantly increased in 2018/19 and onwards, behavioural difficulties decreased for everyone from 2018/19 onwards and wellbeing declined over time for everyone from 2017/18 onwards, regardless of whether they received targeted HeadStart support.

Secondly, we investigated year-on-year changes – in other words, we explored changes in mental health and wellbeing scores from year one of HeadStart to year two, year two to year three and so on. The results mirrored those of the longitudinal analysis. We found that the baseline mental health difficulties scores for the young people who received interventions were particularly high in comparison to those who did not receive targeted interventions. Again, indicating that in general, targeted support was reaching those 'most in need'. As with the longitudinal analysis, we did not find any evidence of improvement in mental health among the young people who received targeted interventions relative to those who did not receive targeted interventions.

Finally, we formally tested the impact of a handful of specific interventions in isolation (known as 'summative evaluations'). These interventions lent themselves particularly well to impact evaluation (e.g., randomised control trials).

Impact of specific interventions

The summative evaluations were a series of three robust evaluations of specific interventions to complement the overarching analysis described above. These interventions were all delivered by HeadStart Newham. Collectively the summative evaluations suggest that full attendance and engagement are crucial to the success of programmes. Small improvements can be found in the mental health and wellbeing of recipients when we take attendance data into account.

Team Social Action

Team Social Action (TSA) is a targeted group-based intervention that was delivered by HeadStart schools in Newham for 12–14-year-olds with mild-moderate emotional, behavioural, attentional or relationship difficulties. Young people selected a topic (e.g., rough sleeping in Newham) and worked together to develop a social action project. Groups included up to 15 young people who met over 10–12 weekly sessions during or after school. A HeadStart youth practitioner facilitated the sessions.

TSA aims to improve young people's wellbeing, peer relationships and feelings about school (i.e., school connectedness) by encouraging them to foster interests, highlighting their achievements, developing their problem-solving skills, and encouraging them to take on and share responsibilities with other young people. In our summative evaluation, we investigated the impact of TSA on young people's wellbeing, perceptions of peer support and school connectedness. We also investigated the implementation of and attendance at TSA, and whether this impacted these outcomes.

We used a waitlist randomised control trial design involving 318 young people from 10 secondary schools in Newham. This means that we randomly selected 50% of the schools to receive the intervention. The outcomes for the pupils at these schools were compared to those of the remaining 50% of schools (control schools), who were placed on a waitlist to participate in the intervention at the end of the trial.

Findings revealed TSA to have no overall impact on mental wellbeing, peer support or school connection. That is, we observed no differences between the intervention and control groups for these outcomes. However, when focusing on where attendance was high there were some positive impacts detected. Specifically, attending at least 10 out of the 12 TSA sessions resulted in small but significant improvements in wellbeing and peer support and a small decline in feelings of school connectedness. Girls and those who were not eligible for FSM were most likely to attend TSA sessions. Intervention experiences were investigated using interviews with a subsample of young people participating in TSA from four schools (N = 15), HeadStart youth practitioners (N = 3), and staff (N=3) from different schools. These interviews revealed that barriers to attending TSA included beliefs among young people that it was an academic intervention or punishment; concerns among parents or carers and young people that participation may detract from academic studies; and a reluctance to participate in mental health interventions. Young people did not feel that TSA had impacted their wellbeing but commented that it provided a distraction from any difficulties they were experiencing.

Individual schools and youth practitioners implemented the intervention in different ways, meaning there was variation in how TSA was delivered. Youth practitioners and staff believed that TSA

strengthened pupil confidence and project management, leadership, and communication skills. Young people did not form friendships with other TSA students; however, the intervention provided them with the opportunity to work with young people from outside their usual peer group. TSA was viewed as a separate entity to school due to a lack of awareness among wider school staff and the absence of school staff in TSA sessions. This supports the finding that attending at least 10 TSA sessions led to a small decline in school connectedness. Our evaluation highlighted the importance of attendance, with increased benefits being observed in relation to peer support and wellbeing for those who attended most sessions.

Our evidence briefing on TSA[55] provides further information on this summative evaluation.

More Than Mentors

More than Mentors (MtM) is a targeted cross-age peer mentoring intervention that was implemented by HeadStart schools in Newham. An older pupil (aged 13–15 years) mentors a younger pupil (aged 11–13 years) with either self- or teacher-reported mild-moderate emotional, behavioural, attention or relationship difficulties. MtM takes place over the course of 10–12 weekly sessions. Mentors are given two days of training (which they are required to pass) and weekly bitesize support sessions, both of which are provided by youth practitioners. In addition, bi-weekly supervision with a clinical psychologist is provided. MtM aims to improve the resilience, confidence, goal setting and problem-solving skills of both mentors and mentees. Sessions take place after school and consist of approximately 10–15 mentors and 10–15 mentees. During sessions, a group activity is followed by one-to-one mentoring time.

Our summative evaluation assessed the impact of MtM on several outcomes for both the mentor and the mentee: wellbeing, perceptions of problem-solving skills, and goals and aspirations. We also investigated the implementation of and attendance at MtM, and whether these impacted the above outcomes. We used a pre-post quasi experimental design involving 257 young people from 11 secondary schools in Newham. An intervention group was compared to a matched control group who had not participated in the intervention. Allocation to these groups was not randomised owing to the design of the intervention. 117 young people participated in the intervention, and 140 young people were in the control group. Outcomes were assessed before and after participation in MtM.

We found that MtM had a positive effect on the wellbeing of mentors but that there was no impact on their problem-solving skills or goals and aspirations. MtM did not have any impact on any of these outcomes for mentees. The level of attendance at MtM sessions was not related to the outcomes of either mentors or mentees. Intervention experiences were investigated using interviews with a subsample of young people who participated in MtM (six mentors and seven mentees), three youth practitioners and three school staff members. These interviews revealed inconsistent delivery across groups. For example, the length of sessions varied, the absence of part of a mentee-mentor pair was dealt with differently and the bitesize training was not always delivered. The importance of identifying mentees who had difficulties they wished to discuss was also highlighted in the interviews, and the relationship between mentee and mentor pairs was identified as a crucial aspect to ensure the success of MtM.

Although we observed no impact of MtM on mentees' wellbeing, interviews suggested that they felt more settled at school and had learnt coping skills to manage their emotions. Although mentees received support and learnt strategies from their mentor to manage problems they were currently experiencing, they generally struggled with problem solving once MtM had ended. Similarly, although mentees received motivation and support to set new goals during MtM, they did not develop the skills or motivation to do this beyond the context of the intervention. Mentors reported experiencing increased self-confidence, communication, leadership and assertiveness skills, and felt a sense of achievement through participation in MtM. Mentors also reported developing problem-solving and goal-setting skills, which they were able to apply outside the context of the intervention.

Findings from this summative evaluation suggest that although MtM could be beneficial in improving the wellbeing of young people acting as mentors, consistent implementation and delivery of the intervention, selecting the right young people to participate and school engagement with interventions are crucial factors for their success.

Our evidence briefing on MTM[42] provides more information on this summative evaluation.

Bounce Back

Bounce Back is a school-based small group mental health intervention. It aims to improve children's understanding of resilience and wellbeing, support them to build their confidence and friendships, and provide practical skills to help them make positive emotional and behavioural changes. The intervention is based on the academic resilience

framework that aims to support children to meet their basic, belonging, learning, coping and core self-needs. This is achieved by improving their five core resilience skills: planning for success, learning from experience, staying motivated, dealing with tricky situations and being able to ask for help.

In this summative evaluation, 24 HeadStart Newham schools and 326 children aged 9–11 years who showed at least one indicator of an emerging mental health difficulty were randomly assigned to either the intervention or waitlist control group. Children in the intervention group participated in weekly one-hour group sessions for 10 weeks with a trained youth practitioner. During the sessions, children learned to develop core resilience skills. Children in the control group were placed on a waitlist to participate in the intervention at the end of the trial. We assessed the impact of the intervention on children's emotional symptoms, behavioural difficulties, problem-solving skills and self-esteem.

Our findings indicated that Bounce Back reduced the emotional symptoms of children in the intervention group, with those attending more sessions showing greater reductions in symptoms. White young people were more likely to attend more sessions than those from other ethnic backgrounds. The intervention did not impact behavioural difficulties or problem-solving, irrespective of attendance rates. We found some evidence that the intervention might improve children's self-esteem, but this finding was not statistically significant.

These findings suggest that Bounce Back can successfully reduce emotional symptoms of at-risk children aged 9–11 years. Increasing the attendance rates of children from minoritised ethnic groups was identified as a future priority. Moreover, Bounce Back may have the potential to improve the self-esteem of children with emerging mental health difficulties, but future trials with a larger sample are needed to confirm this. Finally, the findings of the current trial are limited to a single area (Newham) and are based on short-term outcomes. Therefore, it is important to replicate these findings in other areas and observe long-term effects.

For further information, see the Learning Team's research paper[56] and evidence briefing[57] on the evaluation of Bounce Back.

Young people's and staff perceptions of impact

In addition to exploring the quantitative evidence, we explored the qualitative data from interviews with young people and staff to understand the impact of HeadStart on young people's lives, from their perspectives. From our interviews across the six HeadStart areas over years one to five of the programme (2017–2021), young people described a range of ways in which they felt the support that they had received from HeadStart had had a positive impact on them and their lives:[41]

Experiencing emotional and behavioural improvements such as feeling happy, positive or better in general; feeling more confident; and feeling less angry, anxious, stressed or sad. In addition, young people described feeling more able to calm down when they were feeling angry, worried, or stressed and to persevere in the face of challenges. They also spoke about experiencing improvements in their knowledge of mental health, wellbeing and relationships. Assemblies or lessons about mental health, how to stay safe, and how to handle peer pressure and bullying had helped them to know what to do in difficult situations, including who to talk to and strategies that they could use.

Experiencing social improvements such as making more friends; developing their social skills; having fewer fights and arguments with peers and family members; and improved openness with others. HeadStart provided an opportunity to get out of the house, have fun and be distracted from problems or difficult situations. They also mentioned feeling more able to express their emotions and talk to others about how they were feeling or problems they were experiencing.

Feeling inspired to or learning how to help others including understanding the importance of being kind to others and developing skills to manage conflict between peers. Young people recognised that even if participation or co-production activities (for example) did not directly help them, they may help someone else. Some young people felt inspired to become a peer mentor after being a mentee.

Often, these areas of positive impact were common across the range of HeadStart interventions received by the young people we interviewed, with few intervention-specific differences identified.

Young people also identified areas of negative impact of HeadStart support across our studies.[29; 41] These included:

- feeling left out or jealous when other people were chosen to be involved in HeadStart, but you were not
- finding the content of sessions boring (e.g., when it is repetitive) or stressful (e.g., when it is about topics that worry you)
- feeling sad about support ending.

School staff we interviewed[45] also described their perceptions of the positive impact of HeadStart on young people:

Perceived improvements in young people's resilience, confidence, and wellbeing School staff identified a number of factors to explain these improvements, including the opportunities HeadStart provided for young people to mix with new people and access new extracurricular activities; the provision of a space for young people to have conversations that they would not usually have; and the ability of HeadStart staff to engage effectively with young people.

Perceived improvements in young people's peer relationships For instance young people learning to get along with each other in HeadStart group interventions; being more accepting of differences and receiving help from peer mentors to mitigate bullying.

Perceived improvement in communication School staff felt that some young people were also better able to communicate with others, including being more able to talk about their problems or speak up in class.

Discussion: Impact on mental health and wellbeing

Looking across the programme, we did not detect a statistically significant impact of either targeted or universal HeadStart support on young people's mental health and wellbeing using the quantitative dataset. There may be several reasons for these null findings.

Firstly, to conduct the most robust analysis of these data, counterfactuals – a comparable group not receiving the interventions – are needed to compare the HeadStart sample to. Unfortunately, these were limited due to challenges in including comparison schools and a lack of reliable up-to-date mental health and wellbeing data for this age group from other contemporary studies. The lack of current comparison data made drawing firm conclusions about the impact of HeadStart particularly challenging because there was so much that had changed in young people's lives besides the implementation of HeadStart, because of the coronavirus pandemic.

Secondly, we did not have reliable data about which young people had received targeted intervention(s) and which young people did not, nor on which interventions were being delivered each year. Obtaining information about which young people received support, when and for what period of time relied on the collection of data via our 'Who got What' (WGW) template. This template was completed yearly by the delivery teams across the local partnerships. Some of the partnerships relied on opt-in (rather than opt-out) consent in relation to sharing WGW data with the Learning Team, which meant that we only received a small subset of data. In a separate process we gathered data describing the interventions and when they were being delivered through an online questionnaire (the Template for Intervention Description and Replication [TIDieR]), which was completed and updated yearly by the HeadStart partnerships. Unfortunately, for some partnerships it was difficult to provide complete annual updates, due to pressures on time and capacity, which meant that it was hard for the Learning Team to record which interventions were running across the six partnerships. The difficulties surrounding these two processes means that our 'control group', such as it was, was likely to include young people who did, in fact, receive HeadStart support, dampening the impact findings.

Thirdly, the interventions are not perfectly aligned with data collection which meant that, for example, 'post-intervention' data via the annual WMF survey was collected some time after a pupil had completed an intervention. This could mean that immediate impact was not captured. There is also no uniformity across interventions in terms of when impact was measured, which makes it difficult to extrapolate any reflections on the immediacy (or not) of impact.

Fourthly, summative evaluations showed that the level of young people's engagement with support makes a huge difference on the impact of an intervention's effectiveness. The overall analyses of the quantitative dataset did not take the engagement into account. As the level of engagement varied by individual and across the interventions, these varying levels of engagement might have affected our ability to determine impact overall.

A fifth possible explanation to the muted programme-wide findings is that HeadStart may have included a combination of effective and non-effective interventions. Indeed, the summative evaluations did indicate some effective interventions delivered through HeadStart and some that were less effective, or that needed extensive engagement to achieve positive outcomes. This mixture is perhaps reflective of the 'test and

learn' nature of the HeadStart programme, where partnerships were encouraged to try out approaches to explore their effectiveness and only continue with those that were successful. All interventions were incorporated in the programme-wide analysis, and this mixture of approaches may have diluted the overall effect observed.

In contrast, the findings across our qualitative studies exploring young people's experiences of HeadStart illustrate, from young people's perspectives, the range of ways in which HeadStart had a positive impact on young people's mental health and wellbeing. These include experiencing emotional, behavioural and social improvements, confidence boosts, inspiration and knowledge about how to help others, and coping, help-seeking, and problem-solving skill development.[29; 41; 45; 55] Several of these areas of positive impact were echoed by school staff.[45] We also identified some areas of negative impact across studies, albeit to a lesser extent, including young people feeling bored or stressed by session content.[29; 42; 41; 55]

Impact on young people's school outcomes

HeadStart's programme theory anticipated that support for mental health and wellbeing may also impact on wider outcomes such as academic attainment and school engagement. We investigated if HeadStart was effective in improving three school outcomes: attendance, exclusion and attainment.[58; 59] While we could not find any evidence of positive impact on attendance or attainment, we found a reduction in rates of exclusion in HeadStart schools in the 2016/17 academic year when compared to schools in non-HeadStart areas of the country.

Our analyses drew on administrative data routinely collected by the Department for Education in all schools across England, which enabled us to compare school outcomes for HeadStart areas to outcomes from all other local authority areas across England. We used an approach called synthetic control method (SCM) to create 'synthetic control groups'. This approach creates a weighted average of the outcome variable from all of the local authorities which was used to compare the synthetic control group to the HeadStart local authorities (the 'treated unit').

We found a reduction in exclusion rates in HeadStart areas relative to the non-HeadStart areas. This reduction was bigger in the academic years 2016/17 (0.6 percentage points [ppts]) and 2017/18 (0.8 ppts) than in 2018/19 (0.5 ppts). This represents a 10%–15% relative reduction in the exclusion rate in local authorities that received HeadStart funding on average compared to those who did not. These impacts are on the boundary of statistical significance for 2016/17 and just outside significance for 2017/2018. From the results, we can estimate that HeadStart prevented about 800 students from experiencing a school exclusion in 2016/17. Based on the estimate of the cost of a permanent exclusion being close to £385,000[60] and the cost of missing one session due to fixed term exclusion is estimated at close to £300, the programme has saved an estimated £6 million by reducing exclusions in the 2016/17 school year. While this study showed a decrease in exclusion rates, it cannot tell us the reasons for the decrease. It is possible that the decrease was due to improvement in school policies regarding the management of exclusions or changes in young people's attitudes or behaviours at school. HeadStart did not have an impact on absenteeism or age 16 attainment.[61]

Consistent with the quantitative findings, our qualitative interviews with young people across years one to five of the HeadStart programme (2017–2021) identified positive impact in the school setting.[41] This included feeling able to concentrate more in lessons or improvements in behaviour at school. These improvements were attributed to having goals set by their peer mentors around improving behaviour, worrying less and receiving help from HeadStart with emotional, peer and family difficulties. Young people also mentioned being involved in HeadStart co-production or participation activities to improve their school, such as giving suggestions for how to make the school environment feel like a safe place. As a result, young people described feeling listened to more by school staff and enjoying being able to help others by influencing change within their school.

The summative evaluations of two interventions delivered by HeadStart Newham – MtM[42] and TSA[55] – yielded additional qualitative learning about young people's experiences of school-related impact. Mentees in MtM felt more settled at school as a result of their participation in the intervention. Participating in TSA could be a motivator to attend school on session days so as not to let the group or youth practitioner down and because sessions were enjoyable. However, motivation to attend school generally did not seem to change.

Discussion: Impact on young people's school outcomes

While we could not find any evidence of positive impact on attendance or attainment, we found a reduction in rates of exclusion in HeadStart schools in the 2016/17 academic year and a marginal effect for the following academic year when compared to schools in non-HeadStart areas of the country. While the analyses were not able to shed light on exactly how these effects were achieved, given the focus of the programme, it is likely that the impact on exclusions was due to one or both of the following HeadStart actions. Cultural changes in schools brought about via HeadStart that encouraged schools to take a more relational and less punitive approach to behavioural difficulties. In addition, the support provided in schools reduced the incidence of behavioural difficulties, which in turn, reduced the likelihood of exclusion. Irrespective of the reason, this impact carries practical importance due to the implications of exclusions for young people's wider functioning and adaptation in later life. Young people who are excluded from school are more likely to experience periods not in education, employment or training; to experience later problems with mental or physical health; to be involved in crime; and to experience periods of homelessness.[62; 63]

However, the impact on exclusion reduced over time and by the academic year 2017/2018, there was no discernable difference between HeadStart areas and comparison areas in terms of exclusion rates. It's not clear why this effect diminished over time but it has been previously noted that it can be hard to embed and sustain changes to school culture, particularly where staff turnover is high and where there are significant competing pressures on schools.[64]

In terms of impacts on attainment and attendance, while a relationship between mental health and both attainment and attendance has been previously noted in the research literature, often the relationship is weak (e.g., effects sizes around .1 or below once shared risk factors are accounted for[61]). It is therefore perhaps not surprising that the impact of a programme primarily focused on mental health and wellbeing did not show an impact on these outcomes in the short term.

Quantitative results around the impact of HeadStart on school outcomes also highlighted that the SCM is an attractive methodology for evaluating complex area-level interventions like HeadStart, especially when there is no obvious control group with which to make a comparison analysis. As a data-driven procedure, it reduced discretion in the choice of the comparison control groups and allowed us to investigate complex area-level interventions between local authorities where HeadStart interventions were available and those where the interventions were not available.

Impact on schools and staff

Qualitative interviews with school staff pointed to other potential outcomes from the programme, both for young people and for themselves.[45] School staff members described their perceptions of the impact of HeadStart on the school staff team and on the school in general:

HeadStart complements or adds to existing school provision seeking to promote young people's mental health and wellbeing. Staff commented that a focus on promoting positive mental health and wellbeing had now been threaded through and embedded in their school practices and routines, rather than being a separate workstream. HeadStart frameworks and ideas had also been incorporated into school policies when renewing or reviewing them. HeadStart had provided structure, coherence and a foundation for their existing practice, as well as more resources for schools to be able to effectively implement support.

Perceived improvements in staff skills, communication and wellbeing. School staff described how HeadStart had provided valuable training, learning and professional development opportunities for staff, in relation to supporting the mental health and wellbeing of young people and parents and carers, as well as their own mental health and wellbeing. School staff noticed improvements in their own wellbeing and in their communication with one another following the introduction of HeadStart. They described how they had made new or increased efforts to focus on school staff wellbeing, for instance by introducing new initiatives specifically geared towards helping staff to relax and celebrate their achievements.

Impact on parents and carers

Of the 76 targeted interventions across the partnerships, only 8 were aimed at or included parents and carers. We invited a small sample of parents and carers who had been involved in three HeadStart interventions to take part in qualitative interviews about their experiences.[43] The interventions were the Intensive Mentoring Programme (HeadStart Kent); Barnardo's – Wellness Resilience Action Planning (HeadStart Hull); and Supporting Parents and Children Emotionally (HeadStart Kernow). We aimed to provide a snapshot of parents' and carers' experiences of and perspectives about being involved in different types of HeadStart support. We conducted

interviews with seven parents (six mothers and one father).

Overall parents felt positively about the impact of HeadStart interventions that they had attended. Parents interviewed felt reassured that their children were feeling better or receiving support and more confident in their parenting abilities; noticed improvements in their communication with their children; developed new knowledge and understanding (e.g., about their children's emotional development); and learned new coping techniques and strategies.

Discussion: Impact on schools, staff, parents and carers

The national evaluation of HeadStart largely focused on analysis of the impact of support on young people (and the system), rather than on the adults and professionals around them. From the limited evidence that was gathered, however, we found that school staff not only valued the training and professional development opportunities in relation to supporting the mental health and wellbeing of young people but also noticed improvements in their own wellbeing. Parents also reported improvements in their knowledge and understanding of their children's mental health after having taken part in HeadStart interventions, and felt reassured that their children were being supported. Given the findings reported elsewhere in this report about who young people tend to turn to for support (family, friends and specific school staff members; p39) and the importance of these trusted relationships, it is noteworthy that HeadStart was perceived as effective in strengthening these support systems.

Impact on the wider system and the sustainability of HeadStart principles and practices beyond the funding

As mentioned at the beginning of this report, HeadStart partnerships were expected to take an ecological approach, meaning the young person should be considered within the context or wider system in which they are growing up. Broadly this includes their immediate environment (e.g., family and friends), their local environment (e.g., the neighbourhood they live in) and culture at large (e.g., social conditions, mass media). In other words, as well as supporting improvements for individual young people, HeadStart aimed to change the systems of support around them too, in ways that could be sustained beyond the programme funding.

At around the mid-point of HeadStart delivery, we conducted eight interviews with representatives from the six HeadStart partnerships, the Learning Team, and TNLCF. These interviews explored perceptions of sustainability and systems change.[16] Participants gave definitions of systems change and sustainability within HeadStart that suggested that these concepts were viewed as related processes, as well as end goals.

Participants spoke about HeadStart as being a catalyst, tool or lever to reshape the existing system in a range of ways:

- **Workforce, organisational or individual transformation**, achieved through training and upskilling staff and young people across schools, mental health services and community organisations.
- Increased emphasis on **prevention or early intervention.**
- Improved **'joined-up' working** between organisations, services and individuals, enabling them to share learning and information more easily.
- A shift to a **shared or embedded language, understanding or approach,** for example by taking 'whole city' approaches to mental health and wellbeing.
- A **continuation of 'what works'** in HeadStart through sustained funding, embedding aspects of the programme within existing local agendas, or because local organisations are maintaining delivery beyond the funding period.
- **Influencing local and national policy and practice** and improving commissioners' knowledge of early intervention and prevention.
- Increasing emphasis on **co-production** in policymaking and commissioning.

Participants also highlighted a range of factors that could facilitate sustainability and systems change in the context of HeadStart and programmes like it: building relationships, alliances and networks; securing local ownership, buy-in and leadership of HeadStart; co-production; embedding HeadStart within existing systems; aligning with and building on local or national policy agendas; securing continued funding; and early thinking and planning.

We also explored sustainability as a topic during our interviews with school staff members before the coronavirus pandemic.[45] We identified the following themes:

Concerns about the loss of HeadStart funding and support. School staff expressed sadness and concern about the HeadStart funding period ending. This was because they did not want targeted interventions for young people and support from the HeadStart staff teams to be withdrawn. They felt that they might struggle with capacity or to keep the momentum of HeadStart going. They wondered whether HeadStart interventions would be recommissioned by the local authority or whether schools could make a business case to fund delivery of the interventions themselves.

The legacy of HeadStart. Despite identifying challenges to sustaining HeadStart, school staff felt that the HeadStart legacy and ethos would likely continue after the programme funding period had ended. This was because lasting changes had already been made to the curriculum or to school policies as a result of HeadStart. Moreover, key learning, tools and resources from HeadStart could continue to be used by schools for as long as they were still available. The training that school staff had received through HeadStart was also seen as a key element of the programme's legacy, as trained staff had the skills to continue providing support for young people themselves, for as long as they remained in post. However, school staff also acknowledged that, ultimately, what they would be able to deliver would be a 'HeadStart-lite model', as they did not have the capacity to deliver the same volume of support as HeadStart staff had.

Interviews with HeadStart staff members during the coronavirus pandemic indicated that HeadStart had become more prominent within their local areas because of the support that HeadStart was able to offer to schools, young people and parents and carers during the pandemic[42]. Staff described HeadStart as being a key aspect of wider strategies within their local areas. They felt that HeadStart skills (such as co-production) and resources (including booklets and webpages) were in demand during the pandemic. HeadStart's increased prominence during this period was perceived by HeadStart staff as helpful for their sustainability planning. For instance, some HeadStart staff felt that increased visibility might help them to procure additional funding sources further down the line or help to cement the programme's legacy in their local areas.

Towards the end of the programme, as a follow-up to our earlier work, we explored the perspectives of 30 HeadStart staff and wider stakeholders about local area level and systems change as a result of HeadStart. Participants described HeadStart as having improved joined-up working across the system, including bringing together disparate individuals and organisations, such as through the instigation of multi-agency meetings. Participants also spoke about HeadStart having shifted focus and awareness towards the importance of prevention and early intervention, as well as the more varied and accessible support and training offer that HeadStart had brought to local areas for young people, families, and staff.

Reflecting our earlier work, participants identified the following factors that had enabled local area level change through HeadStart: suitable funding; appropriate positioning of the programme within the local authority; recognition and credibility of HeadStart; effective leadership; relationship building; embracing flexibility and learning; exhibiting best practice in co-production; aligning with and influencing national or local initiatives; and the coronavirus pandemic as a lever for change.

Participants also identified ways in which HeadStart's impact had been more limited on a local area level, for instance when the programme had struggled to gain traction in particular contexts (such as schools) or when the programme only had capacity to reach a proportion of the local area. Participants acknowledged that not everything delivered through HeadStart worked and that there was more work to be done to effect change in an established system. Factors identified as preventing or limiting change included: competing priorities; difficulties building effective relationships and communication channels; uncertainty around sustainability and continued funding; structural challenges inside and outside the programme; and challenges associated with the coronavirus pandemic.

Discussion: The sustainability of HeadStart principles and practices beyond the funding

Interviews carried out around halfway through programme delivery showed that HeadStart staff members tended to view systems change as either a necessary or helpful prerequisite for sustaining HeadStart principles or practices beyond the funding. Contributing to changes in the whole system of support around young people is one way that HeadStart could have ultimately maximised the reach, lasting impact and legacy of the programme. However, this assumes that under such a changed system, beneficiaries will have experienced desirable outcomes that warranted being sustained. Without sufficient impact data, we do not know with certainty whether this is the case for HeadStart.

As a test and learn programme there is an expectation, of course, that some interventions will not continue beyond the life of the programme, whereas others will. From school staff members' perspectives, the legacy and ethos of HeadStart was deemed likely to continue beyond the funded period of the programme through, for example, the embedding of HeadStart learning within school structures and the ability of trained school staff to implement HeadStart support. This highlights the importance of providing schools with the capability to cascade training to other staff. New initiatives must be sufficiently embedded so that they can continue even if key staff members leave.

From HeadStart staff members' perspectives, the coronavirus pandemic played a role in highlighting the importance and prominence of HeadStart within their local areas. This occurred through improving reach (e.g., through delivering services over larger geographic areas to meet more need), changes in support provision (e.g., ensuring that families had access to basic resources, such as food), and becoming a conduit for information provision around young people's mental health and wellbeing.[46] This could potentially have had a positive influence on how well embedded some aspects of HeadStart might become in future ways of working.

Towards the end of the programme, some HeadStart staff and local area stakeholders commented on the legacy of HeadStart within their local areas and referenced aspects of HeadStart implementation that would be sustained through alternative funding sources. However, others expressed uncertainty about how or in what ways the HeadStart programme would be sustained within their local areas. Moreover, while it was clear from HeadStart staff and stakeholders' perspectives the valuable ways in which HeadStart had been contributing to local area level and systems change, it was not possible to ascertain the degree to which lasting change had been influenced through HeadStart.

Overall strengths and limitations of the national evaluation

A significant strength of the HeadStart national evaluation was in the way that it was assembled as a multi-layered programme of research. We considered this the most appropriate way to reflect the nature of HeadStart delivery. TNLCF awarded grants to the six local authority partnerships to design, develop and commission portfolios of interventions based on local need. This approach to funding was innovative in that it moved away from a 'one size fits all' or prescriptive approach and instead allowed partnerships to be truly explorative in terms of what would be most effective for local populations of young people.

This meant that HeadStart was not one intervention or way of supporting young people that could be neatly evaluated in a traditional sense, but rather an ethos shared across partnerships that materialised in many different ways. The multifaceted national evaluation incorporated a population-based survey and qualitative interview approaches, both of which were a large-scale and longitudinal. To complement these major strands of the evaluation were a series of nested, focused evaluations of certain interventions (summative evaluations). Combined, these approaches allowed us to capture the context, experiences and impact of HeadStart support as fully as possible. Through this, over 60 studies, research papers, briefings and other resources were produced by the Learning Team between 2018 and 2023, most of which was drawn on in this report and is publicly available. See the full list of ouputs in Appendix 4.

Our national evaluation aligned most closely with a realist evaluation

methodology in recognition of the complex nature of HeadStart, in which numerous interwoven factors (internal and external) were active during delivery. This layered approach to evaluation captured multiple strands of data in order to explore as many aspects of the programme's logic model as possible. This approach has allowed us to explore programme-wide changes in young people's outcomes as well as the impact of some specific interventions nested within the programme. It has also allowed us to incorporate multiple perspectives in our qualitative work, including those of young people, parents and carers, school staff and HeadStart staff.

We were not able to deliver certain elements of data collection that were part of our original evaluation plan (e.g., the collection of data from comparison groups), and aspects of data collection were significantly affected by the coronavirus pandemic. Some of these challenges could not have been foreseen at the evaluation planning stage and some go hand-in-hand with the collection of messy, real-world data as part of the delivery of complex programmes. Despite these limitations, we remain committed to this multi-stranded approach to the evaluation of real-world programmes. The evaluation has incorporated surveys responses from over 80,000 children and young people and qualitative data from 124 interviewees, including young people (82), school staff (13), parents (7) and HeadStart staff (22). The evaluation was also able to flex to add value by incorporating relatively innovative approaches. In particular, the study exploring school outcomes highlighted the potential for applying SCM in administrative datasets in order to detect impact of area level programmes, and highlighted the potential for such programmes to reduce exclusions in schools.

The contribution of both the quantitative and qualitative data collected to advancing our understanding of young people's experiences of mental health problems is significant. This is not only within the context of the evaluation but also for the wider field. The longitudinal sample of over 30,000 young people (at baseline) who completed the annual WMF survey in schools was one of the largest in recent years. It has already been drawn on by colleagues in the Department for Education, NatCen Social Research, Probono Economics and by other researchers (e.g., the ATTUNE project, a partnership between the University of Oxford and Falmouth University). The anonymised survey data will be made available for future use by other researchers, via the UK Data Service, to maximise its utility and support further understanding about young people's mental health and wellbeing.

Despite the significant strengths of the evaluation approach, and although we have been able to obtain a sense of change in outcomes over time, it has not allowed us to draw any simple conclusions about whether

those changes occurred as a result of HeadStart. This is for a number of reasons which are also outlined in the section "Discussion: Impact on mental health and wellbeing".

First, without an appropriate comparison sample it is difficult to make statements about the specific contribution of HeadStart. We carefully considered various approaches to a comparison sample, for example using existing datasets (e.g., Millennium Cohort study, Understanding Society, the Avon Longitudinal Study of Parents and Children [ALSPAC]) and even recruited a sample of schools for this specific purpose but for reasons outlined in Appendix 1 none of the available options could be realised. It's worth bearing in mind though, that any comparison sample recruited over a similar period to the HeadStart programme would likely have had their own approaches to supporting young people's wellbeing in place. Therefore, they would not be a true 'no treatment' control group. Despite this gap in the overall approach, there is evidence from within the evaluation of positive impact. The inclusion of the summative evaluations was a key component of the overall approach. These smaller evaluations which focused on single interventions were able to capture key pieces of information, such as attendance and engagement data, that could not be incorporated on a national scale. Moderating the analysis according to these variables allowed a more fine-tuned evaluation and showed promising results for young people who attended these interventions (see section 'Impact of specific interventions').

Second, collecting accurate data about HeadStart interventions and who attended them was a challenge throughout the evaluation, see section 'Impact on mental health and wellbeing' for more detail. Ultimately, it meant that there was not absolute clarity on which respondents to the annual survey had received HeadStart interventions and which had not. It is therefore possible that young people included in the 'no-treatment' group for the purpose of analysis had actually received targeted HeadStart support, or indeed other forms of support outside HeadStart, which could blur signs of impact overall.

In the qualitative strand of the evaluation it is possible that information about which young people had received HeadStart support was imperfect too. Some young people may not have reported their involvement in HeadStart in their interviews because they had forgotten it, decided not to discuss it or did not recognise that the support they had received was from HeadStart or an associated organisation.

In addition, we weren't able to gather data about dosage, fidelity

and engagement at the programme-level; all of which could alter the impact of interventions. When we were able to gather this kind of information (see, for example, the summative evaluation of Newham's TSA intervention) we did find evidence of positive impact at higher levels of engagement versus lower levels. Getting sufficient detail on these aspects of delivery was always going to be exceptionally challenging. Each partnership's approach was multifaceted, included a range of whole school and community work alongside targeted interventions and systemic work with partners across agencies. Furthermore, projects changed over the delivery period. Again, this was compounded by the onset of the coronavirus pandemic which necessitated significant reorganisation of intervention delivery.

With regard to outcome measurement, we undertook a thorough and collaborative process to develop the WMF with input from stakeholders from across the programme. A common outcome framework was required to evaluate the HeadStart programme across all six local partnerships. This covered the main (agreed) outcomes of interest to the overall programme - young people's mental health and wellbeing – as well as variables known to be associated with or influence these outcomes. The WMF has been a real success, in no small part through the commitment from HeadStart partnerships and school staff to completing data collection, even during some academic years impacted by the coronavirus pandemic. The WMF was made freely available to users outside of the programme early on and has been widely used. However, it is necessarily a blunt measurement tool from the perspective of individual programmes, which may have more nuanced outcomes of interest. It is possible that some interventions were not effective for the outcomes included in the WMF and this meant we were not able to see a positive impact. Where our summative evaluations were able to make use of locally collected data relating to specific outcomes targeted by individual interventions, there was some evidence of positive impact. This indicates that the combination of effective and ineffective interventions may have resulted in diluted effects overall.

As is anticipated in longitudinal research, both the qualitative and quantitative longitudinal strands of the evaluation suffered some degree of sample attrition, drop out, over the duration of the programme. This was often due to young people moving schools or areas, or a lack of response from their school or parent or carer when it came to arranging their interviews. A small number of young people (or their parent or carer on their behalf) declined to take part in one or more years of the interviews. Sample attrition became particularly acute, of course, following the coronavirus pandemic (see the 'Responding to the Coronavirus pandemic: Changes to the national evaluation' section of Appendix 1). For both strands of the evaluation response rates fell significantly, and for the qualitative strand it led to a reduction of the number of interview timepoints from five to four.

Every effort was taken to maintain sample sizes but ultimately, for the quantitative evaluation especially, analysis was limited to the first three years of data. This was due to the complexity of interpreting year-on-year data which included data collected during the pandemic. On the other hand, the timing of the national evaluation was opportune in that we were able to insert additional survey items and interview questions directly addressing young people's experiences of the pandemic. We also had access to young people's mental health data collected before, during and after the pandemic (with caveats associated with attrition) through which to explore changes in young people's wellbeing over this unprecedented period.

One aspect of the original evaluation that raised significant challenges was the work to support local partnerships to conduct their own economic analysis. Although the tool developed did not lead to significant take-up, important lessons were learned about collecting and using cost data, and the kinds of information that local programmes felt were useful to make persuasive local arguments for future commissioning.

Finally, a common qualification with regard to qualitative data collection methods is that there are of course limitations in the transferability of the findings across the qualitative studies in this report. That is, we cannot assume that the findings speak for other young people, parents or carers, staff and stakeholders who were not interviewed because they were either not asked to be involved, the Learning Team were unable to contact them at particular timepoints or because they chose not to be interviewed. There were many others involved in delivering the HeadStart programme whose views are not represented here.

It is important to consider that a whole range of factors can influence what participants choose to and remember to reveal during interviews. This includes the degree to which they feel that something is relevant, comfortable or pertinent to mention. This means that indications of the prevalence of themes can only represent what participants were asked to, chose to or remembered to talk about, rather than being an objective measure of the incidence of particular issues within a given group of people. Moreover, omission or lack of reference in an interview is not an objective indication that something did not occur or was unimportant, for example that a participant did not draw on a particular coping strategy, or did not experience a particular difficulty in life.

Overall discussion and conclusions of the national evaluation

HeadStart as a national programme was developed in recognition of the importance of supporting the mental health and wellbeing needs of young people. The programme approached this support from an ecological perspective,[65] emphasising that the most comprehensive means of addressing these needs would be a system-wide response, embedding support within families, schools and wider communities.

During the period of the programme (2016–2022), the national picture for children's mental health was one of increasing need, with prevalence rates escalating from one in eight to one in six young people experiencing mental health problems.[17] At the same time, there was a corresponding reduction in young people's subjective wellbeing.[66] Through the HeadStart evaluation we have identified a range of difficulties young people described as undermining their mental health and wellbeing including challenges at school, difficult relationships with peers and family and managing difficult emotions. A wider range of issues also likely feed into this picture of increasing need, including the coronavirus pandemic, increasing economic pressures, climate anxiety and increasing availability of social media.

Our research also pointed to risk factors that were associated with a greater likelihood of experiencing difficulties. These included economic pressures, having SEN and having experienced abuse or difficult family life. Our findings on cumulative risk indicate that the greater the number of risk factors, the more likely it is that young people will experience poor mental health and wellbeing.

As demonstrated in this report, the levers to protect young people's mental health and wellbeing remain constant. Those highlighted through our findings are consistent with those incorporated as potential mechanisms in the initial programme theory and include social support from adults at home, in school and in the community; the young person's own capacity to cope, drawing on a range of self-initiated coping strategies; and formal interventions provided primarily through HeadStart but also through other sources. Our qualitative and quantitative findings exploring protective factors indicate that experiencing multiple sources of support in combination is associated with improved wellbeing and reduced likelihood of experiencing mental health problems.

While the programme-wide analysis did not detect significant associations between receipt of HeadStart support and improved outcomes in young people, a number of challenges in executing the intended design for the evaluation mean we cannot be confident that this lack of association represents robust evidence for a lack of impact. Summative evaluations included in the programme certainly point to some effective interventions within the local programmes. Qualitative findings also point to a range of benefits described by young people, parents and school staff, not just in terms of receiving interventions but also in relation to the engagement of young people in active, influential roles within the programme. There was evidence to indicate that, consistent with the 'test and learn' approach of the programme, HeadStart activities potentially included a range of effective and less effective practices. This combination potentially limited our ability to detect positive effects in the overall analysis. It also emphasises the importance of choosing interventions where the evidence indicates good impact and evaluating interventions in situ to establish whether they are having the desired effects.

Where comparison data were available, we were able to detect some positive impact of the HeadStart programme, particularly with respect to reductions in exclusion rates for schools participating in the programme compared to those nationally who did not. The fact that the reach of the programme has extended to these potentially more distal or longer-term outcomes initially stated in the programme logic model is encouraging. Factors such as exclusion have significant implications for young people's future prospects in terms of social exclusion, employability and contact with the justice system.[67; 68] Findings also suggest that where appropriate comparison data are available, there is potential for detecting positive impacts of programmes like HeadStart. This was not possible within the current evaluation.

The evaluation of HeadStart has involved an extensive programme of analysis. While findings provide no definitive answer to whether HeadStart as a whole 'worked', they provide rich learning around the changing picture of need for children and young people's mental health

and wellbeing and the factors that serve to undermine and protect these outcomes; point to specific examples of effective practices, and where and how support might be improved; and provide rich examples of the benefits of the programme for a range of stakeholders and potential benefits for wider educational outcomes. The findings also encourage reflection on the role of participation in youth-focused programmes and approaches to systems change and sustainability. In the next section we summarise the implications of our learning from the HeadStart programme.

What the findings tell us

The nature of the challenge.

- **Mental health problems are quite common in children and young people.** For example, our research showed 18.4% had high levels of emotional difficulties in the first year of data collection and 18.5% had high scores for conduct. Typically, difficulties were more common for older young people (aged 13/14) than younger young people (aged 11/12).

- **There is evidence that the coronavirus pandemic had negative impacts for young people in terms of their mood, sense of social connections and the support they could draw on.** It also affected the HeadStart partnerships' ability to provide support, and support had to be significantly adapted during this period.

- **Young people's mental health often varies based on their own lived experiences and identities.** Examples measured in HeadStart include special educational needs, gender identification, being a child in need of help and protection (child in need status), being a young carer and ethnicity. For example, there are significant gender differences during adolescence in mental health and wellbeing. Girls' mental health and wellbeing appears to decline as they move from early to later years of secondary school, but boys' mental health and wellbeing appears to be more stable. **Some challenges that young people experience in their life can make mental health difficulties more likely.** For example, experiencing trauma of some kind makes mental health difficulties more likely. Some young people's characteristics make mental health difficulties more likely too. Often this can be because these characteristics mean young people encounter greater difficulties in life. For example, young people who can sometimes experience more mental health problems, and this is probably because they are more likely to face stigma and isolation that other young people don't commonly experience. These experiences and characteristics are often known as 'risk factors'. Having one or more risk factors doesn't mean a young person will definitely experience a mental health problem, it just means the likelihood of them experiencing a mental health problem is higher than it is for those who don't have any of these risk factors. The more risk factors a young person has experience of, the more likely it is that their mental health will suffer.

- However, **there are also experiences and circumstances that reduce the likelihood of a young person experiencing mental health problems.** These are often referred to as 'protective factors'. An example of a protective factor is having warm, supportive family relationships. As with risk factors, the more protective factors a young person experiences, the less likely they are to experience mental health problems.

- Young people experience varying levels and types of support through adolescence. **Support from home and from peers tends to stay quite stable through early adolescence.** However, support from the community and school decreases slightly over this period.

What does help look like?

- Resilience is a term we use to describe what enables some young people to continue to experience good mental health and wellbeing even when they face challenges. **HeadStart shows that building resilience in young people involves both developing their internal resources** – such as their ability to solve problems, manage their emotions and navigate their social relationships – **and embedding support around them**, for example by increasing support from adults at schools, improving community resources and facilities and supporting families to better support children.

- It is hard to come up with clear, definitive statements about the impact of complex programmes like HeadStart. **In terms of some of the large-scale data collection, we couldn't discern a positive**

impact of Headstart as a whole on mental health and wellbeing during the HeadStart period. This could be because the complexity of the programme made it difficult to fully capture what implementation looked like and demonstrate short-term impacts on mental health and wellbeing. It could also be HeadStart encompassed a mixture of practices, some of which were effective and some of which were not.

- However, **there are indications that HeadStart has improved the life experience of a range of children and young people** (and families). We can see this in the qualitative responses children and young people gave the research team, and in some of the summative evaluations which demonstrated the effectiveness of particular interventions. We can also see some reduction in exclusion rates in HeadStart schools.

- Our evaluation shows that **more energy should be invested in ensuring all those that need help are identified.** While it was clear that HeadStart's targeted interventions were aimed at those with high need, and there were some innovative models used to identify those who would benefit from support, there were also indications that some young people who might have benefitted from help didn't receive it.

- HeadStart learning indicates that **where young people experience multiple challenges that affect their mental health, support might need to be 'stepped up'.** This may mean that the support might need to be in place for a long period of time or that there might need to be a number of different types of support put in place (e.g., support within school, support for the family and community-based support).

- The potential **effectiveness of a programme is often influenced by how well it is implemented and engaged with.** For any given type of support, there must be enough of it delivered, and delivered well, for it to make a difference.

- **In terms of sustaining HeadStart** practices beyond the life of the programme, HeadStart partnerships told us that **integrating with local services and fitting within existing systems as far as possible were crucial,** as was developing key relationships and getting buy-in at a senior level (especially in schools).

- **We must continue to act on evidence about what helps young people.** We have been able to 'test and learn' in HeadStart. We have been able to show good practice; we have also seen that not everything rolled out (with good intentions) makes a difference to mental health outcomes. For example, we could not find a significant impact for some interventions, and some young people described having experienced little benefit from being involved in HeadStart. Therefore, it is important to actively monitor and evaluate in any context. Even when interventions are found to be effective, the effects can be limited in a number of ways. For example, some interventions may help in the short term but fail to deliver long-term impacts. Furthermore, not all types of mental health interventions lead to positive change for all those who receive them.

These limitations illustrate why being able to test out new approaches and learn from them is an important process in finding 'what works'.

What have we learnt about evaluating complex programmes?

- **Evaluation of complex programmes should draw from multiple sources of information.** This includes, local evaluations built into the design of local programmes, young people's perspectives from co-production and parent and carer perspectives alongside national evaluations drawing on new data collection from intervention sites, comparison sites and existing administrative datasets (such as those routinely collected in schools). Methods like the synthetic control methods used in our analysis of academic outcomes might be particularly promising to use to create suitable comparison samples derived from relevant administrative datasets.

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Acknowledgments: Kim Burrell, Polly Casey, Kate Dalzell, Jess Deighton, Emre Deniz, Sarah Dolaty, Chloe Edridge, Lauren Garland, Neil Humphrey, Tanya Lereya, Joao Santos, Emily Stapley, Nick Tait and Lawrence Wo.

We would also like to thank: the six HeadStart partnerships and all of the HeadStart schools for their collaboration; the young people who gave their time for HeadStart participation work; all of the Learning Team members past and present who contributed to the evaluation throughout the programme; and Colleen Souness for her constructive feedback thoughout the development of this report.

How to cite this report: Evidence Based Practice Unit. (2023). HeadStart national evaluation final report. Supporting the mental health and wellbeing of children and young people: the role of HeadStart. https://www.annafreud.org/research/past-research-projects/the-headstart-learning-programme/

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The Evidence Based Practice Unit is a partnership of UCL and Anna Freud. The Anna Freud Centre, operating as Anna Freud is a company limited by guarantee, company number 03819888, and a registered charity, number 1077106.

COMMUNITY FUND

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