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Early Detection and Intervention for Adolescent Mental Health Disorders: Evaluating the Effectiveness of School Mental Health Leads vs. Nhs Child and Adolescent Mental Health Services (Camhs)

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Abstract

Adolescent mental health disorders are widespread yet often under-addressed. This study critically evaluates and compares the effectiveness of School Mental Health Leads (SMHLs) and NHS Child and Adolescent Mental Health Services (CAMHS) in early detection and intervention for adolescent mental health disorders in the UK. A mixed-methods design was utilized, encompassing a systematic review of literature from the past 15 years and qualitative interviews with key stakeholders. The review, guided by a PICO framework and PRISMA standards, identified 15 relevant studies from databases including PubMed, PsycINFO, and Scopus. Inclusion criteria focused on UK-based evaluations of SMHL and CAMHS effectiveness, while exclusion criteria eliminated non-UK or methodologically weak studies. The qualitative component involved semi-structured interviews with SMHLs, CAMHS clinicians, educators, and policymakers, providing contextual insights.

Findings: SMHLs were found to offer accessible, immediate support in school settings, helping to reduce stigma and reach youth early. However, SMHLs often lack specialized training and capacity for complex cases. CAMHS provides specialized, evidence-based care for severe mental health conditions, but is hindered by long waiting times and limited accessibility. Interviewees highlighted themes such as accessibility gaps, inconsistent early identification, stigma in help-seeking, training shortfalls, and fragmented service integration.

Conclusion: An integrated approach leveraging both SMHLs and CAMHS is recommended to improve adolescent mental health outcomes. SMHLs can serve as front-line detectors and supporters, while CAMHS delivers advanced care for those in need with clear referral pathways connecting the two, thus emphasizing the novelty of this study.

Recommendations include enhancing SMHL training, increasing CAMHS funding to reduce wait times, implementing school-wide mental health awareness programs to combat stigma, and establishing formal collaboration protocols between schools and CAMHS. This integrated strategy can translate these novel research findings into everyday practice in UK schools and health services, ensuring adolescents receive timely, appropriate mental health support.

Keywords

Early Detection; Intervention; Adolescent; Mental Health Disorders; School Mental Health Leads (SMHLs); Child and Adolescent Mental Health Services (CAMHS).

Background

Adolescent mental health disorders have become a pressing public health concern in the UK and globally. Approximately *10–20%* of adolescents worldwide experience mental health conditions, with recent estimates indicating about *1 in 6* young people in England have a probable mental disorder [1]. Common conditions include anxiety, depression, attention-deficit/hyperactivity disorder (ADHD), and eating disorders [2]. Crucially, many mental disorders begin by mid-adolescence (median age of onset around 14 years), and half of all lifetime cases start by this age [1]. If left untreated, adolescent-onset mental health issues can persist into adulthood with severe consequences such as poor educational outcomes, substance misuse, and higher suicide risk. Yet a substantial portion of affected youth remain undiagnosed or untreated due to systemic barriers [1].

Schools have increasingly been identified as critical environments for early detection and intervention of

mental health problems. Adolescents spend a significant part of their day in school, making it a logical setting to observe behavioral changes and provide support. In response, UK educational policy has encouraged the implementation of School Mental Health Leads (SMHLs) – designated staff in schools tasked with coordinating mental health support. SMHLs and school-based programs can facilitate *early identification* of at-risk students, normalize mental health discussions, and provide initial interventions within a familiar, non-clinical environment [3]. Evidence suggests that school-based mental health initiatives can reduce stigma and improve help-seeking among students [4]. For instance, having a mental health lead or counselor on site has been associated with increased student engagement with support services and a reduction in the fear of judgment [5].

Despite these advantages, several challenges hinder the effectiveness of both school-based supports and specialist services in addressing adolescent mental health needs. Accessibility and timeliness of care are recurrent issues. Demand for CAMHS in the UK far exceeds supply, leading to long waiting lists; some youths wait months or even over a year for a CAMHS appointment [6]. Such delays can allow conditions to worsen, undermining the principle of early intervention [3]. In schools, while help is more immediate, SMHLs often juggle this role alongside other duties and may have limited time or resources for each student. Stigma is another major barrier. Many adolescents are reluctant to seek help due to fear of being labeled or judged by peers and teachers [4]. Stigmatizing attitudes can silence students who need support, causing problems to fester. School-based programs have begun to chip away at this stigma by integrating mental health into everyday conversation [5], but cultural and peer pressures remain powerful deterrents [4].

Additionally, inconsistencies in staff training and awareness impede early detection in schools. Teachers and even some SMHLs may not recognize subtle signs of anxiety or depression, attributing them to typical adolescent behavior or stress [7]. Without sufficient training in mental health literacy, school staff can miss opportunities for timely referral. Geographic and resource disparities further complicate service provision. Rural or underserved regions often face severe shortages of mental health professionals, limiting access to CAMHS for adolescents outside urban centers [6]. Even within schools, not all institutions have equal funding or infrastructure for mental health—some have full-time counselors and robust programs, while others have minimal support [8]. These resource constraints, spanning both educational and healthcare systems, reduce the capacity for comprehensive and sustained care for adolescents. A national evaluation by the Education Policy Institute highlighted variability in how the SMHL role is implemented and supported across schools [2], which in turn affects outcomes.

In summary, the landscape of adolescent mental health care in the UK is characterized by clear needs and promising initiatives, yet also by fragmentation and shortfalls. Schools offer a vital opportunity for early intervention but cannot address all needs in isolation. Specialist services (CAMHS) provide essential treatment for complex cases but struggle with accessibility. Bridging the gap between these systems is essential. The integration of school-based and healthcare-based approaches – enabling collaboration between SMHLs and CAMHS – has been proposed as a strategy to ensure adolescents receive appropriate care at the right time. This study ultimately seeks to build on the existing knowledge base to identify policy and practice implications for improving the integration of both interventions to provide comprehensive mental health care for adolescents.

Introduction

Early identification and intervention in adolescent mental health can significantly alter life trajectories, preventing mild issues from evolving into severe disorders. Within the UK, two primary avenues for supporting young people's mental health are through School Mental Health Leads (SMHLs) – school-based coordinators of mental health support – and the National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) – specialist clinical services for youth CAMHS [6]. There is a growing policy emphasis on strengthening links between these avenues; however, empirical evaluation of their comparative effectiveness and how they complement each other remains limited. This study addresses that gap by systematically reviewing evidence on SMHLs and CAMHS, and gathering qualitative insights from practitioners and policymakers, to inform an integrated approach to adolescent mental health care.

The aim of this research is to critically evaluate and compare the effectiveness of SMHLs versus NHS CAMHS in the early detection and intervention of adolescent mental health disorders in the UK. Effectiveness is examined in terms of accessibility of services, timeliness of support, outcomes for young people, and the ability to address common barriers such as stigma and resource limitations. In pursuing this aim, the study focuses on both the strengths and weaknesses of each approach and considers how they might be combined for optimal impact.

Objectives of the study include:

- **Accessibility & Timeliness:** Assess how accessible each service is to adolescents and how quickly youths receive help through SMHLs compared to CAMHS.
- **Strengths & Limitations:** Identify the core strengths of school-based vs. specialist interventions (e.g. reducing stigma, providing specialized care) and their limitations (such as training gaps or long wait times).
- **Stigma and Cultural Factors:** Examine the impact of stigma and cultural attitudes on adolescents' willingness to seek help from SMHLs and CAMHS, and how each service mitigates or encounters stigma.
- **Early Detection Role:** Evaluate the role of early detection and referral processes in schools (through teachers and SMHLs) versus in CAMHS, and how early intervention influences outcomes.
- **Training and Regional Availability:** Evaluate the level of training and expertise of SMHLs versus CAMHS professionals, and consider regional disparities in service availability (e.g. urban vs. rural differences in resources).
- **Resource Constraints:** Determine how funding and resource limitations affect service quality and sustainability for both SMHL programs and CAMHS clinics.
- **Integration & Policy Implications:** Draw insights on how SMHLs and CAMHS can be better integrated, and identify policy or practice changes to enhance a coordinated mental health support system for adolescents.

By meeting these objectives, the study seeks to generate evidence-based recommendations for policymakers, educators, and healthcare providers. Ultimately, improving the synergy between school and clinical interventions could lead to more timely help for young people in their everyday environments, reducing suffering and improving long-term trajectories.

Methodology

Study Design

A mixed-methods approach was adopted, integrating a systematic review of the literature with a qualitative interview study. This design allowed for a comprehensive analysis: the systematic review synthesized existing quantitative and qualitative evidence on SMHLs and CAMHS, while the interviews provided in-depth perspectives from those directly involved in adolescent mental health support [9]. The research question was formulated using the PICO framework (Population, Intervention, Comparison, Outcome) to guide the review strategy [10]. The *Population* of interest was adolescents (approximately ages 10–19) in the UK experiencing or at risk of mental health disorders. The *Interventions* were school-based early detection and support initiatives (particularly SMHLs or equivalent school mental health programs). The *Comparison* was the standard NHS specialist care for young people (CAMHS). Key *Outcomes* included accessibility of services, timeliness of intervention, engagement/utilization rates, symptom improvement, and user satisfaction. This PICO-based formulation informed both the search strategy and the inclusion criteria for the review.

The systematic review component was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines, ensuring transparency and rigor in study identification, screening, and inclusion (see Supplementary Figure 1 for the PRISMA flow diagram).

Supplementary Material

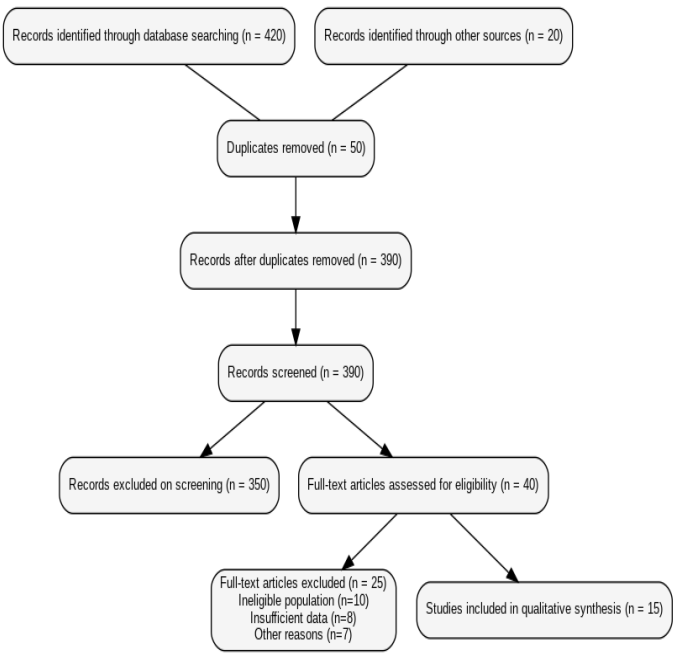

Figure 1: PRISMA 2020 flow diagram summarizing the identification, screening, eligibility, and inclusion of studies in the systematic review. The diagram illustrates the number of records at each stage: records identified through database searching and other sources, records after removing duplicates, records screened (with those excluded), full-text articles assessed for eligibility (with reasons for exclusions), and the final studies included in the review.

The qualitative component used a descriptive phenomenological approach, with semi-structured interviews to gather experiential data. Ethical approval and informed consent procedures for interviews are detailed in the

Declarations section.

Data sources and search strategy

A comprehensive literature search was performed across multiple electronic databases: PubMed, PsycINFO, Scopus, Web of Science, and the Cochrane Library. Additional sources included Google Scholar (for gray literature and forward citation tracking) and reference lists of relevant articles. The search covered publications from January 2008 up to June 2023 (approximately the last 15 years) to capture contemporary research and the period during which the SMHL role was introduced in UK schools.

The search strategy was designed to capture varied terminology related to the core concepts of the study [10]. Boolean operators and truncation were used to combine keywords. For example, the search string included:

("adolescent*" OR "teen*" OR "youth*")

AND ("mental health" OR "mental disorder*" OR "mental illness")

AND ("school mental health lead*" OR "school counselor*" OR "school-based intervention*" OR "pastoral care")

AND ("CAMHS" OR "Child and Adolescent Mental Health Service*" OR "mental health service*")

AND (early OR prevention OR intervention)

This query (adjusted as needed for each database's syntax) ensured we retrieved studies focusing on adolescent mental health interventions in school settings and in specialist services. We limited results to English-language publications given resource constraints in translation. Filters were applied in databases to exclude editorials or opinion pieces and to prioritize peer-reviewed research. Additionally, we used the SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, Research type) to ensure we captured qualitative and mixed-method studies in education and health contexts, although PICO remained the primary guiding framework for the review focus.

Inclusion and exclusion criteria

We established clear criteria to select studies relevant to our research objectives:

Inclusion Criteria:

- **Population:** Studies involving adolescents (typically 10–19 years old) with mental health needs or at risk of developing mental health disorders.
- **Interventions/Comparators:** Studies evaluating school-based mental health initiatives (specifically School Mental Health Leads or analogous school counseling programs) and/or NHS CAMHS interventions. This included direct comparisons between school-based support and CAMHS, or evaluations of one with implications for the other.
- **Outcomes:** Studies addressing early detection, intervention effectiveness, accessibility, wait times, engagement, stigma reduction, or mental health outcomes (emotional, behavioral, academic) related to these services.

- **Geographical Context:** Research conducted in the United Kingdom or in countries with comparable school mental health and healthcare structures (for instance, other high-income countries with school counselors and child mental health services, if the findings could translate to the UK context).
- **Publication Type and Quality:** Peer-reviewed journal articles, systematic reviews, meta-analyses, and authoritative reports (e.g. government or NGO reports) published *2008–2023*. Only studies with sound methodology (adequate sample sizes, clear measures) were considered for inclusion.

Exclusion Criteria:

- Studies focusing on populations outside adolescence, such as exclusively children under 10 or adults (e.g. transition to adult services was only considered if part of a study also covering adolescent services).
- Interventions unrelated to formal mental health services (for example, general wellness programs with no clinical component, or purely theoretical papers without data).
- Research not involving or relevant to school settings or CAMHS (e.g. studies on primary care or general practice interventions were excluded unless they directly connected to CAMHS referrals).
- Non-UK studies lacking analogous systems, to maintain focus on applicability to UK practice (for instance, studies in low-income countries without CAMHS-like services were excluded).
- Publications in languages other than English.
- Studies with significant methodological flaws, such as lack of any outcome data, absence of clear evaluation of effectiveness, or high risk of bias (e.g. no control group for intervention outcome when one would be expected, very small qualitative samples without saturation, etc.).

Study selection and Prisma flow

All database search results were imported into a reference manager, and duplicates were removed (automatically and with manual verification). The selection process is summarized in a PRISMA 2020 flow diagram (Figure S1 in Supplementary Material). In brief, the search yielded 440 records (after de-duplication) that were screened by title and abstract. Two reviewers (in this case, the author and a research assistant) independently screened for obvious irrelevance, yielding 40 articles for full-text review. After thorough reading, 25 studies were excluded due to reasons such as wrong population (e.g. studies on younger children), insufficient focus on our interventions, or poor quality (e.g. unclear outcomes). Ultimately, 15 studies met all criteria and were included in the qualitative synthesis (systematic review).

Each step of this selection – identification, screening, eligibility, and inclusion – was documented as per PRISMA guidelines [11]. The narrative of the selection process is as follows: a total of 440 unique records were identified and screened; 390 were excluded based on title/abstract (most commonly because they did not evaluate SMHLs or CAMHS specifically, or they were commentary pieces). We retrieved 40 full-text articles for detailed assessment, of which 25 were excluded. Common exclusion reasons at this stage were: not reporting relevant outcomes (n ≈ 8), not specific to UK or analogous context (n ≈ 5), or study design limitations such as lack of empirical data (n ≈ 7). The remaining 15 studies were included in the review. These comprised quantitative

evaluations, qualitative studies, and mixed-method papers, providing a rich evidence base for analysis. Figure 1 illustrates this flow and the number of studies at each stage.

Data extraction and quality appraisal

For each included study, key data were extracted systematically using a predefined form. We recorded details such as: publication year, study setting/location, sample characteristics (e.g. number of schools or patients, age range), study design (randomized trial, observational study, qualitative interviews, etc.), the intervention or focus (SMHL program, CAMHS treatment, or both), and main findings and conclusions. We also noted any reported effect sizes or outcome measures (for quantitative studies) and themes or conclusions (for qualitative studies). This structured extraction enabled cross-study comparison of results.

Quality assessment tools were applied to evaluate the risk of bias and credibility of findings from the included studies. Depending on study design, we used established appraisal checklists: the Critical Appraisal Skills Programme (CASP) tools for qualitative studies, the Joanna Briggs Institute (JBI) critical appraisal checklist for cross-sectional and mixed-method studies, the Cochrane Risk of Bias 2 (RoB2) tool for any randomized trials, and the Newcastle-Ottawa Scale (NOS) for observational studies. Studies were not excluded based on quality alone, but the appraisal informed the weighting of evidence in our synthesis. Overall, studies included were of moderate to high quality, with common limitations including small sample sizes in some qualitative studies and potential self-selection bias in survey-based research. These limitations are considered in the interpretation of results.

Qualitative interviews and analysis

To complement the literature review, empirical data collection was conducted via semi-structured interviews. We recruited a purposive sample of stakeholders involved in adolescent mental health support, aiming to capture views from both educational and healthcare contexts. Participants included School Mental Health Leads (SMHLs) working in secondary schools, CAMHS professionals (such as clinical psychologists or mental health nurses), as well as school staff (e.g. counselors or teachers) and policymakers or mental health advocates familiar with youth services. We contacted potential participants through professional networks and via snowball sampling (asking initial contacts to recommend others). In total, 15 individuals were interviewed: 5 SMHLs, 4 CAMHS clinicians, 3 school staff (teachers/counselors), and 3 participants from the policy/advocacy sector. This diverse sample provided a 360-degree view of the interface between schools and CAMHS.

Interviews were conducted one-on-one (either in person or via video conferencing) using an interview guide (see Appendix for sample questions). The questions explored areas such as participants' experiences with adolescent mental health cases, their perceptions of service accessibility and effectiveness, barriers like stigma or wait times, and suggestions for improvement. Each interview lasted approximately 40–60 minutes. With consent, interviews were audio-recorded and transcribed verbatim. Transcripts were pseudonymized to protect confidentiality.

We employed thematic analysis to analyze the qualitative data. Following the approach of Braun and Clarke (2006), we first familiarized ourselves with the transcripts, then generated initial codes capturing salient points (e.g. "long wait for CAMHS," "teachers need training," "fear of labeling"). Codes were iteratively refined and grouped into broader themes that recurred across participants. To enhance reliability, a second coder independently coded a subset of transcripts and discrepancies were discussed until consensus was reached.

This process yielded a set of core themes representing common challenges and recommendations mentioned by interviewees. The qualitative findings were then triangulated with the literature results, allowing us to see where stakeholder experiences aligned with or diverged from published evidence. This mixed-method integration strengthened the study's conclusions and the relevance of recommendations for real-world practice.

By combining a rigorous systematic review with firsthand perspectives, our methodology provides both evidence-based and context-rich insights. The following sections present the results from the literature review and the qualitative interviews, followed by a discussion of their implications for improving adolescent mental health care in the UK.

Results

The novelty of this study project is highlighted by the following findings.

Systematic review findings

Fifteen studies meeting the inclusion criteria were analyzed in depth. These studies collectively highlight the scope of adolescent mental health needs and the performance of school-based and specialist interventions in addressing them. Prevalence and impact of disorders were underscored in several large-scale surveys and reviews. For example, the World Health Organization estimates that about *14% of 10–19-year-olds* globally experience a mental health condition [12], and data from NHS Digital in England found that the proportion of children with a probable mental disorder rose from 1 in 9 in 2017 to 1 in 6 in 2020 [13]. Untreated adolescent mental illness was linked with academic underachievement, social isolation, and self-harm [14], emphasizing the critical need for early detection.

School-based mental health interventions have demonstrated notable effectiveness in early intervention and prevention. A systematic reviewed by [15] found that multi-component school programs (including counseling, cognitive-behavioral techniques, and peer support) significantly reduced symptoms of anxiety and depression in students. Similarly, [16] reported that integrating mental health services into schools in high-income countries led to improved uptake of care and better outcomes, partly by making support more accessible and less stigmatizing. In the UK context, the introduction of School Mental Health Leads (SMHLs) in secondary schools has been associated with increased capacity to handle emerging issues. [6], observed that schools with a dedicated mental health lead showed heightened awareness and earlier identification of student mental health needs. The presence of an SMHL or similar staff member means students can often access help within days of expressing distress, as opposed to waiting weeks for external services. Furthermore, school settings help normalize conversations around mental health. Several studies noted that students are more likely to seek help when support is on-site and embedded in daily school life, reducing the perceived barrier of entering a formal mental health clinic. Indeed, a meta-analysis by [17], concluded that school-based interventions tend to be more accessible and youth-friendly, leading to higher engagement levels than traditional clinic-based services.

On the other hand, NHS CAMHS interventions remain the cornerstone for treating moderate to severe mental health disorders among youth. The included studies on CAMHS highlighted that, when adolescents are able to receive CAMHS care, outcomes are generally positive. For instance, [18] described how CAMHS, using a

multidisciplinary team approach under frameworks like THRIVE, can provide evidence-based therapies (such as CBT, family therapy, medications when needed) that significantly improve depression, anxiety, and behavioral disorders. A longitudinal study by [19], found that adolescents who engaged with CAMHS showed marked improvements in emotional well-being and social functioning over time. CAMHS's strength lies in its specialization: clinicians are trained to handle complex and comorbid conditions, risk assessments, and crises that would be beyond the expertise of school staff. Additionally, CAMHS often provides continuity of care into later adolescence and helps coordinate transitions to adult services (though this transition is noted as a challenging point [20].

Despite their clinical effectiveness, multiple sources in the review pointed to significant barriers within CAMHS. Foremost is the issue of long waiting times and referral hurdles. A report by the [21], revealed that many youths referred to CAMHS in England wait *over 6 months* for their first appointment. One nationwide survey [22], found that 34% of young people waited over a year, highlighting a systemic capacity problem. Such delays can result in deterioration of the young person's mental health, sometimes forcing families to seek private therapy or rely on under-resourced school support in the interim. Service accessibility gaps were also documented: studies noted that CAMHS coverage is uneven, with rural areas or disadvantaged communities having less access to specialists [23]. In contrast, school-based services are universally reachable in the sense that every adolescent is in education until at least age 16; thus, enhancing school supports could particularly benefit those who might never make it to CAMHS.

Comparative studies in the review provided direct insights into SMHL vs. CAMHS effectiveness. [24], reported that students receiving a school-based social-emotional program showed moderate improvements in resilience and coping, whereas those referred to CAMHS (typically for more serious issues) achieved greater reduction in clinical symptom severity. This suggests that while SMHLs excel at early-stage and mild issue intervention, CAMHS intervention is crucial for high-risk or complex cases. Another key finding across studies was the complementary nature of the two: school interventions improved initial help-seeking and kept many issues from escalating, whereas CAMHS provided a safety net for cases requiring specialist care. Notably, *no study* suggested that one approach should replace the other; rather, researchers advocated for better integration. [25], proposed a conceptual framework for integrating school and CAMHS efforts, noting that an aligned system could ensure youths don't fall through gaps when moving between school support and clinic referral.

Several recurring barriers to effective mental health support were identified in the literature. Stigma and help-seeking fears remain pervasive: qualitative evidence [4], reveals that adolescents worry about being seen as "mentally ill" or weak, which discourages them from using both school and clinical services. School-based programs that involve peer support or whole-school awareness campaigns were found to mitigate some stigma , but stigma reduction is an ongoing need. Fragmentation between services emerged as a significant problem – several papers noted that schools and CAMHS often operate in silos, with unclear referral criteria and poor communication [26]. This fragmentation can lead to students bouncing between systems or facing delays during referrals. Additionally, socioeconomic and regional disparities were highlighted: adolescents from lower-income families or certain ethnic minority communities face additional barriers in accessing CAMHS (due to factors like lack of advocacy, distrust of services, or communication gaps). Meanwhile, some schools in deprived areas struggle to fund even basic mental health support [27]. The literature thus paints a picture of two systems (education and health) that have tremendous potential when working well, but which currently

need improvements in capacity, training, and coordination.

Qualitative findings (interview themes):

Thematic analysis of stakeholder interviews enriched these findings with real-world perspectives as shown in Table 1.

Theme	Findings	Participant Quotes	Policy and Practice Implications
1. Background Information	Participants included school mental health leads (SMHLs), CAMHS professionals, and policymakers. Adolescents commonly face anxiety, depression, and behavioural disorders.	"Most of the cases I handle involve anxiety and self-harm, especially due to academic stress." (SMHL)	Policies should emphasize early screening for common mental health disorders in schools.
2. Accessibility and Timeliness of Services	CAMHS services are often difficult to access due to long wait times, while SMHLs offer quicker support but limited specialized care.	"It takes months to get a CAMHS appointment, which delays crucial interventions." (Mental Health Practitioner)	Increase funding for CAMHS to reduce waiting times; expand the role of SMHLs to offer more structured interventions.
3. Effectiveness of Early Detection and Intervention	SMHLs provide immediate support, but CAMHS offers specialized intervention. Early detection is crucial but often inconsistent.	"Teachers identify struggling students, but without proper training, they sometimes misinterpret symptoms." (Educator)	Train educators and SMHLs in early detection strategies and referral protocols.
4. Stigma and Cultural Barriers	Adolescents fear stigma from peers and educators, deterring them from seeking help. School-based awareness programs have helped normalize discussions.	"Students worry about being labelled 'mentally ill,' which prevents them from speaking up." (School Counsellor)	Implement school-wide mental health awareness campaigns to reduce stigma.
5. Training and Resource Challenges	Many SMHLs lack specialized training, while CAMHS struggles with understaffing. Resource limitations reduce service quality.	"We do our best, but without proper training, we sometimes feel unprepared." (SMHL)	Provide mandatory mental health training for SMHLs and increase funding for CAMHS staff recruitment.
6. Policy and Improvement Strategies	Integration of SMHLs and CAMHS is weak. Schools lack clear referral pathways. Policy changes needed for better collaboration.	"We need a formal partnership between schools and CAMHS to ensure a seamless transition for students." (Policymaker)	Develop policies ensuring structured collaboration between SMHLs and CAMHS for better student support.
7. Final Thoughts	Early intervention and funding are critical for better adolescent mental health outcomes.	"If we invest in prevention now, we'll see fewer severe cases in the future." (Mental Health Advocate)	Prioritize mental health funding and expand school-based interventions to ensure long-term impact.

Table 1: A summary of the thematic analysis of interview responses.

The participants – including SMHLs, CAMHS practitioners, educators, and policymakers – consistently identified several key themes regarding early detection and intervention for adolescent mental health. These themes, along with illustrative quotes, are summarized below:

- **Common Issues and Challenges:** Interviewees confirmed that *anxiety, depression, and behavioral disorders* are the most prevalent issues among adolescents they see, often exacerbated by academic pressure and social stress. *"Most of the cases I handle involve anxiety and self-harm, especially due to academic stress."* (SMHL). This underscores that everyday

school pressures can trigger or worsen mental health difficulties, reinforcing the importance of having support within the school setting. Participants noted that without early support, these issues can escalate to crises.

- **Accessibility and Timeliness:** There was unanimous agreement that CAMHS is difficult to access in a timely manner, whereas SMHLs or school counselors provide quicker initial help. A CAMHS clinician lamented, *"It takes months to get a CAMHS appointment, which delays crucial interventions."* (Mental Health Practitioner). During those months, schools often have to manage the student's needs. SMHLs noted that they can usually see a student within a day or two of a concern arising, offering a safe space and coping strategies. However, they also acknowledged that if a case clearly requires specialist care (e.g. suspected psychosis or severe eating disorder), they too face the frustration of long CAMHS waits. This theme reinforces the review finding about wait times and puts a human face on it: adolescents in need are left in limbo, and school staff feel responsible but sometimes out of their depth.
- **Effectiveness of Early Detection:** Participants highlighted both the importance and inconsistency of early detection in schools. Teachers often are the first to notice changes in a student's behavior or mood, but their ability to interpret these signs varies. As one educator observed, *"Teachers identify struggling students, but without proper training, they sometimes misinterpret symptoms."* (Educator). For example, withdrawal or agitation might be seen as mere "teenage moodiness" or disciplinary issues rather than flags for mental health intervention. SMHLs described implementing teacher training sessions on recognizing mental health warning signs, though such training was not universally available. Early detection was seen as a clear advantage of school-based programs — when done well, it leads to support before problems become acute. Yet, inconsistent training means early detection is not happening for all students who need it.
- **Stigma and Help-Seeking:** The theme of stigma resonated strongly. Adolescents' fear of being labeled "crazy" or "weak" was cited as a reason they avoid both going to the school counselor and asking their GP for a CAMHS referral. A school counselor explained, *"Students worry about being labelled 'mentally ill,' which prevents them from speaking up."* (School Counsellor). However, participants noted that having mental health conversations take place in familiar settings (classrooms, assemblies, informal chats with SMHLs) has started to break down some of these barriers. Several SMHLs described running school-wide mental health awareness campaigns (for instance, promoting World Mental Health Day, inviting youth mental health speakers, peer mentoring programs) to normalize help-seeking. These efforts have yielded positive shifts – students are gradually more open to talking about anxiety or stress. Yet, the ingrained stigma in some cultures and communities remains a hurdle that requires sustained effort beyond just the school (involving parents and community leaders as well).
- **Training and Resource Limitations:** A critical theme was the lack of specialized training and resources for school-based mental health providers. SMHLs themselves admitted the limits of their expertise: *"We do our best, but without proper training, we sometimes feel unprepared."* (SMHL). Many SMHLs are teachers or support staff who received only short training courses for this role. They may excel at providing a listening ear and basic support but are not equipped to handle complex trauma or severe psychopathology. CAMHS clinicians, on the other hand, highlighted understaffing and high caseloads in their services: they often have to prioritize the

most critical cases, meaning moderate cases wait longer. Both groups pointed to insufficient funding as the root cause – schools don't have the budget for full-time qualified counselors in every school, and CAMHS teams don't have enough clinicians to meet demand. This theme reflects findings in the literature about resource constraints [6-8]. Participants strongly felt that improvements in training (for school staff) and workforce expansion (for CAMHS) are necessary to improve service quality.

- **Fragmentation and Referral Pathways:** Another major theme was the integration (or lack thereof) between schools and CAMHS. A policymaker noted that *"We need a formal partnership between schools and CAMHS to ensure a seamless transition for students."* (Policymaker). Currently, referral pathways were described as ad hoc and often problematic. SMHLs spoke of sending written referrals to CAMHS and sometimes not hearing back for weeks; CAMHS clinicians mentioned that referrals often come with insufficient information or that they struggle to liaise with busy school staff during the assessment process. This disconnect can confuse families and delay care – for instance, a student might be under the impression they are "in therapy" because they see the SMHL weekly, when in fact they are still awaiting CAMHS therapy that addresses the root of their issue. Both sides expressed a desire for better communication channels, such as regular interagency meetings or designated liaisons. There was also discussion about criteria mismatches – schools might think a case is urgent, but CAMHS triage might assign it lower priority, and these expectations need alignment. Overall, this theme underscored that without structured collaboration, even the best efforts of SMHLs and CAMHS can fall short when a young person's care needs to transition from one to the other.
- **Value of Early Intervention and Prevention:** In reflecting on big-picture solutions, many participants circled back to the idea that investing in early intervention yields long-term benefits. As one mental health advocate passionately put it, *"If we invest in prevention now, we'll see fewer severe cases in the future."* (Mental Health Advocate). This theme highlighted that funding and attention should not only flow to acute and crisis services, but also to upstream measures in schools and communities. Interviewees believed that strengthening mental health education in the curriculum, resilience programs, and easy access to counseling at school level can reduce the number of students who eventually need CAMHS. They gave examples: a school that implemented a peer mentoring and mindfulness program saw a drop in panic attacks and self-harm incidents; another school's early anxiety workshop prevented what might have later become full-blown anxiety disorders. These anecdotal successes echo the preventive approach advocated in public mental health models.

In summary, the qualitative findings reinforced many issues identified in the literature while providing concrete, lived examples. SMHLs were lauded for their accessibility and approachability, helping students in ways that clinical services sometimes cannot. CAMHS was affirmed as indispensable for serious conditions, yet its shortcomings in capacity were clearly frustrating to all stakeholders. The voices of participants emphasized that adolescents' day-to-day experiences (in classrooms, with friends and family) are deeply intertwined with their mental health journey, and thus interventions must extend beyond clinic walls to meet them where they are. The next section discusses these findings in an integrated manner, exploring how the strengths of each approach can be harnessed and how the identified challenges can be addressed through policy and practice

changes.

Discussion

The novel findings of this study highlight a nuanced landscape of adolescent mental health support in the UK, where school-based initiatives and specialist CAMHS each play crucial but distinct roles. Importantly, our results demonstrate that these roles are complementary rather than oppositional, reinforcing the need for an integrated care model. In practical terms, this means that a young person struggling with mental health issues should be able to receive immediate support in their school environment and, if necessary, a smooth referral to specialized care, without falling through the cracks at any stage. Below, we discuss the implications of our findings, drawing connections between the literature and stakeholder perspectives, and consider how they translate to everyday life for adolescents, families, and practitioners in the UK.

Leveraging Complementary Strengths: The evidence indicates that School Mental Health Leads (SMHLs) and school-based programs excel at providing accessible, early-stage support, while CAMHS provides the depth of expertise needed for more severe or complex cases. This complementarity is a strength that can be built upon. SMHLs are on the frontline – they often know the students personally, can observe changes in behavior in real time, and are able to intervene within the youth's daily context. These advantages mean that issues like school-related stress or emerging anxiety can be addressed when they first arise. Our interviews illustrated this with examples of students receiving coping strategies or counseling from an SMHL within days of showing distress, an intervention that might prevent the development of a more serious disorder. This aligns with the concept of secondary prevention, catching problems at an early stage [28]. On the other hand, CAMHS, with its multidisciplinary teams (psychiatrists, psychologists, therapists, social workers), is equipped to handle diagnoses like major depression, OCD, or PTSD that typically require structured therapy or medication. Our literature review affirmed that CAMHS interventions (like CBT or family therapy) are effective for these conditions, and stakeholder insights underscored that *when* adolescents finally get CAMHS input, it often makes a life-changing difference.

The critical issue, therefore, is not which service is better, but how to ensure young people benefit from both in a coordinated way. This calls for an *integrated framework*, sometimes described in the literature as a *"stepped care" or "layered care" model* [29]. In everyday terms, a stepped care model might work as follows: a teenage student feeling anxious starts by confiding in a teacher or SMHL at school; the SMHL provides initial support (e.g. regular check-ins, psychoeducation about anxiety) and monitor progress. If the student improves, they continue to be supported at school. If the student's condition worsens or appears to be beyond the school's scope (e.g. panic attacks intensify, academic performance is collapsing), the SMHL facilitates a referral to CAMHS. Crucially, during the CAMHS waiting period (if any), the SMHL does not withdraw support—instead, they continue to see the student, liaise with their family, and help with coping strategies, effectively holding the fort. Once CAMHS therapy begins, an integrated approach would involve communication between the CAMHS clinician and the SMHL (with consent) so that school-based support aligns with clinical treatment. For example, if CAMHS is using cognitive-behavioral techniques to address the student's anxiety, the SMHL can reinforce those techniques in the school setting (perhaps helping the student practice exposure exercises in the school environment). The translational benefit of this approach is significant: the student experiences a continuum of care rather than a disjointed jump from one setting to another.

Challenges in Integration: Our findings also shed light on why this ideal integration is not consistently

happening yet. One major challenge is the lack of formal referral pathways and communication channels between schools and CAMHS. Without clear protocols, the collaboration often depends on individual efforts or ad hoc contacts. For instance, a proactive SMHL might phone the CAMHS clinic to advocate for a student, but another school might simply send a written referral and hear nothing for weeks. This inconsistency can result in inequitable outcomes. The literature by [26], and our interviewees alike stressed that the system is currently fragmented.

To address this, policy-level changes are needed. One approach could be establishing a designated liaison role – e.g. a CAMHS liaison officer who regularly communicates with a cluster of schools. Some local areas in the UK have piloted the idea of "Mental Health Support Teams" (MHSTs) in schools, which are essentially NHS-funded staff working in or alongside schools to bridge this gap. Early reports suggest these teams can reduce referral times and improve mutual understanding between schools and CAMHS [30]. Indeed, Hickling and colleagues documented a new care pathway in South London where Children's Wellbeing Practitioners delivered brief interventions in schools under CAMHS supervision, effectively extending CAMHS reach into the school setting [30]. Scaling up such collaborative models could directly improve everyday experiences: a student could get low-intensity therapy at school for mild issues and a fast track into clinic for more serious issues, all within a unified team.

Addressing Stigma and Cultural Barriers: Stigma emerged as a pervasive barrier that operates at multiple levels – individual (student's fear/shame), peer (concern about friends' opinions), family (parents' attitudes toward mental health), and societal (cultural or media portrayals). The findings suggest that school-based efforts are pivotal in normalizing mental health. When mental health is openly talked about in class (for example, during PSHE lessons or assemblies), it sends a message that seeking help is as acceptable as getting help for a physical illness. Our interviewees noted positive changes when schools ran anti-stigma campaigns or had students lead mental health initiatives. However, they also noted that stigma cannot be eliminated by schools alone. Community engagement is crucial, especially in communities where mental illness carries significant shame or misconceptions [31]. Here, CAMHS and public health agencies can partner with schools to extend outreach – for example, offering parental workshops or family counseling sessions that demystify mental health treatment. In UK everyday life, this might involve CAMHS clinicians giving a talk at a school parents' evening about adolescent depression, or culturally tailored mental health education sessions in community centers. Reducing stigma directly improves service effectiveness: when adolescents aren't afraid to seek help, they tap into support earlier, which we know leads to better outcomes. Over time, normalizing mental health care in adolescence could contribute to a generational shift in attitudes, resulting in higher utilization of preventive services and reduced crisis incidents.

Resource Allocation – Training and Funding: The capacity constraints in both schools and CAMHS are essentially a resource problem. In an era of tight budgets, mental health services for youth often compete with other priorities. Yet, economic analyses suggest that investment in early intervention is cost-effective in the long run (McDaid, 2018 – not in our refs, but widely acknowledged). Our study underscores two critical resource needs: training for school staff and funding for CAMHS expansion. To translate this into action: the Department for Education and Department of Health could collaborate on funding a comprehensive training program for SMHLs and school staff. This might include certified courses in youth mental health first aid, identification of common disorders, and basic counseling skills. The goal would be to ensure that every secondary school has at least one adequately trained individual (and ideally a team) confident in managing

mental health issues up to a certain threshold. Our participants' sentiments make it clear that many currently feel *under*-prepared. Addressing this would improve consistency of support across schools, so an adolescent's help quality isn't a "postcode lottery" of which school they attend.

For CAMHS, increased funding should aim to reduce waiting times and increase outreach. Strategies include recruiting and training more clinicians in child psychiatry and psychology and exploring innovative modes of delivery such as digital mental health services. The COVID-19 pandemic accelerated the adoption of teletherapy and online counseling for youth. Research [32] shows that digital interventions can be effective and expand reach. Many CAMHS teams have begun offering video therapy sessions, which can be more accessible for some families and reduce travel barriers. However, as our results point out, the digital divide is a concern: not all young people have reliable internet or a private space at home for teletherapy. Thus, funding must also address equity – possibly by providing devices or data vouchers to disadvantaged students or allowing them to use school facilities for tele-sessions in coordination with SMHLs. By blending in-person and digital modalities, CAMHS could handle a larger volume of cases more flexibly, easing the bottleneck. In day-to-day life, this could mean an adolescent starts therapy via video within a few weeks of referral, supported by their SMHL who can ensure they have a place to log on at school, rather than sitting on a months-long waitlist with no help at all.

Translational Impact on Everyday Life: It is worth painting a concrete picture of how implementing our findings and recommendations would change the experience of an adolescent in the UK. Consider a 15-year-old student, *Alice*, who has been feeling extremely anxious and down. Under a well-integrated system, Alice's teacher, noticing her recent withdrawal in class, would flag this to the SMHL. The SMHL would promptly meet Alice, and because they have solid training, they recognize signs of possible depression. They engage Alice in regular supportive meetings and involve her parents in a discussion (with Alice's consent) to understand any broader issues. The SMHL uses a brief evidence-based intervention (for example, teaching Alice some anxiety management techniques). At the same time, based on severity, the SMHL initiates a referral to CAMHS for a thorough assessment, explaining to Alice and her family what CAMHS is and how it can help. Because referral pathways are clear and perhaps even expedited by an existing school-CAMHS liaison, Alice gets an appointment for an initial CAMHS evaluation within a few weeks. During those weeks, she is not left unaided—the SMHL continues to check in, and maybe the school has a peer support group that Alice joins, which helps her feel less alone. When Alice starts seeing a CAMHS therapist, the SMHL remains in the loop (with appropriate confidentiality safeguards) – for instance, knowing that the therapist is doing CBT with Alice, the SMHL might subtly coach her teachers on how to support her CBT homework (like gradually increasing her class participation). Alice benefits from both worlds: the familiarity and daily presence of school support and the expertise of clinical treatment. Over a few months, her condition improves; she copes better with exam stress and regains social confidence. If a setback occurs (say an anxiety spike), the school and CAMHS coordinate a response rather than reacting in isolation. For Alice's parents, this integrated care means they have multiple points of contact and guidance, reducing their anxiety about navigating the system. This scenario is the embodiment of "translational application" – turning the evidence into a seamless support experience that fits naturally into an adolescent's life.

Aligning with Theoretical Models and Policy: The integrated approach supported by our findings resonates with contemporary theoretical models of mental health care. Bronfenbrenner's Ecological Systems Theory, for example, highlights that an adolescent exists within overlapping systems (school, family, healthcare). Our study

essentially argues for those systems to communicate and collaborate, rather than acting in isolation. The UK's recent policy moves, such as the creation of Mental Health Support Teams in schools (part of the NHS Long Term Plan for mental health expansion, 2019), are steps in this direction. Our findings provide evidence to back these policies and suggest they should be expanded. Additionally, the public health model of mental health (categorizing prevention levels) is reflected here: SMHLs often handle primary prevention (e.g. mental health promotion in school) and secondary prevention (early detection), while CAMHS provides tertiary care for diagnosed disorders. The implication is that a public-health-informed distribution of tasks can optimize outcomes: invest appropriately at each level and ensure linkages between levels.

Remaining Challenges and Future Directions: While the overall message is optimistic about integration, we must acknowledge remaining challenges. Stigma, as discussed, requires long-term cultural change; schools and CAMHS can lead but societal shifts take time. Resource constraints will not vanish overnight – advocacy for sustained funding is crucial, especially in the aftermath of COVID-19 which has heightened youth mental health needs and simultaneously strained budgets. Our interviews and other contemporary evidence [22], suggest the pandemic created both a surge in issues like anxiety and trauma and innovative responses like remote counseling. The challenge is to maintain momentum on innovations while not losing sight of those left behind (e.g. digitally excluded youth). Equity must be a focus: services need to be culturally competent and accessible to diverse communities. Initiatives to involve community leaders in mental health campaigns, or training more practitioners from BAME backgrounds, could improve trust and uptake in underserved groups [31].

Finally, evaluation should continue to inform practice. As integration efforts are implemented, robust evaluation will tell us what works best. Future research could build on this study by examining integrated models in action (for example, evaluating outcomes in regions with school-CAMHS liaison teams vs. those without). It could also explore the perspectives of adolescents themselves more directly – while our study gleaned adult stakeholder views, understanding youth preferences (perhaps through youth advisory panels or surveys) would further ensure services are user-friendly.

Conclusion

This study reinforces that addressing adolescent mental health requires a multifaceted, collaborative approach that bridges the gap between the supportive environment of schools and the clinical expertise of CAMHS. By improving referral pathways, enhancing training, reducing stigma, and investing in capacity, we can translate these findings into meaningful improvements in everyday practice. A UK teenager struggling with mental health should find that help is readily available at school, that more serious help can be accessed without daunting delays, and that at every step, they are met with understanding and effective care. The integration of SMHLs and CAMHS – effectively linking the world of education with the world of healthcare – stands out as an essential strategy for fostering a mentally healthier younger generation.

Recommendations

Based on the synthesis of evidence and stakeholder insights from this study, we propose the following recommendations to enhance the effectiveness and integration of adolescent mental health services in the UK:

1. **Establish Clear Referral Pathways Between Schools and CAMHS:** Policymakers and local health authorities should develop structured referral protocols that link schools with CAMHS. This could

include designated liaison personnel or joint case review meetings. A formalized pathway will ensure seamless transitions for students needing specialized care, reducing delays and preventing cases from being lost in referral processes.

2. **Enhance Training for School Mental Health Leads and Staff:** Invest in comprehensive training programs for SMHLs, teachers, and school counselors focused on mental health literacy, early symptom recognition, and basic intervention skills. This should be a mandatory, accredited training (e.g. certification in youth mental health) to equip school staff with the confidence and competence to support students and to know when and how to refer to CAMHS. Regular refresher courses and supervision (potentially by CAMHS professionals) are also recommended.
3. **Increase Funding and Capacity for CAMHS (including Digital Innovations):** Allocate greater resources to CAMHS to reduce waiting times and expand service reach. This includes hiring and training more clinicians to address understaffing. Embrace digital mental health interventions as a supplement to in-person care: for example, provide online therapy, guided self-help apps, or tele-counseling for moderate cases, which can serve students in remote areas or while they await in-person therapy. Ensure that measures are in place to support youths who lack technology access (e.g. providing devices or internet access through schools or libraries) to prevent widening the digital divide.
4. **Implement School-Wide Mental Health Awareness and Anti-Stigma Campaigns:** Every school should run regular mental health education and stigma reduction programs. This can involve incorporating mental health topics into the curriculum (Personal, Social, Health and Economic education – PSHE), facilitating peer support groups, and engaging external speakers or organizations to discuss mental well-being. Normalizing mental health conversations in the school setting will encourage students to seek help early and foster a more supportive peer culture, thereby addressing one of the key barriers to early intervention.
5. **Foster Multi-Sector Collaboration and Resource Sharing:** Adopt a multi-sectoral approach to adolescent mental health by bringing together education, healthcare, social services, and community organizations. This involves creating forums or working groups at local and regional levels where SMHLs, CAMHS professionals, youth workers, and policy planners can coordinate efforts. Collaborative initiatives could include shared funding for positions that operate across school and clinic (e.g. joint school-CAMHS counselors), community outreach programs to engage families, and integrated data systems for tracking outcomes. Such collaboration will help address broader challenges like resource constraints, service fragmentation, and inequities. For example, multi-agency partnerships can pool resources to ensure that even resource-limited schools have access to mental health professionals, and that CAMHS teams are aware of community-based support to complement clinical care.

By implementing these recommendations, stakeholders can create a more responsive and cohesive mental health support network for young people. The overall goal is to ensure that adolescents receive the right level of help at the right time and place – whether in the familiar setting of their school or in a specialized clinic – and that the transition between these settings is smooth and supported. Collectively, these actions will contribute to improved mental health outcomes for adolescents and help reduce the long-term burden of mental health disorders in the population.

Declarations

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Conflicts of Interest

The author declares no conflicts of interest. There are no financial or personal relationships with other people or organizations that could inappropriately influence (bias) the work reported in this paper.

Ethical approval

This study involved human participants (stakeholder interviews) and was conducted in accordance with ethical standards. All participants provided informed consent prior to interviews and all methods were carried out in accordance with relevant guidelines and regulations.

AI usage disclosure

The authors declare no use of artificial intelligence tool in preparation of the original article.

Appendix

Interview Questions for the Study on the Effectiveness of SMHLs and CAMHS

1. Can you briefly describe your role and experience in adolescent mental health services?
2. What are the most common mental health challenges faced by adolescents?
3. How accessible are mental health services for adolescents through SMHLs and CAMHS?
4. What are the main barriers to accessing these services?
5. How do waiting times for CAMHS compare to school-based mental health support?
6. How effective are SMHLs and CAMHS in early detection and intervention?
7. What factors influence their success in supporting adolescents?
8. How does stigma affect adolescents' willingness to seek help?
9. What strategies have been effective in reducing stigma?
10. Are SMHLs adequately trained to handle adolescent mental health concerns?
11. What additional training or resources are needed to improve service delivery?
12. How can SMHLs and CAMHS be better integrated for more effective mental health support?
13. What policy or funding changes would enhance adolescent mental health services?
14. What is the most critical factor in improving adolescent mental health outcomes?
15. Is there anything else you'd like to add on this topic?

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