

REPORT

Centre for  
Mental Health



## Time for action

Investing in comprehensive mental health support for children and young people

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Children & Young People's  
Mental Health Coalition

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## Executive summary

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The mental health of babies, children and young people has been the subject of significant public, political and government interest in recent years.

This report responds to the challenge now facing policy makers – how to make the commitments and aspirations of government a reality. Foremost, it sets out a vision for a comprehensive mental health system for 0-25 year olds.

Our analysis identifies the main mental health challenges faced by babies, children and young people, summarises government ambition for them and makes practical suggestions for the delivery of change. Ideas are presented on the understanding that each service is part of a whole, working toward a comprehensive, seamless system: that no part alone can meet everyone's needs, but that together they can provide all children with the best possible chance of good mental health.

We are some distance from this in 2021.

Services for children and young people's mental health are underfunded in comparison to the return on investment they could secure if they existed at the necessary scale.

A postcode lottery also persists, which is exacerbated by the roll-out of new programmes and initiatives that do not provide nationwide coverage. Some areas receive new resources, others do not.

During austerity, infant mental health has experienced a quiet reduction in universal and targeted services. Government clearly understands the importance of the first 1,001 days, committing £500m over three years to transform Start for Life and family help services in half of council areas in England. But what about the other half? There also remains an accompanying absence of investment in health visitors and other core services which are needed to make the vision of a happy first 1,001 days a reality.

Schools and colleges offer an opportunity, as a universal service, to identify and convene help for students. Whilst school-based support is not suitable for all, a whole school approach has been shown to be successful – yet it is applied inconsistently across settings. This amplifies existing differences between schools which have resulted from mental health initiatives being funded directly from individual school budgets.

16-25 year olds face dramatically different life trajectories and are less likely to secure help for mental health problems than the average adult. High-profile campaigns have highlighted the issues faced by groups within this age range, but there is clear divergence in outcomes resulting from poor access to support. As with younger children, early support hubs would increase the help available to 16-25 years olds.

But essentially, it is the promise of a comprehensive national mental health system for 0-25 year olds that needs to be fulfilled. This requires significant investment and whilst hubs, whole school approaches and early years programmes are very important, they are not a national system.

This remains the challenge for government and is the ultimate conclusion of this work, and many reports like it.

A system should be judged by the level of care afforded to those who receive the least. Given the wide variation in provision, geographically and by age, that is currently an uncomfortable metric of achievement.

	Issue	Facts and figures	Recommendation
1	There is underinvestment in the mental health of 0-25 year olds and spending is highly variable by location. This leads to unacceptable variations in support.	Spend per child ranges from £14-£191 per person. Average adult spending is £225.	The Government should develop a comprehensive, England-wide 0-25 years Mental Health Investment Strategy in order to create a coherent national response for children and young people and end unacceptable variations in spending and provision.
2	The prevalence of mental health difficulties has increased among young people, although primary indicators suggest that life has not worsened over the last 30 years.	In 1999, 9.7% of young people experienced mental ill health. In 2017, 11% aged 6-16 did. In 2021, it is 15%.	The Government should set an ambition in its forthcoming mental health strategy to reduce the prevalence of mental health difficulties among children and young people.
3	Government has recognised the importance of infant mental health, responding with a Spending Review commitment of £300m. However, there is an absence of investment in other core services which are needed to make this a reality nationwide.	This announcement is outweighed by a decade of divestment.  Children’s Centre funding fell by 60% between 2011 and 2018: £1bn per year.  Public Health expenditure on 0-5 year olds fell by 20% between 2016-2020 and the Public Health Grant has fallen in value such that it needs £1.4 billion extra to restore it to 2015/16 spending power.	The Government should increase funding for core services, specifically the Public Health Grant, with an associated recruitment drive to ensure further investment translates into an expanded workforce.
4	Schools offer an ideal framework for 5-16 year olds to identify and coordinate mental health support. But there is no overall strategy and whole school approaches are few in number.	99% of schools believe they are screening for mental health problems.  But only 19% of schools had a single point of contact externally with NHS Children and Young People’s Mental Health Services.	The Department for Education should fully embed a whole school and college approach within the education system.
5	There are large gaps in provision for early preventative and community support for young people’s mental health. There is a postcode lottery in the availability of early help for young people before they need formal mental health care.	Investment in a comprehensive, national network of early support hubs would provide an infrastructure to deliver a key element of a 0-25 years mental health strategy.	The Government should fund a network of early support hubs across the country. A national network of hubs would cost approximately £103m per year and offer help to about 500,000 young people.
6	Acute care – particularly out-of-area – is extremely expensive. It can cost over half a million pounds per child, per year.	Clinically driven alternatives in the community which deliver comparable or better patient outcomes could deliver treatment savings of £137m across England.	NHS England should undertake a national expansion of the New Care Models (Provider Collaboratives) Pilot Scheme.
7	Outcome measurement is poor and lacking in the NHS.	Understanding the return on investment is crucial to understanding if money has been well-spent.	The Department of Health and Social Care should agree and apply a national outcomes framework for children and young people’s mental health support with NHS England.
<p><b>Conclusion: A comprehensive, England-wide 0-25 years Mental Health Investment Strategy is needed to create a coherent national plan for children and young people’s mental health.</b></p>			

## Introduction

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This report describes the investment case for mental health services and support for babies, children and young people in response to the 2021 Spending Review. It offers a range of costs and evidence to inform national government spending decisions, integrated care systems, and local councils for the delivery of prevention, treatment and management of mental health.

We know what works. That timely support from a consistent trusted adult can work wonders. That supporting a child with mental health problems can avoid later difficulties in adulthood. And that there are financial benefits, moral advantages and political capital to be gained.

Overall, total public spending on children has fallen in real terms by 10% since 2010/11, and prevention and early intervention services have been reduced further as increasing proportions are spent on acute need (Kelly, 2018). “England now spends nearly half of its entire children’s services budget on 73,000 children in the care system – leaving the other half for the remaining 11.7 million kids” (Children’s Commissioner for England, 2018).

The Government has made some important pledges to improve mental health support for babies, children and young people, including in the NHS Long Term Plan and the *Best Start for Life* Review of Early Years Provision.

Following the 2021 Spending Review, strategic investment is needed to fulfil these promises. The ultimate test will be what happens locally: in neighbourhoods, schools, colleges and universities, where the promises made will have to be translated into practice.

In the short-term, integrated care systems have an opportunity to make that strategic investment in their areas. While national leadership and investment are vital, many essential elements of a comprehensive mental health offer for 0-25 year olds could be put in place by integrated care systems now.

This report explores how government aspirations for young people’s mental health can be realised, and what needs to change to bring about a comprehensive system of support for mental health during the first 25 years of life.

# 1. Why invest in the mental health of 0-25 year olds?

## Problem

- NHS Children and Young People’s Mental Health Services have historically been underfunded
- The return on investment is formulaically higher for 0-25 year olds than adults because the time horizon for reward is longer. However, spending per capita is less than half that of adults
- Expenditure on mental health care is also highly variable between areas, correlating with wide variances in both provision and outcomes
- The result is an underfunded postcode lottery.

## Argument and substantiation

The NHS Long Term Plan is committed to extending “current service models to create a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults” and delivers “an integrated approach across health, social care, education and the voluntary sector” (NHS, 2019). But it does so from a base of historic underfunding and local variation.

### 1. Underfunding

Investment in mental health care for children and young people has been underfunded for many years. Prior to the NHS Long Term Plan, for example, the National Audit Office encapsulated the problem of underinvestment in the *Five Year Forward View* and *Future in Mind* strategies:

*“The Government has laudable ambitions to improve mental health services for children and young people. It started from a very low base when it developed its strategy and has prioritised improvement programmes which take an important, if modest, step towards achieving its aspirations. The Government has not yet set out or costed what it must do to realise these aspirations in full and there remains limited visibility of activity and spending outside the health sector”* (Bower et al., 2018).

The NHS Long Term Plan seeks to address this disparity by investing in children and young people’s mental health services at a rate faster than both overall NHS funding and total mental health spending (NHS England, 2019). The *Transforming Children and Young People’s Mental Health Provision* Green Paper has also committed to improving access to mental health support through education settings.

The NHS Long Term Plan states:

*“By 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams. Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it”* (page 37).

An additional £79m was made available to expand access to Mental Health Support Teams (MHSTs) from 59 areas in March 2020 to approximately 400 by April 2023, yet funding for these teams beyond 2023/24 is still to be confirmed.

There are significant reasons for increasing investment in the mental health of 0-25 year olds. From an economic perspective, the primary reason is the return on investment calculation. Return on investment measures are driven by three factors:

- The cost of an intervention
- The value of the resulting change e.g. improved health, employment
- The duration of the resulting change.

For children and young people, the unit costs of mental health services are not significantly different to those for adults and the outcomes are currently incomparable due to an absence of a common outcomes framework. This leaves the vector of time, which young people typically have more of than adults.

The formula for Net Present Value (NPV) – the measure that calculates the current value of all future gains from an intervention in one amount – is driven by time.

$$\text{NPV} = \frac{\text{Total benefit (£)}}{(1 + \text{Discount rate})^{\text{time}}} - \text{Initial investment}$$

Consequently, if government was investing in services using a return on investment model, it would be expected that investment in children and young people’s mental health would be higher, per capita, than for adults. This is strengthened further by the fact that the majority of mental health need in adulthood is visible in childhood. 50% of mental health problems are established by age 14, and 75% by the age of 24.

However, the reverse is true when it comes to current (and historic) spending. The Children’s Commissioner for England estimated that mental health NHS spend for young people is £92 per person, compared to £225 per adult. While noting that a higher incidence of ill health among adults drives some of these higher costs, it does not explain such a wide divergence (Children’s Commissioner for England, 2020).

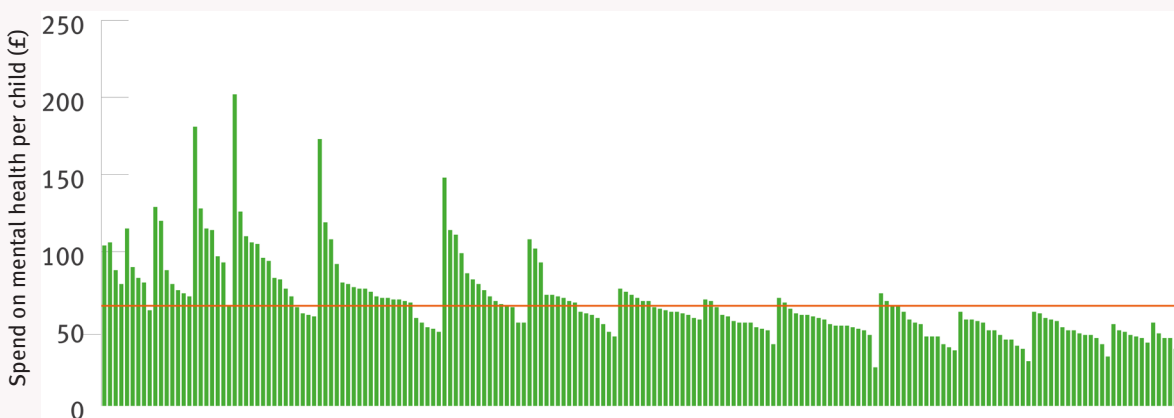
## 2. Postcode lottery

The Children’s Commissioner for England also found large variations in local expenditure. Spend per child ranges from £14 to £191 between different NHS areas (2018/19) (Children’s Commissioner, 2019a).

Figure 1 takes data on expenditure by CCGs on mental health and the score given to a CCG by the Children’s Commissioner. The score is calculated for local areas based on the following five metrics:

- The percentage of their overall budget committed to children’s mental health
- Their spend per child on children’s mental health services
- Their proportion of children locally accessing services
- Waiting times for these services
- The number of referrals closed before treatment.

**Figure 1: Spend on mental health per child versus average for CCGs, in descending order of Children’s Commissioner score**



On the left are the top scorers. The further to the right, the lower the rating. This graph shows an obvious correlation between spend and outcomes. Those with the best outcomes typically spend more than average per person (they are above the orange line). Those with the worst outcomes usually spend less than average (below the orange line). Postcode lotteries – where spending is dependent on location – result in differential outcomes.

## Conclusion

The current system is underfunded and highly variable between different areas. This leads to suboptimal and locally variant outcomes for children and young people.

From an economic perspective, the return on investment case for early support and health care is obvious, because the time horizon is longer. Yet budgetary commitments remain oblique beyond 2023/24, and plans to address the imbalance are currently absent.



## 2. Have things got better or worse for children and young people over the last 30 years?

In 2017, President Barack Obama was optimistic:

*“If you had to choose any moment in history in which to be born, you would choose right now. The world has never been healthier, or wealthier, or better educated or in many ways more tolerant or less violent”* (Ford, 2017).

This chapter discusses whether that is true for young people, specifically through the lens of their mental health:

- Have things got better or worse for a young person today than their counterparts from the 1990s?
- Has the scale of the health care challenge increased or lessened?

In summary, the evidence offers a mixed picture. Family stability, dependence on benefits and incidence of poverty have improved since 1990. Parental mental illness, financial inequity and housing stability have all worsened. Simultaneously, the increased awareness of mental health over the last 30 years has influenced how people with mental health problems seek help. Explaining the causes of increased demand for mental health care remains complex.

### How do we measure mental health for children and young people?

The prevalence of mental ill-health in children and young people in England has increased steadily over the last thirty years. Between 1999 and 2004, rates of mental ill health in young people aged 5-15 increased from 9.7% to 11.2% (NHS Digital, 2018a). In 2017, one in nine young people aged 6-16 were thought to have a mental health problem, and this increased to one in six in 2021 (NHS Digital, 2021). Between 2020 to 2021, over 420,000 young people aged 0-25 were treated for mental health problems (NHS, no date).

There are three primary mental health indicators for children and young people:

- Demographics
- Family context
- Socioeconomic factors.

These can be separated into income and location related factors (NHS Digital, 2019). Factors within these categories vary between pre-school, primary school, and secondary school aged children, but are generally similar.

Current data for each of these factors, as well as trends over the last 30 years, are described here to determine whether childhood is improving or deteriorating.

### Factor 1: Demographics – Sex and Ethnic Groups

There are clear differences in the prevalence of mental ill-health between different sexes and age groups. Girls and boys have an equal chance of developing an emotional disorder in pre-school (0-5 years old) and primary school (5-10 years old), but by secondary school (11-16 years old), girls are at greater risk of developing a mental health difficulty than boys. In pre-school, primary and secondary school years, boys are at greater risk of developing a behavioural disorder compared to girls (NHS Digital, 2019).

When comparing between ethnic groups, surveys indicate that the likelihood of developing mental health difficulties is higher for white children than children from racialised backgrounds in pre-school years, primary school years and secondary school years (NHS Digital, 2019). (This may be partly explained by poor sampling of racialised communities in population level surveys.)

In 2005, there were higher rates of mental health difficulties in white children aged 5-16 years (10.1%) compared to Black (9.2%), Pakistani and Bangladeshi (7.8%), and Indian (2.6%) children. When comparing between sex, more Black girls aged 11-16 years (7.6%), and Pakistani and Bangladeshi girls (7.5%) had an emotional disorder than white girls of that age group (6.2%). In addition, higher rates of Black boys were diagnosed with conduct disorder than any other racial group (Race Equality Foundation, 2014).

However, there is a serious lack of research and statistical data exploring mental health by ethnicity and gender in children and young people in the UK (Roe, 2018; Le, 2021). More

research is required before any conclusions can be made as to whether things have got better for children and young people between sex, gender, and racial groups.

## Factor 2: Family Context

Factors such as unhealthy family functioning, poor parental mental health, living on social security benefits, and living in a household with a lone single parent are related to the development of mental health problems in children and young people (NHS Digital, 2019). Table 1 compares family factors with rates of mental health difficulty among children in three age groups.

**Table 1: Factors influencing the mental health of children and young people in England, 2017 (Office for National Statistics, 2019a)**

Factor	Rate of mental health difficulty		
	2-4 years	5-10 years	11-16 years
Healthy family functioning	5%	8%	11%
Unhealthy family functioning	10%	19%	25%
Good parental mental health	4%	7%	11%
Poor parental mental health	15%	23%	30%
No use of benefits	3%	5%	10%
Social Security benefits (low income or disability)	10%	17%	21%
Married	-	6%	12%
Cohabiting	-	12%	14%
Lone parent - Single	-	17%	27%
Lone parent - Previously married	-	18%	19%
Parents with qualifications	5%	8%	14%
Parents with no qualifications	7%	17%	16%

Note: Percentage data represents the percentage of children in England, 2017, with a 'mental disorder'. 'Mental disorder' includes emotional, behavioural, and hyperactivity disorders, as well as other disorders such as autism spectrum disorder, anorexia nervosa and tics (Office for National Statistics, 2019a).

### ***What has happened to family structure?***

In 2019, there were 1.8 million families consisting of lone parents and dependent children and 69.9% were in employment (Office for National Statistics, 2019b). Between 1999 and 2019, the number of lone parents with dependent children (aged under 18 years) decreased by 9.8%.

We can see from Table 1 that children from single lone parent families are at greater risk of developing a mental health difficulty than children from married or cohabiting families (Office for National Statistics, 2019c).

This shift in family structure suggests that children and young people were at less risk of developing a mental health difficulty in 2019 than they were in 1999. However, the Covid-19 pandemic may influence family structure, potentially putting more children at risk. Future data will inform our understanding on this.

### ***What has happened to parental mental health?***

In 2016, 68% of women and 57% of men who suffered with mental health difficulties were parents. Common conditions were anxiety, depression, and PTSD (Mental Health Foundation, 2016). Between 2018-2019, it was estimated that one in four children between 0-16 years had a mother with a mental health difficulty, and this was predicted to increase (Abel *et al.*, 2019).

Depression and anxiety were the most common disorders among mothers (Abel *et al.*, 2019). We can see from Table 1 that children who grow up with parents with poor mental health are at greater risk of developing a mental health problem than children who grow up with parents with good mental health.

The increased exposure to parental mental illness between 2005 and 2017, and the predicted increase in children growing up with a mother with mental illness, suggests that things have got worse for children and young people over the last 16 years.

## **Factor 3: Socioeconomic factors**

Factors such as household income, parent occupation, social security benefits, region, and household tenure are known to impact the prevalence of mental health problems in children and young people (NHS Digital, 2019).

### **Household income**

Growing up in a household with median income increases the risk of developing behavioural disorders in children aged 11-16 years (NHS Digital, 2019).

The Gini coefficient is a standardised measure used to assess income inequality. Scores range from 0%, where income is equal for all households, to 100%, where income is severely unequal (Department for Work and Pensions, 2020). In 1990, the Gini coefficient for gross income was 36.6%. This increased to an average of 37.4% between 1999 and 2001. Income inequality was highest between 2007 and 2008 at 43%. This decreased to an average of 40.1% between 2009 and 2011 and increased further to 40.8% between 2019 and 2020 (Office for National Statistics, 2021a). This means that, despite fluctuations, gross household income inequality has increased by 4.2% from 1990 to 2020.

Despite this increase in inequality, in 2019, the number of children in absolute low income was the lowest it had been since 2002. However, children are more likely to live in low-income households compared to the overall population (Department for Work and Pensions, 2020).

This suggests that things have got slightly better for children and young people over the last 30 years, despite the small increase in inequality. However, things are unlikely to get any better as children are still more likely to live in low-income households. Moreover, it is likely that the Covid-19 pandemic has further broadened income gaps between households, putting more children and young people at risk, particularly with the withdrawal of the Universal Credit uplift in October 2021 and simultaneous fuel cost increases.

## Parent occupational classification

Children aged 11-16 years with parents working in intermediate occupations are at lower risk of developing an emotional disorder than children of parents in managerial or professional roles (NHS Digital, 2019). Examples of intermediate occupations are clerical, administrative, sales, technical, or engineering roles (Office for National Statistics, 2010).

### *What has happened to parental employment?*

Women and men with dependent children have higher rates of unemployment compared to women and men without dependent children. In the year 2000, 66.2% of mothers and 89.4% of fathers were in employment. This increased to 75.1% of mothers and 92.6% of fathers being in employment in 2019 (Office for National Statistics, 2019b).

From April to June 2018, the highest rates of employment for women with dependent children were in the public administration, education, and health sectors (47.8%) followed by banking and finance (17.1%). The opposite trend was observed for men with dependent children with higher rates of employment in banking and finance (19.8%) followed by public administration, education, and health (16.7%) (Office for National Statistics, 2019b).

The increase in employment for parents with dependent children suggests that things may have got better for children and young people over the last 19 years. However, growth in employment has been partially driven by an increase in professional and managerial posts which have a comparatively detrimental impact on dependent children. The net impact of these competing forces is finely balanced.

## Social security benefits

According to Table 1 (see page 10), children living in a family in receipt of low income or disability social security benefits are at greater risk of developing mental health problems. Children aged 2-4 years are twice as likely to develop a mental health problem if they live in a family receiving these types of benefits. This continues into primary school, where 16.9% of children living in families receiving benefits develop both emotional and/or behavioural

disorders. Young people aged 11-16 years are also at greater risk of developing mental health problems when living in a family receiving benefits (NHS Digital, 2019). What is not clear, however, is the relationship between social security benefits and childhood mental health. Specifically, it is unclear whether the experience of living in a family in receipt of these benefits is the cause of childhood mental health difficulties, or if they are the result of needing the benefits in the first place, or both. There may be various additional factors impacting childhood mental health that result from each of these circumstances that have not been considered.

### *How have uptake rates of social security benefits changed?*

Between 2017 and 2020, the number of households receiving state support decreased from 53% to 50%, which means that half of households in the UK are receiving some form of state benefits (Department for Work and Pensions, 2021). This decrease is despite parents receiving more state support, such as shared parental leave, Child Benefit, tax credits and tax-free childcare, and 30 hours' free childcare for parents with children aged 3-4 years (Office for National Statistics, 2019b).

We can see in Table 1 that children who live in households receiving social security benefits appear to be at greater risk of developing a mental health problem than children living in households receiving no benefits. When looking only at this data, the slight decrease in the use of state support between 2017 and 2020 would suggest a slight decrease in the risk of children and young people developing mental health problems.

However, this decrease in state support could be because some households no longer meet the eligibility requirements due to legislative changes, resulting in a decrease in income for these households and thus an increased risk to a child's mental health. One would assume that more parents taking advantage of state support would lead to an increase in household income and benefit the mental health of children and young people. It is not clear from this data what proportion of the population using state benefits are parents.

## Region

There are regional differences in the mental health of children and young people. Children living in London, aged 5-16 years, are at lower risk of developing a mental health problem than those living elsewhere (NHS Digital, 2019).

In 2017, rates of mental ill health in children aged 5-19 years were highest in East of England (15.6%), followed by the South West (15.5%), and the North West and Yorkshire and the Humber (both 14.7%). The lowest rates were in London (9.0%) followed by the North East (11.6%) (NHS Digital, 2018b).

There are also significant regional and national differences in service provision within the UK. Between 2014 and 2020, the number of children aged 0-18 years who accessed Child and Adolescent Mental Health Services (CAMHS) was 33 per 100,000 in England, 13 in Wales, 61 in Scotland, and 40 in Northern Ireland.

### *How have the regional differences shifted?*

There is a sparsity of regional trend data which constrains the measurement of mental health between areas and limits the conclusions that can be drawn. In addition, hospital admission rates are an unreliable indicator for prevalence of mental ill health, as they are influenced by factors such as criteria for service use and capacity.

Further research is needed; not least so that funding can be targeted regionally as part of the Government's 'Levelling Up' agenda.

One indicator that should give cause for concern is the suicide rate for young people aged 15-24 years. While overall numbers are small, the rate of suicide deaths in this age group increased from 6.6 to 8.1 per 100,000 in England, 4.9 to 9.7 in Wales, 9.8 to 15.1 in Scotland, and 17.2 to 17.8 in Northern Ireland, in 2018 (Royal College of Paediatrics and Child Health, 2020). Understanding these increases and the variations between nations within the UK is important to prevent future tragic losses of young people's lives.

## Household Tenure

Children aged 5-16 years who live in social rented accommodation are at greater risk for developing behavioural disorders than children who are not (NHS Digital, 2019).

### *What has happened to household ownership?*

From 1994 to 2018, the number of children living in owner-occupied households decreased from around 65% to around 55%. The number of children in privately rented accommodation increased from 5% to just over 20% and the number of children in socially rented accommodation decreased from around 25% to just over 20%.

There were equal numbers of children in socially rented and privately rented accommodation in 2018. Research suggests that the rise in private renting was greater for children living in poverty than children who were not. This had long-term effects as a vast proportion of children in privately rented accommodation in pre-school years were found to remain there into secondary school (Bailey, 2020).

Despite the decrease in home ownership, there were still more children living in owned homes than rented homes between 1994 and 2018. However, even with the decrease in social renting, private renting increased, suggesting that things may have got worse for children and young people over the last 24 years, particularly for children in lower income households.

## Conclusion

The prevalence of mental health difficulties in children and young people has risen significantly over the last 30 years in the UK and, consequently, mental health services aimed at supporting children and young people have also changed. Demographics, family context and socioeconomic factors play a substantial role in whether a child or young person will develop a mental health problem.

Overall, there were positive trends in several factors such as a decrease in single lone parent households, a decrease in the number of children in absolute low income and a suggested decrease in the number of families receiving social security benefits.

However, there were also negative trends in several factors such as an increase in exposure to parental mental illness, an increase in

household inequality resulting in children remaining in low-income households, and a decrease in home ownership resulting in an increase in private renting.

As there are conflicting trends between numerous factors, it is difficult to determine whether things have generally got better or worse for children and young people.

### 3. Investment in 0-5 years

#### Problem

- The promotion of good mental health in the early years is vital as it helps lay the foundations for social and emotional development throughout life
- The Government has recognised the pivotal importance of this time, most recently in its Early Years Healthy Development Review Report (HM Government, 2021)
- In 2021, there are limited mental health services for children aged 0-5. Investment in Sure Start has fallen by 60%, with accompanying gaps in public health and specialist service provision
- Health visitors are a key line of support for parental and infant mental health, but numbers have fallen by a fifth since 2015
- The Spending Review committed £300m as part of the ‘Best Start for Life Review’ to improve services for babies and their families. However, no funding for core services, such as health visitors, was included
- A comprehensive investment strategy for all England councils is absent.

#### Argument and substantiation

Overall, there is a clear picture of systemic divestment during austerity. It is in sharp contrast to previous government spending, such as £458m on Sure Start between 1999 and 2002.

The First 1,001 Days Movement’s *A Decade of Disinvestment* report (2021) highlights:

- Annual public health expenditure on services for 0-5 year olds dropped by 20% between 2016/17 and 2019/20
- Funding for and spending on children’s centres has fallen by an estimated 60%, from £1.6 billion in 2010/11 to £600 million in 2017/18. In 2007/08, 45% of all government spending on the early years and childcare support was targeted explicitly at low-income families. By 2018 the share of spending on low-income families had decreased to 27%.

Similarly, services for infants and their parents are limited (Hogg, 2021). For example:

- 42% of CAMHS in England do not accept referrals for children aged two and under

- There are only 39 parent-infant teams in the UK.

The Institute of Health Visiting (2020) found:

*“Official figures indicate that around one in five health visitors were lost between 2015 and 2019 – the full-time equivalent of 18% of the workforce. This is due to public health budget cuts and the failure to protect health visitors’ preventative role by many cash-strapped local authorities, after health visiting commissioning moved from the NHS to local authorities in 2015.”*

*“Almost a third of health visitors report they are now responsible for between 500 and over 1,000 children... The Institute considers the optimal maximum to be 250 children in order for health visitors’ work to be fully effective, fewer in areas of high vulnerability.”*

#### The resulting system failure

Despite wide political and evidentiary support for the first 1,001 days of a child’s life, there are few opportunities for health and social care services to notice, identify and support infants aged 0-5.

## Proposed solution

An investment strategy for infant mental health as part of the wider 0-25 system.

## Argument

HM Government's *Early Years Healthy Development Review* (2021) makes an extremely clear social and economic case for action.

Its Chairman's Foreword by Rt Hon Andrea Leadsom states:

*"The building blocks for lifelong emotional and physical health are laid down in the period from conception to the age of two and we don't give this critical period the focus it deserves. Prevention isn't only kinder, but it's also much cheaper than cure – what happens to an infant in the 1,001 critical days is all about prevention, and a strong, supportive policy framework in this area can truly change our society for the better, while saving billions for taxpayers."*

The Review draws on established scientific evidence to pinpoint the need to counter adverse childhood experiences, support struggling parents and protect children at a point of pivotal brain development.

A strategic response to the Review is required – one which describes the services and investment that will be created to meet the needs of this crucial period of development.

Specifically:

- Evidence-based, targeted investment in babies' development encompassing infant mental health services which are integrated within a system for 0-25 year olds

- Investment in health visiting services – including supporting staff development and training on infant mental health and embedding this within key health checks for babies and toddlers
- Investment and expansion of parent-infant teams
- Investment in a national network of family hubs to ensure mental health support to infants forms part of the offer.

The Spending Review's commitments offer a partial answer. £500m will help develop and reform new services, although this includes the investment needed for family hubs and the Strengthening Families programme which are for children of all ages. It is not a comprehensive funding pledge and the Public Health Grant which funds core services has not been increased. The ultimate problem of resourcing core services to guarantee a high standard of care to all remains unaddressed.

## Conclusion

Following a decade of disinvestment in 0-5 year olds, the Government should draw on its own findings to create a coherent investment strategy for infant mental health care. Initiatives to solve specific issues associated with early years do not create a comprehensive investment strategy, nor do they deliver consistent services across all areas. This requires a review of and increase to core funding, specifically the Public Health Grant, and an associated recruitment drive to ensure further investment translates into an expanded workforce.



## 4. Using existing systems to screen and support children aged 5-16

### Problem

- The education system is the ideal universal framework for 5-16 year olds to identify and coordinate mental health support for children
- But levels of mental health awareness, funding and support within schools, pupil referral units and home schooling are highly variable
- There is a missed opportunity to identify and intervene in the lives of children, through the nationwide implementation of the 0-25 'pathway' described in the NHS Long Term Plan.

### Argument and substantiation

Between 5 and 16, all children should be in formal education, including school, home schooling or alternative provision. This amounts to 8.9 million young people (Department for Education, 2021).

Between 16-18, all children are still classified as being in education, but this can vary significantly from supportive sixth forms to a full-time apprenticeship on a building site where getting the job completed is the primary goal. There is not the same consistency of provision.

This is an investment opportunity for government because schools are an existing, universal system through which children can easily be screened for mental health problems, offered support and provided access to coordinated support. Not all pupils will want to access help through schools, particularly where they feel a school exacerbates the challenges they face. This is highlighted by Mind's research (2021) noting that poor mental health is mistaken for bad behaviour: "Young people who expressed their mental health problems or responded to trauma through anger described how they were punished, including through being placed in isolation or excluded, which contributed to worsening mental health."

However, schools still have, to use the economic term, a 'monopoly' on time interacting with children aged 5-16.

Figure 2 (overleaf) demonstrates how many pupils may be struggling with their mental health in an average secondary class of 30.

Steps have been made to create whole-school and college approaches, but they are currently unfunded, and remain optional. There is a range of statutory guidance issued by the Department for Education focusing on child protection, behaviour and mental health. Key documents include:

- 'Keeping children safe in education'
- 'Supporting pupils at school with medical conditions'
- Statutory guidance on 'Promoting the health and wellbeing of looked after children'
- Advice for school staff on 'Mental health and behaviour in schools'
- Advice on 'Counselling in schools'.

The Department for Education and Public Health England issued guidance on implementing whole-school or college approaches, which the Children and Young People's Mental Health Coalition supported them to update in 2021 (HM Government and CYPMHC, 2021).

While it is a school's statutory duty to protect children from harm and to promote their welfare, protecting and promoting mental health and wellbeing should also fit into this statutory duty.

**Figure 2: Life experiences in an average class of thirty pupils**

One could have experienced the **death of a parent**



Four could be living in **lone parent families**



Five could have a **mental health difficulty**



Five could be **living in absolute poverty**



Seven may have **self-harmed**



Eleven could have experienced **bullying**



A nationwide survey of school and college mental health provision (Department for Education, 2017) highlighted that most schools feel they are doing a great deal to attend to mental health:

- 92% of schools believe they have an ethos which promotes mutual understanding and concern
- 99% of schools believe they are screening for mental health issues.

However, the reality of that provision is disappointing:

- Only 15% used a universal screening tool
- 61% offered in-school counselling, but “very few schools identify a specific clinical model which informs their approach” and “Little was known about the quality of the counselling”

- 44% of school counsellors had a Diploma or equivalent, and 15% had no qualifications
- Only 19% had a single point of contact externally in NHS children and young people’s mental health services.

Crucially, from an investment perspective, 92% of the funding for this comes from school core budgets.

This means that headteachers and governing bodies are deciding on mental health care spend on a school-by-school basis (which is therefore highly variable) and having to choose between this and their teaching budget. This is neither comprehensive nor strategic.

## The resulting system failure

The education system is under-utilised as a framework to deliver coherent and proven mental health support, such as screening, CBT, counselling and mentoring, which would enable the early identification of mental ill health and offer speedy, cost-effective solutions.

## Proposed solution

The Government should make its vision of a whole school approach to mental health, outlined in the 2017 Green Paper, and developed in its recent guidance (HM Government and CYPMHC, 2021) available to *all* school children.

The Children and Young People’s Mental Health Coalition’s Member Report 2021 noted:

*“Whole education approaches are crucial in ensuring the mental health and wellbeing of all pupils and students is promoted and supported. Whilst positive steps have been taken in implementing whole education approaches, our conversations with members, young people and parents still highlighted significant gaps. Our findings highlight that we need a more systematic approach to implementing a whole education approach that is sufficiently resourced.”* (CYPMHC, 2021)

As part of an effective whole school approach, the Government should make school counselling available to every child who needs it, at a cost of £118m per year (rising to £130m after five years). This would fund 2,623 FTE counsellors in schools to support 341,000 children who have mental health support needs across all English state secondary schools. In Wales, school counselling provision has been implemented as part of a whole school approach to mental health.

## Argument and substantiation

A whole school approach refers to a universal, school-wide, and multi-component approach to the promotion of wellbeing and mental health among the whole school community: children, young people, families and staff.

In 2017, the *Transforming Children and Young People’s Mental Health Provision* green paper described a whole school approach, but delivery of the vision has been disappointing (see Table 2). And there are significant whole school approach components, including staff wellbeing and development, support for families and investing in the school environment, where neither funding nor policy has yet been forthcoming.

**Table 2: Vision described within *Transforming Children and Young People’s Mental Health Provision* versus delivery in 2021**

Vision	Delivery (by 2021)
‘A Designated Senior Lead for Mental Health to oversee the approach to mental health and wellbeing’	Delayed until September 2021: Senior Mental Health lead training funds of £1,200 per person have been made available for September to March 2022. Enough for 1/3 of state schools and colleges
‘We will fund new Mental Health Support Teams, supervised by NHS children and young people’s mental health staff, to provide specific extra capacity for early intervention and ongoing help’	85% of the school population do not have access to a support team. Data from NHS England shows that there are now over 280 mental health support teams set up or in training – 183 are operational, covering 15% of pupils in England (NHS England, 2021). A further 103 are in development (NHS England, 2021). No further funding has been committed post 2023/24
‘We will trial a four-week waiting time for access to specialist NHS children and young people’s mental health services’	New consultation on the four-week target announced in July 2021

## Costs and resources required

We have identified costings from three different examples of implementing whole school approaches, and share these below to provide indicative costs.

**Place2Be** provides emotional and therapeutic services in primary and secondary schools. The charity has estimated the cost for the roll out of a whole school approach programme in England would be approximately £280m per year. This would offer:

- A Mental Health Practitioner, to provide targeted support for children
- A School Leader Programme, to assist a school to take a strategic approach to putting in place a whole school approach – mapping and understanding what they already have in place; developing an action plan to implement
- Place2Think, small group supervision sessions for education professionals supporting positive mental health in school communities
- Reflective space for the designated Mental Health Lead – dedicated time in a group session with peers
- A Foundation Programme for Class Teachers – to build knowledge, skills and understanding via a CPD accredited programme.

**HeadStart** in Hull is one of six HeadStart programmes being run across England, funded until 2022, by The National Lottery Community Fund. It aims to explore and test new ways to improve the mental health and wellbeing of young people aged 10 to 16 and prevent serious mental health issues from developing. As part of the programme, policy and practice officers are working with schools to implement a whole school approach across all 97 schools in the Hull local authority area.

The annual average cost per school is estimated at £935 (including special schools and Pupil Referral Units) offering:

- Schools Policy and Practice Officers
- Young people engagement and co-production workers
- Training Officer.

Based on these costs, national implementation would cost approximately £18.35 million per year.

**Compass BUZZ** is a four-year project to support all school leaders, teachers and pastoral staff across all 400 schools in North Yorkshire to gain the knowledge, skills and confidence to support the mental health of their pupils and staff through direct interventions, based on a whole school approach. The project is delivered by wellbeing practitioners included tiered training based upon staff responsibility, and requests for support through consultation on pupil presenting needs and facilitation of a peer network to share learning, best practice and wellbeing initiatives. The legacy of Compass BUZZ is that schools can adapt and deliver a whole school approach with little external support (Compass BUZZ, n.d.).

This model would have initial national set-up costs of £59.5m, falling over subsequent years to £15m, £11.9m and 8.5m in years 1,2 and 3. It has a phased approach to consultation and support which results in costs falling post set-up.

Ultimately, these are low-cost options which could provide national coverage across schools relatively cheaply and, depending on the model, have low running costs in subsequent years.

## Conclusion

A whole school and college approach would embed mental health within the education system, which would have a universal impact on the health of every child and young person.

## 5. Investment in mental health care for 16-25 year olds

### Problem

- Just 22.7% of 16-24 year olds with symptoms of common mental health problems were receiving treatment. The adult population average is 39% (NHS, 2014)
- The likelihood of a mental health difficulty increases with age, and it is much more prevalent among young women: 27.2% of young women and 13.3% of young men were identified as having a probable mental health problem (NHS, 2020)
- Young people enter diffuse pathways after completing Year 11: sixth form, college, armed forces, employment, apprenticeships, prison, parenthood, caring, travelling and nothing at all
- The systemic disruption at 16 makes it harder for services to reach and help young people, at the point when their mental health needs are escalating.

### Argument and substantiation

Centre for Mental Health's *Missed Opportunities* report (Khan, 2016) articulates the pre-pandemic issues faced by people aged 16-25.

Its key messages include:

*In young adulthood, there is a significant increase in self-harm, depression, anxiety and eating disorders, all of which for the first time begin to affect young women more than young men. It is also at this time that we first begin to see more severe mental health diagnoses emerge such as psychosis and personality disorders.*

*Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24. Poor mental health represents a major disease burden for this age group and should be a health improvement priority.*

*Teenage and young adult years continue to provide vital opportunities for intervention among those facing or living with poor mental health. Intervening early in the course of many mental illnesses can significantly reduce life course impairment. Yet very few young adults get early help that has the best chance of making a difference and they are the least likely to seek help – particularly males.*

The pandemic has had a significant impact on the life-chances of young people, and the long-term changes to income, employment and housing will impact on mental health.

People aged 16 to 24 were more than twice as likely (50.8%) to have experienced “lockdown loneliness” as those aged 55 to 69 (24.1%) (Office for National Statistics, 2021).

Almost three in ten (29%) students said they had engaged with mental health and wellbeing services since the start of the Autumn 2020 term. The most frequently specified services used were GP or primary care (47%), online university services (40%), and NHS or the Improving Access to Psychological Therapies (IAPT) programme (29%) (ONS, 2021b).

There are also 16-25 year olds who, prior to the pandemic, faced significant challenges specific to their economic circumstances. The percentage of all young people (aged 16 to 24) in the UK who were not in education, employment or training (NEET) in January to March 2021 was estimated at 10.6% of the population – 728,000 people (ONS, 2021c).

Australian research suggests that NEETs have higher symptom levels of depression, but not anxiety. NEETs reported higher levels of disability, lower levels of social and occupational functioning and higher rates of economic hardship (O’Dea *et al.*, 2014).

Yet the mathematics of interventions for NEET young people are simple, with employment being a key factor. If someone is unemployed, Universal Credit payments for a single person for the duration of a working life (16-67 years) are £191,511. If they are employed, the equivalent taxes and National Insurance contributions generated by minimum wage employment over the same period are £105,020. The difference between those two numbers – the tax revenue where someone is employed, versus the benefit cost when someone is not – is £296,531 per person (DWP, 2021).

## **The resulting system failure**

The emergence of mental health problems between 16-25 occurs while young people are taking very different life trajectories. While choice and variety are crucial to development, mental health support should work effectively across these different environments – whatever paths young people take – to ensure that any gains made during school education are sustained.

## **Proposed solution**

Ensuring that the ambition of the Long Term Plan to create a comprehensive mental health offer for people aged 0-25 is established.

This is a role which early support hubs can help fulfil as part of a comprehensive system of support. Chapter 6 describes the policy and economic case for these.

## 6. Investment in early support hubs

### Problem

- There are large gaps in provision for early preventive and community support
- Evidence given to the Health and Social Care Select Committee on children and young people's mental health (June 2021) said that half of children and young people with mental health problems are not accessing support from mental health services
- 4% of children accessed mental health services in 2019/20. This is equivalent to about a quarter of those who needed support (NHS Digital, 2020).

### Argument and substantiation

Total spending on preventive and early intervention (low-level) mental health services is limited (Children's Commissioner, 2020).

Around £226 million was spent on 'low-level' mental health services in England in the year 2018/19. This equates to £14 per child. Of the total funding:

- 50% comes from the NHS
- 30% comes from local authority children's services
- 20% comes from local authority public health budgets.

Spending rose nationally by 17% (in real terms) between 2016/17 and 2018/19 – but not in every area.

- In 58% of areas spending went up
- In 37% of areas spending went down
- The local authority contribution fell in 60% of areas, whilst CCG funding went up.

The result is that there was wide variation between local areas: a quarter of areas spent more than £15 per child, while another quarter spent less than £4. The lowest was just 26 pence (Children's Commissioner, 2020).

At a system-wide level, acuity is the predominant focus:

*“Local Government in England now spends nearly half of its entire children's services budget on 73,000 children in the care system – leaving the other half for the remaining 11.7 million.”* (Children's Commissioner, 2018)

This is part of a wider, systemic trend of local authority reductions in expenditure on children's services. Pro-Bono Economics calculated that there was a £325m fall in local authority spending on children across England between 2010/11 and 2019/20, with spending per child falling by 14% over the same time period in the most deprived areas (Williams and Franklin, 2018).

### The resulting system failure

The result is a 'dark zone' where screening, early support and prevention have low levels of funding. For example, in recent research by The Children's Society and YoungMinds (2021) on the role of GPs in early support for young people's mental health, it was highlighted that there is a variation in the availability of sub-threshold support. GPs stated their frustration with inadequate services to which they could signpost children and young people.

### Proposed solution

Early support hubs offer easy-to-access, drop-in support on a self-referral basis for young people with low-level mental health needs, up to age 25.

## Argument and substantiation

Early support hubs can be delivered through the NHS, in partnership with local authorities, the voluntary sector and with digital providers. They are designed to provide additional support and not to replace the vital services provided by statutory services.

A mix of clinical staff, counsellors, youth workers and volunteers provide wellbeing support, with a range of services co-located under one roof. These services offer wrap-around support across, for example, psychological therapies, housing advice, youth services and sexual health. The hubs should also link to existing digital resources and services where available, to build an element of digital support into their design. This would improve access and increase flexibility for young people who feel that they have benefited from online support during the pandemic.

Early support hubs are recommended in *Future in Mind* (Department of Health & NHS England 2015) and described as an effective delivery mechanism of mental health care and support for young people:

*“...[Hubs] provide a key role for the voluntary and community sector to encourage and increase the number of one-stop shop services, based in the community... They should be a key part of any universal local offer, building on the existing network of YIACS (Youth Information, Advice, and Counselling Services). Building up such a network would be an excellent use of any identified early additional investment. There may also be a case in future for developing national quality standards for a comprehensive one-stop shop service, to support a consistent approach to improving outcomes and joint working.”*

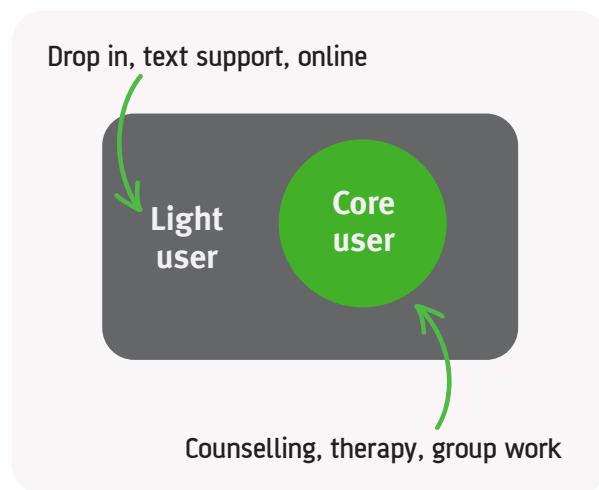
Young people receiving counselling through Youth, Information, Advice and Counselling Services (YIACS) reported comparable clinical outcomes to those accessing therapy through CAMHS or school, while also reporting significantly higher satisfaction with their experience (Balmer *et al.*, 2012). Previous evidence from the UK, Australia, Denmark and Ireland also indicates that early support hubs are able to attract young people who are less

likely to engage with NHS mental health support (O’Keefe *et al.*, 2015) and offer savings to a range of services across the health system and public services (Headspace Denmark, 2020).

## Costs and benefits

Each early support hub is different, making average cost calculations complex. Each person also uses the service differently because the hubs are tailored to individual need.

Broadly, there are ‘light’ and ‘core’ users. Core users receive the majority of services and input in response to their higher level of needs. An indicative national cost is £103m a year.



A hallmark of the hubs is that they develop and respond to specific local need. This means that there are a range of partnership delivery structures, service offers and sizes. Therefore, from a ‘Levelling Up’ perspective, it is important that national roll-out of hubs enables each area to devise and agree its partnership-delivered services in response to local need, but is assured of funding. Targeted funds – which would leave some areas without hubs – would simply increase the existing inequality previously highlighted by the Children’s Commissioner.

An outcomes framework (chapter 8) will be crucial to understanding what difference the expenditure has made, its return on investment, and indicate who future funders would be.

## Conclusion

Early support hubs are a clear opportunity to bridge the existing gap for low- and medium-intensity health care and support.



## 7. Bringing care back home

### Problem

- 4,127 children were admitted to inpatient mental health care in 2019/20 (Children's Commissioner for England, 2020)
- The number of children's mental health services rated inadequate doubled between 2017/18 and 2018/19 (Children's Commissioner for England, 2019b)
- Acute care is expensive, particularly when using out-of-area beds. Costs ranged from £187,351-£513,826 per child, on average, in a Centre for Mental Health evaluation of New Care Models (O'Shea, 2019).

### Argument and substantiation

In 2013, NHS England became the commissioner of what were called Tier 4 (inpatient) services, while Tier 3 (community) services remained the budget responsibility of newly formed clinical commissioning groups (CCGs). This created a framework where relatively similar health care services were being paid for by two different organisations.

This, in turn, financially incentivised local commissioners to change their behaviour: from the perspective of local commissioners, Tier 4 provision had become a zero-cost item, while Tier 3 remained a local cost. The logical response, from a financial perspective, is for a CCG to substitute their Tier 3 provision with 'free' Tier 4 provision. And whilst financial incentives are not the sole driver, increasing use of Tier 4 services became a financially rational decision.

NHS England recognised this problem, and in the Five Year Forward View for Mental Health in 2016 set out plans for a New Care Model for Tier 4 CAMHS and some adult inpatient services. Budgets were delegated to local systems with Lead Providers taking responsibility. An aim of this programme, which was expanded in the NHS Long Term Plan into the renamed 'provider collaboratives', was to end the perverse incentive for local systems to shift costs to NHS England.

However, the programme is not nationwide and progress is variable. This means that the over-reliance on expensive acute beds continues and there is continued under-investment in alternative provision within the community.

### The resulting system failure

Savings from investing in community care in place of acute beds are unrealised.

Similar (or better) outcomes for young people's mental health could be achieved for less money, with a reduced reliance on acute beds, and with less distress caused to families by children being placed out of area.

### Proposed solution

Nationwide expansion of Provider Collaboratives, based on New Care Models for Children and Young People. These are a significant opportunity to join up the system through collective accountability and responsibility.

### Argument and substantiation

*Bringing Care Back Home: Evaluating New Care Models for children and young people's mental health* (O'Shea, 2019) quantified that offering community treatment and intensive support instead of acute beds reduced the cost of treatment by £15.3m for a group of just 217 young people – many of whom had been in wards long distances away from home and family.

By investing in local services, each of the six sites achieved reductions in overall spending, as well as a significant expansion of community-based care. They provided comprehensive offers of 24-hour availability of highly skilled teams and innovative models of support.

Each area identified small numbers of young people whose treatment was comparatively expensive. This ranged from 22-49 people with annual average treatment costs totalling between £7.5m and £13.4m in each site (or £187,351-£513,852 per person).

The programme enabled areas to make significant changes in expenditure. They achieved overall reductions of between £1.1m and £4.1m for 2017/18; a total of £15.3m that can be reinvested in local services. This change was driven by reductions in Out-of-Area Bed Days and Lengths of Stay in hospital, by varying degrees.

Trials of community-based treatments for young people, both in the UK and abroad, have reported good clinical outcomes (Grimes *et al.*, 2011; Rhiner *et al.*, 2011; Adrian & Smith, 2014; Ougrin *et al.*, 2014; Tan & Fajardo, 2017; King *et al.*, 2019). Although there is some variation in the results from randomised controlled trials, overall the findings indicate

that these outcomes are comparable to those of inpatient treatment (Boege, Copus and Schepker, 2014; Kwok, Yuan and Ougrin, 2016; Ougrin *et al.*, 2018). There is also some evidence that the clinical improvements associated with intensive community treatments are equally stable at follow-up as those associated with inpatient treatment, although further research is needed to establish this more firmly (Mattejat *et al.*, 2001; Schmidt *et al.*, 2006).

## Conclusion

Expansion of the New Care Models approach for young people across all 54 mental health trusts could generate a reduction of £137m in acute care bed costs whilst improving community care. As ever, economics should not trump health, and decisions about where to treat someone must remain clinically led, safe and comprehensive.

## 8. An outcomes framework: measuring return on investment

### Problem

- The NHS does not measure the total cost of a patient's treatment across the entire system
- It does not routinely measure clinical and patient outcomes – such as recovery – across its services with consistent metrics
- Benchmarking data is available for local areas to compare performance, but the focus of measurement is often on outputs, such as bed-days, rather than outcomes, and the information is not made publicly available for further analysis
- The historically poor collection of data on performance and outcomes has hampered progress in many ways. Commissioners, policy makers and government need solid and robust data to make informed decisions.

### Argument and substantiation

The NHS Benchmarking Network's project for children and young people's mental health services includes:

- Service models – service provision, provisions for on-call arrangements, and transition services
- Access – referral sources, acceptance rates, and waiting times
- Activity – levels of contacts, rates of discharges, and DNA rates
- Workforce – skill mix, training, absence and sickness rates
- Finance – costs, both pay and non-pay.

Predominantly, the data measures outputs – number of beds, cost of service – rather than outcomes – such as patient health.

The Benchmarking Network gives individual areas a comprehensive briefing on their performance. Measures such as:

- Waiting times (including to second appointment)
- Acceptance and re-referral rates
- Costs of service delivery.

The reports are extremely useful, particularly because they offer national comparisons, so areas are able to understand how they compare to statistical neighbours. This enables commissioners to understand their comparative performance across a range of services.

However, there are three areas of concern:

1. Who resolves the systemic issues of variation in spending, outputs and outcomes? As noted by the Children's Commissioner, there is wide variation between areas in what they spend and the services they offer. The Care Quality Commission's review of mental health services for children and young people found that, "whilst most specialist services provide good quality care, too many young people find it difficult to access services and so do not receive the care that they need when they need it" (2017).

Given these conclusions, and the clear evidence of variation, who resolves these national, systemic differences, and how? The benchmarking data quantifies the variation, but how this translates into changes in government allocation of spending is unclear.

2. Trends over time: The benchmarking reports focus on comparisons between areas, with little data on spend over time, particularly in relation to how need is changing over time. This would be an extremely useful measurement because it would demonstrate the trajectory of change. For example, if spending is consistently falling in an area, but not in a statistical neighbour, this may explain differences in outputs.

3. **Patient outcomes:** The most significant gap in the benchmarking data is patient outcomes. Following all the service delivery and treatment, what has happened to the patients? Has their health improved? Are they leading a happy and fulfilled life? Understanding the impact of health care on patient outcomes is the crucial piece of information needed to judge the effectiveness of any intervention. It is the basis for return on investment calculations, which are needed to ensure funding is spent on services which are effective.

## The resulting system failure

The majority of mental health care spending on children and young people has:

- No common measure of success
- Few measures of changes to patient outcomes
- No data on which to calculate return on investment for health care expenditure.

## Proposed solution

A comprehensive outcomes framework for children which measures mental health outcomes.

## Argument and substantiation

In 2012, Dr Jane Parkinson, Public Health Advisor to NHS Scotland, published *Establishing a core set of national, sustainable mental health indicators for children and young people in Scotland*.

This described a core set of indicators for 0-17 year olds which would complement a set of indicators for adults. The report demonstrates what a comprehensive outcomes framework could be. It could be elongated to include 18-25 year olds, in line with today's mental health services offering coverage from 0-25.

It was devised following a comprehensive review of existing indicators, and champions a health and wellbeing approach to measurement, appreciating that childhood development is a dynamic and variable process.

It looks at the child or young person as a whole and measures success as part of a wider system of education, health, social justice and safety.

The result is a phenomenal set of mental health indicators covering all aspects of a child's life including life events, spirituality and substance use.

The report concludes that "the current indicator set is not the final answer to creating a summary profile of Scotland's mental health for children and young people. However, it provides a firm basis on which to build and develop a greater understanding of the causes and consequences of mental health and how these can best be measured" (page 3). Of particular relevance is the process by which the dataset was created. This can be summarised as:

1. Reviewing the evidence, including from children and young people, to determine a desirable set of indicators and a suitable framework
2. Consulting on a draft framework via a large national event with stakeholders; an electronic consultation (Parkinson, 2010a) with key experts, organisations and networks; and focus groups with specific groups of children and young people whose views on what impacts their mental health were inadequately represented in the literature (Elsley and McMellon, 2010)
3. Reviewing and assessing the suitability of relevant administrative and survey data, currently collected nationally in Scotland, and of existing national indicators
4. Aligning with wider policy initiatives, specifically identifying overlaps with existing indicators sets and outcome measures in current policy and initiatives
5. Identifying, and establishing a consensus on, robust indicators that can be reported on using existing data
6. Identifying additional data needs for desirable data-less indicators and priorities for new data collection to fill these data gaps

7. Exploring opportunities to collect the recommended new data, and working to influence Children and Young People's Mental Health Indicators
8. Ensuring the sustainability of data for the indicator set.

### **What discernible difference would this achieve?**

A similar process in England would enable the creation of a comparable dataset. This would, in turn, create a national framework against which success, return on investment and the health of children and young people could be determined.

### **Conclusion**

Return on investment is crucial for any government spending commitment. If £X is invested, £Y worth of outcomes should be generated. Investment in children's health and wellbeing could be linked to improvements in patient outcomes which were objectively and consistently measured across the range of services used.

## Conclusion

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It is clear, and has been for some time, how to give children and young people the best start in life and how to ensure a firm foundation of optimal mental health.

Life isn't fair. Some children are blessed with consistent, loving families, happy schools, lucky breaks and an adulthood of corresponding success and fulfilment. Others experience trauma, loss, poverty, poor schooling, exclusion, exploitation and adulthoods of corresponding difficulty. Whilst adverse childhoods do not make adverse lifetimes a certainty, they increase the risks and odds of it.

Rectifying the circumstances of birth to give everyone a fair chance to live their best lives is the role of government. Taxes are paid to provide services for those in greatest need. The safety net of public services enables society to pool the risk of illness, adversity and misfortune.

Green and white papers repeatedly articulate what should be achieved and the resources required. The Social Exclusion Task Force, now an item in the National Archives, provided a globally recognised body of research defining the impact of early intervention, working with parents and school interventions. We know what works. Yet the implementation of those welcome ideas has stalled and, of particular concern, staffing levels are falling. Long term targets feel a long way off.

A strategy is a process where a detected problem or risk is examined; its development over 5-10 years is projected, evidence-based solutions are proposed, a long-term response is drafted, and the requisite human/financial resources are awarded and deployed.

This paper concludes that it is the last part of this process which hangs in the balance, following a decade of austerity.

The 2021 Spending Review presented an interesting paradox. Enormous pandemic debts require repayment, yet further austerity was ruled out, at least for the NHS. Whilst we have grown accustomed to promises of multiple 'golden ages', 'world beating programmes' and 'levelling firmly up' to secure a brighter future, the reality of turning glitter into gold will be determined by a funding allocation from HM Treasury.

The pilot programmes offered in the 2021 Spending Review conceal the lack of strategic delivery of minimum standards, national coverage and consistent outcomes. Systemic investment in services and the staff who provide them is needed to meet the Government's own ambitions. Creating a meaningful, efficient and resourced mental health system for children and young people is a target that the government has set itself. Now, it must deliver it.

## References

- Abel, K., Hope, H., Swift, E., Parisi, R., Ashcroft, D., Kosidou, K., Osam, C., Dalman, C., and Pierce, M. (2019) 'Prevalence of maternal mental illness among children and adolescents in the UK between 2005 and 2017: A national retrospective cohort analysis', *The Lancet Public Health*, 4(6), pp. e291-e300. doi: 10.1016/S2468-2667(19)30059-3.
- Adrian, N. and Smith, J.G. (2015) Occupied bed days a redundant currency? An evaluation of the first 10 years of an integrated model of care for mentally ill adolescents. *Clinical child psychology and psychiatry*, 20(3), 458-471.
- Bailey, N. (2020) 'Poverty and the re-growth of private renting in the UK, 1994-2018', *PLOS ONE*, 15(2), pp. e0228273. doi: 10.1371/journal.pone.0228273.
- Balmer, N.J., and Pleasence, P., (2012) *The Legal Problems and Mental Health Needs of Youth Advice Service Users: The Case for Advice and Youth Access*. London: Baring Foundation.
- Boege, I., Copus, N. and Schepker, R. (2014) Effectiveness of hometreatment in light of clinical elements, chances, and limitations. *Zeitschrift für Kinder-und Jugendpsychiatrie und Psychotherapie*, 42(1), pp.27-37.
- Care Quality Commission (2017) *Review of Children and Young People's Mental Health Services*. London: Care Quality Commission. Available from URL: [https://www.cqc.org.uk/sites/default/files/20171103\\_cypmhphase1\\_report.pdf](https://www.cqc.org.uk/sites/default/files/20171103_cypmhphase1_report.pdf) [Accessed 4 September 2021]
- Children's Commissioner for England (2019a) *Early access to mental health support*. London: Children's Commissioner for England. Available from: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2019/04/Early-access-to-mental-health-support-April-2019.pdf> [Accessed 2 September 2021]
- Children's Commissioner for England (2019b) *Children's Commissioner for England response to CQC report on the state of care*. Available from: <https://www.childrenscommissioner.gov.uk/2019/10/15/childrens-commissioner-for-england-response-to-cqc-report-on-the-state-of-care/> [Accessed 6 December 2021]
- Children's Commissioner for England (2020) *The State of Children's Mental Health Services 2020*. London: Children's Commissioner for England. Available from: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/01/cco-the-state-of-childrens-mental-health-services.pdf> [Accessed 2 September 2021]
- Children's Commissioner for England (2021) *The State of Children's Mental Health Services 2020-21*. London: Children's Commissioner for England. Available from URL: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf> [Accessed 4 September 2021]
- Children and Young People's Mental Health Coalition (2021) *Members' Report 2021*. London: CYPMHC. Available from: <https://cypmhc.org/publications/cypmhc-members-report-2021/> [Accessed 6 December 2021]
- Compass BUZZ (n.d.) *Compass BUZZ Project Legacy Report*. York: Compass BUZZ. Available from: <https://www.compass-uk.org/compass-buzz-the-legacy/> [Accessed 9 December 2021]
- Department for Education (2021) *Schools, pupils and their characteristics. Academic Year 2020/21*. London: Department for Education. Available from: <https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics> [Accessed 6 September 2021]
- Department of Health & Department for Education (2017) *Transforming Children and Young People's Mental Health Provision Green Paper*. London: Department of Health and Department for Education. Available from: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/664855/Transforming\\_children\\_and\\_young\\_people\\_s\\_mental\\_health\\_provision.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf) [Accessed 2 September 2021]

- Department for Work and Pensions (2020) *Households below average income: An analysis of the UK income distribution: 1994/95-2018/19*. London: DWP. Available from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/875261/households-below-average-income-1994-1995-2018-2019.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875261/households-below-average-income-1994-1995-2018-2019.pdf) [Accessed 1 September 2021]
- Department for Work and Pensions (2021) *Family resources survey: financial year 2019 to 2020*. London: DWP. Available from: <https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2019-to-2020/family-resources-survey-financial-year-2019-to-2020#income-and-state-support-1> [Accessed 1 September 2021]
- Department for Work and Pensions (2021) *National Minimum Wage and National Living Wage Rates*. London: DWP. Available from: <https://www.gov.uk/national-minimum-wage-rates> [Accessed 1 September 2021]
- Department for Work and Pensions (2021) *Universal Credit*. London: DWP. Available from: <https://www.gov.uk/universal-credit/what-youll-get> [Accessed 1 September 2021]
- Department of Health, NHS England (2015) *Future in mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing*. Available from: [https://webarchive.nationalarchives.gov.uk/ukgwa/20170505113443/https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/414024/Childrens\\_Mental\\_Health.pdf](https://webarchive.nationalarchives.gov.uk/ukgwa/20170505113443/https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf) [Accessed 1 September 2021]
- First 1001 Days Movement (2021) *A Decade of Disinvestment. The loss of services for babies in England. Evidence Brief 4*. London: The Parent Infant Foundation. Available from: <https://parentinfantfoundation.org.uk/1001-days/resources/evidence-briefs/> [Accessed 26 July 2021]
- Ford, L. (2017) *Obama: 'The world has never been healthier, wealthier or less violent'*. The Guardian, 25 September 2017. Available from: <https://www.theguardian.com/global-development/2017/sep/25/obama-the-world-has-never-been-healthier-wealthier-or-less-violent-united-nations-gates-foundation> [Accessed 6 December 2021]
- George, J., Bowyer, A., Low, N., Mullin, J., Osenius-Eite, B., Raraty, R., Rollinson, S and Williams, D. (2018) *Improving Children and Young People's Mental Health Services*. London: National Audit Office. Available from: <https://www.nao.org.uk/wp-content/uploads/2018/10/Improving-children-and-young-peoples-mental-health-services.pdf> [Accessed 27 August 2021]
- Grimes, K.E., Schulz, M.F., Cohen, S.A., Mullin, B.O., Lehar, S.E. and Tien, S. (2011) Pursuing cost-effectiveness in mental health service delivery for youth with complex needs. *Journal of Mental Health Policy and Economics*, 14(2), 73.
- HM Government (2021) *The Best Start for Life: A vision for the 1001 critical days. The early years healthy development review report*. London: HM Government. Available from: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/973112/The\\_best\\_start\\_for\\_life\\_a\\_vision\\_for\\_the\\_1\\_001\\_critical\\_days.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf) [Accessed 27 August 2021]
- HM Government and CYPMHC (2021) *Promoting children and young people's mental health and wellbeing: A whole school or college approach*. Available from: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/1020249/Promoting\\_children\\_and\\_young\\_people\\_s\\_mental\\_health\\_and\\_wellbeing.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1020249/Promoting_children_and_young_people_s_mental_health_and_wellbeing.pdf) [25 October 2021]
- Hogg, S. (2019) *Rare Jewels. Specialised Parent-Infant Relationship Teams in the UK*. London: Parent Infant Partnership UK. Available from: <https://parentinfantfoundation.org.uk/our-work/campaigning/rare-jewels/> [Accessed 1 September 2021]
- Institute of Health Visiting (2020) *Health Visiting in England State of Health Visiting in England*. London: Institute of Health Visiting. Available from: <https://ihv.org.uk/wp-content/uploads/2020/02/State-of-Health-Visiting-survey-FINAL-VERSION-18.2.20.pdf> [Accessed 6 December 2021]
- Khan, L. (2016) *Missed Opportunities: Children and young people's mental health*. London: Centre for Mental Health. Available from: <https://www.centreformentalhealth.org.uk/publications/missed-opportunities> [Accessed 23 August 2021]



- Kelly, E. (2018) *Public Spending on Children in England 2000-2020*. London: Institute for Fiscal Studies. Children's Commissioner for England. Available from: <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/06/Public-Spending-on-Children-in-England-CCO-JUNE-2018.pdf> [Accessed 26 July 2021]
- King, C.A., Arango, A., Kramer, A., Busby, D., Czyz, E., Foster, C.E., Gillespie, B.W. and YST Study Team (2019) Association of the youth-nominated support team intervention for suicidal adolescents with 11-to 14-year mortality outcomes: secondary analysis of a randomized clinical trial. *JAMA psychiatry*, **76**(5), 492-498.
- Kwok, K.H.R., Yuan, S.N.V. and Ougrin, D. (2016) Alternatives to inpatient care for children and adolescents with mental health disorders. *Child and Adolescent Mental Health*, **21**(1), 3-10.
- Le, H. (2021) *Time for concerted action: the mental health of children and young people in England*. Available from: <https://www.centreformentalhealth.org.uk/blogs/time-concerted-action-mental-health-children-and-young-people-england> [Accessed 7 December 2021]
- Marshall, L., Wishart, R., Dunatchik, A. and Smith, N. (2021) *Supporting Mental Health in Schools and Colleges. Quantitative Survey*. London: NatCen Social Research for Department of Health. Available from URL: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/634726/Supporting\\_Mental\\_Health\\_survey\\_report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/634726/Supporting_Mental_Health_survey_report.pdf) [Accessed 6 September 2021]
- Mattejat, F., Hirt, B.R., Wilken, J., Schmidt, M.H. and Remschmidt, H. (2001) Efficacy of inpatient and home treatment in psychiatrically disturbed children and adolescents. *European child & adolescent psychiatry*, **10**(1), S71.
- Mental Health Foundation (2016) *Fundamental facts about mental health*. Mental Health Foundation: London. Available from: <https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf> [Accessed 1 September 2021]
- Mind (2021) *Not making the grade: why our approach to mental health at secondary school is failing people*. London: Mind. Available from: <https://www.mind.org.uk/media/8852/not-making-the-grade.pdf> [Accessed 3 September 2021]
- NHS England (2019) *The NHS Long Term Plan*. London: NHS England. Available from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf> [Accessed 1 September 2021]
- NHS (no date) *Children and young people*. Available from: <https://www.england.nhs.uk/mental-health/cyp> [Accessed 1 September 2021]
- NHS Benchmarking Network (2021) *Children and Young People's Mental Health*. Leeds: NHS Benchmarking Network. Available from: <https://www.nhsbenchmarking.nhs.uk/mental-health-sector#childrenyoung> [Accessed 1 September 2021]
- NHS Digital (2018a) *Mental health of children and young people in England 2017: Summary of key findings*. London: NHS Digital. Available from: <https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf> [Accessed 1 September 2021]
- NHS Digital (2018b) *Mental health of children and young people in England, 2017: Trends and Characteristics*. London: NHS Digital. Available from: <https://files.digital.nhs.uk/A0/273EE3/MHCYP%202017%20Trends%20Characteristics.pdf> [Accessed 1 September 2021]
- NHS Digital (2020) *Mental health of children and young people in England 2020. Wave 1 follow up to the 2017 survey*. London: NHS Digital. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up/copyright> [Accessed 1 September 2021]
- NHS Digital (2021) *Mental Health of Children and Young People in England, 2021: Wave 2 follow up to the 2017 survey*. London: NHS Digital. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2021-follow-up-to-the-2017-survey> [Accessed 20 October 2021]

NHS Digital (2019) *Mental health of children and young people in England, 2017: Predictors of mental disorders*. London: NHS Digital. Available at: <https://files.digital.nhs.uk/55/B5CA8B/MHCYP%202017%20Predictors.pdf> [Accessed 1 September 2021]

Office for National Statistics (2016) *The effects of taxes and benefits on income inequality: 1977 to financial year ending 2015*. Newport: ONS. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/bulletins/theeffectsoftaxesandbenefitsonincomeinequality/1977tofinancialyearending2015> [Accessed 1 September 2021]

Office for National Statistics (2019a) *Children whose families struggle to get on are more likely to have mental disorders*. Newport: ONS. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/childhealth/articles/childrenwhosefamiliesstruggletogetonaremorelikelytohavementaldisorders/2019-03-26> [Accessed 1 September 2021]

Office for National Statistics (2019b) *Families and the labour market, UK: 2019*. Newport: ONS. Available from: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/familiesandthelabourmarketengland/2019#employment-activity-of-mothers-and-fathers-in-a-family> [Accessed 1 September 2021]

Office for National Statistics (2019c) *Families and households in the UK: 2019*. Newport: ONS. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2019> [Accessed 2 September 2021]

Office for National Statistics (2020) *Coronavirus and employment for parents in the UK: October to December 2019*. Newport: ONS. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronavirusandemploymentforparentsintheuk/octobertodecember2019> [Accessed 1 September 2021]

Office for National Statistics (2021a) *Household income inequality UK: Financial year ending 2020*. Newport: ONS. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/bulletins/householdincomeinequalityfinancial/financialyearending2020> [Accessed 1 September 2021]

Office for National Statistics (2021b) *Coronavirus and Higher Education Students, England 24th May – 2nd June*. Newport: ONS. Available from URL: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandhighereducationstudents/england24mayto2june2021> [Accessed 23 November 2021]

Office for National Statistics (2021c) *Young people not in education employment or training (NEET) UK May 2021*. Available from URL: <https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/bulletins/youngpeoplenotineducationemploymentortrainingneet/may2021> [Accessed 6 December 2021]

O'Dea, B., Glozier, N., Purcell, R., et al (2014) A cross-sectional exploration of the clinical characteristics of disengaged (NEET) young people in primary mental healthcare. University of Sydney. *BMJ Open* 2014;4: e006378. doi: 10.1136/bmjopen-2014-006378 [Accessed 7 September 2021]

O'Keeffe, L., A. O'Reilly., G. O'Brien, R., Buckley, and R. Illback (2015) Description and outcome evaluation of Jigsaw: an emergent Irish mental health early intervention programme for young people. *Irish Journal of Psychological Medicine*, Available on CJO 2015 doi:10.1017/ipm.2014.86

O'Shea, N. (2020) *Bringing care back home: Evaluating the New Care Models for children and young people's mental health*. London: Centre for Mental Health. Available from: <https://www.centreformentalhealth.org.uk/publications/bringing-care-back-home> [Accessed 23 November 2021]

- Ougrin, D., Zundel, T., Corrigan, R., Padmore, J. and Loh, C. (2014) Innovations in practice: pilot evaluation of the supported discharge service (SDS): clinical outcomes and service use. *Child and Adolescent Mental Health*, **19**(4), 265-269.
- Ougrin, D., Corrigan, R., Poole, J., Zundel, T., Sarhane, M., Slater, V., Stahl, D., Reavey, P., Byford, S., Heslin, M. and Ivens, J. (2018) Comparison of effectiveness and cost-effectiveness of an intensive community supported discharge service versus treatment as usual for adolescents with psychiatric emergencies: a randomised controlled trial. *The Lancet Psychiatry*, **5**(6), 477-485.
- Parkinson, J. (2012) *Establishing a core set of national, sustainable mental health indicators for children and young people in Scotland: Final Report*. NHS Health Scotland, Public Health Information Scotland and Healthier Scotland.
- Race Equality Foundation (2014) *The importance of promoting mental health in children and young people from black and minority ethnic communities*. London: Race Equality Foundation. Available from: <http://raceequalityfoundation.org.uk/wp-content/uploads/2018/02/Health-Briefing-332.pdf> [Accessed 2 September 2021]
- Rhiner, B., Graf, T., Dammann, G. and Fuerstenau, U. (2011) Multisystemic Therapy (MST) for adolescents with severe conduct disorders in German-speaking Switzerland-implementation and first results. *Zeitschrift für Kinder-und Jugendpsychiatrie und Psychotherapie*, **39**(1), 33-39.
- Roe, J. (2018) Ethnicity and children's mental health: Making the case for access to urban parks. *The Lancet Planetary Health*, **2**(6), pp. E2345-E235. doi: 10.1016/S2542-5196(18)30122-0.
- Royal College of Paediatrics and Child Health (2020) *State of Child Health 2020*. London: RCPCH. Available from: <https://stateofchildhealth.rcpch.ac.uk/evidence/nations/england> [Accessed 1 September 2021]
- Schmidt, M.H., Lay, B., Göpel, C., Naab, S. and Blanz, B. (2006) Home treatment for children and adolescents with psychiatric disorders. *European child & adolescent psychiatry*, **15**(5), 265-276.
- Tan, J.X. and Fajardo, M.L.R. (2017) Efficacy of multisystemic therapy in youths aged 10–17 with severe antisocial behaviour and emotional disorders: systematic review. *London Journal of Primary Care*, **9**(6), 95-103.
- Williams, M. and Franklin, J. (2018) *Children and Young People's Services Spending 2010-2020*. London: Pro-Bono Economics. Available from: <https://www.ncb.org.uk/sites/default/files/uploads/files/Children%27s%20services%20spending%202010-11%20to%202019-20.pdf> [Accessed 23rd August 2021]
- Wilson, T. and Papoutsaki, D. (2021) *An unequal crisis: The impact of the pandemic on the youth labour market*. London: Young Futures Foundation, Institute for Employment Studies, Blgrave Trust. Available from: [https://youthfuturesfoundation.org/wp-content/uploads/2021/02/IES-Report\\_12Feb2021\\_-FINAL.pdf](https://youthfuturesfoundation.org/wp-content/uploads/2021/02/IES-Report_12Feb2021_-FINAL.pdf) [Accessed 7 September 2021]
- YoungMinds and the Children's Society (2021) *First Port of Call. The role of GPs in early support for young people's mental health*. London: YoungMinds and The Children's Society. Available from: <https://www.youngminds.org.uk/media/2csbkvlz/final-the-role-of-gps-in-early-support-for-young-peoples-mental-health.pdf> [Accessed 6 September 2021]

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