CENTRE FOR MENTAL HEALTH

Mental Health Network
NHS Confederation

INVESTMENT PRIORITIES FOR MENTAL HEALTH 2025

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EXECUTIVE SUMMARY

At a time of rising demand for mental health care and years of declining mental wellbeing in society, mental health services in England are under enormous pressure. The upcoming ten-year health plan and Spending Review present the Government with the chance to deliver on its manifesto commitment to address the disparities between mental and physical health in the NHS and elsewhere. This is an opportunity for the Government to ensure public money is spent wisely, on services that will meet people's needs effectively, equitably and in a timely manner, while boosting economic activity, increasing living standards and improving health, in support of its core missions. Commissioned by the NHS Confederation's Mental Health Network as part of the Mental Health Economics Collaborative (MHEC), this report draws on existing evidence about six investment priorities that would support better mental health and represent good value for money.

The six priorities are:

1. ENABLING HEALTH VISITORS TO SUPPORT NEW MOTHERS' MENTAL HEALTH

Context: Around one in four women (25.8%) experience a perinatal mental health problem (Office for Health Improvement and Disparities, 2025), up to 70% will hide or underplay maternal mental health difficulties, and suicide continues to be a leading cause of maternal death in the first year after childbirth (Maternal Mental Health Alliance, n.d.). Untreated perinatal mental health problems have long-term health and social costs amounting to roughly £8.1bn per cohort of births (Bauer *et al*., 2014).

Recommendation: Provide sufficient funding and resources to enable professionals in regular contact with pregnant women and new mothers (such as midwives and health visitors) to assess and provide early mental health interventions for those identified as in need of additional support. Adopting this type of approach to service provision is estimated to produce a net saving of £490m over ten years (Bauer *et al*., 2022).

2. PROVIDING EVIDENCE-BASED PARENTING PROGRAMMES

Context: Conduct disorders affect as many as 1 in 20 5-19 year olds (4.6%) in England (NHS Digital, 2017) and are associated with a range of negative life outcomes, including lower educational attainment, poorer mental health and increased involvement in criminal activity (Colman *et al*., 2009; Olino *et al*., 2011).

Recommendation: Build universal access to evidence-based parenting programmes, such as Triple P and Incredible Years (IY). The IY parenting programme has been reported as an effective intervention that benefits all families, including disadvantaged families and those from racialised communities (Gardner *et al*., 2017). Such programmes produce potential savings ranging from £1,000 to £8,400 per child over a 20-year period (ibid).

3. EXPANDING THE NETWORK OF EARLY SUPPORT HUBS FOR YOUNG PEOPLE

Context: Around 50% of mental health problems are established by the time a child reaches the age of 14, and 75% by the age of 24. Early support hubs offer easy-to-access drop-in support on a self-referral basis for young people who may not meet the threshold for children and young people's mental health services (Children and Young People's Mental Health Coalition, 2024).

Recommendation: Continue to invest in expanding early support hubs for young people, building on the 70 currently in operation, as well as the rollout of Mental Health Support Teams (MHSTs) in all schools. Together, these will take us closer to a comprehensive system of support for children and young people's mental health.

4. EXPANDING OFFERS WITHIN THE NHS TALKING THERAPIES PROGRAMME

Context: The number of referrals to the NHS Talking Therapies programme has more than doubled over the last decade. Although efforts have been made to widen access, we know that certain groups are consistently underrepresented in NHS Talking Therapies, including people from racialised communities (NHS Race & Health Observatory, 2023), older adults (Prosser *et al*., 2024), and people presenting with complex needs (Bell and Pollard, 2022).

Recommendation: First, address the gap in service provision for people with complex or severe needs. This would involve establishing a new service dedicated to supporting people with complex or severe needs to run in parallel with the NHS Talking Therapies programme.

Second, meet increasing demand through careful implementation of digitally enabled therapies (DETs) as a complement to, but not a replacement for, existing provision. NICE-recommended DETs could save thousands of NHS therapist hours and early economic analysis suggest that these technologies could be cost-effective (NICE, 2024a).

5. EXPANDING INDIVIDUAL PLACEMENT AND SUPPORT (IPS) EMPLOYMENT SERVICES

Context: People living with severe mental illness are more likely to be excluded from employment; when in employment, they are more likely to experience discrimination and inequality at work. Being out of work also poses a risk to mental health. Unemployment, job and financial insecurity, and recent job loss are risk factors for suicide attempts (World Health Organisation, 2024). Individual Placement and Support (IPS) is by far the most successful and cost-effective approach to supporting people with mental health difficulties, and many other groups of disabled people, into paid work.

Recommendation: Sustain the current expansion of IPS until everyone living with a mental illness has ready access to IPS when and where they want it.

6. PROVIDING ALTERNATIVES TO HOSPITAL ADMISSION IN A MENTAL HEALTH CRISIS

Context: Mental health crisis care is struggling to meet rising levels of need and severity, especially among children and young people. This is leading to protracted waiting times in A&E, pressure on mental health inpatient services, and the continued use of out-of-area placements due to a lack of local provision.

Recommendation: Invest in alternatives to acute inpatient mental health care. This should build on the six current neighbourhood 24/7 community pilot sites and draw on the wide range of alternatives to hospitalisation for people experiencing a mental health crisis.

Investing in mental health care is essential, and it will be more effective in all areas if it follows these key principles:

- **Take a holistic approach to mental health care:** Acknowledge and address key social determinants of poor mental health including welfare issues, such as financial security and housing. Adequate provision of welfare advice is likely to improve mental health outcomes and produce additional benefits like reducing stays in hospital, preventing homelessness, and avoiding relapse.
- **Offer tailored and flexible support:** Maximise accessibility of effective interventions and reduce attrition rates by allowing choice and flexibility to service users, including where they receive support (e.g. online or in person), and how the support is delivered.
- **Provide adequate mental health support in later life:** Improve provision of and access to tailored mental health care for older adults. With an ageing population, it is an imperative over the next ten years that we see a greater focus on meeting the mental health needs of older citizens.
- **Build a stronger mental health workforce:** Prioritise staff wellbeing through adequate funding of mental health services. Without sufficient resourcing and capacity, mental health systems will continue to struggle, and our proposed investment areas are unlikely to produce the intended benefits.

INTRODUCTION

POLICY CONTEXT

At a time of rising demand for mental health care and years of declining mental wellbeing in society, mental health services in England are under enormous pressure. Lord Darzi's review of the NHS identified that while mental health services expanded during the NHS Long Term Plan period (2019-24), they have been unable to keep pace with need and the overall share of NHS spending on mental health care has remained stagnant.

In 2024/25, the share of NHS spending devoted to mental health declined to 8.78% despite the protection afforded to local budgets from the Mental Health Investment Standard (Streeting, 2025). While spending on mental health services in 2025/26 is expected to rise to £15.6 billion, this represents 8.71% of NHS total spending (ibid) — in effect, a further reduction in the share of spend.

Lord Darzi's report identified that under-investment in mental health services has long roots and is deeply entrenched in our health and care system:

> *"There is a fundamental problem in the distribution of resources between mental health and physical health. Mental health accounts for more than 20 per cent of the disease burden but less than 10 per cent of NHS expenditure. This is not new. But the combination of chronic underspending with low productivity results in a treatment gap that affects nearly every family and all communities across the country."* (Darzi, 2024)

The result of this deeply entrenched disparity in our health care system is mental health services that are characterised by long waits for treatment and high thresholds for support, meaning intervention is often late and at crisis point. As the report noted:

> *"Long waits [for mental health services] have become normalised: there were 345,000 referrals where people are waiting more than a year for first contact with mental health services — a figure higher than the entire population of Leicester."* (Darzi, 2024)

The ten-year health plan and Spending Review present the Government with an opportunity to address the disparities between mental and physical health in the NHS and elsewhere, and to ensure public money is spent wisely on services that will meet people's needs effectively, equitably, and in a timely manner. This report draws on existing evidence about investment priorities that would represent good value for money.

We know from past and recent experience that investing wisely in mental health pays off. From the creation of the Improving Access to Psychological Therapies programme (now NHS Talking Therapies) in 2008, to the more recent development of community perinatal mental health services, investing in evidence-based interventions can bring about significant improvements in people's lives and major economic and social benefits. Outside the NHS, programmes such as Sure Start (Carneiro *et al*., 2024) and the Better Mental Health Fund (Woodhead, McHayle and Newbigging, 2023) have also demonstrated the value of preventive interventions in both the short and long term.

The Government has set out its priorities for reform of the health care system in the form of three shifts: from treatment to prevention, from hospital to community, and from analogue to digital. Investing in mental health can help to achieve all three of these shifts — indeed, they cannot be achieved without it. The priorities identified in this report directly support those three shifts.

This report is written in the context of highly pressured public finances. The investment priorities we have identified are ones that have sound economic evidence and proven health and social benefits.

Many of the priorities in this report relate to children and young people's mental health. In 2025, we published *Future Minds* (Centre for Mental Health *et al*., 2025), a report setting out the scale of investment needed to turn around rising levels of mental ill health among young people in England. We also explored the value of preventive approaches to children's mental health (Woodhead, 2025).

This report explores evidence about investment priorities across all age groups including later life, which has previously been ignored as a priority for mental health despite the country's ageing population (Iskander-Reynolds, 2024).

METHOD

Our recommendations were derived from a rigorous search through databases such as Google, Google Scholar and PubMed. We carried out our search using keywords such as 'economic evaluations', 'mental health services', 'mental health providers' and 'cost-effective interventions.'

Following initial discovery, we hosted an online roundtable with a total of 21 key stakeholders and experts (by experience and by practice) in mental health to discuss the proposed areas of investment and to identify additional areas that may have been overlooked in the first stages of our research. The six priorities proposed in this report were chosen based on the available evidence of clinically effective and cost-effective interventions we discovered in the literature, with the valuable insights and feedback from our stakeholder engagement incorporated throughout.

OVERVIEW OF OUR NATION'S MENTAL HEALTH

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

According to the NHS England children and young people's survey, in 2023 about 1 in 5 children and young people aged 8 to 25 years had a mental health problem in England: 20.3% of 8-16 year olds; 23.3% of 17-19 year olds; and 21.7% of 20-25 year olds.

The survey also found that:

- One in four children (26.8%) aged 8 to 16 with a mental health problem had a parent who could not afford for their child to take part in activities outside school or college, compared with one in ten (10.3%) of those without a mental health problem
- Eating disorders were identified in 12.5% of 17 to 19 year olds, with rates four times higher in young women (20.8%) than young men (5.1%)
- Children aged 11 to 16 with a mental health problem were also five times more likely than those without a mental health problem to have been bullied in person (36.9% compared with 7.6%), and more likely to have been bullied online (10.8% compared with 2.6%) (NHS Digital, 2023).

Furthermore, there is a significantly greater prevalence of eating disorders among young people in their late teenage years compared to younger children. The figure jumps from 26 out of 1,000 11-16 year olds to 125 out of 1,000 17-19 year olds (Doyle *et al*., 2024).

The Children Society's 2024 survey offers very recent insights into how children and young people in the UK (aged 10 to 17) are feeling about their lives. It found that:

- Similar to previous years, children and young people were more likely to be unhappy with school (14.3%) compared to other areas of life
- In terms of broader social issues, children and young people were more likely to be 'very' or 'quite' worried about rising prices (41%), followed by crime (35%) and environmental issues (33%) (Chollet *et al*., 2024).

ADULTS' MENTAL HEALTH

The next wave of the Adult Psychiatric Morbidity Survey is due to be published in July 2025, which will offer the most up-to-date picture of the state of the nation's mental health in the English adult population. Nevertheless, we know from recent sources that mental health among adults has worsened and the need for mental health support is higher than ever before:

- One in four adults experience at least one diagnosable mental health problem in any given year. Mental health problems represent the largest single cause of disability in the UK
- Between December 2024 and January 2025, around 1 in 13 adults (7.7%) in the UK reported feeling lonely 'always' or 'often' (ONS, 2025)

- In 2023, nearly 6% of adults in the UK rated their life satisfaction as low, compared with 4% in 2018 (ONS, 2024)
- Referrals to mental health services in England increased from 4.4 million in 2016-17 to 6.4 million in 2021-22 (National Audit Office, 2023)
- 604,861 adults with a severe mental illness were accessing support from community mental health services in England at the end of April 2024 (Mind and Centre for Mental Health, 2024)
- In 2023-24, 37% of claims for disability benefits were primarily for mental health reasons — a 9-percentage point increase from 28% in 2019-20 (representing a jump from 3,900 claims to 12,100 claims a month) (Latimer, Pflanz and Waters, 2024).

OVERVIEW OF THE ECONOMIC AND SOCIAL COSTS OF MENTAL ILL HEALTH

Centre for Mental Health's analysis of the costs of mental ill health on individuals, society and the economy found that, in 2022, the cost of mental ill health in England was £300 billion (Cardoso and McHayle, 2024). This equates to double the NHS's entire budget for England in that same year (£153bn). The cost is comprised of three major elements:

- **Economic costs of £110bn:** Losses to the economy due to mental ill health. These include the business costs of sickness absence and 'presenteeism' at work, as well as staff turnover and unemployment among people with mental health problems
- **Human costs of £130bn:** The value, expressed in monetary terms, of reduced quality of life and premature mortality among people living with mental health difficulties
- **Health and care costs of £60bn:** This includes support provided by public services, including £13.6bn in specialist NHS mental health care and £1.9bn in general practice, and informal care provided by family and friends.

A large share of the costs stemming from mental ill health is borne by people living with mental health difficulties and their families: a total of £175bn. Businesses carry a total cost of £101bn, while for government the cost is £25bn annually (see Table 1).

The report further suggests that the majority of costs deriving from mental ill health do not fall on health care systems, but are instead reflected in decreases in wellbeing and productivity losses. Mental ill health has a devastating impact on individuals, support networks, government, businesses, and society as a whole (Cardoso and McHayle, 2024).

In a similar vein, The King's Fund (2024) found that the Department of Health and Social Care spent £182bn in 2022/23. This money was used to fund a wide range of health and care services, including GP services; ambulance, mental health, community and hospital services that are commissioned by the NHS; and public health services that were commissioned by local authorities. It also funded some social care services, which are mainly commissioned by local authorities. It was also reported that £2.8bn of the Department of Health and Social Care's budget is spent on administration costs for the department and the health and care system, such as running costs, regulatory costs and business services, including the NHS payroll. In 2024/25, the total budget is set to increase to £192bn, an increase of £1.1bn on 2023/24 when adjusted for inflation (The King's Fund, 2024).

The King's Fund also examined costs relating to A&E services. In 2022/23, the estimated average cost of a patient taken to A&E by ambulance was £417 (The King's Fund, 2024). Ambulance call outs that didn't result in a trip to A&E cost an estimated average of £287. The cost of someone going to A&E depends on the type of service, ranging from a major consultant-led department in a hospital to an urgent care centre or walk-in clinic, as well as the type of treatment they receive. For someone who attends an urgent care centre and receives the lowest level of investigation and treatment, the average cost in 2024/25 is £91. For a person receiving more complex investigation and treatment at a major A&E department, the average costs range from £137 to £445. In 2022/23 the average cost of a 10-minute face-to-face GP consultation was estimated to be £56 (The King's Fund, 2024).

Table 1: Aggregate costs of mental ill health across government, industry and personal spheres

Government costs	Value
NHS community and hospital health services	£13,620,000,000
Lost tax revenue	£5,693,311,069
GP expenditure	£1,932,000,000
Local authority social services	£1,580,000,000
Accommodation for unhoused people with mental health problems	£1,312,000,000
Mental health medication	£586,704,371
Social security - administrative costs	£306,223,092
Total	**£25,030,238,532**
Industry costs	**Value**
Economic costs	
Staff turnover	£43,060,657,333
Presenteeism	£41,802,782,590
Economic inactivity	£9,233,838,682
Sickness absence	£6,541,033,511
Total	**£100,638,312,116**
Personal costs	**Value**
Economic costs	
Unpaid work	£3,364,394,659
Human costs	
Working-age population	£90,173,620,727
Children and young people (<20)	£18,798,732,000
Retired population (>65)	£14,401,500,845
Suicide and self-harm	£7,103,000,000
People in prison (wellbeing and avoidable sentences) - *not included in total*	*£2,229,287,261*
Health and care costs	
Informal care to people with mental health difficulties	£39,715,354,341
Private spending on mental health services - counselling, therapy, other private similar services	£1,125,480,204
Total	**£174,682,082,776**
TOTAL COST	**£300,350,633,424**

First published in Cardoso and McHayle, 2024

Evidence shows that lack of early intervention can mean that people don't access mental health care until they reach crisis point. Implementing better mental health support could therefore help to avert some of these (more expensive) crisis costs.

According to a statement by the Department of Health and Social Care, in the financial year 2024-25, mental health spending amounted to £14.9bn and all 42 integrated care boards (ICBs) are forecasting to meet the Mental Health Investment Standard. Real-terms spending on mental health in 2024-25 is forecasted to be £695m higher than in 2023-24. For 2025-26, mental health spending is expected to reach £15.6bn. This represents another significant uplift in real-terms spending on mental health — £320m, compared to the previous financial year (Parliament UK, 2025).

However, mental health services have been unable to keep pace with rising need (Darzi, 2024) and the overall share of NHS spending on mental health care has in fact declined to 8.71% (Streeting, 2025).

1 ENABLING HEALTH VISITORS TO SUPPORT NEW MOTHERS' MENTAL HEALTH

CONTEXT

According to the Office for Health Improvement and Disparities (2025), around one in four women (25.8%) experience a perinatal mental health problem. As many as 70% will hide or underplay maternal mental health difficulties, and suicide continues to be a leading cause of maternal death in the first year after childbirth. There are many types of perinatal mental health difficulties, with depression and anxiety being the most researched areas. Other examples include obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and psychosis.

Perinatal mental health problems not only impact the wellbeing of mothers but are also associated with adverse emotional, behavioural, and even physical development of the child. In the antenatal stage, untreated maternal depression was found to be associated with increased risk of complications including premature birth, low birth weight, and stillbirth (Jahan *et al*., 2021). Meanwhile, there is strong evidence to show that postnatal depression can have a wide range of negative impacts on the child, such as increased risk of developing insecure attachment styles, impaired cognitive performance, and behavioural issues — all of which can persist into adolescence and cause adverse long-term outcomes in later life (Stein *et al*., 2014).

The consequences of untreated perinatal mental health problems are therefore long-lasting and costly. For example, maternal depression, anxiety and psychosis were estimated to carry long-term economic and social costs of approximately £8.1bn for every one-year cohort of births in the UK. This equates to almost £10,000 per birth, with a large proportion (72%) of these costs related to adverse impacts on the child. It should be noted that as these figures were recorded over a decade ago, it is likely that the costs are now higher (Bauer *et al*., 2014).

Under the NHS Long Term Plan (NHS, 2019) we saw significant investment into specialist perinatal mental health services, which has helped to address some gaps in service provision. However, there continues to be large variation in the type of support and care that is available in local areas, exacerbated by common challenges including complex and inequitable referral pathways, use of non-evidence-based interventions, overly long waiting lists, and insufficient funding (Maternal Mental Health Alliance, 2024).

Moving forward, it is essential that the commitment to improve maternal mental health services at both national and local level remains steadfast to ensure continued and sustained development of these vital services.

EVIDENCE-BASED INTERVENTIONS

In an economic review of maternal mental health services, Bauer *et al*. (2022) demonstrated the cost-effectiveness of integrated service provision as a way to address unmet maternal mental health needs. This approach involves training professionals in regular contact with expectant or new parents (such as midwives and health visitors) to assess their mental health and provide early intervention for those identified as in need of additional support. Trained professionals would then coordinate subsequent care and, if appropriate, provide low-intensity treatment to support maternal wellbeing.

As reported by Bauer *et al*. (2022), this approach holds the potential to produce substantial savings over a ten-year period, including:

1. Over £52m of cost savings for the NHS
2. Additional health-related quality of life improvements worth £437m
3. A combined net benefit of £490m.

To ensure sufficient resourcing is available, it was estimated that an additional 347 midwives, 891 health visitors and 302 mental health practitioners are required for a full-scale integration of this approach. The combined training and employment costs were further estimated to be £124m per year (Bauer *et al*., 2022).

In support of this approach, some studies have demonstrated the clinical and cost effectiveness of health visitor training programmes as a form of universal preventive intervention to support maternal mental health. For example, the PoNDER Health Visitor (HV) training programme was found to not only have reduced the risk of developing postnatal depression for those with early signs of mental health difficulties (Brugha *et al*., 2011) but was also demonstrated to have a positive impact for mothers at lower risk of postnatal depression (Henderson *et al*., 2018). Over 6 months, the PoNDER HV programme was reported to be cost-reducing, with adjusted costs £82 lower in the intervention group compared to the control group (Henderson *et al*., 2018).

2 PROVIDING EVIDENCE-BASED PARENTING PROGRAMMES

CONTEXT

'Conduct disorders', also known as 'disruptive behaviour or dissocial disorders', are characterised by repetitive and persistent patterns of antisocial, aggressive, or defiant behaviour (NICE, 2023). Conduct disorders are among the most common mental health and behavioural problems in children and young people (NICE, 2013). Data published by NHS Digital (2017) showed that as many as 1 in 20 5-19 year olds (4.6%) in England had a behavioural disorder, with rates higher in boys (5.8%) than in girls (3.4%). More recent data demonstrated a 35% increase in conduct-related problems among young people over the course of the Covid-19 pandemic (Bull *et al*., 2022).

Research has documented a wide range of negative life outcomes associated with conduct disorders. For example, 50% of people diagnosed with a conduct disorder in childhood went on to be diagnosed with 'antisocial personality disorder' (Knapp *et al*., 2011). Studies show that adolescents with mild to severe conduct disorder face increased risk of adverse outcomes, including lower educational attainment, greater likelihood of unemployment, financial difficulties, relationship breakdowns, poorer mental health, early mortality, and increased involvement in criminal activity (Colman *et al*., 2009; Olino *et al*., 2011). Importantly, research also suggests that young people with conduct disorders are both more likely to become parents at a younger age and display parenting problems, consequently increasing the risk of their children also developing conduct disorders (Fairchild *et al*., 2019).

The economic implications of untreated conduct disorders are significant, with the cost of crime related to conduct disorder in England estimated to be as high as £22.5bn a year, and up to £1.9m over the lifetime of someone in repeated contact with the criminal justice system (Knapp *et al*., 2011). As such, early identification and intervention for children and young people with possible conduct disorders are both crucial to reducing the risk of developing more problematic behaviours and subsequently reducing the long-term economic burden of associated adverse outcomes in later life.

EVIDENCE-BASED INTERVENTIONS

Widening access to evidence-based parenting programmes could be a cost-effective approach to support those with, or at risk of developing, conduct disorders. Parenting programmes are designed to equip parents with the understanding, awareness and skills to build a supportive, nurturing and responsive relationship with their child.

There is evidence to suggest that some parenting programmes are effective as early prevention strategies to lower the risk of mental health problems and poor emotional development for children (Ryan *et al*., 2017). There are many variations of parenting programmes, which means that the approach, delivery and effectiveness can vary substantially. For instance, a recent review of 47 parenting programmes from 23 countries, including the UK, found mixed evidence in programme outcomes (Social Mobility Commission, 2023).

However, common benefits of these programmes include:

- Increased parental knowledge and skills to support their children
- Strengthened awareness of the importance and impact of their role as parents
- Improved parental wellbeing
- Enhanced peer support and community integration.

Importantly, there is evidence to suggest that effective implementation of evidence-based parenting programmes is likely to yield significant cost savings. Under the assumption that parenting programmes successfully reduce the likelihood of conduct disorder persisting into adulthood, the estimated total gross savings over a 25-year period amount to £9,288 per child (Knapp *et al*., 2011).

Two parenting programmes known as Incredible Years (IY) and Triple P have stronger evidence bases demonstrating their effectiveness. As an example, a systematic review and meta-analysis of Triple P suggested that the programme had a positive effect on a range of measures, including children's social, emotional and behavioural outcomes, parenting satisfaction and efficacy (Sanders *et al*., 2014).

Similarly, Gardner *et al*. (2017) found that the IY programme led to a range of positive outcomes, including reduced symptoms of ADHD, greater use of parental praise, and lowered use of harsh or inconsistent discipline. Additionally, the study suggested that the intervention effects were strongest in children with more severe baseline disruptive behaviour and were consistent in disadvantaged families or those from racialised communities. In 2014, the IY programme was reported to incur an average cost of £2,414 per person. Meanwhile, economic analyses suggest that the IY parenting programme could produce potential savings ranging from £1,000 to £8,400 per child over a 20-year period, which would likely offset the programme costs over time (Gardner *et al*., 2017).

Notably, parenting programmes can be delivered using the principle of proportionate universalism — an approach advocated by Marmot *et al*. (2010) whereby policies and interventions are delivered universally, but more intense support is offered for those that need it most. With the expansion of family hubs across England, these sites are well placed to provide access to these programmes.

3 EXPANDING THE NETWORK OF EARLY SUPPORT HUBS FOR YOUNG PEOPLE

CONTEXT

Around 50% of mental health problems are established by the time a child reaches the age of 14, and 75% by the age of 24. Early support hubs offer easy-to-access drop-in support on a self-referral basis for young people who may not meet the threshold for children and young people's mental health services (Children and Young People's Mental Health Coalition, 2024). Access to early support can prevent infants, children and young adults from developing enduring difficulties that can have devastating long-term impacts on their lives, as well as on their loved ones. The provision of early support hubs also helps to reduce pressures on the NHS, allowing them to prioritise more severe cases (GOV.UK, 2023).

In October 2023, the previous Government announced almost £5 million to fund early support hubs nationwide and deliver support to children and young people (GOV.UK, 2023). Furthermore, in February 2024, additional funding for early support hubs was offered to local communities by the Government. This included 24 hubs receiving a share of almost £8 million to help young people get support with their mental health at an earlier stage, and funding for other services including psychological therapies, specialist advice and wider issues which may affect a young person's mental health, including sexual health, exam worries, jobs, drugs, alcohol and financial worries (GOV.UK, 2024a).

Providing support in schools is also crucial. According to the Department of Education (2024), Mental Health Support Teams (MHSTs) are now in place in around 8,500 schools and colleges across the country. This equates to 34% of schools and colleges in England, with 498 expert teams offering support to children experiencing anxiety, depression and other common mental health problems. In 2023-24, 4.2 million pupils were covered by an MHST, which equates to a 44% coverage of pupils in schools and further education in England (GOV.UK, 2024b).

Furthermore, NHS England's 2025/26 priorities and operational planning guidance highlights plans to expand Mental Health Support Teams, which is consistent with the Government's aim of reaching 100% coverage by 2029/30 (NHS England, 2025a).

EVIDENCE-BASED INTERVENTIONS

The evidence base for early support hubs was explored in a joint briefing by the Children and Young People's Mental Health Coalition, Centre for Mental Health, Mind, The Children's Society, Youth Access, Black Thrive and BACP in support of the joint #FundTheHubs campaign. It showed that early support hubs have beneficial outcomes for young people in the UK (Children and Young People's Mental Health Coalition *et al.*, 2024). The strongest evidence base relates to the Youth Information, Advice and Counselling Services (YIACS) model (Youth Access, 2024), of which around 70 exist in England today. The Children and Young People's Mental Health Coalition (2025) recently published a blueprint for the expansion of Young Futures hubs, setting out both the key principles they should adhere to, and more details about their implementation.

In terms of cost, Centre for Mental Health and partners collected bottom-up spending data from a sample of existing hubs, generating overall figures for set-up and running costs for an average hub. We estimate that at current prices, each hub would have an annual running cost of £1.1m to £1.4m per hub, meaning an annual total of approximately £169m to £210m for 153 hubs. Capital costs for the set-up of hubs could be between £890,000 and £1.46m per hub. If we assume that 70 existing hubs are still operational, the set-up costs of national rollout would be between £74m and £121m (based on 153 upper tier local authorities). Some set-up costs could perhaps be offset if existing facilities or organisations could be adapted or scaled up into early support hubs (Centre for Mental Health *et al*., 2025).

The Mental Health Support Team (MHST) programme aims to increase the availability of early mental health support in education settings. MHSTs support the mental health needs of children and young people in primary, secondary and further education (ages 5 to 18) through providing an evidence-based approach to early intervention. The programme has been implemented in some schools and institutions. However, there is currently no funding guaranteed to ensure the programme will continue its rollout beyond March 2025. Investing in the rollout and funding of MHSTs can help to improve children and young people's understanding of mental health and wellbeing, as well as improve relationships between educational institutions and mental health services. This rollout should also ensure that MHSTs are meeting the needs of children and young people from all backgrounds (Centre for Mental Health, 2025).

4 EXPANDING OFFERS WITHIN THE NHS TALKING THERAPIES PROGRAMME

CONTEXT

According to the most recent wave of the Adult Psychiatric Morbidity Survey from 2014, around one in six adults surveyed in England had a common mental health problem, including depression and anxiety disorders (McManus *et al*., 2016). Launched in 2008, the NHS Talking Therapies programme (formerly Improving Access to Psychological Therapies) offers evidence-based talking therapies, such as cognitive behavioural therapy (CBT) and counselling, for adults with common mental health problems. The programme also offers employment support by assigning employment advisors to help patients with tasks, ranging from CV writing and interview preparation to advising on reasonable adjustments in the workplace. According to NHS England (2025a), a growing number of people are receiving employment advice through the programme, with figures showing a 62% increase between 2023 (41,907) and 2024 (67,794). To access an NHS Talking Therapies service, individuals can either be referred by their GP or submit a self-referral form.

According to the latest annual report on the NHS Talking Therapies programme, a total of 1.83 million referrals were made in 2023/24 – an increase of 4% from 1.76 million in 2022/23 (NHS England, 2024a). Compared to figures reported in 2013/14 (883,968), the number of referrals has more than doubled over the last decade, signalling a sharp rise in need for mental health support in the UK.

To ensure timely access to treatment, all NHS Talking Therapies services aim to provide 75% of patients with their first appointment within six weeks of referral, increasing to 95% of patients within 18 weeks of referral (NHS England, n.d.). These targets have consistently been met over recent years – for example, in 2023/24, 90.5% of referrals waited up to six weeks for their first appointment with a NHS Talking Therapies service, while 98.4% had an initial wait time of up to 18 weeks for treatment (NHS England, 2024a).

However, it is highly likely that a substantial number of people who would benefit from mental health support are currently not accessing an NHS Talking Therapies service. While the Government had set a target to widen access to accommodate 25% of people (around 1.7 million) with a common mental health problem, only around 1.2 million people had accessed support through the NHS Talking Therapies programme in 2023/24 (NHS England, 2024a). Importantly, we know that certain groups are consistently underrepresented in NHS Talking Therapies, including racialised communities (NHS Race & Health Observatory, 2023), older adults (Prosser *et al*., 2024), and people presenting with complex needs (Bell and Pollard, 2022). Intervention is therefore necessary to increase both the accessibility and capacity of the Talking Therapies programme, to narrow the gaps in its service provision.

EVIDENCE-BASED INTERVENTIONS

Firstly, the gap in service provision for people with complex or severe needs within the NHS Talking Therapies programme must be addressed. In its current form, NHS Talking Therapies does not offer treatment for people with addictions, people who have been given a diagnosis of 'personality disorder', or people with severe mental health problems (such as schizophrenia or bipolar disorder). Meanwhile, based on the recommendations put forward by NICE (n.d.), a range of specialised treatment options are necessary to support the recovery of those living with complex or severe mental health needs. These treatment options require different types of training, expertise and skills compared to the current treatment offers for people with depression and anxiety disorders. This means that a new service dedicated to supporting complex or severe cases should be established to run in parallel with the NHS Talking Therapies programme. According to Frayman *et al*. (2024), such a service would involve no net cost to public funds as treatment would pay for itself within the first two years, while bringing great benefits (based on estimated additional health years and employment rates) to people who are in need of such support.

Second, any further implementation of digitally enabled therapies (DETs) within the NHS Talking Therapies programme should be accompanied with the necessary training and support to both professionals and service users to maximise its benefits.

As an attempt to make mental health support more accessible and to meet increased demands, the NHS has started to integrate DETs as part of its treatment offers. DETs are accessible through online platforms and apps and are designed to be used with assistance from a trained therapist or practitioner.

Indeed, young people are increasingly adopting DETs, driven by their familiarity with technology and the flexibility that these solutions offer. Many people may prefer the anonymity and convenience of accessing mental health support via apps and online platforms, which can mitigate the stigma associated with seeking help (NHS Confederation, 2023).

In recent months, NICE (2024b) recommended seven DETs to treat depression and anxiety in adults. According to NICE, DETs hold the potential to save thousands of NHS therapist hours:

- DETs recommended for PTSD could save over 5,000 hours of therapist time per 1,000 people
- DETs recommended for social anxiety could save almost 2,500 therapist hours per 1,000 people
- DETs for depression could save around 600 therapist hours per 1,000 people.

Early economic analysis of the seven DETs recommended by NICE suggest that these technologies could be cost-effective based on current prices and evidence. Early value assessments have also shown promising outcomes for treating symptoms of depression and anxiety. However, more evidence is needed to determine the actual clinical and cost effectiveness of such technologies (NICE, 2024a; NICE, 2023).

While DETs present a transformative possibility to mental health care, an over-reliance on digital tools could lead to risks of uneven access for people who are vulnerable to digital exclusion, ultimately widening existing health inequalities. As the Race Equality Foundation (2023) notes, digital exclusion can be caused by a range of factors, such as limited internet access, lack of digital literacy, and low motivation to adopt digital tools – all of which are crucial for effective engagement with DETs. To maximise the benefits of such technologies in the NHS, it is crucial for policymakers and health systems to implement targeted interventions that address these challenges. Examples of initiatives could include subsidising internet access, tailoring digital literacy training, and designing DETs with diverse users in mind.

At the same time, it must be noted that any future implementation of technologies in the health care setting should not be viewed as a replacement for in-person care. In the context of the NHS Talking Therapies programme, it is essential to continue developing and presenting in-person therapies as an option alongside DETs to ensure all who would benefit from the service can access it when they need it.

5 EXPANDING INDIVIDUAL PLACEMENT AND SUPPORT (IPS) EMPLOYMENT SERVICES

CONTEXT

People living with severe mental illness are more likely to be excluded from employment; when in employment, they are more likely to experience inequality at work. Being out of work also poses a risk to mental health. Unemployment, job and financial insecurity, and recent job loss are risk factors for suicide attempts (World Health Organisation, 2024). Individual Placement and Support (IPS) supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer (Centre for Mental Health, n.d).

The cost of implementing IPS at the level of provision recommended in government commissioning guidance is estimated at around £67m a year nationally. In comparison, current spending on day and employment services is around £184 million a year. This implies that IPS could be readily established within existing provision by diverting resources from less effective services (Centre for Mental Health, n.d).

EVIDENCE-BASED INTERVENTIONS

There is now overwhelming international evidence that 'place then train' models of employment support – and IPS in particular – are much more effective than traditional approaches (such as vocational training and sheltered work) at getting people into employment.

The EQOLISE project compared IPS with other vocational and rehabilitation services in six European countries, and concluded that:

- IPS clients were twice as likely to gain employment (55% versus 28%) and worked for significantly longer
- The total costs for IPS were generally lower than standard services over the first six months
- Individuals who gained employment had reduced hospitalisation (Burns and Catty, 2008).

Furthermore, a trial by Marsden *et al*. (2024) explored the advantages and cost-effectiveness of Individual Placement and Support versus standard employment support for people with alcohol and drug dependence in England. It was found that IPS helped more people attain employment in the open competitive labour market than standard employment support. IPS was found to be cost-effective from the perspective of HM Treasury's 'willingness to pay' threshold for an intervention of £70,000 per Quality Adjusted Life Year (QALY) gained, for people with alcohol and drug use problems alike (Marsden *et al*., 2024).

Another study assessed the cost-effectiveness of supported employment compared with standard care (day services) for adults with autism in the United Kingdom. It was found that supported employment resulted in better outcomes compared with standard care, at an extra cost of £18 per additional week in employment or £5,600 per QALY. Although the authors' analysis suggested that supported employment schemes for adults with autism in the UK are cost-effective compared with standard care, further research will be needed to confirm these findings and create stronger evidence (Mavranezouli *et al*., 2014).

Furthermore, in ten economic analyses of IPS (four conducted in the USA and six outside the USA), the total costs for IPS were found to be less than the comparison in six studies, as well as equal in two studies and greater in two studies (Bond, 2023). All ten of the economic analyses showed significantly better employment outcomes for IPS than the comparison group. Bond further highlighted that the economic analyses reviewed were primarily short-term studies of 12 to 18 months in duration. Long-term studies (that is, studies with follow-up periods of five years or more) suggested that the benefits of IPS persist and even increase over time. Therefore, the long-term benefits from IPS may exceed those found in the existing cost-effectiveness studies (Bond, 2023).

We acknowledge the existing plans to expand IPS, such as The NHS Long Term Plan committing to supporting 55,000 people with severe mental illness to gain and retain employment by 2023/24, and the 2021 Drug Strategy, to expand IPS to community substance use services in all English local authorities by 2024-25. However, it is crucial that expansion remains a government priority and the principles of IPS are adhered to, so that everyone living with a mental illness has ready access to a high-quality IPS service when and where they want it.

6 PROVIDING ALTERNATIVES TO HOSPITAL ADMISSION IN A MENTAL HEALTH CRISIS

CONTEXT

The provision of urgent and emergency care is a major concern across the NHS, with services around the country under growing pressure since the pandemic. This has led to longer waiting times in A&E, especially for people attending with a mental health emergency.

People with mental health difficulties are currently twice as likely to spend 12 hours or more from their time of arrival in A&E as other patients. The Royal College of Emergency Medicine reported that nearly 12% of all patients with mental health problems spend more than 12 hours in A&E from their time of arrival and are twice as likely to spend 12 hours in A&E when compared to all attendances (Royal College of Emergency Medicine, 2022).

There has been an especially alarming increase in the number of children and young people presenting at A&E with mental health needs. In 2022, children and young people in mental health crisis spent more than 900,000 hours in A&E (Campbell, 2023). Between 2017 and 2023, the number of young people aged 11 to 25 admitted to hospital for mental health reasons increased by 20% to about 150,000, while admission episodes increased by a third within the same time period (Crenna-Jennings *et al*., 2024).

The gap between mental and physical health waiting times in A&E has grown over the last five years. The Darzi Report (2024) showed that the median wait (in minutes) in 2019 was 225 for people with a mental health problem compared with 192 for people without a mental health problem. By 2024, the wait for people with a mental health problem was 335 minutes, compared with 224 for other patients.

Where a person needs to be admitted to hospital following a mental health emergency, but a bed cannot be found locally, they may be sent to a hospital outside their local area, sometimes a long distance from home. This is known as an inappropriate out-of-area placement. At the end of March 2024, there were 900 recorded out-of-area placements in England – 805 of which were reported as inappropriate (NHS England, 2024b).

More recently, NHS England reported almost 160,000 over four-hour delays between the decision to admit to hospital and admission in January 2025. The daily average in January 2024 was 5,120, while by January 2025 this had increased to 5,148 – a 0.5% increase. Of these, 61,529 were delayed over 12 hours (between decision to admit to hospital and admission). This equates to 1,985 delays of over 12 hours per day, an increase of 13.3% (233 patients daily) from January 2024 (NHS England, 2025b).

NHS England has allocated £75m to support reducing inappropriate out-of-area placements for mental health patients. This money will be targeted towards acute and Psychiatric Intensive Care Unit out-of-area placements (£46m), rehabilitation (£16m), and secure care (£13m) (NHS England, 2025c).

Furthermore, data from NHS England's Mental Health Services Data Set (MHSDS) shows that in 2023/24, the number of very urgent adult referrals to crisis teams more than doubled, reaching 3,063 in March 2024. This suggests people are becoming more unwell while waiting for the help they need. Recovery time in hospital may therefore increase, meaning bed occupancy rates will remain high (Care Quality Commission, 2025).

According to a recent analysis by Matias *et al*. (2024), the total cost of secondary mental health services in England increased by 13% between 2016 (£5.1bn) and 2019 (£5.7bn):

- This was driven by an increase in outpatient/community costs of 27% and increase in inpatient costs of 6%
- Working-age men represented a higher cost per patient ranging from £5,000 to £15,000 (compared to an average cost of £4,100 for women)
- Care for patients living in the most deprived decile had a total cost that ranged from £761m to £840m across the three years — this was notably higher than the costs for patients living in the least deprived decile which ranged from £244m to £300m.

Notably, there is substantial variation across England in the range of mental health services that are available outside of hospital. Targeted services for groups who face barriers to mental health care are particularly lacking, such as those for LGBTQ+ people, racialised communities, refugees and asylum seekers (Crenna-Jennings *et al*., 2024). To address these gaps in service provision, the NHS Long Term Plan committed to creating more comprehensive crisis pathways in every area to meet the needs and preferences for accessing crisis care.

For example, NHS England has recently completed allocation of an additional £261m targeted investment in community-based crisis teams and 'crisis alternatives' from 2019-2021. Every area has been allocated funding to invest in alternative models of crisis support, such as crisis cafes, safe havens and crisis houses, providing an alternative to A&E or inpatient psychiatric admission. This funding is expected to continue over five years, with a total of £179m being invested in all areas to increase the range of alternative services that can meet different needs and preferences for accessing crisis support (NHS England, 2021).

More recently, in October 2024, the Government announced £26m to open new mental health crisis centres which aim to reduce pressure on A&E services (GOV.UK, 2024c). While it is promising to see a much-needed increase in funding for certain areas of the mental health system, such commitments only address a fraction of what is needed to improve care for people with mental health difficulties.

Furthermore, in 2024, the NHS launched six neighbourhood centres to provide local support to people with severe mental illness. These mental health centres aim to provide people with psychological therapies, medication and other interventions, as well as access to expertise that can help with other important issues. Some centres will also include options such as crisis or hospital beds alongside the provision of early intervention, community, rehabilitation and inpatient care integrated into a single team approach. The project is in its early days. However, if successful, extending these centres to more areas within the next two years could increase positive impacts on the nation's mental health, improve quality of life indicators, and reduce hospitalisation (South London and Maudsley Foundation Trust, 2024; Birmingham and Solihull Foundation Trust, 2024).

EVIDENCE-BASED INTERVENTIONS

Slade *et al*. (2010) conducted an observational cohort study in 12 services. Six services providing a residential alternative to standard inpatient services were chosen, including: a clinical crisis house; a short-stay ward; a crisis team beds service; and two non-clinical alternatives. For each alternative service they identified a standard acute ward which accepted patients from a similar catchment area and, where possible, was served by the same community mental health services as the chosen alternative service. The comparative results show an improvement in all outcomes during admission for both types of services. However, the patients in alternative services stayed for a shorter period of 20.6 days and the cost of care was cheaper (£3,832 compared to £9,850), while standard services cost an additional £2,939 for each unit of improvement in mental health scores (Slade *et al*., 2010).

Another potential alternative to hospital admission relates to the use of the 'Hospital at Home' (HAH) model, which is widely used across a range of medical specialties to reduce pressure on inpatient beds and allow patients to receive care in their own homes. A randomised controlled trial explored the effectiveness of HAH care for a group of older patients who were recruited mainly from primary care or acute hospital assessment units from nine sites across the UK. The study found that, overall, HAH was less costly than hospital admission, with an average cost reduction of £2,265 per patient (from an average hospital cost per patient of £17,390 to £15,124 for HAH) (Shepperd *et al*., 2022). Importantly, despite these cost savings, HAH care was not associated with worse patient outcomes, including quality of life and survival after six months (Shepperd *et al*., 2022). In a similar vein, a review of mental health services based on the HAH model reported that these services were effective alternatives to inpatient care for certain patients, with moderate evidence signalling the additional cost-effectiveness of such models due to a reduction in number and length of hospital admissions (Towicz *et al*., 2021).

CONSIDERATIONS FOR IMPLEMENTATION

OFFERING HOLISTIC AND TAILORED CARE

Across all six areas of investment, stakeholders and experts by experience who attended our roundtable expressed the importance of taking a holistic approach to mental health care and considering the impact of social determinants and other factors on a person's mental health. It is crucial to consider the ways to overcome barriers to accessing mental health support, and this includes implementing flexible, tailored and effective interventions in local areas. People having a meaningful choice in the kind of service they access is also of vital importance.

Stakeholders also highlighted the impact of welfare issues on people's mental health. Poor mental health is frequently linked with financial problems such as unmanageable debt and difficulties with housing and benefits. This link is particularly strong for those with a severe mental illness and the cost of these problems can be very high, including to the NHS and to social care (Parsonage, 2013). The integration of welfare advice into mental health services can be beneficial for people experiencing mental health problems by addressing their financial difficulties, in turn improving their mental health. This integration could lead to cost savings through reducing patients' length of stay in hospital, preventing homelessness, improving quality of life, and preventing relapse (Parsonage, 2013).

Similarly, the NHS Confederation explored the critical role of housing in helping people with severe mental illness to live as independently as possible while accessing the support they need to live and thrive in local communities. Recommendations include the integration and development of more consistent and explicit models of supported housing services that are built on good practice, quality, and collaboration between people with lived experience and their clinical, supported housing, and social care teams (NHS Confederation, 2022; Look Ahead, 2021).

SUPPORTING MENTAL HEALTH IN LATER LIFE

Around 75% of people aged 65 and over have reported experiences of significant anxiety or low mood since turning 65, with 10% reporting frequent or persistent experiences of poor mental health (Seaman *et al*., 2020). Meeting the needs of people of all ages is a moral and practical imperative (International Longevity Centre UK, 2025). Yet, despite clear evidence signalling the need for better mental health care in later life, this group is often overlooked within mental health services and associated policymaking.

In a recent report, Iskander-Reynolds (2024) found that:

- Ageism and discrimination often stop older people from accessing support as poor mental health is frequently dismissed by health professionals as an 'inevitable' part of getting older
- Older people face barriers in access to mental health support at every level; from being disregarded by professionals to facing a lack of specialist services and being overlooked by national and local mental health strategies in England.

As such, the authors recommend that NHS England should ensure any successor to the Long Term Plan includes specific provisions for mental health care in later life and that the effectiveness of the community mental health framework for adults and older adults be reviewed.

There is some evidence to suggest that interventions aimed at preventing social isolation among older people can be a cost-effective way to promote positive mental and physical wellbeing in later life (Wittenberg *et al*., 2019). For example, Coulton *et al*. (2015) reported an association between choir attendance for older adults and significant improvements in quality-of-life measures after six months. In terms of the economic value of the intervention, the researchers predicted a 60% probability of intervention being more cost-effective than no intervention, based on a 'willingness to pay' threshold of £20,000 for each additional Quality-Adjusted Life Year (QALY) gained.

ADDRESSING WORKFORCE CHALLENGES IN THE MENTAL HEALTH SECTOR

Addressing workforce challenges was also a major point raised by stakeholders that could help with the implementation of interventions. This includes creating strategies to improve retention and recruitment of staff and providing consistent staff training opportunities. Between 2010 and 2023, the NHS mental health workforce has grown by approximately 23% (Gilburt and Mallorie, 2024). While it is promising to see an increase in staffing, data suggests that the workforce is less experienced as a higher proportion of psychiatrists are in more junior positions in 2022 (27%) compared to 2010 (15%) (Gilburt and Mallorie, 2024). Additionally, staff recruitment and retention remain a concern, with figures from December 2024 demonstrating that 9.5% of the total NHS workforce had unfulfilled vacancies for roles related to mental health (NHS England, 2025d). The challenges that come with staffing shortages, paired with increased demand for mental health care, have been identified as a major barrier to delivering and fulfilling NHS plans for service expansion and improvement (National Audit Office, 2023).

Without sufficient resourcing and capacity, mental health systems will continue to struggle, and the benefits of our proposed investment areas are unlikely to be realised. To build towards a stronger mental health workforce, Bell and Pollard (2022) make the following recommendations for the NHS:

- Continue efforts proposed by the Advancing Mental Health Equalities strategy (NHS England, 2020) to diversify the mental health workforce, to ensure it is representative of the communities it serves and to encourage a wider range of contributions from professionals of different disciplines
- Produce long-term workforce planning backed up with adequately resourced training and placement opportunities
- Create robust workforce planning, including action to address barriers to joining the mental health workforce, and the discrimination faced by many professionals which limits career progression and opportunities for appointment to senior leadership positions
- Make staff wellbeing a priority by creating healthy and flexible work cultures and environments to enhance job satisfaction in the mental health sector.

CONCLUSION

For many years, mental health in England has been deteriorating and without intervention, the problems will only exacerbate. The upcoming ten-year health plan and Spending Review present the Government with an opportunity to deliver its manifesto commitment to address disparities between mental and physical health, while also ensuring public money is spent wisely on services that will make a difference to the nation's mental health.

Based on available economic evidence, this report has presented six investment priorities that would support better mental health and represent good value for money. These are:

1. Enabling health visitors to support new mothers' mental health
2. Rolling out evidence-based parenting programmes
3. Expanding the network of early support hubs for young people
4. Expanding offers within the NHS Talking Therapies programme
5. Expanding Individual Placement and Support employment services
6. Providing alternatives to hospital admission in a mental health crisis.

Investing in the above priorities would be more effective if the following key principles are considered and implemented throughout:

- Take a holistic approach to mental health care by addressing key social determinants of poor mental health
- Offer tailored and flexible support to maximise accessibility of mental health support and reduce attrition rates
- Provide adequate mental health support in later life to meet the growing mental health needs of our ageing population
- Build towards a stronger mental health workforce by prioritising staff wellbeing through adequate funding.

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