Centre for Mental Health Managed Clinical Advisory Group Response to the Mental Health Review Call for Evidence

Executive summary

Centre for Mental Health is an independent charity. We take the lead in challenging injustices in policies, systems and society, so that everyone can have better mental health. By building research evidence to create fairer mental health policy, we are pursuing equality, social justice and good mental health for all.

This response is submitted by Centre for Mental Health on behalf of the Children and Young People Secure Estate Managed Clinical Advisory Group, commissioned by NHS England to bring together professional and child participation expertise to inform policy, commissioning and service improvement across the children and young people secure estate. The group includes Young Advisors with lived experience of the estate, working alongside health, commissioning and policy professionals to promote trauma-informed, child-centred and integrated approaches to care. It includes direct submissions for this call for evidence and summaries of recommendations from a series of coproduced discussions with young advisors and clinicians in the children and young people secure estate.

Children in, on the edges of, and leaving the children and young people secure estate often have multiple and overlapping mental health, neurodevelopmental, educational, social care, family and justice-related needs. Their distress may not present through clear diagnostic symptoms, but through behaviour, withdrawal, risk-taking, disengagement from education, emotional dysregulation or relationship difficulties. As Young Advisors have emphasised, services must "look for the need behind the behaviour".

The central message of this response is that the system should adapt to the child, not require the child to fit fragmented service thresholds. Mental health support for children in the secure estate works best when organised around whole-system, child-centred pathways rather than disconnected clinical interventions. This requires shared formulation, integrated working across health, education, social care, youth justice and community services, and sustained relational support before, during and after secure placements.

Transitions are identified as particularly high-risk points. Children may experience admission to secure settings, movement between placements, discharge into the community, leaving care, or transfer into adult systems. These transitions are too often treated as administrative handovers rather than relational and developmental processes.

Young Advisors were clear that support should not stop when a young person leaves custody or secure welfare placement.

The response also highlights the importance of prevention. The strongest approaches intervene early, relationally and across the systems that shape children's lives: families, schools, communities, health services, social care and youth justice. Prevention should include parenting and caregiver support, inclusive education, trauma-informed and neurodiversity-aware practice, youth diversion, social prescribing, meaningful activity, peer support and gender-responsive provision.

For children whose needs sit in the so-called "missing middle", the problem is not simply clinical complexity but system design. These are children whose needs are overlooked, misunderstood, fall below thresholds, or sit across multiple agencies that each see only part of the picture. Services need to work with complexity and uncertainty earlier, rather than waiting for diagnosis, crisis or escalation into custody, care breakdown or secure welfare placement.

The response calls for commissioning, funding and accountability arrangements that follow children's pathways rather than organisational boundaries. This means aligned or pooled budgets, shared outcomes frameworks, place-based and whole-pathway commissioning, co-production with children and families, investment in community and peer-led provision, and clear governance across health, justice, local authority, education and community partners.

Overall, the response argues that improving mental health outcomes for children with multiple and complex needs, in and around the secure custodial and welfare estate, requires a decisive shift: from fragmented, threshold-driven and crisis-led systems towards integrated, relational, trauma-informed and developmentally attuned support that starts earlier, stays longer and addresses the social conditions that shape children's lives.

Recommendations

1. Build integrated, child-centred pathways around the whole child, underpinned by shared formulation

Mental health services should be organised around children's full needs and life circumstances, not separate professional or organisational boundaries. Pathways should include health, education, social care, youth justice, family support, community organisations and specialist mental health provision, and be underpinned by shared, trauma-informed and neurodiversity-aware formulation developed with children and families.

Recommendation: Government and system leaders should require integrated pathways for children in, on the edges of, and leaving the secure estate, with shared accountability across health, justice, education, social care, community, youth services and local authority partners, and with formulations that travel with children across placements and services where appropriate.

2. Treat transitions as relational and developmental processes

Transitions into, within and out of the secure estate should not be managed as administrative handovers. Children need continuity of trusted relationships, early discharge planning, secure accommodation arrangements, education or activity provision, and support that continues beyond release or placement change.

Recommendation: Commissioners should fund through-the-gate transition support, relational navigation, advocacy and post-release community support as core components of secure estate pathways.

3. Intervene earlier, before distress escalates into crisis

The response highlights that many children later entering the secure estate show signs of distress long before crisis occurs, including behavioural difficulties, emotional dysregulation, school disengagement, trauma and unmet SEND. Young Advisors emphasised the need for earlier intervention, including around the transition to secondary school.

Recommendation: Mental health reform should prioritise earlier identification and support in schools, families, youth services, social care and community settings, particularly for children showing distress through behaviour, exclusion, disengagement or risk-taking.

4. Invest in families, carers and consistent caregiving

The document identifies positive parenting and caregiver support as important preventative approaches and emphasises the need to support parents, carers, foster carers and residential staff to provide warm, consistent and developmentally informed care.

Recommendation: Parenting and caregiver support should be commissioned as part of children's mental health and youth justice prevention, including for families, foster carers, kinship carers and residential care staff.

5. Strengthen inclusive education and reduce exclusion

Schools are described as one of the most important sites of prevention. The response highlights the protective role of inclusive education and the risks associated with exclusion, off-rolling and unmet SEND or neurodevelopmental needs.

Recommendation: Mental health reform should explicitly link with education policy to reduce exclusion, improve early identification of SEND and neurodevelopmental needs, and embed trauma-informed, culturally responsive and inclusive practice in schools.

6. Expand social prescribing, mentoring, peer support and meaningful activity

Young Advisors repeatedly highlighted the importance of activity, music, sport, mentoring, peer support and positive role models in building confidence, identity, connection and hope. The response argues that these should be viewed as part of prevention and recovery, not optional extras.

Recommendation: Commissioners should invest in community-based social prescribing, mentoring, peer support, creative activity, sport, volunteering and employment pathways for children at risk of, in, and leaving the secure estate.

7. Address racial trauma, discrimination, gender-based harm and inequality

The document identifies inequality as a central factor shaping children's mental health trajectories. It highlights racial trauma, discrimination, poverty, exploitation, gender-based violence, diagnostic bias and barriers to trust as issues that must be addressed directly.

Recommendation: Services should be explicitly equity-informed, culturally competent and gender-responsive, with dedicated attention to racialised children, girls, children affected by exploitation, and children whose distress is internalised, masked or misunderstood.

8. Support the "missing middle" through flexible, needs-led provision

The response describes the "missing middle" as children whose needs are overlooked, misunderstood, below thresholds or spread across multiple agencies. It argues that this is a system design problem and that services must be able to work with complexity before crisis.

Recommendation: Local systems should commission flexible, multidisciplinary support for children with emerging or multiple needs who do not meet specialist thresholds but require timely help to prevent escalation.

9. Use data to improve continuity, shared planning and accountability

The document argues that data should reduce repeated assessments, prevent children having to retell traumatic experiences, and enable formulations, care plans and transition plans to follow children across systems. It also identifies potential for linked data to identify unmet need and service gaps.

Recommendation: Data systems should be designed to support continuity of care, shared planning, earlier intervention and accountability for inequalities, while protecting children's rights to privacy, transparency and informed involvement.

10. Reform commissioning so funding, accountability and co-production follow the child's pathway

The response argues that current arrangements too often incentivise organisations to manage immediate pressures within separate budgets, even where early intervention would benefit multiple systems. It calls for aligned commissioning across Integrated Care Boards, local authorities, education, justice and community partners, with co-production embedded in commissioning, governance and evaluation.

Recommendation: Government should enable pooled or aligned budgets, whole-pathway commissioning, shared accountability and outcomes frameworks covering wellbeing, safety, stability, education, relationships and long-term life chances, with children, families and people with lived experience involved as partners in service design and governance.

The mental health needs of children in, on the edges of, and leaving the secure estate cannot be met through clinical services alone. They require a whole-system response that recognises distress early, understands behaviour as communication, sustains trusted relationships and addresses the social conditions that shape children's lives. Reform should therefore be organised around one guiding question: **what does this child and family need to thrive?**

Full response

1: Hospital to community

How can mental health services work more effectively across services and sectors (linking in and out of the children and young people secure estate (CYPSE)

Mental health services for children on the edges of, in and leaving the CYPSE are most effective when they operate as part of a whole-system, child-centred pathway rather than as discrete clinical services responding to crisis. Children in the CYPSE frequently have overlapping mental health, neurodevelopmental, educational, social care and family needs, often shaped by trauma, poverty and inequality.

Crucially, children's distress rarely presents in clear-cut or diagnostic ways. More often, it is expressed through behaviour, withdrawal, risk-taking, disengagement from education or difficulties in relationships. Effective systems therefore need to understand behaviour as a communication of need rather than simply as risk or non-compliance. As Young Advisors have repeatedly told us:

"Look for the need behind the behaviour " (Young Advisors)

This requires a **whole-system workforce** across health, education, social care, youth justice and community services with shared understanding of child development, trauma and neurodiversity.

Evidence consistently shows that trauma-informed approaches are associated with improvements in mental health, wellbeing and engagement (Branson et al., 2017; Malvaso, Day and Boyd, 2024). In the CYPSE, the Framework for Integrated Care (SECURE STAIRS) provides an example of how multidisciplinary working, shared formulation and trauma-informed practice can place the child's story at the centre of care and improve workforce capability (Atkinson et al., 2023; Rogers et al., 2025). However, these integrated approaches are often not sustained when children return to community settings.

Support should therefore be organised around **shared multidisciplinary formulation**, developed with children and families, rather than fragmented assessments and service thresholds. Formulation-led approaches help professionals build a shared understanding of the child's strengths, needs, experiences and protective factors.

Integrated working is particularly important for children whose needs cut across traditional service boundaries. Effective systems require:

- shared accountability across health, education, social care, youth justice and community services;
- coordinated pathways that follow the child rather than organisational boundaries;
- aligned decision-making and thresholds;
- information-sharing arrangements that reduce duplication and repeated assessment.

Children's mental health cannot be separated from the contexts in which they live. Effective support therefore needs to address poverty, school and social exclusion, family stress, housing instability and social isolation alongside emotional wellbeing. Education, youth provision, community organisations and family support should be viewed as core contributors to children's mental health.

Children, families and communities should also be active partners in service design and delivery. Emerging evidence suggests that meaningful co-production can improve the relevance and responsiveness of youth mental health services, particularly where young people with lived experience are supported to contribute as credible partners in service design and decision-making (Jones et al., 2024). This is particularly important for groups

who may distrust statutory systems or face barriers to support (Jones et al., 2024; McGovern et al., 2024).

Finally, systems should prioritise **relational continuity**. Children with complex needs often experience multiple transitions between placements, services and professionals. Consistent, trusted relationships are among the strongest protective factors supporting engagement, wellbeing and recovery.

As one MCAG Young Advisor put it:

"Relationships before intervention."

This means ensuring continuity of trusted adults, involving families and carers wherever possible, and maintaining community-based support before, during and after secure placements. Social prescribing, mentoring and peer support can also help children develop connection, identity and purpose.

Summary

Mental health services work best when they are organised around a simple principle:

The system should adapt to the child, not the child to the system.

This requires:

- trauma-informed, neurodiversity-aware and relational practice;
- shared formulation and integrated pathways;
- co-production with children and families;
- alignment across services and sectors;
- attention to social determinants and inequalities; and
- continuity of trusted relationships.

Without these foundations, fragmentation will continue to drive escalation into crisis, exclusion and secure settings, despite the involvement of multiple services.

What further support should be provided for people with severe and enduring mental illness?

For children in, or on the edges of, the CYPSE, severe and enduring mental illness is rarely the result of a single event or condition. More often, it emerges through the interaction of vulnerability, cumulative adversity and delays in receiving appropriate

support. Improving outcomes therefore requires earlier intervention, sustained relational support, and services that address mental health alongside the wider conditions shaping children's lives.

A key challenge is that children's distress often does not fit traditional mental health pathways. It may be expressed through behaviour, withdrawal, risk-taking, school disengagement or emotional dysregulation rather than clear diagnostic symptoms, meaning needs can go unrecognised until they become more severe and entrenched.

Evidence shows that around three quarters of mental health conditions emerge before the age of 25 (McGorry and Mei, 2018), yet substantial delays in access to support remain. Around one in five children have a probable mental health disorder, but fewer than half receive contact with NHS-funded mental health services (NHS Digital, 2023; The King's Fund, 2024). Even after referral, many children either wait extended periods or do not access treatment at all (Children's Commissioner for England, 2024). For children already facing adversity, these delays can allow difficulties to escalate and become increasingly complex.

For many children in the CYPSE, what becomes severe and enduring is not simply the mental health condition itself, but the cumulative impact of unmet need, repeated adversity, social exclusion and delayed support. Poverty, abuse, neglect, developmental trauma, domestic violence, racism, discrimination, school exclusion and family instability all increase risks, particularly when multiple and persistent (Shonkoff and Garner, 2012; Khan et al., 2017; Marmot et al., 2020).

Support for severe and enduring mental illness should therefore extend beyond clinical treatment alone. It should include:

- earlier identification and intervention across education, social care, youth justice and health services;
- support that recognises behaviour as a potential expression of distress;
- continuity of trusted relationships and relational support;
- access to meaningful activity, community connection and social prescribing approaches;
- support for families and carers;
- coordinated responses to poverty, exclusion and wider social determinants of health.

There should also be greater recognition of inequality in shaping mental health trajectories. Children in the CYPSE are disproportionately exposed to racial trauma, discrimination, poverty, exploitation and gender-based violence. Effective support

therefore requires culturally competent, gender-responsive and equity-informed services that address barriers to access, mistrust and diagnostic bias.

Alongside specialist treatment, children with severe and enduring mental health difficulties need opportunities to build protective factors that support recovery and resilience. Evidence consistently highlights the importance of stable relationships, supportive environments, community connection, identity, belonging and meaningful participation in improving outcomes, even where significant risk and vulnerability are present (Rutter, 2012; Sameroff, 2010; Carter et al., 2022).

Ultimately, while severe mental illness cannot always be prevented, its severity, persistence and long-term impact can often be reduced when services intervene early, remain engaged over time, and work alongside families, communities and other systems.

Summary

For children in the CYPSE, improving outcomes for severe and enduring mental illness requires:

- earlier identification and access to support;
- recognition of behavioural presentations as expressions of distress;
- sustained relational and community-based support;
- investment in social prescribing and recovery-focused approaches;
- explicit action to address racial trauma, inequality and gender-based harm; and
- support that addresses both mental health needs and the wider social conditions that contribute to them.

The goal should not simply be to treat severe mental illness once it has become entrenched, but to reduce its severity, persistence and impact through earlier, coordinated and relational support.

What are the main barriers to continuity of care across transitions, including child to adult services?

Transitions are among the highest-risk points in a child's journey into and out of the CYPSE. Children may experience admission to secure settings, movement between placements, discharge into the community, leaving care, and transfer to the adult prison estate. These transitions are often marked by disruption, uncertainty and loss of trusted relationships, with particularly harmful consequences for children who have experienced trauma, instability, neurodevelopmental differences and social disadvantage (Olaitan and Pitts, 2020; Khan, Harris and Sinclair, 2021; Fitzpatrick et al., 2022).

The central barrier is that transitions are too often treated as **administrative events rather than relational and developmental processes**. Services focus on eligibility, thresholds and handovers, while children experience the loss of trusted adults, routines and support networks.

MCAG Young Advisors repeatedly emphasise the importance of continuity:

"Just because a young person has left a YOI, that support shouldn't just stop there."

1. **Fragmented systems and cliff edges**

A major barrier is fragmentation between child, adult and community services. Children often experience repeated assessments, duplicated processes and inconsistent plans as they move between systems, rather than a single coordinated pathway (Yampolskaya, 2023; Fitzpatrick et al., 2022).

Transitions from children to adult services are particularly problematic. Young people often move from developmentally informed, relationship-based services into systems that feel less flexible, less relational and less able to respond to trauma, neurodevelopmental needs and emotional immaturity. Moves from the children's secure estate into the adult prison estate are especially concerning.

2. **Placement uncertainty and poor discharge planning**

Another significant barrier is uncertainty about where children will live and what support will be available following discharge. Accommodation, education and support arrangements are often agreed late in the process, leaving children with little time to prepare.

MCAG Young Advisors highlighted the impact of this uncertainty:

"One young person didn't know until three days before they were due to leave where they were going – that would really mess up my mind."

For children who have experienced repeated instability and rejection, this uncertainty can undermine progress made during placement and reinforce beliefs that adults and systems are unreliable.

Earlier and more coordinated discharge planning is needed, including accommodation pathways that can be secured before release and commissioning arrangements that enable local authorities to hold appropriate community provision in readiness.

3. **Loss of relationships, social capital and community support**

Current systems are largely designed to transfer responsibility between services; they are not designed to transfer relationships.

Evidence consistently highlights the importance of trusted adults, mentors and advocates who remain involved before, during and after transitions (Olaitan and Pitts, 2020; Fitzpatrick et al., 2022). Continuity should therefore extend beyond case management and include support to rebuild **social capital** following release.

Many children leave secure settings with disrupted social networks, limited opportunities and few positive role models. Community organisations, peer mentoring and specialist support can help children build belonging, confidence, employment skills and positive future identities.

Young people in peer and lived-experience programmes often describe these opportunities as transformative, helping them move from identities defined by risk and system involvement towards leadership, expertise and aspiration.

4. Gender-responsive and culturally responsive support

Girls and racialised children can face additional barriers during transitions.

For girls, histories of exploitation, sexual violence, relational trauma and internalised distress can make transitions particularly destabilising unless support is explicitly gender-responsive (Agenda and SCYJ, 2021; Khan, Harris and Sinclair, 2021; Staines et al, 2024).

For racialised children, experiences of racism, adultification and discrimination may contribute to mistrust of statutory systems and reduce willingness to seek support. Community-based organisations, culturally competent practitioners and mentors with lived experience can play an important role in supporting engagement and continuity.

5. A commissioning challenge as much as a service challenge

Perhaps the most significant barrier is that continuity of care often depends on the commitment of individual professionals rather than being embedded within commissioning arrangements.

Effective transitions require commissioned pathways that include:

- Relational navigation and advocacy
- Through-the-gate support
- Joint child-adult working arrangements
- Accommodation planning
- Outreach from secure settings into community services
- Peer mentoring and social capital programmes

- Gender-responsive and culturally responsive provision.

Without dedicated funding, shared accountability and commissioned pathways, continuity remains vulnerable to organisational boundaries and resource pressures.

Summary

The main barriers to continuity of care are:

- Fragmentation between child, adult and community systems;
- Loss of trusted relationships during transitions;
- Late and poorly coordinated discharge planning;
- Housing and placement instability;
- Insufficient support to rebuild social capital and community connections;
- Inadequate gender-responsive and culturally responsive provision; and
- An over-reliance on individual professional commitment rather than commissioned transition pathways.

For children in the CYPSE, transitions are fundamentally a **relational, developmental and commissioning challenge**, not simply an administrative one. Continuity is achieved when support begins early, spans organisational boundaries, maintains trusted relationships and helps children build stable, meaningful lives beyond the secure estate.

2: Analogue to digital

What evidence is there on digital/AI tools that improve access or complement relational care?

While the CYPSE has limited evidence to contribute on digital health innovation, it is important to note that children in the CYPSE experience some of the greatest health inequalities and are among the least likely to access mainstream health services. Without deliberate efforts to address access, trust and inclusion, there is a risk that digital innovations could widen rather than reduce existing inequalities.

How can data be used more innovatively?

Data should be used to improve continuity of care, reduce duplication and support more personalised care, rather than simply for monitoring and reporting.

A persistent challenge within the CYPSE is that information does not always follow children effectively across services, placements and transitions. As a result, children are often repeatedly assessed and asked to retell traumatic experiences, creating frustration, disengagement and the risk of re-traumatisation.

More innovative use of data should support integrated, child-centred information sharing so that relevant information, multidisciplinary formulations and transition plans follow the child across systems. This would reduce repeated assessments, strengthen continuity and support a shared understanding of needs, strengths and protective factors.

There is also significant potential to use linked data across health, education, social care and justice systems to identify patterns of unmet need, multiple disadvantage and service gaps, enabling earlier intervention and more targeted commissioning.

In summary, data should be used to:

- Reduce the need for children to repeatedly tell their story
- Improve continuity across placements and transitions
- Support shared formulations and care plans
- Identify unmet need and opportunities for earlier intervention
- Strengthen coordinated planning while maintaining children's rights to privacy, transparency and informed involvement in decisions about their information.

3: Sickness to prevention

Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health??

For children in, or at risk of entering, the CYPSE, **the strongest preventative approaches intervene early, relationally and across the systems that shape children's lives**. Prevention should be a coordinated approach that strengthens families, schools, communities and services before difficulties escalate into exclusion, care breakdown, exploitation, violence, custody or secure welfare placement.

1. Early intervention and support for families

The evidence consistently demonstrates the value of intervening early, before difficulties become entrenched. Despite increased investment, a substantial treatment gap remains: around **one in five children and young people have a probable diagnosable mental condition**, yet fewer than half receive contact with NHS-funded mental health

services (NHS Digital, 2023; The King's Fund, 2024). The Children's Commissioner found that of almost 949,000 children referred to specialist mental health services in 2022–23, only 32% received support (Children's Commissioner for England, 2024).

This matters because many children who later enter the CYPSE show signs of distress long before crisis occurs. Behavioural difficulties, emotional dysregulation, school disengagement, trauma and unmet SEND are often visible years earlier.

MCAG Young Advisors were clear about the importance of acting sooner:

> *"I think all the work that we do should be earlier in the young person's life… they need intervention and diversion away from that lifestyle as soon as possible before they get too deep into that life."*

One Young Advisor identified transition into secondary school as a particularly important opportunity:

> *"Secondary school — around that age — that would have worked best for me."*

Alongside early intervention for children, **positive parenting and caregiver support** are strongly evidenced. Parenting programmes can reduce behavioural difficulties and improve outcomes when implemented well (Parsonage, Khan and Saunders, 2014; Youth Endowment Fund, 2024). Prevention should also support parents, carers, foster carers and residential staff to provide consistent, warm and developmentally informed care supported by integrated multi-disciplinary support and a formulation led approach when challenges emerge.

2. Inclusive education and reduced exclusion

Schools remain one of the most important sites of prevention. Whole-school approaches, anti-bullying work, support for school belonging and social and emotional learning, staff mental health literacy and easier access to support all contribute to better outcomes (Khan, 2016).

The introduction of **Mental Health Support Teams (MHSTs)** has strengthened early intervention capacity within schools. However, significant gaps remain, and many schools continue to carry substantial responsibility for supporting children with complex mental health, behavioural and safeguarding needs while waiting for specialist support.

For children at risk of entering secure settings, **inclusive education is a critical protective factor**. School exclusion and off-rolling can disconnect children from protective relationships and increase exposure to risk-focused systems. Preventative approaches should prioritise educational inclusion, early identification of SEND and neurodevelopmental needs, trauma-informed school practice and culturally responsive approaches that strengthen belonging.

3. Trauma-informed and neurodiversity-aware approaches

Strong evidence supports trauma-informed, neurodiversity-aware and formulation-led approaches across children's services (Branson et al., 2017; Malvaso, Day and Boyd, 2024). These approaches recognise that distress often presents through behaviour and that effective responses require understanding the context behind that behaviour.

4. Diversion, social prescribing and meaningful activity

Evidence supports diversion from formal justice pathways wherever safe, relational and community-based alternatives can meet need (Petrosino, Turpin-Petrosino and Guckenburg, 2010). This is particularly important for children whose behaviour reflects trauma, adversity, unmet need or exploitation rather than serious risk.

There is also growing evidence for the role of **social prescribing, meaningful activity and community participation** in improving wellbeing and preventing escalation (Hayes et al., 2023; Bertotti et al., 2022).

MCAG Young Advisors consistently highlight the importance of activities that build confidence, identity and connection:

"The past two years I learned guitar… it almost saved my life."

"When you're out of your room doing activities… it takes your mind off things."

Sport, music, creative activity, mentoring, volunteering and employment opportunities should be treated as part of prevention rather than optional extras.

5. Peer support and positive identity

The strongest prevention approaches also build hope, agency and belonging. MCAG Young Advisors consistently describe peer support as highly credible and effective:

"Peer to peer is probably the most important thing ever."

"If you see someone in a higher position who was where I am now, I can role model myself to them."

Investment in peer mentoring, lived-experience leadership, youth participation and employment pathways can help children develop positive identities beyond risk, offending or service involvement.

What works for girls and boys

Prevention should be gender-responsive, culturally responsive and tailored to individual presentation. Distress may be expressed differently across children and can be shaped by gender, culture, neurodiversity and life experience. Evidence

highlights the importance of recognising how girls' experiences of trauma, exploitation, internalised distress and masked neurodevelopmental need can be overlooked or misunderstood within gender-neutral systems (Khan, Harris and Sinclair, 2021; Staines et al., 2024). Evidence from the NHS England CYPSE MCAG Boys Briefing and stakeholder engagement similarly suggests that boys' distress may be more readily expressed through anger, risk-taking, withdrawal or silence, increasing the likelihood that vulnerability is interpreted as risk rather than need. Gender-diverse and non-binary children may face additional stigma, exclusion and mental health challenges. Services should therefore be equipped to recognise diverse presentations of distress and respond in ways that are inclusive, trauma-informed and affirming of children's identities and experiences.

Summary

The strongest evidence supports:

- Early intervention at the first signs of difficulty
- Positive parenting and caregiver support
- Inclusive education and reduced exclusion
- Trauma-informed and neurodiversity-aware practice
- Diversion from formal justice pathways
- Social prescribing and meaningful activity
- Peer support and lived-experience leadership
- Gender-responsive and developmentally informed support.

Ultimately, prevention is most effective when systems stop asking:

"How do we manage this child's risk?" and instead ask:

"What relationships, opportunities, family support and community conditions would help this child thrive before crisis becomes inevitable?"

How can services better support the "missing middle"?

The term **"missing middle"** does not describe a single group of children. Rather, it refers to children whose needs are overlooked, misunderstood, fall below service thresholds, or sit across multiple agencies that each see only part of the picture.

For children, distress often does not present through clear diagnostic symptoms. It may be expressed through behaviour, school disengagement, emotional dysregulation, risk-taking, poor attendance, family conflict or substance use. Neurodevelopmental needs such as FASD, autism, ADHD and speech, language and communication difficulties may also remain hidden. As a result, children can be labelled as challenging, non-compliant or low priority rather than recognised as needing support.

The "missing middle" therefore includes:

- Children with emerging needs that do not meet specialist thresholds;
- Children whose difficulties could be prevented from escalating with timely support;
- Children with multiple intersecting needs across mental health, neurodevelopment, family adversity, education and social care.

Without early intervention, these needs often accumulate until children later present in crisis, experience exclusion, enter care or become involved with youth justice services. This is particularly concerning given the long-term social and economic costs associated with severe behavioural difficulties in childhood (Parsonage, Khan and Saunders, 2014).

Supporting the missing middle requires services that can work with complexity and uncertainty rather than waiting for diagnosis or crisis. Some children may need school-based support, mentoring or counselling; others require more intensive wraparound support across health, education, social care, youth services, community organisations and families.

Community and youth organisations are particularly important because they are often better able to engage children and families who may distrust statutory services or have experienced stigma, discrimination or previous poor experiences of support.

Ultimately, the "missing middle" is not primarily a clinical problem—it is a **system design problem**. Children are less likely to fall through gaps when services work together, intervene early and organise around the whole child and family rather than organisational boundaries.

4: Factors enabling best practice

What commissioning, funding and accountability arrangements are needed?

Children in the CYPSE have complex, multi-layered needs spanning mental health, neurodevelopment, education, trauma, social care, social capital and justice

involvement. Commissioning must therefore be **aligned across health, justice, local authority, education and national programmes**, with systems working to shared priorities rather than fragmented organisational responsibilities.

Funding and accountability should follow the child's pathway before, during and after custody. This means coordinated commissioning across Integrated Care Boards (ICBs), local authorities, education, youth justice and community and voluntary sector services, with **shared responsibility for outcomes**, especially where children experience out-of-area placements, complex transitions or involvement with several systems at once.

A key challenge is that the benefits of early intervention often fall to different organisations from those expected to invest. Parenting support, educational inclusion, youth work, community mental health and neurodevelopmental support can generate savings across social care, health, justice and welfare systems (Parsonage, Khan and Saunders, 2014), but current arrangements often incentivise organisations to manage immediate pressures within their own budgets.

More creative commissioning approaches are therefore needed, including:

- Pooled or aligned budgets that follow the child's pathway, not organisational boundaries;
- Needs-led commissioning informed by population health, inequalities and local patterns of unmet need;
- Shared outcomes frameworks covering wellbeing, safety, stability, education, relationships and long-term life chances;
- Place-based and whole-pathway commissioning across custody, community and transition points;
- Joint accountability across health, justice, local authority, education and community partners.

The **Total Place** programme demonstrated the potential benefits of understanding public spending across whole systems and reducing duplication through collaboration, while also highlighting barriers such as siloed budgets, fragmented accountability and short-term funding arrangements (HM Treasury, 2010; Humphries and Gregory, 2010; Hoddinott and Davies, 2025).

Commissioned provision should be:

- Trauma-informed, neurodiversity-aware, formulation-led and child-centred;

- Community-based, relational and able to sustain support before, during and after custody;
- Coproduced with children, families and people with lived experience;
- Able to work with children whose needs do not fit neatly within traditional service boundaries.
- Coproduction should be embedded in commissioning structures, not added as consultation after decisions are made. The NHS England Managed Clinical Advisory Group (MCAG) model demonstrates the value of involving young people directly in policy, commissioning and service development.

There should also be greater investment in community organisations, youth services, social prescribing, mentoring and peer-led provision, which young people describe as helping them build trust, identity, belonging and hope.

Finally, commissioning arrangements should be underpinned by shared **planning**, transparent **data and clear governance across organisations**. This should include oversight of pathway performance, quality and safety, outcomes and inequalities, so that partners are collectively accountable for whether children receive timely, relational and effective support.

In short, commissioning should be organised around a simple question:

"What does this child and family need to thrive?"

rather than:

"Which service does this child fit into?"

References

Agenda and Standing Committee for Youth Justice (2021) *Young Women's Justice Project Literature Review*. London: Agenda and SCYJ.

Atkinson, S., McKeown, A., Caveney, D., West, E., Kennedy, P.J. and Macinnes, S. (2023) 'The SECURE STAIRS Framework: preliminary evaluation of trauma-informed training developments within the Children and Young People's Secure Estate', *Community Mental Health Journal*.

Bertotti, M., Hayes, D., Berry, V., Jarvis-Beesley, P. and Husk, K. (2022) 'Social prescribing for children and young people', *The Lancet Child & Adolescent Health*, 6(12), pp. 835–837.

Branson, C.E., Baetz, C.L., Horwitz, S.M. and Hoagwood, K.E. (2017) 'Trauma-informed juvenile justice systems: a systematic review of definitions and core components', *Psychological Trauma: Theory, Research, Practice, and Policy*, 9(6), pp. 635–646.

Carter, B., Paranjothy, S., Davies, A. and Kemp, A. (2022) 'Mediators and effect modifiers of the causal pathway between child exposure to domestic violence and emotional and psychological problems among children and adolescents: A systematic literature review', *Trauma, Violence, & Abuse*, 23(2), pp. 594–604.

Children's Commissioner for England (2024) *Children's mental health services 2022–23*. Available at: https://www.childrenscommissioner.gov.uk (Accessed: 22nd June 2026).

Fitzpatrick, C., Hunter, K., Shaw, J. and Staines, J. (2022) *Disrupting the Routes Between Care and Custody for Girls and Women*. Lancaster: Lancaster University.

Hancock, S. (2025) *Delivering the Best for Girls in Custody: An Independent Review of Placement Options for Girls in the Children and Young People Secure Estate*. London: Ministry of Justice.

Hayes, D., Jarvis-Beesley, P., Mitchell, D., Polley, M. and Husk, K. (2023) *The impact of social prescribing on children and young people's mental health and wellbeing*. London: National Academy for Social Prescribing.

HM Inspectorate of Prisons, Ofsted, HM Inspectorate of Probation, Care Quality Commission and Care Inspectorate Wales (2022) *Outcomes for Girls in Custody: A Thematic Review*. London: HMIP.

HM Treasury (2010) *Total Place: A Whole Area Approach to Public Services*. London: HM Treasury.

Hoddinott, S. and Davies, N. (2025) *The Case for Total Place 2.0*. London: Institute for Government.

Humphries, R. and Gregory, S. (2010) *Place-based Approaches and the NHS: Lessons from Total Place*. London: The King's Fund.

Jones, V.R., Waring, J., Wright, N. and Fenton, S.-J. (2024) 'A rapid realist review of literature examining co-production in mental health services for youth', *JCPP Advances*, 4(4), e12272.

Kazdin, A.E. (1997) 'Parent management training: evidence, outcomes, and issues', *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(10), pp. 1349–1356.

Khan, L. (2016) *Missed Opportunities: A review of recent evidence into children and young people's mental health*. London: Centre for Mental Health.

Khan, L., Saini, G., Augustine, A., Palmer, K., Johnson, M. and Donald, R. (2017) *Against the Odds: Evaluation of the Mind Birmingham Up My Street Programme*. London: Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/publications/against-odds/ (Accessed: 3 July 2026).

Khan, L., Harris, A. and Sinclair, C. (2021) *Out of Sight: Girls in the Children and Young People's Secure Estate*. London: Centre for Mental Health.

Malvaso, C., Day, A. and Boyd, C. (2024) 'The outcomes of trauma-informed practice in youth justice: an umbrella review', *Journal of Child & Adolescent Trauma*, 17, pp. 939–955.

Marmot, M. et al. (2020) *Health Equity in England: The Marmot Review 10 Years On*. London: Institute of Health Equity.

McGorry, P.D. and Mei, C. (2018) 'Early intervention in youth mental health: progress and future directions', *BMJ Mental Health*, 21(4), pp. 182–184.

NHS Digital (2023) *Mental Health of Children and Young People in England, 2023: Wave 4 Follow-up to the 2017 Survey*. Leeds: NHS Digital.

NHS England CYPSE Managed Clinical Advisory Group (2026) *Differences and commonalities between boys' and girls' needs in the Children and Young People's Secure Estate*. MCAG Briefing Paper. Unpublished internal briefing.

Olaitan, P. and Pitts, J. (2020) 'Collaborative working in the resettlement of young people leaving custody', *Safer Communities*, 19(3), pp. 89–101.

Parsonage, M., Khan, L. and Saunders, A. (2014) *Building a Better Future: The Lifetime Costs of Childhood Behavioural Problems and the Benefits of Early Intervention*. London: Centre for Mental Health.

Petrosino, A., Turpin-Petrosino, C. and Guckenburg, S. (2010) 'Formal system processing of juveniles: effects on delinquency', *Campbell Systematic Reviews*, 2010(1).

Rogers, A., Fuggle, P. and Fonagy, P. (2025) *The Framework for Integrated Care: A catalyst for change*. London: Anna Freud and NHS England Health and Justice. Available at: https://www.annafreud.org/services/services-for-professionals/the-framework-for-integrated-care-a-catalyst-for-change/ (Accessed: 3 July 2026).

Rutter, M. (2012) 'Resilience as a dynamic concept', *Development and Psychopathology*, 24(2), pp. 335–344. https://doi.org/10.1017/S0954579412000028.

Sameroff, A. (2010) 'A unified theory of development: A dialectic integration of nature and nurture', *Child Development*, 81(1), pp. 6–22. https://doi.org/10.1111/j.1467-8624.2009.01378.x.

Shonkoff, J.P. and Garner, A.S. (2012) 'The lifelong effects of early childhood adversity and toxic stress', *Pediatrics*, 129(1), pp. e232–e246.

Staines, J., Fitzpatrick, C., Shaw, J. and Hunter, K. (2024) 'We need to tackle their well-being first': understanding and supporting care-experienced girls in the youth justice system', *Youth Justice*, 24(2), pp. 185–203.

The King's Fund (2024) *Mental Health 360: Services for Children and Young People*. London: The King's Fund. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/mental-health-360-services-children-young-people (Accessed: 3 July 2026).

Yampolskaya, S. (2023) 'Doorways to adversity: challenges of youth involved in multiple systems', *Child Welfare*, 101(1), pp. 1–28.

Youth Endowment Fund (2024) *Parenting programmes*. London: Youth Endowment Fund.

Published July 2026

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research.

Support our work here: www.centreformentalhealth.org.uk/donate

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019