



UNIVERSITY OF
BIRMINGHAM

Mental Health Policy Commission

INVESTING IN A RESILIENT GENERATION

Keys to a Mentally Prosperous Nation
Executive Summary and Call to Action



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FOREWORDS

GUS O'DONNELL

I worked in the Treasury for a quarter of a century. I learned that there are always lots of ideas about how to spend more taxpayers' money and very few about how to raise more revenue. This report is a notable exception. It realises that there is no magic money tree that will provide the £1.77 billion that would be needed to treat all the young people who need help with their mental health. And with Brexit looming, the prospect of finding an extra 23,800 staff is just fanciful. The answer is the obvious one: prevention, not cure, should be the primary policy goal. This applies not just to mental health services but to physical health and a whole range of public spending.

So why has the allocation of spending gone so wrong? First, voters can see new hospitals, patients are aware of the drugs they take, and they experience real problems when waiting lists are too long. There are also powerful vested interests who do well out of spending money curing people. Public Accounts Committees spend their time criticising spending decisions that don't produce as much as promised but rarely look at the mix between prevention and cure.

Now imagine a world where we re-prioritise spending and allocate more to prevention. This investment will pay off handsomely, as this report demonstrates. But in the short run, progress on curing people will slow down. Vested interests will make a lot of noise as will short-sighted politicians. So how do we make the re-prioritisation politically and publicly acceptable?

First, you have to demonstrate the evidence in a persuasive way that this will lead to better outcomes. This is no simple task. In the Treasury we were inundated with 'spend to save' suggestions that frequently ended up with more spending and little saving. So it is vital to be able to track the impact of the extra spending on improved outcomes and lower future spending. As the report recommends, this will mean getting the Office for National Statistics to think hard about how to classify spending between prevention and cure. The Office for Budget Responsibility could also help by using this approach when preparing its analysis of long-term fiscal trends.

The 2019 Spending Review presents a perfect opportunity to implement these ideas. The Government desperately needs to show that it has the capacity to think about something other than Brexit. This would be a radical and very welcome approach to making 'Global Britain' a better place in the long-term.

Such a spending review could embrace an approach to use spending to improve the quality of life, or well-being, of all of us. In health this would mean re-allocating money from physical to mental health but, more generally, it would mean spending more on prevention and, in time, less on cure. It would mean spending more on helping children and young people to develop resilience. We need less emphasis on exam results as the evidence is clear that they actually matter less for their future well-being and earnings. This of course needs to be backed by hard evidence, so we

should start systematically measuring the well-being of our children and young people.

None of this is easy. It means getting departments to work across boundaries and it needs different layers of government to work collaboratively not competitively. This will be best achieved by having clear outcomes and budgets that span these different groups. I tried to implement these kinds of approaches when I was in the civil service but with very limited success. This report could be a path breaker demonstrating how such an approach could work in the vital area of mental health. It is time for change and I hope the Government will embrace this challenge.

Gus O'Donnell

Former Cabinet Secretary and Head of the Civil Service, 2005–2011

JACQUI DYER

It has been a delight to be part of this Commission and to say a few words of welcome to our report. The commitment, diversity, and focus of the commission members has resulted in a robust report that is timely and profound. We are in the midst of a Mental Health Act Review, a Children and Young People's Mental Health Green Paper, and an Integrated Communities Strategy consultation. This illustrates a governmental and societal awareness that the mental challenges of our time must be attended to with gusto and commitment.

We can no longer turn a blind eye to the early needs of our population if we really want each and every one of us to be resilient both mentally and emotionally. A flourishing and safe society depends on our leadership to make this happen. Without this attention, particularly for communities who experience multiple disadvantages and multiple discrimination, the issue is urgent. Inter-generationally so many of our population are suffering in silence with the only access to support barely taking place at crisis point. This is a totally unsustainable and negligent approach.

We must not waver in our duty to deliver this report's recommendations as we seek to make the paradigm shift required away from increasing numbers of mental illness across all communities.

Jacqui Dyer

University of Birmingham Mental Health Policy Commission Member

PAUL FARMER

Over the last few years, we have seen an extraordinary shift in awareness and understanding around mental health. People with their own lived experience are more likely to be open about their mental health problems, the media see it as a major issue, and senior public figures – politicians, members of the Royal Family, and business leaders – are all recognising the importance of mental health to our society. Public attitudes have shifted for good.

But this new-found awareness of mental health exposes the absence of fundamental building blocks that we need to address a major health and social issue. The commitment to parity of esteem with physical health is important, but mental health is still in the foothills of achieving that parity.

Nowhere is this more apparent than in the field of prevention. Most school children today regularly receive messages about their sugar and calorie intake, the dangers of drugs and alcohol, and the importance of physical activity. But almost nothing about mental health. Local government spends only one per cent of its public health budget on mental health prevention – until very recently it was listed under 'miscellaneous' spend.

As a consequence, mental health services are overrun, and too many people lose their jobs, lose their potential or lose hope as a result of not being able to act, or receive the help and support they need. Yet we know that a collective effort – recognising the role of individuals, work, housing, addressing inequalities and safety – could make a significant difference.

As thoughts start to turn to a new settlement for the NHS, a new mental health plan to follow the *Five Year Forward View for Mental Health*, and the increasing clamour for progress, this Commission is extremely timely. It sets out a clear argument for investing in prevention in a systematic way. It argues that we should regard this investment in our society in the same way as we have seen investment in Crossrail or HS2 as a long-term investment.

Mental health is likely to be one of the major challenges facing 21st-century Britain – this Commission sets out a persuasive argument for early investment so that future generations are better prepared for life's challenges.

Paul Farmer

Chief Executive, MIND

Investing in a Resilient Generation: Making the Case

The Commission believes that closing the prevention gap should be made a fifth Grand Challenge by the Government. This would have the goal of halving the number of people living with life-long mental health problems within a generation.



Children and adults with high resilience resources are **half as likely** to have a diagnosable mental health condition¹



Mental ill-health costs the UK taxpayer an estimated **£70–£100 billion** per year (4.5 per cent of the UK's GDP)²



Half of all mental health problems manifest by the **age of 14**, with **75 per cent** by age 24^{3,4}

1 IN 10 children have a diagnosable mental health problem⁵



The frequency of mental health problems in children and young people is **increasing with the rate of self-harm** among young women **three times higher** than a generation ago⁶



10 YEARS

There is on average a **ten-year delay** between young people experiencing their first symptoms and receiving help⁷

7 pence in every **£** the NHS spends is on children's mental health and just over 1p of this is spent on early intervention⁸



3 IN 4 CHILDREN

with a diagnosable mental health condition **do not get** access to the **support** that they need⁹



There is good evidence for interventions, which need adopting and scaling-up



Scaling-up child and adolescent mental health services to ensure that every child receives timely support requires an extra **23,800 staff** at a cost of **£1.77 billion**¹⁰

Social exclusion and social disadvantage increase the risk of all types of mental health difficulties in children and young people, from depression to psychosis¹¹



Adverse childhood experience (particularly sexual and psychological abuse, and being exposed to domestic violence or bullying) substantially increases the risk of poor mental health¹²



EXECUTIVE SUMMARY AND CALL TO ACTION

Executive Summary

MOST ENDURING MENTAL HEALTH PROBLEMS SHOW THEIR FIRST SIGNS BEFORE THE AGE OF 25.

The root causes of mental health problems can often be traced to adversity in childhood or adolescence, but the effects can have a life-long impact on well-being and the ability to live a satisfying and productive life throughout adulthood.

The personal, social, and economic costs of poor mental health are huge, with the cost to the taxpayer alone being estimated at £70 billion to £100 billion per year (4.5 per cent of the UK's GDP)¹. The Commission sees a compelling case for investing in the positive mental health of young people in order to build a resilient generation for the future.

Today, access to appropriate support and treatment remains a lottery for young people – with long waiting lists and services that do not address the range of challenges that they are facing. Despite heroic efforts to scale-up services by 2021, at best only a third of young people in England facing mental health difficulties are likely to have access to the support and treatment they need.

A stock-take by Public Health England (PHE) found that most local areas had taken some action towards the prevention of mental health problems². However, despite a welcome emphasis on children and young people's mental health, the overall level of priority given to prevention 'varied significantly'.

Work by NHS Benchmarking for the Commission demonstrates that, without a concerted focus on prevention and early response, meeting demand for young people's mental health services by scaling-up existing provision would require an extra 23,800 staff at a cost of £1.77 billion – which is clearly unrealistic in terms of funding and recruitment. Closing the treatment gap by scaling-up access to treatment alone would be a mistake.

Instead, the Commission believes that it is time to change the paradigm and close the 'prevention gap' by tackling the causes of poor mental health at their root instead of years later in treatment. The Commission's case for change is simple: the nation's future prosperity requires a sustained investment in the nation's mental resilience, starting early and supporting families, schools, workplaces, and communities to be the best they can be at nurturing the next generation.

Pointing to the work of Derek Wanless for HM Treasury in 2004³, the *Five Year Forward View for Mental Health* argued for a 'radical upgrade in prevention and public health' to reduce the 'stock' of population health risks to stem the 'flow' of costly NHS treatments.

This report sets out the evidence base around the factors that can impact on young people's mental health. This can be summarised in terms of four key building blocks for building a resilient generation:

Resilient young people



Figure 1: Building a resilient generation: four building blocks

By systematically deploying evidence-informed practices and programmes that maximise resilience and minimise risk factors, it is within our grasp to halve the number of people living with life-long mental health problems in a generation.

What is required is transformational change that embeds prevention in all policies and practices that affect young people. From the evidence that the Commission received, this report sets out a number of promising approaches that have been identified, which address each of the key building blocks.

Building block	Local focus to build the resilience of young people
Positive family, peer, and community relationships	Enhanced perinatal support with a specific focus on the mental health of mothers and infants
	Parenting programmes , which include fathers, where possible, and have a whole-family focus
	Intensive support for families facing difficulties, building on the Family Recovery Project model with embedded mental health expertise
	Investing in the social infrastructure of communities with a stronger focus on the needs of young people
Minimise adverse experiences and exclusions	Ensure vulnerable families and young people have a secure base within the community in terms of income, housing, and access to health, education, and employment – using a combination of universal provision and targeted approaches such as Housing First
	Community and family-based approaches to reduce harm caused by identifiable Adverse Childhood Experiences , such as abuse, domestic violence, bullying, or victimisation
Mentally friendly education and employment	Whole-school Social and Emotional Learning programmes that are universal but can offer additional support for more vulnerable children
	Whole-school approaches for addressing harmful behaviour , particularly bullying, substance abuse, and reducing exclusions
	Supporting successful transitions in education (eg, primary/secondary school transition) and into employment
	Encouraging employers to support the mental well-being of their workforce and make public reporting on employee engagement and well-being a requirement
Responding early and responding well to first signs of distress	Accessible and friendly ‘one-stop-shop’ services for young people – eg, the Australian Headspace model or the Tavistock-AFC Thrive model here in the UK. The best services are those that are co-designed with young people and their families
	An inclusive approach that involves family and friends in developing understanding and support, and that addresses social, relationship, or identity issues that may underlie young people’s mental distress – eg, Open Dialogue

Table 1: Local action to build a resilient generation

Call to Action

1 Investing in whole-system change

No single action or single agency, in isolation, can ensure that the causes of poor mental health are minimised. What is required is a whole-system prioritisation of prevention and early action in childhood and adolescence. This means making mental health everyone's business – and broadening the focus beyond those who are involved in providing treatment and support.

The focus on whole-system change through joint-sectoral action promoted by PHE's Prevention Concordat⁴ sets the right direction. It is the Commission's view that without this whole-system approach, the prevention gap cannot be closed. However, what is required is a radical up-scaling of the Prevention Concordat's impact. This requires investment and leadership.

National and local government must work together to mobilise the public and private sectors, civil society, and academia to tackle the causes of poor mental health in young people. The Commission proposes that closing the prevention gap is made an Industrial Strategy Grand Challenge⁵ in recognition that mental illness is the single largest global burden of disease and adversely affects prosperity and productivity.

Investing in a Resilient Generation Grand Challenge bids would focus investment on evidence-informed whole-system initiatives that would act as test-beds for local innovation. Through these, we will be able to refine our understanding of what works best in delivering effective prevention and early response. These real-world experiments will seek to affect systemic change across a complex interlocking 'system of systems'.

Local consortia bidding for funding would have to demonstrate how they will work across these interlocking systems, better utilise existing resources and community assets, and generate relevant data to support rapid-cycle evaluation, learning, and accountability.

ACTIONS

- 1.1. PHE, as the Government's executive agency for the public's health, should work with local government and Innovate UK to shape a new Grand Challenge Fund: Investing in a Resilient Generation.
- 1.2. The Department for Education and the Department for Health and Social Care should work with the Department of Business, Energy, and Industrial Strategy as joint sponsors of the Investing in a Resilient Generation Grand Challenge programme to ensure continuity and sustainability.
- 1.3. PHE and the Office for National Statistics (ONS) should convene a taskforce to identify what data is currently available, and what data could be available, that could best evidence:
 - social determinants of mental health;
 - incidence and severity of adverse childhood experiences;
 - resilience and social connectedness;
 - family stress/family resilience;
 - well-being at school and at work; and
 - social infrastructure within communities.

2 Making early action the new business as usual

There needs to be strong leadership and governance to ensure that prevention is in all policies and that all policies are assessed for their impact on mental health. Leadership must come from both central and local government, but be firmly rooted in co-production principles and practice.

Nationally, the Cabinet Office should be charged by the Prime Minister to lead this work supported by PHE. With the authority of the Prime Minister, the Cabinet Office should lead on the strategy and programme management necessary to ensure that prevention and early action are prioritised across government.

The Government should use the 2019 Spending Review to address the institutional bias against early action, changing the default from spending on late action – on consequences – to spending on early action – on causes.

Local government has a critical role to play with its responsibility as the leader and shaper of place. With its public health duties and powers, local government can act as a convenor of leaders across the interlocking 'system of systems', leading by example.

The Prevention Concordat offers a range of tools to support and encourage local government and others to mainstream mental health promotion and illness prevention. It included updated economic modelling of the return on investing in a range of interventions⁶ for young people.

The Commission believes that these well-evidenced interventions should be commonplace and that they offer 'best buys' for closing the 'prevention gap'.

ACTIONS

- 2.1. Charge the Cabinet Office with responsibility for leadership and governance to ensure that prevention is in all policies by putting in place the strategy and programme management necessary to ensure that prevention and early action are prioritised across government. This requires both cross-government working and collaboration with local government.
- 2.2. As part of the process of equality impact analysis for new government policy, the potential direct and indirect impact on mental health should be considered explicitly – including social and economic factors that have been demonstrated to have a major impact on mental health outcomes.
- 2.3. Based on the evidence gathered by the Commission and the economic modelling by the London School of Economics and Political Science (LSE)⁷ for PHE's Prevention Concordat, the following interventions offer the immediate 'best buys' with long-term impact for children, young people, and families, and should be the norm in every locality:

Intervention	Payback
Provide and increase access to debt and welfare services	Five years
Parenting programmes addressing conduct disorder, especially those that include fathers and that have a whole-family focus ⁸	Six years
Enhanced perinatal support with a specific focus on the mental health of mothers and infants ⁹	
Whole-school Social and Emotional Learning programmes that are universal but can offer additional support for more vulnerable children ¹⁰	Three years
Whole-school approach to addressing harmful behaviour such as bullying ^{11, 12}	Four years
Encourage employers to provide well-being programmes in the workplace	One year
Encourage employers to deliver stress prevention in the workplace	Two years
Population-level suicide awareness training and intervention	Ten years

Table 2: Evidence for savings from investing in preventative interventions

- 2.4. Health Education England should be charged with developing a workforce strategy to support the shift in organisational culture and professional practice necessary to ensure prevention and early action are mainstreamed.
- 2.5. The Financial Conduct Authority (FCA) should be asked to consider the business and societal benefits of 'human capital' reporting and should consult on making public reporting on employee engagement and well-being a requirement.

3 Changing the rules of the game: funding early action

The Commission believes that the 2019 Spending Review should allocate resources to front-end loading investment in a radical up-scaling of the Prevention Concordat and an Investing in a Resilient Generation Grand Challenge. A longer time-frame of ten years would further widen the scope for adopting programmes with long-term payback periods.

At the same time, the Office for Budget Responsibility (OBR) should be charged with the task of reporting on the long-term sustainability of spending on the consequences, rather than the causes, of poor mental health. This will in turn enable further changes to public accounting rules to be made, allowing long-term payback to be recognised by spending on prevention.

Furthermore, HM Treasury should commission the ONS to start the process of classifying spending on early action, starting with the Department of Health and Social Care, Department for Education, Department of Housing, Communities, and Local Government, the Ministry of Justice, and the Home Office.

A Spending Review is also the moment to set clear accountability in government for driving early action. While the Cabinet Office should lead on the Investing in a Resilient Generation Grand Challenge, the Commission believes that HM Treasury is best-placed to take on the overall task of re-setting the public finance rules to promote early action and prevention.

ACTIONS

- 3.1. During the 2019 Spending Review, at the start of the spending review period, re-allocate a share of anticipated increased spending on 'late action' by the end of the spending review period on funding the 'best buys' for early action and prevention recommended by the Commission and launching the Investing in a Resilient Generation Grand Challenge Fund.
- 3.2. Make HM Treasury responsible for holding all spending departments to account for spending on early action – the causes – and late action – the consequences – including ensuring that the rewards of spending on early action are fairly shared between the investing and the benefiting agencies or departments.
- 3.3. Task the ONS with classifying spending on early action. Part of this work would include developing and consistently applying definitions and measures of early action and social infrastructure.
- 3.4. Widen the remit of the OBR to report, as part of its annual Fiscal Sustainability Report, on the sustainability of spending and acting too late.

4 Getting started on the ground

The Commission believes that every locality should put in place a comprehensive approach to enhance the resilience and mental health of young people. The four building blocks and the most promising approaches identified by the Commission, along with the national 'best buys', form a strong basis for local action in every corner of the nation.

ACTIONS

- 4.1. Local leadership is needed and local authority Public Health leads should initiate collaborative conversations with other agencies, schools, and community groups about how they are going to work together to build a resilient generation in their area.
- 4.2. Identify 'quick wins' that can capitalise on local resources and enthusiasm – and that can deliver immediate benefits (such as whole-school approaches to social and emotional learning) as well as improve long-term mental health outcomes. These would lay a foundation for a broader strategy for local innovation across sectors, and provide the basis for a successful Investing in a Resilient Generation Grand Challenge bid.

5 Research, monitoring, and evaluation: learning from 'what works'

The Commission believes that, to make the best use of taxpayer funding, we must evaluate the whole-system impact of innovation in each of the Investing in a Resilient Generation Grand Challenge sites. With Innovate UK and the Research Councils coming together under the umbrella of UK Research and Innovation, there is an opportunity to pool funding to support an integrated programme of research and innovation.

A combination of different research approaches is needed to help demonstrate proof of concept and proof of scalability. Evaluating a Grand Challenge innovation requires a framework for examining:

- (a) the mechanisms involved in delivering whole-system community-based interventions ('how is it working?'); and
- (b) whether it is achieving the desired short-term and long-term outcomes.

ACTIONS

- 5.1. Embed a rapid evaluation framework in all successful Investing in a Resilient Generation Grand Challenge sites to provide feedback on what is and is not working effectively, and in what contexts.
- 5.2. As part of the Investing in a Resilient Generation Grand Challenge, commission a 'big data' research project to:
 - learn more about how service and community systems interact and how to improve them to benefit people at risk of mental health problems;
 - provide a population-level snapshot of resilience indicators and progress towards building a resilient generation; and
 - identify areas for change to improve quality and impact.

Conclusions

CLOSING THE TREATMENT GAP IS AN IMPOSSIBLE DREAM IF WE FAIL TO STEM THE TIDE OF PEOPLE LIVING WITH MENTAL ILL-HEALTH.

While there remains an urgent need to significantly improve access to support and treatment, this alone is not sufficient. We must look 'upstream' and shift the focus towards maximising young people's resilience and minimising the risks to their mental health. It is by closing the prevention gap that we can close the treatment gap too.

As this report demonstrates, there is sufficient evidence to act now to begin the systematic shift of paradigm envisaged by the Commission¹³. The Investing in a Resilient Generation Grand Challenge would be designed to facilitate this whole system working, better utilising existing resources and potentials at a local level, building

the local infrastructure, and integrating action and learning across local government, education, business, community and voluntary organisations, and academia.

Such a decisive step would position the UK as a global leader in addressing the single largest global health challenge. To delay is to countenance avoidable harm. The costs of failing to marshal the necessary resources and implement large-scale programmes are huge.

The time for small-scale pilots is over. It is time to change the paradigm and close the prevention gap.

Give the young people of today the potential to be the adults of tomorrow.



The Commission's Case for Change

Ten years ago, the Government Office for Science concluded that if we are to thrive in a rapidly changing world, our mental capital and mental well-being are of critical importance to our future prosperity and well-being as a nation¹⁴.



An individual's mental capital and mental well-being crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behaviour, social cohesion, social inclusion, and our prosperity¹⁵.

Poor mental health has an impact on individuals and their families and can reduce people's quality of life and life chances. The financial picture is also stark. Mental ill-health costs the UK taxpayer an estimated £70 billion to £100 billion per year (4.5 per cent of the UK's GDP)¹⁶, and as many as 70 million sick days per year are taken by employees as a direct result of poor mental health, meaning that poor mental health is the primary reason for absence in the workplace^{17, 18, 19}.

The impact of poor mental health raises questions about what can be done to reduce its incidence, strengthen people's capacity to manage their mental health, and intervene early to prevent mental health problems becoming entrenched. While there is a clear case for sustained investment in mental health treatment services, the Commission believes this is not sufficient. What is also required is action to improve the population's mental health and reduce poor mental health.

ONE IN TEN CHILDREN HAVE A MENTAL HEALTH DISORDER, INCLUDING ANXIETY AND DEPRESSION.



Common mental health problems often begin in childhood: one in ten children have a mental health disorder²⁰, including anxiety and depression. Mental health problems in children and young people can be life-long. Half of life-long poor mental health starts before the age of 14 and three quarters by the age of 24^{21, 22}. The frequency of mental health problems in children and young people is increasing²³ and differences in mental well-being between population groups can be seen at an early age²⁴. For example, more young women than ever are now presenting with anxiety or depression symptoms and rates of self-harm in women are the highest since records began.

WE MAY WELL BE STORING UP PROBLEMS FOR THE FUTURE.

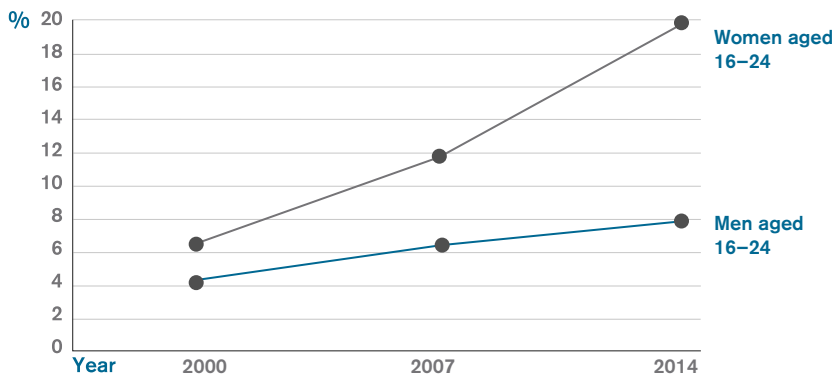


Figure 2: Rates of reporting of self-harm in young people²⁵

To neglect mental illness in young people is not only morally unacceptable, but also an enormous economic mistake²⁶.

In turn, poor mental health can reduce life chances and compound social inequalities, contributing to low income, unemployment, social isolation, and increased likelihood of relationship difficulties and breakdown²⁷.

There is already strong evidence that preventative interventions achieve substantial financial savings in the long-term – and there is strong evidence that 'good mental health in the first few years of life is associated with better long-term mental, physical, and social outcomes'²⁸. Economic modelling can help to quantify the financial case for targeted preventative interventions to give children and young people the best start in life.

Target	Intervention
Families	Debt and welfare services – every £1 invested results in an estimated saving to society of £2.60 (over five years)
Mothers	£400 investment per birth in universal and specialist provision for perinatal mental health problems would lead to savings to society in the region of £10,000 per birth, including £2,100 to the public sector
Children	Whole-school anti-bullying programmes – every £1 invested results in an estimated saving to society of £1.58 (over four years)
Children	Social and emotional learning – every £1 invested results in an estimated saving to society of £5.08 (over three years)
Children	Parenting programmes addressing conduct disorder – every £1 invested results in an estimated saving to society of £7.89 (over six years)
Young people and adults	Well-being programmes in the workplace – every £1 invested results in an estimated saving to society of £2.37 (over one year)
Young people and adults	Stress prevention in the workplace – every £1 invested results in an estimated saving to society of £2.00 (over two years)
Young people and adults	Suicide prevention – every £1 invested results in an estimated saving to society of £2.93 (over ten years)

Table 3: Examples of the economic case for investing in evidence-based preventative interventions^{29, 30, 31, 32}

WHILE ONE IN TEN CHILDREN EXPERIENCE POOR MENTAL HEALTH, ONLY ONE IN FOUR OF THESE HAVE ACCESS TO MENTAL HEALTH SERVICES³³.



One approach to improve young people’s mental health is to increase access to treatment and the range of support available. Indeed, the *Five Year Forward View for Mental Health* proposes to increase access to Child and Adolescent Mental Health Services (CAMHS) to 35 per cent of young people with an identifiable need by 2020–2021³⁴. However, this leaves 65 per cent of children and young people without access to the support they need to improve their mental health and future prospects.

CAMHS WORKFORCE PROFILING – FUTURE PROJECTIONS				ADDITIONAL STAFF NEEDED			
Number of CYP accessing community CAMHS each year (caseload)	Equal to	Equivalent % of total in need (approximate)	Additional WTE staff required	Consultant Psychiatrists	Registered Nurses	Clinical Psychologists, Psychotherapists, Allied Health Professionals, and Mental Health Practitioners	All other disciplines
170,500	Existing levels	25%	N/A	N/A	N/A	N/A	N/A
240,500	Additional 70,000	35%	3,251	232	964	1,417	638
341,000	Additional 170,500	50%	7,919	581	2,411	3,542	1,385
545,600	Additional 375,100	80%	17,421	1,277	5,301	7,793	3,050
682,000	Additional 511,500	100%	23,756	1,742	7,232	10,627	4,155


Table 4: Future projections for the CAMHS workforce to respond to the needs of children and young people³⁵



The Commission has concluded that simply investing in ‘more of the same’ would neither be feasible (in terms of funding or workforce capacity) nor sufficient to address the potential scale of need. What is required is a twin-track approach with increased investment in support and treatment alongside a concerted drive on prevention. It is also evident that, on average, less than half of young people referred to CAMHS were subsequently accepted for treatment³⁶. Poor mental health is also associated with an increased risk of young people dropping out of education, which will adversely affect their employment prospects and earning potential³⁷. This picture of late and insufficient support for young people’s mental health supports the Commission’s call for a radical re-think of the paradigm of waiting for symptoms to appear before the impact of poor mental health of children and young people is recognised.

Effective prevention can be achieved through a combination of targeted new investment and whole-system re-modelling of existing provision for young people to foster resilience and minimise the incidence and long-term impact of adverse childhood experiences, such as sexual abuse or domestic violence. This requires both national and local government leadership to work together with the education sector, health services, employers, and the community and voluntary sector to re-orient what they are already doing to provide a more coherent focus on young people’s mental health.

The Commission believes that the current evidence offers a compelling case for a new paradigm that seeks to close the ‘treatment gap’ by closing the ‘prevention gap’. This is the focus of this report and the Commission’s Call to Action.



Concerned about this ‘treatment gap’, the Commission asked the NHS Benchmarking Network to draw on their data to profile the workforce implications of scaling-up access to treatment for young people. They estimated that ensuring all young people receive support from specialist mental health services would require approximately 23,800 additional staff at an estimated cost of £1.77 billion³⁸.

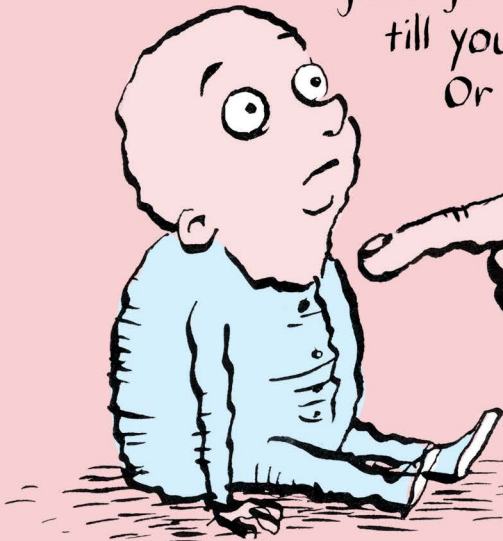
REFERENCES

1. Hughes, K., Ford, K., Davies, A., Homolova, L., and Bellis, M., 2018. *Sources of resilience and their moderating relationships with harms from adverse childhood experiences: Welsh Adverse Childhood Experience (ACE) and Resilience Study – Report 1: Mental Illness*. Public Health Wales NHS Trust. Available at: [http://www.wales.nhs.uk/sitesplus/documents/888/ACE%20&%20Resilience%20Report%20\(Eng_final2\).pdf](http://www.wales.nhs.uk/sitesplus/documents/888/ACE%20&%20Resilience%20Report%20(Eng_final2).pdf) [Accessed 20 April 2018].
2. Davies, S.C., 2014. *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence*. London: Department of Health. Available at: <https://www.gov.uk/government/publications/chief-medical-officer-cmo-annual-report-public-mental-health> [Accessed 23 January 2017].
3. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., and Walters, E.E., 2005. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), pp.593-602.
4. Kessler, R.C., Amminger, G.P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., and Ustun, T.B., 2007. Age of onset of mental disorders: a review of recent literature. *Current Opinion in Psychiatry*, 20(4), p.359-364
5. The Mental Health Taskforce, 2016. *The Five Year Forward View for Mental Health*. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> [Accessed 20 January 2017].
6. McManus, S., Bebbington, P., Jenkins, R., and Brugha, T. (eds.), 2016. *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. Available at: <https://digital.nhs.uk/catalogue/PUB21748> [Accessed 2 March 2018].
7. Kessler, R.C., Amminger, G.P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., and Ustun, T.B., 2007, *op. cit.*
8. Frith, E., 2016. *CentreForum Commission on Children and Young People's Mental Health: State of the Nation*. London: CentreForum. Available at: <https://centreforum.org/live/wp-content/uploads/2016/04/State-of-the-Nation-report-web.pdf> [Accessed 20 May 2018].
9. NHS Benchmarking Network, 2018. *Addressing the CAMHS Treatment Gap: Report for the University of Birmingham Commission*. Unpublished report.
10. *Ibid.*
11. O'Donoghue, B., Roche, E., and Lane, A., 2016. Neighbourhood level social deprivation and the risk of psychotic disorders: a systematic review. *Social Psychiatry and Psychiatric Epidemiology*, 51(7), pp.941-950.
12. Hughes, K., Ford, K., Davies, A., Homolova, L., and Bellis, M., 2018, *op. cit.*
13. Davies, S.C., 2014, *op. cit.*
14. Kings Fund and Public Health England, 2017. *Stocktake of local strategic planning arrangements for the prevention of mental health problems, Summary report*. London: Public Health England.
15. Wanless, D. 2004. *Securing good health for the whole population: Final report*. London: HM Treasury.
16. Public Health England, 2017. *Prevention concordat for better mental health*. London: Public Health England.
17. HM Government, 2017. *Industrial Strategy: Building a Britain fit for the future*. Cm 9528. London: HM Government. Available at: <https://www.gov.uk/government/publications/industrial-strategy-building-a-britain-fit-for-the-future> [Accessed 5 March 2018].
18. McDaid, D., Park, A.L., Knapp, M., Wilson, E., Rosen, B., and Beecham, J., 2017. *Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health*. London: Public Health England. Available at: <http://www.lse.ac.uk/business-and-consultancy/consulting/assets/documents/commissioning-cost-effective-services-for-promotion-of-mental-health-and-wellbeing-and-prevention-of-mental-ill-health.pdf> [Accessed 1 September 2017].
19. *Ibid.*
20. Knapp, M., McDaid, D., and Parsonage, M., 2011. *Mental Health Promotion and Prevention: The Economic Case*. London: Department of Health. Available at: <https://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/MHPP%20The%20Economic%20Case.pdf> [Accessed 29 May 2018].
21. Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., and Adelaja, B., 2014. *Costs of perinatal mental health problems*. London: Centre for Mental Health. Available at: <https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=07afd94b-92cb-4e47-8439-94cbf43548d8> [Accessed 14 January 2017].
22. *Ibid.*
23. McDaid, D., Park, A.L., Knapp, M., Wilson, E., Rosen, B., and Beecham, J., 2017, *op. cit.*
24. McDaid, D., Hopkin, G., Knapp, M., Brimblecombe, N., Evans-Lacko, S., and Gan, C., 2017. *The Economic Case for Prevention in Young People's Mental Health: Bullying*. London: MQ. Available at: <https://s3.eu-central-1.amazonaws.com/www.joinmq.org/The+Economic+Case+for+Prevention+in+Young+People's+Mental+Health+-+Bullying.pdf> [Accessed 30 May 2018].

25. Nurse, J., Dorey, S., Yao, L., Sigfrid, L., Yfantopolous, P., McDaid, D., Yfantopolous, J., and Moreno, J.M., 2014. *The case for investing in public health: a public health summary report for EPHO 8*. Copenhagen: World Health Organization Regional Office for Europe. Available at: http://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf [Accessed 6 February 2017].
26. Foresight Mental Capital and Wellbeing Project, 2008. *Final Project report*. London: Government Office for Science. Available at: <https://www.gov.uk/government/collections/mental-capital-and-wellbeing> [Accessed 17 January 2017].
27. *Ibid.*, p.10.
28. Davies, S.C., 2014, *op. cit.*
29. McManus, S., Bebbington, P., Jenkins, R., and Brugha, T. (eds.), 2016, *op. cit.*
30. Deloitte Centre for Health Solutions, 2017. *At a tipping point? Workplace mental health and wellbeing*. Available at: <https://www2.deloitte.com/content/dam/Deloitte/uk/Documents/public-sector/deloitte-uk-workplace-mental-health-n-wellbeing.pdf> [Accessed 29 May 2018].
31. Stevenson, D. and Farmer, P., 2017. *Thriving at Work: the Stevenson/Farmer review of mental health and employers*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/658145/thriving-at-work-stevenson-farmer-review.pdf [Accessed 21 January 2018].
32. The Mental Health Taskforce, 2016, *op. cit.*
33. Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., and Walters, E.E., 2005, *op. cit.*
34. Kessler, R.C., Amminger, G.P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., and Ustun, T.B., 2007, *op. cit.*
35. Davies, S.C., 2014, *op. cit.*
36. McManus, S., Bebbington, P., Jenkins, R., and Brugha, T. (eds.), 2016, *op. cit.*
37. *Ibid.*
38. Knapp, M., Ardino, V., Brimblecombe, N., Evans-Lacko, S., Lemmi, V., King, D., Snell, T., Murguia, S., Mbeah-Bankas, H., Crane, S., Harris, A., Fowler, D., Hodgekins, J., and Wilson, J., 2016. *Youth mental health: new economic evidence*. London: Personal Social Services Research Unit. Available at: www.pssru.ac.uk/publication-details.php?id=5160 [Accessed 3 March 2017].
39. Friedli, L., 2009. *Mental health, resilience and inequalities*. Geneva: World Health Organization. Available at: http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf [Accessed 29 May 2018].
40. McDaid, D., Hewlett, E., and Park, A.L., 2017. Understanding effective approaches to promoting mental health and preventing mental illness. *OECD Health Working Papers*, No. 97. Paris: OECD Publishing. Available at: <http://www.oecd.org/health/health-working-papers.htm> [Accessed 9 April 2018].
41. Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., and Adelaja, B., 2014, *op. cit.*
42. McDaid, D., Park, A.L., Knapp, M., Wilson, E., Rosen, B., and Beecham, J., 2017, *op. cit.*
43. McDaid, D., Hopkin, G., Knapp, M., Brimblecombe, N., Evans-Lacko, S., and Gan, C., 2017, *op. cit.*
44. Knapp, M., McDaid, D., and Parsonage, M., 2011, *op. cit.*
45. Green, H., McGinnity, Á., Meltzer, H., Ford, T., and Goodman, R., 2005. *Mental Health of Children and Young People in Great Britain: 2004*. Basingstoke: Palgrave Macmillan. Available at: <https://files.digital.nhs.uk/publicationimport/pub06xxx/pub06116/ment-heal-child-young-peop-gb-2004-rep1.pdf> [Accessed 27 October 2017].
46. The Mental Health Taskforce, 2016, *op. cit.*
47. *Ibid.*
48. *Ibid.*
49. Hjorth, C.F., Bilgrav, L., Frandsen, L.S., Overgaard, C., Torp-Pedersen, C., Nielsen, B., and Bøggild, H., 2016. Mental health and school dropout across educational levels and genders: a 4.8-year follow-up study. *BMC Public Health*, 16(1): 976.
50. NHS Benchmarking Network, 2018, *op. cit.*

HISTORIC CLAIMS

YOU are going to make a lot of bad choices in your life – choosing the wrong parents, the wrong socio-economic group, and the wrong social welfare home, where you are going to get yourself abused. After that you are just going to carry on making bad choices till you end up in prison. Or a psych ward.



When are you going to take some responsibility for yourself?

MURDOCH 14/02/15

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NO SINGLE ACTION OR SINGLE AGENCY, IN ISOLATION, CAN ENSURE THAT THE CAUSES OF POOR MENTAL HEALTH ARE MINIMISED.

WHAT IS REQUIRED IS A WHOLE-SYSTEM PRIORITISATION OF PREVENTION AND EARLY ACTION IN CHILDHOOD AND ADOLESCENCE. THIS MEANS MAKING MENTAL HEALTH EVERYONE'S BUSINESS – AND BROADENING THE FOCUS BEYOND THOSE WHO ARE INVOLVED IN PROVIDING TREATMENT AND SUPPORT.

Closing the mental health treatment gap is an impossible dream if we fail to stem the tide of people living with mental ill-health. While there remains an urgent need to significantly improve access to support and treatment, this alone is not sufficient. We must look 'upstream' and shift the focus towards maximising young people's resilience and minimising the risks to their mental health. It is by closing the prevention gap that we can close the treatment gap too.

As this report demonstrates, there is sufficient evidence to act now to begin the systematic shift of paradigm envisaged by the Commission.

Such a decisive step would position the UK as a global leader in addressing the single largest global health challenge. To delay is to countenance avoidable harm. The costs of failing to marshal the necessary resources and implement large-scale programmes are huge. The time for small-scale pilots is over. It is time to change the paradigm and close the prevention gap.